KAISER PERMANENTE®

PHASE

PREVENTING HEART ATTACKS & STROKES EVERY DAY

Engaging Patients as Active Partners

PHASE Grantee Convening

June 11, 2019
Oakland, CA

KAISER PERMANENTE® *in the community*

CENTER FOR COMMUNITY HEALTH AND EVALUATION
www.cche.org

CCI
CENTER FOR CARE INNOVATIONS

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Participating Organizations

Consortia

Community Health Center Network (CHCN)
Community Health Partnership (CHP)
Redwood Community Health Coalition (RCHC)
San Francisco Community Clinic Consortium (SFCCC)

Public Hospital Systems

Alameda Health System (AHS)
San Francisco Health Network (SFHN)
San Joaquin General Hospital (SJGH)
San Mateo Medical Center (SMMC)
Santa Clara Valley Health & Hospital System (SCVHHS)
Los Angeles County Department of Health Services*

Health Centers

Camarena Health
Chapa-De Indian Health
Community Medical Centers
Elica Health Centers
Golden Valley Health Centers (GVHC)
Livingston Community Health
One Community Health
Sacramento Native American Health Center (SNAHC)
Valley Health Team (VHT)

*LADHS is participating in the Southern California cardiovascular risk reduction program, Transforming Cardiovascular Care in our Communities (TC3),

Your Nametag:
Your Guide to the Day

Table

This is your table number. You'll be seated with others from your organization or network for most of the day.

PHASE Champion
Center for Care Innovations

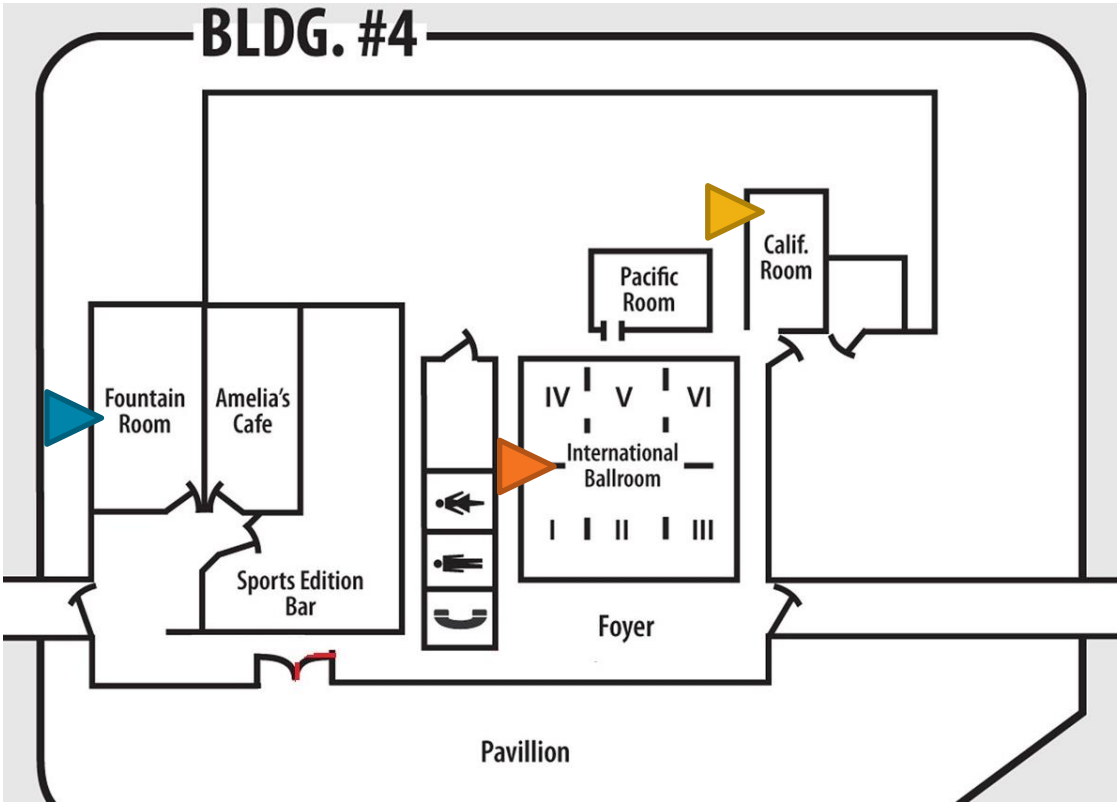
Table: #
WS: ABC

WS: Workshop Assignment

- A: Fountain Room - Engaging Patients in Self-Management
- B: California Room - Using Human Centered Design to Bring Patient Voice to Improvement Projects
- C: Main Ballroom - Change Ideas for Patient Engagement,

Venue Map

See above for the workshops room assignments.



