KAISER PERMANENTE®

PHASE

PREVENTING HEART ATTACKS
& STROKES EVERY DAY

Sharing Ideas to Accelerate Progress

PHASE Grantee Convening

June 5, 2018
Berkeley, CA

KAISER PERMANENTE®

in the community

CENTER FOR COMMUNITY HEALTH AND EVALUATION

www.cche.org

Preventing Heart Attacks and Strokes Everyday (PHASE) is an evidence-based, cost-effective combination of medications and lifestyle counseling that can reduce heart attacks and strokes, especially among those with heart conditions or diabetes. 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.

kp.org/phase

Table of Contents

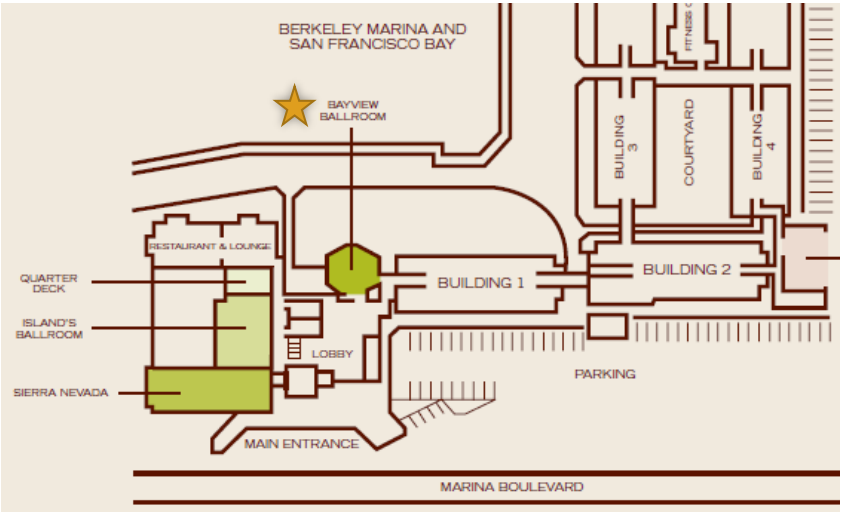
Agenda

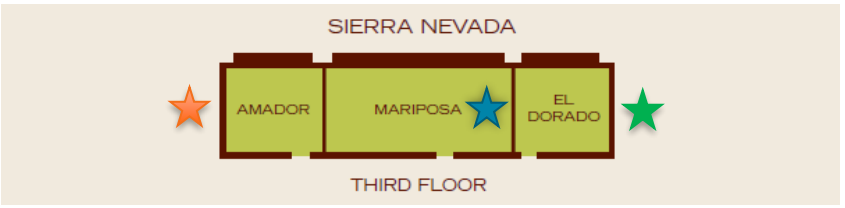
8:30 – 9:00	**Breakfast & Registration**
9:00 – 9:15	**Welcome, Overview of the Day** *SA Kushinka, Program Director, Center for Care Innovations* *Kaiser Permanente Northern CA Community Benefit*
9:15 – 9:30	**Building Block Bingo**
9:30 – 10:00	**Results of Kaiser Permanente's PHASE Implementation** *Jamal Rana, MD, PhD, Kaiser Permanente*
10:00 – 10:15	**Fifteen Minutes of PHASE Fame** **A Guy, a Team, a Mission: One Clinic's Approach to Heart Health** *Douglas Frey, FNP, LifeLong Medical Center*
10:15 – 10:30	**Refresh & Stretch**
10:30 – 11:30	**Data Gallery Walkabout** *Center for Community Health and Evaluation*
11:30 – 11:45	**Fifteen Minutes of PHASE Fame** **From Idea to Impact: Our Congestive Heart Failure Clinic Journey** *Joan Singson, Director of Population Health Management, San Joaquin General Hospital*
11:45 – 12:30	**Charter for Improvement: Update for Second Half of the PHASE Grant & Team Time** *Jerry Osheroff, MD, Principal, TMIT Consulting* *Alexis Wielunski, Program Manager, CCI*

12:30 – 1:30	**Nourishment & Networking** *Peer Consults from 1:00 –1:30*
1:30 – 3:00	**Workshops – Patient Engagement Suite** 1. Empanelment for Team-Based Care and Population Health Management: Connecting the Dots for Better Patient Engagement *Regina Neal, Qualis Health* 2. Building Care Team–Patient Communication Skills to Enhance Health Outcomes *Michele Nanchoff, Institute for Healthcare Communication* 3. Patient Activation: Rethinking Patient Non-Compliance *Juliane Tomlin, Center for Care Innovations*
3:00 – 3:15	**Refresh & Stretch**
3:15 — 3:30	**Fifteen Minutes of PHASE Fame** **It's Up to All of Us: Extending the Hypertension Care Team Beyond the Clinic** *Bo Greaves, MD, Hearts of Sonoma County*
3:30 – 3:45	**News from Your Support Partners**
3:45 – 4:00	**Closing & Inspiration Disco!**

Notes

Venue Map



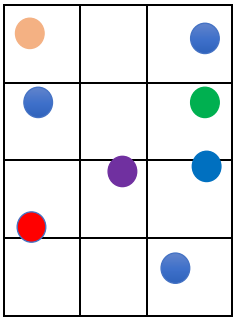


The main convening room is the **Bayview Ballroom.** Breakouts are on the third floor, and located as follows:

- **Patient Activation: Rethinking Patient Non-Compliance**
  Amador Room
- **Building Care Team–Patient Communication Skills to Enhance Health Outcomes**
  Mariposa Room
- **Empanelment for Team-Based Care and Population Health Management: Connecting the Dots for Better Patient Engagement**
  El Dorado Room

Building Block Bingo

How to Play



1. Take a set of dots from the table.
2. Flip to the Participant Directory at the end of this booklet and find your name.
3. Write the number corresponding to your name on your dots. (So you can identify who is doing what, and follow up with colleagues later to seek advice.)
4. Look at the statements in each of the Bingo boxes on the next page. Each statement or activity falls under one of the Building Blocks of PHASE. All activities listed here were drawn from Year End Reflections submitted in January.
5. Your goal is to find others in the room to whom each statement applies.
6. You will have them place a dot on that statement box on your card. Use your dots to help others fill their boxes.
7. Start mingling and finding best practices!

Key: Building Blocks of PHASE				
Supportive, Engaged Leadership & Culture	QI Culture & Process Improvement Methodology	Data-Driven Decision Making	Panel Management	Team-Based Care

PHASE BINGO

In our organization we...

