



Credit: FatCamera

# Population Health Learning Network (PHLN) Toolkit

TOOLS AND RESOURCES TO ALIGN POPULATION HEALTH MANAGEMENT STRATEGIES TOWARD VALUE-BASED CARE AND PAYMENT

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SPONSORS

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- Blue Shield of California Foundation
- California Health Care Foundation
- Dignity Health



Table of Contents

Introduction . . . . . 2

Background . . . . . 2

Value-Based Payment. . . . . 5

Learning Organizations . . . . . 7

Team-Based Care 2.0 . . . . . 12

Strategies to Enhance Access . . . . . 15

Behavioral Health Integration (BHI) . . . . . 18

Care Management for Complex Patients . . . . . 20

Social Needs . . . . . 22

Data & Analytics . . . . . 25

# Introduction

The Population Health Learning Network (PHLN) convened 25 safety net primary care organizations over the course of two years to learn, share, build, and refine care models and implement strategies to strengthen and advance their population health management (PHM) efforts. It was designed to improve the health and well-being of more than 1.2 million Californians.

This toolkit is a compilation of tools and resources shared over the course of this two-year program. They are intended to support others with PHM improvement efforts.

## Background

Historically, primary care has been designed to provide episodic care to individuals who booked appointments or needed time-sensitive care. Practices designed workflows and staffing models to address the medical needs of patients who made appointments and this care was delivered primarily through face-to-face encounters. Over the past two decades, a sea change swept through health care, forcing organizations to rethink—and reorganize—care for their patients and communities.

Rather than only the reactive care of the past, primary care is now also focused on proactively managing the health of a defined population of patients assigned to them. Recognizing that social determinants account for up to 80% of health outcomes, there is also a need to broaden the PHM lens to understand the social, political, and cultural context in which patients and their families live and to focus on providing whole person care.

Transitioning to this model requires a host of new strategies, skills, care team members, workflows, and technology use. Instead of waiting for a sick patient to make an appointment, staff now contact patients to come in to address gaps in care or to manage a chronic condition. And new care team roles are designed to support this and other functions. To provide more of a whole-person orientation, including addressing the non-medical factors that impact a person's health, care teams are forming community partnerships to address social needs, like with organizations that address food insecurity, housing, and legal issues.

Moving beyond the traditional office visit as the only mode of patient connection has also led to the use of email, phone, telehealth and other ways to connect patients to information and care. Finally, all these factors rely on the ability of a provider and care team to know who their patients are, what needs they have, the relative urgency of those needs, and what services would help. As such, effective use of data is essential to identify, segment, and appropriately respond to medical, behavioral, and social needs through effective care interventions.

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To support safety net clinics in making the care delivery changes needed to succeed in a value-based environment, CCI launched the PHLN in March 2018. This effort was supported by the California Health Care Foundation, Blue Shield of California Foundation, and Dignity Health. The PHLN focused on building capacity in eight core population health domains. To do so, the PHLN offered an array of learning opportunities, including:

### IN-PERSON CONVENINGS AND VIRTUAL SESSIONS

Participants attended three in-person learning sessions as well as optional virtual sessions. These activities focused on identifying and sharing best practices, lessons learned, and challenges advancing PHM.

### LEADING PROFOUND CHANGE WORKSHOPS & WEBINARS

Participants engaged in in-person workshops and virtual sessions to understand how to blend tools and mindsets from human-centered design and quality improvement in order to lead and sustain change at their organizations.

### SITE VISITS

Participants attended site visits to exemplary organizations, where hosts reviewed their organization's care team model, leadership structure, and PHM processes and systems. The structure of the site visits included small group discussions, clinic tours, and opportunities to interact with different members of the care team. Site visits locations included:

- Cambridge Health Alliance (Massachusetts)
- Cherokee Health Systems (Tennessee)
- Clinica Family Health (Colorado)
- La Clinica (Oregon)
- Petaluma Health Center (California)
- Southcentral Foundation (Alaska)

### COACHING

Participants were connected with a coach with an improvement science background or expertise in the core PHLN content domains. Monthly or as needed coaching calls helped to support teams in tracking progress in their PHLN goals.

In addition, teams were offered funds to implement a project in Year 2 of the PHLN. Funded projects addressed social needs, care team roles, behavioral health integration, patient outreach, data tools, and risk stratification.

### OUTCOMES

CCI engaged JSI California (JSI) as its evaluation partner. Surveys and in-depth interviews explored participants' experiences and perceptions of the value of support received and impact of the PHLN. Teams completed a baseline and endline capability assessment and submitted narrative reports and data on various measures to provide insight on changes in their PHM capabilities and progress toward desired outcomes over time.

## Highlights from the evaluation findings include:

There was a high level of engagement in and appreciation for the PHLN learning opportunities. Teams reported high satisfaction with the PHLN and emphasized that face-to-face learning, peer sharing, and coaching support were highlights of participation.

The PHLN's most significant contributions to transformation efforts included reinforcing PHM as a priority, equipping teams with concrete tools and information, and providing financial resources to advance a PHM project within their organization.

