# WELCOME

# PHASE Grantee Convening

*Sharing Ideas to Accelerate Progress*

June 5, 2018

KAISER PERMANENTE®

PHASE

PREVENTING HEART ATTACKS & STROKES EVERY DAY

# Thank You to Our Co-Designers

## Convening Goals:

- Knowledge Dissemination
- Peer Sharing
- Skill Building

## What we heard from Co-Design:

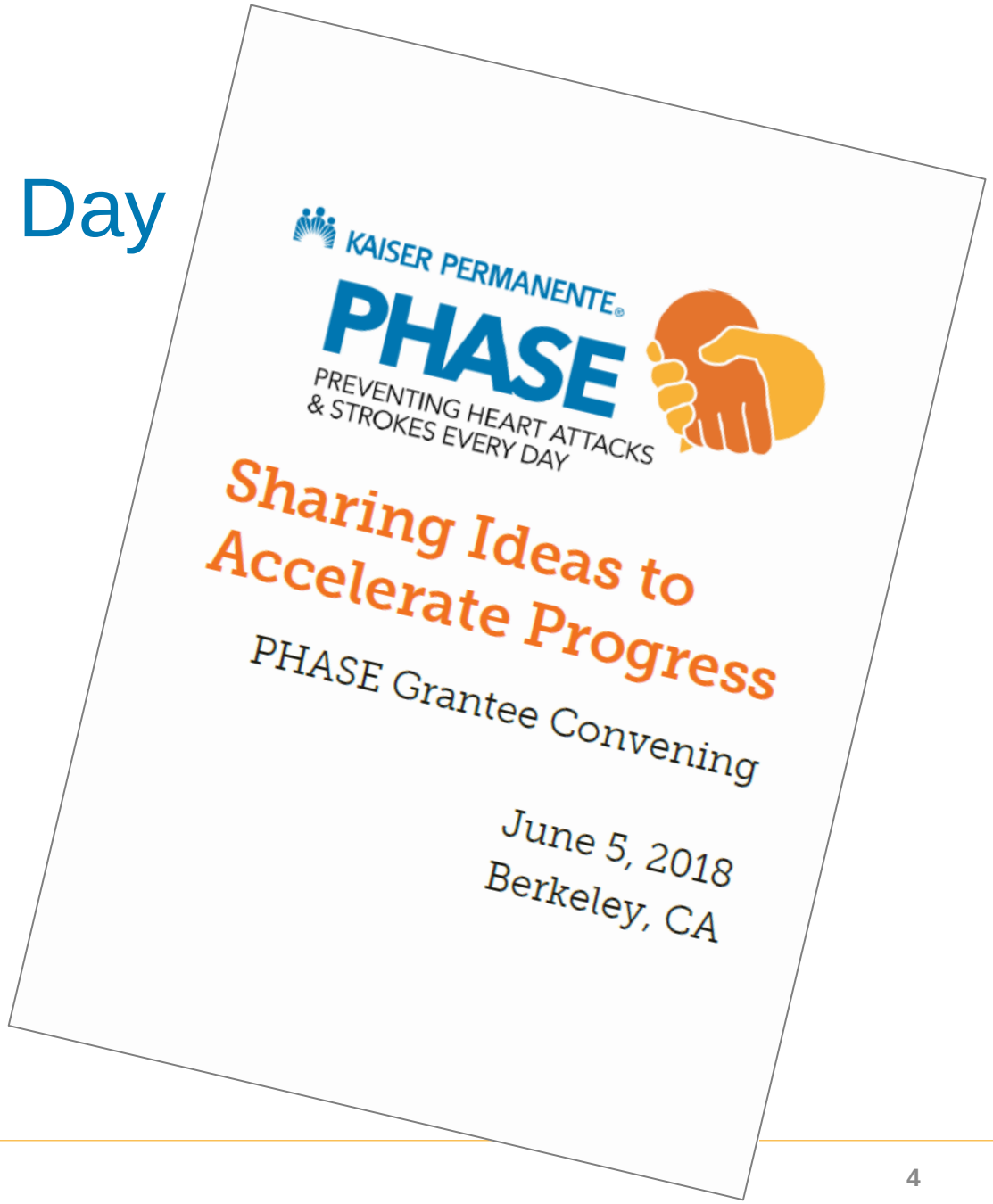
- Learning from Peers
- Patient Engagement Issues are Key

# Video!

# Your Guide to the Day


Your Workshop

Where you'll start your Data Gallery Walkabout



# The Power of Storytelling: 15 Minutes of PHASE Fame

**Douglas Frey, FNP Lifelong Downtown Oakland Clinic**

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

**Joan Singson, Director of Population Health Management – SJGH**

*From Idea to Impact: Our Congestive Heart Failure Clinic Journey*

**Bo Greaves, MD – Hearts of Sonoma County**

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

# What's In Store - Morning

## Knowledge Sharing From Kaiser Permanente

- Dr. Jamal Rana, Kaiser Permanente

## Data Gallery and Walkabout

- Measuring our progress and learning from bright spots

## Charter for Improvement & Team Time

- Set your goals for the second half of the PHASE grant cycle

# Lunchtime Peer Consults & Conversations

- Michelle Rosaschi, Redwood Community Health Coalition
  - *Diabetes Care Journey Map*
- Felicia Batts, Livingston Community Health
  - *PHASE on a Page and the MediCal formulary*
- Nurse Led HTN Care

# What's In Store - Afternoon

## Patient Engagement Workshops

- Session indicated on your name tag:
  #1 Empanelment to Support Team Based Care – El Dorado Room
  #2 Patient/Care Team Communication – Mariposa Room
  #3 Patient Activation – Amador Room

## On the Horizon

- What's in Store for Support, TA and Coaching

## Inspiration Disco

- A fun way to end the day!

# Odds and Ends

- Rideshare to BART or Amtrak
  - Sign up at registration table
- Drivers: parking validation sticker
  - With receipt of evaluation form!
- Conference materials (workshops, handouts)
  - *https://www.careinnovations.org/phase-june-2018-convening*

# PHASE Building Block Bingo

1. Take a set of dots from the table.
2. Find your name in the Participant Directory.
3. Write the number corresponding to your name on your dots.

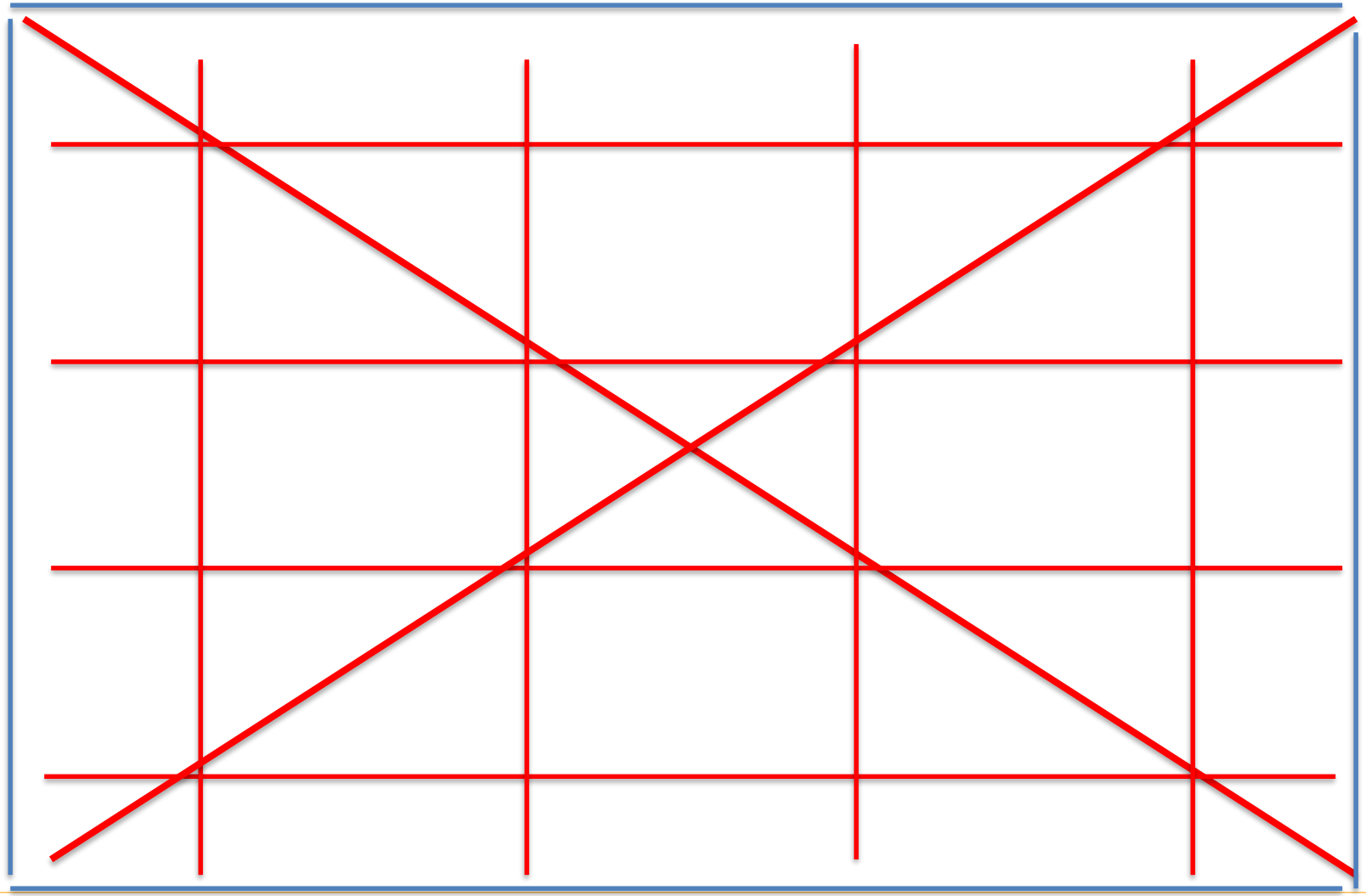
| Key: Building Blocks of PHASE | | | | |
|---|---|---|---|---|
| Supportive, Engaged Leadership & Culture | QI Culture & Process Improvement Methodology | Data-Driven Decision Making | Panel Management | Team-Based Care |

# PHASE Building Block Bingo

4. Look at the statements in each of the Bingo boxes on the next page.
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. When you get four in a row, call **BINGO**!
8. Claim your fabulous prizes at the registration table at lunch or before you leave.

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

# Ten Ways to Win!



# Reducing Heart Attack and Stroke Risk: Impact of PHASE at Kaiser Permanente Northern California


## Jamal S. Rana MD, PhD, FACC

**Chief , Division of Cardiology, Eastbay**

**Adjunct Investigator, Division of Research**

**Kaiser Permanente Northern California**

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# Agenda

**WHY**

**WHAT**

**HOW**

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# WHY

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# DIABETES

- Between 1990 and 2010, adults reporting diabetes more than tripled, from 6.5 million to 20.7 million.
- Optimal risk factor control among individuals with diabetes -high risk for heart attacks and stroke- is considered the cornerstone for contemporary clinical practice.
- It has proven challenging to achieve risk factor control in clinical practice.