Utilize care team members in new ways so they work at top of license (including nurse-led care)	Have a process for orienting new clinical staff and leaders to PHASE	Train staff to use Motivational Interviewing techniques	Offer classes or referrals for exercise and healthy eating education and programs
Review HTN control data reports during huddles	Stratify patients to focus outreach or interventions on those with highest HTN risk	Train and/or conduct refreshers for MAs on accurate BP measurement and documentation	Have identified PHASE Champions to gain alignment on our guidelines for hypertension and diabetes management
Have designated staff who call patients who need a BP and/or medication check	Provide care teams with BP control data and run charts monthly	Implement alternative visit types for hypertension management (i.e. RN/MA BP check visits, or phone or group visits)	Hold staff trainings to refresh hypertension care knowledge
Conduct health coaching for patient education and to establish self-management goals	Produce monthly reports on gaps in hypertension and diabetes management	Review PHASE quarterly reports and dashboards with our Board of Directors	Regularly conduct PDSAs as part of continuous quality improvement processes

Reducing Heart Attack and Stroke Risk

Kaiser Permanente's PHASE Implementation

Dr. Jamal Rana, MD, PhD, FACC
Chief, Division of Cardiology, East Bay, Kaiser Permanente; Adjunct Investigator, Division of Research, Kaiser Permanente Northern California

Dr. Rana was born in Pakistan. After finishing medical school at Aga Khan University, he moved to Boston for a research fellowship at Harvard Medical School. He did his medicine residency at University of Pittsburgh Medical Center and completed his cardiovascular fellowship at Cedars-Sinai Heart Institute in Beverly Hills.

He is currently Chief of Cardiology, East Bay, Kaiser Permanente Northern California and an Adjunct Investigator with Kaiser Permanente's Division of Research. He has more than 100 peer reviewed publications and is the winner of the TMPG 2017 Collin F. Morris research award for clinician investigators.

Fifteen Minutes of PHASE Fame: At a Glance

A Guy, a Team, a Mission: One Clinic's Approach to Heart Health

10:00 AM – 10:15 AM

Douglas Frey, FNP
LifeLong Medical Center, Downtown Oakland
Contact Douglas at 510-701-7680.

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From Idea to Impact: Our Congestive Heart Failure Clinic Journey

11:30 AM – 11:45 AM

Joan Singson, Director of Population Health
San Joaquin General Hospital
Contact Joan at jsingson@sjgh.org.

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It's Up to All of Us: Extending the Hypertension Care Team Beyond the Clinic

3:15 PM – 3:30 PM

Bo Greaves, MD
Hearts of Sonoma County
Contact Bo at bo.greaves@gmail.com.

Fifteen Minutes of PHASE Fame: Speakers

Douglas Frey

Family Nurse Practitioner
Lifelong Medical Center

Douglas is the son of a rural veterinarian and was raised on a small farm in the Sierra Nevada Foothills. He received his Bachelor's degree from Pomona College in Media Studies. After working in Los Angeles on films and TV, he moved to the Bay Area, where he innovated at Oprah Winfrey's company, Oxygen Media, in the early days of Internet and TV "convergence."

Later, Douglas received his MSN degree from Samuel Merritt University. For the last six years, he has been providing adult primary care to high-need, medically complicated patients at LifeLong Medical Care's Downtown Oakland Clinic, where his work includes hands-on pain treatment using myofascial release.

Douglas is a HRSA NURSE Corps Loan Repayment recipient and chair of LifeLong's EHR Clinicians Committee. Passionate about panel management, last year Douglas was recognized as a CDC Million Hearts Campaign 2017 Hypertension Control Champion.

Joan Singson

Director of Population Health Management
San Joaquin General Hospital

Joan Singson is the Director of Population Health Management at San Joaquin General Hospital, in San Joaquin County. She leads an amazing team that supports the health care organization's efforts to enhance patient care and improve health outcomes.

She has served as a training and technical assistance provider for the Centers of Disease Control and Prevention's Division of HIV/AIDS Prevention, the U.S. Family and Youth Services Bureau, and the California Department of Public Health. Joan joined San Joaquin General Hospital in May 2017.

Bo Greaves, MD

Hearts of Sonoma

Bo Greaves, MD, is a family physician who has practiced in Sonoma County since 1987. He retired two years ago as medical director of Vista Family Health Center, the largest site within Santa Rosa Community Health Centers and home of the Santa Rosa Family Medicine Residency Program.

Dr. Greaves currently helps lead Sonoma County Health Action's Committee on Healthcare Improvement and its Hearts of Sonoma County cardiovascular risk reduction collaboration, and also chairs the Sonoma County Health Action Leadership Team.

Data Gallery

Activity Directions

There are 6 stations each focusing on a clinical measure:

(1) Tobacco screening with follow-up
(2) Depression screening with follow-up
(3) BMI screening with follow-up
(4) BP control (DM & HTN)
(5) A1c
(6) Select Rx measures

Each station includes graphs reflecting cohort trends and individual grantee performance and examples of strategies used by high performers or those that are most improved.

Round 1 (30 min): Find the station that matches the color dot on your nametag to start. You will spend 5 min per station and rotate with the chime. In this round, stations will not be facilitated, but a PHASE support team representative will be at each station to answer clarifying questions. Groups can talk and/or write questions, comments, observations on post its & put those on the flipchart paper to the side of the poster.

Round 2 (20 min): Each participant will be able to pick 2 stations to return to for this round. A person from the grantee(s) featured in each poster will be at their station to talk about promising practices and answer questions. We will rotate after 10 min. Teams are encouraged to split up to hear about more than 2 promising practices.

Reflective Questions

- What in these data do you find most compelling?
- What surprises you about these data?
- What questions do you still have about the data, findings, or spotlights?

Data Gallery

Participating Organizations

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

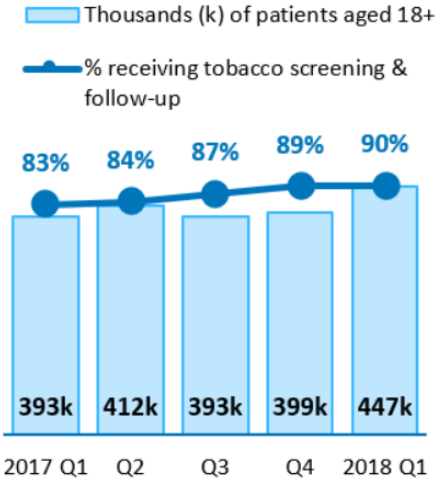
Public Hospital Systems
Alameda Health System (AHS)
San Francisco Health Network (SFHN)
San Joaquin General Hospital (SJGH)
San Mateo Medical Center (SMMC)
Santa Clara Valley Health & Hospital System (SCVHHS)

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)

Charts on the following pages were prepared by the Center for Community Health and Evaluation, June 2018.