Teams reported improvement in many self-monitored measures. Anecdotal reports suggest that PHLN participation may have contributed to discrete improvements in patient and care team experience.

Based on capability assessment results, the majority of teams saw relative improvements in each PHM domain.

Although the onset of the COVID-19 pandemic disrupted normal operations, several teams reported that their organizations leveraged learnings and strategies developed through PHLN participation in their COVID-19 response.

## PHLN SITE VISITS

PHLN included site visits to organizations with mature approaches to PHM. We recap the major takeaways from each visit, documented in short "Reflections" articles authored by CCI staff. In addition, you will find resources these organizations shared throughout this toolkit.

## PHLN PARTICIPATING ORGANIZATIONS

Axis Community Health	Los Angeles LGBT Center	San Francisco Health Network
Bay Area Community Health (formerly Tri-City Health Center)	Native American Health Center	San Ysidro Health
Chapa-De Indian Health	Neighborhood Healthcare	Santa Barbara Neighborhood Clinics
CommuniCare Health Centers	North County Health Services	Santa Rosa Community Health
Community Medical Centers, Inc.	North East Medical Services	Serve the People Community Health Center
L.A. County Department of Health Services - Primary Care	Northeast Valley Health Corporation	Venice Family Clinic
La Clínica de La Raza	Open Door Community Health Centers	Venice Family Clinic
LifeLong Medical Care	Ravenswood Family Health Center	Vista Community Clinic
	Salud Para La Gente	Western Sierra Medical Clinic

<sup>1</sup> The purpose of the capacity assessment was to explore organizational capacity in core PHLN domains and to assess changes over time. The tool was organized into eight categories (learning organizations, team-based care, planned care and inreach, proactive outreach, behavioral health integration care management for complex patients, social needs, and data governance and analytics.) Within each, teams self-assessed the degree to which various facets were implemented within their system. The tool assessed things like clarity of team roles, use of care plans, panel assignments, risk stratification, and screening.



# Value-Based Payment

Value-based payment arrangements include mechanisms to hold health care providers accountable for the care they provide. Such arrangements typically focus on quality, cost, utilization, and/or patient experience. The benefits of value-based care extend to all facets of the health care system. This section provides resources to support organizations with changes that are central to moving from volume to value. They address transforming care models, coordinating across teams, and getting buy-in from staff and stakeholders.

## SLIDE PRESENTATION: CAPABILITIES NEEDED FOR VALUE-BASED CARE

The Center for Health Care Strategies outlines four capabilities to succeed in a value-based payment environment: (1) care models to manage complex patients; (2) data-driven decision making; (3) coordinating effectively with external providers and community-based organizations; and, (4) building internal and external support.

▶ [Click to view the PDF slides.](#)

## WEBINAR: VALUE-BASED PAYMENT MODELS

The Center for Health Care Strategies describes a range of value-based payment models implemented by community health centers, including key drivers and lessons learned as part of the implementation process.

▶ [Click to view the recording and slides.](#)

## SLIDE PRESENTATION: REFLECTION AND LOOKING AHEAD AT VALUE-BASED PAYMENT AND POPULATION HEALTH

Parinda Khatri, PhD, from Cherokee Health Systems, offers methods for organizations to lay the groundwork for transitioning to value-based payment by assessing their current state environment, preparing for change, and improving relationships. The presentation is organized around three elements: social and community factors (e.g., transportation, food security), collaboration and partnerships (e.g., team-based care, expanded workforce), and data (e.g., transparency, interoperability).

▶ [Click to view the PDF slides.](#)

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*The future is traditional primary care supplemented with telemedicine and alternative visit types. The only question is if we will be allowed to take part in that future by having access to payment models that support it. The more flexibility we have to meet the needs of our patients, the better population health we can provide.*

### BRIEF: ADVANCING PAYMENT INNOVATION WITHIN FQHCS: LESSONS FROM CALIFORNIA

This Center for Health Care Strategies brief provides insight into California's experience with a pilot program for federally qualified health centers testing an alternative payment arrangement. It documents the pilot development process, payment methodology, and key lessons to date.

▶ [Click to view the PDF.](#)

### SLIDE PRESENTATION: PARTNERSHIPS WITH OUR PAYORS

La Clinica, a system of federally qualified health centers in Oregon, describes their work with Coordinated Care Organizations, the experience on the journey from volume to value, and how to assess readiness for payment reform (using a model developed by the National Association of Community Health Centers).

▶ [Click to view the PDF slides.](#)



Credit: SDI Productions



Southcentral Foundation wall hanging image from CCI site visit.

## SOUTHCENTRAL FOUNDATION

The Southcentral Foundation (SCF) is located in Alaska and provides a range of health and wellness services to Alaska Native and American Indian people. SCF gained acclaim for its work in transforming all aspects of their organization. They consider patients to be “customer-owners” and view this shift in thinking as critical to empowering and activating patients to make informed decisions about their care.