Agenda

8:30 – 9:00	Breakfast & Registration
9:00 – 9:15	Welcome and Overview of the Day Alexis Wielunski, MPH, Center for Care Innovations Kaiser Permanente Northern California Community Health
9:15 – 10:45	Patient Partnership in Direct Care Moderator: Michael Rothman, DrPH, Center for Care Innovations Care Neighborhood CHW Case Management Program, Community Health Center Network Health Coaching Program for MAs, Livingston Community Health Center Using the Patient Activation Measure, Judith Hibbard, PhD, University of Oregon
10:45 – 11:00	Refresh & Stretch
11:00 – 12:30	Patient Partnership at the Clinic and Systems Levels Moderator: Anjana Sharma, MD, MAS, UCSF Department of Family & Community Medicine Black/African American Hypertension Equity Workgroup, San Francisco Health Network Patient Voice Collaborative, LifeLong Medical Care
12:30 – 1:30	Lunch & Networking
1:30 – 3:00	Workshops Engaging Patients in Self-Management Kate Lorig, DrPH, Self-Management Research Center Virginia Gonzalez, MPH, Self-Management Research Center Using Human Centered Design to Bring Patient Voice to Improvement Projects Diana Nguyen, Center for Care Innovations Jennifer Covin, Health Quality Partners Change Ideas for Patient Engagement Denise Armstorff, Performance Improvement Expert, Master Coach, & Trainer
3:00 – 3:15	Refresh and Stretch
3:15 – 3:45	Team Activity: Reflection and Action Planning Session Denise Armstorff, Performance Improvement Expert, Master Coach, & Trainer
3:45 – 4:00	News from Your Support Partners, Closing & Evaluations Alexis Wielunski, MPH, Center for Care Innovations

Morning Panel Discussion Sessions

Each grantee organization with have their own poster to record their ideas and reflections, and to create action plans for patient partnership. Please write the grantee organization name at the top, and we will provide prompts and instructions for completing the posters throughout the day.

Session 1: Patient Partnership in Direct Care

In our opening session, we'll hear from speakers to inspiring your thinking and planning around engaging patients in their own care.

Session Moderator

Michael Rothman, DrPH, Center for Care Innovations

COMMUNITY HEALTH CENTER NETWORK

Care Neighborhood CHW Case Management Program

Angela O'Brien, LCSW, Community Health Center Network

Livingston COMMUNITY HEALTH
Care for all. Salud para todos.

Health Coaching Program for MAs

Rosa Pavey and Hope Perez, Livingston Community Health Center

Using the Patient Activiation Measure

Judith Hibbard, PhD, University of Oregon

Session 2: Patient Partnership at the Clinic and Systems Levels

Why partner with patients? In this session, we'll explore the answer to this question and hear about models of patient partnership at the clinic/systems level. We'll also hear from patient advisors that work with these groups:

Moderator

Anjana Sharma, MD, MAS, UCSF Department of Family & Community Medicine

Co-Moderator

Ana Vilma Aquino, Patient Advisor, UCSF

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Black/African American Hypertension Equity Workgroup and Patient Advisory Councils

Jacque McCright, Mr. Patrick McKenna, and Ms. Rosalyn Frazier, San Francisco Health Network

LifeLong Medical Care
Health Services For All Ages
a california health+ center

Patient Voice Collaborative

Lucinda Bazile and Johnnie Clark, LifeLong Medical Care

Notes

Patient Engagement Planning Worksheet

My clinic's priority performance measures:

STEP 1: Describe your landscape

- What is unique about the patient population you serve?
- What are some unique challenges and opportunities your practice is currently facing for achieving your PHASE goals?

STEP 2: Define patient engagement at your site

- How does your clinic leadership currently gain patient input? *(ex. surveys, informally, advisory groups)*
- What community groups or local networks does your clinic currently engage with?
- What is helpful about this patient input? What is lacking with regard to your PHASE goals?

STEP 3: Develop an action plan

Patient Role

- How could patients be involved in achieving your PHASE goals?

Staff Engagement

- Who would be your champions at your site?
- How would you get leadership support?