Tobacco screening and follow-up if positive for tobacco use

% receiving tobacco screening and follow-up across the initiative*



Example strategies of how PHASE contributed to improved rates of tobacco screening & follow-up:

Data

- Retrained MAs on workflows around data documentation
- Improved data mapping & validation
- Implemented CDS alerts in EHRs

Team-based care

- Trained care team on motivational interviewing

* 5 grantees spread to additional sites in Q1 2018, leading to population increases.

San Joaquin General Hospital reported that improvements in rates were driven by:

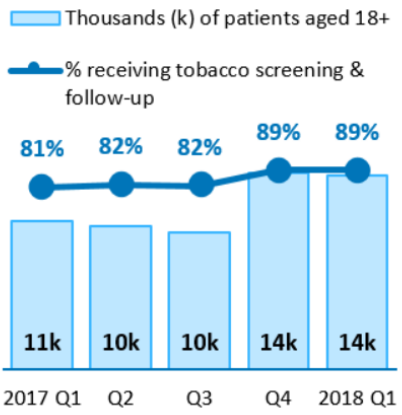
Evidence-based practice:

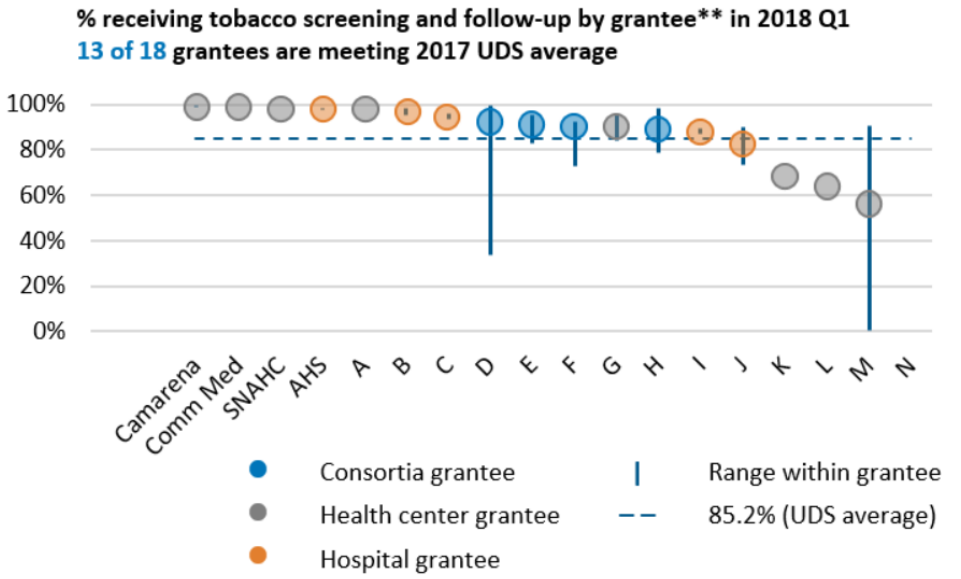
- Training for clinic teams on process for assessment, referral and follow
- Reinforcement of process with medical assistants and other clinic staff

Data:

- Workflow changes on data capture and documentation
- Use of EHR prompts for clinic staff to follow up on tobacco use and/or pharmacological interventions (e.g., nicotine patch)

% receiving tobacco screening and follow-up





**The 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.

Axis Community Health (member of CHCN) improved data capture & quality through:

Quality improvement:

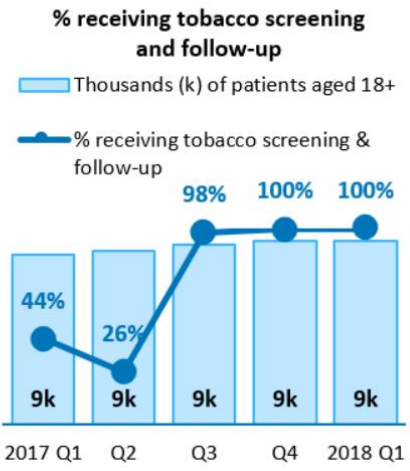
- Using a data audit tool to ensure use of structured fields in EHR

Data:

- MA-specific data reports were provided to hold staff accountable to the workflow

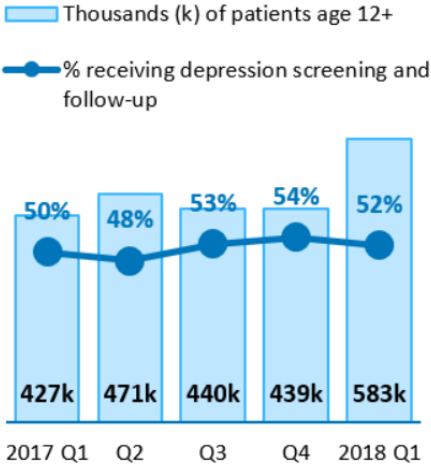
They also improved follow-up support by:

- Retraining MAs on motivational interviewing and brief interventions.



Depression screening and follow-up if positive for depression

% receiving depression screening and follow-up across the initiative*



PHASE grantees improved depression screening and follow-up through:

Evidence-based practice

- Behavioral health integration efforts, including workflow for warm hand-offs
- Rolling out screening through standing orders & MA training

Data improvements

- Standardizing data capture in structured fields in the EHR
- Improving mapping from EHR to reporting tools

* 5 grantees spread to additional sites in Q1 2018, leading to population increases.