SCF isn't only focused on patients, however. They also invest in staff, carving out time from clinical care so that care team members can meet and discuss changes in their practice. View SCF through Diana Nguyen's eyes in her Reflections article.

▶ [Click to view webpage article.](#)

# Learning Organizations

Learning organizations use a systems approach to develop concrete processes that support individual and team learning and improvement. This section includes resources to develop that systems approach. It includes tools that provide insight into conceptual issues (e.g., technical versus adaptive change) and also blend human-centered design and quality improvement methodologies to help communicate early and often about change initiatives, build a culture of improvement, and support team functioning. Resources are organized into three subsections: Organizational Culture; Change Management; and, Communicating, Spreading, and Sustaining Change.

## Organizational Culture

Organizational culture can be seen as a set of shared assumptions about an organization's mission, priorities, structure, and day-to-day work. These assumptions--often unspoken--impact the ways in which people view their role and undertake their work. This section offers insight into key aspects of the organizational culture at two safety net systems, Southcentral Foundation and Petaluma Health Center. Learn how they manage the change process, engage staff and patients to prioritize areas for improvement, and assess the success of their efforts.

### SLIDE PRESENTATION: SOUTHCENTRAL FOUNDATION OVERVIEW – NUKA SYSTEM OF CARE

This presentation introduces the “change everything” strategy used by Southcentral Foundation. Their organizational transformation included transitioning to customer ownership, establishing leadership and operational principles, creating a new organizational and functional committee structure, and redesigning care. The result? Improved employee and patient satisfaction and reductions in emergency department and inpatient utilization.

▶ [Click to view the PDF slides.](#)

### SLIDE PRESENTATION: WHAT IT MEANS TO BE A LEARNING ORGANIZATION

Learn the tools and systems Southcentral Foundation uses to facilitate change, including the methods to support staff during times of transition.

▶ [Click to view the PDF slides.](#)

### SLIDE PRESENTATION: HUMAN RESOURCES: RELATIONSHIP-BASED HUMAN RESOURCES

Explore Southcentral Foundation's relationship-based approach to staffing and methods for performance management.

▶ [Click to view the PDF slides.](#)



**SLIDE PRESENTATION: LEADERSHIP DECISION MAKING AND THE FUTURE**

Collaboration, innovation, and excellence at all levels of the organization can create a solid structure that makes it possible to go from “great idea” to best practice. Petaluma Health Center shares their approach to change, decision-making, and engagement.

▶ [Click to view the PDF slides.](#)

## Change Management

Change management is an approach to address the intellectual and emotional aspects of small or large transitions. Through the PHLN and in collaboration with Christi Zuber, PhD (Founder and Managing Director of Aspen Labs), CCI introduced Leading Profound Change. It explores how Lean, Human Centered Design, and the Model for Improvement work together to create and manage change. This section includes resources from Leading Profound Change workshops and webinars, including both strategic considerations and practical tools (e.g., worksheets, templates). It also includes presentations about change management processes from La Clinica and Petaluma Health Center.

**WEBINAR: LEADING PROFOUND CHANGE**

Christi Zuber, PhD and Debbie Rosen, Director of Quality and Health Education at Northeast Valley Health Corporation, describe how to combine quality improvement and human-centered design to manage change. The webinar also introduces the Leading Profound Change framework.

▶ [Click to view recording and slides.](#)

**WEBINAR: BRAINSTORMING TECHNIQUES FOR LEADING PROFOUND CHANGE**

Want to take brainstorming to the next level? This webinar introduces techniques to stretch creative ideas, get input, sort through the chaos of ideas, and prepare for action.

▶ [Click to view recording and slides.](#)

**WEBINAR: JOURNEY MAPPING FOR LEADING PROFOUND CHANGE**

Presenters introduce journey mapping as a tool to gain empathy for the stakeholder experience and improve stakeholder collaboration.

▶ [Click to view recording and slides.](#)

**HANDOUT: METHODS OF PROFOUND CHANGE**

Understand quality improvement and human-centered design methods and tools that facilitate change.

▶ [Click to view PDF.](#)

**BOOKLET: LEADING PROFOUND CHANGE METHODS**

Get tips on capturing and planning for a change or innovation effort, including how to communicate your initiative.

▶ [Click to view PDF.](#)

**EXERCISES: CHANGE AGENT CRASH COURSE**

Use this compendium of exercises to push an organization’s thinking on how to lead change and launch change efforts forward. It includes templates for storyboard creation, empathy mapping, identification of “echoes and blindspots” and more.

▶ [Click to view PDF.](#)



Credit: whyframestudio

### WEBINAR AND WORKSHEET: PDSAS FOR LEADING PROFOUND CHANGE

Individuals who are new to conducting Plan-Do-Study-Act (PDSA) cycles or those desiring a refresher can use listen to the webinar or review the slides to learn how to effectively design and test changes. Use the PDSA Cycles Tracker worksheet to log each change and its outcome.

