FINAL REPORT

Prepared By:
Community Clinics Health Network
April 24, 2015

ALL HEART / PHASE CONVENING

Thursday, March 5, 2015
Hilton Orange County

Sponsored By: 

www.ALLHEARTHEALTH.org

EVENT FLYER

Mark your calendar and join us for an informative day to share and learn with other ALL/PHASE clinics and safety net providers.

ALL HEART/PHASE Convening

Thursday, March 5, 2015

10:00 a.m. – 4:00 p.m.

Hilton Orange County / Costa Mesa
3050 Bristol St, Costa Mesa, CA 92626

4:00 p.m. – 6:00 p.m.
Join us for a fun-filled networking reception with clinics and partners!

ALL HEART
A prescription for a heart healthy community

REGISTER ONLINE HERE

www.ALLHeartHealth.org

Special hotel room rates available for $149/night.

Stay for an extra day and join us for the
14th Annual Health Care Symposium
on Friday, March 6, 2015 at the Hilton!

Sponsored by : KAISER PERMANENTE® *in the community*

EVENT OVERVIEW

Purpose:
The purpose of the ALL HEART/PHASE Convening is to promote the spread of the Kaiser Permanente evidence-based ALL HEART/PHASE model in the safety net population and to share best practices and lessons learned in ALL HEART/PHASE implementation and evaluation.

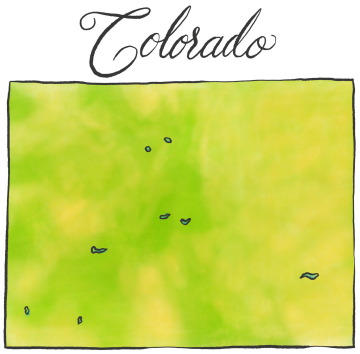
Objectives:
By the end of the ALL HEART/PHASE Convening, participants will be able to:

- Describe the health benefits of the ALL HEART/PHASE medication regimen, including TAL;
- Identify a specific ALL HEART/PHASE best practice that can be implemented at their site;
- Gain awareness of the latest recommendations and indications from new research related to diabetes and hypertension and cardiovascular disease outcomes;
- Describe how behavioral health staff can integrate into the diabetes/hypertension care team;
- Identify evaluation highlights from the ALL HEART program.

Audience:
Past and present ALL HEART and PHASE clinics and grantee teams including providers, quality managers and data specialists; clinic teams interested in learning more about ALL HEART and PHASE activities and outcomes

PARTICIPATION FROM THREE STATES

Baldwin Park	California
Coronado	California
Costa Mesa	California
Daly City	California
Escondido	California
Glendale	California
Irvine	California
Long Beach	California
Los Angeles	California
Moreno Valley	California
Oakland	California
Pasadena	California
Petaluma	California
Redlands	California
Redwood City	California
Riverside	California
Sacramento	California
San Diego	California
San Fernando	California
San Francisco	California
San Jose	California
San Leandro	California
San Marcos	California
San Mateo	California
Santa Monica	California
Vista	California
Woodland Hills	California
Yorba Linda	California
Denver	Colorado
Seattle	Washington

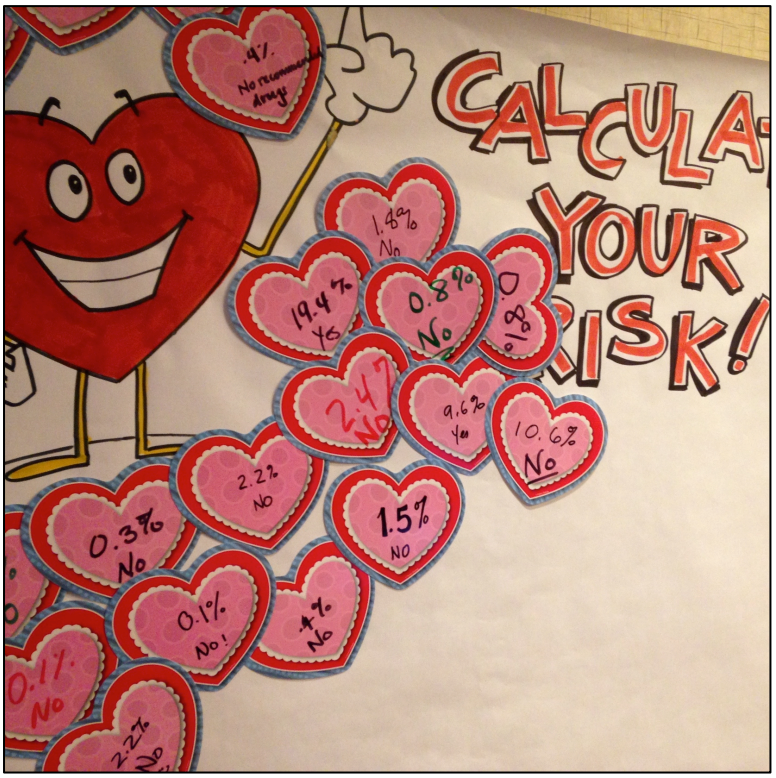


AGENCIES REPRESENTED

4Patient Care
Alameda Health System
Be There San Diego
CARES Community Health
Center for Care Innovations
Center for Community Health and Evaluation
City of Pasadena Public Health Department
Coalition of Orange County Comm. Health Centers
Community Clinic Association of Los Angeles County
Community Clinics Health Network
Community Health Partnership
Community Health Systems, Inc
Community Partners
Council of Community Clinics
Eisner Pediatric and Family Medical Center
Emdeon
Family Health Centers of San Diego
Health Services Advisory Group, Inc.
Healthcare Consulting
Imperial Beach Health Center
Kaiser Permanente
Kaiser Permanente Los Angeles Medical Center
Kaiser Permanente South Bay Medical Center
Krokidas & Bluestein, LLP
La Maestra Community Health Center
Los Angeles County Department of Health Services
Neighborhood Healthcare
North County Health Services
Northeast Valley Health Corporation
Pasadena Public Health Department
Redwood Commmunity Health
Riverside Community Health Foundation
Riverside County Department of Ambulatory Care
Riverside County Health System
San Francisco Community Clinic Consortium
San Francisco Department of Public Health
San Francisco Health Network
San Mateo Medical Center
Santa Clara Valley Medical Center
Serving Kids Hope
South Central Family Health Center
St Bernardine Medical Center
The Children's Clinic
The Urena Group
UCSF Center for Excellence in Primary Care
Venice Family Clinic
Vista Community Clinic

HANDS ON PARTICIPATION

Participants were encouraged to assess their risk for cardiovascular disease at the "Risk Calculator Station".



GRANTEE POSTER SESSION

ALL HEART 2014/2015 PILOT PROJECTS

ALL HEART is an evidence-based, cost effective means of improving health outcomes for diabetic community clinic patients ages 50 and over.

ALL HEART clinics identify patients ages 50 and over with diabetes and patients of any age at high risk for CVD and apply the ALL intervention: aspirin, lisinopril (and ACE inhibitor) and a lipid-lowering medication (specifically statins). ALL HEART patients are also educated on healthy lifestyle changes and encouraged to create self-management goals.

ALL HEART

A prescription for a heart healthy community

KAISER PERMANENTE®

In 2014, four of the 14 ALL HEART clinics chose to participate in pilot projects to explore medication adherence and/or medication therapy management at their clinics.

In 2015, the ALL HEART grant activities expanded to include hypertension population management and behavioral health integration. Three of the 14 ALL HEART clinics chose to participate in pilot projects to improve clinical outcomes for their patient population.

Eisner Pediatric & Family Medical Center

EISNER PEDIATRIC & FAMILY MEDICAL CENTER

Integrating behavioral health into the primary care team

Planned Activities

- Co-locate a behavioral health professional within a primary care team
- Include the behavioral health professional in care team meetings
- Delineate a workflow for screening and referral to integrated behavioral health specific to individuals with diabetes, hypertension, and CAD.
- Develop a process for warm handoffs and referrals to behavioral health services
- Develop clear protocols by which patients are able to access psychosocial support to enhance medical care and self-management of risk factors/illness
- Provide self-management/short negotiating interviewing training to site physicians and other care team members

A care team that includes the primary care provider, case manager, and integrated behavioral health clinician will help patients address and manage their medical conditions, mitigate risk factors, and ameliorate psychosocial stressors.

Patients will interact regularly with a case manager, and the team will engage in bidirectional consultation/communication via the EHR. Patient progress also will be tracked using the electronic health record.

Sole funding provided by: KAISER PERMANENTE®

ALL HEART at Imperial Beach Health Center

Imperial Beach Community Clinic

This pilot takes a deep dive into the data for those diabetic patients age 50+ not currently on a Statin and/or ACE to find out why.

ALL HEART reports were filtered to identify those patients who were not on the medication treatment regimen.

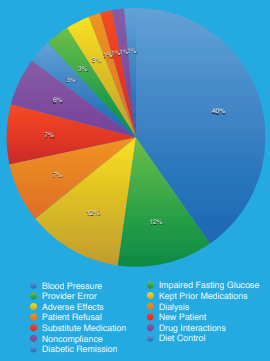
Reason Identified for not being on an ACE inhibitor:

1. Patient already has blood pressure controlled and the provider did not want the patient to be on additional medication with possible adverse side effects.

Reason Identified for not using statin medication:

1. LDL cholesterol was already at goal.
2. Patient has elevated liver function tests. Providers did not want to give the patient a medication which could possibly cause harm if their liver was already not functioning properly.

