What to expect today…

Subject matter experts

Skill building workshops

Engagement with peers

Active participation

Reflection & team time
Your Guide to the Day

PHASE Champion
Center for Care Innovations

Table: #
BB: ABC
WS: 🧵

Turn to p. 6 for how to decode your nametag

Today’s materials can be found online:
careinnovations.org/resources/phase-toward-equity-hypertension-care/

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PHASE Learning Community

- 18 grantees
- 198 clinic sites
- 204k patients
Welcome!

Jean Nudelman
Director, Northern California Community Benefit
Icebreaker: Poll Time!

Go to www.menti.com and enter the code:

85 43 2
Testing changes using Plan-Do-Study-Act (PDSA)
Health Equity = Social Justice in Health

Positive statement of the ideal state

All people have the opportunity to attain their full health potential, and no one is disadvantaged because of their social position or other socially determined circumstance.

Health Inequality or Health Disparity

A difference or disparity in health outcomes that is systematic, avoidable, and unjust that is tied to social, economic, or environmental disadvantage

A health disparity is a metric we use to measure progress toward health equity.
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The 3 Improvement Questions (or the wonky side of Maya’s Puzzle method)

- What are we trying to accomplish?
- How will we know a change is an improvement?
- What change can we make that will result in improvement

Source: Institute for Healthcare Improvement
Recognize, Prioritize, Mobilize: What Health Care Organizations Can Do to Address Disparities

Alyce Adams, PhD
Kaiser Permanente Division of Research
Recognize, Prioritize, Mobilize
What health care organizations can do to address disparities

Alyce S. Adams, PhD
Associate Director, Health Care Delivery and Policy
Kaiser Permanente Division of Research

PHASE Learning Community Convening
November 29, 2018
# Outline

<table>
<thead>
<tr>
<th>Impact of disparities and inaction</th>
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<td>Diabetes and Hypertension as drivers of disparities</td>
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<td>Modifiable determinants of disparities in diabetes and HTN</td>
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<td>The limitations of one size fits all models of intervention</td>
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<tr>
<td>Targeting multi-level factors: Patient, Provider, Health System</td>
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<td>Action planning for disparities reduction</td>
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<tr>
<td>Discussion</td>
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Impact of Disparities and the Consequences of Inaction

- The roots of racial and ethnic health disparities in the U.S. lie in structural inequalities and interacting factors at the biological, behavioral, environmental, sociocultural, and health care system level.

- Persistent racial and ethnic disparities are a moral and social justice issue, and also a financial one.
  - Cost ~ $34b per year in health care costs
  - Savings from elimination ~ $1 trillion dollars.
Access is necessary, but insufficient to address disparities in outcomes

- **Health care is only one determinant of disparities**
  - Biological, physiological, psychosocial
  - Societal: Socioeconomic, environmental factors

- **Variation within and across health care systems**
  - Quality and care delivery
  - Affordability and true accessibility
  - Patient-provider & patient-system dynamics
Diabetes and Cardiovascular Disease

- Disproportionately affect communities of color and those with lower SES

- Considerable variation within racial and ethnic groups
Diabetes Prevalence by Race/Ethnicity

Source: CDC, National Diabetes Statistics Report

AI/AN = American Indian/Alaska Native.

Note: Error bars represent upper and lower bounds of the 95% confidence interval.

Data source: 2013–2015 National Health Interview Survey, except American Indian/Alaska Native data, which are from the 2015 Indian Health Service National Data Warehouse.
Prevalence of Heart Disease and Stroke, 2011-2014

Source: AHA, Heart Disease and Stroke Statistics 2018
Figure 4. Disparities in Rate of Potentially Preventable Hospital Stays for Diabetes Between Hispanic Adults and Non-Hispanic White Adults Exist Across Income Levels

Source: Agency for Healthcare Research and Quality, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, State Inpatient Databases disparities analysis file, 2006. This file is designed to provide national estimates on disparities for the National Healthcare Disparities Report using weighted records from a sample of hospitals from the following 24 states: AR, AZ, CA, CO, CT, FL, GA, HI, KS, MA, MD, MI, MO, NH, NJ, NY, OK, RI, SC, TN, TX, VA, VT, and WI.
Drivers of Disparities

- Individual Socioeconomic Circumstances
  - Education, income, wealth, occupation

- Physical and Cultural Community Environment
  - Health behaviors, health resources, health beliefs

- Healthcare Financing and Delivery
  - Health care providers, institutions

- Personal Management of Health
  - Community environment

Source: Meyers 2007
Interventions: What Works and What Doesn’t?