# WHAT

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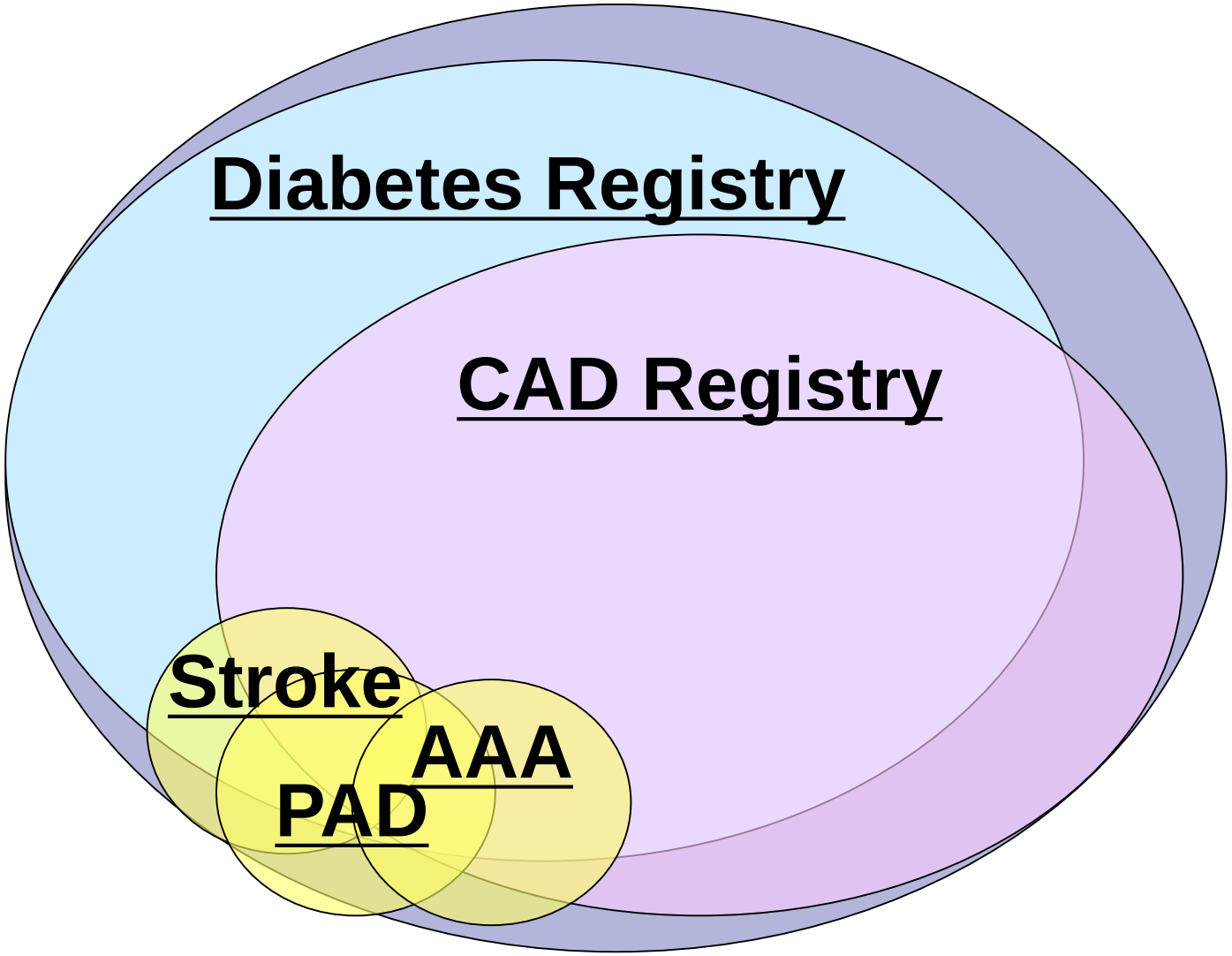
# Preventing Heart Attacks and Strokes Everyday

- In 2004, Kaiser Permanente Northern California, launched the (PHASE) program.

- A major focus of this population management program was to consistently deliver evidence-based preventive therapies for controlling blood glucose, low-density lipoprotein cholesterol (LDL-C), and blood pressure.

# PHASE Registry






The Permanente Medical Group, Inc. • Supported by Quality and Operations Support, Joe Young, MD; Marc Jaffe, MD (6/14/2018)

## Dx's/ Events

LAST 24 months (rolling)

2+ DM Dx

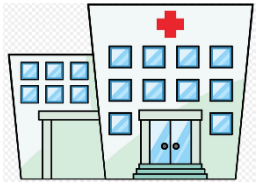
OR

1+ DM Rx

DM Registry

2+ CV Dx

OR



1+ CV hospitalization

CAD Registry

PHASE Registry

LAST 36 months (rolling)

1+ AAA Dx

OR

1+ CVA DX

OR

1+ PAD/PVD DX



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# Diabetes Registry: Ages 18+
# A1c & LDL PROMPT lists: Ages 18 to < 76

- Current members who meet any of these criteria within last **24 months:**
  - 2+ ambulatory DM Dx (closed office encounter, separate service dates) with an MD/DO/NP or PharmD, RNX
  - **OR** 2+ inpatient DM Dx
  - **OR** 2+ ED DM Dx
  - **OR** filled DM Rx at KP pharmacy (excluding metformin, actos, DM supplies)
- ***Exclusions:*** Member with a diagnosis of
  - Gestational diabetes in last 24 months
  - Steroid induce diabetes (STERO) in last 24 months
  - Polycystic ovaries (PCOS) diagnosis since 1994

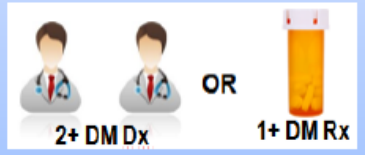
# PROMPT A1c & LDL "Lists" (Based on PHASE Registry):

Patients eligible for Population Mgmt, Safety Net Lab Ordering, Regional Outreach

## Diabetes Registry → A1C PROMPT Lists 18-76 y.o.

Current members who meet any of these criteria within the **last** 24 months:

- 2+ ambulatory DM Dx (closed office encounters, separate service dates. MD or APM)
- 2+ inpatient DM Dx
- 2+ ED DM Dx
- Filled DM Rx (excluding metformin, actos, DM supplies) at a KP pharmacy




**Onlisting***
Must meet DM Registry criteria

**Diabetes Review Registry/ PROMPT DM- Review Registry**

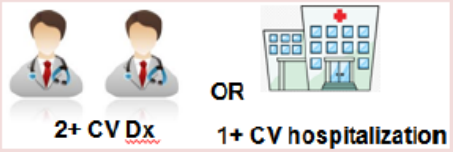
**Offlisting***
Use "offlist" button in PROMPT

Offlist

## CAD Registry → LDL PROMPT Lists 18-76 y.o.

Current members who meet any of these criteria within **last** 24 months:

- 1+ hospitalizations with an AMI Dx
- 2+ ambulatory Dx with a qualifying cardiac Dx
- **ONE WAY TICKET:** 1+ hospitalization after 1994 with a procedure Dx of PTCA or CABG




**Onlisting***
Must meet CAD Registry criteria

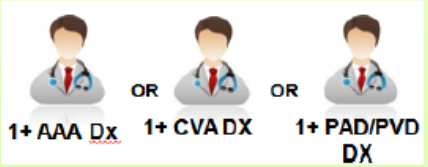
**CAD Review Registry (Not yet visible in PROMPT)**

**Offlisting***
Offlist Workflow for CAD Registry (PROMPT LDL list) is coming soon

## Other CV Dx → LDL PROMPT Lists 18-76 y.o.

Current members who meet any of thees criteria within **last** 36 months:

- 1+ Abdominal Aortic Aneurysm (AAA) Dx
- 1+ qualifying Peripheral Vascular Disease (PVD/PAD) Dx
- 1+ Qualifying Stroke (CVA) Dx




**Onlisting***
Must meet Other Dx Registry criteria

**Offlisting***
See "Coding Cleanup for Stroke & PAD" located on QOS website under "Coding"

**TIA Offlist Workflow coming soon**

**PHASE Registry exclusions that are viewable in PROMPT**: ESRD, Skilled Nursing Facility (SNF), Hospice, Ages > 76

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# HOW

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# Acknowledgements

Marc Jaffe MD

Rick Dlott MD

Irene Chen MD

The PHASE TEAM

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# 1. REGISTRY

- Identified potentially eligible individuals with for cardiac risk reduction activities.

- Updated quarterly using outpatient diagnostic codes, pharmacy data, and hospitalization records from health plan databases,

- Similar to the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) specifications, patients were not included on the basis of elevated HbA1c measurements alone, rather a combination of inpatient diagnoses of diabetes, outpatient diagnoses of diabetes, and diabetes medication prescriptions

 

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# 2. Keeping track and reporting

- Annual prevalence of hypertension, LDL-C, and HbA1c control to the NCQA in accordance with HEDIS specifications.

- NCQA HEDIS definition for good blood pressure control was determined using the blood pressure reading from the most recent outpatient clinic measurement recorded during the measurement year.

- NCQA HEDIS quality goal performance for LDL-C < 100 mg/dL and HbA1c > 9% was determined using the most recent laboratory values.

 

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# 2. Keeping track and reporting

- More frequent internal cardiovascular risk factor control reports were developed for quality improvement use every 1 to 3 months for each KPNC medical center and distributed to the center directors.

- A central management team identified centers that demonstrated successful practices and disseminated effective strategies to the other medical centers.

# 3. Treatment algorithm: Keeping it Simple

- Comprehensive and simplified evidence-based cardiovascular risk factor control algorithm for step therapy was developed in 2004.

- The treatment algorithm combined the recommendations of 4 different guidelines
  - Coronary Artery Disease Guideline,
  - Diabetes Guideline
  - Cholesterol Guideline
  - Hypertension Guideline
- Summary recommendations referred to as "**PHASE on a Page.**"

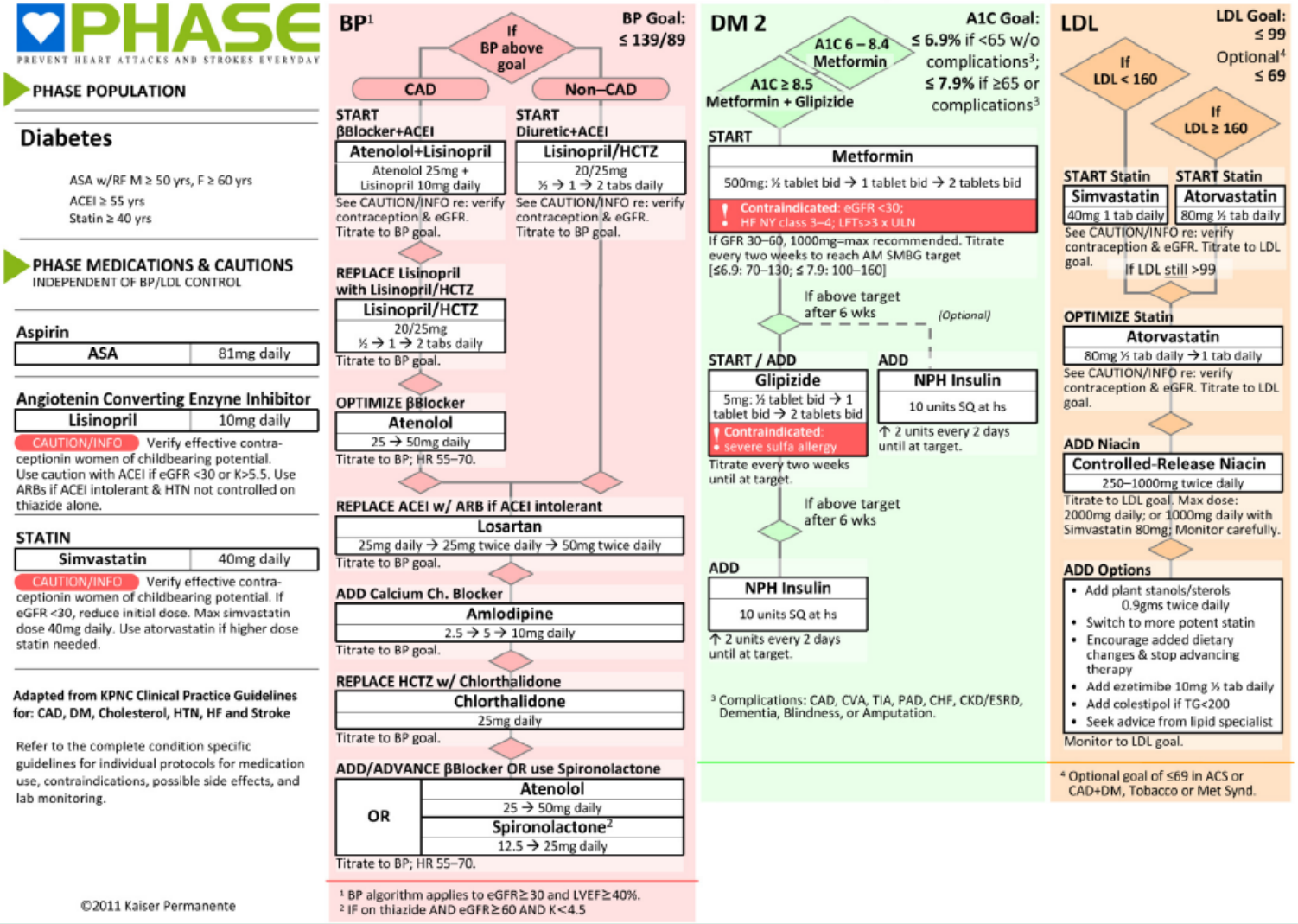


**Figure 1** Kaiser Permanente Northern California cardiovascular risk factor treatment algorithm for people with diabetes. This figure is modified from the 2011 "PHASE on a Page" algorithm as a sample. This treatment algorithm is informational only. It is not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by practitioners, considering each patient's needs on an individual basis. Treatment algorithm recommendations apply to the populations of patients. Clinical judgment is necessary to design treatment plans for individual patients.

