



PHASE Capacity Building Programs in Sacramento and Central Valley/Fresno

Evaluation Executive Summary – March 2017

Driven by its mission to improve health, Kaiser Permanente Northern California developed PHASE (Preventing Heart Attacks and Strokes Every day), an evidenced based, population management approach for patients most at risk for heart attacks and strokes. PHASE focuses on preventing cardiac and cerebrovascular events with proven medications and aggressive risk factor management. Since 2003, Kaiser Permanente has reduced heart attacks and stroke-related hospital admissions among its own members by 60 percent through implementing PHASE.

Recognizing the potential public health benefits of making PHASE available to other organizations, Kaiser Permanente Northern California Region Community Benefit Programs began providing grant support and technical assistance to safety net organizations to implement, spread and sustain PHASE. From 2006 to 2014, the organization provided eight grants to northern California regional consortia and public hospitals.

In early 2015, Kaiser Permanente Northern California began reflecting on what had been learned during the previous PHASE grants to determine what it wanted to accomplish going forward. It established the PHASE Support Team—comprised of external technical assistance (TA) providers and evaluators—to support expanded PHASE redesign and implementation efforts. As a result of this process, Kaiser Permanente began publicly defining **PHASE as an evidence-based, population health management program and clinical protocol that, when followed, reduces cardiac events**. In addition, learnings from previous evaluation efforts helped focus the PHASE initiative further, with emphasis on six “PHASE Building Blocks” that were critical to the program’s successful implementation:

- Adoption of evidence-based clinical guidelines
- Engaged leadership and supportive culture
- Quality improvement culture and process improvement methodology
- Data-driven decision making
- Team-based care
- Panel management

Kaiser Permanente Northern California began looking to spread PHASE to areas of the region that had not yet been reached—particularly Sacramento and the Central Valley and Fresno. In the absence of a consortium that focused specifically on supporting Federally Qualified Health Centers in these regions, Kaiser Permanente Northern California looked at ways to provide support directly to the health centers. Because these health centers hadn’t been exposed to PHASE, the focus was on building capacity in the PHASE Building Blocks in order to prepare health centers to be able to effectively implement PHASE in the future.

- In 2015, Kaiser Permanente Northern California launched a learning community in Sacramento focused on quality and process improvement, which was led by the Institute for High Quality Care (IHQC). This

program provided two-year grants (January 2015- December 2016) to six community health centers in the Sacramento region (\$75,000/year).

- In 2016, Kaiser Permanente Northern California launched a second learning community focused on data-driven decision making in the Central Valley and Fresno (CVF), which was led by the Center for Care Innovations (CCI). This program provided one-year, \$75,000 grants (January-December 2016) to five community health centers in the CVF region.

This is a summary of the evaluation reports for these two capacity building programs.

Sacramento Clinical Capacity Building Program for Chronic Care Management

The Sacramento learning community built on Kaiser Permanente Northern California and the Sierra Health Foundation's previous capacity building investments in these community health centers. The quality and process improvement program curriculum was developed by IHQC based on their experience running similar programs. IHQC's quality improvement (QI) curriculum is based on The Model for Improvement, a framework developed by the Associates in Process Improvement¹ and promoted by the Institute for Healthcare Improvement.² Fundamental steps of the model include: forming a team; setting aims; establishing measures; and selecting, testing, implementing, and spreading changes.

Sacramento Grantees

Cares Community Health
Chapa-De Indian Health
Elica Health Center
Sacramento Native
American Health Center
WellSpace Health
Winters Healthcare

This two-year grant involved a planning and implementation phase. The program planning phase ran from January to September 2015, and included: clinical capacity assessment; in-person planning workshop; and development of project charters. The implementation phase, launched in late September 2015, paired in-person workshops with technical assistance and, as needed, customized support from IHQC. These efforts aimed to build QI capacity and help teams apply what they learned to a chronic care management project.

Health centers primarily used their grant funding to support release time for staff to participate in the program and lead project implementation. In addition to funding staff time, some grantees used grant funds to invest in systems improvements necessary to support their QI efforts (e.g., registries).