- One size fits all strategies to improve access and care can reduce disparities in insurance and processes of care.

- Disparities related to individual patient behavior and the patient-provider relationship (e.g., medication adherence) are more difficult to move.

- Removing barriers to care can exacerbate disparities when those already engaged in healthcare services are first to take advantage of expanded benefits.

- Impact of culturally-tailored interventions depends on the setting & evidence quality is highly variable.
Where are the opportunities for reducing disparities in health systems?

MODIFIABLE DETERMINANTS
Understanding the factors that impact how patients make decisions about health and healthcare

- Health Literacy
- Beliefs about Medicines
- Trust in the Health Care System
- Knowledge of Benefits

Source: Meyers 2007
Addressing structural barriers within the health care system

- Race/ethnicity concordance
- Language concordance
- Provider communication
- Empowered patients (e.g., values affirmation)
- Ongoing provider education & training
- Incentives and leadership support for culture change
How do we go from knowing about disparities to doing something about them?

ACTION PLANNING
Global positioning for equitable health care outcomes

- Identify a starting place (Recognize)
  - Use the EHR to confront differences in health indicators by race/ethnicity and other subgroups

- Agree on a common destination (Prioritize)
  - Reduce the gap by X% in the next 2 years
  - Identify landmarks related to mechanisms of change

- Create your map (Mobilize)
  - Open lines of communication between researchers, care providers and policy makers
  - Identify human and technological resources
  - Conduct small tests of change or pilots
What needs to be in our toolkit?

- Science and informatics: real time access to data that capture the care experience
- Patient-clinician partnerships: engaged and empowered patients
- Incentives: aligned to promote value
- Culture: leadership support for continuous learning
Promising Interventions/Strategies

- Increasing realized access
  - Language accessibility
  - Underinsurance
  - Health literacy

- Patient-Centered Care: Motivational Interviewing

- Empowering Patients: Values Affirmation

- Workforce Interventions
Engaging patients and communities in designing interventions that work

- Engagement of stakeholders throughout the research and quality improvement process
- Co-Design/Experience-Based Design
- “Not about us, without us”

Source: Clancy 2009; Mayer et al 2017; Pillans 2017
Questions and Discussion

▪ What would it take to engage patients and communities in care re-design?

▪ How do we address the needs of smaller subgroups of patients who may need more high touch than high tech?

▪ What are the challenges ahead for disparities reduction?
Where is your organization on the equity journey?

- **Recognize**
  - Looking at or planning to use available data to identify differences in health indicators by race/ethnicity and other subgroups

- **Prioritize**
  - Set a goal to reduce the gap by X% in the next 2 years
  - Communicate goals and obtain buy in from executives to care team

- **Mobilize**
  - Identify human and technological resources
  - Conduct small tests of change or pilots
From the Field: Two Organizations and their Journey Toward Equity

Ellen Chen, MD
Primary Care Director of Population Health, San Francisco Health Network

Joseph Young, MD
PHASE Physician Lead, Clinical Lead for Hypertension, Kaiser Permanente Northern California
Addressing Health Disparities in Hypertension Care for Black African Americans

Helen Gambrnah, BS
Sarah Cox, MPH
Ellen Chen, MD
San Francisco Health Network (SFHN)

Only integrated delivery system for San Francisco, accountable for 90,000 publicly insured or uninsured patient lives
Disparities in San Francisco

- On average, B/AA SF residents live:
  - 10 years less than Whites
  - 11 years less than Latinos
  - 14 years less than Asians

- 47% of B/AA residents have hypertension (HTN) compared to 18% of White residents

- Heart failure is **20 times more common** in B/AA patients under 50 years old than White patients

---

**Median Income**

In San Francisco, there is significant inequality in household income between races.