# 3. Treatment algorithm: Keeping it Simple

- Updated every 2 years or more frequently according to emerging clinical trial evidence and national guidelines.

- Clinicians were encouraged to follow the algorithm unless clinical discretion required otherwise.

# 3. Treatment algorithm: Keeping it Simple

- Dissemination of guidelines and the treatment algorithm occurred through
  - distribution of printed documents,
  - e-mail,
  - clinical tools (e.g, pocket cards),
  - videoconferences,
  - lectures,
  - partnering with pharmacy managers, and use of the
  - electronic medical record (EMR) decision support tools.

# 4. Building Teams

- Medical centers used nurse and pharmacist care managers, working under system-wide designed and locally endorsed treatment protocols with referral from and under the supervision of primary care physicians, to identify, contact, educate, engage, treat, and follow eligible patients.
- In addition to the use of registries, performance metrics, and evidence-based treatment protocols, the PHASE program utilized nurses and pharmacists in care management roles.
- Patient was initially contacted by and subsequently communicated with the care managers by phone, secure e-mail communication, fax, letter, and in-person visits determined by the preference of the patient and information required to assess risk factor control.

# 4. Care Manager Nurses and Pharmacists

| Each Clinic | Interventions | Home Based |
| --- | --- | --- |
| ▪ Deployed to support the primary care team and to help individuals control blood glucose, lipids, and blood pressure, as well as to ensure the proper use of cardiovascular prevention drugs, such as statins, aspirin, angiotensin-converting enzyme inhibitors, and β-blockers, when appropriate. | ▪ Included providing self-care education, titrating medications according to protocol, and identifying candidates for referral to health education classes (e.g, for smoking cessation or diabetes education). | ▪ Telephone calls, letters, and encrypted secure e-mail messages. This protocol facilitated treatment initiation and intensification without requiring physician input or in-person clinic visits, while simultaneously improving patient convenience and affordability |

 

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CLINICAL RESEARCH STUDY

THE AMERICAN JOURNAL of MEDICINE®

# Improved Cardiovascular Risk Factors Control Associated with a Large-Scale Population Management Program Among Diabetes Patients

**Jamal S. Rana, MD, PhD,[a,b,c] Andrew J. Karter, PhD,[c,d] Jennifer Y. Liu, MPH,[c] Howard H. Moffet, MPH,[c] Marc G. Jaffe, MD[e]**

*[a]Division of Cardiology, Kaiser Permanente Northern California, Oakland; [b]Department of Medicine, University of California, San Francisco; [c]Division of Research, Kaiser Permanente Northern California, Oakland; [d]Department of General Internal Medicine, University of California, San Francisco; [e]Division of Endocrinology, Kaiser Permanente Northern California, South San Francisco.*

 

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# METHODS

- Patients identified as having diabetes from 2003-2013 were included (n range = 97,879 - 122,118).

- The comparison group comprised reported national mean National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) commercial rates of risk factor control from health plans that participated in the NCQA HEDIS quality measure reporting process.

- To identify substantial changes in trends, we carried out joinpoint regression analyses and calculated average annual percentage change (AAPC).

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# KPNC Diabetes Population for HEDIS Performance Years 2004-2013

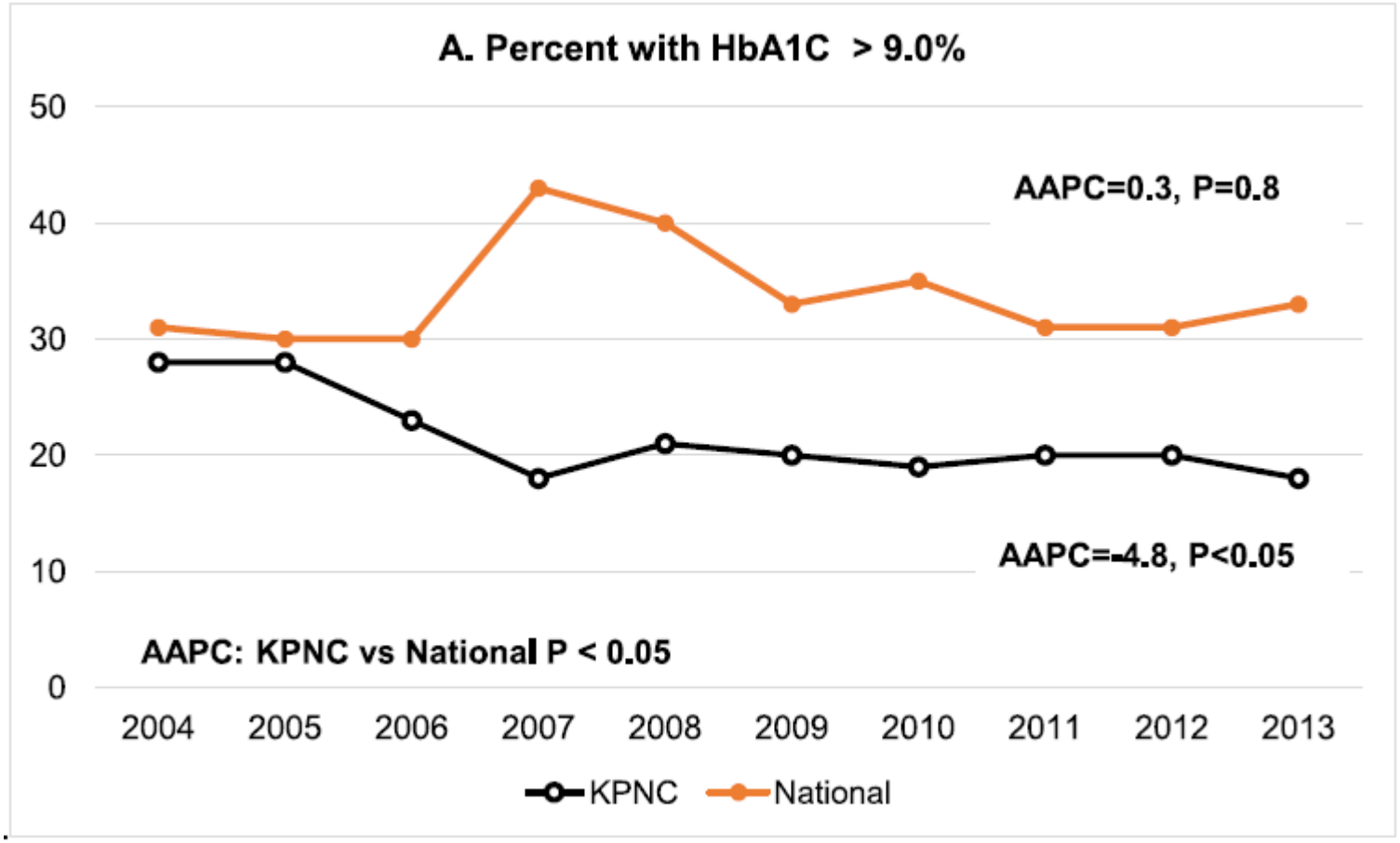
**Table** Patient Characteristics of the Kaiser Permanente Northern California (KPNC) Diabetes Population for HEDIS Performance Years 2004-2013

| Characteristic | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|---|---|---|---|
| Population (n) | 98,345 | 104,518 | 110,124 | 113,587 | 118,816 | 122,177 | 121,919 | 116,065 | 111,236 | 114,853 |
| Age (y), mean (SD) | 51.9 (9.24) | 52.2 (9.23) | 52.9 (9.63) | 53.12 (9.59) | 53.7 (9.85) | 54.3 (9.88) | 54.0 (9.84) | 54.2 (9.89) | 54.2 (10.00) | 54.4 (9.99) |
| Women | 44,161 (44.9) | 46,879 (44.9) | 50,058 (45.5) | 51,330 (45.2) | 53,769 (45.3) | 55,034 (45.0) | 54,649 (44.8) | 52,278 (45.0) | 49,942 (44.9) | 51,500 (44.8) |
| Ethnicities | | | | | | | | | | |
| White | 40,676 (41.4) | 42,680 (40.8) | 44,776 (40.7) | 45,854 (40.4) | 47,623 (40.1) | 49,530 (40.5) | 48,319 (39.6) | 45,346 (39.1) | 42,422 (38.1) | 42,889 (37.3) |
| Black | 10,796 (11.0) | 11,174 (10.7) | 11,644 (10.6) | 11,651 (10.3) | 12,552 (10.6) | 12,928 (10.6) | 12,826 (10.5) | 12,182 (10.5) | 11,687 (10.5) | 11,825 (10.3) |
| Asian/Pacific Islander | 19,461 (19.8) | 21,298 (20.4) | 23,017 (20.9) | 24,286 (21.4) | 26,004 (21.9) | 27,325 (22.4) | 28,148 (23.1) | 27,391 (23.6) | 26,890 (24.2) | 28,605 (24.9) |
| Latino | 17,512 (17.8) | 19,261 (18.4) | 20,765 (18.9) | 22,068 (19.4) | 23,210 (19.5) | 23,454 (19.2) | 24,229 (19.9) | 23,886 (20.6) | 23,691 (21.3) | 24,933 (21.7) |
| Others | 9900 (10.1) | 10,105 (9.7) | 9922 (9.0) | 9728 (8.6) | 9427 (7.9) | 8940 (7.3) | 8397 (6.9) | 7260 (6.3) | 6546 (5.9) | 6601 (5.7) |
| Hypertension | 60,987 (62.0) | 67,019 (64.1) | 74,227 (67.4) | 77,540 (68.3) | 82,922 (69.8) | 85,715 (70.2) | 83,385 (68.4) | 78,760 (67.9) | 73,398 (66.0) | 73,454 (64.0) |
| BMI (kg/m$^2$), mean (SD) | 31.85 (5.20) | 32.16 (6.38) | 32.47 (7.25) | 32.59 (7.52) | 32.58 (7.51) | 32.59 (7.51) | 32.58 (7.52) | 32.51 (7.47) | 32.46 (7.44) | 32.41 (7.45) |
| Smoking | | | | | | | | | | |
| Never | 54,525 (55.4) | 61,172 (58.5) | 66,542 (60.4) | 70,632 (62. 2) | 73,362 (61.7) | 74,932 (61.3) | 75,517 (61.9) | 71,977 (62.0) | 68,902 (61.9) | 71,942 (62.6) |
| Past | 19,268 (19.6) | 23,093 (22.1) | 27,804 (25.2) | 29,717 (26.2) | 32,431 (27.3) | 34,521 (28.3) | 33,863 (27.8) | 32,392 (27.9) | 31437 (28.3) | 32,404 (28.2) |
| Current | 17,032 (17.3) | 15,329 (14.7) | 13,586 (12.3) | 12,510 (11.0) | 12,747 (10.7) | 12,580 (10.3) | 12411 (10.2) | 11,593 (10.0) | 10,813 (9.7) | 10,423 (9.1) |
| HbA1c (%), mean (SD) | 7.51 (1.68) | 7.51 (1.73) | 7.59 (1.71) | 7.39 (1.64) | 7.28 (1.57) | 7.36 (1.58) | 7.38 (1.59) | 7.68 (1.67) | 7.74 (1.67) | 7.67 (1.63) |
| Total cholesterol (mg/dL), mean (SD) | 186.58 (41.59) | 182.36 (41.31) | 177.01 (40.84) | 172.79 (40.85) | 169.76 (40.88) | 167.73 (40.13) | 166.57 (40.08) | 167.02 (40.52) | 165.87 (39.70) | 164.80 (39.86) |
| LDL-C (mg/dL), mean (SD) | 104.34 (33.01) | 101.33 (32.63) | 97.70 (32.02) | 94.10 (32.30) | 92.00 (32.45) | 90.29 (31.94) | 89.62 (31.97) | 90.49 (32.39) | 88.97 (31.68) | 88.10 (31.36) |
| HDL-C (mg/dL), mean (SD) | 46.36 (12.20) | 45.57 (11.92) | 44.80 (11.73) | 45.14 (11.81) | 45.19 (11.91) | 45.46 (12.05) | 45.99 (12.23) | 46.32 (12.39) | 45.93 (12.31) | 46.04 (12.28) |
| Triglycerides (mg/dL), mean (SD), | 184.68 (126.15) | 182.98 (124.38) | 179.11 (121.10) | 176.54 (118.04) | 172.26 (113.55) | 169.60 (110.02) | 166.38 (109.21) | 164.23 (107.21) | 162.18 (106.27) | 159.28 (105.81) |
| Statin use | 56,352 (57.3) | 65,781 (62.9) | 75,766 (68.8) | 79,351 (69.9) | 82,752 (69.6) | 87,534 (71.6) | 87,311 (71.6) | 83,339 (71.8) | 80,003 (71.9) | 82,956 (72.2) |
| Insulin use | 18,099 (18.4) | 19,111 (18.3) | 22,204 (20.2) | 25,366 (22.3) | 27,553 (23.2) | 28,927 (23.7) | 29,073 (23.8) | 30,843 (26.6) | 33,029 (29.7) | 34,409 (30.0) |
| Oral hypoglycemic use | 66,361 (67.5) | 71,753 (68.7) | 77,490 (70.4) | 81,476 (71.7) | 84,537 (71.1) | 86,992 (71.2) | 86,993 (71.4) | 85,180 (73.4) | 82,581 (74.2) | 84,227 (73.3) |

Values are presented as number (percentage) unless otherwise noted.