Most grantees were successful at applying QI tools to implement their projects, which resulted in some improvements to clinical and operational metrics.

While this program was a cohort within the overall PHASE initiative, health centers were not required to focus their project on reducing risk for CVD. Instead, they focused on QI and process improvement and were encouraged to apply the QI skills and tools they learned to address a chronic care management project that was a high priority for their health center. While there was no explicit requirement to align with the PHASE protocol or population of interest, five of the six health centers identified projects focusing on patients with a diagnosis of diabetes or hypertension. One health center focused on cervical cancer.

¹ <http://www.apiweb.org>

² <http://www.ihl.org/resources/Pages/HowtoImprove/default.aspx>

Through participation in the program, **all teams reported gains in building their capacity for QI and process improvement, despite significant challenges.** Some successes included: improving clinical work flows; using QI tools to improve team huddles; and establishing QI teams that meet regularly to discuss data.

By applying these QI tools, processes, and skills to an improvement project, **grantees demonstrated improvements in some of the key clinical or operational measures that they were targeting.** For example:

- Two health centers decreased the percentage of patients with diabetes that had out of control blood sugar (as measured by hemoglobin A1c lab results).
- One health center decreased cycle time for pap smear visits from 80 minutes to 55 minutes.
- Three health centers reported improvements in preventive and proactive care measures (e.g., screening)

Grantees reported that project progress was facilitated by leadership and staff support, shared vision and team work (e.g., common goal of better patient care, willingness to jump in), access to data to inform their efforts, and having dedicated time to participate and work on their projects. Several grantees indicated a commitment to continue to build on the work they completed as part of this grant.

The most common challenges reported were managing significant staff and leadership turnover, and limited staff capacity. Turnover was experienced at all levels of the clinic organizations, including executive leaders, providers, QI managers, and other key staff such as data analysts or medical assistants. Across the cohort, this impacted teams' ability to move their project work forward and impacted team morale. Access to quality data was also a significant challenge for this cohort.

While focused on QI capacity, grantees reported that the program helped build capacity in all of the PHASE Building Blocks.

Grantees reported that participation in the program helped build capacity across the domains, including:

Supportive leadership and culture, despite high levels of leadership turnover. During the two-year program, this cohort experienced significant turnover in the "c-suite". However, in both the baseline and follow-up assessments, grantees rated their health centers relatively high in this domain. They reported their health centers had leaders who supported QI and medical directors who valued proactive care. IHQC noted that some health centers could have benefited from increased leadership engagement to overcome challenges.

Increased confidence in and capacity for QI. Clinic teams reported significant strides had been made in establishing a QI infrastructure. Several teams reported increased confidence in their QI teams, that their QI teams and committees were still meeting regularly and reporting on their data. While responses to the baseline and follow-up capacity assessments for this cohort are not directly comparable,³ it is promising that while 42% of questions in the QI domain were rated as "not yet prepared" at baseline, only 5% of the QI questions at the follow-up scored in the lower two levels, which supports qualitative data that there was improvement in this domain.

³ To understand current health center capacity and practices, the grantees completed the BCCQ Clinical Assessment at the start of the program (Spring 2015). To align with the other PHASE cohorts, grantees completed the PHASE Building Blocks Assessment at the end of the program (Fall 2016). These two assessments are similar but results are not easily comparable.

Improved access to meaningful data. At both baseline and follow-up assessments, the data domain was rated as the lowest of the domains. All team representatives reported taking action to improve their capacity in this area. At the end of the program, three teams reported improvements had been made. IHQC agreed that teams are now better able to look at run charts, communicate about their data, and have gained familiarity with interpretation of population-level data. Grantees also reported that data were more frequently shared across the teams instead of being “siloes” with providers. While grantees did make progress, they noted that challenges in this domain persisted, including difficulty retrieving meaningful, accurate data from current data systems, and pulling reports.

