Building Capacity Block by Block

Evaluation discussion - PHASE Grantee Convening

November 29, 2018

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Purpose of this document

- Share the successes and challenges within each Building Block that all of the groups came up with
- Document the strategies that groups called out as contributing to improvements in blood pressure control

Content

- Instructions for the activity that grantee participants engaged in during the November 29, 2018 convening
- Strategies that convening participants felt contributed to improvements in blood pressure control
- Successes and challenges in the following Building Block domains, followed by the activity sheets:
  - Leadership
  - Quality improvement (QI)
  - Data
  - Team-based care
  - Panel & population management

Instructions for the Building Capacity Block by Block activity

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Peer sharing activity instructions

- Small group discussions about the Building Blocks of PHASE. Each group will focus on one Building Block
- Use the provided questions to guide your discussion
- One person will take notes
- 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?

Strategies that contribute to improvements in blood pressure control

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Strategies that contribute to improvement in BP control

- Personal relationships, relationships with patients; the "personal touch"
- QI "cracking the whip"
- Outreach to patients who don't come in
- Using variable outreach: calls, letters, texts
- Training engaged staff in use of EMR, standing orders, patient visit planning
- MA training in BP check, documentation, and communication
- Codify policy/procedures on taking BP: 15 min rest, manual re-check, inform MD
- Taking and documenting 2 BPs, improving skills around BP
- New HTN guidelines with explicit goal of target, e.g. from 140 to 130.
- Standardized orders
- PDSAs that are incrementally "SMART"
- Taking a multi-faceted approach
- Group visits
- RN-led visits
- Chart prep and pre-visit planning:
    - Huddles
    - Using patient visit summaries
- SMBP
- Consistency with same MA and provider so patient feels valued, respected, and heard
- MA use of alerts and letting providers know
- Med director sharing the data
- For consortia, highlighting PHASE as a "bright spot" has motivated a drive to improve the performance of all clinics

Leadership

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Building Capacity Block by Block: Leadership

Successes

- Incentivizing leaders in terms of financial rewards related to achieving targets, has had some success
- Medical site director – leadership meets/supports them

Challenges

- Losing MAs to competing organizations
- Level of leadership suite and BOD involvement
- Leadership is focused on other areas
- In the consortium model "a rising tide lifts all boats" doesn't always work, because there is variation of resources available within the individual clinics within the consortium, and this leads to different levels of capacity
- Turnover in clinical leadership is a constant challenge in maintaining interest and momentum for PHASE
- Getting leadership buy-in
- Getting the "right," and engaged leadership

Building Capacity Block by Block: Leadership

How are grantees improving leadership?

Identifying champions to advance work

- Cultivating champions who can drive work forward
- Having regular meetings with champions to provide further education, space to problem-solve, and celebrate success
- Using cross-site peer group meetings to socialize new ideas and cultivate champions across sites
- Involving director-level leaders in monitoring specific areas of focus, such as pilots of self-monitoring BP

Engaging leaders with performance data & quality improvement processes

- Sharing data with executive leaders and connecting it to organizational goals, such as improvement in clinical quality measures

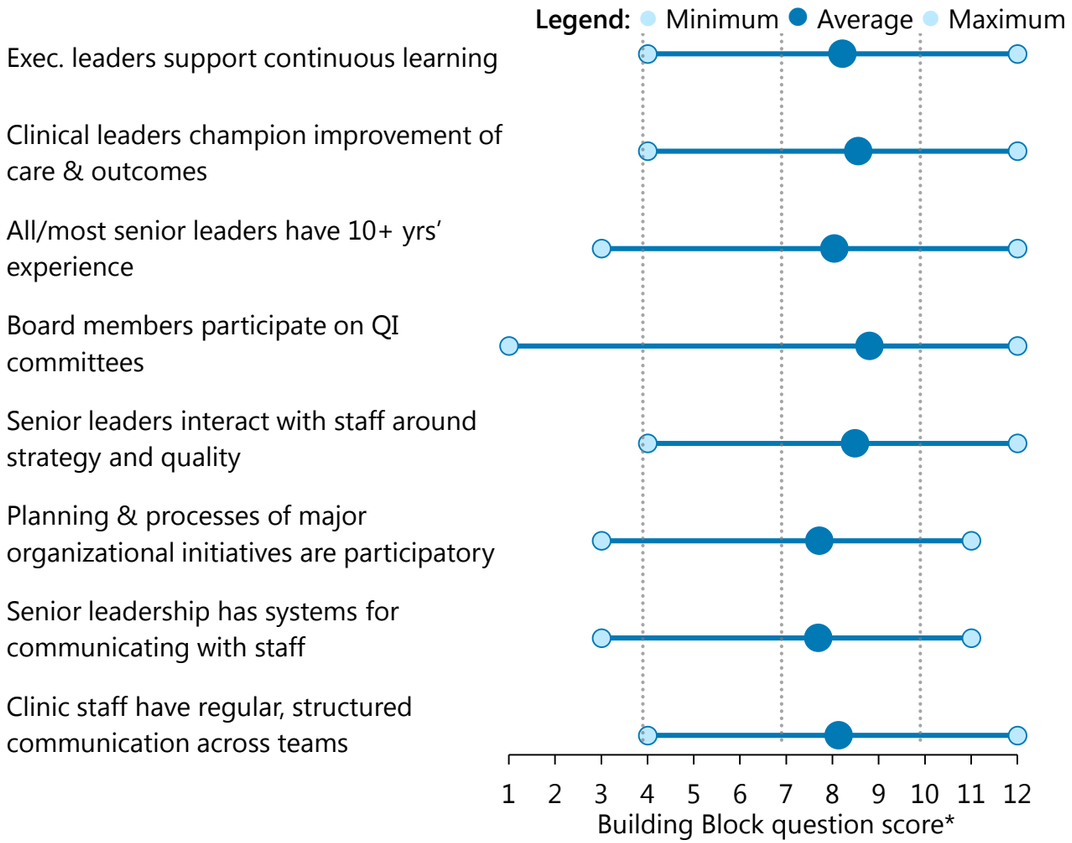
Developing vision, goals, and infrastructure to support the work

- Creating cross-disciplinary, cross-site teams to address organizational priorities (e.g., data integrity and care team transformation)
- Communicating alignment between initiatives and broader organizational strategy (e.g., linking to a "North Star")
- Using data scorecards in clinic meetings to prioritize and set goals aligned with the broader organization's goals

What is the range of leadership 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).

