WELCOME

PHASE Grantee Convening

Toward Equity in Hypertension Care

November 29, 2018

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PREVENTING HEART ATTACKS & STROKES EVERY DAY

What to expect today…

Subject matter experts

Active participation

Engagement with peers

Skill building workshops

Reflection & team time

Your Guide to the Day

PHASE

Champion

Center for Care Innovations

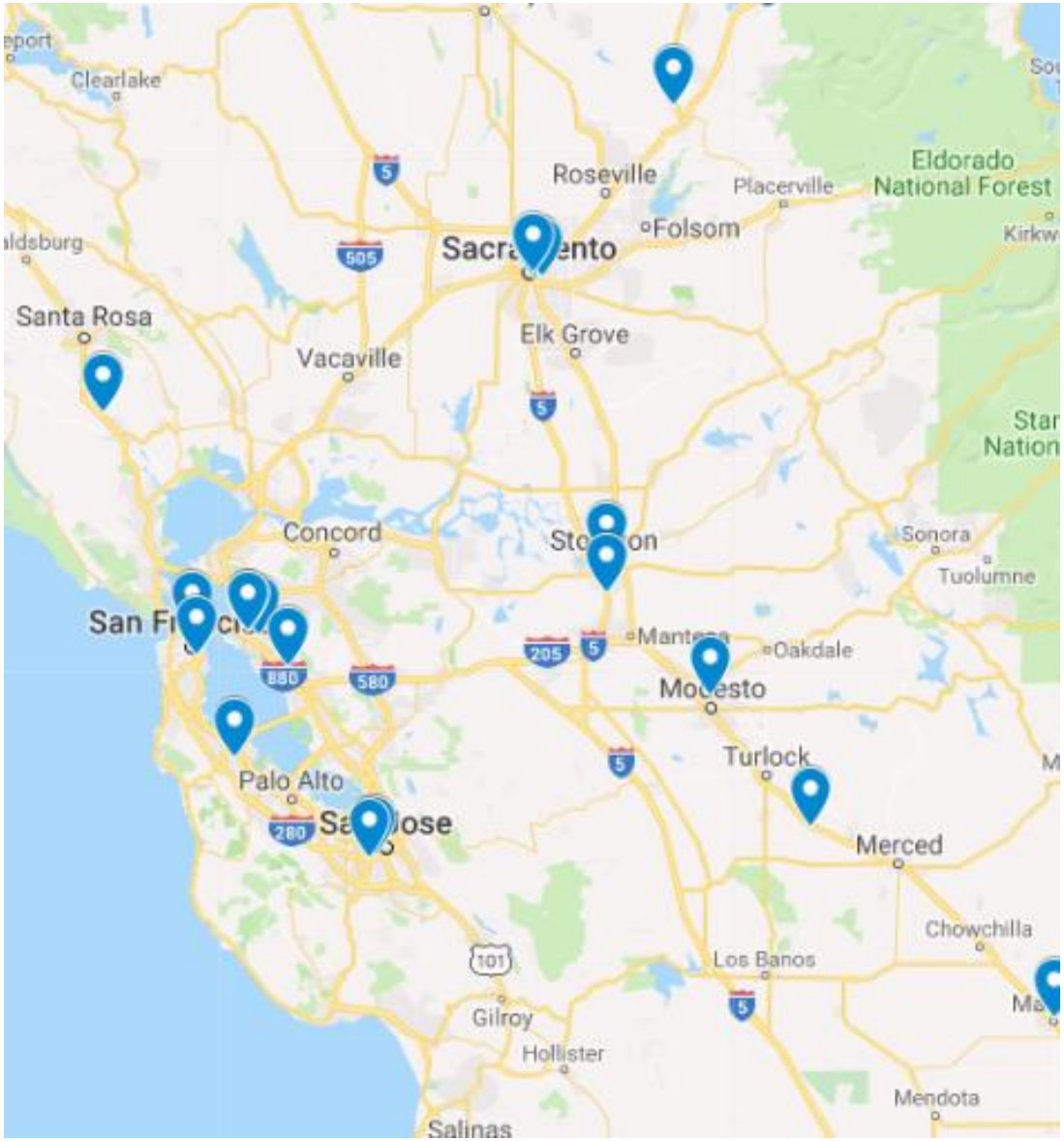
Table: #
BB: ABC
WS:

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/

PHASE Learning Community

- 18 grantees
- 198 clinic sites
- 204k patients



Jean Nudelman

Director, Northern California Community Benefit

Welcome!

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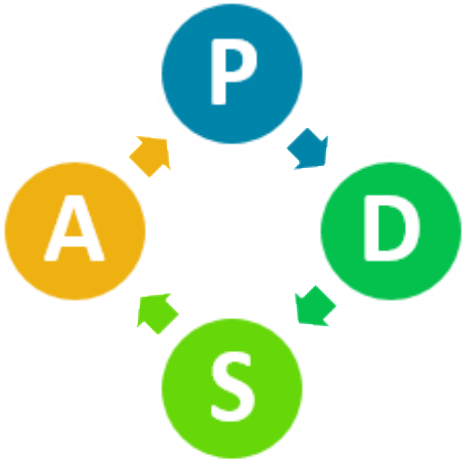
PREVENTING HEART ATTACKS & STROKES EVERY DAY

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

Source: What are health disparities and health equity? We need to be clear. *Public Health Rep*. 2014;129 Suppl 2(Suppl 2):5-8.

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

Sources: What are health disparities and health equity? We need to be clear. *Public Health Rep*. 2014;129 Suppl 2(Suppl 2):5-8.

A **health disparity** is a metric we use to measure progress toward **health equity**

EXPERIENCE

+

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

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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

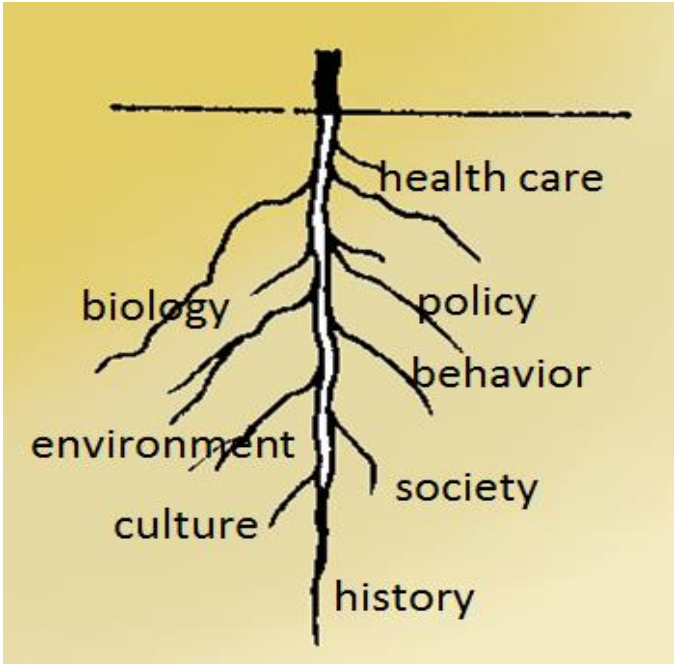
PHASE Learning Community Convening
November 29, 2018

Outline

- Impact of disparities and inaction
- Diabetes and Hypertension as drivers of disparities
- Modifiable determinants of disparities in diabetes and HTN
- The limitations of one size fits all models of intervention
- Targeting multi-level factors: Patient, Provider, Health System
- Action planning for disparities reduction
- Discussion

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.



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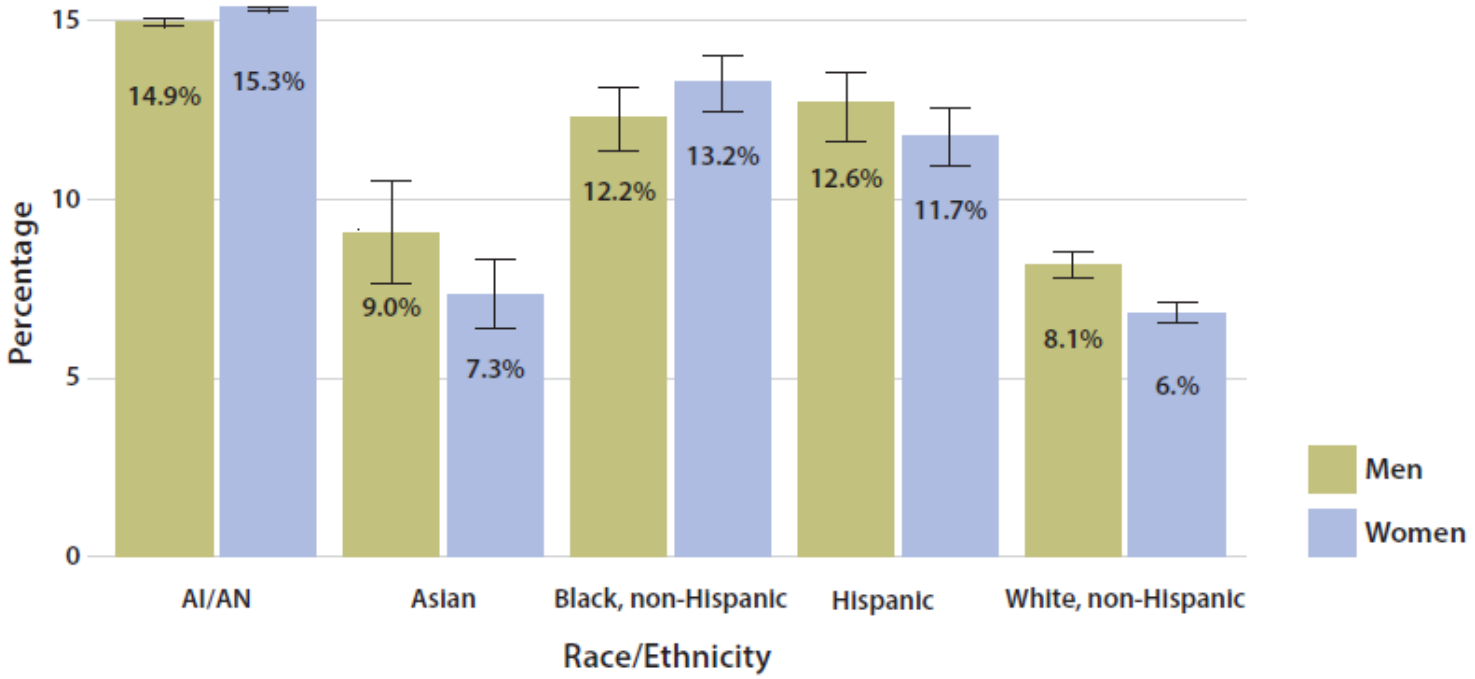
Access is necessary, but insufficient to address disparities in outcomes

- **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



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.