- White household median income is over **$100k**
- Black/African American household median income is **$30k**

---

1. California Department of Public Health, Deaths Statistical Master File 2010-2013
4. American Communities Survey 2014
Hypertension Equity Workgroup

• SFHN – Primary Care
  o Clinic champions from seven equity sites
  o Patient Advisors

• SFDPH – Population Health Division
  o Disease Prevention and Control
  o Community Health Equity & Promotion

• SFDPH – Black/African-American Health Initiative
MESSAGING and MEASURING EQUITY as a PRIORITY
SFHN Primary Care Vision

1st Choice for Health Care and Well Being

Improve the Health of the Patients We Serve
Optimize Access, Operations, and Cost-Effectiveness
Ensure Excellent Patient Experience

Safety  Quality  Care Experience  People Development  Financial Stewardship  Equity

Build a Strong Foundation of a Healthy, Engaged, and Sustained Primary Care Workforce

We Provide High Quality Health Care that Enables San Franciscans to Live Vibrant, Healthy Lives
Strategies for Messaging and Data Sharing

**DEFINE**
message Equity as a priority using shared language

**SHARE**
share disparity data monthly with various stakeholders

**DISCUSS**
develop resources and spaces for critical conversations around race
EQUITY METRIC:
Hypertension Control

1 in 4 SFHN PC patients have hypertension. Research shows that a blood pressure reduction of 12 mmHg for 11 patients prevents 1 death over 10 years. Of the 9,600 B/AA patients within the SFHN, approximately 39% have hypertension. While BP control rates for B/AA patients improved from 62% to 64% over the last fiscal year of 2017-2018, the disparity gap between B/AA and the total population only decreased 1% from 8% to 7%.

GOAL:
SFHN Goal
By June 2019, increase BP control for B/AA patients with hypertension from 61.4% (June 2018) to 65.3% (10% RI).

PCC Goal
Increase BP control by 15% RI or 71% threshold for B/AA patients with hypertension

October, 2018
(data through September 2018)

16 Additional net B/AA patients with controlled blood pressure this month

64.0% Compared to 63.6% in August, 2018

49 B/AA patients needed to control BP to reach goal

WHY WE MEASURE THIS:
Ms. Lee dropped into clinic for a blood pressure check. She was not currently taking her blood pressure medications and had been recently admitted to the hospital for poorly controlled hypertension. The RN used the HTN toolkit for BP coaching, B/AA patient brochure and distributed a home BP cuff. The patient returned to clinic in 1 week with her BP at goal and was monitoring her BP at home daily.

2/11 Met relative improvement goal of 15% this month

Met 15% RI goal
Did not meet RI goal
SFHN PC Hypertension Blood Pressure Control

Jan. 2015 – Sept. 2018
Total PC vs. B/AA

Network-wide change in BP control criteria (<140/90)


B/AA BP Control %  Total PC BP Control %  B/AA Goal  Total PC Goal

61% of 17,903  70% of 17,793

53% of 4,039  64% of 3,741

-> 8% gap  6% gap ->

49 San Francisco Health Network
INTERVENTIONS FOR IMPROVEMENT
Steps for Development

Team-Based Care
- Registered Nurse/Pharmacist
- Chronic Care Visits

Social Determinants of Health
- Food Pharmacies

Outreach

Messaging Equity as a Priority
Workforce Development

**Bring it Down Medication Algorithm**
Support medication titration & adherence

**Institute for Health Communication Training**
Training to message patient centered behaviors

**Outreach Script + Observation Checklist**
Outreach resources align with ICARE model
Outcomes

% of BP Control for patients* who received a cuff vs. patients who did not, stratified by race (n=164)

*HTN patients with uncontrolled BP in July, 2017 and seen in SFHN PC between August, 2017 – March, 2018
Food Pharmacy Model

Access

Community Connections

Sustained Behavior Change, Improved Health Outcomes

Knowledge

Tools

Skills
Patient Data *(across all 4 sites)*

- **Total number of unique participants:** 385
- **Average:** 16 patients/session
- **Percentage of B/AA patients:** 70.3%

*Patients who attended 3 or more sessions
**Averaged first 3 BP readings from outpatient visits within the 6 months prior to their first session and within 6 months after their last session*
From the Field: Two Organizations and their Journey Toward Equity