See reverse side for full wording of the eight questions in this domain.

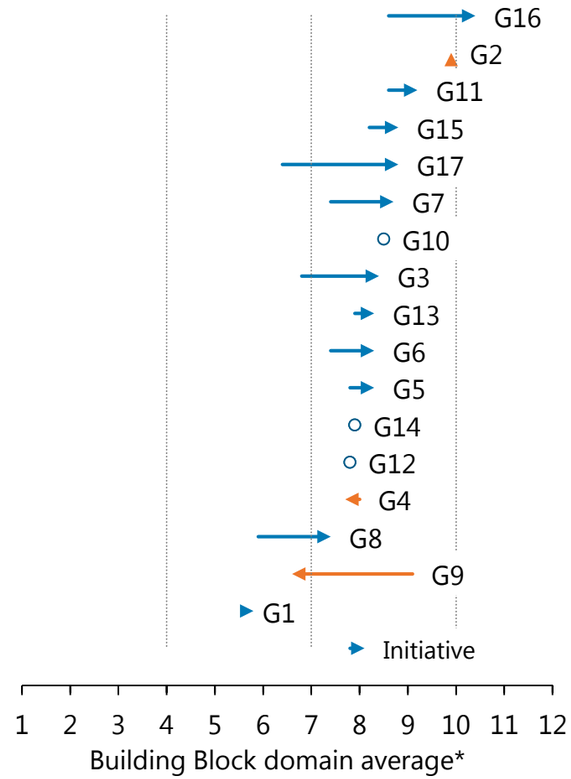


How have leadership domain averages changed over time?

13 of 17 grantees (G1-G17) reported improved scores at mid-initiative since baseline.

Legend: ◀ Decrease ❍ No change ▶ Increase

Length of arrow = amount of change over time



Level of capacity	*Score (scale 1-12)
A (highest)	10-12
B	7-9
C	4-6
D (lowest)	1-3

PHASE Building Blocks Assessment: Leadership

	Level D			Level C			Level B			Level A		
1. Executive leaders	…are focused on short-term business priorities.			…visibly support and create an infrastructure for quality improvement, but do not commit resources.			…allocate resources and actively reward quality improvement initiatives.			…support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
2. Clinical leaders	…intermittently focus on improving quality.			…have developed a vision for quality improvement, but no consistent process for getting there.			…are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.			…consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
3. All/most senior leaders	…have less than 3 years of experience their current positions and little to no previous clinical leadership experience.			…have less than 3 years in current position but have had substantial previous clinical leadership experience.			…have at least 3 years in current position but less than 10 years total clinic leadership experience.			…have at least 3 years in current position and more 10 years total clinic leadership experience.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
4. Board members	… receive no regular reports on organizational QI activities.			… receive annual report on organizational QI activities.			… meet with organization's QI team at least twice a year.			… participate on Board QI committee that meets at least 3 times a year.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
5. Senior leaders (engagement)	…mainly work in their own offices and rarely interact with clinic staff around issues of strategy, quality, and patient satisfaction.			…intermittently focus on improving quality and occasionally interact with clinic staff on substantive issues but their time is usually taken up by administrative meetings.			… interact with front line staff around issues of strategy, quality, and patient satisfaction; however, leaders don't have a strong sense of what's working well at the clinic or recent challenges.			…frequently interact with front line staff around issues of strategy, quality, and patient satisfaction. Leaders have a strong sense of both what's working well at the clinic as well as recent challenges or issues.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
6. Major organizational initiatives	… include top-management only (often relying heavily on external consultants); clinic staff are rarely involved in these initiatives.			… planning and execution processes include representatives from most key players or departments; but clinic staff are often not involved.			… planning and execution processes are participatory and include key players or departments; clinic staff interests are valued & staff are sometimes involved.			… planning and execution processes are participatory, include all departments and are team-oriented. Teams work together to align both clinical and administrative interests.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
7. Senior leadership (communication)	… often fails to have timely communication with managers, providers, and staff.			…discuss major issues with senior leaders and managers, but do not regularly present to providers and staff.			…discuss major issues with senior leaders and managers and then frequently present to providers and staff in an intentional way.			…has systematic ways of communicating & engaging with managers, providers, staff, and the community in an ongoing way.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
8. Clinic staff	… tend to operate in silos with care teams, sites, and/or departments rarely communicating with each other.			… occasionally communicate across care teams, sites, and departments, but do not have a structured way for the communication to occur.			… have regular, structured communication across care teams, sites, and departments but do not regularly communicate ideas upward to managers and senior leaders.			…have regular, structured communication across care teams, sites, departments, and senior leaders. Staff has a good rapport with each other and feels open to voicing and do voice concerns and improvement ideas upward to managers and senior leaders.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Adapted by the Center for Community Health and Evaluation for Kaiser Permanente's PHASE initiative with permission from Center for Excellence in Primary Care (CEPC) and Building Clinic Capacity for Quality (BCCQ) Program, October 2016.
Scale: Level D: score of 1-3 (lowest capacity) ||| **Level C**: score of 4-6 ||| **Level B**: score of 7-9 ||| **Level A**: score of 10-12 (highest capacity)

Quality improvement

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Building Capacity Block by Block: Quality Improvement (QI)

Successes

- Weekly PHASE team huddles
- Training
- Documenting Promising Practices – disseminating to the health centers
- Hiring a data analyst to complete the team
- PRIME metrics incentivized
- QI Coordinator assigned to different sites – bi-weekly meetings with teams: share data, provider coaching, identify gaps

Challenges

- Need admin time for patient outreach
- Provider buy-in
- Not enough staff
- Different EHRs – tailoring to each center
- Need to normalize the equity conversation
- Patient buy-in, especially with adherence

Building Capacity Block by Block: Quality Improvement (QI)

How are grantees improving QI?