Source: CDC, National Diabetes Statistics Report

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Prevalence of Heart Disease and Stroke, 2011-2014

Source: AHA, Heart Disease and Stroke Statistics 2018

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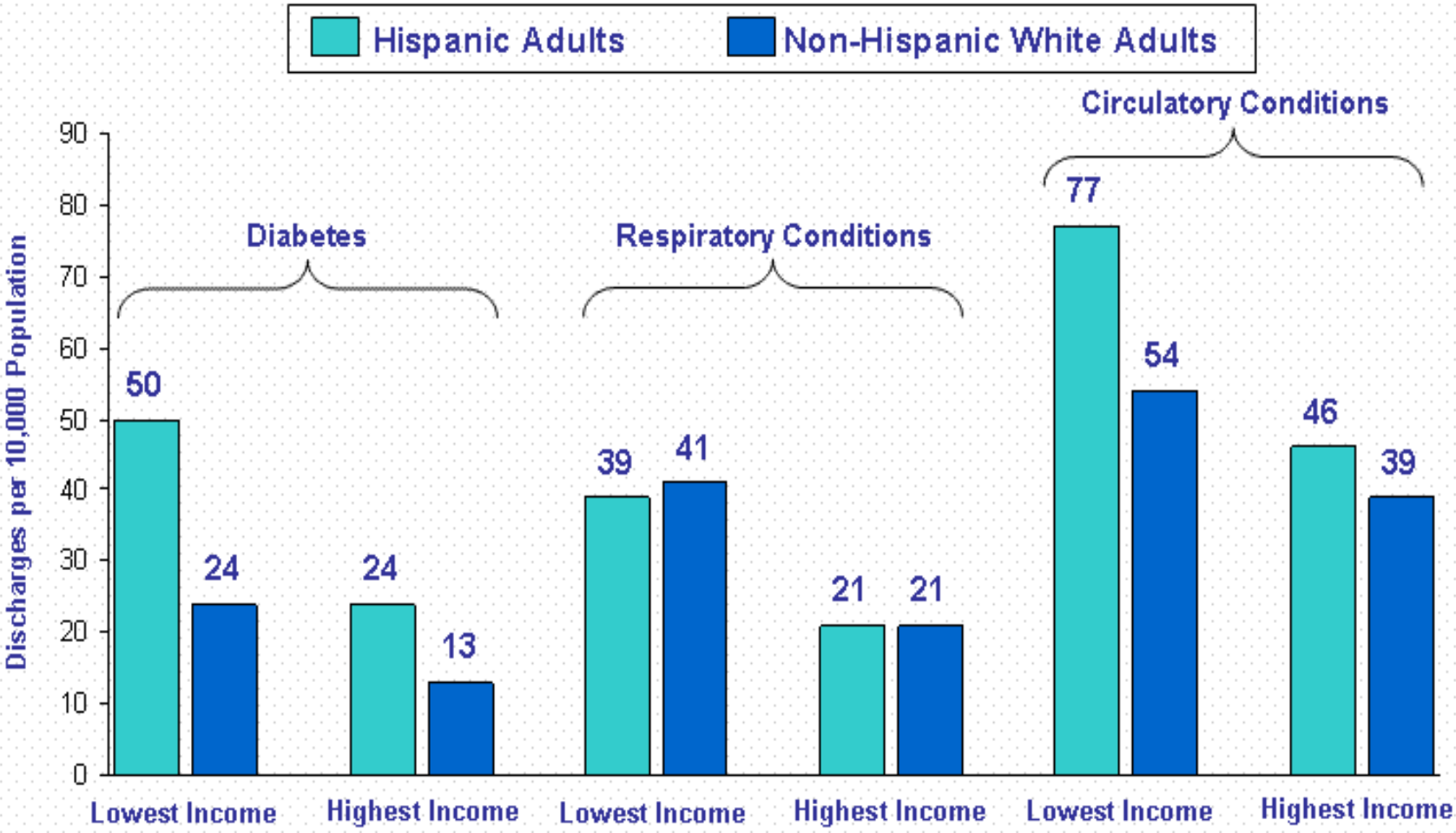
Figure 4. Disparities in Rate of Potentially Preventable Hospital Stays for Diabetes Between Hispanic Adults and Non-Hispanic White Adults Exist Across Income Levels



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

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?

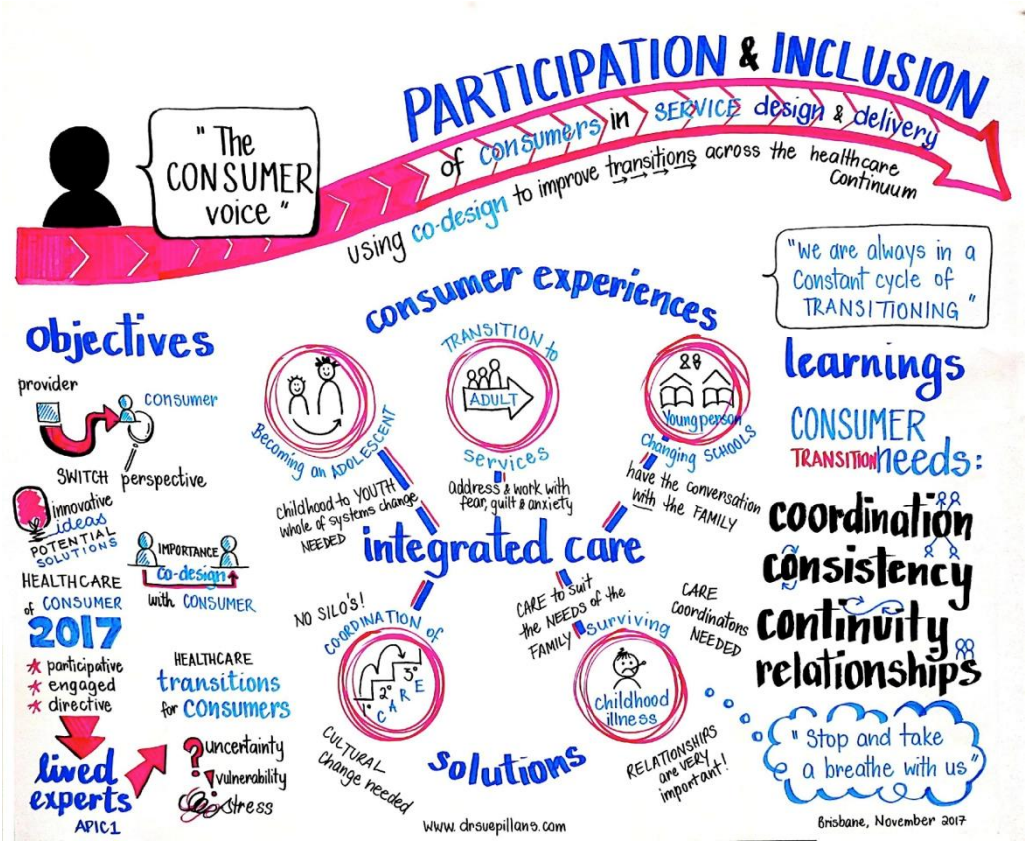
- Science and informatics: real time access to data that capture the care experience
- Patient-clinician partnerships: engaged and empowered patients
- Incentives: aligned to promote value
- Culture: leadership support for continuous learning

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

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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 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

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Addressing Health Disparities in Hypertension Care for Black African Americans

Helen Gambrah, BS
Sarah Cox, MPH
Ellen Chen, MD

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Health Network (SFHN)

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

Health care is here

1 Balboa Teen Health Center
2 Southeast Health Center
3 3rd Street Youth Center & Clinic
4 Castro-Mission Health Center
4 Dimensions Clinic
5 Chinatown Public Health Center
6 Larkin Street Youth Services
7 Tom Waddell Urban Health Center
8 Curry Senior Center
9 Community Behavioral Health Services
10 Laguna Honda Hospital and Rehabilitation Center
11 Cole Street Clinic
12 Zuckerberg San Francisco General Hospital
12 Richard Fine People's Clinic
12 Family Health Center
12 Positive Health Program
12 Children's Health Center
13 Hip Hop to Health Clinic
14 Silver Avenue Family Health Center
15 Potrero Hill Health Center
16 Ocean Park Health Center
17 Hawkins Village Teen Health Center
18 Burton High School Based Health Center
19 Maxine Hall Health Center

Hospitals

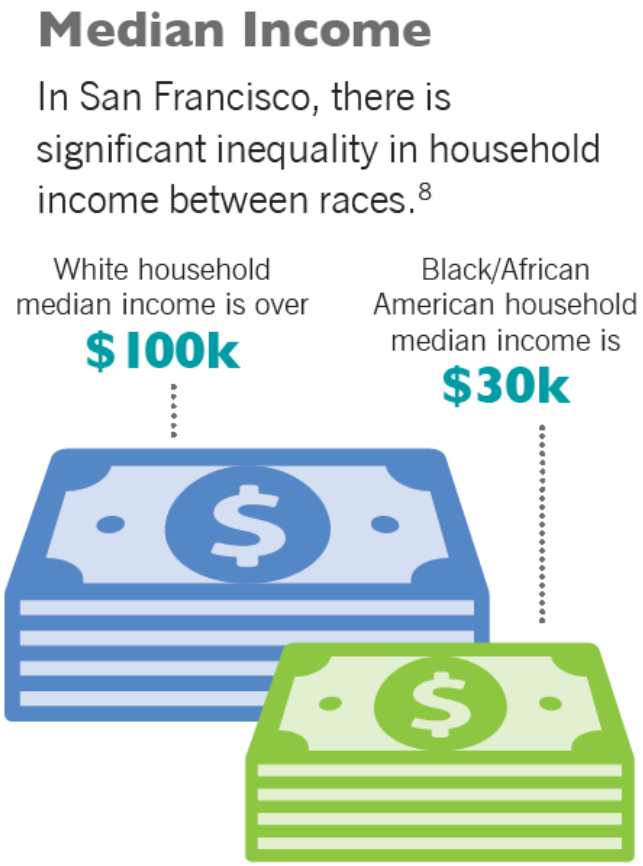
San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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[1]