Ellen Chen, MD
Primary Care Director of Population Health, San Francisco Health Network

Joseph Young, MD
PHASE Physician Lead, Clinical Lead for Hypertension, Kaiser Permanente Northern California
Reflections on the Equity Roadmap

Morning Reflection (Turn to Page 11)

1. Where is your organization in the “Recognize, Prioritize, Mobilize” roadmap?

2. What would you tell your colleagues who weren’t here about what you just heard?

3. What information do you need to know to take your next step toward equity?
BREAK

• Reconvene by Building Blocks after the break

• Look at nametags for assignments:
  ▪ LD: Leadership
  ▪ QI: Quality Improvement
  ▪ DD: Data-Driven Decision Making
  ▪ TM: Team-Based Care
  ▪ PM: Panel & Population Management
Culturally Humble, Appropriate, and Respectful: Kaiser Permanente’s Specialty Blood Pressure Clinic for African-American Patients

Nailah Thompson, DO, MPH
Primary Care Physician, Clinical Hypertension Specialist, Kaiser Permanente
African Americans are more likely to die at early ages from all causes.
hardheaded

Don't LABEL Me

BIAS

STEREOTYPE
Reasons for Medication Non-Adherence

- Pt Feels Not Needed
- Affordability
- Side Effects
- Forgetfulness
- Lack of Info: Drug/Dz
- Lack of Dz Concern
- Poor Social Support
- Low Rx Satisfaction
- Poor Physician Relationship

Implicit Bias → Perception → Diagnostic Ability → Health Outcomes → Patient-Centered Communication → Clinical Decision-Making
Specialty Blood Pressure Clinic

A Kaiser clinic spells success for African-American patients by lowering blood pressure with a new approach.

By Andrea A. Firth

Oakland resident Danny Slick has dealt with hypertension for the past 30 years. The 55-year-old has taken medication off and on, and his blood pressure has fluctuated up and down. Slick’s primary care physician referred him to the Specialty Blood Pressure Clinic at Kaiser Permanente Oakland Medical Center in July, and within a couple of months, his blood pressure was within normal range.

Dr. Nathaniel Thompson, a hypertension specialist, launched the Specialty Blood Pressure Clinic, which runs two days a week, in 2015 to treat African Americans with uncontrolled high blood pressure, above 160/100 mm Hg. For Slick, Thompson changed his medication and encouraged him to stick with taking it. “It’s done the trick,” said Slick, adding that the staff at the clinic made him comfortable and made him feel as though he was a person, not just a number. “They are the reason I’m getting better.”

Despite the fact that many patients today are surgery that they have hypertension, getting their high blood pressure under control is a different story. But Kaiser’s specialty clinic is changing that. Slick is one success story, and there are many more. After two years, 80 percent of the more than 200 patients that Thompson has treated at the clinic have gotten their high blood pressure under control.

“Hypertension is more common in the African-American population. It is a bit of an easier control, and leads to worse outcomes, like hypertensive stroke and dialysis,” said Thompson. “The idea for the specialty clinic is to get people to actually get their blood pressure under control.”
No Trust = No Relationship
Thank you

Questions?
The plan...

Provide an update on initiative-level data

Engage with your peers about learnings and challenges related to the Building Blocks of PHASE

Share insights & reflections
PHASE Metrics

Q3 update
Reach of PHASE

196 clinic sites

108K patients with diabetes

152K patients with hypertension

207K total patients
## Performance on HEDIS metrics

<table>
<thead>
<tr>
<th></th>
<th>Current performance</th>
<th>HEDIS 75&lt;sup&gt;th&lt;/sup&gt; percentile</th>
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<tbody>
<tr>
<td>Blood pressure control for patients with HTN</td>
<td>71.0%</td>
<td>64.8%</td>
</tr>
<tr>
<td>Blood pressure control for patients with DM</td>
<td>75.7%</td>
<td>68.5%</td>
</tr>
<tr>
<td>Blood sugar (A1c) control for patients with DM</td>
<td>67.2%</td>
<td>64.5%</td>
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# Performance on HEDIS metrics