- ▶ [Click to view recording and slides.](#)
- ▶ [Click to view PDF Cycles Tracker worksheet](#)
- ▶ [Click to download Cycle Tracker worksheet in Word.](#)

### WEBINAR AND WORKSHEET: PROTOTYPING FOR LEADING PROFOUND CHANGE

Looking for a creative way to share ideas and gain feedback early? Learn more about prototyping tools and how to use them to quickly test ideas and gather stakeholder input. Use the prompts in the prototyping worksheet to begin designing your own.

- ▶ [Click to view recording and slides.](#)
- ▶ [Click to view worksheet PDF.](#)

### WEBINAR: LEVERAGING MULTIPLE TOOLS FROM LEADING PROFOUND CHANGE METHODS

Presenters review the Leading Profound Change framework and describe how the framework can be used to improve staff engagement.

- ▶ [Click to view recording and slides.](#)

### SLIDE PRESENTATION AND TOOL: EASE IN CHANGE – CHANGE MANAGEMENT AND PROJECT PLANNING

La Clinica introduces the Ease in Change planning tool, designed to help staff think through change using five steps: explore, engage, examine, execute, and ensure excellence.

- ▶ [Click to view PDF slides.](#)
- ▶ [Click to view PDF tool.](#)

### SLIDE PRESENTATION: QUALITY IMPROVEMENT PROGRAM

Petaluma Health Center describes their quality improvement program. Keys to improvement include using prioritization and goal setting, maintaining a reporting schedule, and making room for flexibility.

- ▶ [Click to view PDF slides.](#)

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*The importance of sharing with others doing the same type of work is even more important and relevant [since COVID-19]. Everyone is figuring out how to do the work in a new way.*

**IHI QUALITY IMPROVEMENT TOOL: DRIVER DIAGRAM**

A driver diagram reflects a team's theory of what contributes to ("drives") the achievement of a project aim. This method is a useful tool to communicate to both internal and external stakeholders about priorities, change areas, and activities that will likely lead to the desired goal.

[▶ Click to view PDF](#)

## Communicating, Spreading, and Sustaining Change

Effectively communicating change is critical to successful implementation. The tools in this section will help shape messages for staff and stakeholders, determine the best communication channels, and sustain and spread population health initiatives.

**SLIDE PRESENTATION: SPREADING AND SUSTAINING POPULATION HEALTH INNOVATIONS**

Learn from Carolyn Shepherd, MD, about the domains that are essential to executing your vision for population health. Dr. Shepherd addresses communication, infrastructure, measurement, and leadership engagement.

[▶ Click to view PDF slides.](#)

**WHITE PAPER: IHI SUSTAINING IMPROVEMENT**

The framework presented in this IHI report demonstrates how healthcare organizations can use sustained improvements to support the safety, effectiveness, and efficiency of patient care. IHI focuses on the daily work of frontline managers who are supported by a high-performance management system. That system that uses standard tasks and responsibilities for managers at all levels of the organization.

[▶ Click to view PDF.](#)

**WORKSHEET AND EXAMPLE: KEY MESSAGES FOR STAFF**

From Armstroff Consulting, this template helps leaders translate change concepts into more accessible and specific messages for staff. It helps leaders communicate why a change is needed, the work required to make the change, and why others should care about the change. View an example of a completed template designed for a social needs project.

[▶ Click to view PDF key messages template](#)

[▶ Click to download key messages template in Word](#)

[▶ Click to view completed template PDF.](#)

“

*I think the improvements we made were definitely in part due to the work with the PHLN....[it] gave us the tools and time needed to make these infrastructure changes.*

**WORKSHEET: SUSTAINING PHLN INNOVATIONS—MONITORING KEY ORGANIZATIONAL AREAS**

Adapted from the Heart of Change Field Guide, this worksheet can help organizations understand what is needed to sustain population health innovations.

▶ [Click to view PDF.](#)

▶ [Click to download Word.](#)

**COMMUNICATION ASSESSMENT TEMPLATE: SPREAD AND SUSTAINING CHANGE - AUDIENCE**

Adapted from the Heart of Change Field Guide, use this template to understand who and how to communicate about changes in order to sustain population health innovations.

▶ [Click to view PDF.](#)

▶ [Click to download Word.](#)

**TIP SHEET: COMMUNICATING THROUGH VIDEO**

Learn more about how to film a video on a smartphone, including tips for sound, lighting, permissions, and getting extra footage for interspersing.

▶ [Click to view PDF.](#)



# Team-Based Care 2.0

Team-based care involves the delivery of health care by multiple individuals who work collaboratively amongst themselves and with patients. Team-Based Care 2.0 builds on this foundational concept by introducing experimentation with and expansion of care team roles and methods to promote cross-team communication. This section takes a deep dive into care team composition and thinking about what functions will enhance capabilities around population health. Resources are organized into three subsections: Care Team Models; Care Team Roles; and, Team Communication.

## Care Team Models

Care team models are typically designed to tap into the multidisciplinary skills and insights of its members, where the whole team coordinates activities for the well-being of the patient. This section includes presentations that describe team structures, roles and competencies to meet the demands of population health management.