Patients not on ACE inhibitor



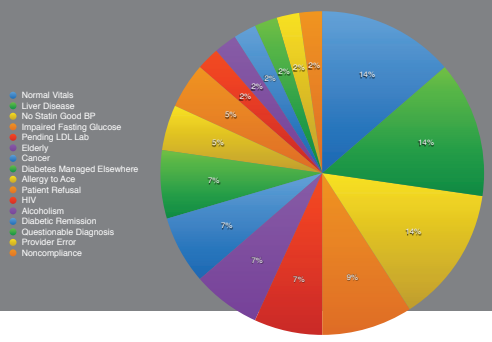
Results: Provider education

1. There is a cardiovascular benefit by simply being on the ACE Inhibitor, and, as long as their blood pressure was not excessively low, they shouldn't suffer adverse effects.
2. There is a cardiovascular benefit of the statin medication, even with normal cholesterol.
3. It is safe to have patients on these medications, even with mild liver function test elevation.

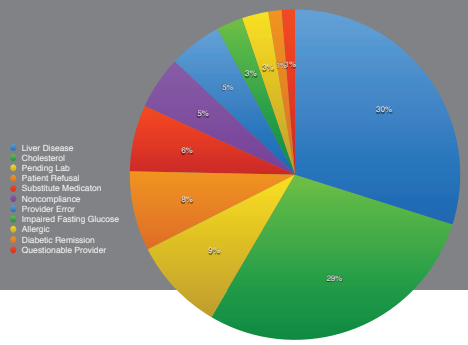
Future Plans

Imperial Beach Health Center plans to incorporate an automatic reminder system into Allscripts EMR. This reminder system will send a notice to the provider who sees a diabetic patient when they are not on both of these medications. It will be built into our diabetic patient manager. This will allow tracking data going forward in our quarterly i2i reports, which gives our providers regular statistics on their diabetic patient panel.

Patients on neither statin medication nor ACE inhibitor



Patients not on statin medication



Sole funding provided by: KAISER PERMANENTE®

Los Angeles County Department of Health Services

Health Services
LOS ANGELES COUNTY

Present and Future Benefits of A-L-L: Expanding Cardiovascular Disease Risk Reduction for Patients with Diabetes

Los Angeles County Department of Health Services (LAC DHS), Ambulatory Care Network: Research and Innovation

Los Angeles County Department of Health Services (LAC DHS) is the second largest safety-net system in the US and is responsible for the care of nearly 800,000 unique patients who utilize nearly 3 million encounters per year. The Safety-Net patient population is ideally situated to test the efficacy of interventions aimed at improving selection, adherence, and persistence to a combination of aspirin, an ACE-I/ARB, and a statin.

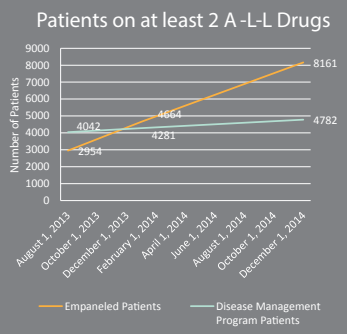
An electronic prompt was created to screen patients for A-L-L criteria (age 50 years and over with diabetes), determines which if any of the A-L-L medications the patient is on, and prompts care providers to prescribe any A-L-L medications the patient is on not currently on, or provide a reason for not prescribing them. This is integrated into the LAC DHS electronic Medication Reconciliation (e-MedRecon) module of the Disease Management Registry (DMR) used by the Diabetes Disease Management Programs. A modified A-L-L report is active in i2i, the registry used in DHS Patient Centered Medical Homes.

	Empaneled Patients		Disease Management Program Patients	
Description	**Count**	**Percentage**	**Count**	**Percentage**
Patients on ASA, ACE, and Statin	5,678	43%	4,253	83%
Patients on ASA, and ACE	1,060	8%	194	4%
Patients on ASA and Statin	724	5%	162	3%
Patients on ACE and Statin	699	5%	173	3%
Patients only on ASA	386	3%	62	1%
Patients only on ACE	727	5%	80	2%
Patients only on Statin	385	3%	46	1%
Patients not on ACE, ASA or Statin	3,640	27%	150	3%
Total patients touched by grant	**13,299**	**100%**	**5,120**	**100%**

Activities

PRACTICE-BASED RESEARCH NETWORKS pbrn

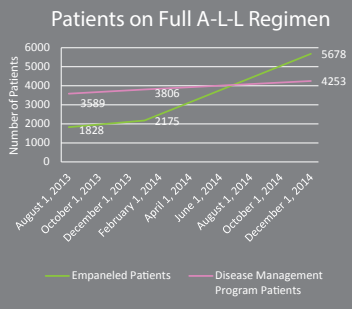
- Trained providers on the benefits of A-L-L.
- Created and use an Adult Type 2 Diabetes Protocol.
- Integrated the A-L-L prompt into the e-MedRecon module of the Disease Management Registry (DMR) at 7 LAC DHS clinical sites with Diabetes Disease Management Programs.
- Designed a method to identify patients who meet A-L-L and then screen them for the A-L-L medications within i2i. This was added to the Diabetes Tracking Type (a user-defined collection of measures) so that identified patients will appear on a summary sheet for providers at each clinic visit.
- The A-L-L tracking type is in use at more than 120 Patient Centered Medical Homes in DHS.



Conclusions/Findings

As of Dec 31, 2014, 83% of patients touched in the Disease Management Programs are on all 3 A-L-L drugs and 97% are on at least one drug. 43% of all eligible DHS empaneled patients are on all 3 A-L-L drugs, and 73% are on at least one A-L-L drug. We credit the success of this program to three key factors: integration of A-L-L into workflow, making it easy for providers to do the "right" thing, and provider education on the benefits of A-L-L.

Please contact PI Jeffrey Guterman at jguterman@dhs.lacounty.gov or the project coordinator Laura Myerchin Sklaroff at lsklaroff@dhs.lacounty.gov with questions or comments.



Funding for this project provided by: KAISER PERMANENTE®

Neighborhood Healthcare

NEIGHBORHOOD HEALTHCARE
a californiahealth+ center

Neighborhood Healthcare(NHC) has an established chronic disease management program to better improve the health outcomes of patients. Personal care teams focus on individual patients providing self-management education, preventative care and regular monitoring of health conditions.

Medication Therapy Management

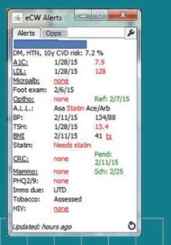
- Pilot at 3 NHC Health Centers with adult primary care
- Collaborative practice agreements between providers and pharmacists with prescribing rights
- Pharmacist led one on one patient visits
- Ensures patients are on the right medication bundles
- Reduces potential dangerous drug interactions
- Ensures patients understand the importance of their medication
- Provides tools for self-managing their medications
- **Success story:** Female patient entered program with uncontrolled blood pressure. She had three different bottles of Lisinopril with old dosages and was confused about which pills to take. Pharmacist set medication plan with patient, discarded old medication bottles and discussed lifestyle changes. In just 4 weeks, the patient's blood pressure was at goal!

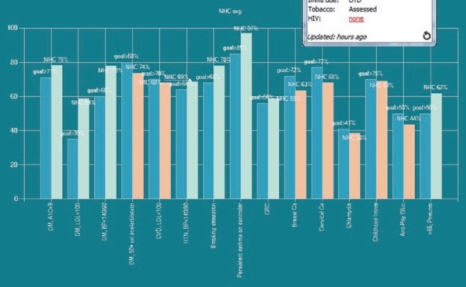
Alerts Application

- All NHC Health Centers
- Alerts Care Team of care gaps and missed opportunities at point of service
- Care Team MAs order all labs and services needed
- Alerts PCP if ALL med(s) needed at point of service
- Displays current patient's stats
- Calculates Framingham risk score

Registered Nurse ALL Heart Medication Protocol

- Pilot at 1 NHC Health Center with adult primary care
- RN runs registry list of patients who are not on ALL medication bundle
- RN loads prescription(s) and orders labs according to protocol
- RN sends order to provider for review and final Rx transmittance
- RN notifies patient with final outcome
- RN feedback: Protocol is easy to follow and some patients are able to gain compliance with medication. Patients needing additional support are scheduled to see their providers. Some providers prefer to manage their own patient lists.





Internal Registry

- All NHC Health Centers
- Developed to identify patients due for services and improve clinical measures
- Generates call list of patients due for services
- Outreach calls are placed by MA Care Coordinator or Care Team MAs
- Graphical presentation of real time clinical data

Sole funding provided by: KAISER PERMANENTE®

Northeast Valley Health Corporation

Northeast Valley Health Corporation
a californiahealth center

Integrating Pharmacists into the Healthcare Team: Statin Medication Therapy Management

Medication therapy management (MTM) is an effective method to initiate statin therapy as an intervention in diabetic care and is associated with improved clinical measures (such as blood pressture or LDL cholesterol), fewer adverse drug events, and patient adherence.

The primary objective of this pilot is to utilize a statin therapy MTM program to provide pharmaceutical care with improved medication safety, adherence and compliance in order to improve patient outcomes in controlling diabetes and hyperlipidemia. Improved clinical outcomes can decrease the possibility of cardiac events.