<table>
<thead>
<tr>
<th></th>
<th>2017, Q1</th>
<th>2017, Q3</th>
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<tbody>
<tr>
<td>Blood pressure control for patients with HTN</td>
<td>75K</td>
<td>108K</td>
</tr>
<tr>
<td>Blood pressure control for patients with DM</td>
<td>49K</td>
<td>83K</td>
</tr>
<tr>
<td>Blood sugar (A1c) control for patients with DM</td>
<td>49K</td>
<td>73K</td>
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## Performance on HEDIS metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th># of grantees who have improved</th>
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</thead>
<tbody>
<tr>
<td>Blood pressure control for patients with HTN</td>
<td>13 of 18</td>
</tr>
<tr>
<td>Blood pressure control for patients with DM</td>
<td>11 of 18</td>
</tr>
<tr>
<td>Blood sugar (A1c) control for patients with DM</td>
<td>8 of 18</td>
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# Performance on UDS metrics

<table>
<thead>
<tr>
<th></th>
<th>Current performance</th>
<th>UDS average</th>
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<tbody>
<tr>
<td>Tobacco screening &amp; follow-up</td>
<td>87.2%</td>
<td>85.2%</td>
</tr>
<tr>
<td>BMI screening &amp; follow-up</td>
<td>60.8%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Depression screening &amp; follow-up</td>
<td>57.2%</td>
<td>60.3%</td>
</tr>
<tr>
<td>Service</td>
<td># of grantees who have improved</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td>Tobacco screening &amp; follow-up</td>
<td>6 of 17</td>
<td></td>
</tr>
<tr>
<td>BMI screening &amp; follow-up</td>
<td>4 of 16</td>
<td></td>
</tr>
<tr>
<td>Depression screening &amp; follow-up</td>
<td>10 of 16</td>
<td></td>
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</table>
## Performance on UDS metrics

<table>
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<tr>
<th></th>
<th>2017, Q1</th>
<th>2018, Q3</th>
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<tr>
<td>Tobacco screening &amp; follow-up</td>
<td>287K</td>
<td>447K</td>
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<tr>
<td>BMI screening &amp; follow-up</td>
<td>234K</td>
<td>347K</td>
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<tr>
<td>Depression screening &amp; follow-up</td>
<td>206K</td>
<td>358K</td>
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PHASE Building Blocks

Peer sharing activity
Grantees reported modest improvements in all of the PHASE Building Blocks since baseline

- Leadership
- Quality improvement
- Data-based decision making
- Team-based care
- Panel & population management

Score:

- Level D (1-3)
- Level C (4-6)
- Level B (7-9)
- Level A (10-12)
Continuing to build infrastructure and manage EHR changes
- Planning before an EHR transition, e.g. beginning mapping process
- Centralizing analytics & reporting to reduce burden on individual sites
- Implementing new reporting and/or population health management tools
- Integrating use of data dashboards within population health and care teams

**How are grantees improving data-based decision making?**

**What is the range of data-based decision making scores by question?**

At mid-initiative (May 2018), there was a wide variety of capacity across health centers and clinics. (N=62 health center organizations and hospital sites).

- Question 1
- Question 2
- Question 3
- Question 4
- Question 5
- Question 6
- Question 7
- Question 8

**How have data-based decision making domain averages changed over time?**

- 11 of 17 grantees (G1-G17) reported improved scores

**How are grantees using data to monitor blood pressure (BP) control?**

- Regularly providing care teams with dashboards highlighting BP goals and performance
- Working with IT to create a HTN registry to track patients
## Building Capacity Block by Block: Data-Based Decision Making

<table>
<thead>
<tr>
<th></th>
<th>Level D</th>
<th>Level C</th>
<th>Level B</th>
<th>Level A</th>
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<tbody>
<tr>
<td><strong>14. Performance measures</strong></td>
<td>...are not available for the clinical site.</td>
<td>...are available for the clinical site, but are limited in scope.</td>
<td>...are comprehensive, including clinical, operational, and patient experience measures — and available for the practice, but not individual providers.</td>
<td>...are comprehensive — including clinical, operational, and patient experience measures — and fed back to individual providers.</td>
</tr>
<tr>
<td><strong>Score</strong></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
<td>10 11 12</td>
</tr>
<tr>
<td><strong>15. Reports on care processes or outcomes of care</strong></td>
<td>...are not routinely available to practice teams.</td>
<td>...are routinely provided as feedback to practice teams but not reported externally.</td>
<td>...are routinely provided as feedback to practice teams, &amp; reported externally (e.g. to patients, other teams / external agencies) but with identities masked.</td>
<td>...are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams and external agencies.</td>
</tr>
<tr>
<td><strong>Score</strong></td>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
<td>10 11 12</td>
</tr>
</tbody>
</table>
Peer sharing activity