Livingston Community Health improved their rate of depression screening and follow-up through:

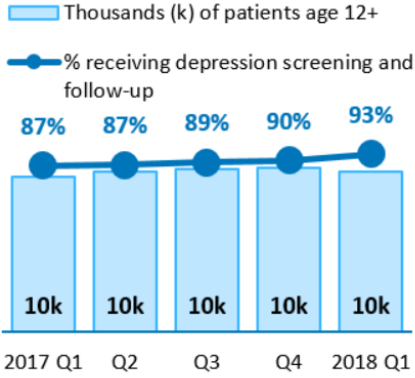
Quality improvement:

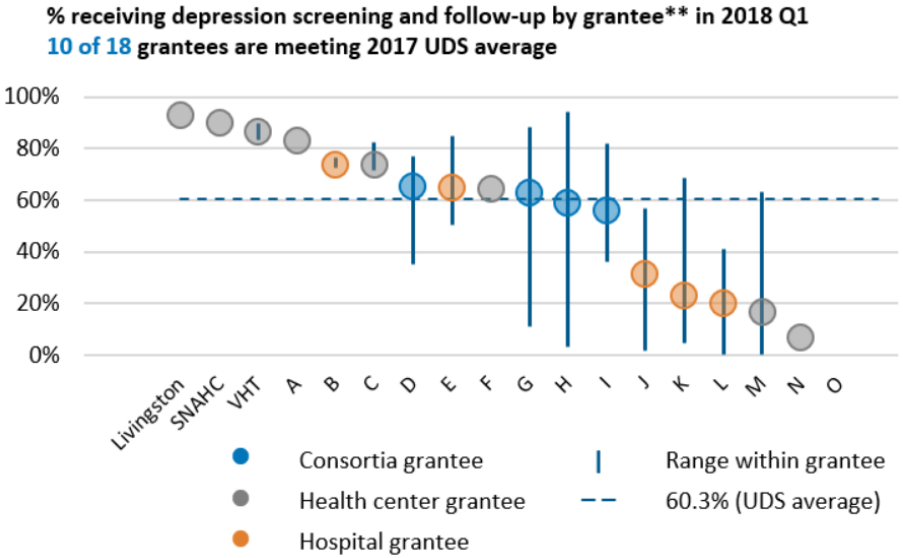
- Chart audit to check if patients who screened positive were receiving appropriate follow up. Designed new workflow that includes process map and resource document

Data:

- Reduced inconsistent documentation of measure and improved mapping with i2i. Provided guidance to staff as to how to document the screening results.

% receiving depression screening and follow-up





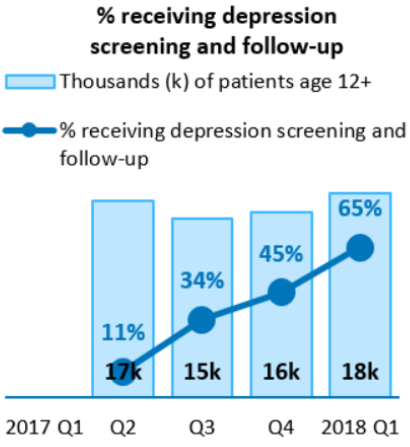
**The top performers for each measure are called out by name. Other grantees are shown in order of performance; the letter for a grantee can change with each chart.

Alameda Health System leveraged PHASE and PRIME alignment to improve depression screening and follow-up though:

Evidence-based practice: Piloted workflow for universal BH screening; developed standard work; expanded universal BH screening to all sites

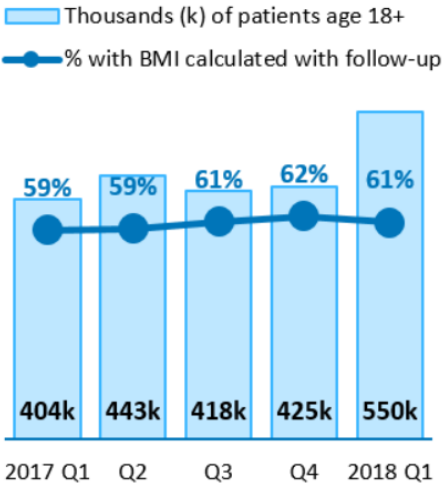
Quality improvement: Developed process measures to audit & provide feedback on screening rates & follow-up

Data: Real-time data to measure fidelity to BH screening standard work at site, provider and MA levels; monthly meetings with leadership to review performance, share best practices, and problem-solve



BMI calculated and follow-up if BMI outside normal parameters

% with BMI calculated with follow-up across the initiative*



Example strategies of how PHASE grantees are increasing BMI screening and follow up:

Data

- Improving data capture by creating click boxes versus free text
- Developing standard workflows for relevant team members
- Regularly reviewing data with all staff

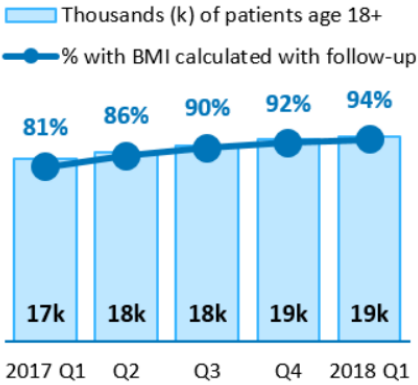
* 5 grantees spread to additional sites in Q1 2018, leading to population increases.

Petaluma Health Center (member of RCHC) improved BMI screening and follow-up through:

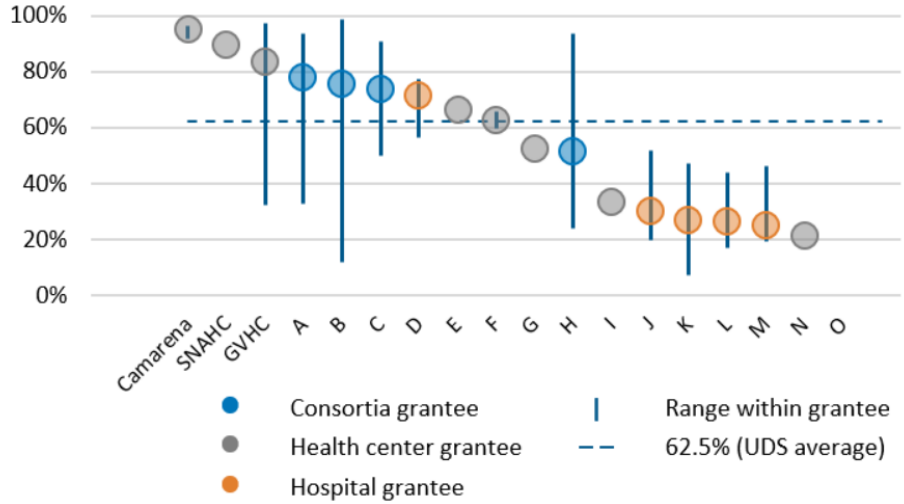
Quality improvement and team-based care:

- Rooming template applied to charts during morning huddle
- MAs trained to collect BMI, ask about healthy eating/exercise, and provide counseling
- MAs worked with interested patients to set self-management goal (SMG)
- Rooming template use and SMGs monitored by the Quality department
- Process reinforced during orientation, trainings, and competency checks
- Enhanced training in eCW