Recruitment

- *What voices should you prioritize to meet your goal? (ethnic demographics, language demographic, medical condition, etc.)*
- Where will you recruit patients? *(ex. waiting room, community centers, survey, clinician/staff nomination)*

Resources

- What resources could be leveraged to support this?
- Can you provide an incentive?

Set a SMART goal

- By _____ date, we will have engaged _ patients through

  _____

  _____ activity

- We will have met _____ times
- We will present our findings to

  _____

- We will know it is a success because

  _____

  _____

WORKSHOP A:

Engaging Patients in Self-Management

Location:

Fountain Room

Workshop Description: Patient self-management programs help people and their caregivers manage symptoms, improve quality of life, and reduce healthcare costs. In this workshop, participants will learn how to integrate or partner with evidence-based self-management programs for patients with hypertension and diabetes.

Suggested Audience: Program managers/directors and care team members focused on chronic disease management

Kate Lorig, Dr.P.H., Partner, Self-Management Resource Center

Virginia González, MPH, Training Director, Self-Management Resource Center

Resources:

- SMRC Evidence Based Behavioral Tips for the busy Health Care Professional
- SMRC Sites in Northern California

Evidence Based Behavioral Tips for the busy Health Care Professional

Kate Lorig
Kate@selfmanagementresource.com

1. **Focus all teaching on patient's main concerns.** These can be determined by asking "When you think about diabetes, what do you think of?" or "What are you afraid might happen?" Use the answers to tailor your education. For example, if the response to the first question is "pain", then you can answer that pain can be caused by several different things and that there are many ways of dealing with pain.

2. **Screen frequently for depression.** "What do you do for fun?" If the patient cannot give a positive answer, then further screening and possible treatment is needed.

3. **Have a set of consistent key messages**. A key message is detailed enough to allow a patient to self-tailor while not overwhelming the patient with details. Examples of key messages are;

- ✓ "You should not have more pain when you finish exercising than before you start but exercise may not be pain free."
- ✓ "You cannot cause yourself permanent damage by exercising."
- ✓ "Weight loss is a function of eating less and moving more."
- ✓ "Start an exercise program by doing what you can do now, do this 4-5 times a week and add to it by 10% ever week or two."
- ✓ "Take your pills with some activity you do every day such as brushing your teeth."
- ✓ "It is easier to control pain when it is not severe. Take your medicine when you have only mild pain. Don't wait to see if it will get worse."
- ✓ "To lose weight try the 200 plan. Add 100 calories of exercise a day (about a half hour) and reduce food intake by 100 calories a day (a cookie or two). This will result in a loss of 20 pounds a year.

4. **Have patients set specific behavioral goals or action** plans for the next month or so. Be sure to ask about these during the next visit. Include caregivers/families for those patients with cognitive deficits or need assistance with home management of care plan. Success with action plans is more important than making a plan.

5. **Know about and refer to community resources** such as exercise classes, patient education classes, meditation classes, support groups etc. Then refer with a specific name and telephone number. To find evidence based programs (falls prevention, exercise, diabetes, pain management, chronic disease self-management, depression and others in your community use this program locator http://www.eblcprograms.org/evidence-based/map-of-programs/ Most of these programs are free or low cost.

6. **Always tell patients when to expect new medications to start working**. Many patients expect new medications to have effects in hours or at least in days. When this does not happen, they often stop taking the medications or reduce the dose before full effectiveness is reached.

7. **When asking patients about taking medications assume that there may have been problems**. Ask, "What problems have you had taking this medication?" This makes it much easier for the patients to say they forgot, the medicine was too expensive or that they did not like the side effects.

8. **Be sure to address the patient's symptoms even if not medically significant**. "The good news is that I can not find anything seriously wrong with you but I know that you still have pain, so I suggest…."

12. **Frame your discussions to expand patient's perception of the problem**. For example, "sounds like you have lots of reasons for being depressed and just like other medical problems we have treatments." "Fatigue can be caused by lots of things, disease, deconditioning, medication, poor nutrition, poor sleep, anxiety, and depression or maybe several of these. Think about each and try some new things like a little exercise when you are tired or eating a bit better. Sometimes a little experimentation will give you helpful answers.

13. **Acknowledge that following a regime might be difficult.** "Taking these meds as directed might be a bit difficult but I know you can do it".

14. **If a patient appears anxious or depressed suggest that they take a few minutes each day to write down their feeling**. There is a growing literature on therapeutic writing suggesting that just the act of writing decreases negative emotions. Make it clear that you do not want to see what they wrote and will not read it. This is not for someone who is clinically depressed.

