KAISER PERMANENTE®

PHASE

PREVENTING HEART ATTACKS & STROKES EVERY DAY

Quarterly Data Report: Q4 2017

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 and how that relates to the initiative overall, helps 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 /// February 2018

Questions about clinical data definitions?
Please contact Carly Levitz
levitz.c@ghc.org

Questions about the PHASE evaluation?
Please contact Jennie Schoeppe
schoeppe.j@ghc.org

KAISER PERMANENTE®
PHASE
PREVENTING HEART ATTACKS & STROKES EVERY DAY

Reach of the PHASE initiative in Q4 2017

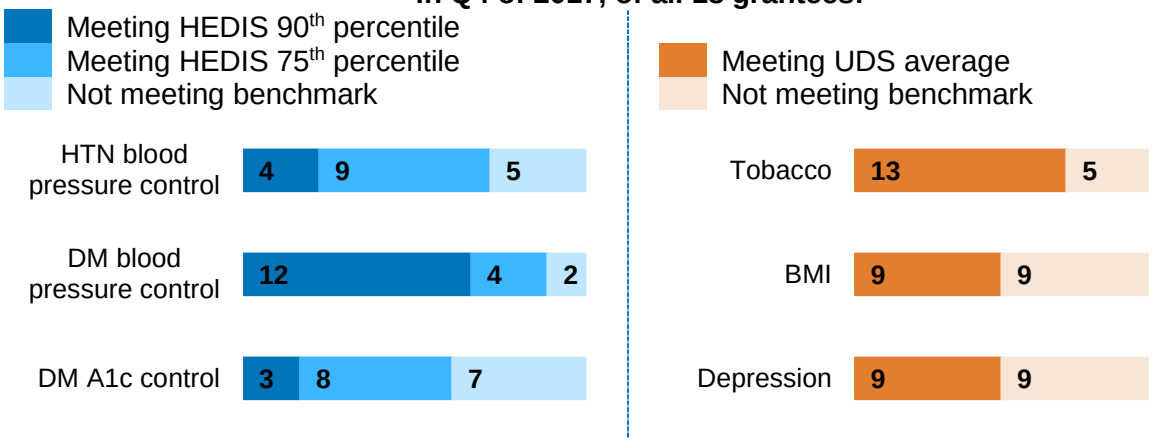
- HTN patients: 123,000
- DM patients: 88,100
- ASCVD patients: 20,800
- Total patients: 179,800
- Hospital sites and HCs: 69

Key Outcomes

77.1% of patients with diabetes (DM) are on a statin

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

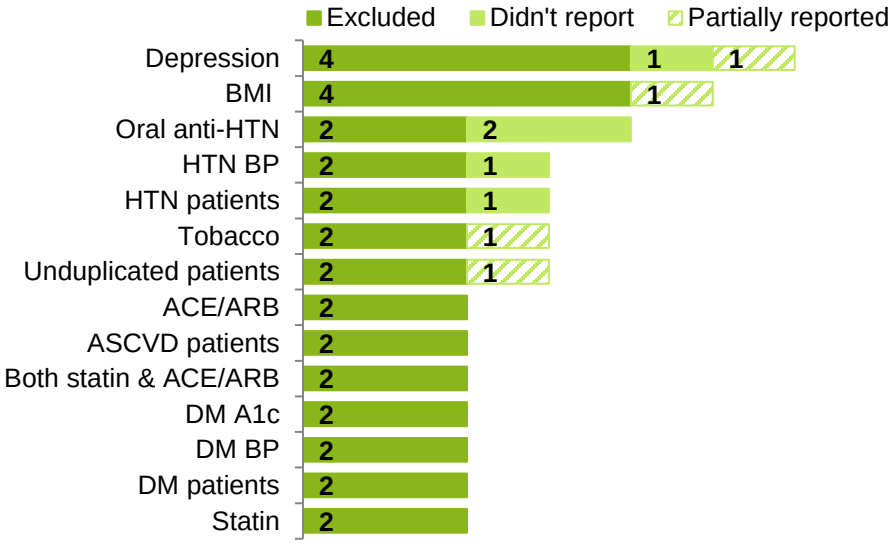
In Q4 of 2017, of all 18 grantees:



If a grantee did not report or have a reliable value for the measure, they are considered "not meeting benchmark."

