KAISER PERMANENTE®

PHASE

PREVENTING HEART ATTACKS & STROKES EVERY DAY

Kaiser Permanente developed the Preventing Heart Attacks and Strokes Every day (PHASE) program in 2002 to reduce cardiovascular disease (CVD) among our members and patients. By applying evidence based treatment to populations at risk, the PHASE program has reduced CVD morbidity by 60 percent among KP members. In 2006, KP began working with its health care safety net partners in Northern California, providing both funding and clinical expertise, to translate and implement PHASE in community-based care settings. Today, 112 clinic sites in Northern California, which includes 25 public hospital/health department clinics (representing 4 public hospital systems) and 87 clinic sites from 32 health centers (representing 4 consortia) are providing care to more than 120,000 patients with diabetes and hypertension.

Clinic consortia and public hospitals were at the HEDIS 75 percent for controlled blood sugar and blood pressure in Q3 2016.

Key Learnings of PHASE 2006-2016

Successful implementation of PHASE requires not only the clinical protocol, but also on the effective implementation of population health management practices, the "Building Blocks of PHASE"

- Fostering a supportive and engaged leadership and culture
- Ensuring a quality improvement culture and process improvement methodology
- Employing Data-driven decision making
- Promoting team-based care
- Ensuring the capacity for population/panel management

2017-2019: The Next Cycle of PHASE in the Community

This initiative will continue to focus on integrating and sustaining evidence-based standards of care in public hospitals and community health centers by continuing to work with existing PHASE grantees—clinic consortia and hospitals—to expand the reach and scope of PHASE, as well as work with health centers in the Central Valley and Sacramento to adopt, implement and spread of PHASE. This initiative has three key goals:

- Increase the adoption and implementation of the PHASE protocol within the safety net.
- Strengthen the capabilities of safety net organizations across all PHASE building blocks.
- Improve care teams' clinical ability to report and use data to drive performance improvement within participating sites and, for continuing PHASE grantees, within the support system (consortia/hospital system).

2017-19 Grantees

- Alameda Health System
- Camarena Health
- CARES Community Health
- Chapa-De Indian Health Program
- Community Health Center Network
- Community Health Partnership of Santa Clara
- Community Medical Centers
- Elica Health Center
- Golden Valley Health Centers
- Livingston Community Health
- Redwood Community Health Coalition
- San Francisco Community Clinic Consortia
- San Francisco General Hospital Foundation
- San Mateo Medical Center
- Santa Clara Valley Medical Center
- San Joaquin General Hospital
- Sacramento Native American Health Center
- Valley Health Team

EVALUATION & TRAINING

- Center for Care Innovations – Project Office
- Center for Community Health & Evaluation

The initiative will continue to engage a set of technical assistance providers as a PHASE support team to provide a structured approach to technical assistance (described below), across the full spectrum of readiness and implementation at the provider, clinic, and system (consortia/hospital) level.

Measuring Outcomes and Impact

PHASE grantees that have already adopted the PHASE protocol will continue to be evaluated on their ability to implement systems that capture core clinical measures. The goal is to increase grantee capacity to report using publicly available quality and care measures consistently with those used by the health care field, including many that are consistent with those that are part of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

Grantees and their participating clinic sites will be required to submit regularly scheduled standardized clinical data reports which include, at a minimum:

- Reach: Number of PHASE clinic sites and patients
- Health outcomes of patient base: A1C levels, Blood Pressure
- Medication: Patients prescribed the medication protocol, medication adherence (measurement under development)
- Screening and follow-up: BMI, smoking, and depression.

In addition to the core metrics, building on current PHASE evaluation findings, the PHASE Support Team will provide opportunities for grantees to learn how to improve clinical care by collecting, tracking, and responding to data in the following four areas that are directly linked to improvements in CVD:

- Medication adherence
- Patient engagement
- Depression screening & follow-up
- Screening and referral to social nonmedical programs

Health centers that are in the beginning stages of adopting PHASE (including those in the Central Valley and Sacramento) will initially focus on building their capabilities within the PHASE Building Blocks, and will work to develop their ability to implement, scale, and report on the PHASE clinical protocol measures.