15. **Before giving advice, check what the patient knows and what they are already doing**. Brainstorming is a good way to do this. I.e. "tell me what you know about diabetes".

17. As they say in motivational interviewing, **resist the "righting" reflex**. This means do not try to make everything right or OK

18. When suggesting behavior change, follow the patient and what the patient feels he or she can do not what you think they should do**. Go for the real not the ideal**. Some change is better than no change, even if it is not perfect.

19. **Close the loop**. At the end of a visit have the patient explain to you what they have heard and what they will do. Also summarize any points they may have missed and what you will do next.

LICENSED ORGANIZATIONS OFFERING SMRC SELF-MANAGEMENT PROGRAMS IN THE GREATER BAY AREA OF NORTHERN CALIFORNIA

Alameda County

Kaiser Permanente Regional Health Education
1950 Franklin
St Fl 13th
Oakland, CA 94612
510-987-1536

Calaveras County

Calaveras Health & Human Services Agency
Public Health Services
891 Mountain Ranch Rd
San Andreas, CA 95249
Contact: Bonnie Nordby
bnordby@co.calaveras.ca.us

Fresno County

Fresno County Department of Public Health
P.O. Box 11867
Fresno, CA 93721
559-600-6449

St. Agnes Medical Center
3103 E. Herndon Ave.
Fresno, CA 93720
Contact: Mariana Ramirez
mariana.ramirez@samc.com

Clinica Sierra Vista
1945 N. Fine Avenue, Suite 116
Fresno, CA 93727
Contact: Reyna Villalobos
reyna.villalobos@clinicasierravista.org

Humboldt County

Humboldt Independent Practice Association
2662 Harris Street
Humboldt, CA 95503
Contact: Kerri Escudero
kescudero@humboldtipa.com

Kern County

Dignity Health dba Mercy Hospital of Bakersfield
2215 Truxtun Avenue
Bakersfield, CA 93301
Contact: Debbie Hull or Romala Ramkissoon
debbie.hull@dignityhealth.org or
romala.ramkissoon@dignityhealth.org

Lake County

Lake County Tribal Health Consortium
PO Box 1950
Lakeport, CA 95453
Contact: Gemalli Austin
gaustin@lcthc.org
707-263-8382 x1601

Mariposa County

John C Fremont Healthcare District
5300 State Highway 49
P.O. Box 216
Mariposa, CA 95338
209-966-3631

Merced County

Merced County Department of Public Health
260 E. 15th St
Merced, CA 95341
209-381-1104

Monterey County

Community Hospital of the Monterey Peninsula
P.O. Box HH
Monterey, CA 93942
Contact: Ellen Watson
ellen.watson@chomp.org

Napa/Solano County

Area Agency on Aging - Napa/Solano County
400 Contra Costa Street
P.O. Box 3069
Vallejo, CA 94590
707-644-6612

County of Solano
Solano Public Health,275
Beck Avenue MS 5-240,
Fairfield, CA 94533
707-784-8611 or 707-644-6612

Sacramento Area

Dignity Health
3400 Data Drive
Rancho Cordova, CA 95670
https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/healthier-living-workshops

CommuniCare Health Centers
P.O. Box 1260
Davis, CA 95617
Contact: Evan Priestley
evanp@communicarehc.org

Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534
Contact: Rebecca Boyd Anderson
rboyd@partnershiphp.org
707-863-4502

San Francisco

30th Street Senior Services/On Lok
225 30th Street # 3
San Francisco, CA 94131
415-550-6003

Dignity Health
185 Berry Street, Suite 300
San Francisco, CA 94107
916-851-2793

Department of Aging and Adult Services-San Francis
1650 Mission St, 5th Floor
San Francisco, CA 94103
415-355-6774

North East Medical Services
1520 Stockton Street
San Francisco, CA 94133
415-391-9686 x5904

San Francisco VA Medical Center
4150 Clement Street
Bldg. 1, Room 1
San Francisco, CA 94121
415-221-4810 x3632

San Mateo County

South County Community Health Center, Inc.
dba Ravenswood Family Health Center
1796 Bay Rd., Bldg. #2
East Palo Alto, CA 94303
Contact person: Luisa Buada
lbuada@ravenswoodfhc.org
650-330-7410

Santa Clara County

The Health Trust
3180 Newberry Drive, Suite 200
San Jose, CA 95118
Contact: Erika Zuñiga
erikaz@healthtrust.org
408-961-9812