Building QI infrastructure

- Creating chronic care dashboards to find and monitor opportunities for improvement
- Developing infrastructure for reviewing and refining PDSAs, and sharing best practices
- Hiring data analysts in the QI dept.
- Placing coaches at each site to help with implementing QI processes

Using QI to improve care team huddles

- Having QI coaches work on-site with scare teams
- Doing PDSAs to evaluate and improve process of care team huddle prep
- Documenting current huddle practices and piloting adjustments based on findings

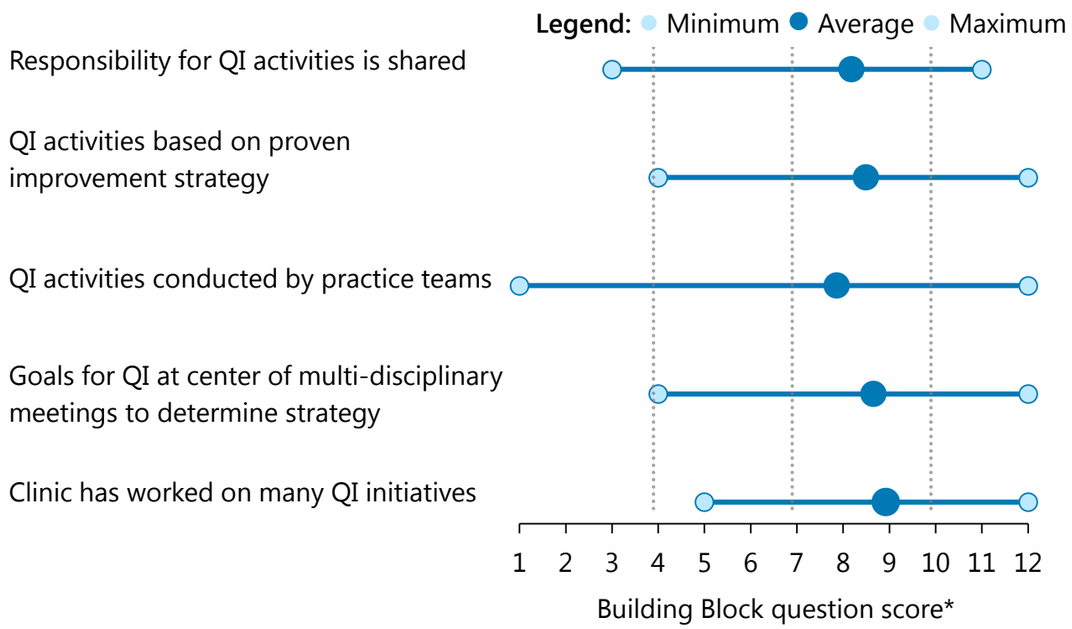
Using data to enhance QI efforts

- Reviewing data monthly by care team to inform improvement strategies
- Posting data in staff areas to show how teams are doing and where they can improve
- Optimizing EHR to include clinical decision making tools / modules

What is the range of QI 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).

See reverse side for full wording of the five questions in this domain.

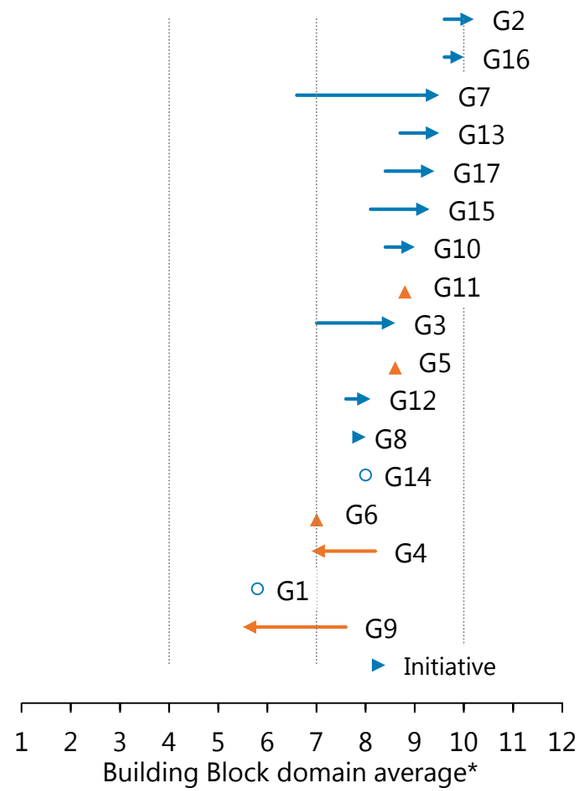


How have QI domain averages changed over time?

10 of 17 grantees (G1-G17) reported improved scores at mid-initiative since baseline.

Legend: ◀ Decrease ❍ No change ▶ Increase

Length of arrow = amount of change over time



Level of capacity	*Score (scale 1-12)
A (highest)	10-12
B	7-9
C	4-6
D (lowest)	1-3

How are grantees using QI to improve blood pressure (BP) control?