Activities:

1. A chart review was conducted on 66 patients who are 50 years or older, have type 2 diabetes and are not on statin therapy with LDL>100mg/dL. A recommendation to add a statin to the patients' treatment plan was made to the primary care clinician, to prevent future cardiovascular complications.
2. Following approval from the provider, the Pharmacy Intern telephoned patients to educate them on the disease state and medication.
3. Adherence to medication was evaluated at baseline and at 2 weeks along with safety. Efficacy to therapy was monitored at 4-6 weeks with corresponding lipid panel and liver function tests.
4. The Morisky medication adherence-scale was utilized along pharmacy pick-up history to monitor patient's adherence.
5. Baseline LDL-C values were compared with values obtained at follow-up.
6. Incidence of adverse drug reactions (ADRs) during treatment were also collected.

Average LDL Levels of those currently on service

122 LDL Time of screening

88 LDL Most recent value

Conclusions:

- Incorporating medication therapy management resulted in an improved patient care of diabetic patients with dyslipidemia at NEVHC-San Fernando Clinic
- An improvement in measured adherence was observed in this study using the Morisky 8-item questionnaire at baseline and at two weeks follow-up.
- 85% of patients picked up their medication at their pharmacy of choice after first time counseling.
- Patients in this study were provided with the contact information of the Pharmacy Intern. This may have improved patient willingness to initiate treatment by providing a sense of security in knowing that there was someone to contact if a problem occurred.
- Statistically significant reductions in total cholesterol and LDL-C levels of six patients at 4 to 6 weeks follow-up.
- Occasional drug-drug interactions or errors were identified through the process of reviewing patients' medications.
- The MTM model, and the interdisciplinary team approach can be used to implement similar protocols.
- Adherence to other medications and improvement to blood pressure control was noted as a positive side effect.

Products:

- Workflow algorithm was established
- A statin treatment initiation protocol was created
- Acceptance of 75% of the recommendations to start and manage statin therapy on these patients.
  - o Some of the reasons that resulted in non-approvals were patients experiencing myopathy, having a slight liver enzyme elevation in the past, patient in frail condition (>75years old) and reluctant to start a new medication.

Phase 2 of the pilot will expand the size of the Statin MTM Pilot by reaching out to more providers

Sole funding provided by:

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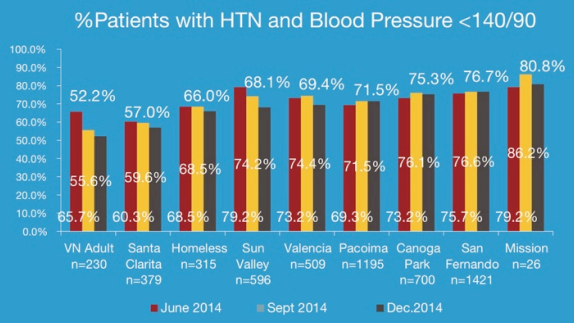
Northeast Valley Health Corporation

Northeast Valley Health Corporation
a californiahealth+ center

ALL HEART Hypertension Management Pilot

Northeast Valley Health Corporation (NEVHC) is piloting a Hypertension Management Pilot at Santa Clarita Health Center. The Santa Clarita Health Center opened in 2011 and the impact of limited access to health care services for the underserved population in the Santa Clarita Valley was felt immediately.

In September 2014, 56% of the adult patients with a diagnosis of hypertension at the Santa Clarita Health Center were in control with a blood pressure of less than 140/90 at their last visit. This is compared to an average of 72.4% throughout all NEVHC Health Centers.



Pilot will Measure:

1. The percentage of patients with a diagnosis of hypertension who have their blood pressure under control
2. Number of patients attending blood pressure education classes
3. Number of patients participating in the blood pressure machine lending program and the texting program
4. Report on changes (if appropriate) on blood pressure management protocols

Planned Activities:

1. Conduct a chart audit to assess management of patients diagnosed with hypertension.
2. Adult Medical Director and the Director of Pharmacy to present the JNC8 Guidelines to provider and care team
3. Review the Clinical Decision Support Tool to alert providers and care team members about which anti-hypertensive medications the patient is taking.
4. Monthly hypertension classes; Nutrition, Physical Activity, Medications, Stress Management, Healthy lifestyle strategies
5. Provide education materials during the primary care visit.
6. Strengthen the referral process for blood pressure follow-up to RDs, HTN class, and nurse visits
7. Implement the home BP machine lending program.
8. Implement the BP and Self-Management Goals Texting Program.

% NEVHC Patients with HTN and Blood Pressure <140/90

72.5% May 2014

72.2% June 2014

72.4% Sep 2014

70.7% Dec 2014

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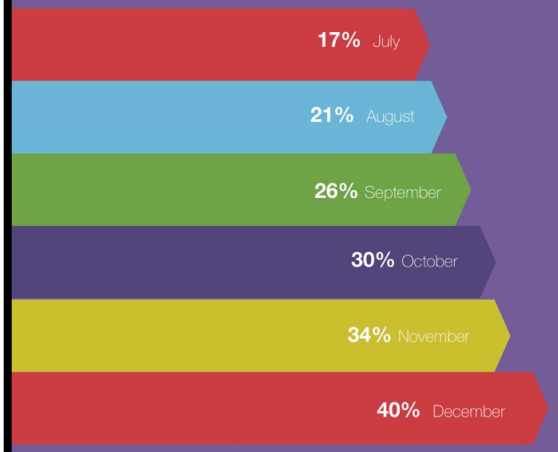
South Central Family Health Center

South Central Family Health Center

ALL HEART is a simplified cardiovascular risk reduction algorithm. One of the most efficient ways to correct deviations from an algorithm is to give providers feedback at every opportunity as to how their current management differs from the algorithm's recommendation. Providers in turn give feedback to help improve the implementation of the algorithm.

Eligible Patients With Medication Regimen Meeting ALL HEART Recommendations

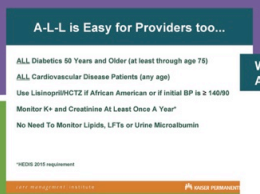


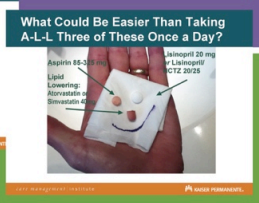
Activities

- Daily Team Huddle reports derived from i2i tracks data that is pasted into Excel and processed with a macro.
- In July 2014, we began incorporating ALL HEART into the Team Huddle reports, replacing older recommendations for monitoring microalbumin excretion and LDL levels.
- Providers could follow the recommendation or write a comment or suggestion.
- Adherence to the ALL HEART recommendations was measured over time.

Findings

- Patients with a medication regimen consistent with ALL HEART recommendations increased from 17% to 40% over six months.
- ACEI/ARB, Statin, Aspirin and Thiazide use all showed similar improvement.





Conclusions & Lessons Learned

- Team Huddle reports are an effective way to increase adherence to ALL HEART recommendations for cardiovascular risk reduction.
- Providers like the ALL HEART algorithm because it's intuitive and easy to remember. When they see an ALL HEART medication recommendation in a Team Huddle report there is no mystery as to how the recommendation was derived.
- A smart implementation that minimizes inappropriate recommendations builds provider confidence in the Team Huddle report.
- New providers need formal training to understand the rationale behind ALL HEART
- Additional training may be necessary to overcome misperceptions about the ACEI/Thiazide combination pill.

Future Directions

- We believe 60% adherence to an ALL HEART-compatible regimen is achievable at our clinic.
- We are incorporating ALL HEART interventions into our Pay-For-Performance reports to give providers panel-level feedback on a quarterly basis.
- We want to continue refining our Team Huddle reports while anticipating that our EHR will eventually have similarly-capable tools. The effort devoted to improvement of these reports needs to be balanced with the effort expended to keep the information in the EHR standardized, accurate and up to date.

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Vista Community Clinic

Vista Community Clinic
Choose Health ™

Hypertension Project

The purpose of the Vista Community Clinic (VCC) pilot is to implement the JNC8 hypertensive guidelines amongst hypertensive patients. VCC will focus on utilizing care coordinators to follow up with patients, closely monitor medication adherence, and motivate patients toward heart healthy lifestyle changes.

Activities

- Establish a Provider Champion and Program Lead
- Develop a report to identify hypertensive patients no in control and/or not on combo medications
- Utilize Care Coordinators as health coaches
- Contact patients weekly to ensure medication adherence and progress toward goals
- Provide education and assess patient knowledge
- Identify and address barriers to care
- Motivate and develop self-management action plans
- Disseminate provider report cards to monitor compliance with the guidelines
- Meet monthly with Hypertension Subcommittee to review clinical outcomes

Conclusions

- Initial reports show that less than 50% of our selected patient population is currently on the medication bundle recommended by the JNC8 guidelines.
- Our Provider Champion and Program Lead have made presentations at Provider Council meetings and site-specific clinic staff meetings.
- Report cards and patient lists have been distributed to providers and care coordinators, highlighting the goal of 80% or better.
- The report cards include most recent blood pressure, medication status, and lists of the identified patients.
- Every other month, the provider and care coordinator review each report card to monitor progress

Sole funding provided by: KAISER PERMANENTE®

AGENDA

ALL HEART/PHASE Convening

Thursday, March 5, 2015
9:00 a.m. | Breakfast & Registration 10:00 a.m. – 4:00 p.m. | Meeting
4:00 p.m. – 6:00 p.m. | Networking Reception
Hilton Orange County | 3050 Bristol St., Costa Mesa, CA 92626
Wifi: AVMS-meetings| User Name: councilclinics | Password: councilclinics15

