Zoom Call-In Instructions

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    Meeting ID: 130 784 380

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  ▪ On your phone, enter your “# [your unique participant ID] #”

Click here to find your participant ID
Introducing PHASE 2020: Using Improvement Methods to Achieve World Class & Equitable CVD Care

PHASE Learning Community Webinar
October 31st, 2019
Webinar Objectives

• Get excited about the new structure and approach for the proposed PHASE 2020-2022 program
• Be aware of upcoming opportunities for current PHASE grantees
• Get a sense of what other grantees are planning to working on, and start to identify connections you can make to accelerate your learnings and projects

Who is on the webinar?

• Organizations that submitted proposals for the 2020-2022 PHASE Grant Cycle
• PHASE Support Partners
# PHASE 2020-2022 RFP Goals

<table>
<thead>
<tr>
<th>Goals</th>
<th>Measures</th>
<th>Benchmarks</th>
</tr>
</thead>
</table>
| Manage chronic conditions of high-risk populations to decrease their risk of cardiovascular disease (CVD) and/or cardiovascular events. | • BP control for patients with hypertension  
• BP control for patients with diabetes  
• Poorly controlled A1c (> 9%) for patients with diabetes  
• Statin prescription for those at high risk of cardiovascular events | • National Medicaid HEDIS 90th percentile value  
• UDS national average value                                                                                                                     |
| Improve ability to screen for key CVD risk factors as well as the ability to follow-up with patients who have those risk factors. | • Patients screened for tobacco use and received follow-up if screened positive  
• Patients with BMI calculated and received follow-up if BMI outside normal parameters  
• Patients screened for depression and received follow-up if screened positive | • UDS national average value                                                                                                                      |
| Advance health equity by achieving high performance for all populations on measures impacting cardiovascular health. | • Grantees to define a sub-population, measure, and target goal based on needs of patients and existing disparities | • Benchmarks depending on measure                                                           |
## Equity Goal: Proposed Populations & Measures

<table>
<thead>
<tr>
<th>Grantee</th>
<th>Type</th>
<th>Equity Goal: Target Population</th>
<th>Equity Goal: Target Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHS</td>
<td>Public Hospital</td>
<td>Black/African American patients</td>
<td>Diabetes BP</td>
</tr>
<tr>
<td>Chapa-De</td>
<td>Health Center</td>
<td>American Indian &amp; Alaskan Native Patients</td>
<td>A1c, BP</td>
</tr>
<tr>
<td>CHCN</td>
<td>Consortia</td>
<td>Black/African American patients</td>
<td>HTN BP</td>
</tr>
<tr>
<td>CHP</td>
<td>Consortia</td>
<td>To be determined by health centers</td>
<td>To be determined by health centers</td>
</tr>
<tr>
<td>CMC</td>
<td>Health Center</td>
<td>Black/African American patients</td>
<td>HTN BP</td>
</tr>
<tr>
<td>Elica</td>
<td>Health Center</td>
<td>Low-income adults (18+)</td>
<td>HTN, Coronary artery disease, myocardial infarction, and/or diabetes</td>
</tr>
<tr>
<td>Golden Valley</td>
<td>Health Center</td>
<td>Homeless patients</td>
<td>Depression screening, BP control with HTN or diabetes</td>
</tr>
<tr>
<td>One Community</td>
<td>Health Center</td>
<td>African American women, age 18-85</td>
<td>BP readings of 140/90, who do not have a hypertension diagnosis</td>
</tr>
<tr>
<td>RCHC</td>
<td>Consortia</td>
<td>Uninsured adult patients</td>
<td>Diabetes</td>
</tr>
<tr>
<td>SFCCC</td>
<td>Consortia</td>
<td>Homeless patients, African-American</td>
<td>Hypertensive, diabetes</td>
</tr>
<tr>
<td>SFGH</td>
<td>Public Hospital</td>
<td>Black/African American patients</td>
<td>High risk for CVD and/or cardiovascular events</td>
</tr>
<tr>
<td>SJGH</td>
<td>Public Hospital</td>
<td>Black/African American patients</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>SMMC</td>
<td>Public Hospital</td>
<td>Black/African American patients</td>
<td>Hypertension</td>
</tr>
<tr>
<td>VHT</td>
<td>Health Center</td>
<td>Medical underserved low-income patients</td>
<td>At risk of CVD</td>
</tr>
</tbody>
</table>
What PHASE grantees have proposed doing to reach their goals
How do we improve?