BMI calculated with follow-up if needed



% with BMI calculated with follow-up by grantee in 2018 Q1**
9 of 18 grantees are meeting 2017 UDS average



**The 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.

Sacramento Native American Health Center improved data capture & quality through:

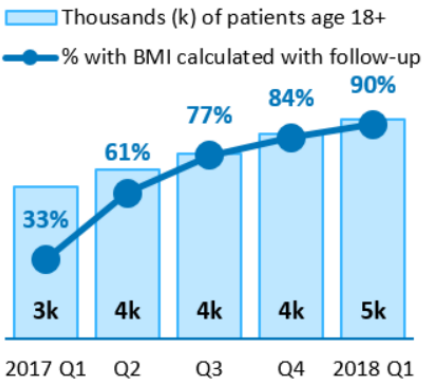
Quality improvement:

- Identified errors in staff and provider documentation of measures
- Educated team in correct and consistent documentation

Data mapping and capture:

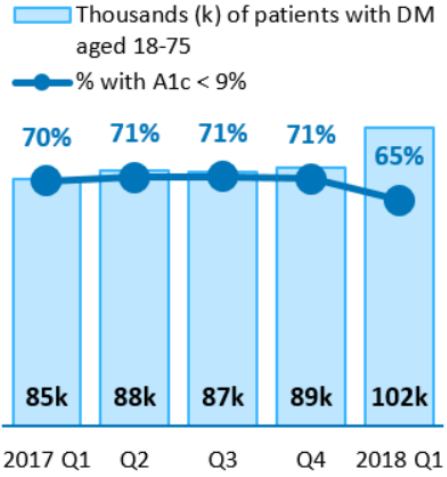
- Focused on getting all PHASE measures mapped correctly
- Built automations into EHR (Next Gen) to improve data capture

BMI calculated with follow-up if needed



Diabetes (DM) hemoglobin A1c < 9%

% of patients with diabetes with A1c < 9% across the initiative*



Example strategies of how PHASE grantees are addressing A1c:

Team-based care
- Developing nurse protocols
- Hiring chronic care managers to manage complex patients
- Using pharmacist visits

Quality improvement
- Performing PDSAs around A1c testing

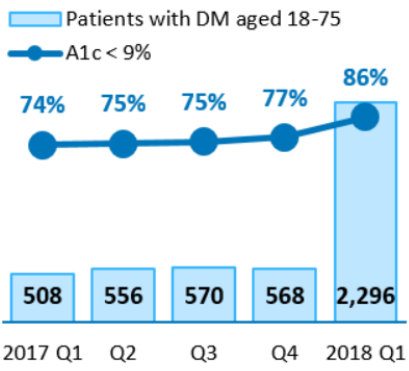
* 5 grantees spread to additional sites in Q1 2018, leading to population increases.

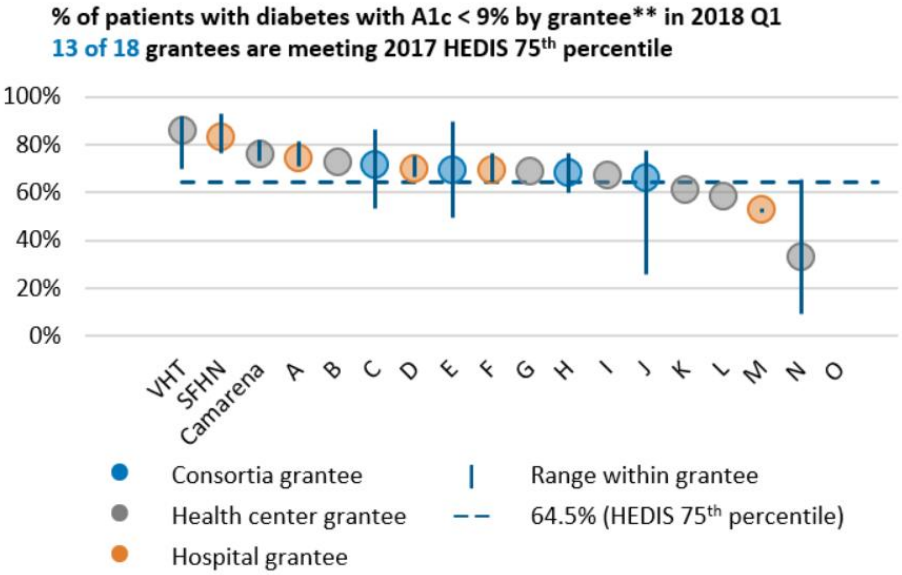
Valley Health Team (VHT) reported that improvements were driven by:

Population health management:
- Provided care teams with a Patient Visit Summary for each HTN and DM patient before visits
- Patient Visit Summary includes last several A1c results

Team-based care:
- Patients who need an A1c checked are walked to LabCorp inside VHT sites, making it easy to get lab work done the same day

% of patients with diabetes with A1c < 9%





**The 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.

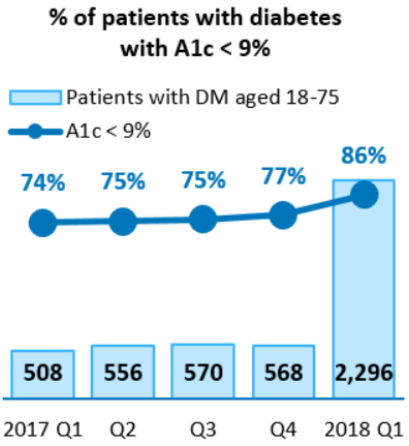
Camarena achieved high levels of A1c control through:

Team-based care:

- Trained MAs as health coaches to identify patients, provide education, set self-management goals, & follow up with patients
- Developed standing orders for MAs to complete a care plan the same day for patients with A1c>9%

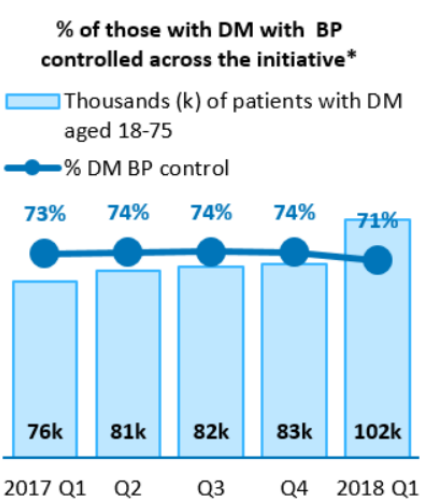
Population health management:

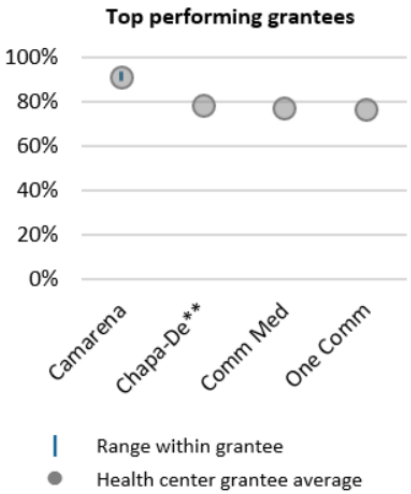
- Used pre-visit planning to identify patients in need of an A1c test and/or in need of a care plan for those with out of control A1c



Blood pressure (BP) control for patients with diabetes (DM)

12 of 18 grantees are meeting the HEDIS 75th percentile of 68.5%





* 5 grantees spread to additional sites in Q1 2018, leading to population increases. ** Chapa-De changed its EHR in summer 2017 so data are not fully representative of the patient population.

Community Medical Centers (Comm Med) improved data quality & reporting through:

Data mapping:

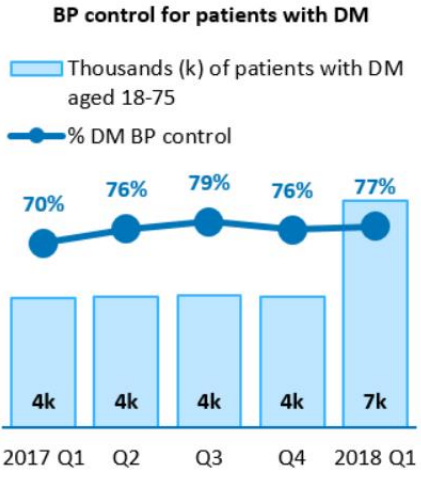
- Improved mapping of PHASE measures for accurate reporting

Creation of i2i toolkit:

- Created i2i toolkit to support population management

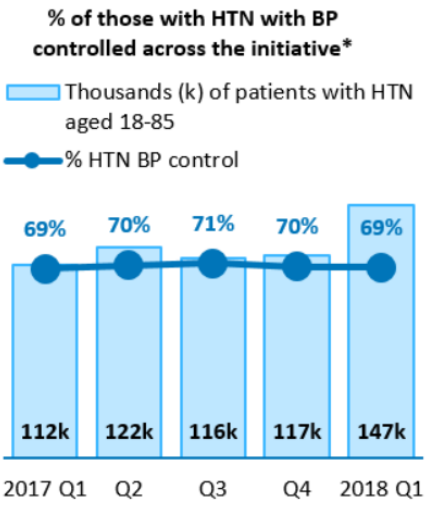
They also improved control by:

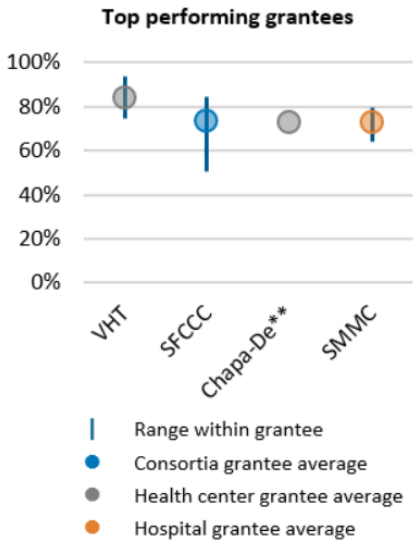
- Added new team members
- Established work flows for BP rechecks
- Conducted BP training & competency checks



Blood pressure (BP) control for patients with hypertension (HTN)

12 of 18 grantees are meeting the HEDIS 75th percentile of 64.8%





*5 grantees spread to additional sites in Q1 2018, leading to population increases. ** Chapa-De changed its EHR in summer 2017 so data are not fully representative of the patient population.

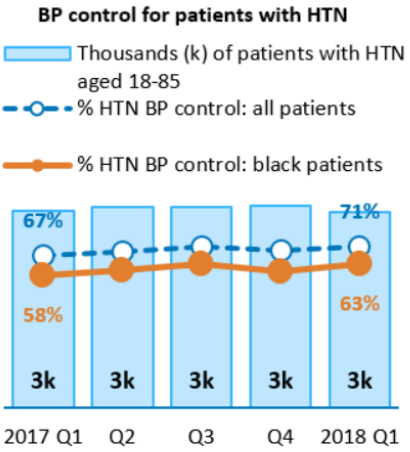
Richard Fine People's Clinic (SFHN) reduced HTN disparities by:

Population health management:

- Outreach to address racial inequity using culturally appropriate scripts***
- Established HTN equity as a priority
- Tracked outreach efforts

Team-based care:

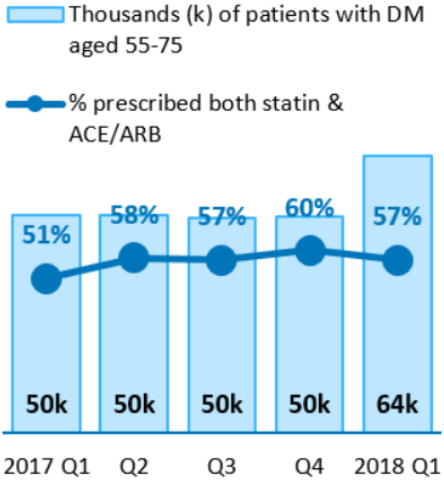
- Pharmacist conducts panel management and triages HTN patients to appropriate team members



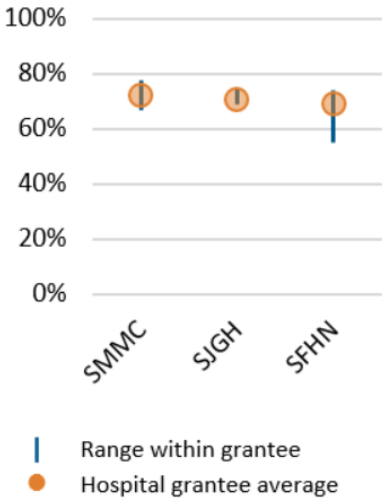
*** PHASE grantees are not required to submit race/ethnicity data; SFHN provided these data for the spotlight.

Prescription rates for those with diabetes (DM)

% prescribed both a statin and an ACE/ARB across the initiative*



Top performing grantees



* 5 grantees spread to additional sites in Q1 2018, leading to population increases.