AGENDA

9:00 - 10:00am	**Registration, Poster Session, Breakfast and Networking** **ROOM: FOUNTAIN TERRACE – LOBBY LEVEL**
10:00 - 10:15am	**Welcome and Introductions/Opening Remarks** **ROOM: CATALINA II – LOBBY LEVEL** Jill Webber, MPH, Program Manager, Community Clinics Health Network Marc Jaffe, MD, Clinical Leader, Kaiser Permanente Northern California Cardiovascular Risk Reduction (PHASE) Program Jim Schultz, MD, MBA, FAAFP, Chief Medical Officer, Neighborhood Healthcare
10:15 - 11:00am	**ALL HEART/PHASE from Adopting Clinical Protocols to Advancing Value Based Care** **ROOM: CATALINA II – LOBBY LEVEL** **Session Description:** A panel discussion on how the ALLHEART/PHASE program is vital to addressing the rapidly changing health care environment. **Panelists:** • Allen Cheadle, PhD, Director, Center for Community Health and Evaluation • Mary Maddux-Gonzalez, MD, Chief Medical Infomatics Officer, Redwood Community Health • Jeffrey J. Guterman, MD, MS, Chief Research & Innovation Officer, Los Angeles County Department of Health Services **Moderator:** Christina Wildlake, MS, Project Manager III, Community Benefit Program, Northern California Region, Kaiser Permanente
11:00– 11:15am	**Break**
11:15- 12:30pm	**The New Cholesterol Guidelines: Should I be on a Statin?** **ROOM: CATALINA II – LOBBY LEVEL** **Session Description:** Calculating the 10-Year ASCVD risk and implications for dyslipidemia treatment recommendations, including, why statins. **Panelists:** • Wiley Chan, MD, Director, Guidelines & Evidence-Based Medicine, Northwest Permanente • Jim Schultz, MD, MBA, FAAFP, Chief Medical Officer, Neighborhood Healthcare **Moderator:** R. James Dudl, MD, Clinical Advisor, Community Benefit and Diabetes Lead, Care Management Institute, Kaiser Permanente

AGENDA (cont.)

12:30 - 1:15pm	**Lunch & Networking** **ROOM: BRISTOL III – LOBBY LEVEL**
1:15 - 2:15pm	**Breakout Session 1: Total Wellness – Addressing Behavioral Health as Part of Chronic Care Management** **ROOM: CATALINA II – LOBBY LEVEL** **Session Description:** Integrating behavioral health consultants into the health care team. **Speaker:** Mary Lou Maldonado, RN, LMFT, Clinician, La Maestra Community Health Centers **Moderator:** Nicole Howard, MPH, Director of Programs and Fund Development, Community Clinics Health Network
	Breakout Session 2: Documenting Efforts to Address Social Determinants of Health through Community to Clinic Integration **ROOM: FOUNTAIN TERRACE – LOBBY LEVEL** **Session Description:** A panel discussion about HEAL zones and how local clinics are working with community organizations to encourage and incentivize underserved population to make health choices. **Panelists:** • Patricia A. Ronald Riba, MD, MA, Founder and Medical Director, Serving Kids Hope • Lily Martínez, MPH, CHES, IBCLC, Director of Health Education and Outreach, The Children's Clinic **Moderator:** Clara Steimberg, Project Manager, Community Benefit, Kaiser Permanente
2:15 – 2:30 pm	**Break**
2:30- 3:45pm	**New Opportunities to Address Racial, Ethnic and Gender Disparities** **ROOM: CATALINA II – LOBBY LEVEL** **Session Description:** A panel discussion that will introduce some of the new research in the management of hypertension, starting with effective strategies to take, what works with improving medication adherence, and disparities with special populations. **Panelists:** • R. James Dudl, MD, Clinical Advisor, Community Benefit and Diabetes Lead, Care Management Institute, Kaiser Permanente • Marc Jaffe, MD, Clinical Leader, Kaiser Permanente Northern California Cardiovascular Risk Reduction (PHASE) Program • Winston F. Wong, MD, MS, Medical Director, Community Benefit and Director, Disparities Improvement & Quality Initiatives, Kaiser Permanente **Moderator:** Coralie Chan, MPH, Program Manager, National Community Benefit, Kaiser Permanente
3:45- 4:00pm	**Closing Remarks** **ROOM: CATALINA II – LOBBY LEVEL** Winston F. Wong, MD, MS, Medical Director, Community Benefit and Director, Disparities Improvement & Quality Initiatives, Kaiser Permanente
4:00 – 6:00pm	**Networking Reception** **ROOM: BRISTOL III – LOBBY LEVEL**

Sole Funding Provided by: KAISER PERMANENTE in the community

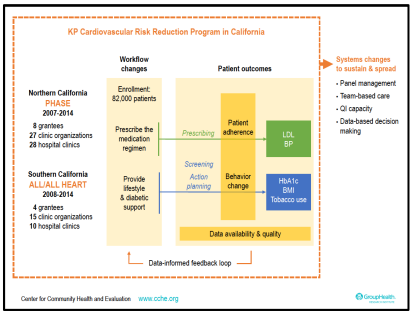
Welcome & Opening Remarks

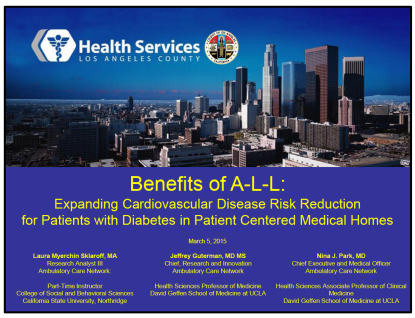
- Jill Webber, MPH, Program Manager, Community Clinics Health Network
- Marc Jaffe, MD, Clinical Leader, Kaiser Permanente Northern California Cardiovascular Risk Reduction (PHASE) Program
- Jim Schultz, MD, MBA, FAAFP, Chief Medical Officer, Neighborhood Healthcare

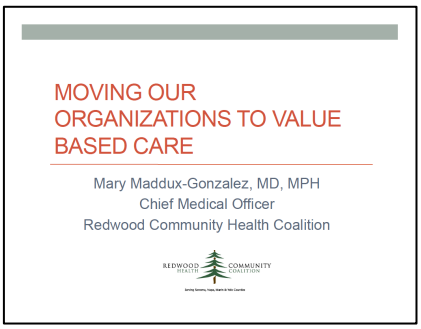
Dr. Mark Jaffe

Dr. Jim Schultz

Morning Session I







ALL HEART/PHASE from Adopting Clinical Protocols to Advancing Value Based Care

Session Description:

A panel discussion on how the ALLHEART/PHASE program is vital to addressing the rapidly changing health care environment.

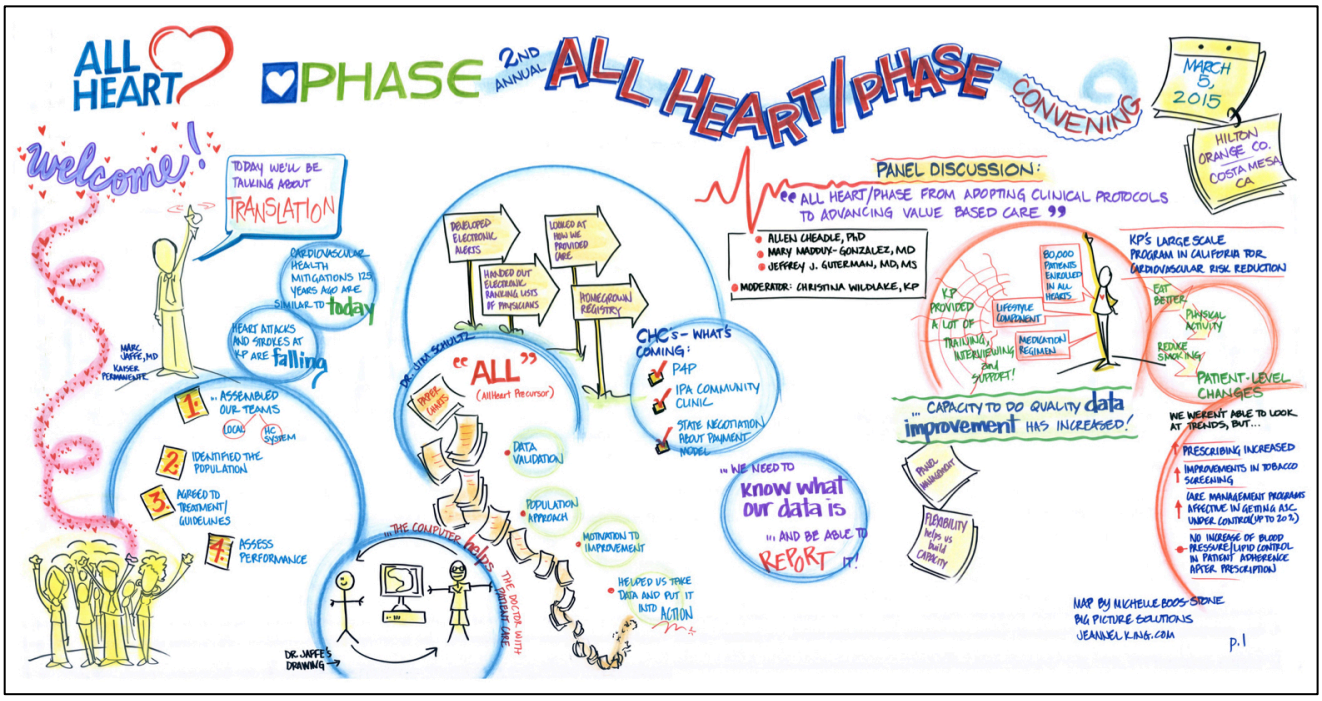
Panelists:

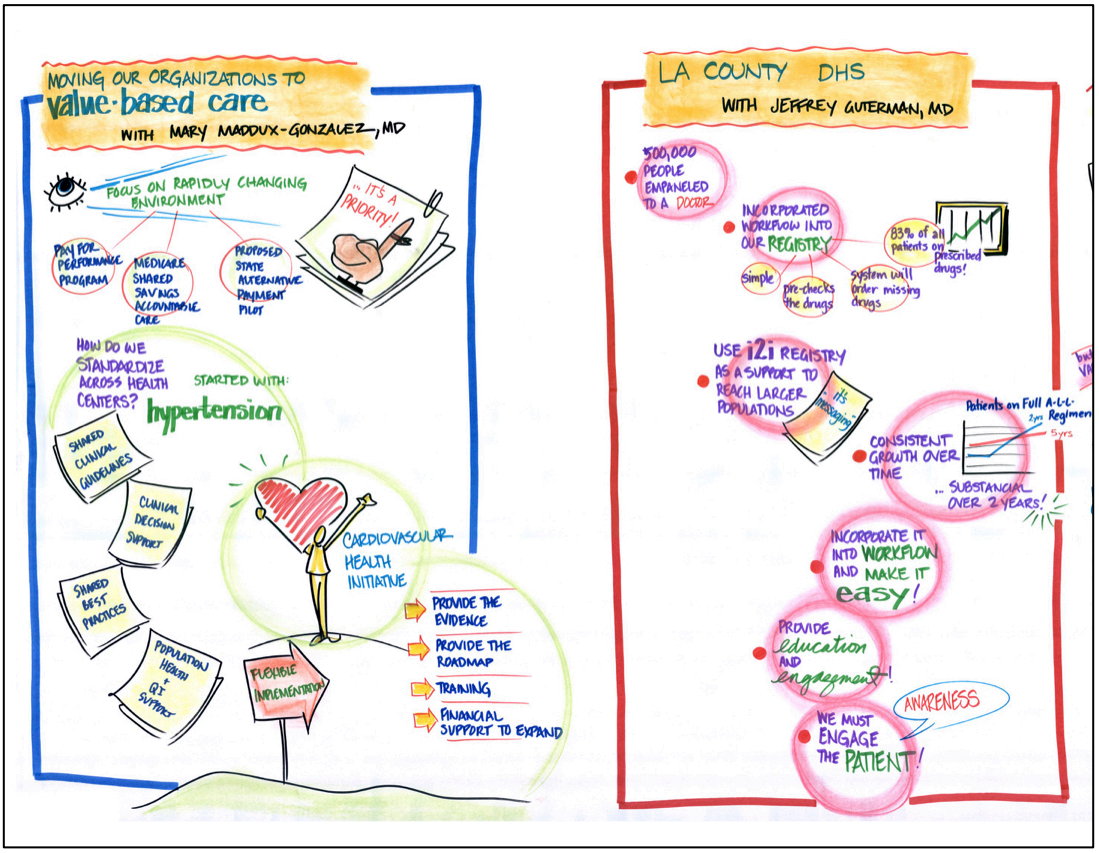
- Allen Cheadle, PhD, Director, Center for Community Health and Evaluation
- Mary Maddux-Gonzalez, MD, Chief Medical Officer, Redwood Community Health
- Jeffrey J. Guterman, MD, MS, Chief Research & Innovation Officer, Los Angeles County Department of Health Services

Moderator:

- Christina Wildlake, MS, Project Manager III, Community Benefit Program, Northern California Region, Kaiser Permanente

Dr. Allen Cheadle

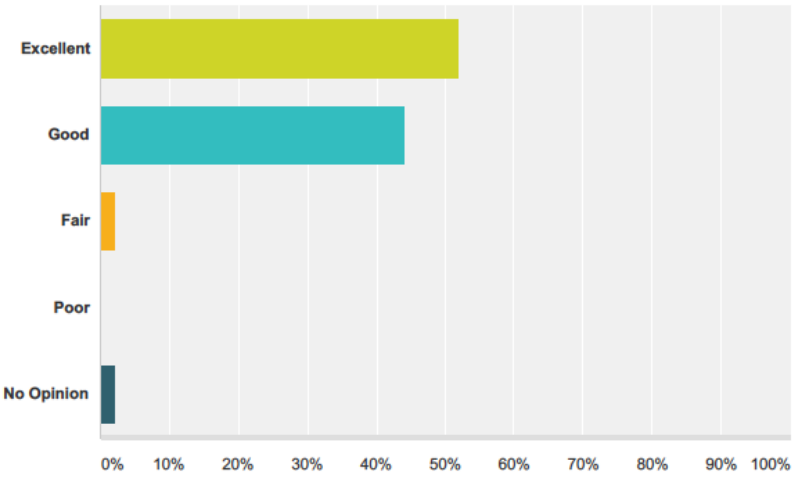

ALL HEART
PHASE
2ND ANNUAL
ALL HEART/PHASE CONVENING
MARCH 5, 2015
HILTON ORANGE CO. COSTA MESA CA
welcome!
TODAY WE'LL BE TALKING ABOUT TRANSLATION
CARDIOVASCULAR HEALTH MITIGATIONS 15 YEARS AGO ARE SIMILAR TO today
HEART ATTACKS AND STROKES AT KP ARE falling
MARC JAFFE, MD KAISER PERMANENTE
1. ASSEMBLED OUR TEAMS
LOCAL
HC SYSTEM
2. IDENTIFIED THE POPULATION
3. AGREED TO TREATMENT/GUIDELINES
4. ASSESS PERFORMANCE
DR. JAFFE'S DRAWING
DEVELOPED ELECTRONIC ALERTS
LOOKED AT HOW WE PROVIDED CARE
HANDED OUT ELECTRONIC RANKING LISTS OF PHYSICIANS
HOMEGROWN REGISTRY
"ALL"
(AllHeart Precursor)
PAPER LISTINGS
DATA VALIDATION
POPULATION APPROACH
MOTIVATION TO IMPROVEMENT
"THE COMPUTER helps" THE DOCTOR WITH GUIDELINE CARE
HELPED US TRACK DATA AND PUT IT INTO ACTION
CHC's - WHAT'S COMING:
PAP
IPA COMMUNITY CLINIC
STATE NEGOTIATION ABOUT PAYMENT MODEL
"WE NEED TO know what our data is
"AND BE ABLE TO REPORT IT!
PANEL DISCUSSION:
"ALL HEART/PHASE FROM ADOPTING CLINICAL PROTOCOLS TO ADVANCING VALUE BASED CARE"
ALLEN CHEADLE, PhD
MARY MADDUX-GONZALEZ, MD
JEFFREY J. GUTERMAN, MD, MS
MODERATOR: CHRISTINA WILDLAKE, KP
KP PROVIDED A LOT OF TRAINING, INTERVIEWING and SUPPORT!
LIFESTYLE COMPONENT
MEDICATION REGIMEN
80,000 PATIENTS ENROLLED IN ALL HEARTS
KP'S LARGE SCALE PROGRAM IN CALIFORNIA FOR CARDIOVASCULAR RISK REDUCTION
EAT BETTER
PHYSICAL ACTIVITY
REDUCE SMOKING
PATIENT-LEVEL CHANGES
"... CAPACITY TO DO QUALITY data improvement HAS INCREASED!
PANEL MANAGEMENT
FLEXIBILITY helps us build CAPACITY
WE WEREN'T ABLE TO LOOK AT TRENDS, BUT...
PRESCRIBING INCREASED
IMPROVEMENTS IN TOBACCO SCREENING
CARE MANAGEMENT PROGRAMS EFFECTIVE IN GETTING A1C UNDER CONTROL (UP TO 20%)
NO INCREASE OF BLOOD PRESSURE/LIPID CONTROL IN PATIENT ADHERENCE AFTER PRESCRIPTION
MAP BY MICHELLE BOOS-STONE
BIG PICTURE SOLUTIONS
JEANNEL KING.COM
p.1


MOVING OUR ORGANIZATIONS TO value-based care
WITH MARY MADDUX-GONZALEZ, MD
FOCUS ON RAPIDLY CHANGING ENVIRONMENT
"IT'S A PRIORITY!"
PAY FOR PERFORMANCE PROGRAM
MEDICARE SHARED SAVINGS ACCOUNTABLE CARE
PROPOSED STATE ALTERNATIVE PAYMENT PILOT
HOW DO WE STANDARDIZE ACROSS HEALTH CENTERS?
STARTED WITH: hypertension
SHARED CLINICAL GUIDELINES
CLINICAL DECISION SUPPORT
SHARED BEST PRACTICES
POPULATION HEALTH + QI SUPPORT
CARDIOVASCULAR HEALTH INITIATIVE
FLEXIBLE IMPLEMENTATION
PROVIDE THE EVIDENCE
PROVIDE THE ROADMAP
TRAINING
FINANCIAL SUPPORT TO EXPAND
LA COUNTY DHS
WITH JEFFREY GUTERMAN, MD
500,000 PEOPLE EMPANELED TO A DOCTOR
INCORPORATED WORKFLOW INTO OUR REGISTRY
Simple
pre-checks the drugs
System will order missing drugs
83% of all patients on prescribed drugs!
USE i2i REGISTRY AS A SUPPORT TO REACH LARGER POPULATIONS
it's Prescription
CONSISTENT GROWTH OVER TIME
Patients on Full A-L-L Regimen
2yrs
5yrs
... SUBSTANCIAL OVER 2 YEARS!
INCORPORATE IT INTO WORKFLOW AND MAKE IT easy!
PROVIDE education AND engagement!
WE MUST ENGAGE THE PATIENT!
AWARENESS

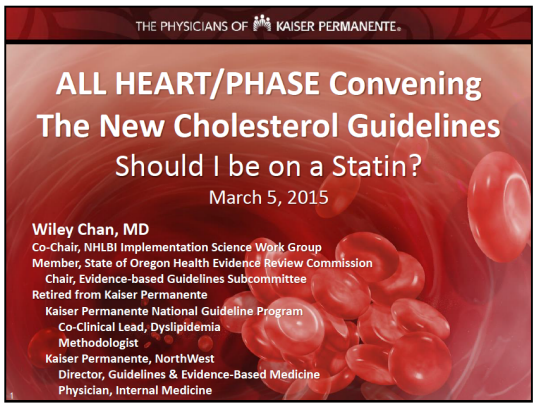
Morning Session 1
Evaluation Results

Q2 Session 1:ALL HEART/PHASE from Adopting Clinical Protocols to Advancing Value Based Care

Answered: 50 Skipped: 1



Answer Choices	Responses	
Excellent	52.00%	26
Good	44.00%	22
Fair	2.00%	1
Poor	0.00%	0
No Opinion	2.00%	1
Total		50



The New Cholesterol Guidelines: Should I be on a Statin?