BMI = body mass index; HbA1c = hemoglobin A1c; HDL-C = high-density lipoprotein cholesterol; HEDIS = Healthcare Effectiveness Data and Information Set; LDL-C = low-density lipoprotein cholesterol; SD = standard deviation.

# Healthcare Effectiveness Data and Information Set (HEDIS)

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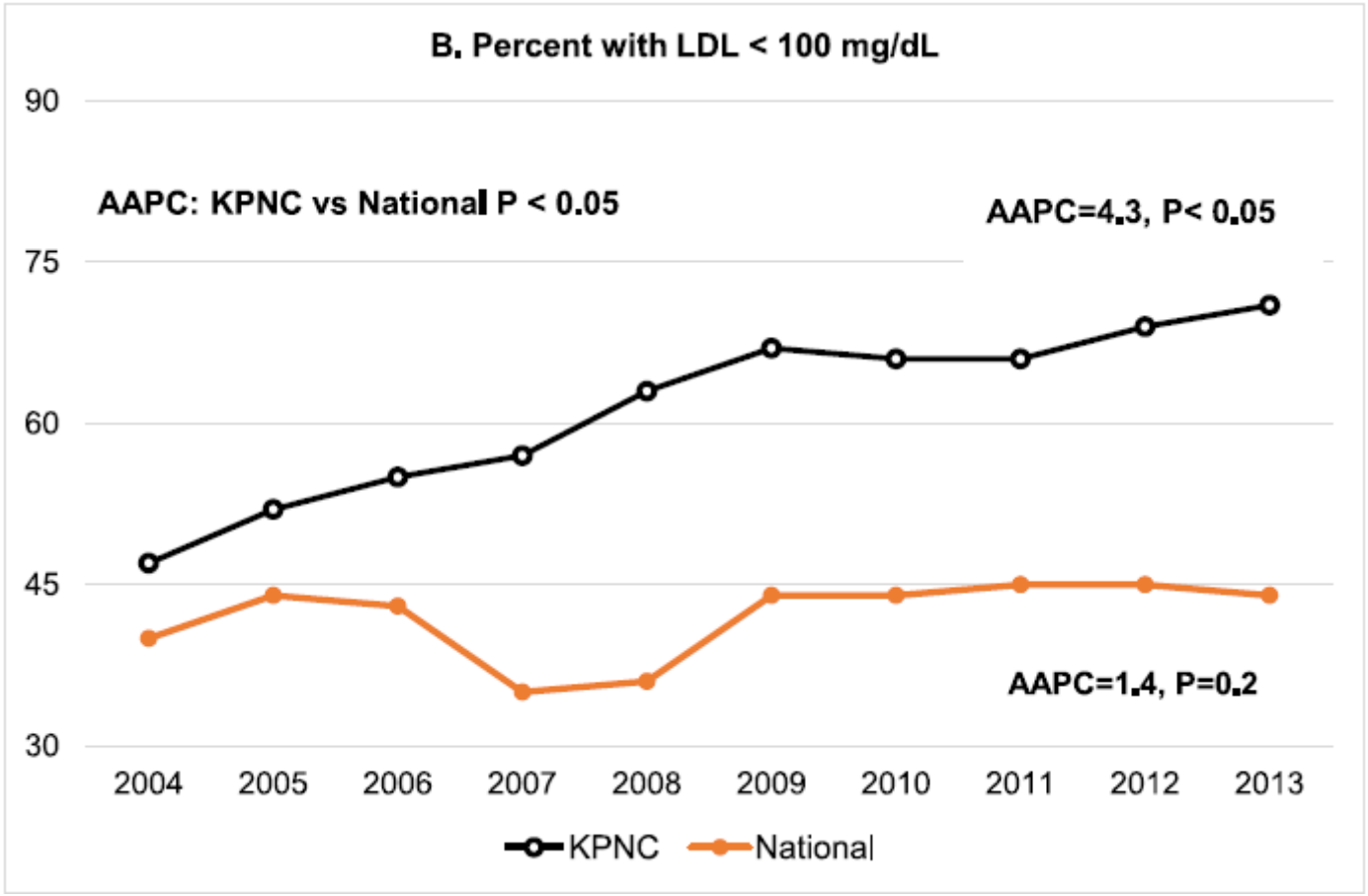
# Healthcare Effectiveness Data and Information Set (HEDIS)

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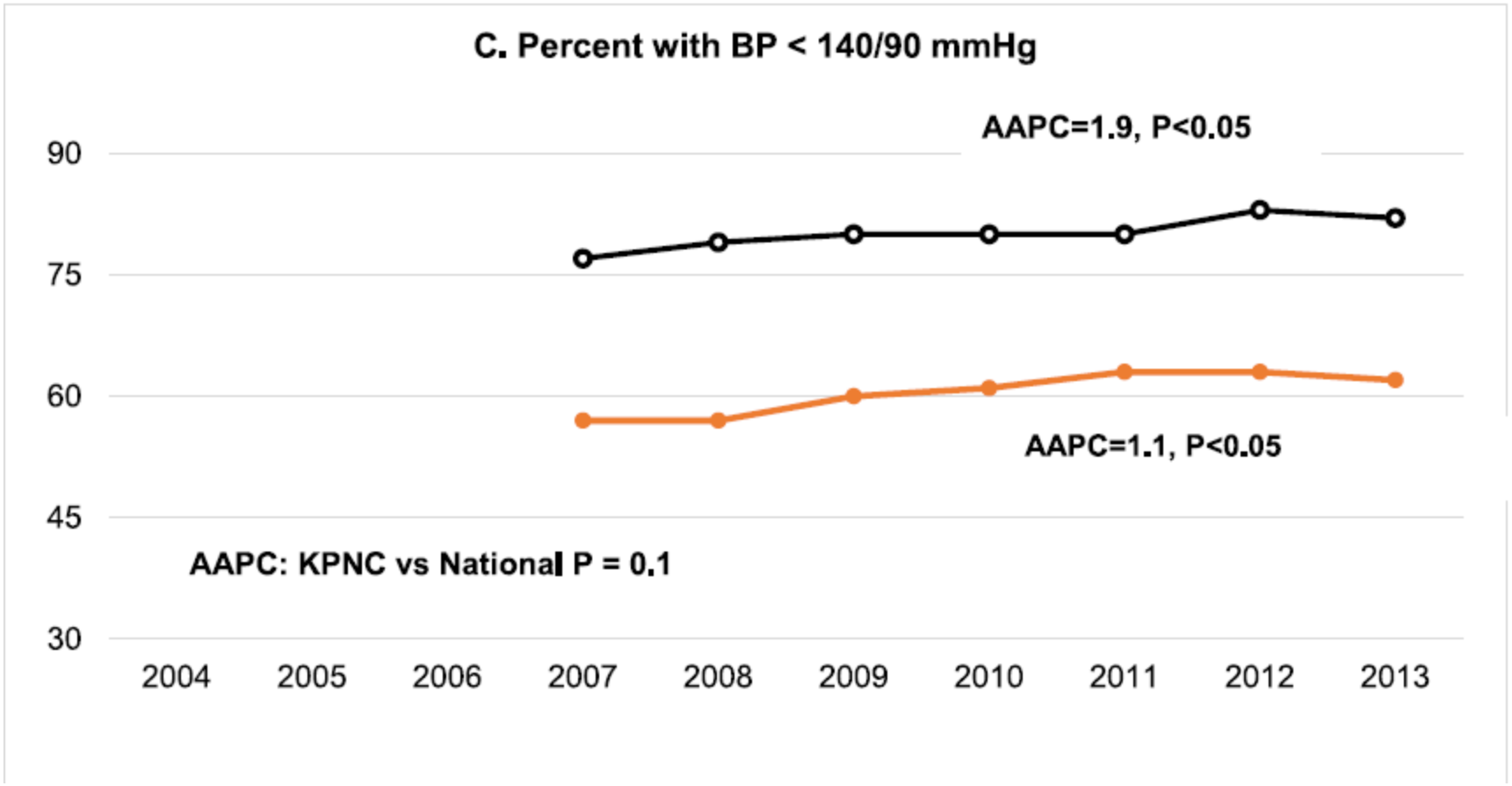
# Healthcare Effectiveness Data and Information Set (HEDIS)



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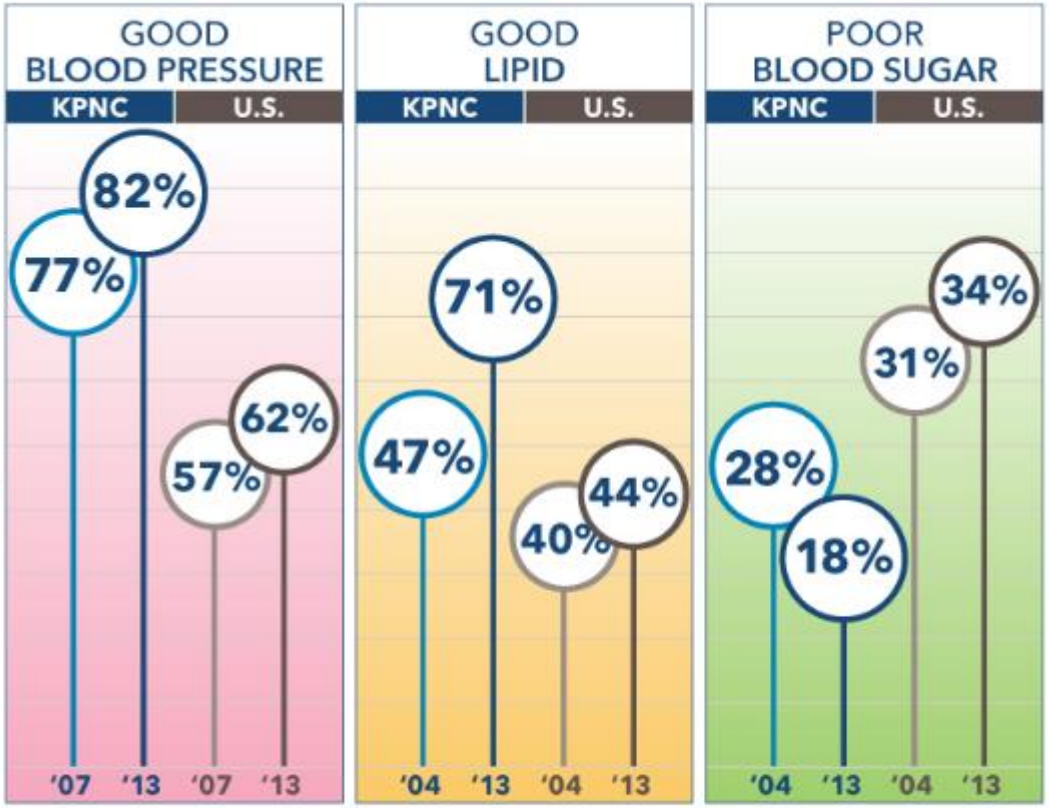
# WHY

Kaiser Permanente's PHASE program **outperforms nation** on **controlling** **3** CARDIOVASCULAR risk factors for **diabetes patients***




*Rana et al. Am J Med 2018

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# Take away

Our encouraging findings speak to the strength of the PHASE program . This study shows that the PHASE program addresses the daunting challenge of controlling risk factors in a high-risk population consistently and over an extended period of time, by the systematic application of a simple treatment protocol, a comprehensive registry, performance metrics, and task sharing with care managers.