- 47% of B/AA residents have hypertension (HTN) compared to 18% of White residents[2]

- Heart failure is **20 times more common** in B/AA patients under 50 years old than White patients[3]



[1]*California Department of Public Health, Deaths Statistical Master File 2010-2013*
[2]*UCLA Center for Health Policy Research. California Health Interview Survey. 2011-14.*
[3]*Gilbert C. Foundation Confronts Disparities for African Americans Suffering from Heart Failure. Journal of the National Medical Association. 2005;97(2):142-194.*
[8]*American Communities Survey 2014*

Hypertension Equity Workgroup

- SFHN – Primary Care
  - Clinic champions from seven equity sites
  - Patient Advisors
- SFDPH – Population Health Division
  - Disease Prevention and Control
  - 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

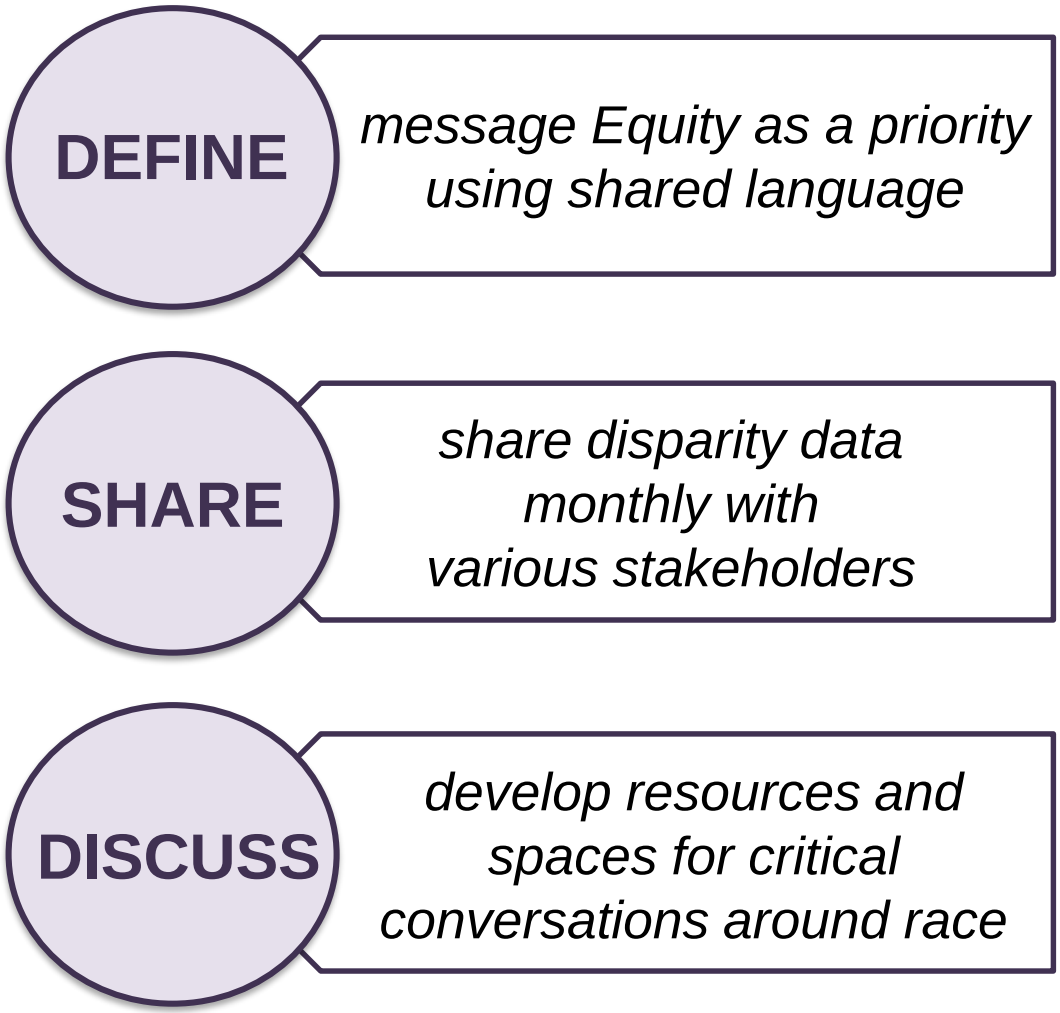
Ensure Excellent Patient Experience

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



EQUITY

METRIC:

Hypertension Control

WHY WE MEASURE THIS:
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

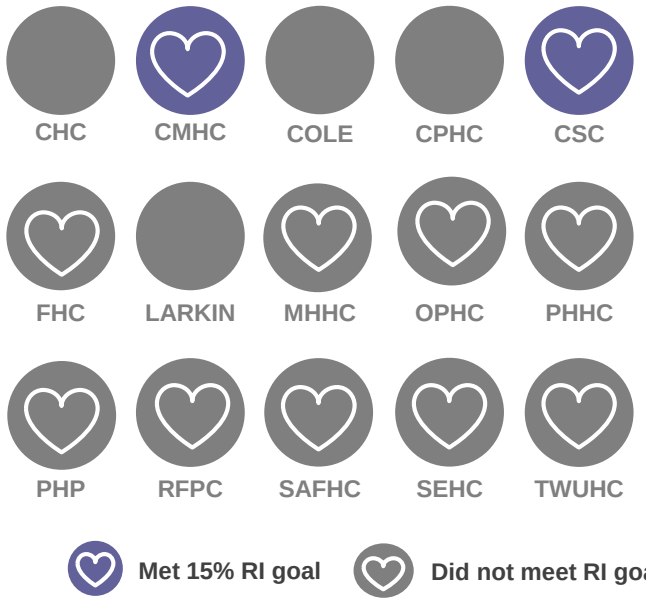
October, 2018
(data through September 2018)

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**

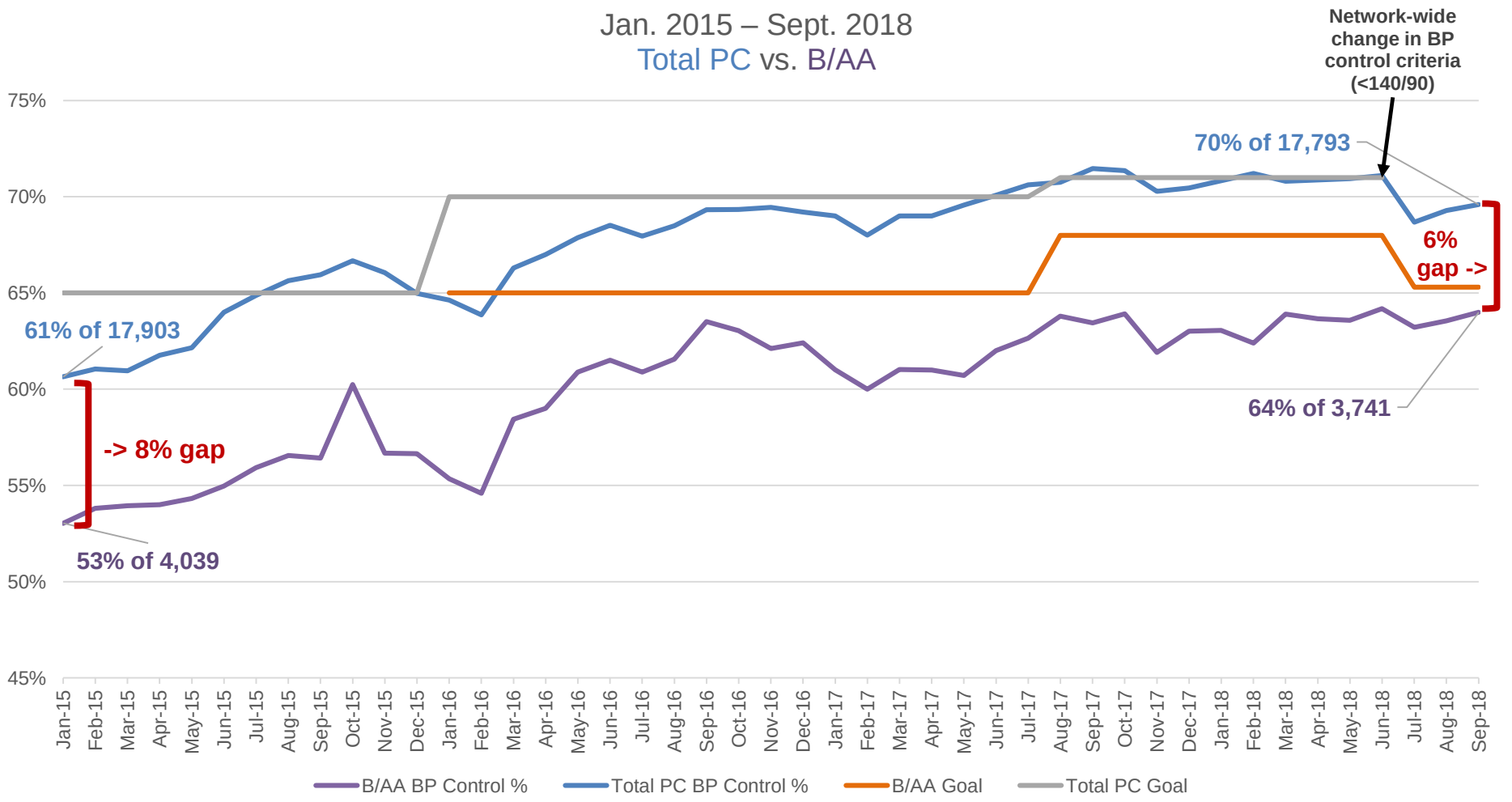
2/11 **Met relative improvement goal of 15% this month**



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.