Session Description:
Calculating the 10-Year ASCVD risk and implications for dyslipidemia treatment recommendations, including, why statins.

Panelists:

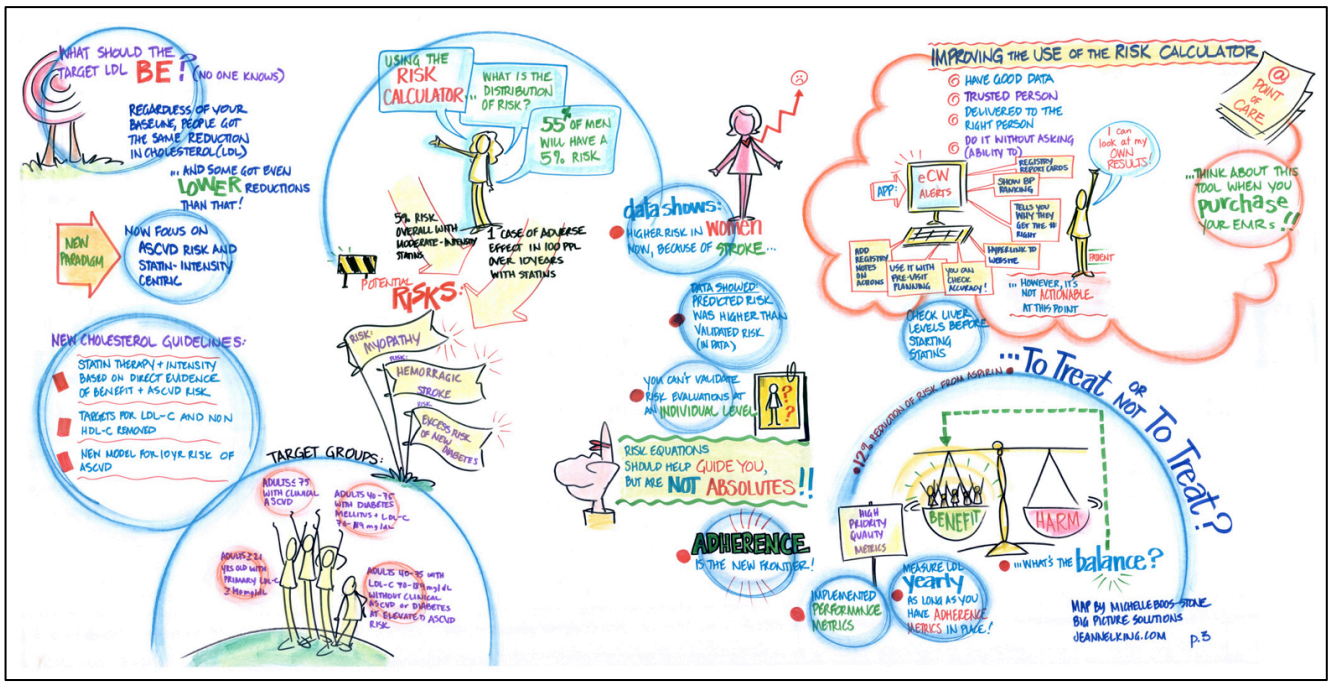
- Wiley Chan, MD, Director, Guidelines & Evidence-Based Medicine, NW Permanente
- Jim Schultz, MD, MBA, FAAFP, Chief Medical Officer, Neighborhood Healthcare

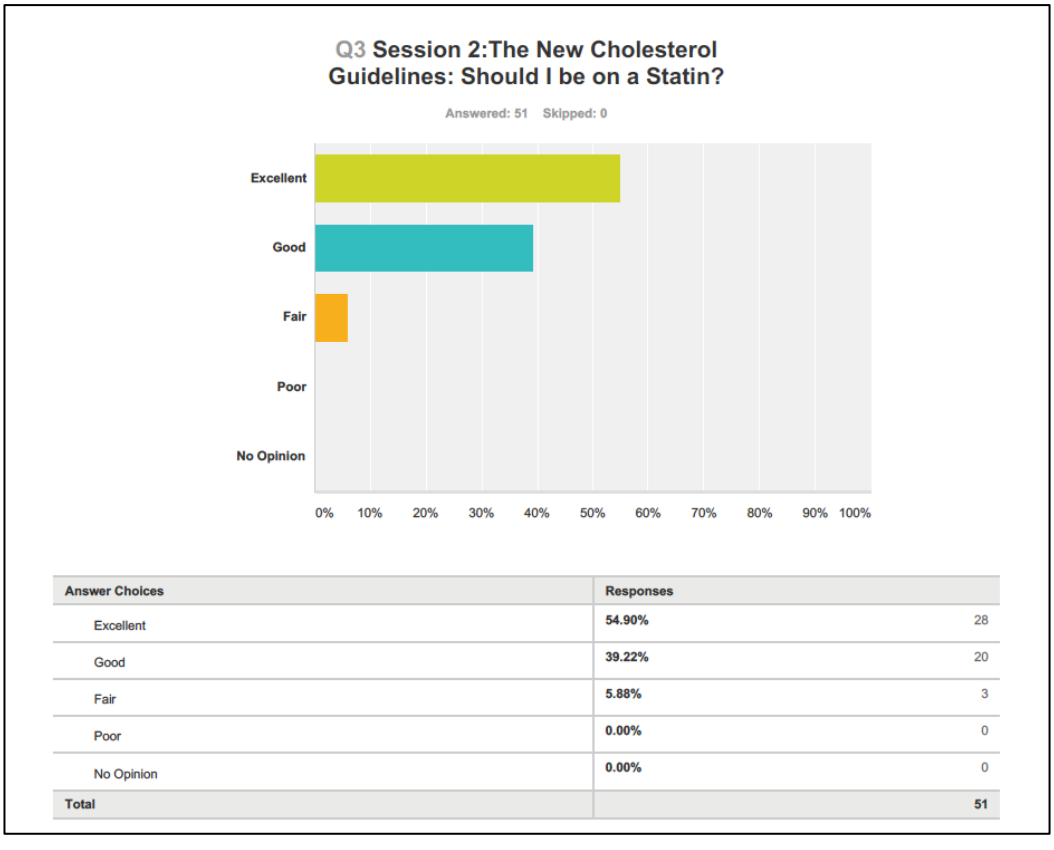
Moderator:

- R. James Dudl, MD, Clinical Advisor, Community Benefit and Diabetes Lead, Care Management Institute, Kaiser Permanente

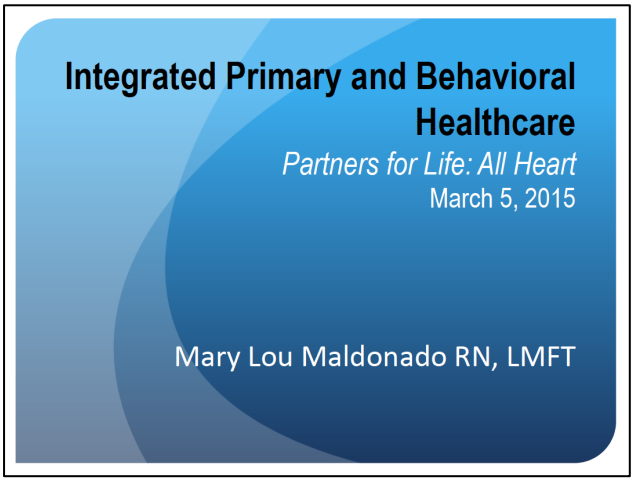
Dr. Wiley Chan

Morning Session 2
Graphic Art & Evaluation Results





Answer Choices	Responses	
Excellent	54.90%	28
Good	39.22%	20
Fair	5.88%	3
Poor	0.00%	0
No Opinion	0.00%	0
Total		51



Total Wellness – Addressing Behavioral Health as Part of Chronic Care Management

Session Description:

Integrating behavioral health consultants into the health care team.