1. **Small group discussions** about the Building Blocks of PHASE. Each group will focus on one Building Block.

2. **Report back** a take-away from your group’s discussion with the larger group.
Discussion questions

For the Building Block you are discussing:

1. What have been your team’s successes and/or “Bright Spots”? What has helped you be successful?

2. What has your team struggled with or where have you failed? What have you learned from these “Fabulous Flops”?

3. What strategies do you think are contributing most to improvements in BP control?
Insights and reflections

Spokesperson share a take-away from your group’s discussion with the larger group
Thank you

Center for Community Health and Evaluation

Maggie Jones – maggie.e.jones@kp.org
Jennie Schoeppe – jennie.a.schoeppe@kp.org
Carly Levitz – carly.e.levitz@kp.org

www.cche.org
Creating a Diabetes Care Playbook: Our QI Journey

Brandon Bettencourt, RN
Director of Quality Improvement, Chapa-De Indian Health
Pre-Lunch Reminders

12:30pm-1:30pm
Table Discussions (12:45 - 1:25pm)

- What is success for Self-Measured Blood Pressure (SMBP) programs?

- Lunch and Share with Dr. Adams: Improving Care Quality, Coordination, and Outcome
Health Equity Workshops

Workshops begin at 1:30

The Empathy Effect: Countering Bias to Improve Health Outcomes

Robinson B

Building Community Partnerships for Hypertension Outreach

Nile Hall (here!)

Structural Determinants of Health: Examining and Addressing the Forces behind Inequity

Robinson A
Go to www.menti.com and enter the code:

85 43 2

Please use up to three words to describe your workshop experience.

(For example: inspiring, practical, hands on, sobering, thought-provoking, etc.).

Your responses will build a Word Cloud in Nile Hall.
Testing changes for equity using Plan-Do-Study-Act (PDSA)
Team Time – Equity PDSA Worksheet

Use this worksheet to help you plan next steps after this convening. Please write legibly and take a photo of the completed worksheet for your records; CCI will collect this worksheet.

EQUITY AIM

This aim should support your PHASE goals and strategies you already set in your 2018 Charter for Improvement. E.g. in one year, for a pilot population, reduce DM a1c control between white and African American/Black patients by 25%. If your organization already has an equity goal related to PHASE (e.g. a DM or HTN goal articulated in a strategic plan or in a disparities reduction plan for PRIME), write it here.

ORGANIZATION NAME: ________________________________

CHANGES

Define 3 changes you need to achieve this aim. E.g. 1. figure out what the current disparity is, 2. understand root causes of the disparity, 3. test an intervention.

1.

2.

3.
**FIRST PDSA ACTION PLAN**

For one of the changes, complete the plan section for your first PDSA. Fewer, more specific tasks that can be started next week are better. E.g. By December 7th, Lucia will find out who can run a query to randomly select 10 charts for Black/African American patients and 10 for white patients to prepare for a chart review.

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible</th>
<th>Timeline</th>
<th>Where &amp; Other Notes</th>
</tr>
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<tbody>
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**PREDICTIONS & MEASURES**

Predict what will happen when the test is carried out and list the measures that will determine if the prediction is correct. E.g. 1. we will be able to identify the 20 charts for a chart review by December 7th, 2. we will find 2 nurses to review two charts each by December 14th, 3. the nurses will find the chart review template to be easy to use, 4. we will review all 20 charts and be able to identify 4 actionable causes of the disparity in A1c control by December 21st.