### SLIDE PRESENTATION: GETTING TO THE TEMPLATE OF THE FUTURE CARE TEAMS 2.0

Dr. Carolyn Shepherd reviews Team-based Care 1.0 and describes significant attributes of high value practices for Team-based Care 2.0, getting to the template of the future.

▶ [Click to view PDF slides.](#)

### SLIDE PRESENTATION: EFFECTIVE STRATEGIES FOR TEAM-BASED CARE

Cambridge Health Alliance offers strategies to create a strong team culture, define the role of each team member, provide ongoing staff training, support individual development, and sustain team dynamics.

▶ [Click to view PDF.](#)

### GRAPHIC: CARE TEAM STRUCTURE

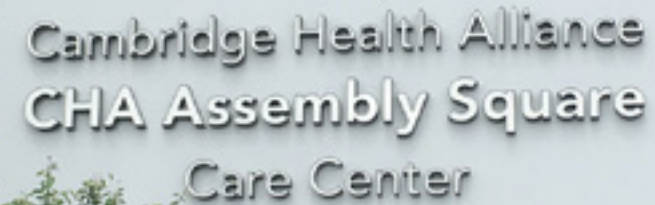
This graphic represents the care team structure at the Los Angeles LGBT Center. It includes staffing ratios for the core team and case management staff.

▶ [Click to view PDF slides.](#)

### SLIDE PRESENTATION: CARE TEAMS AND POPULATION HEALTH

La Clinica describes how their leadership and care teams are structured to manage population health. It also includes staffing ratios.

▶ [Click to view PDF slides.](#)



## Cambridge Health Alliance CHA Assembly Square Care Center

### CAMBRIDGE HEALTH ALLIANCE

Located in Massachusetts, Cambridge Health Alliance (CHA) is a system of hospitals and health centers that cares for approximately 140,000 patients. Clinics in the CHA system have core teams that include a physician, physician assistant, nurse, MA, receptionist and licensed practical nurse. When they added a physician assistant to the team, they were able to grow their panel size, almost tripling the number of patients they could serve. PHM is the responsibility of the core teams at each site, and daily core team huddles facilitate this work.

CHA also considers their 18 pharmacists and three pharmacy technicians as care extenders, using their experience as medication specialists to offer drug therapy monitoring, individualized drug therapy counseling, and chronic disease management. Learn more about the site visit in this Reflections article by Tammy Fisher.

▶ [Click to view webpage article.](#)



**SLIDE PRESENTATION: CHEROKEE HEALTH SYSTEMS' CLINICAL MODEL OF INTEGRATION**

Cherokee Health Systems offers insight into their integrated care team model, care team composition and roles, approaches to communication, and care processes.

▶ [Click to view PDF slides.](#)

**SLIDE PRESENTATION: SOUTHCENTRAL FOUNDATION INTEGRATED CARE TEAMS**

Southcentral Foundation shares how they use an integrated care team to manage workflow and customer-owner panels and actively examines segmentation of high utilizers to optimize resources.

▶ [Click to view PDF.](#)

**SLIDE PRESENTATION: PETALUMA HEALTH CENTER CARE TEAMS**

Petaluma Health Center's presentation describes the family medicine care team and shared resources that streamline patient care.

▶ [Click to view PDF slides.](#)

**HANDOUT: RICHMOND ENGAGEMENT AND COMMUNITY HEALTH (REACH) TEAM DESCRIPTION AND CARE TEAM ROLES**

This two-pager summarizes the care team for the REaCH program, which sought to reduce health care utilization for a subset of at-risk patients. The project used community, home-based, and clinic-based interventions, as well as a multidisciplinary care team.

▶ [Click to view PDF slides.](#)

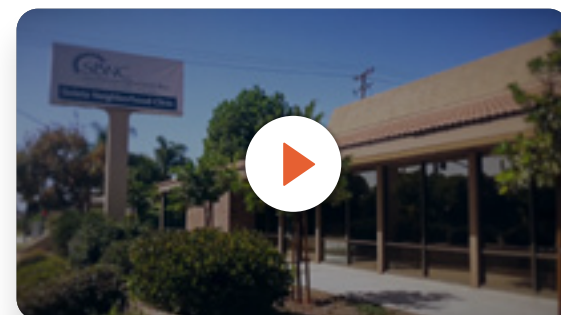
## Care Team Roles

Defining who is part of the care team and their specific responsibilities is a crucial component of high-performing teams. There are many considerations in thinking through the types of roles to include and how these roles work together. This section includes examples of and guidelines for how organizations define team roles and leverage the expertise of staff.

**VIDEO: PANEL MANAGER ROLES AT SANTA BARBARA NEIGHBORHOOD CLINICS**

This video shows how Santa Barbara Neighborhood Clinics recruited and integrated Registered Nurses as Panel Managers. Panel Managers work closely with Medical Assistants (MAs) and focus on specific conditions (e.g., diabetes) to improve the patient's care.