Improved ability to deliver team-based, patient-centered, proactive care. At baseline, grantees perceived team-based care to be a relative area of strength and reported significant and continuing progress related to team-based care as part of the program. This included: expanding team member roles; making teams more multi-disciplinary; establishing team agreements and workflows; and improving communication. Grantees reported that participation in the program also improved their overall approach to population health management through:

- Increased focus on, and a more structured approach to care management
- More intentional focus on improving population-level clinical metrics
- Enhanced efforts related to outreach, in-reach, and follow-up care
- Refined workflows to improve patient-centered and proactive care for patients

Participants reported a high degree of satisfaction with the overall program.

Teams gave overwhelmingly positive reviews to the program and IHQC faculty. The program was reported to be well organized and structured. Clinic teams reported that IHQC faculty members were knowledgeable, supportive, personable, and responsive. Grantees noted that the program brought “focus” to their ability to address QI and helped them target interventions; they reported that IHQC gave respectful feedback to help improve projects. Additionally, the skills learned in this program were seen as highly applicable and relevant to participants. In post-workshop surveys, all respondents reported that they could apply the information they learned to their jobs.

Participants reported that in-person workshops and practical tools and templates contributed most to their progress. Clinic teams viewed these workshops as an incredibly valuable part of the program; they appreciated the opportunity to learn from experts and their peers, and having dedicated time to work with their teams.

Participants also shared an appreciation for the program’s collaborative learning environment. They emphasized the value of sharing ideas, peer learning, and networking. Participants discussed how hearing from other clinics helped them understand success factors, learn how teams working with a similar patient population overcame challenges, and apply lessons learned by others to their own clinic’s QI efforts. They reported that the importance of a supportive, safe space in which to give and receive support cannot be underemphasized in this work.

While health centers improved their readiness for PHASE during the program, additional support may be required to facilitate successful implementation.

The health centers participating in this program have been undergoing significant changes driven by shifts in the health care environment. In response, they have been rapidly growing and expanding services, implementing new IT systems, and strengthening key clinical and operational capacities. Many of the clinics have been doing this

work while managing significant turnover in leadership and key staff positions across their organizations. This program has provided them with resources to reflect on their clinic practice, identify opportunities for improvement, and develop and enhance skills in the area of quality and process improvement, which can ultimately impact their ability to effectively manage population health. Moving forward, they may require additional assistance related to overcoming challenges with leadership stability and data systems functionality in order to successfully implement, sustain, and spread PHASE across their health center.

Building Capacity for Data-Driven Decision Making in Central Valley & Fresno

In 2016, Kaiser Permanente Northern California awarded one-year grants to a cohort of five community health centers in the Central Valley and Fresno region. The grant funding supported community health center participation in a learning community and aimed at increasing their capacity for data-driven decision making—ultimately building capacity to implement population health management programs like PHASE. The program, led by CCI, focused on data management capabilities including: leadership and governance, technology, performance measurement and reporting, communicating with data, and building a data-driven culture.

CVF Grantees

Camarena Health

Community Medical Center

Golden Valley Health Centers

Livingston Community Health

Valley Health Team

The program kicked off in late February 2016. The first three months were spent learning about capacities required for successful implementation of PHASE and articulating project roadmaps and data strategies. The remainder of the grant period included three in-person workshops, monthly webinar learning sessions, quarterly team leader calls (for peer exchange across grantees), monthly individual team coaching calls, and, as needed, customized support. The coaching and technical assistance aimed to build data-driven decision making capacity and help teams apply what they learned to a data analytics project.

Most grantees were successful at increasing capacity for data-driven decision making, particularly related to data quality, data-driven culture, and use of panel-level data.

As a cohort within the overall PHASE initiative, these five health centers were asked to select from the PHASE clinical quality measures for their data analytics project. By focusing on a small number of metrics (2-6), grantees worked to advance data analytics capacity in a high priority area for their health center.