- Piloting and monitoring self-measured blood pressure programs
- Conducting annual medical assistant & nurse competencies on BP measurement, and providing refresher trainings based on audits
- Using weekly dashboards with repeat BP data to provide feedback and coaching
- QI coaches work closely with sites to implement processes & protocols to monitor & improve hypertension outcomes

PHASE Building Blocks Assessment: Quality Improvement (QI)

	Level D			Level C			Level B			Level A		
9. The responsibility for conducting quality improvement activities	…is not assigned by leadership to any specific group.			…is assigned to a group without committed resources.			…is assigned to an organized quality improvement group who receive dedicated resources.			…is shared by all staff, from leadership to team members, and is made explicit through protected time to meet and specific resources to engage in QI, and staff feel empowered to offer ideas.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
10. Quality improvement activities	…are not organized or supported consistently.			…are conducted on an ad hoc basis in reaction to specific problems.			…are based on a proven improvement strategy in reaction to specific problems.			…are based on a proven improvement strategy and used continuously in meeting organizational goals.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
11. Quality improvement activities are conducted by	…a centralized committee or department.			…topic specific QI committees.			…all practice teams supported by a QI infrastructure.			…practice teams supported by a QI infrastructure (e.g., dedicated QI staff) with meaningful involvement of patients and families.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
12. Goals and objectives for quality improvement	…do not exist.			. …exist on paper, but are not widely known.			…are known by staff, but are only occasionally discussed in meetings.			…are the centerpiece of multidisciplinary meetings aimed at developing strategies to meet objectives.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
13. The clinic has worked on	…fewer than 3 quality and process improvement initiatives over the last three years. The clinic has seen very little or no improvements in efficiency or outcomes as a result of these projects. Staff that work on these improvement projects meet as needed.			… a few (<5) quality and process improvement initiatives over the last three years, but most projects have focused on improving operational efficiencies (cycle time, no show rates, workflows, etc.). Staff that work on these improvement projects meet monthly. A committee that oversees these all quality improvement projects meets quarterly.			…many (>5) quality and process improvement initiatives over the last three years, and can point to some improvements in clinical outcomes (e.g., screening/immunization rates, HbA1c, blood pressure, etc.). The project team(s) is/are currently working on 2+ improvement projects and meets every other week. A committee that oversees these efforts meets monthly to quarterly.			… many (>5) quality and process improvement initiatives over the last three years, has demonstrated improvements across multiple clinical outcomes, and has standardized many of these improvements across the organization. Staff working on current quality improvement efforts meet weekly, and a committee that oversees these efforts meets at least monthly.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

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Data-driven decision-making

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Building Capacity Block by Block: Data-Based Decision Making

Successes

- Emphasizing data quality with senior leadership
- Leadership buy-in
- Consortia collecting and analyzing site data
- Huddles: day to day outcomes – review dashboards, communication of the data and the plan
- Use of alerts and chart prep
- Sending weekly data reports to clinics
- Collecting 2 BP readings
- Improving the quality of the data
- Sending data report direct to providers inboxes
- Building an infrastructure for sharing and displaying data
- Restructuring data efforts onto the QI team – a non-clinical analyst

Challenges

- Lack of staff
- Disconnect between data and team
- Staff turnover makes building patient and clinician relationships difficult
- Getting reports directly from EHR: different systems
- Data validation
- Lack of engagement of all providers to use clinical protocol
- Issues with proper documentation of second BP of MAs (they weren't doing it consistently)
- Need to analyze data by racial "subgroups" to be able to identify and address disparities by sub-populations
- Provider engagement and buy-in
- Ongoing issues with data accuracy (eCW)

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

Improving data sharing & transparency

- Distributing data and using it to develop action plans for making improvements
- Sharing performance & quality metrics with executive leaders
- Determining how analytics can support the care team and regularly sharing data with teams

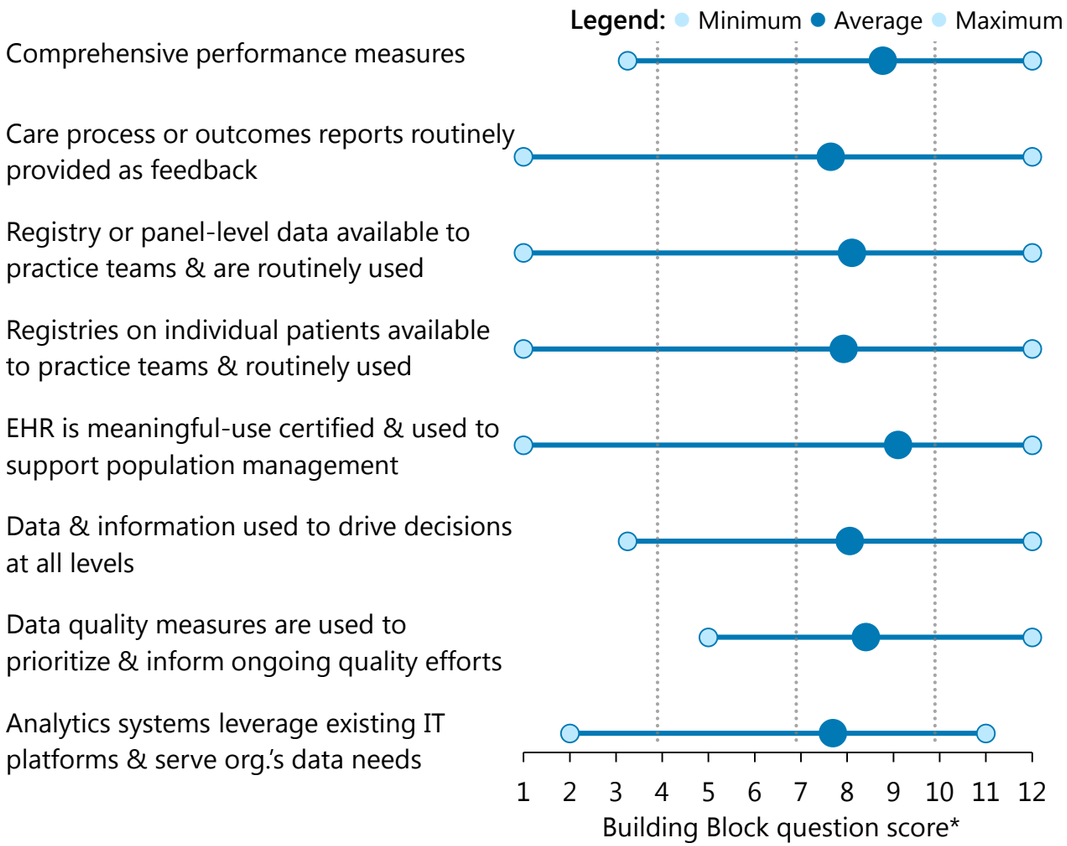
Ensuring continuous data QI

- Working on automating processes to check integrity of data soon after its reported
- Validating PHASE reports in i2iTracks
- Creating cross-site data integrity teams to review data for mapping & quality issues

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).