▶ [Click to view video.](#)



**GUIDELINES: THE NURSING AND CASE MANAGEMENT DEPARTMENT TEAM**

Petaluma Health Center's guidelines describe the roles of the nursing team, case management, and patient navigators. Guidelines include information about the specific patient needs that each department meets and how these roles benefit the care team and clinic.

▶ [Click to view PDF.](#)

**COMPETENCIES CHECKLIST: MA AND LEAD MA TRAINER**

This competency assessment tool is used by La Clínica de La Raza to define the skill level of trainers tasked with supporting Medical Assistants. It can also be used for orientation, training, to evaluate success, and to identify areas for improvement.

▶ [Click to view PDF.](#)

**CASE STUDY: REDEFINING CARE TEAM ROLES TO IMPROVE COLORECTAL CANCER SCREENING**

PHLN participant, Los Angeles LGBT Center, wanted to improve the rates of screening for colorectal cancer. To achieve this goal, they restructured their care team to improve efficiency and accountability. Among other changes, they added a "Flow Facilitator" to the care team and adapted the role of the Licensed Vocational Nurse Care Coordinator. Learn more about their work in this CCI case study.

▶ [Click to view webpage.](#)

## Team Communication

Effective communication and feedback are key to building and maintaining trust among teams. It is also foundational to developing consensus and resolving conflict. This section includes planning and feedback tools to improve engagement with staff and increase team cohesion.

**FEEDBACK TOOL: CULTURE OF GLOWS & GROWS**

Use this tool from La Clínica de La Raza to train staff how to provide feedback using GLOWS (e.g., praise, affirmation, positive reinforcement) and GROWS (e.g., what can be done differently).

▶ [Click to view PDF.](#)

**FEEDBACK TOOL: FAVORITE FORMS OF FEEDBACK & TEAMLET AGREEMENTS WORKSHEET**

Use this tool to train staff on giving and receiving feedback.

▶ [Click to view PDF.](#)

“

*I think that the work we have done building up our population health infrastructure is serving us well in this unprecedented time. When our patients stopped calling us, we were ready to start calling them.*

Credit: sturti

# Strategies to Enhance Access

An essential part of population health management is ensuring that patients can access care when and where they need it. Creating sufficient access is predicated upon understanding your patient population and their needs, the needs of your community, and options for care that meet the patient where they are. This section outlines strategies that enable efficient inreach and outreach while leveraging technology to improve availability, efficiency, and outcomes. Resources are organized into three subsections: Inreach, Outreach and Planned Care; Advanced Access; and, Alternative Visits.

## Inreach, Outreach, and Planned Care

A tenet of population health management is providing patients with the evidence-based care that they need, including routine preventive care and management of chronic conditions. Teams must also communicate, through huddles and other channels, to ensure nothing is missed. This section includes tools to help teams identify and meet patient needs and proactively communicate with patients about these needs, including when there is a gap in care.

### SLIDE PRESENTATION: PLANNED CARE, POPULATION MANAGEMENT, AND DATA MANAGEMENT

Petaluma Health Center describes their approach to planned care and maximizing the use of technology, including risk stratification, data mining, and care team alerts.

▶ [Click to view PDF slides.](#)

### HANDOUT: OUTREACH/INREACH ACTIVITY MATRIX

This handout from Community Medical Centers lists roles and responsibilities for inreach and outreach teams. appointments.

▶ [Click to view PDF slides.](#)

**PLANNED CARE:** [Dr. Carolyn Shepherd](#) defines planned care as organized, patient focused care that is based on scientific evidence, planned in advance of the visit and delivered so that the team optimizes the health of every person on their panel.

**INREACH:** Communications and work with existing patients who are already assigned to a provider's panel.

**OUTREACH:** Communications designed either to engage patients who are assigned to the clinic but may have fallen out of care, or to engage patients who are new to the clinic.

“

*In the past few months, we have gotten more positive feedback from patients than I've seen in my five years here...not just from the patient surveys, but patients sending in letters or going on Yelp. There just seems to be a lot of kudos to our staff. One patient said, "I got the type of care that I would never have imagined and I just can't say enough about your organization."*

**SCRIPT: PRIMARY CARE PROVIDER VISIT CALL SCRIPT FOR PEDIATRIC CARE**

This script can be adapted or used to make outreach calls to schedule patient appointments.

▶ [Click to view PDF.](#)

**PLANNING TOOL: HUDDLES**

The Los Angeles LGBT Center uses this tool to plan their daily 15-minute huddle among their core care team, specialty care, and case management.

▶ [Click to view PDF.](#)

**PLANNING TOOL: PRE-VISIT PLANNING & HUDDLES**

Neighborhood Healthcare shared their huddle planning tool for the day before and day-of the patient visit.

▶ [Click to view PDF.](#)

## Advanced Access

Sometimes referred to as open access or same-day appointments, advanced access scheduling is a method of ensuring timely access to care for patients. In an advanced access model, patients can typically access both routine and urgent care on the same day it is needed. This section includes resources to learn more about the implementation of advanced access at Lifelong Medical Care and Chapa-De Indian Health.