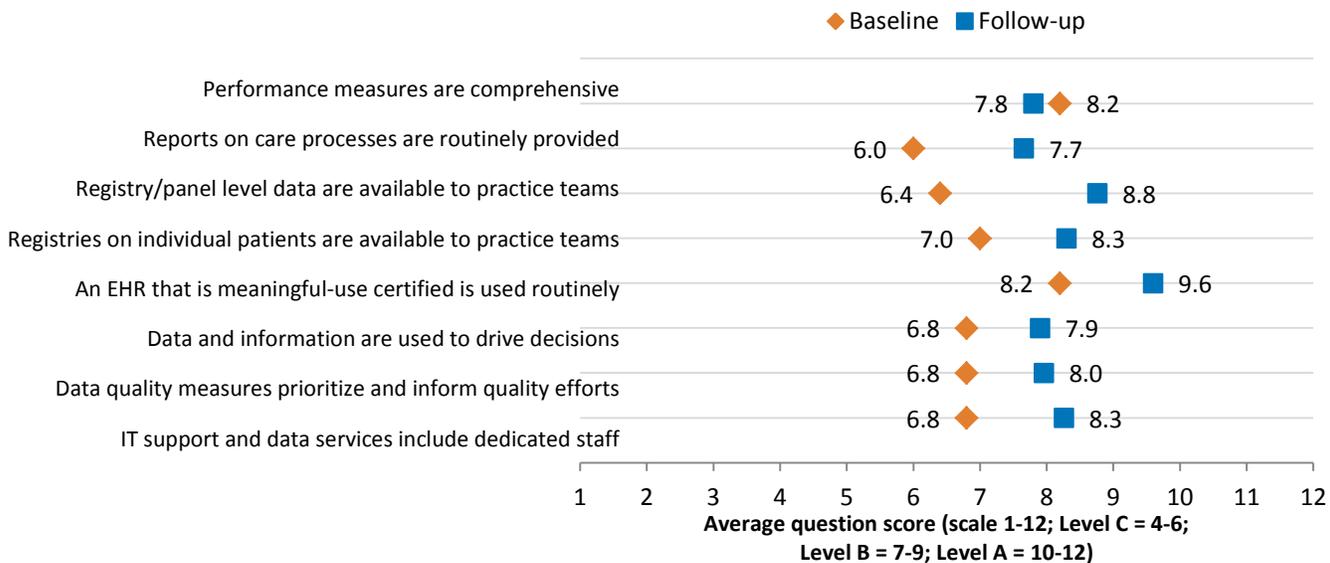
Capacity for data-based decision making is one of the foundational building blocks for effectively engaging in population health management and for programs like PHASE. In April 2016, all five grantees completed the PHASE Building Blocks Assessment⁴ to provide insights related to self-assessed capacity early in the program. The data-

⁴ The PHASE Building Blocks Assessment has 32 questions in the following five domains: Leadership and Culture, Quality Improvement Infrastructure, Data-based Decision Making, Team-based Care, and Panel/population Health Management. Health center team members individually rated their health centers on a 12-point scale, which is broken into Levels A through D (with Levels C and D suggesting an opportunity for improvement). Teams then met with CCHI and CCI to review individual responses and agree to a consensus rating for each item.

based decision making domain was administered again in December 2016. **The cohort average increased for all but one question in the data-based decisions domain** (see figure on the next page).

In addition to looking at the average rating for each question, the percent of responses at lower levels of the assessment were examined to identify potential areas for improvement. At baseline, **over 50% of the questions in the data-based decision making domain were identified as opportunities for improvement, this reduced significantly to 13% at follow-up.**

Building Blocks Assessment: data-based decision making questions (n=5)



Four of the five CVF grantees' Building Blocks assessments identified **gains related to data quality, data-driven culture, and use of panel-level data**, which was also supported by the qualitative interview data. Successes included:

- **Data quality:** establishment of dashboards; creation of standardized clinical workflows to improve accuracy of data entry; and use of error report analyses and data validation tools to improve quality.
- **Data-driven culture:** shifting ownership of data; increasing staff demand for data. For example one grantee stated, *"[Clinical staff] is taking responsibility for why the numbers aren't right. They are asking 'Tell me why' and 'How can we fix it?'"*
- **Panel-level data:** data were available to assess and manage care for practice populations.

Grantees reported that their progress in improving data-based decision making was facilitated by:

- Having dedicated work time for participating in the program
- Letting others—outside of the QI team—use, own, and interact with data
- Having data to inform decisions, noting that data are difficult to argue with and can show "the truth"
- Moving toward data transparency by emphasizing data are for learning not punishment
- Garnering leadership support

As a result of implementing their data-analytics project, several grantees reported improvements in selected clinical and operational metrics.