Speaker:

- Mary Lou Maldonado, RN, LMFT, Clinician, La Maestra Community Health Centers

Moderator

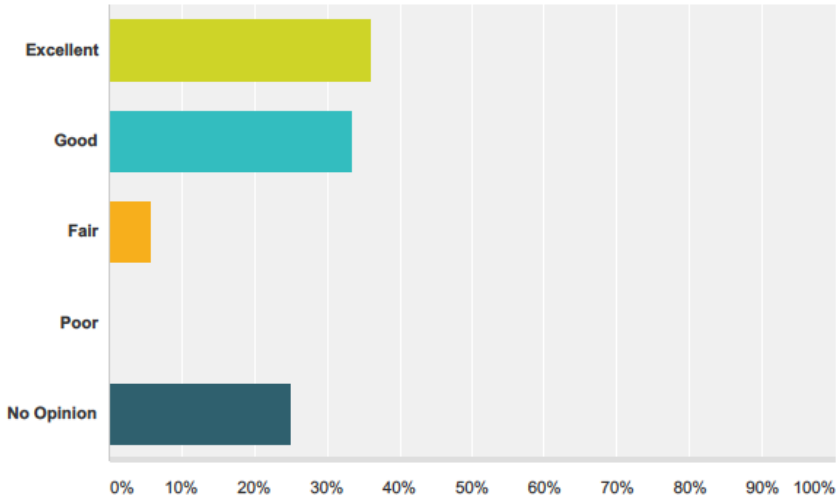
- Nicole Howard, MPH, Director of Programs and Fund Development, Community Clinics Health Network

Nicole Howard and Mary Lou Maldonado

Breakout Session 1
Evaluation Results

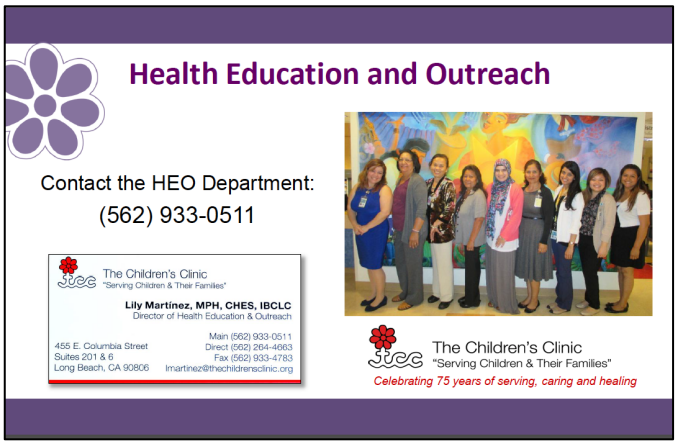
Q4 Session 3 - Breakout 1:Total Wellness - Addressing Behavioral Health as Part of Chronic Care Management

Answered: 36 Skipped: 15



Answer Choices	Responses	
Excellent	36.11%	13
Good	33.33%	12
Fair	5.56%	2
Poor	0.00%	0
No Opinion	25.00%	9
Total		36

Breakout Session 2



Documenting Efforts to Address Social Determinants of Health through Community to Clinic Integration

Session Description:

A panel discussion about HEAL zones and how local clinics are working with community organizations to encourage and incentivize underserved population to make health choices.

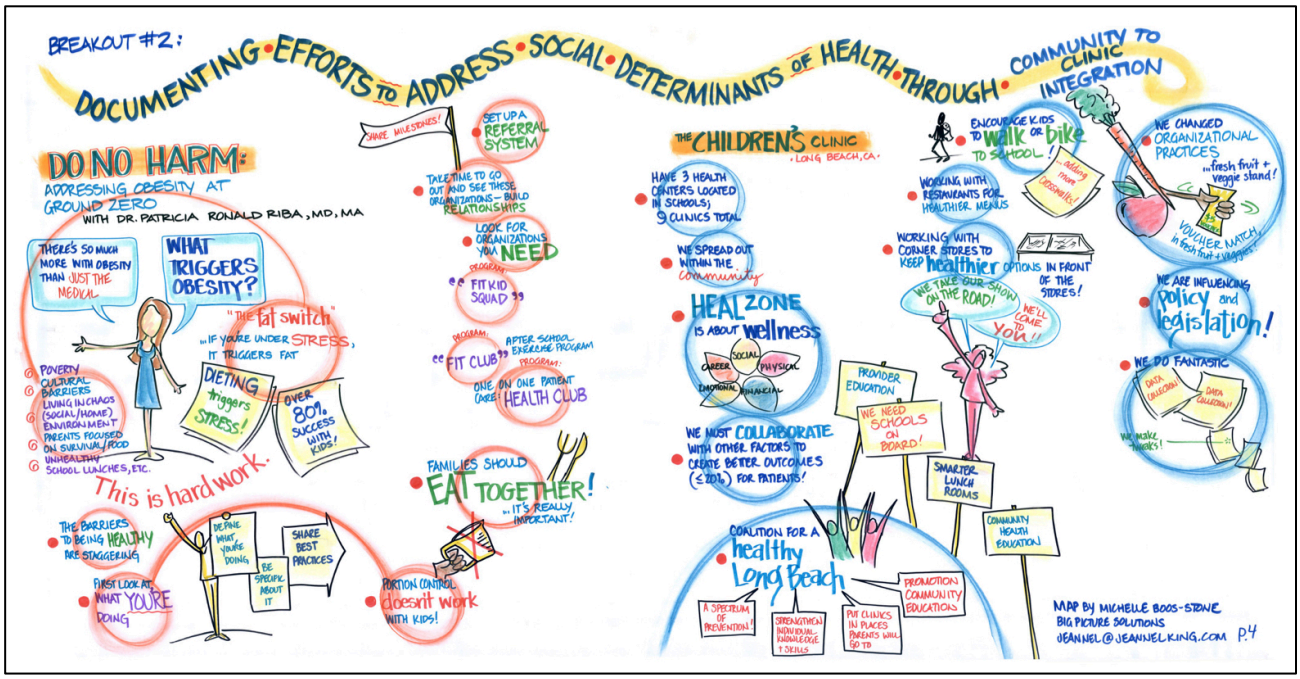
Panelists:

- Patricia A. Ronald Riba, MD, MA, Founder and Medical Director, Serving Kids Hope
- Lily Martínez, MPH, CHES, IBCLC, Director of Health Education and Outreach, The Children's Clinic

Moderator:

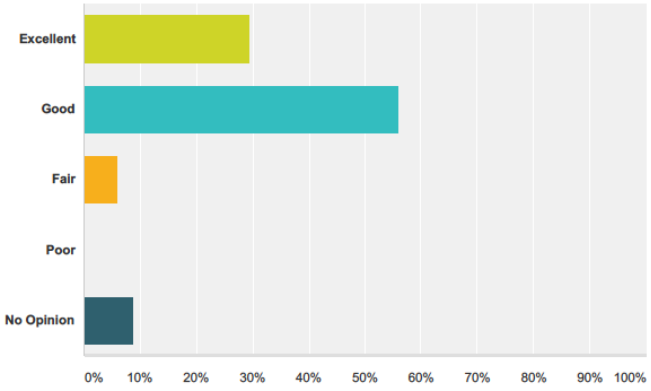
- Clara Steimberg, Project Manager, Community Benefit, Kaiser Permanente

Breakout Session 2
Graphic Art & Evaluation Results



Q5 Session 3 - Breakout 2:Documenting Efforts to Address Social Determinants of Health through Community to Clinic Integration

Answered: 34 Skipped: 17



Answer Choices	Responses	
Excellent	29.41%	10
Good	55.88%	19
Fair	5.88%	2
Poor	0.00%	0
No Opinion	8.82%	3
Total		34

New Opportunities to Address Racial, Ethnic and Gender Disparities

Session Description:

A panel discussion that will introduce some of the new research in the management of hypertension, starting with effective strategies to take, what works with improving medication adherence, and disparities with special populations.

Panelists:

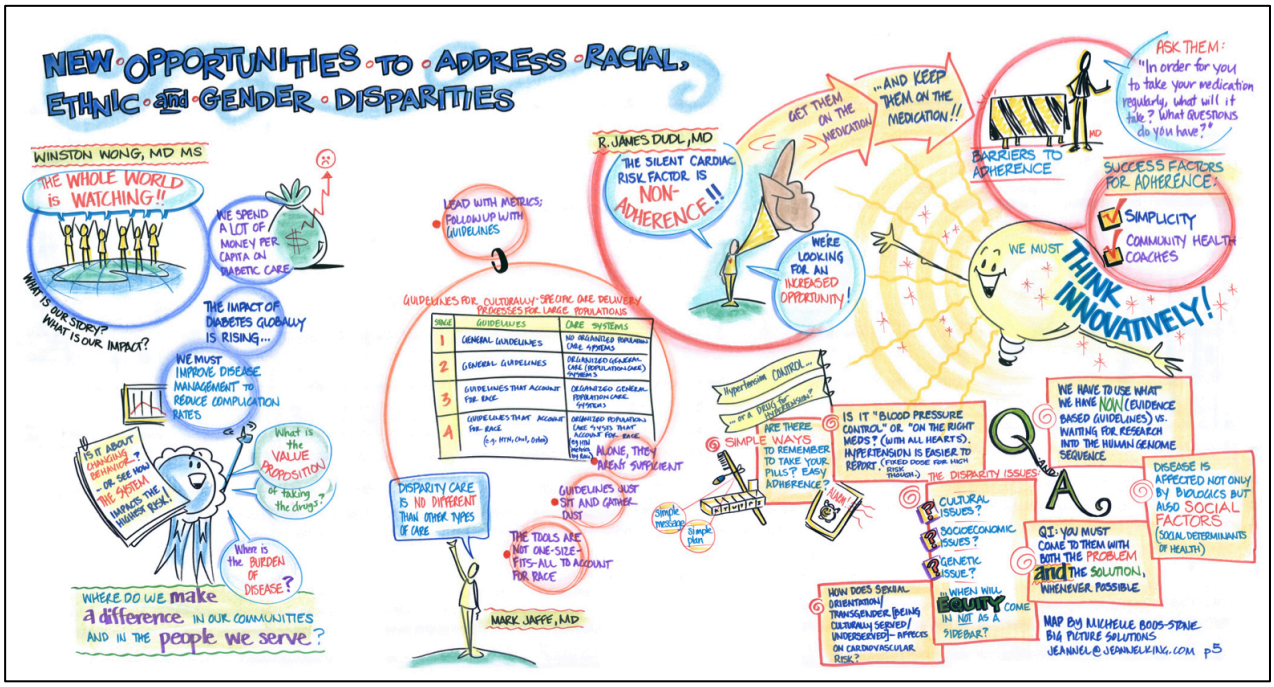
- R. James Dudl, MD, Clinical Advisor, Community Benefit and Diabetes Lead, Care Management Institute, Kaiser Permanente
- Marc Jaffe, MD, Clinical Leader, Kaiser Permanente Northern California Cardiovascular Risk Reduction (PHASE) Program
- Winston F. Wong, MD, MS, Medical Director, Community Benefit and Director, Disparities Improvement & Quality Initiatives, Kaiser Permanente