**WEBINAR: OPEN ACCESS**

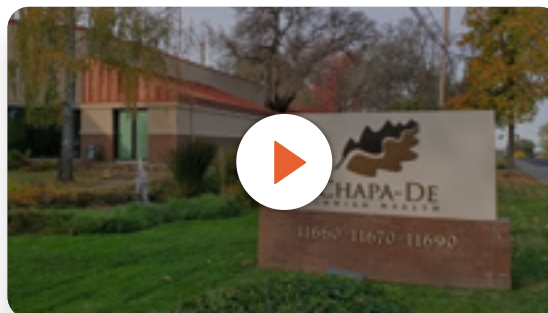
LifeLong Medical Care discusses their work on open access scheduling. They define their approach to open access across eight clinics, share a sample scheduling template, and associated improvements (e.g., increases in the number of new patients seen, reductions in no show rate).

▶ [Click to view recording and slides.](#)

**VIDEO: ADVANCED ACCESS SCHEDULING AT CHAPA-DE INDIAN HEALTH**

Chapa-De Indian Health introduces the concept of advanced access scheduling to reduce wait times for appointments and improve the continuity of care.

▶ [Click to view video.](#)



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*We're doing advanced access scheduling, which we weren't doing before. And it's completely because of our involvement in PHLN.*



## Alternative Visits

Providing care via telehealth or through shared medical appointments are two alternatives to the traditional in-person encounter between patient and clinician. This section includes examples of how technology-enabled care and group visits can be used to expand the capacity of a health center to meet patient's needs.

### SLIDE PRESENTATION: USING TECHNOLOGY AND ALTERNATIVE VISITS TO EXPAND ACCESS AND CARE

Petaluma Health Center shares how they use technology and alternative visits to expand capacity beyond traditional clinic-based appointments. This enables team members to work at the top of their license and spend more time managing chronic diseases.

▶ [Click to view PDF slides.](#)

### CURRICULUM: DIABETES GROUP VISITS CURRICULUM

This guide from Serve the People provides information about the mission and vision of group medical visits, including the powerful effect on patient buy-in and outcomes.

▶ [Click to view PDF.](#)

### WORKSHEETS: GROUP VISIT FLOW TEMPLATES

This worksheet enables teams to document staff roles and responsibilities for group visits, including designating which staff are involved in group visits and the time required. An annotated version of the worksheet provides more guidance as to how to complete the form.

▶ [Click to view PDF.](#)

▶ [Click to view annotated worksheet PDF.](#)



# Behavioral Health Integration (BHI)

Behavioral health integration is an umbrella term for efforts to harmonize the delivery of physical, mental, and substance use disorder care. The goal is to understand a patient's needs using a whole-person orientation. BHI can also increase efficiency, improve overall health outcomes, and enhance patient experience. Resources in this section offer insight in the various approaches to BHI and ways to leverage technology to support integration efforts. Resources are organized into two subsections: Integration Strategies and Behavioral Health Registries.

## Integration Strategies

A number of factors influence the way organizations integrate physical and behavioral health, including staffing model, patient population, physical plan, and health plan contracts. Resources in this section offer insight into the various models for BHI and effective integration strategies.

### SLIDE PRESENTATION: INTRODUCTION TO BEHAVIORAL HEALTH INTEGRATION

Southcentral Foundation defines various behavioral health integration models, including the evolution of BHI within their organization. They also explain brief intervention and standard screening tools used for diagnosis.

▶ [Click to view PDF slides.](#)

### SLIDE PRESENTATION: SCREENING AND MEASUREMENT-BASED CARE

Lori Raney, MD, outlines considerations for strengthening integrated behavioral health. Her presentation describes the principles of integrated care, sample workflows, processes for measurement-based care, the role of behavioral health care managers, referrals to higher levels of care, and process and outcome measures.

▶ [Click to view PDF.](#)

### HANDOUT: STRATEGIES TO GAIN PCP BUY-IN FOR INTEGRATED CARE

This handout can serve as a guide to getting buy-in at multiple levels of an organization. This buy-in is vital to achieving effective and efficient integrated care.

▶ [Click to view PDF.](#)

### WORKFLOW: BEHAVIORAL HEALTH INTEGRATION PATIENT INTAKE AND ASSESSMENT

This workflow shows how Office Specialists, Medical Assistants, Primary Care Providers, and Behavioral Health Providers work together to provide integrated primary care.

▶ [Click to view PDF.](#)

### WORKSHEET: COLLABORATIVE CARE GAP ANALYSIS TEAM EXERCISE

Health Management Associates offers this worksheet to help organizations determine progress with behavioral health integration, as well as strengths and weaknesses.

▶ [Click to view PDF.](#)

▶ [Click to download Word.](#)

**SLIDE PRESENTATION: STRATEGIES FOR EFFECTIVE BEHAVIORAL HEALTH INTEGRATION**

Dr. Raney describes the steps to effectively integrate behavioral health, including task sharing, care team design, use screening tools, registry use, and provider/staff buy-in.

