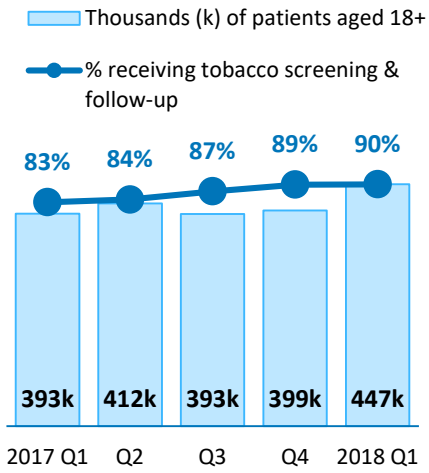
Tobacco screening and follow-up if positive for tobacco use

% receiving tobacco screening and follow-up across the initiative*



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

Data

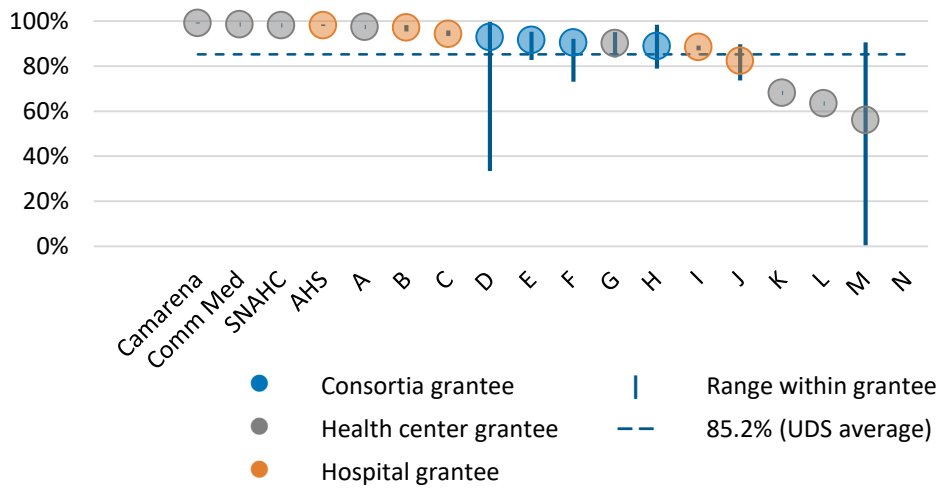
- Retrained MAs on workflows around data documentation
- Improved data mapping & validation
- Implemented CDS alerts in EHRs

Team-based care

- Trained care team on motivational interviewing

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

13 of 18 grantees are meeting 2017 UDS average



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

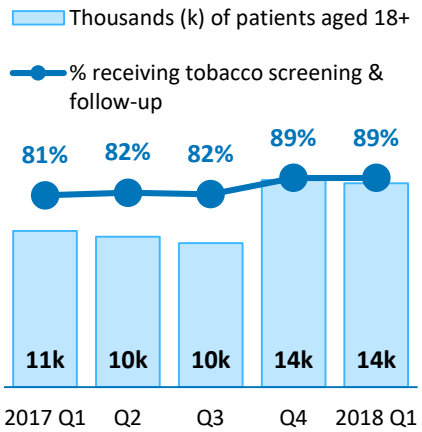
Evidence-based practice:

- 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)

% receiving tobacco screening and follow-up



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

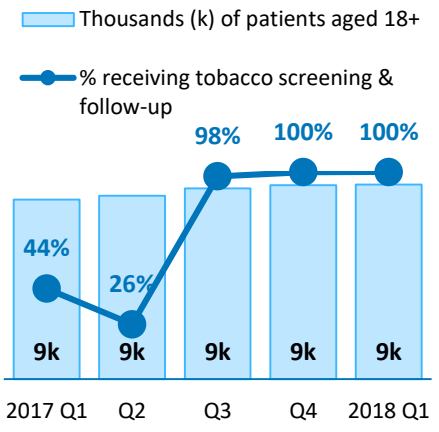
Data:

- 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.