Moderator:

- Coralie Chan, MPH, Program Manager, National Community Benefit, Kaiser Permanente

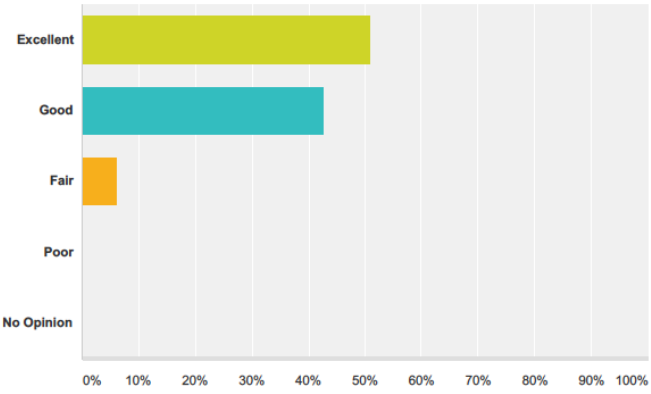
Dr. Jim Dudl

Afternoon Presentation
Graphic Art & Evaluation Results



Q6 Session 4:New Opportunities to Address Racial, Ethnic and Gender Disparities

Answered: 49 Skipped: 2



Answer Choices	Responses	
Excellent	51.02%	25
Good	42.86%	21
Fair	6.12%	3
Poor	0.00%	0
No Opinion	0.00%	0
Total		49

Closing Remarks

Winston F. Wong, MD, MS, Medical Director, Community Benefit and Director, Disparities Improvement & Quality Initiatives, Kaiser Permanente

What is one thing you learned at today's event that will help you in your daily work?

Responses
Approach to statin mgmt.
The importance of integrating primary care and mental health teams.
It (all information) was valuable.
Barriers
Number of barriers to consider when addressing adherence
As a behavioral health provider, the concept of the risk guidelines was new/useful. Appreciated the behavioral health presenter/presentation, but I would have like it to be more specific to heart disease/chronic disease management.
Great review of new statin guidelines. I will definitely be sharing the PowerPoint.
The work being done resources results & thoughts to culturally specific care delivery
Healthcare must be affordable in order for us to make on impact on CV Dx etc. to establish better healthcare & make a difference
Patient education and outreach measures
Great info, and great effort to engage participants
Work on simplicity to help providers and staff carry out population management easily and effectively.
Increase use of cardio-vascular risk calculator
Should put more emphasis on non-medical interventions
Infrastructure/social determinants of health are critical in the successful implementation of ALL HEART
Invest in interventional interviewing training for staff.
Important focus on ALL + HTN w/ focus on adherence and behavioral change
Food restriction as a strategy is counterproductive when addressing childhood obesity Adherence is the silent killer right now
- Rising importance of statins - Need to focus on med adherence
More time for lunch; Q&A
New cardio-vascular risk calculator
Define roles for care team
Engage the entire team!

What is one thing you learned at today's event that will help you in your daily work?

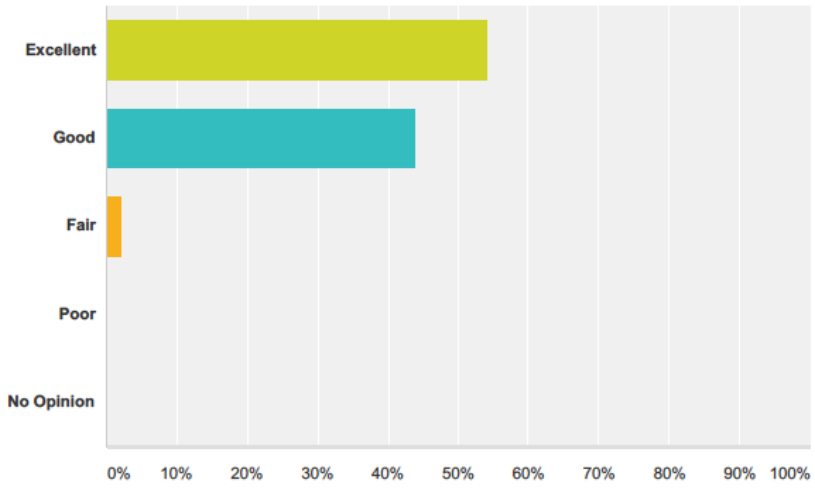
New cholesterol guidelines
The efforts amongst all the other attendees to work and improve our PI and what has worked for them and what we can apply in our organization.
Great topics I think the efforts to address social determinants was very useful
The challenge for behavioral health to change gears & work in primary care
Will prioritize development of i2i registry data that includes medication prescriptions
Need to continue focusing on impact / patient outcomes vs. process measures (Rx rate) Need to change communication about advancing value-based care vs. adopting clinical protocols.

^^ Statins
Integration of social determinants of health in identification of high risk pop'n.
The lipid guidelines
What best practices can be used for data to help out & identify risks of our patients.
Diabetes prevention CVD prevention
Simplicity - changing our system to help pts.
Focus on adherence
Ways to integrate primary care & behavioral health. New guidelines for cholesterol & statins.
The ability to have made new personal connections. I enjoyed being exposed to Dr. Patricia Reba's work and will be checking out her website.

How would you rate the event overall?

Q7 How would you rate the event overall?

Answered: 48 Skipped: 3



Answer Choices	Responses	
Excellent	54.17%	26
Good	43.75%	21
Fair	2.08%	1
Poor	0.00%	0
No Opinion	0.00%	0
Total		48

Additional Participant Comments

Simple adherence
Very interesting presentations! Thank you.
I think a break-out group re: practical strategies with other BH providers would have been more useful to me. Well organized; appreciate care to details & healthy options at lunch! *We should actively recruit more (any!) African-American staff to this project. Yea for the artist!
Thank you!
The team did a great job putting this seminar together
Loved Wiley Chan's presentation, very engaging Excellent ideas etc. from Dr. Riba on childhood obesity
- Artwork provided an interesting interlude that stayed relevant to the material at hand - Dr. Riba was a very engaging speaker and presented a lot of practice changing information that can be implemented in our clinics tomorrow and make a significant impact on patient health outcomes
Very helpful conference I recommend moving the artist further to the back / I loved her drawings but sometimes it was distracting
- All of this was interesting -- and I kept thinking how am I supposed to use it in my centers?
Excellent. Thank you!
Event was high yield -- inspiring, educational & invigorating. Next year, I would like to bring a much larger team from our health system and community partners to this meeting. Looking forward to ALL HEART / PHASE 3rd annual meeting next year! (Session 2 comment) Dr. Schultz was outstanding (rating was between Excellent and Good)
Too many speakers assumer the audience is doctors. Panel on disparities with 3 male doctors?? Winston comments sort of all over the place -- Dr. Jaffe mentioned black pts but only one addressed gender, ethnic or ones disparities.
Excellent event coordination and speakers! Thank you!
This was an excellent & informative event. I enjoyed the information & interaction.

Additional Participant Comments

This was an outstanding event. Working with other facilities similar to ours and having us together under one roof is an excellent way to assist in issues/measure we face and/or how to prepare/prevent..
(Breakout 2 comment) Both great speakers
- Great to hear best practices -- want to hear more from community clinics and have time for exchange in future - Appreciate inclusion of racial disparities
Very good convening. Well organized w/ relevant info. Perhaps for next year, encouragement to mingle.
Please have this next year.
Would be great to have some grantee specific breakouts to start collaborative learning process & introduction to leads who will facilitate these collaborate learning groups.
(Breakout 2 comment): More about how they reached out to community.
Really would love to have a conf. or committee on beh health & how to move forward with integrated care.
Great speaker choices. Very engaging.
Great conversation at the end I'd like to learn more what other grantees are doing -- maybe breakdown by EHR/other analytics tools. Also, please send contact list!
Excellent event! Good job staying on schedule.
The conference was well-structured. Lunch was great, also! Good networking!

"This was an outstanding event!"

"Please have this next year."

"Great conversations."

"Well organized with relevant info."

All Convening Handouts and Slides are Available Online

ALL HEART

A prescription for a heart healthy community

www.allhearthealth.org

A Program Of:

COMMUNITY CLINICS HEALTH NETWORK

Sole Funding Provided By:

KAISER PERMANENTE®