Example strategies of how PHASE grantees are increasing prescribing rates for high risk patients across both HTN & DM populations:

Evidence-based practice
- Adopting and providing education on PHASE on a Page

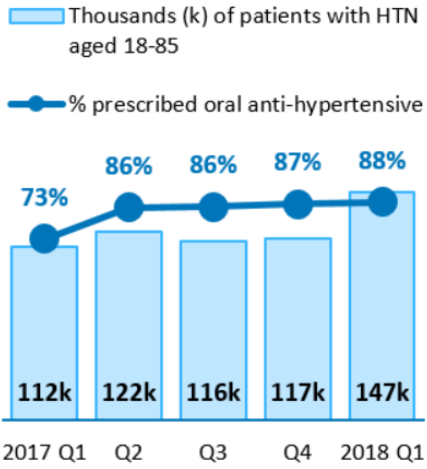
Team-based care
- Developing nurse and pharmacist protocols around medication titration

Data
- Implementing EHR/CDS alerts
- Validating and cleaning data (e.g., medication classifications)
- Reviewing and sharing provider-level data regularly

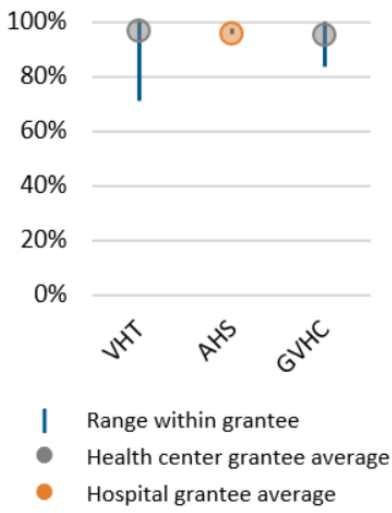
Population health management
- Using pre-visit planning or huddles to identify patients not on recommended medications

Prescription rates for those with hypertension (HTN)

% prescribed an oral anti-hypertensive across the initiative*



Top performing grantees



* 5 grantees spread to additional sites in Q1 2018, leading to population increases.

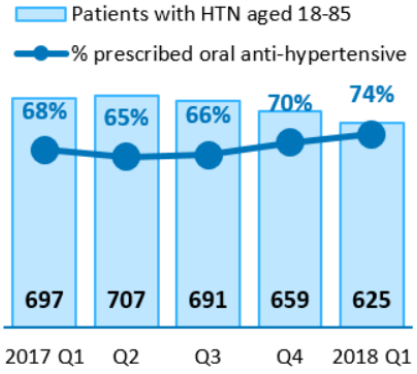
South of Market Health Center (member of SFCCC) improved the prescribing rate of oral anti-hypertensives through:

Evidence-based practice:
- Reviewed hypertensive guidelines with providers
- Implemented guidelines in NextGen

Quality improvement:
- Used PDSAs
- Regularly reviewed data

Team-based care:
- RN care managers reconciled medications
- Started RN visits focusing on medication review

% prescribed an oral anti-hypertensive



Data Gallery Notes

Patient Engagement Workshops

Empanelment for Team-Based Care and Population Health Management: Connecting the Dots for Better Patient Engagement

Regina Neal, MPH, MS
Director of Practice Transformation Consulting, Qualis Health

Session Location: El Dorado Room

Workshop Objectives:

- Assess empanelment in your practice and identify steps to strengthen your empanelment system
- Review elements for improved population health management, including empanelment and team-based care
- Discuss effective strategies to support and engage patients to manage their BP
- Identify specific areas where your organization can better enable patients to engage as partners in their care to improve BP control
- Leave the session with at least two action steps to continue the work discussed in the workshop

Workshop Description:
Empanelment enables primary care practices to "change the game" for patients by making access to and continuity with their primary care provider (PCP) and care team possible – key ingredients for successful patient engagement. In turn, having a defined population of focus enables the PCP and care team to provide the right care to the right patient at the right time. This leads to improved

outcomes and improved patient experience – which are also key requirements in a value-based environment.

In the workshop, empanelment expert Regina Neal will review key steps for empanelment. She will also discuss common challenges – and options for solutions – to help organizations continue to pursue empanelment, which offers high value for enabling population health management by care teams.

Using a QI framework, the workshop will assess strategies that care teams can use to support and engage their panel of patients to achieve improved BP control. The session will include opportunities for participants to identify empanelment barriers and "workshop" solutions with Regina and other participants.

Presenter Bio:
Regina Neal's perspective on implementing new models of primary care delivery is informed by more than 25 years of experience gained through positions with care delivery systems, health plans, public health departments, and consulting firms. Regina is an experienced consultant, practice coach, and trainer. She has substantial experience in the PCMH model of care, including performance improvement, leadership and change management, access, empanelment, and team-based care.

Regina helps clients deliver high-quality, patient-centered care by successfully implementing changes that transform practice with the goal of ensuring accountable, sustainable, and patient-centered systems of care.

Regina earned a Master of Public Health and a Master of Science in Urban Planning from Columbia University and a Bachelor of Science in Biology from Marymount Manhattan College.

Patient Engagement Workshops

Building Care Team–Patient Communication Skills to Enhance Health Outcomes

Michele Nanchoff, PhD, RPsych
Senior Trainer,
Institute for Healthcare Communication

Session Location: Mariposa Room

Workshop Objectives:

- Learn the fundamentals of improved care team-to-patient communications: engaging the person, empathizing with their concerns and situation, educating with clear language using proven strategies, and enlisting the patient as a partner and focus of care
- Identify the difference between biomedical tasks and communication tasks
- Practice a key patient education strategy and communication skill
- Explore ways you can take this new knowledge back to the exam room – and share with colleagues

Workshop Description:
Effective communication between members of the care team and patients yields numerous benefits — from more accurate diagnoses and more engaged patient decision making to improvements in job satisfaction and higher patient satisfaction scores.

Great! Now how do we get there?

Patient-centered communication skills are learnable. This fast-paced, research-based workshop from the Institute for Healthcare Communication will teach you these techniques and strategies – and give you a chance to practice.

Presenter Bio:
Dr. Michele Nanchoff is a psychologist, marriage and family therapist, and nurse. She operates a counselling and consulting practice in Calgary, Canada. Bringing over 30 years of experience in mental health and counselling in primary care, tertiary care, and ambulatory care settings, she also provides coaching to physicians and other health professionals to improve their communication skills.