San Francisco Health Network

SFHN PC Hypertension Blood Pressure Control



INTERVENTIONS FOR IMPROVEMENT

Steps for Development

Team-Based Care

Registered Nurse/Pharmacist
Chronic Care Visits

Social Determinants of Health

Food Pharmacies

Messaging Equity as a Priority

Workforce Development

Bring it Down Medication Algorithm

Support medication titration & adherence

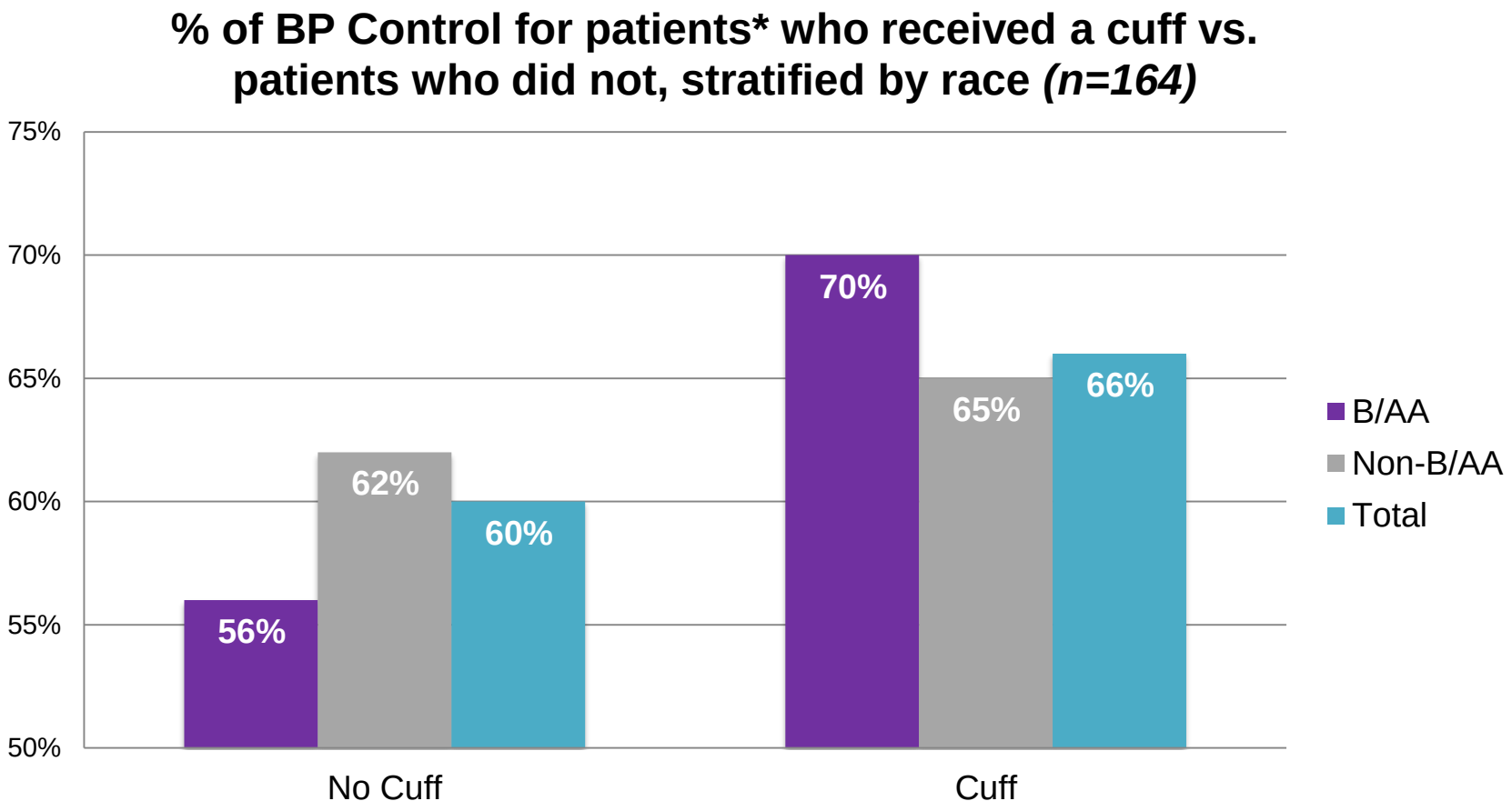
Institute for Health Communication Training

Training to message patient centered behaviors

Outreach Script + Observation Checklist

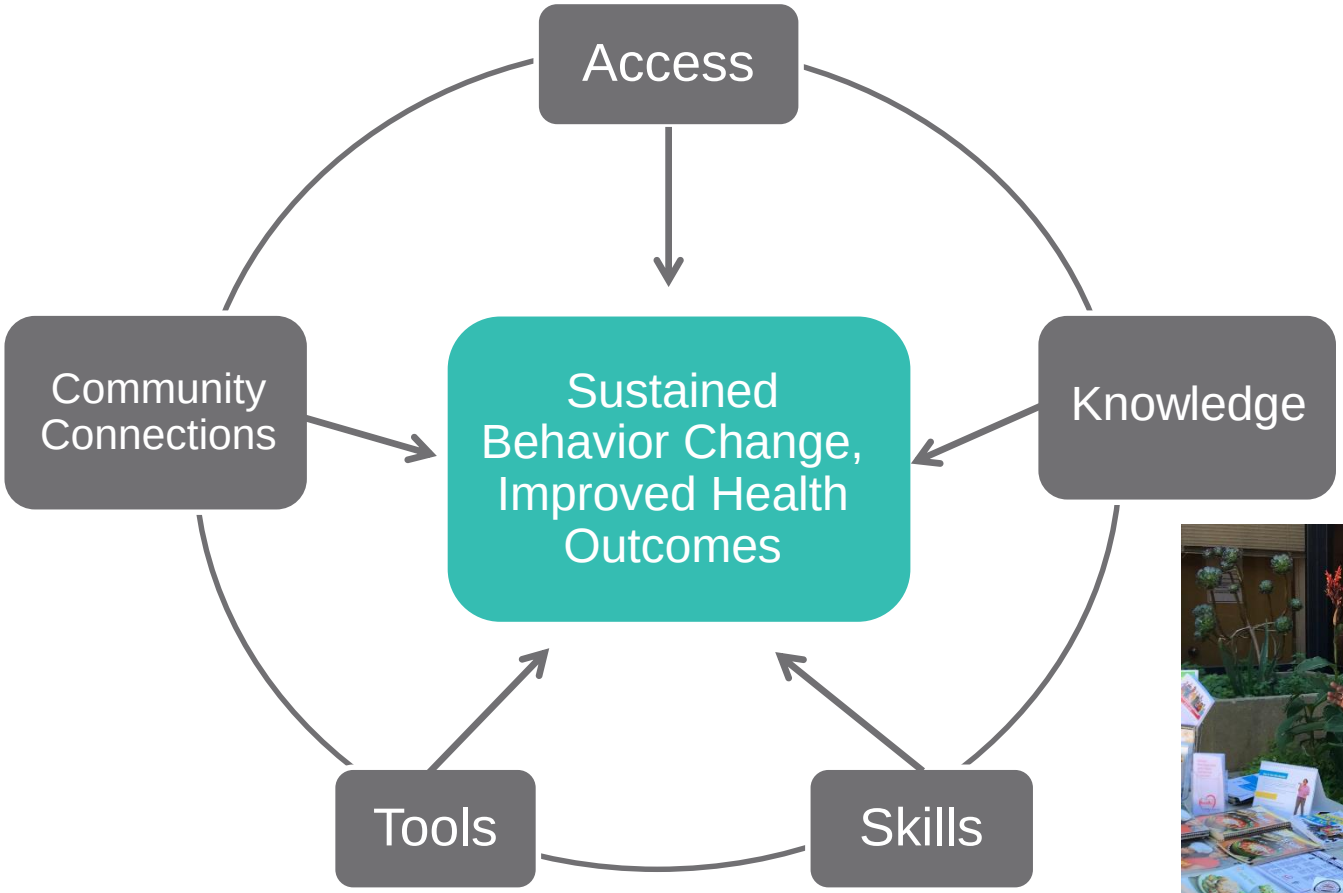
Outreach resources align with ICARE model

Outcomes



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

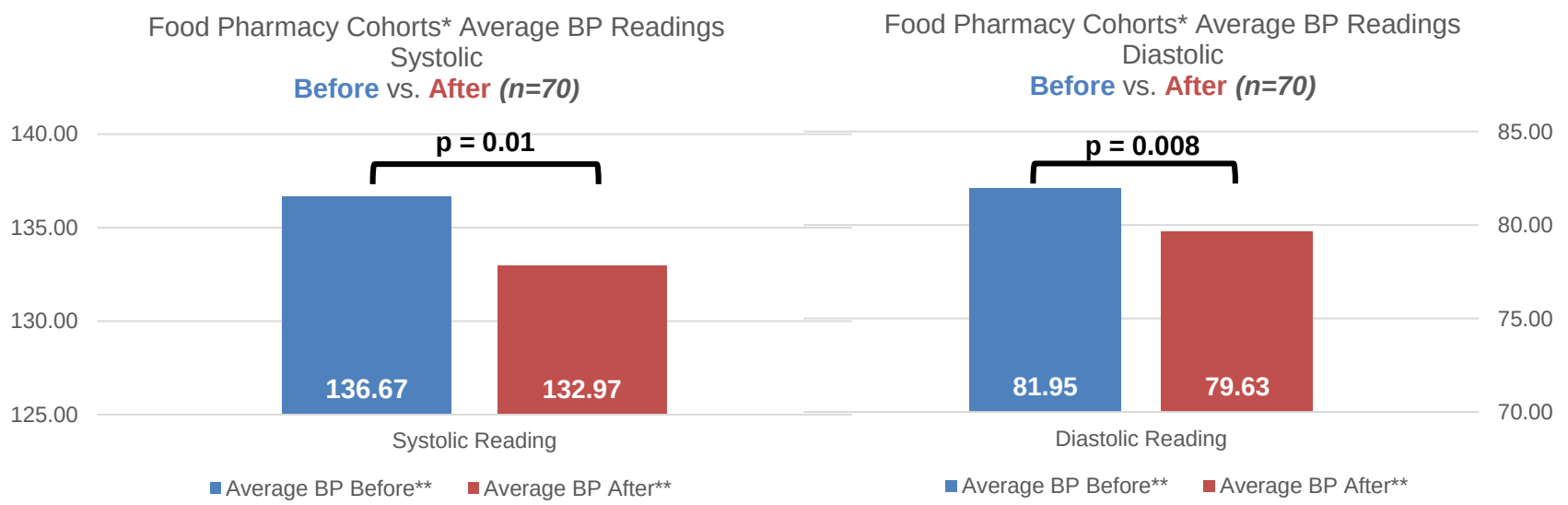
Food Pharmacy Model



Outcomes

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

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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