See reverse side for full wording of the eight questions in this domain.

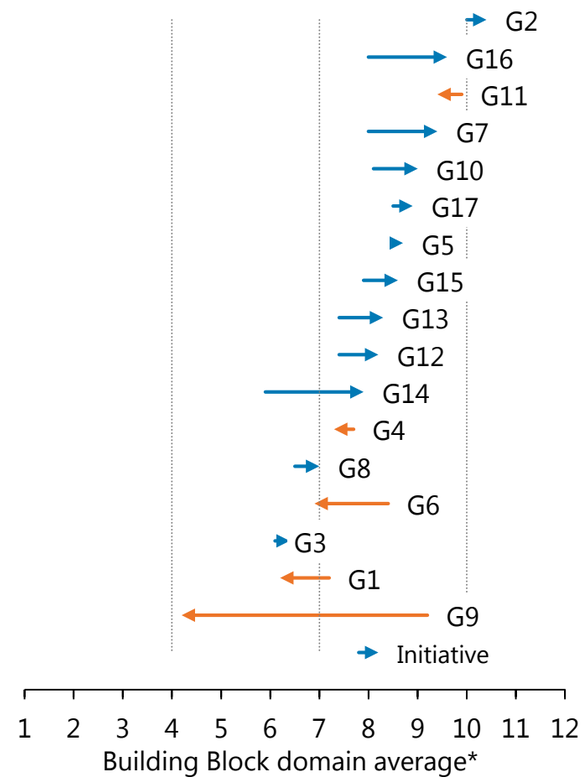


How have data-based decision making domain averages changed over time?

11 of 17 grantees (G1-G17) reported improved scores at mid-initiative since baseline.

Legend: ◀ Decrease ❍ No change ▶ Increase

Length of arrow = amount of change over time



Level of capacity	*Score (scale 1-12)
A (highest)	10-12
B	7-9
C	4-6
D (lowest)	1-3

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
- Using repeat BP reports with weekly data dashboards to provide feedback and coaching
- Identifying and sharing the work of successful sites with others (e.g. workflow, data collection, team structure, job roles, standing orders)

PHASE Building Block Assessment: Data-Based Decision Making

	Level D			Level C			Level B			Level A		
14. Performance 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
16. Registry or panel level data	…are not available to assess or manage care for practice populations.			…are available to assess and manage care for practice populations, but only on an ad hoc basis.			…are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.			…are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
17. Registries on individual patients	…are not available to practice teams for pre-visit planning or patient outreach.			…are available to practice teams but are not routinely used for pre-visit planning or patient outreach.			…are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states.			…are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
18. An electronic health record that is meaningful-use certified	…is not present or being implemented.			…is in place and is being used to capture clinical data.			…is used routinely during patient encounters to provide clinical decision support & to share data with patients.			…is also used routinely to support population management and quality improvement efforts.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
19. Data and information	…are used mostly for retrospective reporting using historical data. Line staff has very little exposure to data for day-to-day decision making			…are available and used by department heads, but not uniformly required when making operational decisions or changing strategy.			…are used by managers, directors and department heads on a regular basis. Data are pushed down and across the organization and required to support business cases and key decisions.			…are used to drive decisions at all levels in the organization. Line staff knows how their day-to-day actions affect performance metrics and achievement of goals. Data literacy is a hallmark of the organization.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
20. Data quality	…is not a priority. Most efforts are focused on clean-up and individual intervention.			… reviews occur within selected teams, departments or sites but the efforts are usually one time efforts and not sustained on an ongoing basis.			…tracking reports are produced on a regular basis for departments. Data quality efforts occur regularly across the organization; common errors are assessed and training occurs to address them.			…measures (e.g., % accuracy) prioritize and inform ongoing data quality efforts and trace errors to individuals for training. Data collection and aggregation is highly automated with built-in data quality checks and exception reports.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
21. IT support and data services	… for analytics consists mainly of maintenance and support of database platforms that capture health record data (e.g., EHR, PM). Dedicated analytics systems or tools are limited in functionality.			…for analytics includes support for reporting and data mining from existing systems and basic analytics support. Analysis tools are limited to spreadsheets and databases with limited functions for systematic reporting and advanced data analyses. Limited structures exist to prioritize data requests.			… has established analytics systems to support the needs of high priority areas, selected departments or sites and for some levels of staff (e.g., leadership only). Some structures and processes are in place to prioritize data requests and provide self-service access to reports and dashboards.			… include dedicated IT staff that are deployed to maintain and support optimization of analytics systems. Analytics systems interface with and leverage existing IT platforms, fully support organization data needs to build a data-driven culture with self-service analytics. Data governance processes are fully formed to guide the provision of data analytic services.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

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Scale: Level D: score of 1-3 (lowest capacity) ||| **Level C**: score of 4-6 ||| **Level B**: score of 7-9 ||| **Level A**: score of 10-12 (highest capacity)

Team-based care

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Building Capacity Block by Block: Team-based care

Successes

- Chart scrubbing – establishing gaps, and creating patient summaries
- Pre-visit planning and huddles
- Standing orders for MAs
- Use of teamlets – MD/MA sit together
- Use of pods
- Redesigned work flows → MA visit, MD visit, LVN visit
- Major redesign of how primary care work flows
- "Promising Practices" – interview high performing exemplar clinics
- Health coaches (usually MAs)
- RNs doing triage, RN-led visits
- MA/LVNs partnered with MDs
- SMBP – success factors: trust, see more frequently at first
- Optimize MA/provider ratio – 1:1.5 or 1:2
- Recognize and empower MAs
- Training: annual training, competencies, monthly trainings, 1:1 for those who miss trainings
- Training providers to empower their staff

Challenges

- TURNOVER – retention issues
- Unlicensed staff – needing better check offs for skills
- Poor communication from provider to patient can lead to patient confusion
- Getting cuffs and BP numbers back (SMBP)
- NS rates for HTN focused clinics
- Data validation to be able to show providers accurate data
- Access to affordable [unlegible]

Building Capacity Block by Block: Team-based care

How are grantees improving team-based care?