% receiving tobacco screening and follow-up



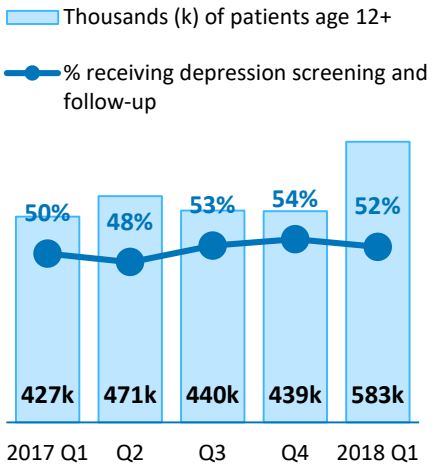
KAISER PERMANENTE® PHASE PREVENTING HEART ATTACKS & STROKES EVERY DAY

*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

Depression screening and follow-up if positive for depression

% receiving depression screening and follow-up across the initiative*



PHASE grantees improved depression screening and follow-up through:

Evidence-based practice

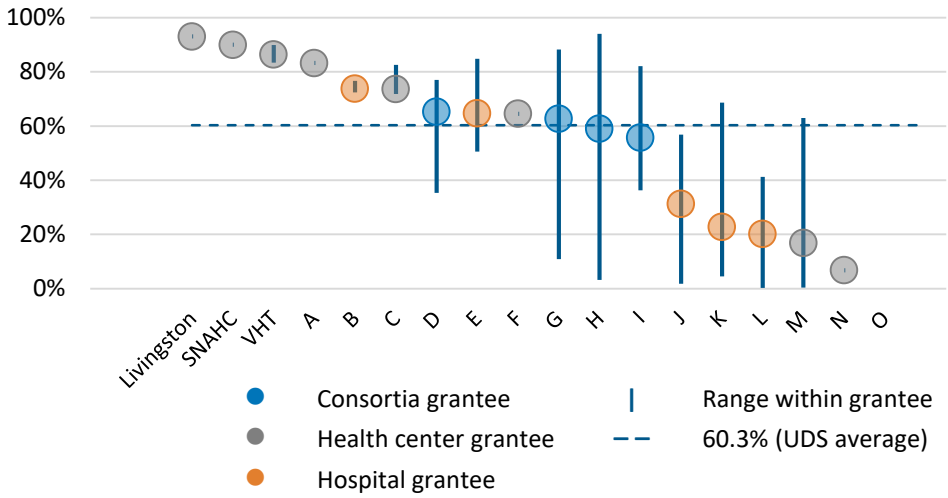
- Behavioral health integration efforts, including workflow for warm hand-offs
- Rolling out screening through standing orders & MA training

Data improvements

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

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

10 of 18 grantees are meeting 2017 UDS average



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

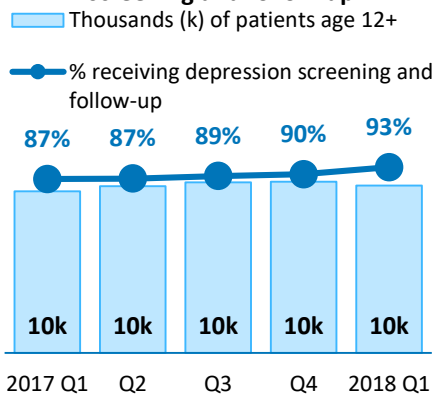
Quality improvement:

- 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.

% receiving depression screening and follow-up



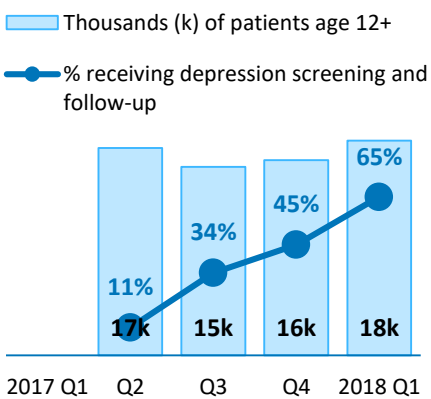
Alameda Health System leveraged PHASE and PRIME alignment to improve depression screening and follow-up though:

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

% receiving depression screening and follow-up



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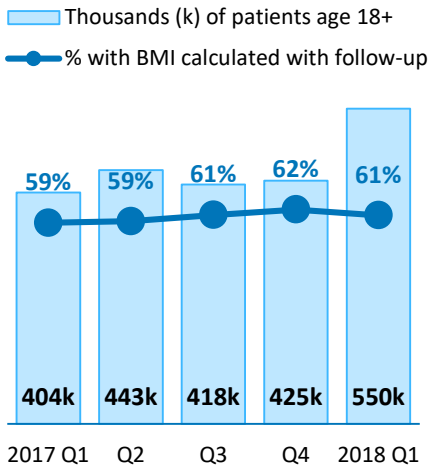
Prepared by the **Center for Community Health and Evaluation** | June 2018

BMI calculated and follow-up if BMI outside normal parameters

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



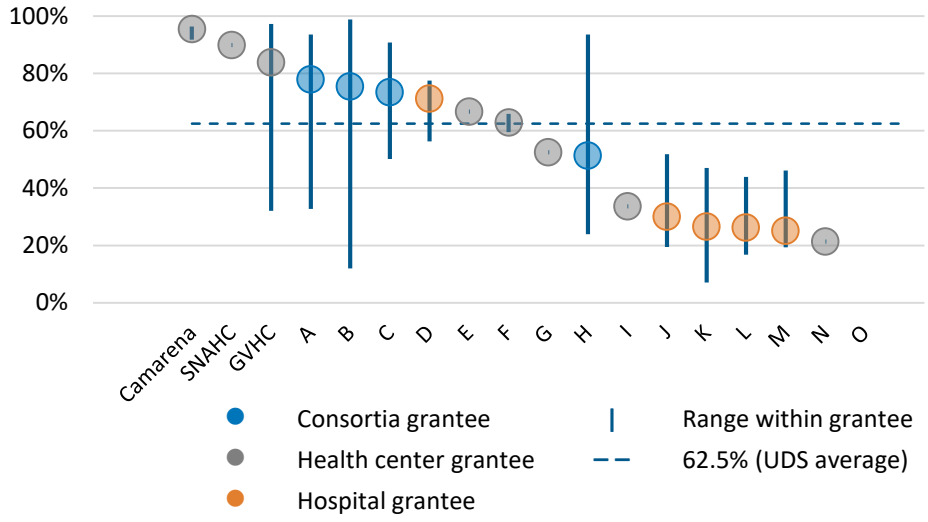
Example strategies of how PHASE grantees are increasing BMI screening and follow up:

Data

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

% with BMI calculated with follow-up by grantee in 2018 Q1**

9 of 18 grantees are meeting 2017 UDS average

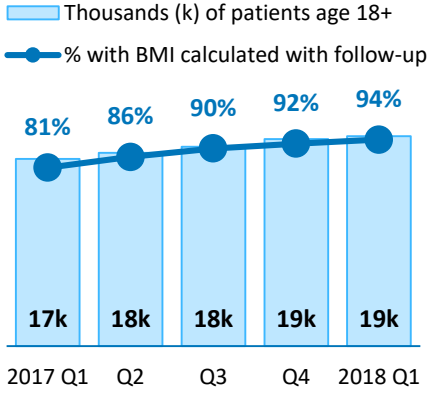


Petaluma Health Center (member of RCHC) improved BMI screening and follow-up through:

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

BMI calculated with follow-up if needed



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

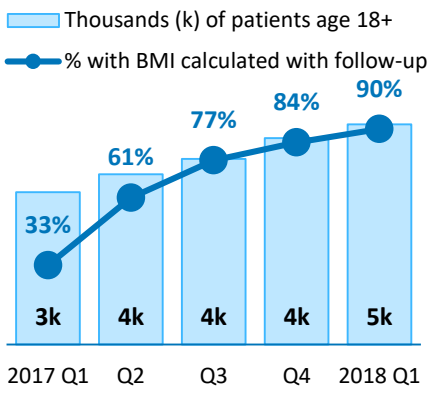
Quality improvement:

- 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

BMI calculated with follow-up if needed



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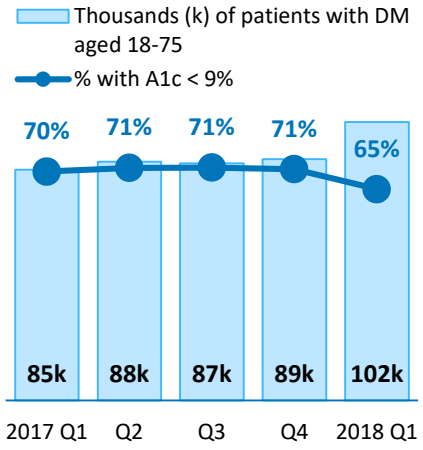
Prepared by the **Center for Community Health and Evaluation** | June 2018

Diabetes (DM) hemoglobin A1c < 9%

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

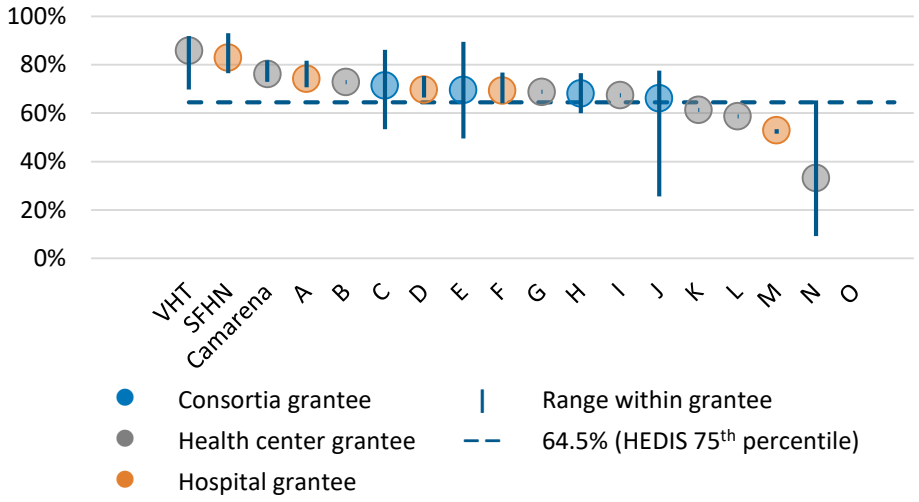


Example strategies of how PHASE grantees are addressing A1c:

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% by grantee in 2018 Q1**
13 of 18 grantees are meeting 2017 HEDIS 75th percentile

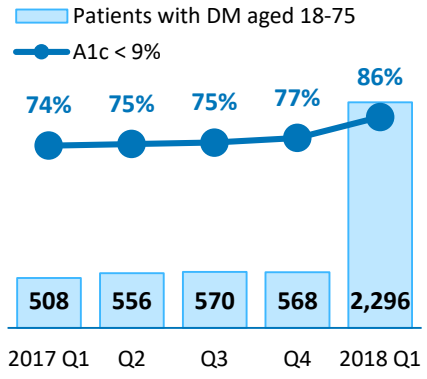


Valley Health Team (VHT) reported that improvements were driven by:

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

% of patients with diabetes with A1c < 9%

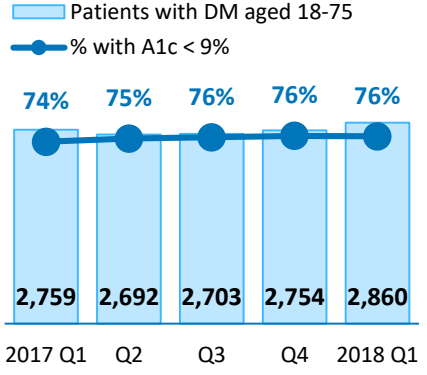


Camarena achieved high levels of A1c control through:

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

% of patients with diabetes with A1c < 9%



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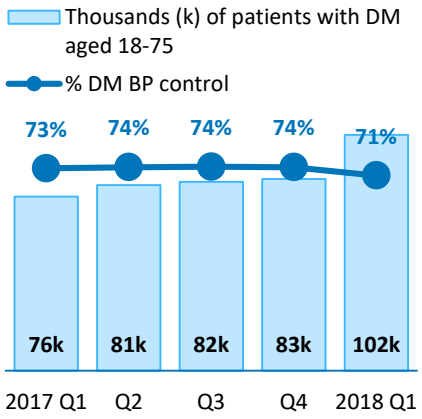
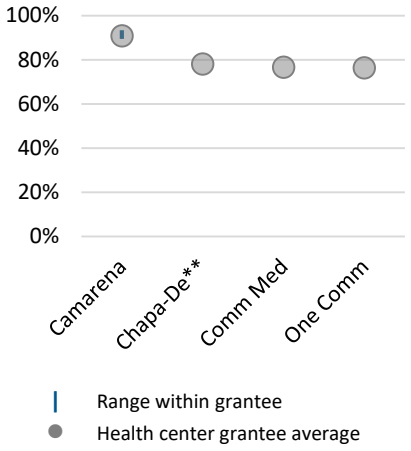
Blood pressure (BP) control for patients with diabetes (DM)

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

% of those with DM with BP controlled across the initiative*



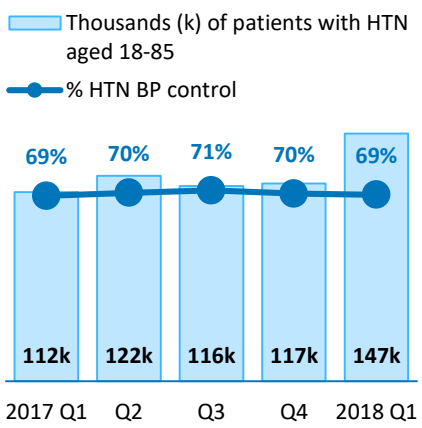
Top performing grantees



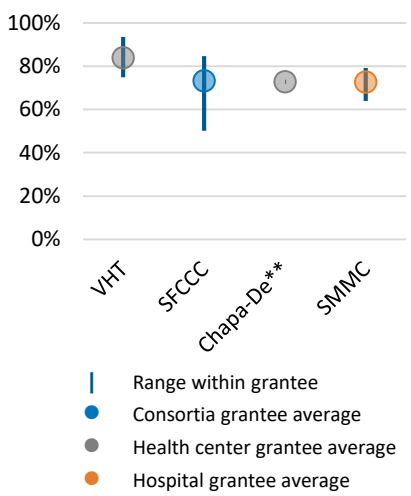
Blood pressure (BP) control for patients with hypertension (HTN)

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

% of those with HTN with BP controlled across the initiative*



Top performing grantees



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

Data mapping:

- Improved mapping of PHASE measures for accurate reporting

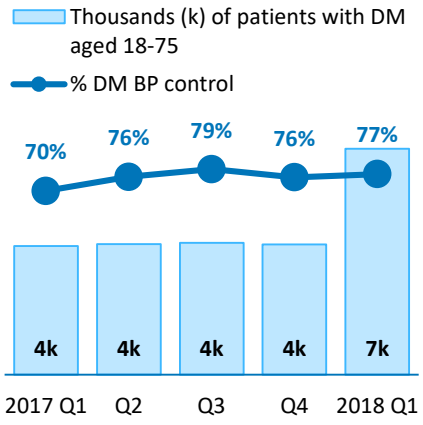
Creation of i2i toolkit:

- 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



Richard Fine People's Clinic (SFHN) reduced HTN disparities by:

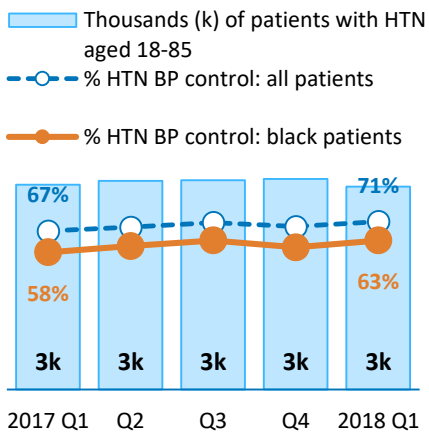
Population health management:

- 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

BP control for patients with HTN



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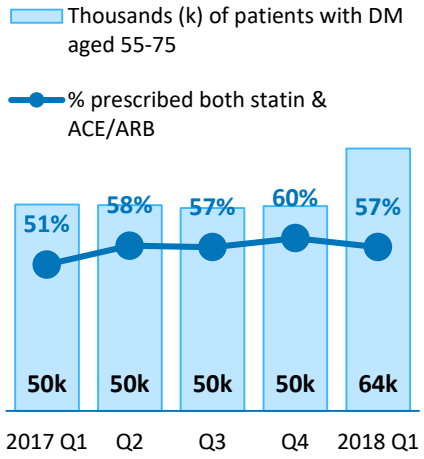
*5 grantees spread to additional sites in Q1 2018, leading to population increases. ** Chapa-De changed its EHR in summer 2017 so data are not fully representative of the patient population. *** PHASE grantees are not required to submit race/ethnicity data; SFHN provided these data for the spotlight.

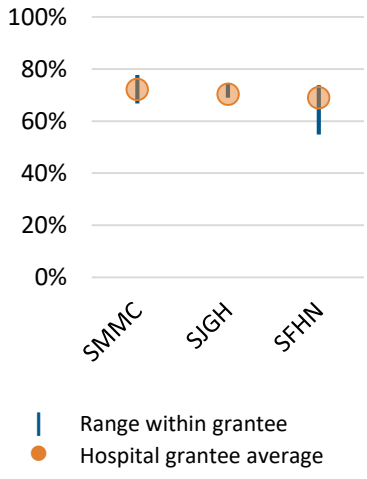
Prepared by the **Center for Community Health and Evaluation** | June 2018

Prescription rates for those with diabetes (DM)

% prescribed both a statin and an ACE/ARB across the initiative*

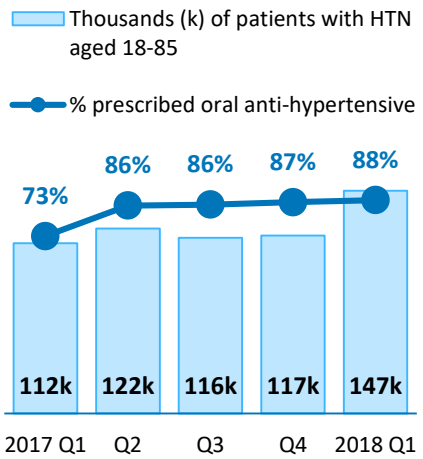


Top performing grantees

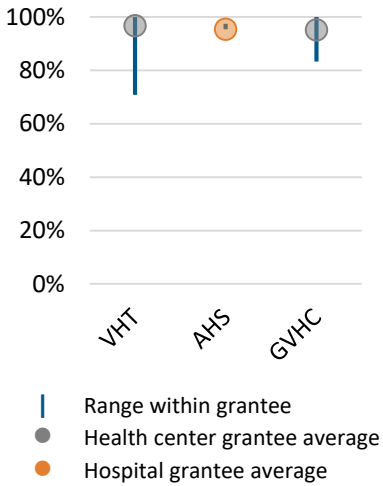


Prescription rates for those with hypertension (HTN)

% prescribed an oral anti-hypertensive across the initiative*



Top performing grantees



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

Team-based care
- Developing nurse and pharmacist protocols around medication titration

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

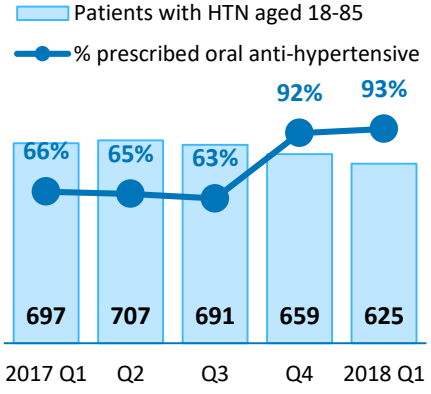
South of Market Health Center (member of SFCCC) improved the prescribing rate of oral anti-hypertensives through:

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

% prescribed an oral anti-hypertensive



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