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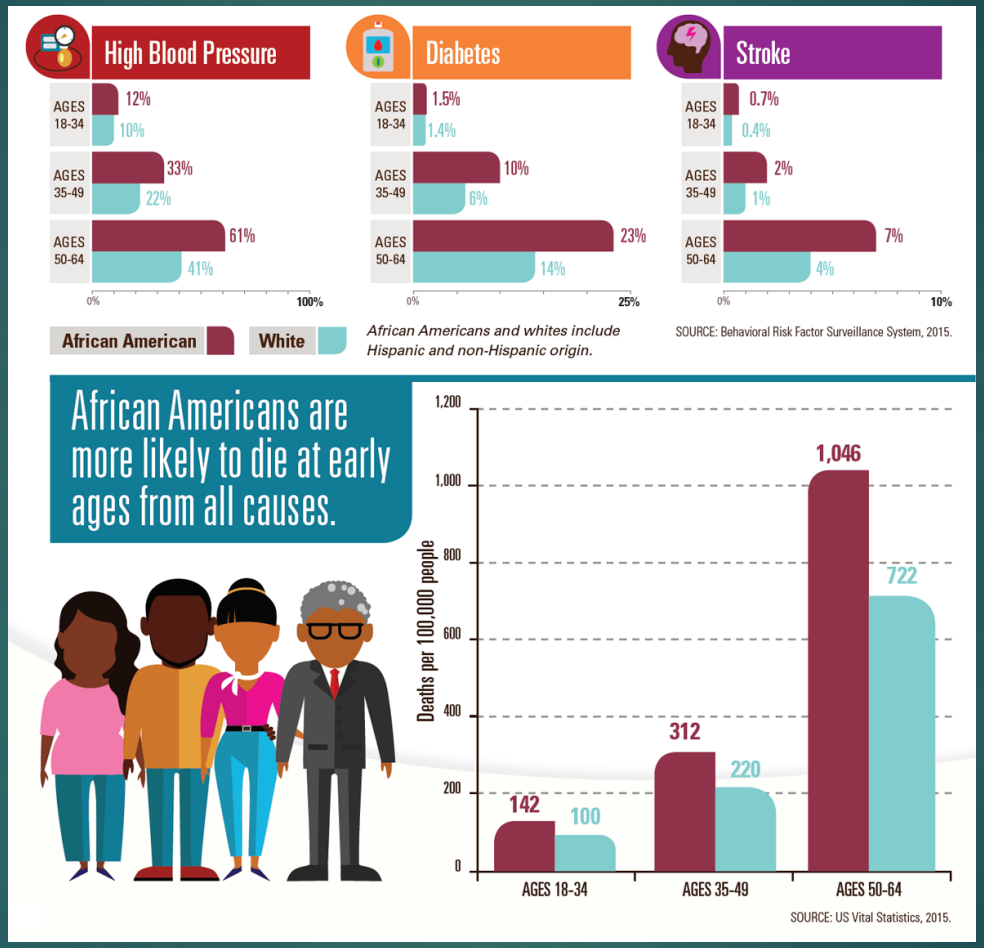
NAILAH THOMPSON, DO MPH

CERTIFIED HYPERTENSION SPECIALIST

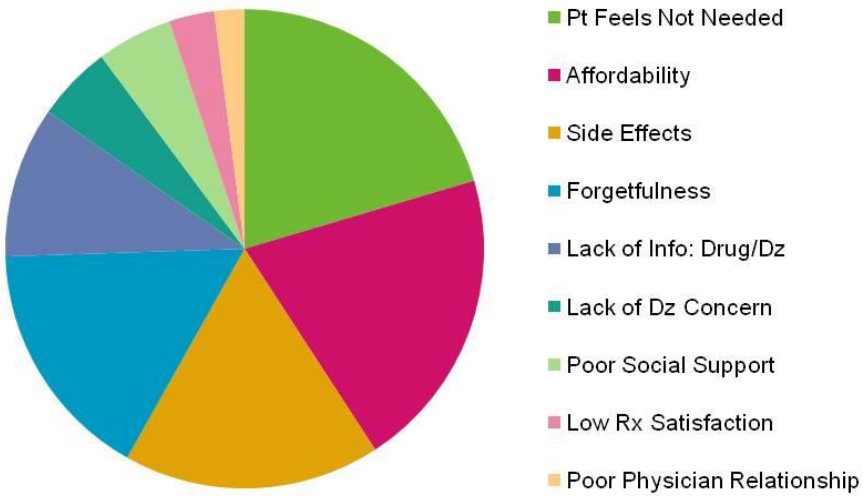
DIRECTOR INTERNAL MEDICINE HEALTH EQUITY AND DISPARITIES RESIDENCY

11/29/18


High Blood Pressure
AGES 18-34
12%
10%
AGES 35-49
33%
22%
AGES 50-64
61%
41%
0%
100%
Diabetes
AGES 18-34
1.5%
1.4%
AGES 35-49
10%
6%
AGES 50-64
23%
14%
0%
25%
Stroke
AGES 18-34
0.7%
0.4%
AGES 35-49
2%
1%
AGES 50-64
7%
4%
0%
10%
African American
White
African Americans and whites include Hispanic and non-Hispanic origin.
SOURCE: Behavioral Risk Factor Surveillance System, 2015.
African Americans are more likely to die at early ages from all causes.
Deaths per 100,000 people
1,200
1,000
800
600
400
200
0
142
100
312
220
1,046
722
AGES 18-34
AGES 35-49
AGES 50-64
SOURCE: US Vital Statistics, 2015.