Strengthening & standardizing the care team

- Observing and mapping current roles in order to standardize them
- Devising workflows for medical assistants (MAs), nurses, and others for pre-visit planning huddles
- Piloting different roles and testing them at different sites
- Training office staff and MAs in roles and process for moving a patient through the clinic step-by-step
- Working to overcome the challenge of finding time for warm hand-offs between team members by standardizing scheduling templates

Implementing RN-led chronic care visits for HTN and/or DM management

- Piloting different role descriptions and processes surrounding the visits
- Finalizing hypertension (HTN) protocols and procedures
- Training RNs in empowering patients to self-manage and/or in medication titration
- Triaging patients to see RNs based on patient need

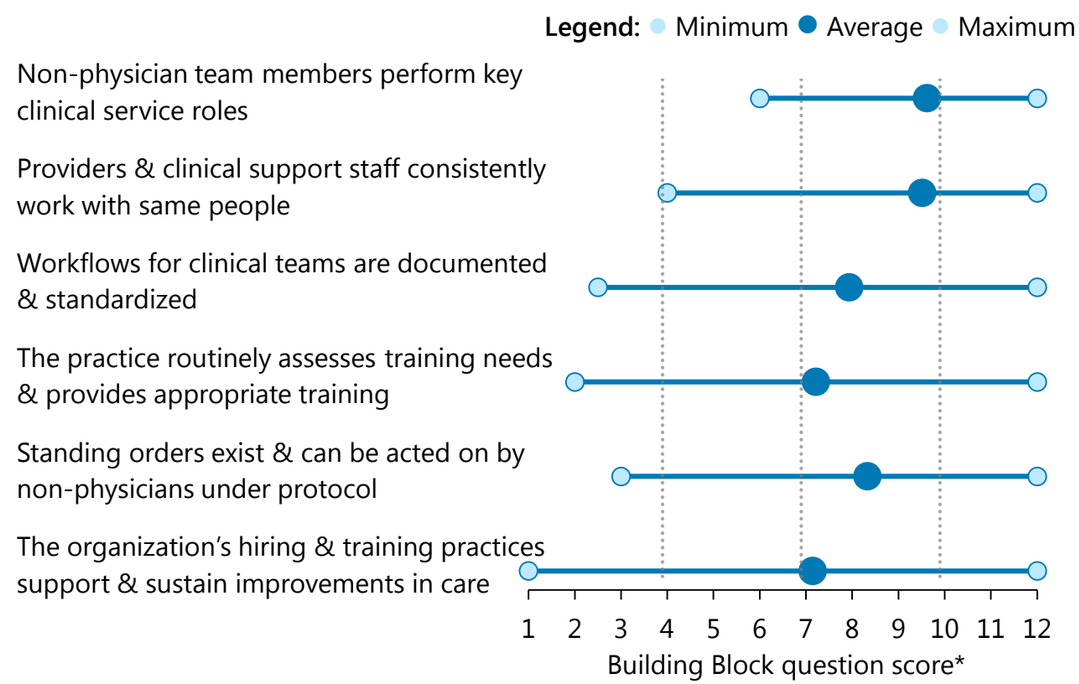
Utilizing pharmacists in primary care

- Partnering with Health Plans to update formularies to better serve the patients
- Using pharmacists for medication adherence and medication therapy management visits

What is the range of team-based care 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).

See reverse side for full wording of the six questions in this domain.

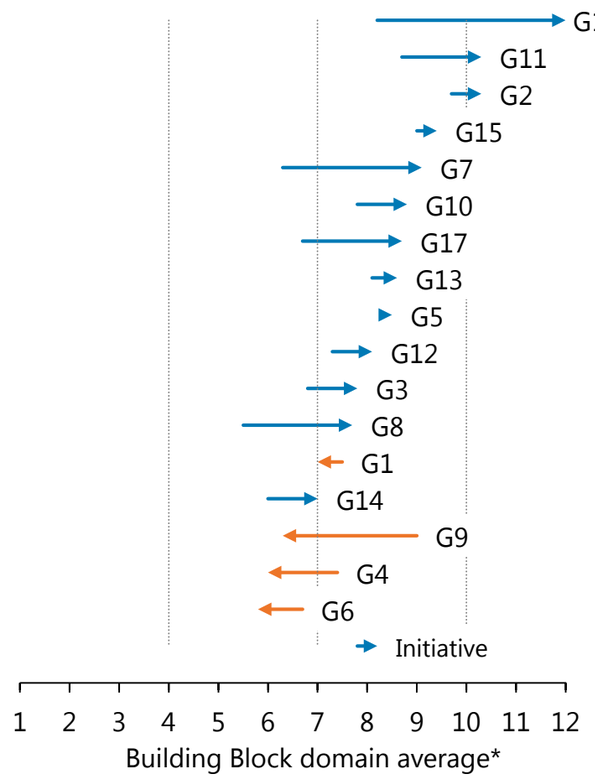


How have team-based care domain averages changed over time?

12 of 17 grantees (G1-G17) reported improved scores at mid-initiative since baseline.