Santa Clara Valley Medical Center
751 S. Bascom Avenue
San Jose, CA 95128
Contact: Jose Garcia
Josem.garcia@hhs.sccgov.org
408-885-3142

Santa Cruz County

Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
Contact: Deborah Pineda
dpineda@ccah-alliance.org
831-430-5568

Stockton Area

Dignity Health - St. Joseph's Medical Center
1800 N. California St.
Stockton, CA 95204
Contact: Arlene Favis
arline.favis@dignityhealth.org
209-944-8357

Tulare County

Kaweah Delta Health Care District
400 W. Mineral King Ave
Visalia, CA 93291
Contact: Alma Torres-Nguyen
altorres@kdhcd.org
559-624-2416

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IMPORTANT NOTE: The Evidence Based Leadership Council has a program locator for use by clinics and the public to find evidence based self-management, falls prevention, exercise and depression management (PEARLS) programs.

http://www.eblcprograms.org/evidence-based/map-of-programs/

WORKSHOP B:

Using Human Centered Design to Bring Patient Voice to Improvement Projects

Location:

California Room

Diana Nguyen
Senior Program Coordinator,
Center for Care Innovations

Jennifer Covin, MPH
Director of Programs,
Health Quality Partners

Workshop Description:

Human-centered design (HCD, or design thinking) is an approach to problem solving that is rooted in understanding people's needs and experiences. This workshop will introduce the practice of "co-design," wherein the stakeholders affected by the problem – patients in this case – play a pivotal role in co-creating services, programs, and improvement efforts. Participants will learn about examples of how safety net providers have successfully used HCD to co-design with patients, including co-designing a Self-Measured Blood Pressure program.

Suggested Audience:

Anyone who is working on designing or improving an SMBP program. Beginners or those new to Human-Centered Design.

Resources:

- HQP's SMBP Case Study: careinnovations.org/wp-content/uploads/2017/10/RIC_case_study_HQP.pdf
- Resources from CCI's Human-Centered Design Program, Catalyst:
    - **Facilitating a co-design session:** careinnovations.org/resources/catalyst-method-facilitating-co-design-session/
    - **Journey Mapping:** careinnovations.org/resources/webinar-journey-mapping-for-leading-profound-change/
    - **Design Research 101:** careinnovations.org/resources/catalyst-design-research-101/
    - **Catalyst Methods Cards:** careinnovations.org/wp-content/uploads/All_MethodCards_Catalyst_2019.pdf
    - **Catalyst Online:** Sign up to receive bite-size doses of human-centered design practice delivered to your inbox at careinnovations.org/catalyst-online/

WORKSHOP C:

Change Ideas for Patient Engagement

Location:

Main Room (International Ballroom)

We strongly recommend that each PHASE team sends at least one person to this workshop.

Denise Armstorff, Performance Improvement Expert, Master Coach, & Trainer

Workshop Description:

In this workshop, participants will develop plans to tests change ideas for patient engagement in their PHASE projects. Individuals participating in this workshop will have selected an idea, developed the plan portion of a PDSA, and considered multiple iterations of the test.

Intended Audience:

PHASE team leads, QI team members, and others wanting a QI introduction or refresher.

Resources:

- PDSA Template
- PDSA Example
- Iteration Sheet
- Example data collection sheet

ARMSTORFF CONSULTING

Date:
Name of Test:

Describe briefly, at a high-level, the test of change you are planning (What is the objective? What questions do we want answered with this test?):

PLAN
What is your plan? (Answers who, what, when, and where):

List the tasks needed to set up this test of change	Person responsible	When/where will it be done?

Predict what you believe will happen when the test is carried out

What data will be collected to determine if your test is successful?

DO

Describe what happened when you ran the test (what did you observe?)

STUDY

Describe the measured results and how they compared to the predictions (what did you learn?)

ACT

Describe what modifications will be made to the plan for the next cycle (based on your learnings)

PDSA WORKSHEET

Date: May 26, 2019
Name of Test: In-reach Cervical Cancer Screening

Describe briefly, at a high-level, the test of change you are planning (What is the objective? What questions do we want answered with this test?):

For any female patient in the denominator who presents at the clinic for any appointment, we will provide important education regarding cervical cancer screening

Our objective is to test whether the education (script) provided will produce either 1) a same-day cervical cancer screening completion or 2) a scheduled return appointment for a cervical cancer screening.