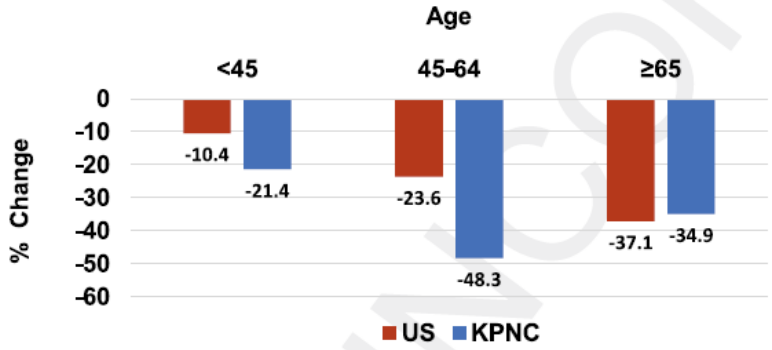
Senior author Marc G. Jaffe MD, of Kaiser Permanente's South San Francisco Medical Center and the Resolve to Save Lives Cardiovascular Health Initiative , is leading efforts to spread a similar approach worldwide to help low- and middle-income countries implement proven strategies to prevent cardiovascular disease.

"We are excited to share our experiences with others who treat high risk individuals, not only in California, but also across the world,"

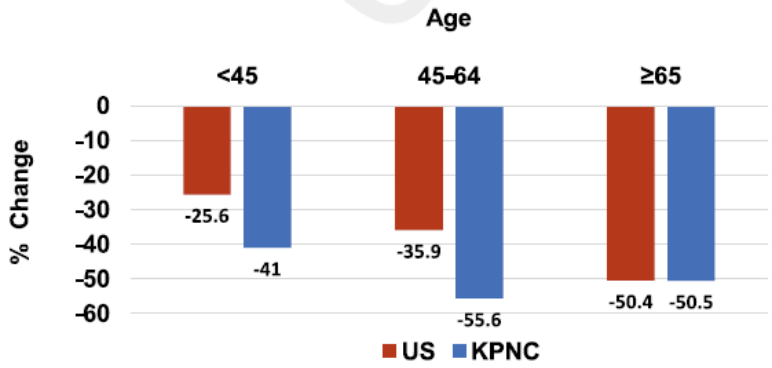
 | 

# Decline in age-adjusted mortality rates (% change) from 2000 to 2015, United States versus KPNC

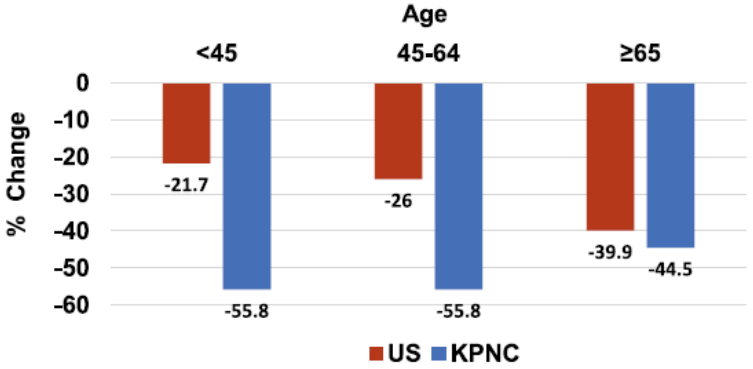
**A. Heart Disease**



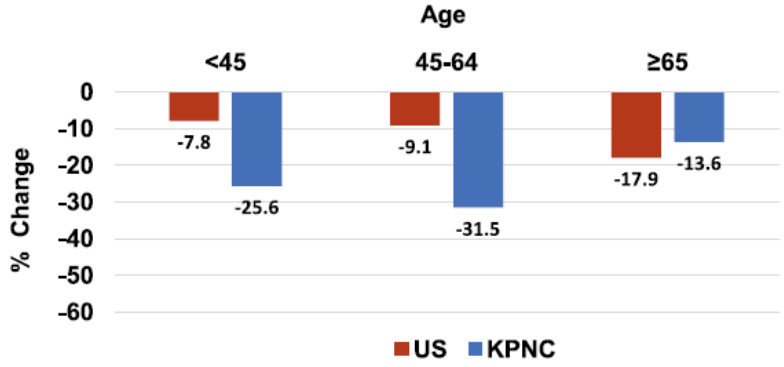

**B. Coronary Heart Disease**




**C. Stroke**




**D. All-Cause**



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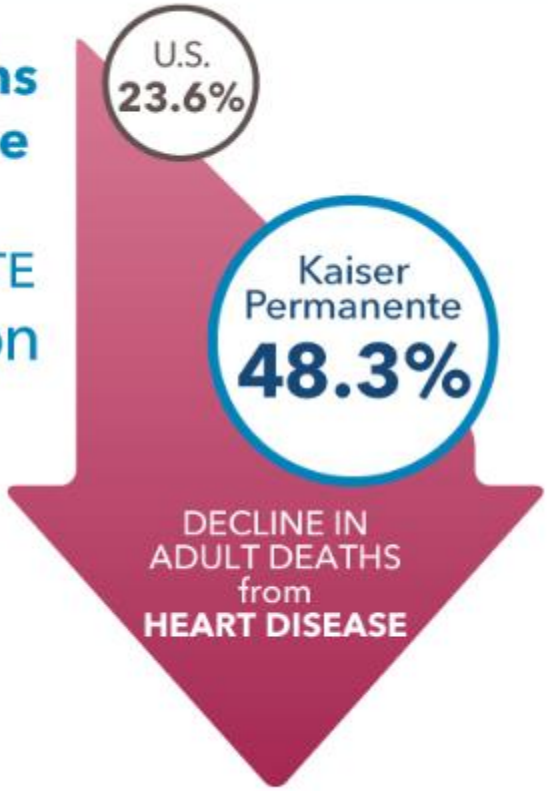
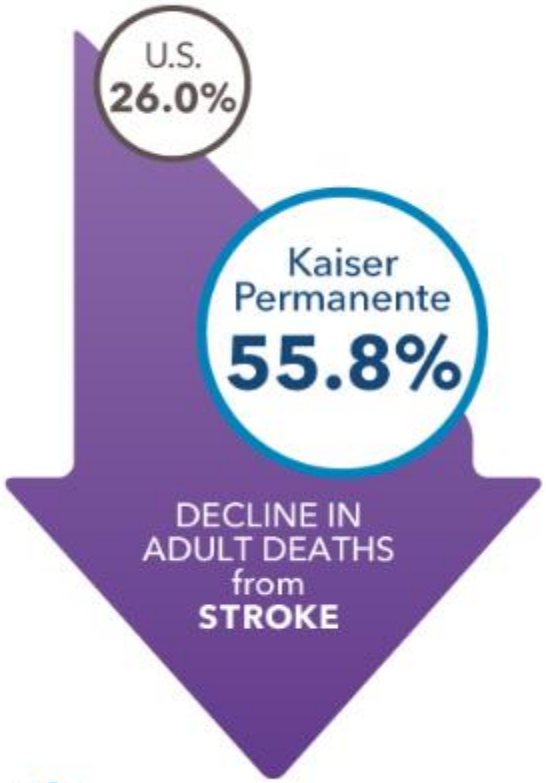
# From 2000 to 2015

## In **Reducing Deaths** from **Heart Disease** and **Stroke,** KAISER PERMANENTE Outpaces Nation




*NCal region, 45-64 year olds; Sidney et al., Am J Med 2018.

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# THANKYOU

 

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


## Douglas Frey, FNP

*LifeLong Medical Center, Downtown Oakland*


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# PHASE Data Gallery

Sharing Ideas to Accelerate Progress
PHASE Grantee Convening
June 5, 2018

Maggie Jones, Carly Levitz, Jennie Schoeppe
*Center for Community Health and Evaluation*

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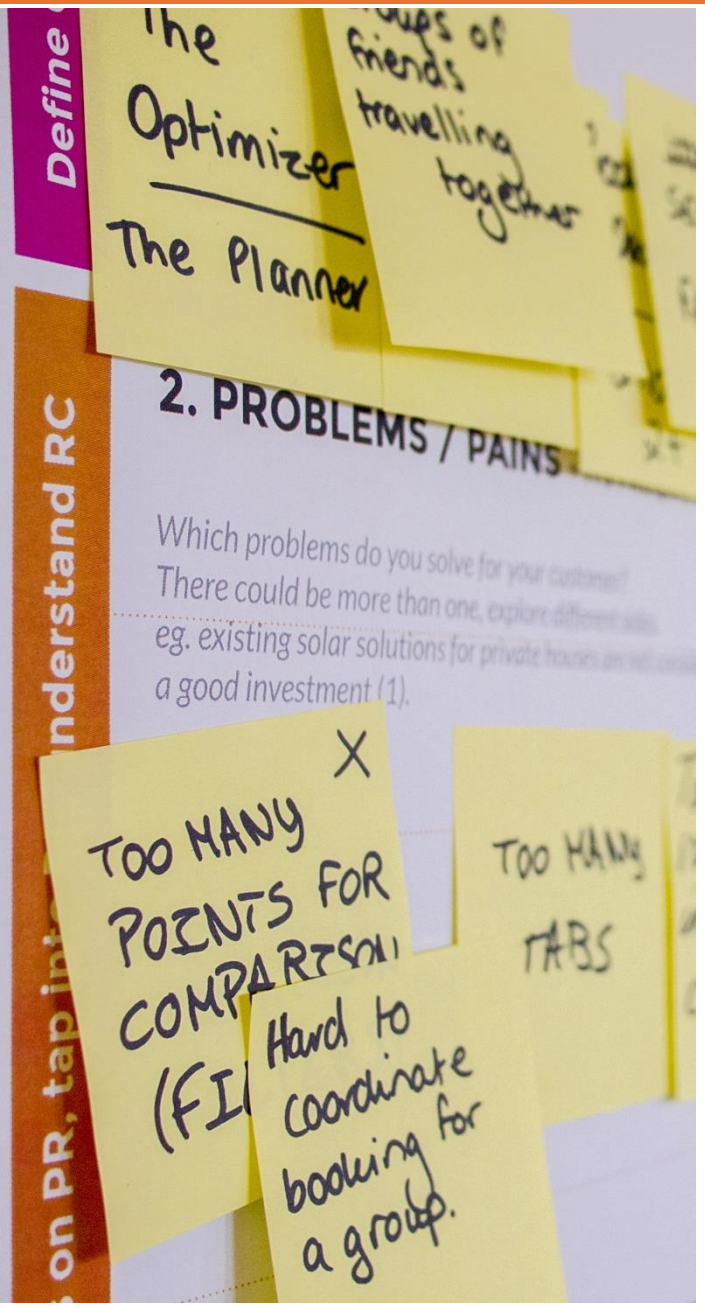
# Goals for the data gallery

**Share** initiative-level data & progress on key metrics

**Receive feedback** to inform mid-initiative report

**Facilitate peer sharing** through spotlights & discussion




# The plan

1. Data gallery to review data (30 min)
2. Learning from spotlights (20 min)
3. Insights & reflections (5 min)

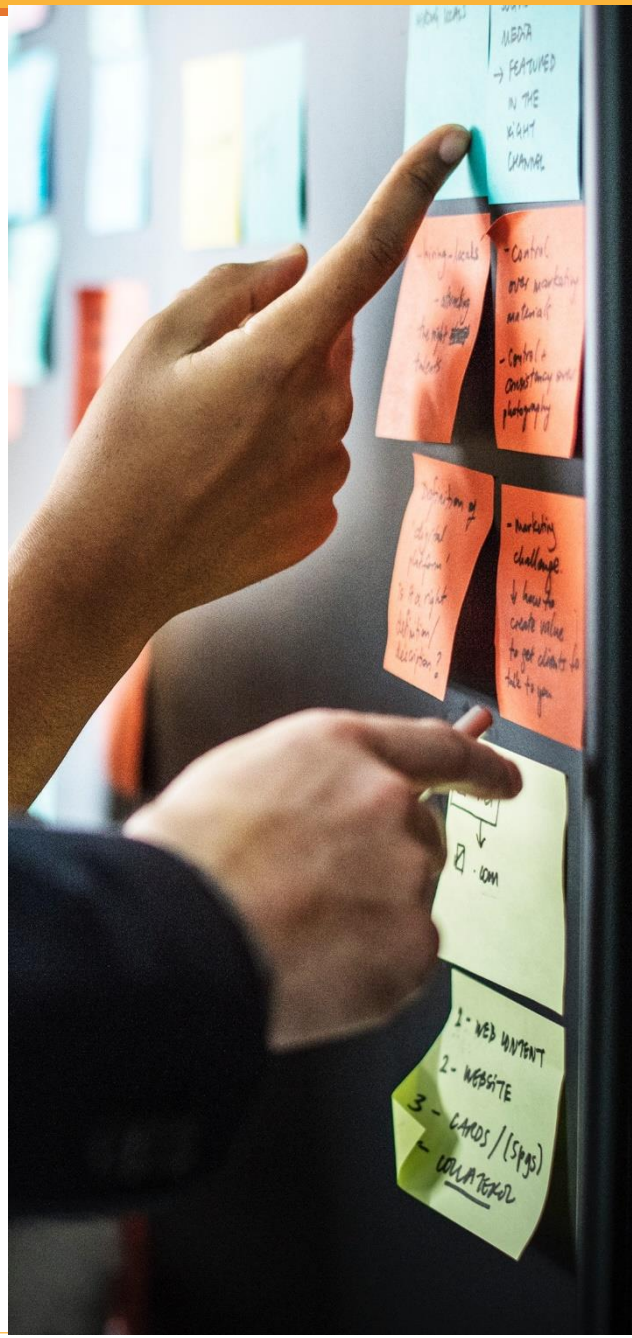
# Data gallery

**Review** data on the wall at each station

**Consider** compelling, surprising, or confusing aspects of the data

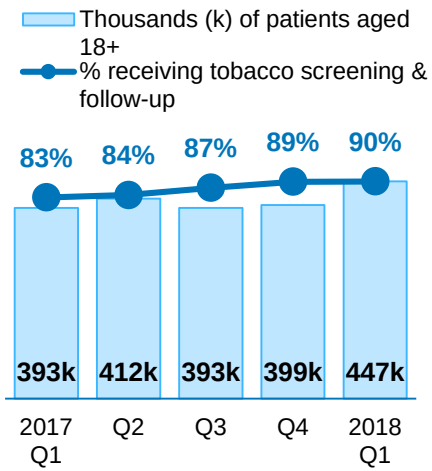
**Ask yourself** about which spotlights you want to know more