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, 2 grantees' 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.



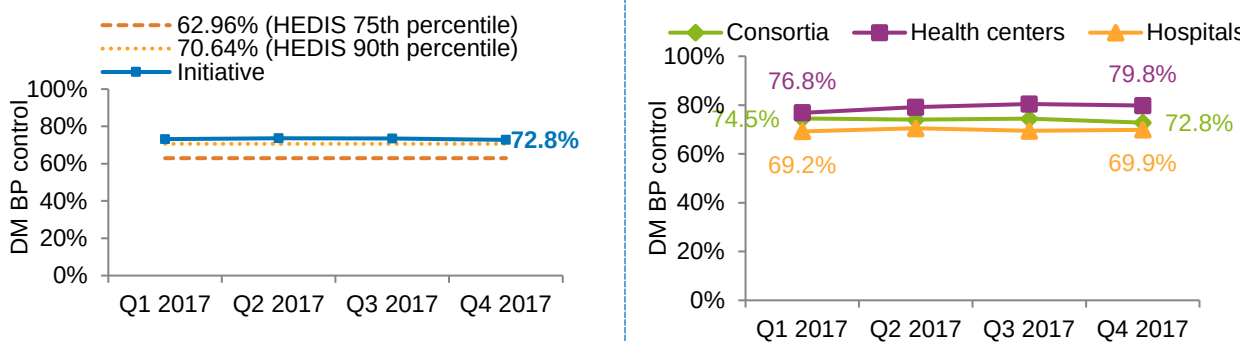
Intiative results – clinical data outcomes

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

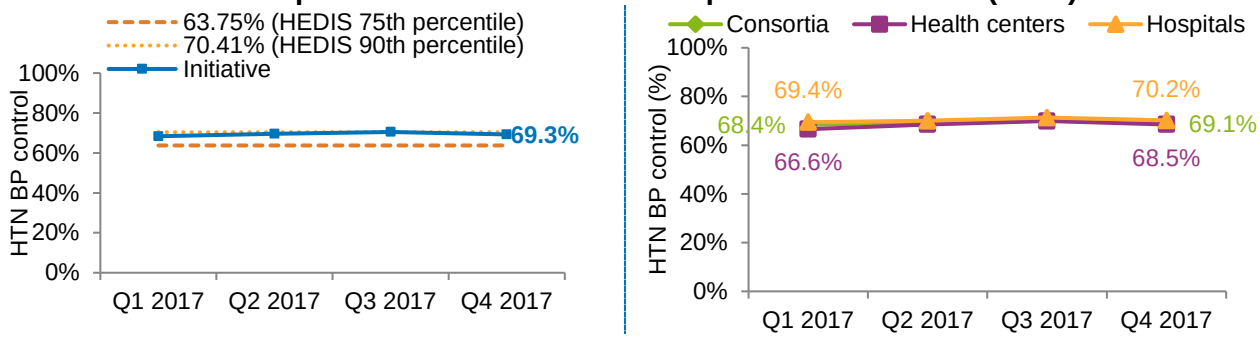
The initiative has attained **72.8% of patients with diabetes who have their blood pressure in control**. At the start of the initiative, the average was above 70.64% (the HEDIS 90th percentile) and has remained steadily above it. The health center grantees have the highest percent of patients with diabetes with their blood pressure controlled (an absolute 10% above the public hospitals), though the averages for each type of grantee are still all above HEDIS 75th percentile.

% of patients with diabetes with blood pressure controlled by grantee type (N=16)



Across the initiative, there is an average of **69.3% of patients with hypertension with their blood pressure in control**. The initiative average has remained above the HEDIS 75th percentile for blood pressure control for those with hypertension, and is nearing the 90th percentile (70.41%). There is less variation across grantee types in this measure than in the blood pressure control for those with diabetes.