• Set aims
• Establish and track measures
• Develop theories about the current system and processes
• Generate and test change ideas
Aim Statement
ABC Clinic will improve the health of its diabetic patients by decreasing the % of patients with uncontrolled diabetes (HbA1c > 9) from 92% [121 patients] to 50% [60 patients] by August 31, 2020

Primary Drivers (Systems Elements)
- Electronic Health Records Utilization
- Team-based Care
- Patient Engagement

Secondary Drivers (Areas for Change/Intervention)
- System alerts regarding care gaps
- Appointment reminders
- Report generation and analysis
- Pre-visit planning activities
- Outreach to Patients
- Standing orders
- Team huddles
- Group Appointments
- Shared Agenda-planning
- Case Management
## Proposed PHASE 2020-2022 Roadmap

### PHASE 2020-2022 Aim

<table>
<thead>
<tr>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td><img src="image" alt="Improvement Cycle 1" /></td>
<td><img src="image" alt="Improvement Cycle 2" /></td>
<td><img src="image" alt="Improvement Cycle 3" /></td>
</tr>
</tbody>
</table>

**Action period 1: rapid testing**
- Confirm 3 year aim, define initial areas of focus & teams.

**Action period 2: rapid testing**
- Assess progress and learnings, define next areas of focus.

**Action period 3: rapid testing**
- Assess progress and learnings, define next areas of focus.

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**Coaching, Technical Assistance, Facilitation of “All Teach All Learn” Learning Community by CCI**

**Assessment of Capabilities, Measurement and Analysis of Data by CCHE**

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Upcoming Learning Events
PHASE Learning Community Webinars

November 21, 1-2pm

**Defining PHASE 2020 Projects:** What problem do you need to solve? What team do you need to solve it?

For organizations that submitted proposals for PHASE 2020-2022.

December 12, 1-2pm

**Reflecting on 2017-2019 Progress & Celebrating Accomplishments:** Leveraging PHASE Success for the Future

For all 2017-2019 PHASE leads and core teams.
Peer Learning Site Visit: December 3

PHASE grantees will have the opportunity to visit a health center that exemplifies innovative population health management practices. On December 3rd, participants can visit one of two sites:

Space is limited – please register your interest by Tuesday, November 19.

Registration survey will be sent to PHASE team leads
Motivational Interviewing Community of Practice – January – April 2020

In partnership with Elizabeth Morrison Consulting, CCI is launching a Motivational Interviewing (MI) Community of Practice. MI is effective in improving patient health outcomes, patient experience, and job satisfaction.

The MI CoP consists of monthly 6-hour in person training sessions for 4 months, with participants engaging in homework and practice workshops at their organization between sessions.

Space for 2 or 3 participants from about 5 organizations.

Applications due Dec. 2\textsuperscript{nd}

Optional Informational Webinar: November 13\textsuperscript{th} at 12pm
Questions?
Break Outs -

*Listen for connections you want to make with others!*

<table>
<thead>
<tr>
<th>Public Hospitals w/ Michael</th>
<th>Consortia w/ Denise</th>
<th>Sac. FQHCs w/ Jerry</th>
<th>Central Valley FQHCs w/ Juliane</th>
</tr>
</thead>
</table>
| 1. SFHN  
2. AHS  
3. SJGH  
4. SMMC | 1. CHCN  
2. CHP  
3. SFCCC  
4. RCHC | 1. Chapa-De  
2. One Community  
3. Elica | 1. Golden Valley  
2. Community Medical Centers  
3. Valley Health Team |
1. Thinking about the goals you outlined in your PHASE 2020-2022 workplan, where is the biggest gap in performance between where you are now and where you want to be by the end of 2022?

2. What do you think are the key drivers of that gap? How do you know?

3. What support would be most helpful from other PHASE grantees and from the PHASE support partners (CCI, CCHE, and KP)?
Report Out from Break Out Groups: Key Takeaways

1. Where are the biggest gaps in performance?
2. What are the key drivers?
3. What support would be helpful?
Next steps

1. Register for November and December Webinars

2. Look out for emails about the December Peer Learning Site Visit and the Motivational Interviewing Community of Practice & decide if you will send someone from your organization
Thank you!

Please fill out the webinar evaluation survey: https://www.tfaforms.com/4668124

Questions?

Contact Alexis Wielunski, Center for Care Innovations
alexis@careinnovations.org