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PHASE | November 29, 2018, Convening
Evaluation & What’s Next

CCI
Support, Technical Assistance, and Learning Community
Convening Evaluation

Grantee Gathering
November 29, 2018 – Oakland, California

Thank you for completing the following survey. Your responses are confidential and will be analyzed collectively with other participant responses. Aggregate data are used to provide the PHASE support team with feedback regarding the quality of the convening and collective benefit to the participants.

1. The convening was well organized:
   - Strongly Disagree
   - Disagree
   - Agree
   - Strongly Agree

2. The length of the convening was:
   - Too short
   - About right
   - Too long

3. The quantity of information presented in the convening was:
   - Not enough
   - About right
   - Too much

4. The level of participant interaction/engagement in the convening was:
   - Not enough
   - About right
   - Too much

5. I made connections today with other grantees that will strengthen my team’s PHASE efforts:
   - Strongly Disagree
   - Disagree
   - Agree
   - Strongly Agree
   - N/A (not a grantee)

6. On a scale of 1-5, please select the number below that best represents your overall experience with today’s convening:
   - 1 = Poor
   - 2 = Fair
   - 3 = Good
   - 4 = Very Good
   - 5 = Excellent

7. Please select the number below that best represents your response to the statement: The convening today was a valuable use of my time.
   - 1 = Strongly Disagree
   - 2 = Disagree
   - 3 = Neutral
   - 4 = Agree
   - 5 = Strongly Agree

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8. I will be able to apply something I learned today to advance our PHASE efforts:
   - Strongly Disagree
   - Disagree
   - Agree
   - Strongly Agree
   - N/A (not a grantee)

9. To what extent did you find the sessions at the convening useful?
   - Not useful
   - Somewhat useful
   - Useful
   - Very useful
   - N/A
   - Did not attend
   - a. Recognize, prioritize, mobilize: What health care organizations can do to address disparities (Dr. Adams)
   - b. From the field: Two organizations and their journey toward equity (Dr. Chen, Dr. Young)
   - c. Morning team activity: Equity goal setting
   - d. Afternoon team activity: Action planning session
   - e. 15 Minutes of PHASE! - Culturally humble, appropriate, and respectful: Kaiser Permanente’s specialty blood pressure clinic for African American patients (Dr. Thompson)
   - f. 15 Minutes of PHASE! - Creating a diabetes care playbook: Our QI journey (Brandon Bell, Minn)
   - g. Building capacity block by block: Peer sharing activity (COHI)

10. To what extent do you agree that your confidence increased as a result of participating in the workshops?
    - Strongly Disagree
    - Disagree
    - Agree
    - Strongly Agree
    - N/A
    - a. The Empathy Effect: Countering bias to improve health outcomes (Dr. [Name])
    - b. Building community partnerships for hypertension outreach (Chris [Name], Dr. Taylor)
    - c. Structural determinants of health: Examining and addressing the forces behind inequity (Structural competency working group)

11. If you will be able to apply something you learned, please provide an example of what you anticipate being able to apply to your PHASE efforts.

12. What was the most valuable part of the convening?

13. Please provide any suggestions for how the convening could be improved.

14. In what ways can the PHASE support team help you or your organization advance equity?

15. Please indicate your role/connection to PHASE.
   - Participant from a public hospital
   - Participant from a consortium
   - Participant from a health center
   - Kaiser Permanente
   - Other (please specify):

Thank you for completing this survey!
Communication Tools

Monthly Newsletter (First Thursday each month)

Calendar invites for program events

PHASE Support Portal Page (www.careinnovations.org/phasesupport/)
Upcoming Summit & Virtual Trainings

• IHI Summit on Improving Patient Care
  ▪ April 11–13, 2019, San Francisco, CA

• Leading Quality Improvement: Essentials for Managers
  ▪ Virtual expedition begins January 2019

• Practical Tips for Large-Scale Improvement Initiatives
  ▪ Virtual expedition begins January 2019

• Becoming an Age-Friendly Health System
  ▪ Virtual expedition begins February 2019

• Pain Management: Moving Beyond Opioids
  ▪ Virtual expedition begins March 2019

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

[careinnovations.org/phasesupport/onboarding]
1. Year End Reflection

Instructions, expense template, submission link sent to PHASE team lead
Stay tuned for info about the Spring 2019 Convening!

Thank you!