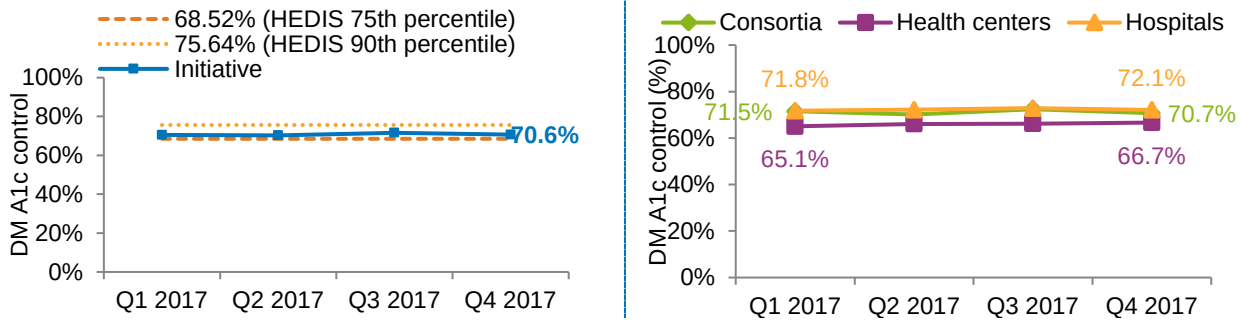
Percent of patients with HTN with blood pressure controlled (N=15)



Of patients with diabetes, 70.6% have their A1c controlled. This is just above the HEDIS 75th percentile for control of A1c, which is 68.52%. There is some variation across grantee types, with health centers around an absolute 4% lower than the other grantee types. On

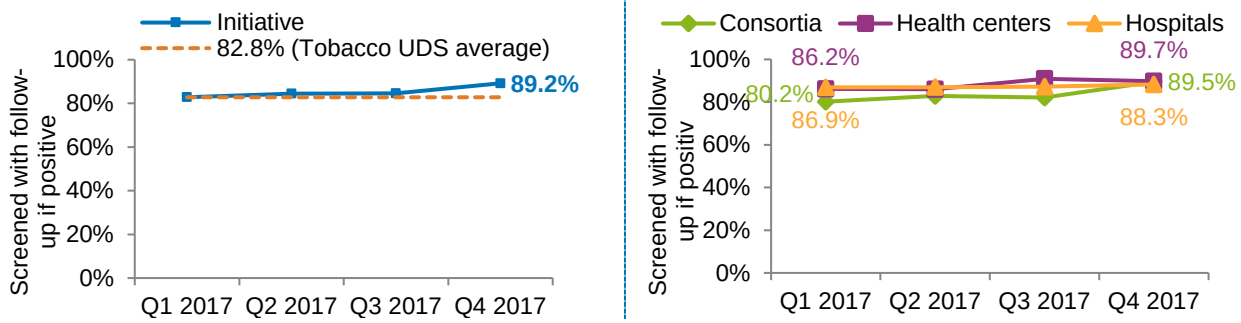
average, the health center grantees are not yet meeting the HEDIS 75th percentile, though they are close to it (within 2 percentage points).

Percent of patients with diabetes with A1c controlled (N=16)



Tobacco use is a significant risk factor for cardiac events. **The grantees perform well on the measure for tobacco screening and follow-up, reaching 89.2%**, which surpasses the UDS average of 82.8%. All grantee types are meeting the benchmark of the UDS average, and the difference between grantee types is very small (less than 1 absolute percentage point).