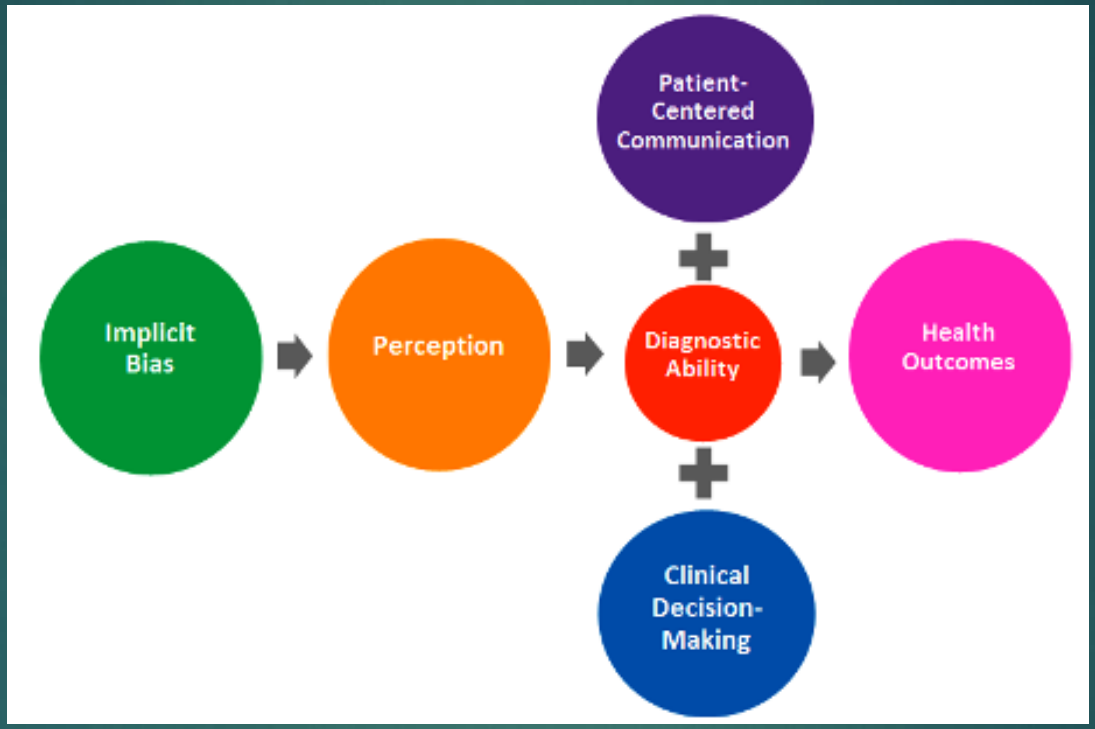
hardheaded

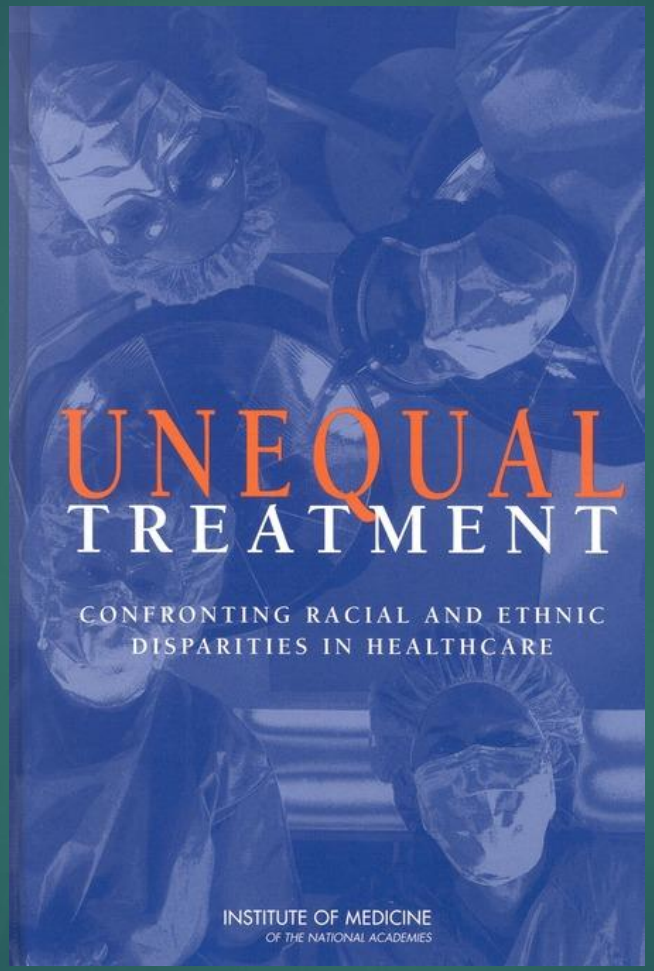
Reasons for Medication Non-Adherence

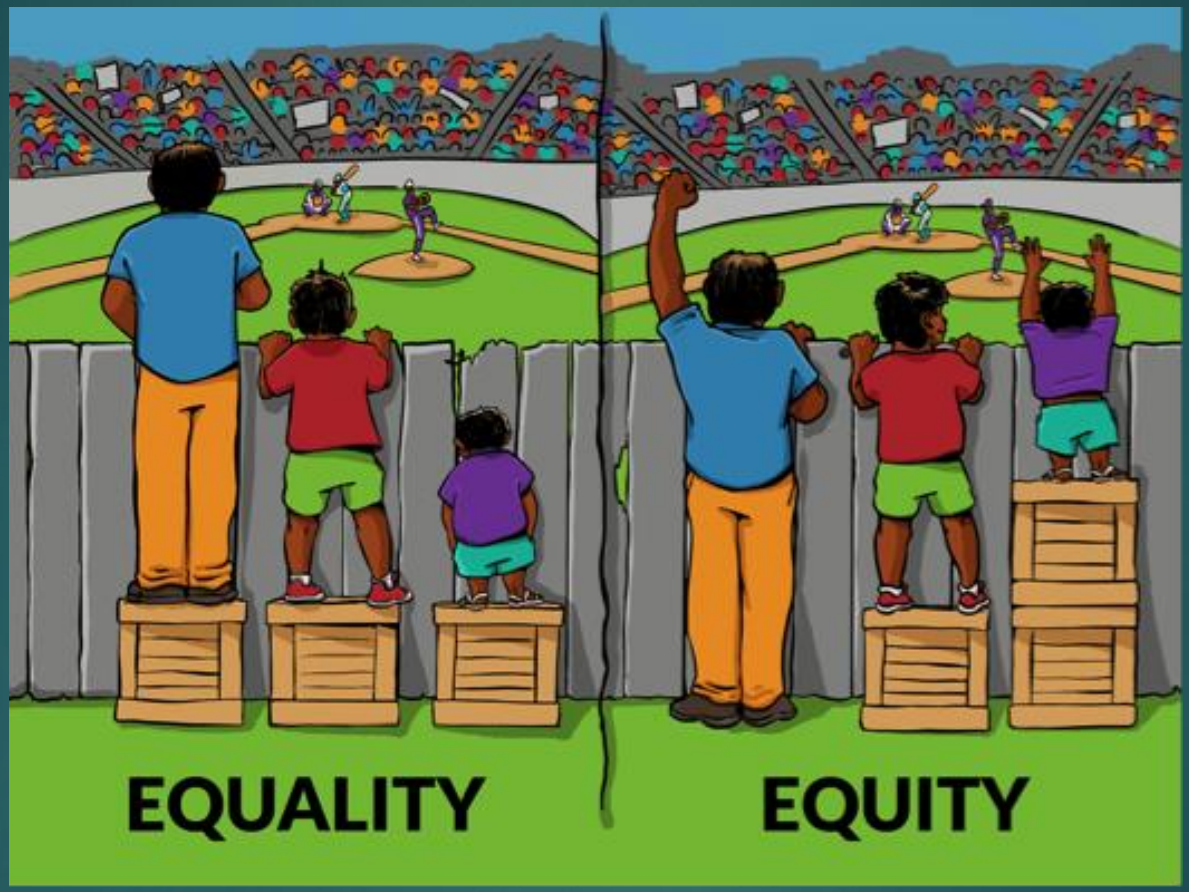


Source: Koroneos, G., Oct 2008.


Bias
Ideality
Perfection
Refinement
Constructiveness
Prudence
Secretiveness
Reserve
Policy
Desire for Liquids
Alimentiveness
Modulation
Calculation
Figure
Estimate


Patient-Centered Communication
Implicit Bias
Perception
Diagnostic Ability
Health Outcomes
Clinical Decision-Making


UNEQUAL
TREATMENT
CONFRONTING RACIAL AND ETHNIC
DISPARITIES IN HEALTHCARE
INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES


EQUALITY
EQUITY

Specialty Blood Pressure Clinic

Tia

Dabryla

DeAndra


No Trust
=
No Relationship


SIDE
EFFECTS


Verizon
1:23 PM
99%
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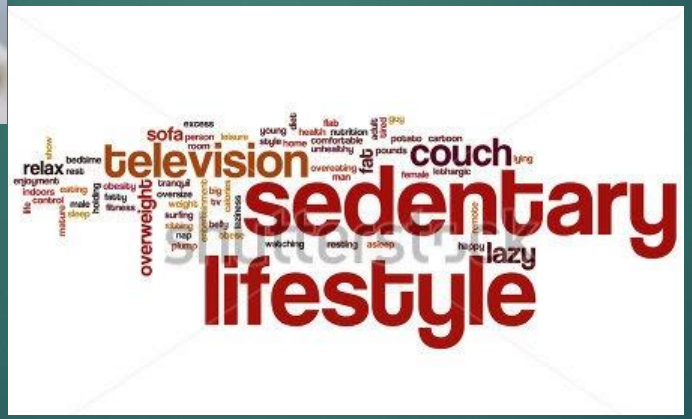
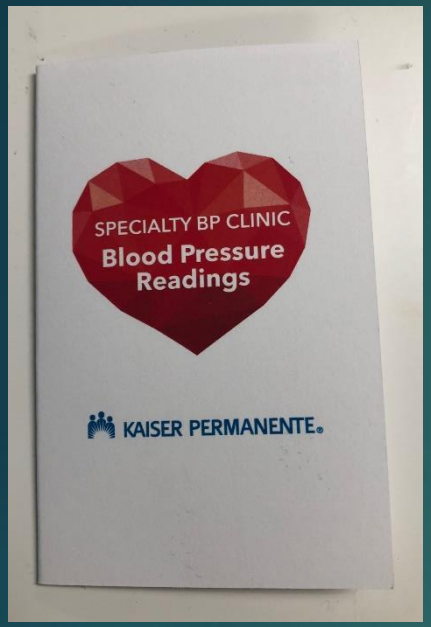
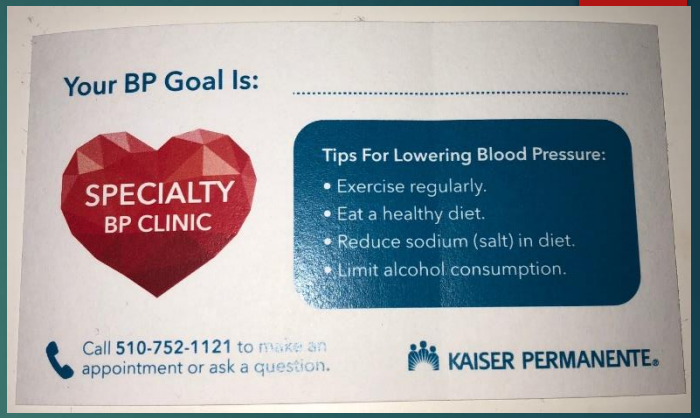
Messages
4 New Messages
Appointments
No Upcoming Appointments
Pharmacy
Medical Record
No New Test Results
2 Reminders


2x
a day?
AM or PM?
Take
with
food?
May be
drowsy?
Half or
whole?


sofa
television
couch
relax
fat
sedentary
overweight
lazy
lifestyle


SPECIALTY BP CLINIC
Blood Pressure Readings
KAISER PERMANENTE


Name
Medical Record #
Doctor's Name
My BP Goal
Call 510-752-1121
to make an appointment
or ask a question.


Your BP Goal Is:
SPECIALTY
BP CLINIC
Tips For Lowering Blood Pressure:
• Exercise regularly.
• Eat a healthy diet.
• Reduce sodium (salt) in diet.
• Limit alcohol consumption.
Call 510-752-1121 to make an appointment or ask a question.
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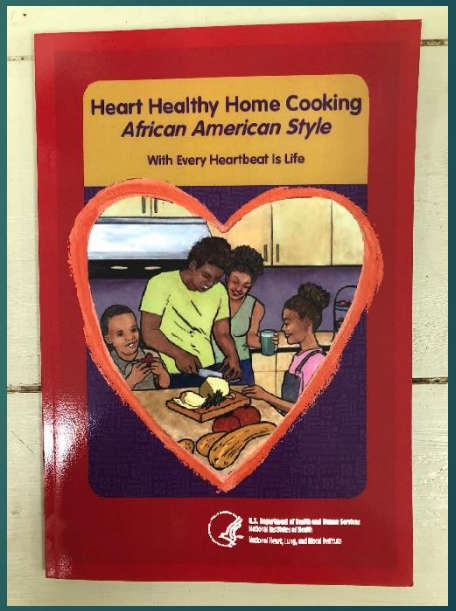
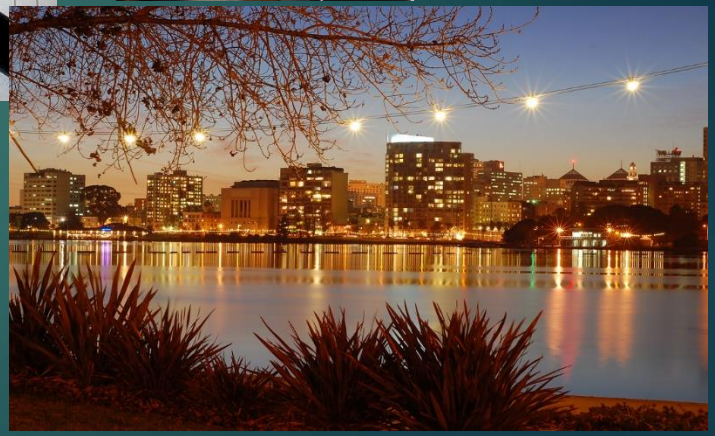

Heart Healthy Home Cooking
African American Style
With Every Heartbeat Is Life


Ask
A
Doctor
Our History.


GOLDEN STATE
WARRIORS


thank you


Questions?