**React & interact** by writing thoughts, reactions, questions on post-its and post on the wall



# 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

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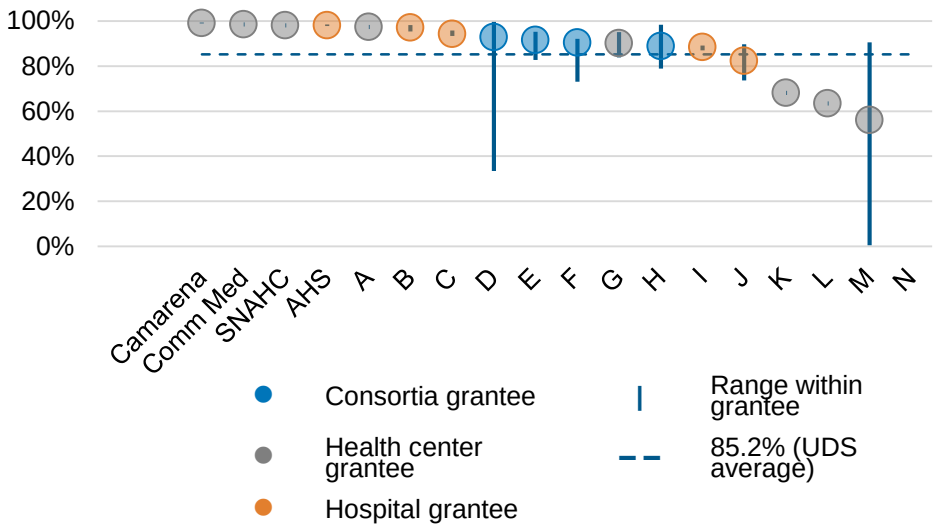
Prepared by the **Center for Community Health and Evaluation** | June 2018

# Tobacco screening and follow-up if positive for tobacco use

**% receiving tobacco screening and follow-up by grantee** in 2018 Q1**

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# Tobacco screening and follow-up if positive for tobacco use

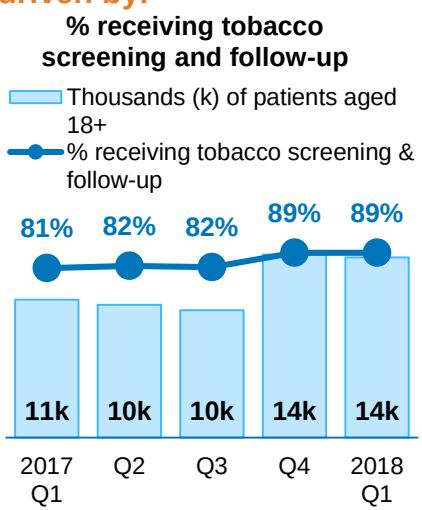
## San Joaquin General Hospital reported that improvements in rates were driven by:

**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)




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

**Quality improvement:**

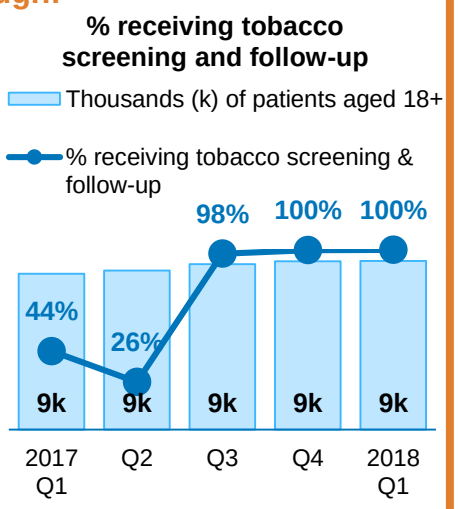
- Using a data audit tool to ensure use of structured fields in EHR

**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.

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Prepared by the **Center for Community Health and Evaluation** | June 2018

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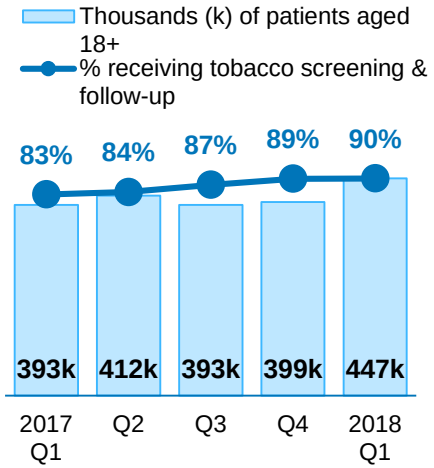


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**Team-based care**
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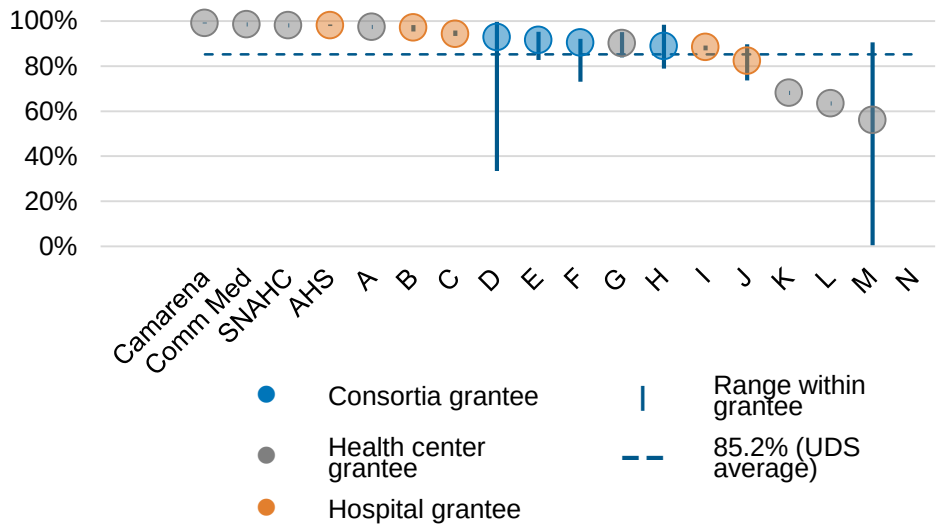


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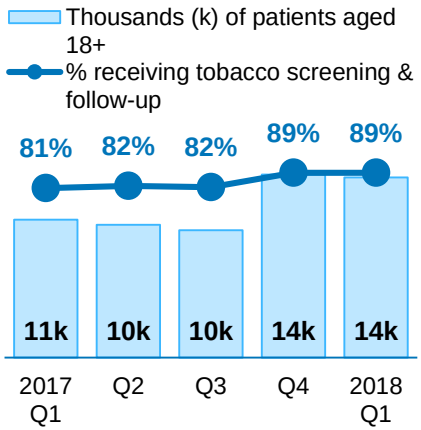


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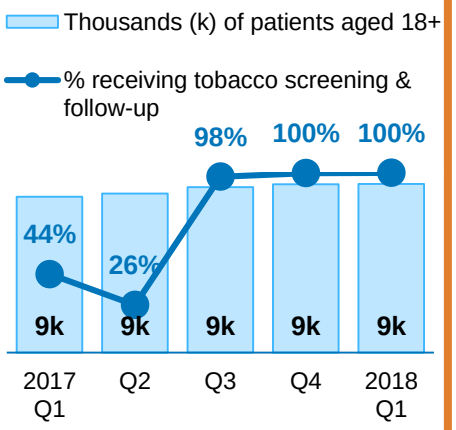


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*5 grantees spread to additional sites in Q1 2018, leading to population increases. **The top performers for each measure are called out by name. Other grantees are shown in order of performance; the letter for a grantee can change with each chart.

Prepared by the **Center for Community Health and Evaluation** | June 2018

# Data gallery – where to go first

| | Initial Station | Facilitator |
|---|---|---|
|  | Tobacco screening & follow-up | Alexis |
|  | Depression screening & follow-up | SA |
|  | BMI screening & follow-up | Angela |
|  | Hemoglobin A1c control | Jennie |
|  | Blood pressure control | Maggie |
|  | Prescription rates | Carly |

# Data gallery (30 min)

**Review** data on the wall at each station

**Consider**:

1. What do you find most compelling about these data?
2. What surprises you about the data?
3. What additional questions do you have about the data or findings?
4. Which spotlights are you interested in learning more about?

**React & interact**: Write your thoughts, reactions, questions on post-its and post on the wall

# Learning from spotlights (20 min)

**Identify two posters** for which you'd like to hear from the organizations featured in the spotlights

**Pick one poster** to visit first:

- You will have 10 minutes at each station
- Each organization featured with share a brief summary of their work and respond to questions
- Please distribute yourselves around the room

# Insights & reflections

What was a key **insight** from the data gallery?

What **reflections** do you have about the data or the activity?

# Thank you

Center for Community Health and Evaluation

Maggie Jones - jones.margaret@ghc.org
Jennie Schoeppe - schoeppe.j@ghc.org
Carly Levitz - levitz.c@ghc.org

www.cche.org

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# From Idea to Impact: Our CHF Clinic Journey