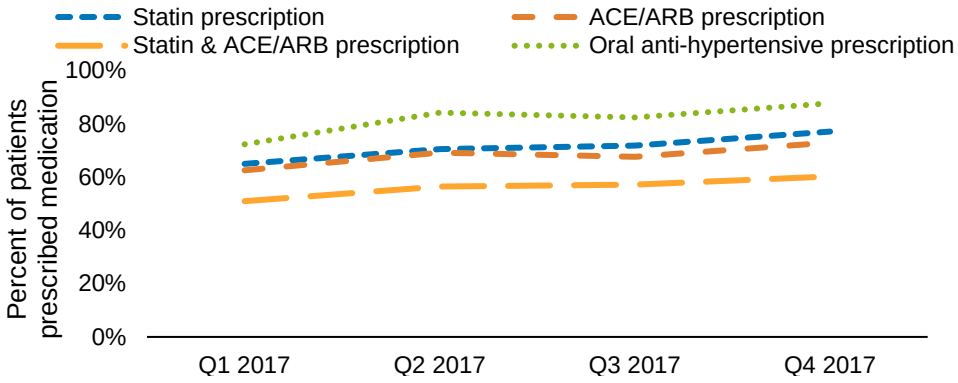
Percent of patients screened for tobacco use and received follow-up if screened positive for smoking (N=16)



Additional outcomes

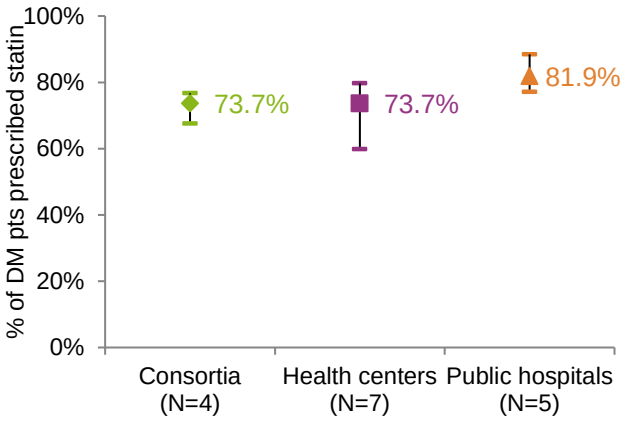
In addition to the outcomes that were identified in the initiative-wide goal, the evaluation is also tracking process measures that relate to reducing risk of CVD and managing chronic conditions. A key contribution of Kaiser Permanente to the safety net is PHASE-on-a-page—a medication algorithm that, 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 88% of the hypertensive patient population has been prescribed an oral anti-hypertensive. Of the diabetic patient population, just over 60% have been prescribed a statin and an ACE or ARB.

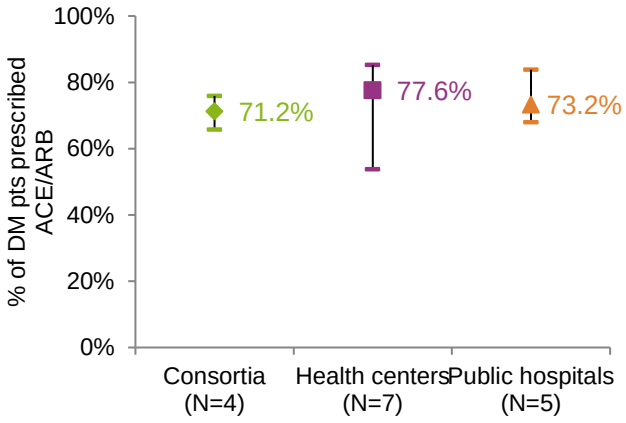


There is a wide range of prescription rates for each of the key cardio-protective medications across grantees, though the ranges have decreased over time. For two measures, the public hospitals have higher rates than other grantee types, and the health centers lead the other two measures. As noted on page 1, two grantees are not yet able to report on oral anti-hypertensive prescription rates.