Building Capacity Block by Block

Evaluation discussion - PHASE Grantee Convening

November 29, 2018

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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

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Reach of PHASE

196 clinic sites

108K patients with diabetes

152K patients with hypertension

207K total patients

Performance on HEDIS metrics

	Current performance	HEDIS 75th percentile
Blood pressure control for patients with HTN	**71.0%**	64.8%
Blood pressure control for patients with DM	**75.7%**	68.5%
Blood sugar (A1c) control for patients with DM	**67.2%**	64.5%

Performance on HEDIS metrics

	# of patients in control		
	2017, Q1		2017, Q3
Blood pressure control for patients with HTN	75K	→	**108K**
Blood pressure control for patients with DM	49K	→	**83K**
Blood sugar (A1c) control for patients with DM	49K	→	**73K**

Performance on HEDIS metrics

	# of grantees who have improved
Blood pressure control for patients with HTN	**13** of 18
Blood pressure control for patients with DM	**11** of 18
Blood sugar (A1c) control for patients with DM	**8** of 18

Performance on UDS metrics

	Current performance	UDS average
Tobacco screening & follow-up	**87.2%**	85.2%
BMI screening & follow-up	**60.8%**	62.5%
Depression screening & follow-up	**57.2%**	60.3%

Performance on UDS metrics

	# of grantees who have improved
Tobacco screening & follow-up	**6** of 17
BMI screening & follow-up	**4** of 16
Depression screening & follow-up	**10** of 16

Performance on UDS metrics

	# of patients receiving screening & follow-up		
	2017, Q1		2018, Q3
Tobacco screening & follow-up	287K	→	**447K**
BMI screening & follow-up	234K	→	**347K**
Depression screening & follow-up	206K	→	**358K**

PHASE Building Blocks

Peer sharing activity

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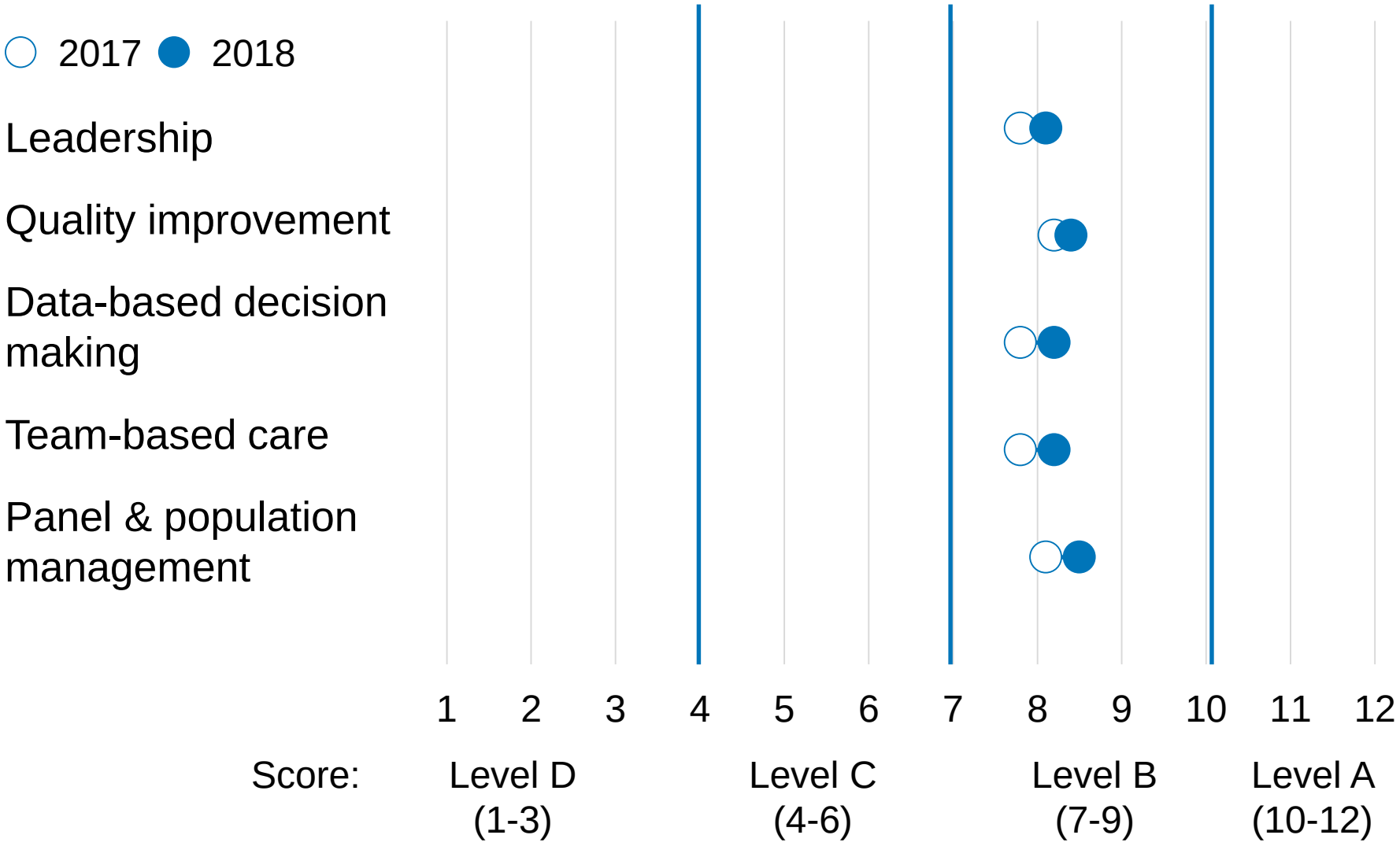
Grantees reported modest improvements in all of the PHASE Building Blocks since baseline



Building Capacity Block by Block: Data-Based Decision Making

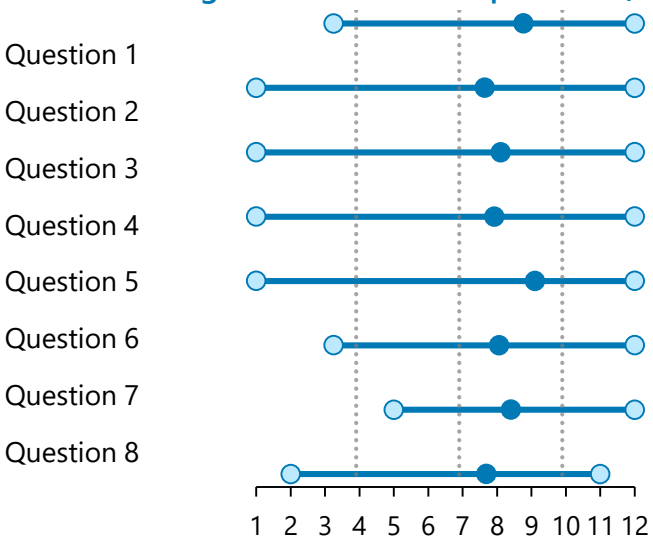
How are grantees improving data-based decision making?

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

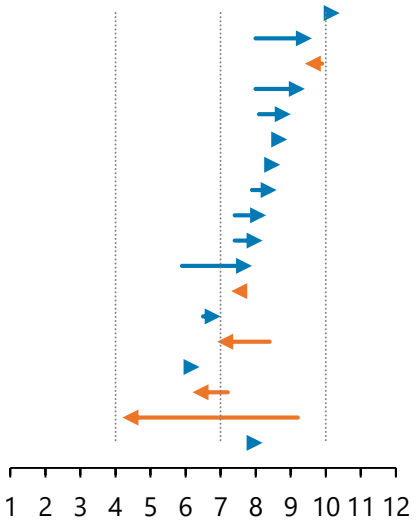
What is the range of data-based decision making scores by question?

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).



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

	Level D			Level C			Level B			Level A		
14. Perform-ance measures	…are not available for the clinical site.			…are available for the clinical site, but are limited in scope.			…are comprehensive ,including clinical, operational, and patient experience measures – and available for the practice, but not individual providers.			…are comprehensive – including clinical, operational, and patient experience measures – and fed back to individual providers.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
15. Reports on care processes or outcomes of care	…are not routinely available to practice teams.			…are routinely provided as feedback to practice teams but not reported externally.			…are routinely provided as feedback to practice teams, & reported externally (e.g. to patients, other teams / external agencies) but with identities masked.			…are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams and external agencies.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

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

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Creating a Diabetes Care Playbook: Our QI Journey

Brandon Bettencourt, RN

Director of Quality Improvement, Chapa-De Indian Health

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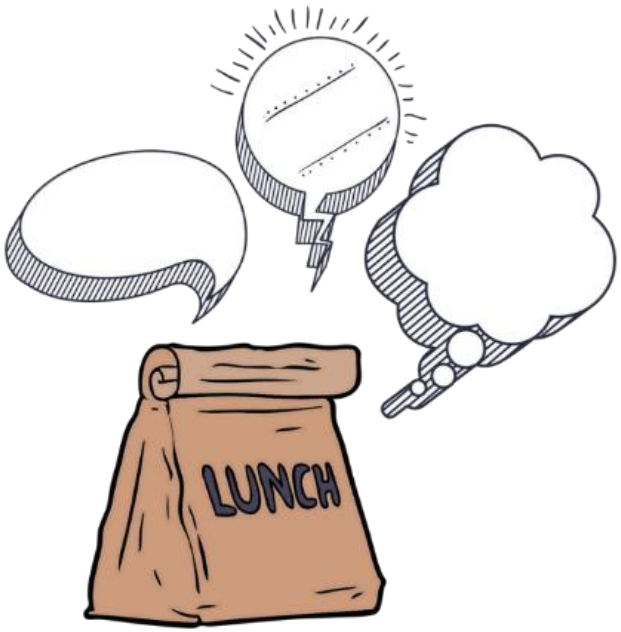
Pre-Lunch Reminders

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

PHASE
Champion
Center for Care Innovations

Table: #
BB: ABC
WS: 

Robinson B	The Empathy Effect: Countering Bias to Improve Health Outcomes
Nile Hall (here!)	Building Community Partnerships for Hypertension Outreach
Robinson A	Structural Determinants of Health: Examining and Addressing the Forces behind Inequity

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

85 43 2

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

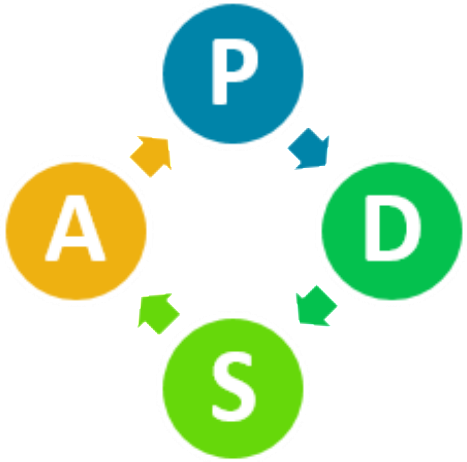
(For example: inspiring, practical, hands on, sobering, thought-provoking, etc.).