Legend: ◀ Decrease ❍ No change ▶ Increase

Length of arrow = amount of change over time



Level of capacity	*Score (scale 1-12)
A (highest)	10-12
B	7-9
C	4-6
D (lowest)	1-3

PHASE Building Blocks Assessment: Team-based care (TBC)

	Level D			Level C			Level B			Level A		
22. Non-physician practice team members	…play a limited role in providing clinical care.			…are primarily tasked with managing patient flow and triage.			…provide some clinical services such as assessment or self-management support.			…perform key clinical service roles that match their abilities and credentials.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
23. Providers (Physicians, NP/PAs) and clinical support staff	…work in different pairings every day.			…are arranged in teams but are frequently reassigned.			…consistently work with a small group of providers or clinical support staff in a team.			…consistently work with the same provider/ clinical support staff person almost every day.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
24. Workflows for clinical teams	…have not been documented and/or are different for each person or team.			…have been documented, but are not used to standardize workflows across the practice.			…have been documented and are utilized to standardize practice.			…have been documented, are utilized to standardize workflows, and are evaluated and modified on a regular basis.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
25. The practice	…does not have an organized approach to identify or meet the training needs for providers and other staff.			…routinely assesses training needs and assures that staff are appropriately trained for their roles and responsibilities.			…routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides some cross training to permit staffing flexibility.			…routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides cross training to assure that patient needs are consistently met.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
26. Standing orders that can be acted on by non-physicians under protocol	…do not exist for the practice.			…have been developed for some conditions but are not regularly used.			…have been developed for some conditions and are regularly used.			…have been developed for many conditions and are used extensively.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
27. The organization's hiring and training processes	…focus only on the narrowly defined functions and requirements of each position.			…reflect how potential hires will affect the culture and participate in quality improvement activities.			…place a priority on the ability of new and existing staff to improve care and create a patient-centered culture.			…support and sustain improvements in care through training and incentives focused on rewarding patient-centered care.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Adapted by the Center for Community Health and Evaluation for Kaiser Permanente's PHASE initiative with permission from Center for Excellence in Primary Care (CEPC) and Building Clinic Capacity for Quality (BCCQ) Program, October 2016.
Scale: Level D: score of 1-3 (lowest capacity) ||| **Level C**: score of 4-6 ||| **Level B**: score of 7-9 ||| **Level A**: score of 10-12 (highest capacity)

Panel & population health management

KAISER PERMANENTE®
PHASE
PREVENTING HEART ATTACKS
& STROKES EVERY DAY

Building Capacity Block by Block: Panel & Population Management

Successes

- Panel management with pharmacists and IVD and then encourage provider to follow up with patient
- Use of clinic pharmacist to treat HTN patients
- Moving to Relevant system, care team members can assess their own outreach lists, can decide on their main area of focus
- Secure protected time for provider/MA teamlets for panel management – 1 hour per month
- Outreach lists – central with call center, lists slit up among sites, includes other quality metrics on the lists (e.g. what patient is due for).
- Outreach ("HEDIS blasts") to those with HTN
- Transparent data sharing so provider see colleague's scores
- Group visits (Marin County) – 80 patients outreached with HTN – invited to group visits, 2 BP readings during visit, complex care RNs log the number, patients learn strategies; other available classes
- Focusing on infrastructure and systems
- Pre-visit planning (Azara)
- Standing orders
- Using incremental framework (HTN registry → Provider lists given → Care management and PCP
- Standardized training for MAs in BP checks
- Healthy Heart – laminated hearts as visual cues
- RN-led HTN clinic
- Standard protocols for RN, MA to see patients for BP
- Glucometers provided prior to visit for data to be used during visit
- *Success factor:* having interdisciplinary teams
- *Success factor:* Continuous training (cross training) people will to do the work
- *Success factor:* engaged PCPs and MAs, and nurses

Challenges

- Staff turnover
- Bay area expensive place to live – contributes to turn over
- Provider recruitment
- Issues with data not being interchangeable across registries and systems, e.g. EPIC to i2i to Tableau – need for cross walking definitions, validation etc.
- Tough to engage the patients who need it most
- Difficult to engage patients for a variety of reasons including: travel, employment, culture sensitivity, language
- Had challenge with in-person visits and have seen some improvement with telehealth

Building Capacity Block by Block: Panel & Population Management

How are grantees improving panel & population management??

Improving in-reach and/or outreach

- Creating chronic disease registry reports to target high-risk patients for outreach
- Creating or modifying tools to improve use and quality of registries
- Clearly defining team roles and establishing standard processes for in-reach and outreach

Using self-management tools to manage high-risk populations

- Piloting self-measured blood pressure programs and/or evaluating readiness to do so
- Considering texting software to promote post-ED/hospitalization follow-up & self-management messaging to chronic care patients
- Creating structures for follow-up visits for self-management goals

Using medication protocols like PHASE-on-a-Page to manage diabetes and HTN

- Supporting use of protocol by financially incentivizing PCPs based on BP control rates
- Working with endocrinology to develop a DM algorithm and align it with formularies
- Talking with providers at each site about medication protocols & management
- Applying HTN protocols to huddle reports
- Using in-house pharmacies to enhance medication fill rates and/or looking into mail delivery of medications