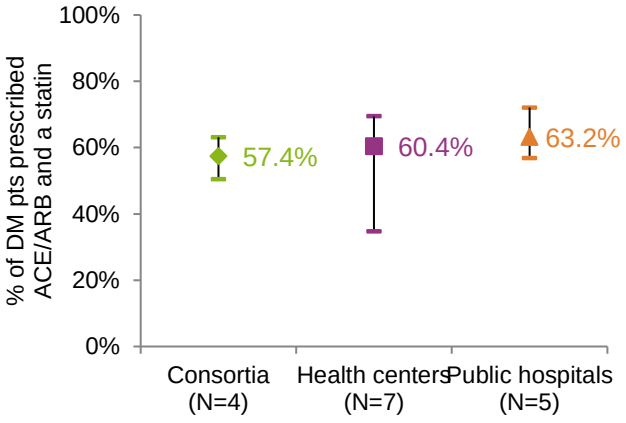
Statin prescription rate in Q4 2017 for patients with DM (N=16)



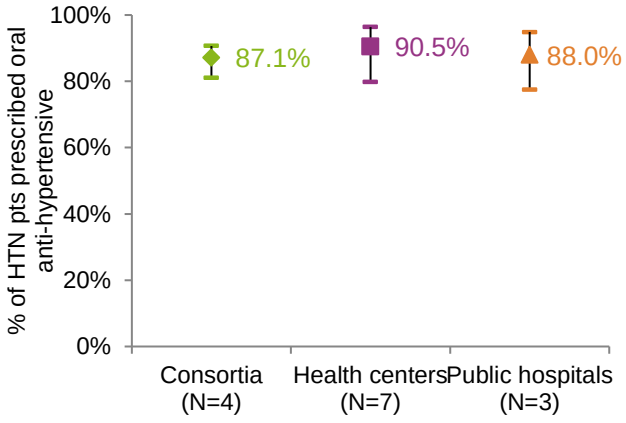
ACE/ARB prescription rate in Q4 2017 for patients with DM (N=16)



Statin and ACE/ARB prescription rate in Q4 2017 for patients with DM (N=16)

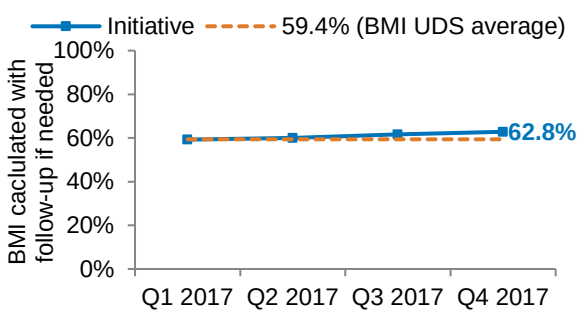


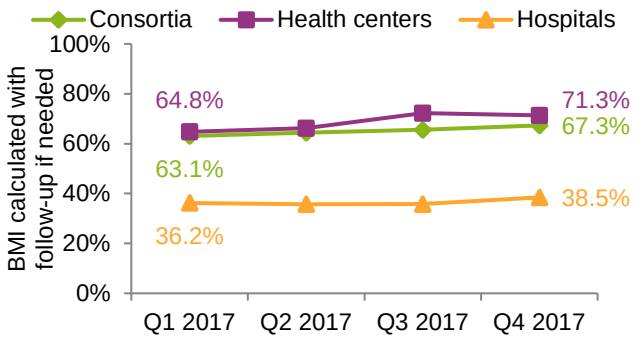
Oral anti-hypertensive prescription rate in Q4 2017 for patients with HTN (N=14)



Initiative-wide **62.8% of patients receive BMI screening and follow-up if needed.** The initiative has surpassed the UDS average of 59.4% in Q4 of 2017. All grantee types have increased their rates slightly from the start of the grant. There is still a large difference between the hospital grantees and the other grantees. In the first Data Community of Practice, the hospital grantee representatives suggested that it is because BMI tracking has not been a priority, particularly because it's not a required measure under PRIME.

Percent of patients with BMI calculated and with follow-up if BMI is outside the healthy range (N=14)





Grantee performance on **depression screening with follow-up if positive is at 55.7% of patients**. The average has continued to increase over time, remaining above the threshold of the UDS average (50.6%). 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. Consortia grantees have made the most progress (an absolute 8% increase), and the hospital grantees have increased by about 4%.

Percent of patients screened for depression with follow-up if they are positive for depression (N=14)