During the program, some teams were able to make measurable improvements on their selected PHASE quality metrics. **Two grantees achieved statistically significant improvements for blood pressure control among their patient population.** Individual grantee achievements included:

- 5% improvement in BP control among patients with diabetes over a 9-month period (a statistically significant change); two other grantees saw a slight improvement in the same measure (both reporting 3% improvement over different time periods).
- 6% improvement in BP control among patients with hypertension over an 8-month period (a statistically significant change); two other grantees reported modest improvements in this measure.
- 12% increase in follow-up for patients with high BMI, including a documented follow-up plan.

Grantees reported strengths in their capacity for quality improvement and opportunities for improvement in the areas of leadership and culture, team-based care, and population health management.

In addition to understanding capacity related to data-based decision making, grantees also discussed the importance of the other the PHASE Building Blocks domains to successfully implement a population health management program like PHASE.

Most grantees reported improvements in supportive leadership, vision, and culture during the program.

Supportive leadership and culture is a fundamental characteristic for clinics to effectively participate in PHASE. On a post-program grantee survey, two of the five grantees reported that leadership engagement had increased. In interviews, two other grantees discussed growing engagement/attention from leaders, specifically related to investment in and use of data.

Quality improvement (QI) infrastructure and practices were a key strength for grantees entering the program, and most reported it increased through the program.

While some grantees entered the program year with relatively strong QI infrastructure, four of the five grantees reported capacity for QI increased greatly. This is likely because grantees were using and improving their QI infrastructure, tools and processes to implement their data management processes and analytics projects (e.g., data mapping, error analysis, report testing, and data visualization).

Team-based care improved for three of five grantees over the program year.

Three of the five grantees reported their capacity for team-based care had increased. Reported improvements in this domain included: increased communication between medical assistants and providers; involvement of care coordinators; and team coordination to improve PHASE measures.

Grantees were building capacity in the Building Blocks necessary for panel/population health management.

For most grantees, population health management was supported by patient empanelment, the use of registry and panel-level data to inform proactive patient care (e.g., in-reach, outreach efforts), and use of their electronic health record to support panel management and QI.

Participants reported a high degree of satisfaction with the technical assistance and support.

Grantees reported high levels of satisfaction with the technical assistance (TA) and training, and felt well supported throughout the program. One site reported that their feedback to the TA providers was incorporated along the way and “every convening has gotten better and better.” All grantees reported that the TA made a contribution to key PHASE outcomes, including: improved clinical systems/processes to ensure high quality care and improved data integrity and utilization.

Grantees indicated learning workshops, customized TA and specialized data analytic tools contributed to the most to their progress.

Workshops: The three learning workshop ratings improved dramatically over the course of the program year. Workshops were consistently rated “excellent” or “very good” by a majority of survey respondents.

Check-in calls and customized TA: Grantees reported that the team check-calls with their coach were helpful for encouragement and accountability. The team leader check-in calls across the cohort helped grantees learn from each other. Grantees also indicated that they appreciated the responsiveness of CCI to individualized requests.

Project workbook: All grantees reported that the workbook was a useful tool that helped them to identify measures, identify data strategies, and develop a reporting structure for the measures.

Health centers increased their capacity for data-driven decision making during the program, yet continued to report challenges that may influence PHASE implementation going forward.

By providing practical tools and experiential learning, the CVF learning community helped grantees progress towards a data-driven decision making culture and improved data management processes. All five grantees provided examples of increased their capacity in data-based decision making. Key capacity was built in the areas of data quality and data-driven culture for most grantees, and several grantees reported improvements in selected clinical and operational metrics. In addition to improving capacity related to data-based decision making, grantees reported improvements in the other key PHASE Building Blocks. Moving forward with PHASE implementation, it is noteworthy that these grantees reported ongoing challenges related to data entry and data mapping that may require additional support in order to be able to report on all of the PHASE metrics. Grantees also expressed a desire for more support and technical assistance to advance their team-based care work in order to successfully implement, sustain, and spread PHASE across their health centers.