PLAN

What is your plan? (Answers who, what, when, and where):

- Use a script to communicate the importance of cervical cancer screening and encourage women to have screening same-day or schedule a return appointment
- **Primary points of "script" in MAs own words:**
  - We really encourage women to complete cervical cancer screening, as there are medical studies regarding how these studies can provide early detection of cervical cancer.
  - If detected early, cervical cancer is one of the most successfully treatable cancers.
  - While I know it is not an easy exam, we will do our best to make you feel comfortable AND once completed, you won't have to return for 3 years!

List the tasks needed to set up this test of change	Person responsible	When will it be done?
Scrub charts to identify all eligible female patients with next-day appointment who are due for screening	Debbie	Tuesday, 5/28
For patients identified during chart-scrubbing on previous day, discuss importance of cervical cancer screening with patient during rooming process	Debbie	Wednesday, 5/29
If patient agrees to same-day screening, communicate with provider to complete screening	Debbie/Dr. Jo	Wednesday, 5/29
If patient prefers to come back, schedule a return appointment	Debbie/Dr. Jo	Wednesday, 5/29

Predict what you believe will happen when the test is carried out

- Of patients that Debbie talks to 20% will agree to a same-day screening
- Of patients that Debbie talks to, 40% will schedule an appointment.
- Of patients that Debbie talks to, 20% will say that they already had a screening elsewhere
- Of the patients that had screening done with a different provider, 80% of records are collected
- 20% of patients will not make an appointment

What data will be collected to determine if your test is successful?

	Same-day Screening			Return Appointment				Screening Done Elsewhere?		
Patient's Identified as Needing PAP	Same-day Offered? (Y/N)	Same-day Completed? (Y/N)	Comments (Why/Why Not?)	Return Appt. Scheduled? (Y/N)	If yes, date of appt.	If no, why not?	Return Appt. Kept? (Y/N)	If yes, where?	Date Records Requested	Date Records Received

DO

Describe what happened when you ran the test (what did you observe?)

STUDY

Describe the measured results and how they compared to the predictions (what did you learn?)

ACT

Describe what modifications will be made to the plan for the next cycle (based on your learnings)

PDSA TEST ITERATION WORKSHEET

Iteration #	Test Progression/Iteration	Scale of Test
1		
2		
3		
4		
5		
6		
7		

Very Small-scale Tests: Small, rapid, iterative tests aimed at testing an idea/theory to quickly learn how it impacts a process and intended outcome. Iterations are based on learnings from preceding test(s) and continue until there is a high degree of belief that the process can produce the intended outcome.

Follow-up Tests: Repetitive small-scale cycles of a previously tested process where there is a high-degree of belief that it will produce the intended outcome, which is tested under different circumstances (sites, people, shifts) to continue to build confidence and a high degree of belief that the process will consistently produce the intended outcome in the new circumstances.

Wide-scale Tests: Repetitive cycles of a process that has previously been tested and has resulted in the intended outcome with measured consistency, which is now tested with higher volumes (e.g., patients, providers, sites). Also known as "ramp-up" phase.

Implementation: Developing standard work, desktop procedures, and policies to support and sustain the new process. Includes setting "out-of-bounds" measure to ensure process is monitored for consistent desired outcome.

Data Collection Example
Foot Exam Test

Identified Diabetic Patient Needing Foot Exam	Was Foot Exam Completed by MA? [If no, provide comments regarding why]	Did Foot Exam Impact Length of Scheduled Appt.? (Y/N)	If Yes, what was the difference in time	Satisfaction Rating (☺/☹)		Comments
				Dr. Zee	MA Sally	
1	No	Yes	15	☹	☹	Filaments had not been stocked in exam room; Dr. Zee prepared while Sally found filaments and Dr. Zee performed exam to save time
2	No	No	0	☺	☺	Pt. was experiencing chest pain, which was the focus of the appt.
3	Yes	Yes	5	☺	☺	Pt. needed some additional instruction/ education
4	Yes	Yes	0	☺	☺	MA felt well-prepared and Dr. Zee appreciated additional time that he could spend with patient

Notes

Attendee Directory

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Preventing Heart Attacks and Strokes Everyday (PHASE) is an evidence-based, population health management program and clinical protocol that, when followed, reduces heart attacks and strokes. Developed by Kaiser Permanente in 2002, PHASE has helped reduce heart attacks and strokes among Kaiser Permanente members who were at risk. With funding and the expertise of their physicians, Kaiser Permanente has been sharing PHASE with community clinics and public hospitals since 2006.

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