## Joan Singson

*Director of Population Health, San Joaquin General Hospital*

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# Charter for Improvement

Jerry Osheroff, MD, FACP, FACMI
TMIT Consulting, LLC

Alexis Wielunski, MPH
Center for Care Innovations

June 5, 2018

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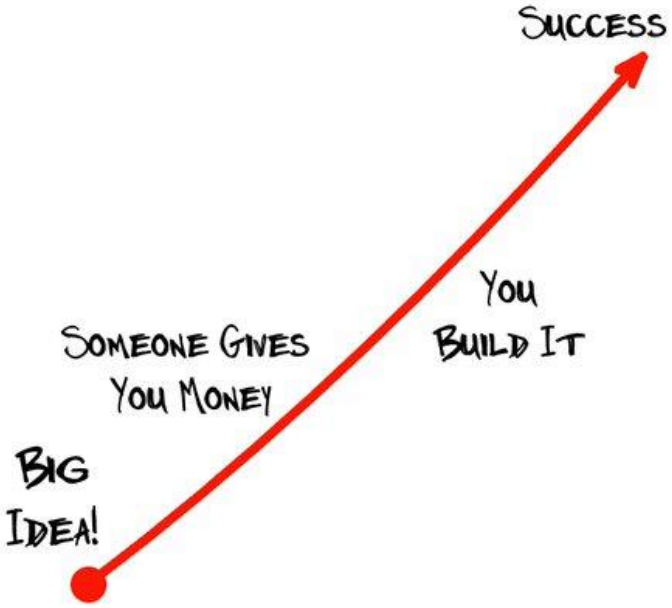
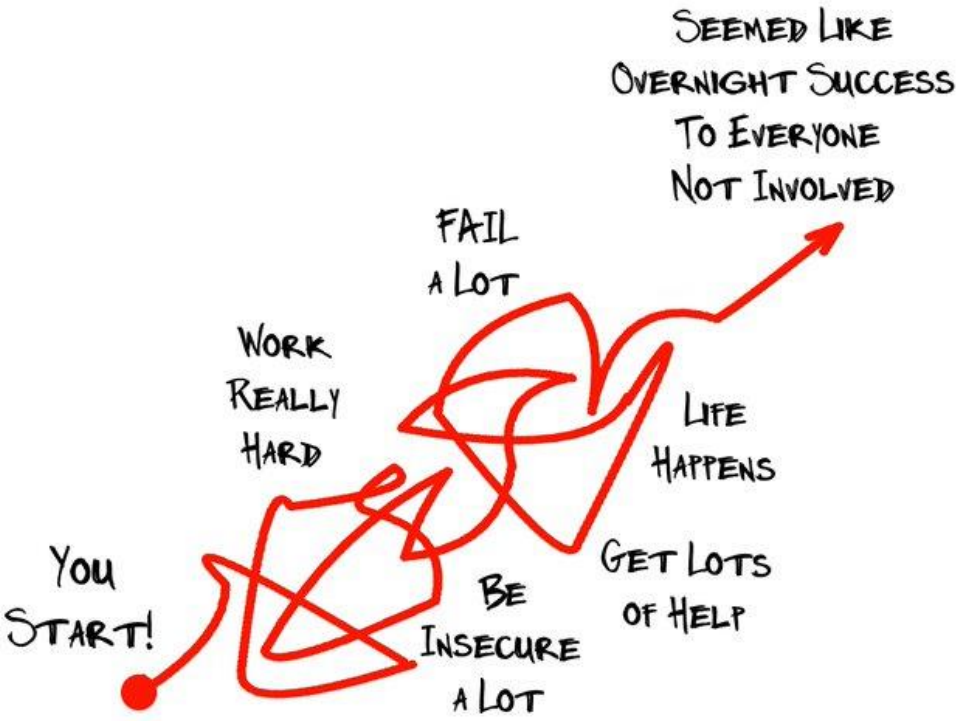



WHAT PEOPLE THINK IT LOOKS LIKE . . .




WHAT IT REALLY LOOKS LIKE . . .

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# Charter for Improvement: Instructions and Goals Worksheet

**July 2018-December 2019**

## CFI Instructions and Overview

**Purpose.** 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. Your team's completion of the CFI process is also part of your PHASE grant requirements and will help us monitor progress and harvest lessons learned from grantees. Following this guide, you will find a goals worksheet for your team to complete.

**Structure.** The CFI has three components: goals, improvement approaches, and harvesting lessons learned. Goals and improvement approaches are set at the beginning and mid-point of the grant cycle. Harvesting lessons occurs at the end of each grant year. Taken together as a living document, the CFI serves as a springboard for substantial improvements in care processes, population health, and your organization's care transformation capabilities.

*The most important thing is to find out what is the most important thing* Shunryu Suzuki

# Charter for Improvement

## Goals

- Define the win-wins
- Set the targets

## Structured Improvement Approach

- Define the path to get there
- Capacity Building

## Harvest Lessons Learned

- Analyze, evaluate, share, and apply
- Adopt, adapt, abandon

# 2018 PHASE Goals

## Deepen the Win-Wins

- P4P Targets
- PRIME participation
- Build practice transformation capacity
- Strengthen QI infrastructure

# 2018 PHASE Goals

## Move the Needle(s)

| Disease Management | Screening & Follow Up | Prescriptions |
|---|---|---|
| **HTN controlled BP** | Tobacco | HTN antihypertensive |
| **Diabetes controlled BP** | BMI | Diabetes ACE/ARB |
| Diabetes controlled A1c | Depression | Diabetes statin, ACE/ARB |
| | | Diabetes statin |

*HEDIS 75th/90th Percentiles

# 2018 PHASE Goals

## PHASE Spread

Substantial opportunity to prevent *more* heart attacks and strokes by bringing *more* patients with uncontrolled HTN under control.

✓If only applying PHASE in some sites, develop/implement plans to *spread capacity building and care process re-engineering* across more – if not all – sites.

# Improvement Approach

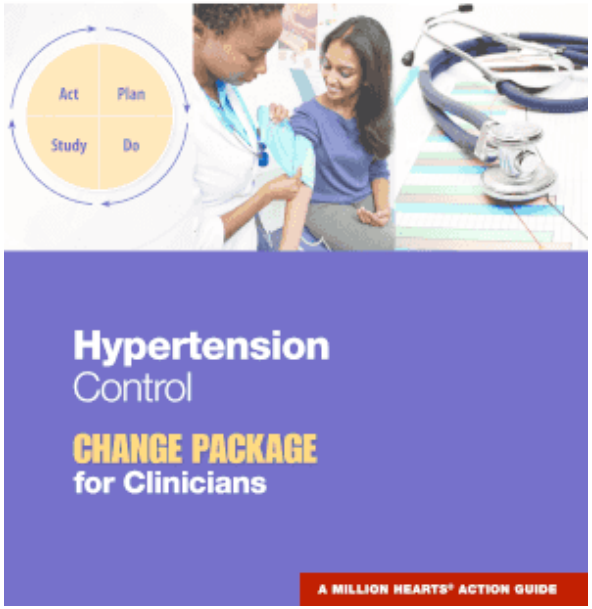
*"Systems are perfectly designed to produce the results they deliver"*

- What are our current target-related care processes?
- What processes and tools are used by high performers?
- What changes will we make to improve processes/outcomes?

# Improvement Approach

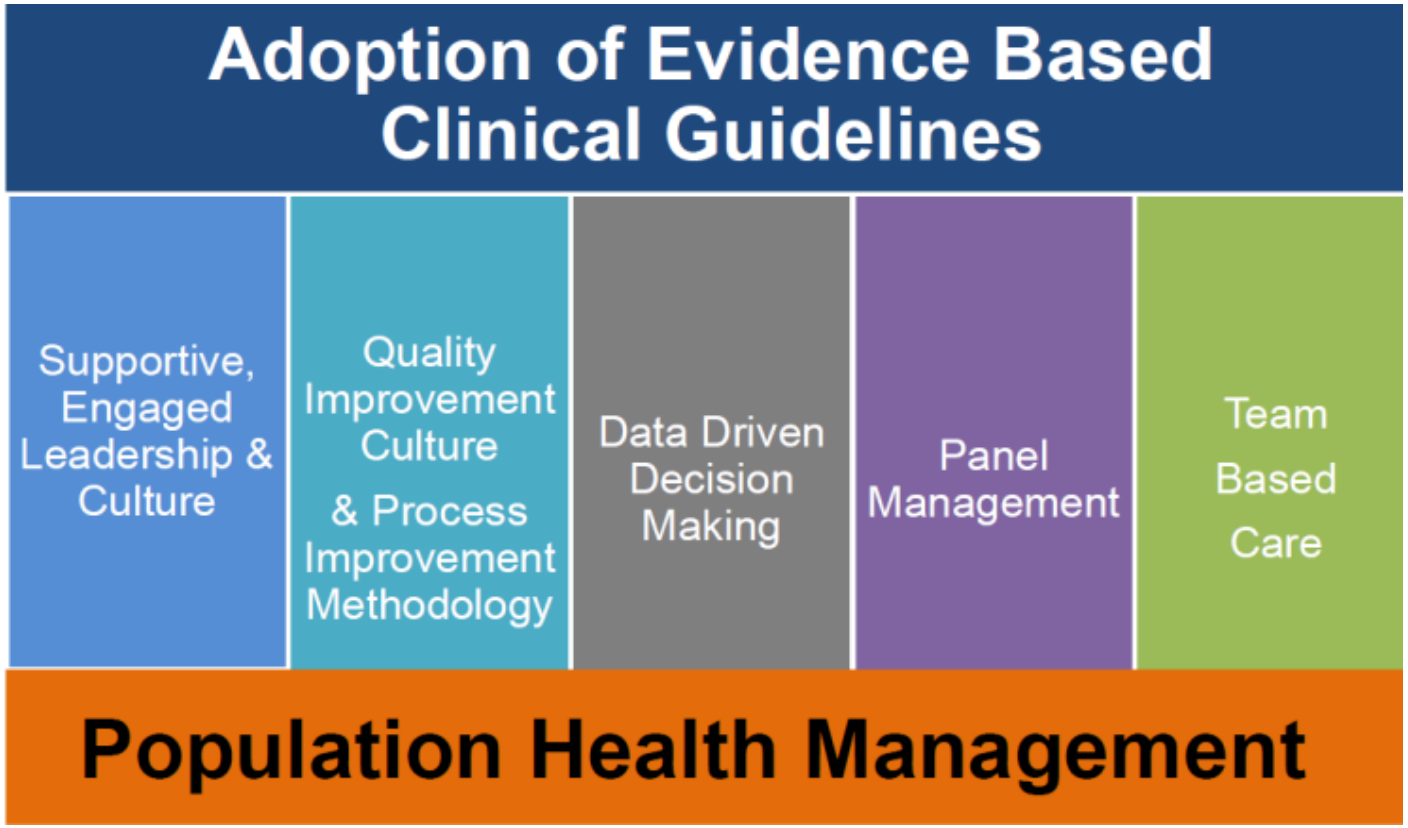
## What Should Be?

- Consider proven approaches and tools to improve care processes and outcomes.
- Hypertension Control Change Package, peers, PHASE “Bright Spots”



# Improvement Approach

## Capability Building Support

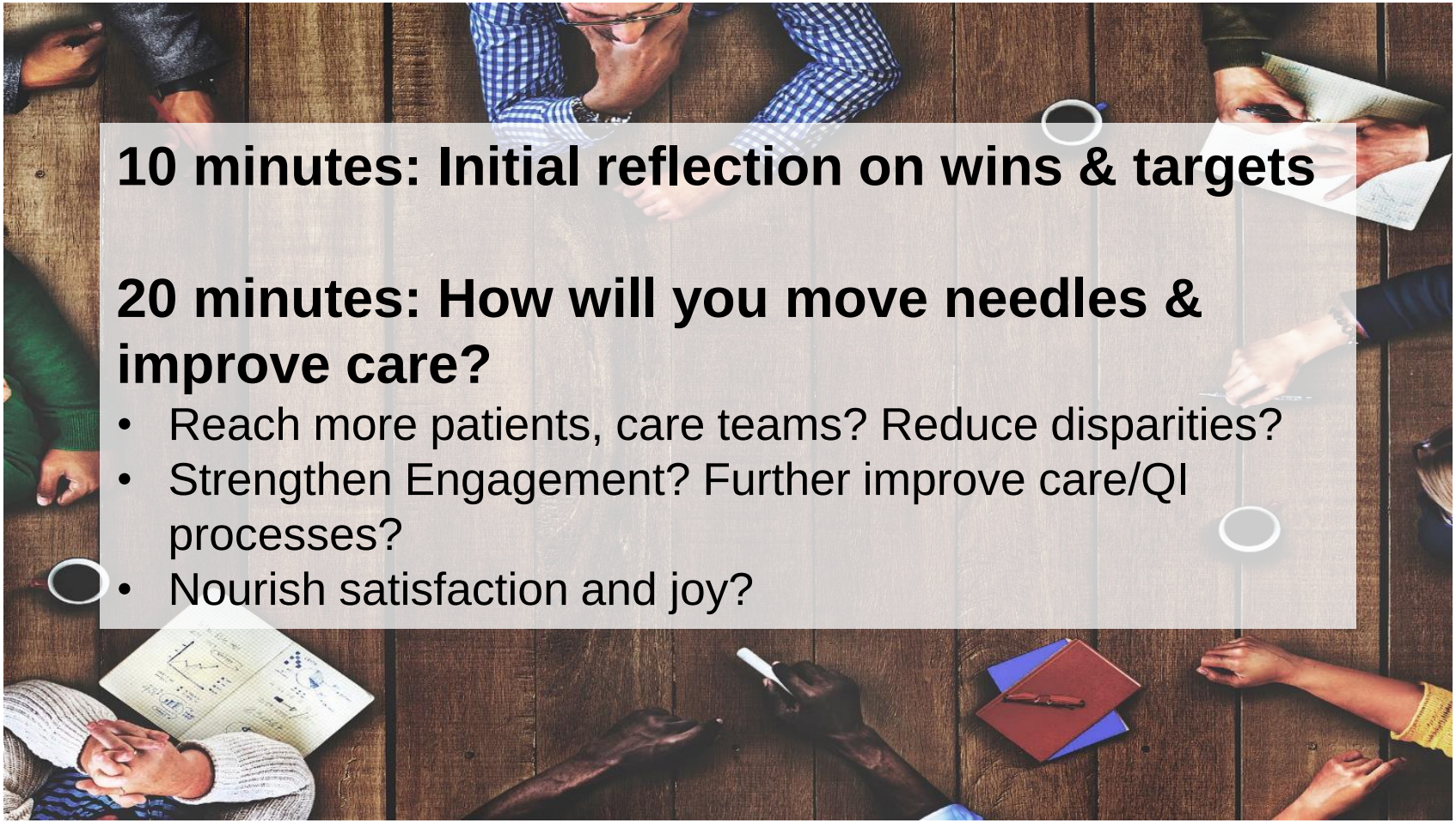


# Submitting Your Charter for Improvement

- Goals worksheet
  - Enter your responses in the online form at https://www.careinnovations.org/phase-cfi-update-submission/
  - Due **July 2, 2018**

- Year-End Reflection
  - Due December 2018
  - More information to follow

# Team Time



**10 minutes: Initial reflection on wins & targets**

**20 minutes: How will you move needles & improve care?**

- Reach more patients, care teams? Reduce disparities?
- Strengthen Engagement? Further improve care/QI processes?
- Nourish satisfaction and joy?