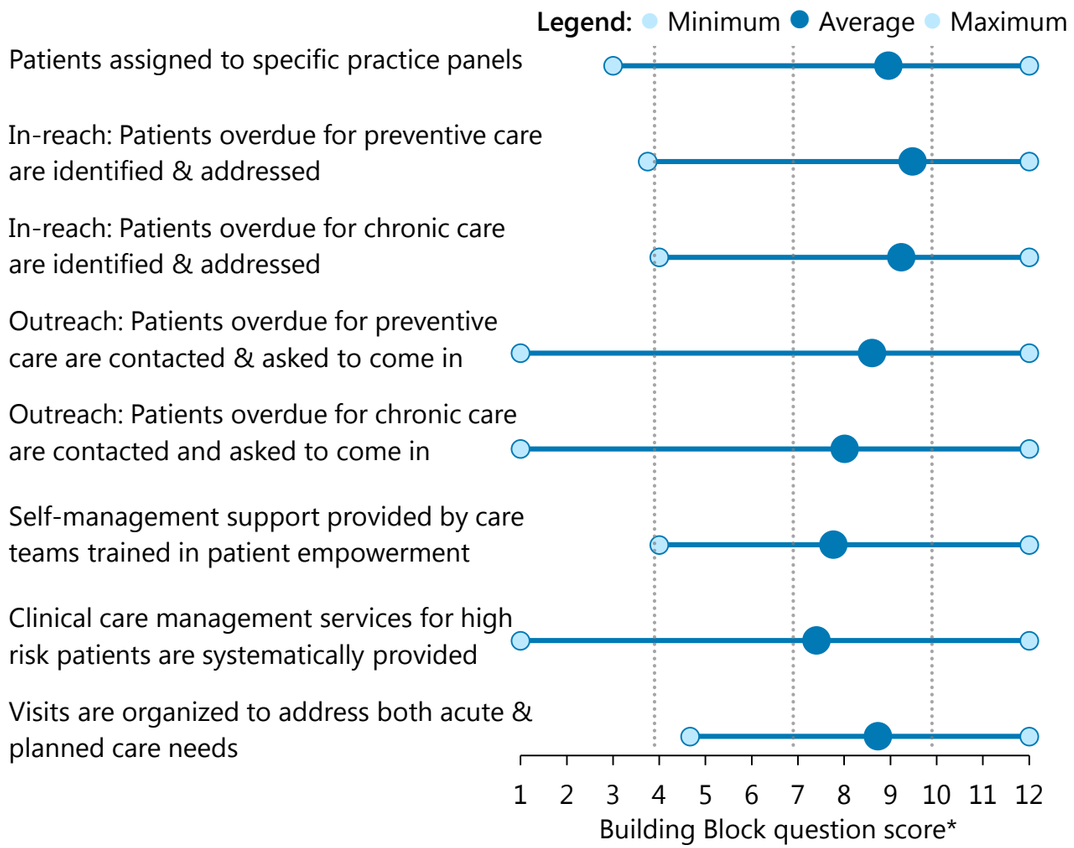
Linking blood pressure work with social determinants of health (SDOH) to increase impact

- Linking black/African American HTN equity work to tobacco cessation since 55% of their black patients smoke
- Developing SDOH plan of action with health plans and another PHASE grantee in same county
- Implementing self-measured blood pressure monitoring program specific to black/African American patients with HTN

What is the range of panel & population management 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).

See reverse side for full wording of the eight questions in this domain.

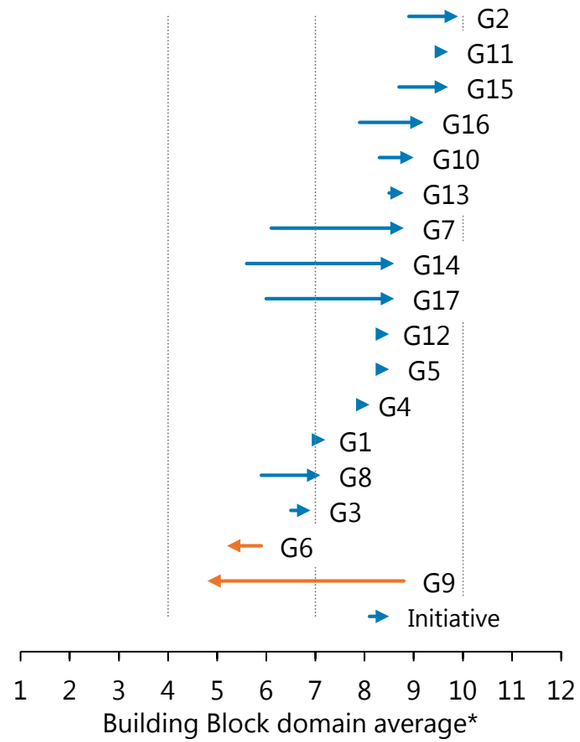


How have panel & population management domain averages changed over time?

14 of 17 grantees (G1-G17) reported improved scores at mid-initiative since baseline.

Legend: ◀ Decrease ❍ No change ▶ Increase

Length of arrow = amount of change over time



Level of capacity	*Score (scale 1-12)
A (highest)	10-12
B	7-9
C	4-6
D (lowest)	1-3

PHASE Building Blocks Assessment: Panel & Population Management

	Level D			Level C			Level B			Level A		
28. Patients	…are not assigned to specific practice panels.			…are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.			…are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.			…are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
29. A patient who comes in for an appointment and is overdue for preventive care (e.g., cancer screenings)	…will only get that care if they request it or their provider notices it.			…might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but this is inconsistently used.			…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient specific orders from the provider.			…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., administer immunizations or distribute colorectal cancer screening kits) based on standing orders.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
30. A patient who comes in for an appointment and is overdue for chronic care (e.g., diabetes lab work)	…will only get that care if they request it or their provider notices it.			…might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but this is inconsistently used.			…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient specific orders from the provider.			…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., complete lab work) based on standing orders.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
31. When patients are overdue for preventive (e.g., cancer screenings) but do not come in for an appointment	…there is no effort on the part of the practice to contact them to ask them to come in for care.			…they might be contacted as part of special events or using volunteers but outreach is not part of regular practice.			…they would be contacted and asked to come in for care, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.			…they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., distribute colorectal cancer screening kits) based on standing orders.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
32. When patients are overdue for chronic care (e.g., diabetes lab work) but do not come in for an appointment	…there is no effort on the part of the practice to contact them to ask them to come in for care.			…they might be contacted as part of special events or using volunteers but outreach is not part of regular practice.			…they would be contacted and asked to come in for care, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.			…they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., complete lab work) based on standing orders.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
33. Self-management support	…is limited to the distribution of information (pamphlets, booklets).			…is accomplished by referral to self-management classes or educators.			…is provided by goal setting and action planning with members of the practice team.			…is provided by members of the practice team trained in patient empowerment and problem solving methodologies.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
34. Clinical care management services for high risk patients	…are not available.			…are provided by external care managers with limited connection to practice.			…are provided by external care managers who regularly communicate with the care team.			…are systematically provided by the care manager functioning as a member of the practice team, regardless of location.		
Score	1	2	3	4	5	6	7	8	9	10	11	12
35. Visits	…largely focus on acute problems of patient.			…are organized around acute problems but with attention to ongoing illness and prevention needs if time permits			…are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for planned care visits.			…are organized to address both acute and planned care needs. Tailored guideline-based information is used in team huddles to ensure all outstanding patient needs are met at each encounter.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

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