Your responses will build a Word Cloud in Nile Hall.

Team Activity

Action Planning

Testing changes for equity using Plan-Do-Study-Act (PDSA)



Team Time – Equity PDSA Worksheet

ORGANIZATION NAME: _____

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.

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.

ORGANIZATION NAME: _____

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.

Task	*Responsible*	*Timeline*	*Where & Other Notes*

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.

Evaluation & What's Next

CCI

Support, Technical Assistance, and Learning Community

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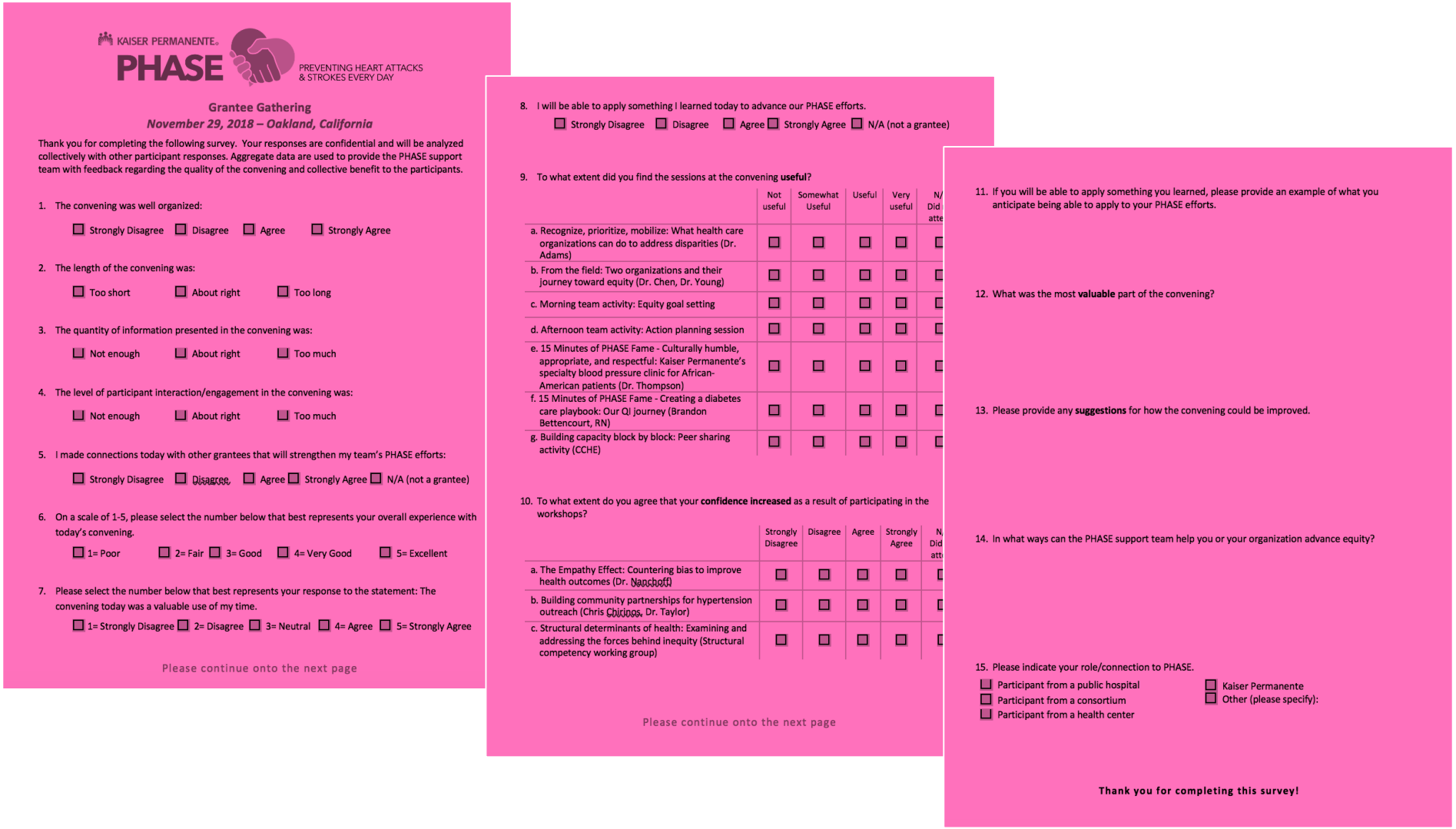
Convening Evaluation



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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

Please continue onto the next page

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/ Did atte
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 Fame - Culturally humble, appropriate, and respectful: Kaiser Permanente's specialty blood pressure clinic for African-American patients (Dr. Thompson)	☐	☐	☐	☐	☐
f. 15 Minutes of PHASE Fame - Creating a diabetes care playbook: Our QI journey (Brandon Bettencourt, RN)	☐	☐	☐	☐	☐
g. Building capacity block by block: Peer sharing activity (CCHE)	☐	☐	☐	☐	☐

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/ Did att
a. The Empathy Effect: Countering bias to improve health outcomes (Dr. Nanchoff)	☐	☐	☐	☐	☐
b. Building community partnerships for hypertension outreach (Chris Chirinos, Dr. Taylor)	☐	☐	☐	☐	☐
c. Structural determinants of health: Examining and addressing the forces behind inequity (Structural competency working group)	☐	☐	☐	☐	☐

Please continue onto the next page

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

http://www.surveygizmo.com/s3/3508992/Kaiser-Permanente-Community-Benefit-Common-Application-Form-for-Professional-Development-Training-Opportunities

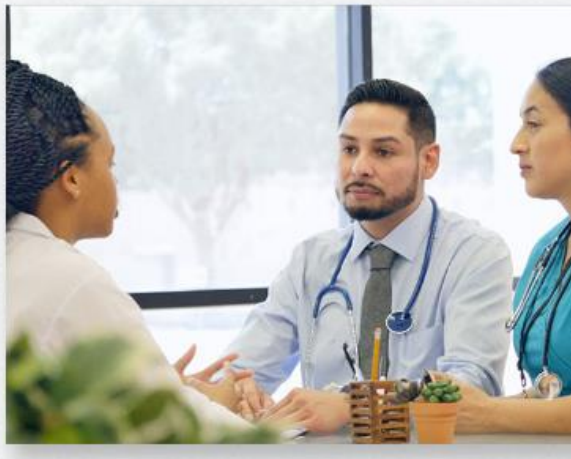
New to PHASE? Start Here.

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

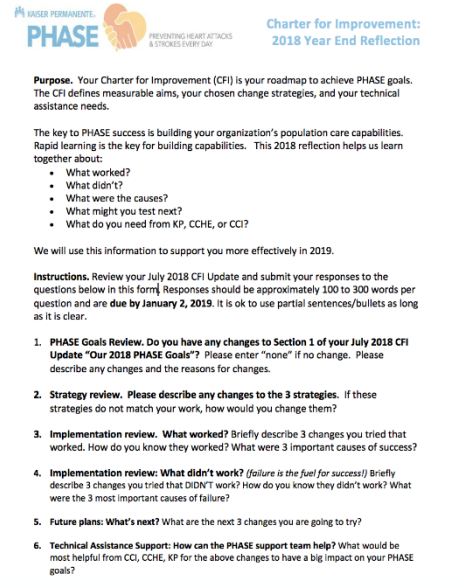
Executive Leadership



Care Team

careinnovations.org/phasesupport/onboarding/

Annual Report: Due January 2, 2019



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Charter for Improvement: 2018 Year End Reflection

Purpose. Your Charter for Improvement (CFI) is your roadmap to achieve PHASE goals. The CFI defines measurable aims, your chosen change strategies, and your technical assistance needs.

The key to PHASE success is building your organization's population care capabilities. Rapid learning is the key for building capabilities. This 2018 reflection helps us learn together about:

- What worked?
- What didn't?
- What were the causes?
- What might you test next?
- What do you need from KP, CCHE, or CCI?

We will use this information to support you more effectively in 2019.

Instructions. Review your July 2018 CFI Update and submit your responses to the questions below in this form. Responses should be approximately 100 to 300 words per question and are **due by January 2, 2019**. It is ok to use partial sentences/bullets as long as it is clear.

1. **PHASE Goals Review. Do you have any changes to Section 1 of your July 2018 CFI Update "Our 2018 PHASE Goals"?** Please enter "none" if no change. Please describe any changes and the reasons for changes.
2. **Strategy review. Please describe any changes to the 3 strategies.** If these strategies do not match your work, how would you change them?
3. **Implementation review. What worked?** Briefly describe 3 changes you tried that worked. How do you know they worked? What were 3 important causes of success?
4. **Implementation review: What didn't work?** *(failure is the fuel for success!)* Briefly describe 3 changes you tried that DIDN'T work? How do you know they didn't work? What were the 3 most important causes of failure?
5. **Future plans: What's next?** What are the next 3 changes you are going to try?
6. **Technical Assistance Support: How can the PHASE support team help?** What would be most helpful from CCI, CCHE, KP for the above changes to have a big impact on your PHASE goals?

Grant Expense Report Template

BUDGET REPORT

Expenditure Report
Using the Expenditure Report Template below, please insert your most recently approved budget and complete the following information for each line item:

- Expenses to date
- Any Unspent balance

Budget Narrative
Please complete the budget narrative column describing how funds were spent.

Unspent Funds
If there is an unspent balance remaining for your grant, please contact your grants manager to discuss the situation. Please be prepared to discuss the reason for unspent funds as well as thoughts and timeline for spending balance.

NORTHERN CALIFORNIA REGION
Kaiser Permanente Community Benefit Programs
KAISER PERMANENTE

Rev. May 2014

1. Year End Reflection

2. Expense Report

Instructions, expense template, submission link sent to PHASE team lead

Stay tuned for info about the Spring 2019 Convening!

Thank you!

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