Dr. Nanchoff is a senior trainer for the Institute for Health Care Communication. She conducts workshops and courses in clinician-patient communication throughout Canada and the U.S. In addition, Dr. Nanchoff holds an adjunct faculty appointment with the Department of Family Medicine at the University of Calgary.

Patient Engagement Workshops

Patient Activation: Rethinking Patient Non-Compliance

Juliane Tomlin, MA
Senior Manager, Practice Transformation,
Center for Care Innovations

Session Location: Amador Room

Workshop Objectives:

- Find out why a "non-compliant" patient might really be an "inactivated" patient
- Learn how an "activated" patient with the knowledge, skills, and confidence to manage their health and health care can positively impact quality outcomes, cost, utilization, and patient experience
- Gain skills and tools your care team can use to increase your patients' activation level for improved hypertension control
- Find out how to tailor your interventions to a patient's activation level for optimal efficiency and effectiveness of resources

Workshop Description:
Do you struggle with compliance among your PHASE patients? This workshop will demonstrate a new way to approach these challenges: with the goal of "activating" your patients so that they have the knowledge, skills, and confidence to manage their own health and health care.

Research demonstrates that "activated" patients:

- Have lower costs and utilization
- Have increased adherence to treatment plans and medication use
- Have improved outcomes
- Use fewer resources
- Are more likely to benefit from techniques such as health coaching and Motivational Interviewing

Through case studies and hands-on exercises, this workshop will provide tools and insights that you can take back to your team to set your patients up for success—by turning them into "activated" consumers who play a more engaged role in their own health.

Presenter Bio:
As a Senior Manager at the Center for Care Innovations, Juliane Tomlin provides strategic direction for practice transformation initiatives, trains and supports practice facilitation coaches and senior leaders, and facilitates redesign efforts to improve patient outcomes.

Prior to joining CCI, Juliane was a principal consultant at Kaiser Permanente's Care Management Institute, where she worked closely with senior leaders to design and execute a national cancer care strategy, and led improvement portfolios in colorectal cancer, care coordination, and complex pediatrics care.

Juliane leverages her clinical psychology education and experience as a therapist to facilitate successful change management and care delivery optimization. She received a bachelor's degree from the University of Michigan, Ann Arbor, and a master's degree in counseling psychology from Naropa University.

Workshop Notes

Charter for Improvement Update

The Charter for Improvement (CFI) is intended to provide a roadmap for achieving your PHASE goals and objectives during each half of the 2017-2019 grant cycle. The CFI is a "contract" between your organization, Kaiser Permanente and the PHASE support team, and identifies what you hope to achieve, the work you'll need to do and the technical assistance available to meet your goals.

Aligning your deeper organizational imperatives or strategic initiatives will help sustain PHASE momentum and will amplify its benefits for your organization, your care teams, and your patients.

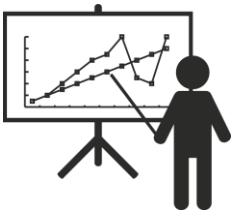
The CFI Goals Worksheet will help your team formalize and share what it hopes to accomplish though its July 2018 – December 2019 participation in PHASE and lay a strong foundation for success.

Your responses to the Goals Worksheet questions are due by 5pm July 2, 2018 via an online form.

CFI Notes

On the Horizon from Your Support Partners

Run Charts and Funnel Charts: Taking the Pulse of Improvement Efforts



July 18, 2018
12:00 – 1:00 p.m.
Jerry Lassa, MS Statistics, our resident statistician and faculty member of the Safety Net Analytics Program, will provide a primer on creating run charts and funnel charts.

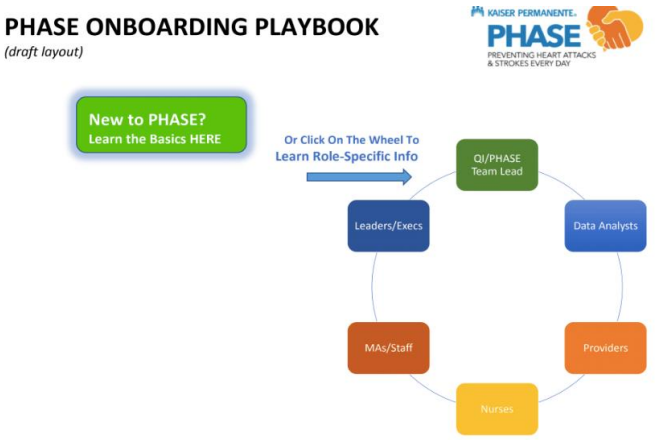
These two important statistical analysis tools help you to gain a deeper understanding of the data in your improvement efforts by helping to flag significant trends in performance and sift out provider-level opportunities to improve. Jerry will also provide an easy to use Excel template for participants to create these simple yet impactful visual analyses.

Co-Design Session for Group Coaching and Peer Sharing

July 16, 2018
12:00 – 1:00 p.m
Help us help you in new and better ways! To meet our support goals of spreading expert coaching and peer learning more broadly across the PHASE cohort, CCI will be hosting a virtual co-design session in mid-July. Check the newsletter for more details and sign up.

Onboarding Playbook

Please check out the first version of our Onboarding Playbook, found at **PHASEsupport.org**, and let us know what you think—especially if you're orienting new team members to PHASE.



We'll be supplementing the current version with videos, tools, and a deeper set of resources by role so that everyone in a PHASE-participating organization understands what they need to *know* and what they need to *do* to achieve excellence in hypertension control.

Next In-Person Convening

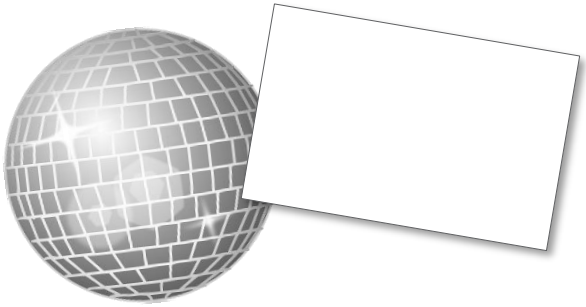
November 29, 2018

8:30 a.m.- 4:00 p.m.

Save the date for the Fall In-Person Convening.

Inspiration Disco

How to Play



1. Use the index card to capture ONE thing you heard today that inspired you.

2. When the music begins, take a pen and walk around, continually passing your index cards to one another.

3. When the music **STOPS**, stop trading and read the card. On the back, rate the observation from 1 to 5. A rating of 5 means that the observation really inspired you too! A lower rating means that it wasn't so inspirational for you.

4. After the 4th round, add your score and total the points.

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Thanks for spending the day with us!

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