# Thank you

Jerry Osheroff - josheroff@tmitconsulting.com

Alexis Wielunski – alexis@careinnovations.org

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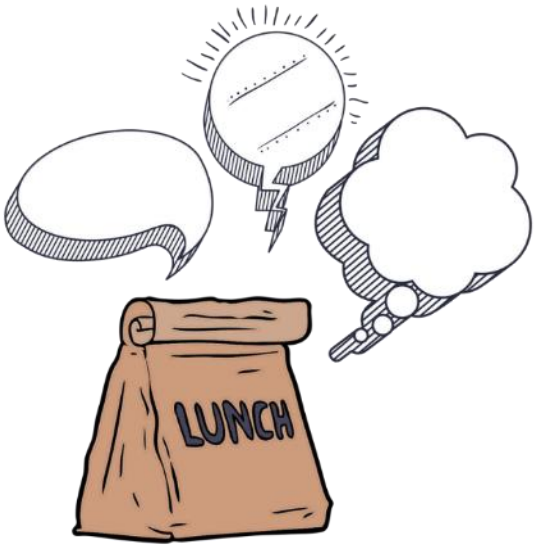
# Lunchtime Announcements

- Dietary restriction tickets
- Peer consults in the main room @1:00
- Reconvening in workshops after lunch
- Rideshare sign ups

# Lunch & Peer Consults (1:00 -1:30pm)




- **Peer consult: Diabetes Patient Education Journey Map**
  - Table 10 with Michelle Rosaschi, Redwood Community Health Coalition
- **Peer consult: Using PHASE on a Page and the Medi-Cal formulary**
  - Table 11 with Felicia Batts, Livingston Community Health
- **Peer Networking: Nurses of PHASE**
  - Table 12 - Follow up to Nurse-Run Hypertension Care Webinar Series

# Workshops:
# Patient Engagement Suite


| | |
|---|---|
| **Amador Room** | **1** - Patient Activation: Rethinking Patient Non-Compliance |
| **Mariposa Room** | **2** - Building Care Team–Patient Communication Skills to Enhance Health Outcomes |
| **El Dorado Room** | **3** - Empanelment for Team-Based Care and Population Health Management: Connecting the Dots for Better Patient Engagement |

# It’s Up to All of Us: Extending the HTN Care Team Beyond the Clinic


## Bo Greaves, MD

*Hearts of Sonoma County*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# What's On the Horizon

## CCI

*Support , Technical Assistance and Learning Community*

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# Continue What's Working Well

Responsive Assistance

2x Year Convenings

3x Year Wireside Chats

Training and Skill Building

Support and technical assistance to focus on moving the needle on targeted measures, building population health management capabilities and re-engineering care processes.

# How Might We…

- ….encourage more peer sharing?
- …make coaching available to more participants?
- …provide group consultations with the right amount of structure and flexibility/ responsiveness?

# Ideas we are exploring…

Design "support clusters" based on common activities documented in CFIs

Offer regular group coaching or drop in "curbside consultation"

Offer 1:1 appointment slots with a variety of subject matter experts (QI/PI, Data, Panel Mgmt., etc.)

Offer 1:1 appointment slots with several coaches; grantees sign up as desired

# What support would you be most excited about?

| | |
|---|---|
| I would be most excited about this type of support | I would also be excited about this type of support |

Design "support clusters" based on common activities documented in CFIs

Offer regular group coaching or drop in "curbside consultation"

Offer 1:1 appointment slots with a variety of subject matter experts (QI/PI, Data, Panel Mgmt., etc.)

Offer 1:1 appointment slots with several coaches; grantees sign up as desired

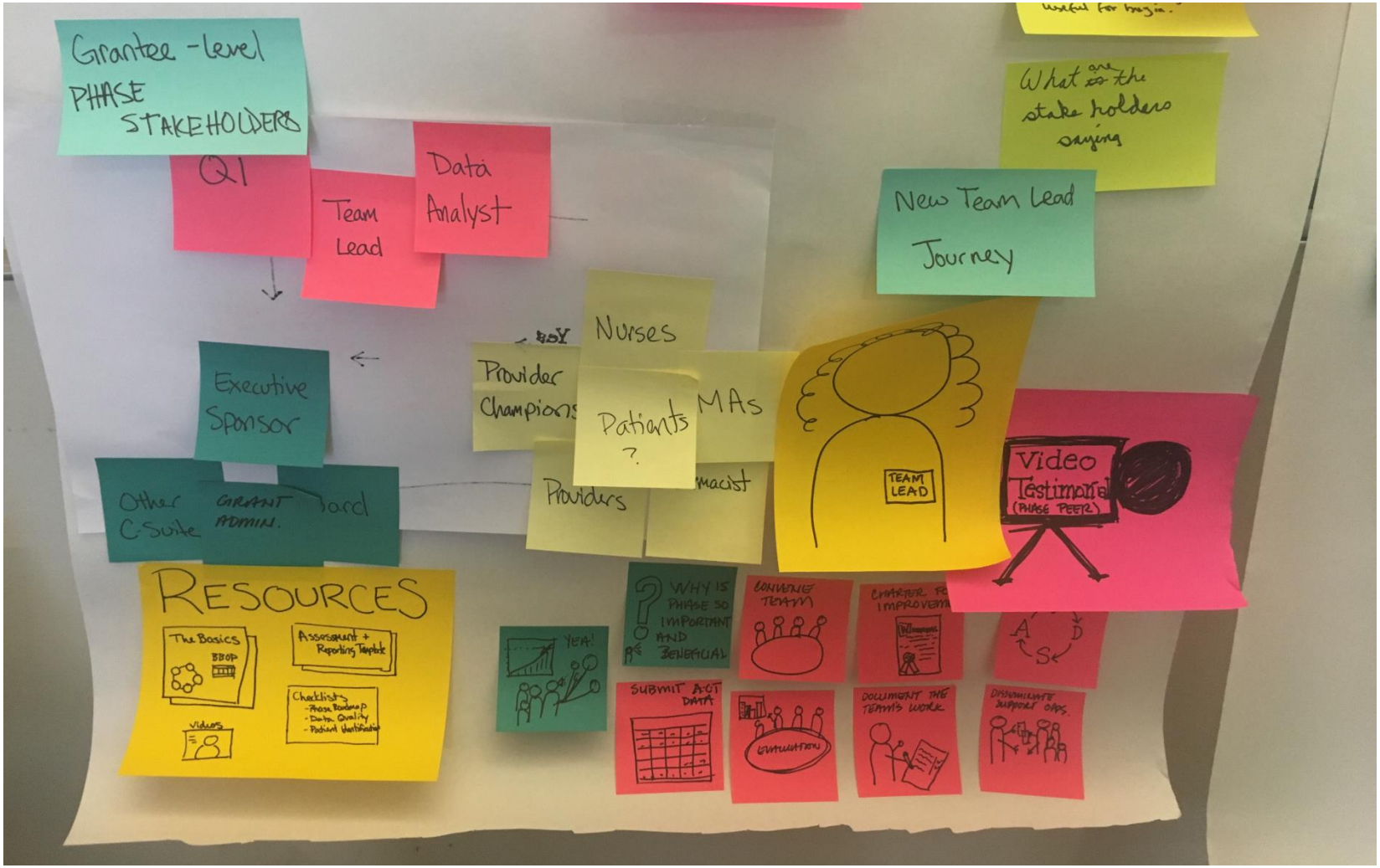
# Co-Design Session for Group Coaching and Peer Sharing

**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 & sign up.

# Onboarding Playbook



# New to PHASE? Start Here.

Welcome to the Onboarding Playbook! Here you'll find materials to get you up to speed on the PHASE program. If you'd like to learn more, the full library of resources are available on PHASE Support Portal.

## Select your role to access onboarding materials:

QI/PHASE Team Lead

Executive Leadership

Care Team

# On the Horizon: Redesigning the Resource Center

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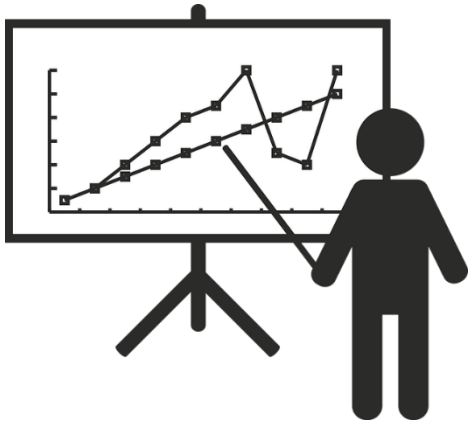
- PHASE Convening & Webinar Resources
- CFI Year-End Reflection
- Resources by Category
  - Clinical Decision Support / Quality Improvement
  - Hypertension Protocols & Change


www.careinnovations.org/phasesupport/

# Upcoming Webinar: Run Charts and Funnel Charts: Taking the Pulse of Improvement Efforts



**July 18, 2018**
**12:00 – 1:00 p.m.**

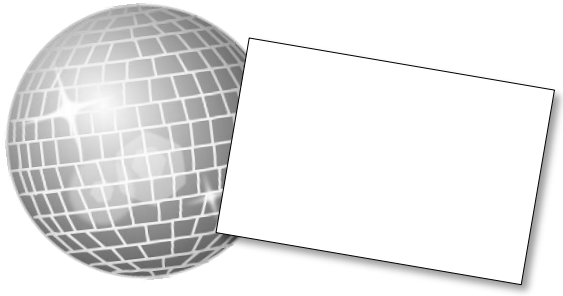
Jerry Lassa,
MS Statistics

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.

# Save the Date for Next Convening!

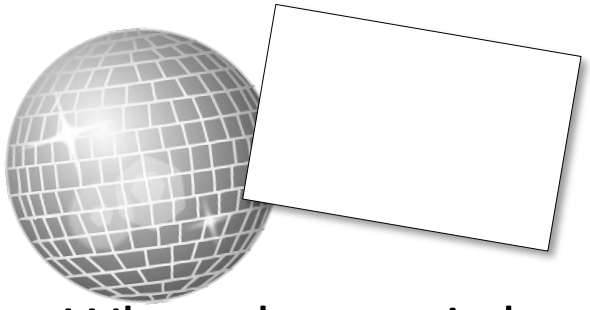

## Thursday, November 29th, 2018

8:30am- 4:00pm



# Inspiration Disco

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



# Inspiration Disco

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

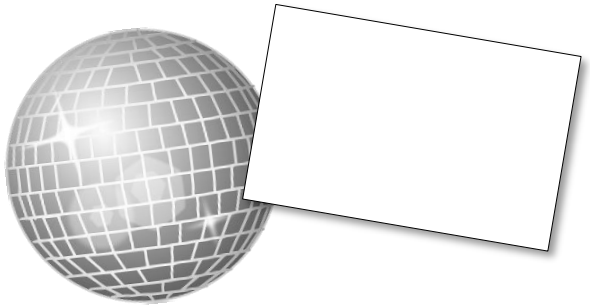
- When the music **STOPS,** stop trading and read the card. On the back, rate the observation from **1 to 5**

.....1.....2.....3.....4.....5.....

not so much

wow, I agree

- After the 4th round, add your score and total the points. Who's got a 20? 19? 18?



# Inspiration Disco

- When the music begins, take a pen and walk around, **continually passing** your index cards to one another.
- 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.
- After the 4th round, add your score and total the points. Who's got a 20? 19? 18?

# Thank You!

*Please turn in your evaluations & travel home safely!*

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