Tobacco screening and follow-up if positive for tobacco use

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

**Data**
- Retrained MA's on workflows around data documentation
- Improved data mapping & validation
- Implemented CDS alerts in EHRs

**Team-based care**
- Trained care team on motivational interviewing

**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 MA's on motivational interviewing and brief interventions.

*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.
Depression screening and follow-up if positive for depression

PHASE grantees improved depression screening and follow-up through:

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

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

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

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

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

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

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

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

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

*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
BMI calculated and follow-up if BMI outside normal parameters

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

Thousands (k) of patients age 18+

- 404k
- 443k
- 418k
- 425k
- 550k

2017 Q1 Q2 Q3 Q4 2018 Q1

59% 59% 61% 62% 61%

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

**Data**

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

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

**Quality improvement and team-based care:**

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

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

**Quality improvement:**

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

**Data mapping and capture:**

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

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

Thousands (k) of patients with DM aged 18-75

% with A1c < 9%

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>2018 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>85k</td>
<td>87k</td>
<td>87k</td>
<td>89k</td>
<td>102k</td>
</tr>
</tbody>
</table>

% of patients with diabetes with A1c < 9% by grantee** in 2018 Q1
13 of 18 grantees are meeting 2017 HEDIS 75th percentile

% of patients with diabetes with A1c < 9%
0% 20% 40% 60% 80% 100%

VHT SFHN Camarena A B C D E F G H I J K L M N O

Diabetes (DM) hemoglobin A1c < 9%

Example strategies of how PHASE grantees are addressing A1c:

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

Quality improvement
• Performing PDSAs around A1c testing

% of patients with diabetes with A1c < 9%

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

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

Camarena achieved high levels of A1c control through:

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

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

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

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

- % of those with DM with BP controlled across the initiative*
  - Thousands (k) of patients with DM aged 18-75
  - % DM BP control

- Camarena
- Chapa-De**: 73%
- Comm Med: 74%
- One Comm: 74%
- Average: 74%
- Top performing grantees: 71%

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2017 Q1</th>
<th>2017 Q2</th>
<th>2017 Q3</th>
<th>2017 Q4</th>
<th>2018 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>76k</td>
<td>81k</td>
<td>82k</td>
<td>83k</td>
<td>102k</td>
</tr>
</tbody>
</table>

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

- Data mapping:
  - Improved mapping of PHASE measures for accurate reporting

- Creation of i2i toolkit:
  - Created i2i toolkit to support population management

- They also improved control by:
  - Added new team members
  - Established work flows for BP rechecks
  - Conducted BP training & competency checks

BP control for patients with DM

- Thousands (k) of patients with DM aged 18-75
- % DM BP control

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2017 Q1</th>
<th>2017 Q2</th>
<th>2017 Q3</th>
<th>2017 Q4</th>
<th>2018 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>4k</td>
<td>4k</td>
<td>4k</td>
<td>4k</td>
<td>7k</td>
</tr>
</tbody>
</table>

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

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

- % of those with HTN with BP controlled across the initiative*
  - Thousands (k) of patients with HTN aged 18-85
  - % HTN BP control

- 2017 Q1: 69%
- 2017 Q2: 70%
- 2017 Q3: 71%
- 2017 Q4: 70%
- 2018 Q1: 69%

- Richard Fine People’s Clinic (SFHN) reduced HTN disparities by:
  - BP control for patients with HTN
    - Thousands (k) of patients with HTN aged 18-85
    - % HTN BP control: all patients
    - % HTN BP control: black patients

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

- Team-based care:
  - Pharmacist conducts panel management and triages HTN patients to appropriate team members

- Top performing grantees

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2017 Q1</th>
<th>2017 Q2</th>
<th>2017 Q3</th>
<th>2017 Q4</th>
<th>2018 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>3k</td>
<td>3k</td>
<td>3k</td>
<td>3k</td>
<td>3k</td>
</tr>
</tbody>
</table>

*5 grantees spread to additional sites in Q1 2018, leading to population increases. ** Chapa-De changed its EHR in summer 2017 so data are not fully representative of the patient population. *** PHASE grantees are not required to submit race/ethnicity data; SFHN provided these data for the spotlight.

Prepared by the Center for Community Health and Evaluation | June 2018
Example strategies of how PHASE grantees are increasing prescribing rates for high risk patients across both HTN & DM populations:

Evidence-based practice:
- Adopting and providing education on PHASE on a Page
- Reviewed hypertensive guidelines with providers
- Implemented guidelines in NextGen

Team-based care:
- Developing nurse and pharmacist protocols around medication titration
- RN care managers reconciled medications
- Started RN visits focusing on medication review

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

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

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

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

Quality improvement:
- Used PDSAs
- Regularly reviewed data

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

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