▶ [Click to view PDF slides.](#)

**SURVEY: BEHAVIORAL HEALTH PROVIDER READINESS**

Open Door Community Health Center designed this tool to better understand behavioral health providers readiness for integration. It includes questions about competencies in various behavioral health modalities, confidence in treating patients with behavioral health conditions, alignment with primary care, and other issues.

▶ [Click to view PDF slides.](#)

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*(The PHLN) has helped to better integrate our department in terms of pediatrics and behavioral health, now that we have team members in both departments. Providers are more comfortable contacting the behavioral health department, and behavioral health is more comfortable and aware of who is participating as a peds provider. When we get a referral or transfer of a patient, behavioral health providers aren't thrown off.*

## Behavioral Health Registries

Registries are databases of patient information that are commonly used to track patient progress. They are typically associated with a specific condition or disease, like diabetes or cancer. These electronic platforms can be just as useful in behavioral health as they are in primary care. The tools in this section provide more insight into the implementation and use of a behavioral health registry.

**CASE STUDY AND HANDOUT: AXIS COMMUNITY HEALTH**

As part of its work in the PHLN, Axis Community Health wanted to improve its behavioral health data infrastructure to better track patient outcomes, adjust treatment, and provide quality care. This case study describes the registry they created, key changes, and outcomes. Axis also created a one-page summary of their registry that defines its purpose, patient inclusion criteria, and use cases.

▶ [Click to view case study webpage.](#)

▶ [Click to view one-page registry summary PDF.](#)

**ACTIVITY: REGISTRY REVIEW EXERCISE**

The AIMS Center designed an exercise to assist clinics with improving their registries. It includes a sample registry report along with discussion questions (e.g., what patients are not engaging in care).

▶ [Click to view PDF.](#)

# Care Management for Complex Patients

Care management is an umbrella term for support provided to patients and families in order to improve their health and reduce the likelihood that a condition may worsen. Care management is designed around the needs of specific populations and offers support according to the intensity of those needs. Services typically include the development of a care plan, medication management, patient activation, and care coordination. Resources in this section offer insights into effective care management and how to deploy care management resources to those who will derive the most benefit. Resources are organized into two subsections: Care Management Strategies and Risk Stratification.

## Care Management Strategies

Designing a care management strategy relies on an in-depth understanding of your patient population and their specific needs. This section provides insight into a number of ways that organizations can evaluate these needs and design services accordingly.

### SLIDE PRESENTATION AND FRAMEWORK: TAILORING CARE: DELIVERING THE RIGHT CARE TO THE RIGHT PATIENTS

Central City Concern summarizes the value of population segmentation and approaches to advanced care management for high-need subpopulations. Central City Concern also created a patient segmentation framework that depicts patient complexity.

- ▶ [Click to view slides.](#)
- ▶ [Click to view PDF framework.](#)

### SLIDE PRESENTATION: POPULATION HEALTH MANAGEMENT & CARE COORDINATION

Cherokee Health Systems describes their approach to care coordination, including the responsibilities of care team members, methods to coordinate (e.g., patient dashboard, morning huddle), and a sample care team report.

- ▶ [Click to view PDF slides.](#)

### SLIDE PRESENTATION: COMPLEX CARE MANAGEMENT: A DIABETES CASE STUDY

Oregon Health Sciences University presents the experience of their Richmond Clinic in implementing complex multidisciplinary care management and designing an innovative care team structure to manage diabetes care.

- ▶ [Click to view PDF slides.](#)



Site visit to Cherokee Health Systems.

## CHEROKEE HEALTH SYSTEMS

Headquartered in Knoxville, Tennessee, Cherokee Health Systems is known for their integration of primary care and behavioral health. Central to their model is a care team consisting of both primary care providers and behaviorists. Integration is so ingrained in their culture that Cherokee Health Systems guarantees access to behavioral health expertise “wherever behavioral problems show up.” And they’ve thoughtfully designed their system to support this access. They also hold behavioral health and primary care providers equality responsible for closing gaps in care, taking advantage of all patient contact to ensure needs are met. Megan O’Brien shares more takeaways from this site visit in her Reflections article.

- ▶ [Click to view webpage article.](#)

## PETALUMA HEALTH CENTER

This Northern California health center leads the way in both culture and technology. Transparency is a key part of the culture. As such, all staff can access key organizational goals, current status, and a drill down for action. Each shift (morning, afternoon, and evening) starts with a mandatory all-team huddle. And the most creative idea yet? The huddles start with Huddle TV, a short, light-hearted video all staff watch together. Like SCF, Petaluma wants to hear directly from staff and patients about what's working and what could be better. Read more of Michael Rothman's insights into Petaluma's work in his Reflections article.

▶ [Click to view webpage article.](#)



## HANDOUT: CHRONIC CARE MANAGEMENT ELIGIBILITY CHEAT SHEET

Lifelong Medical Care shares their "cheat sheet" to determine whether a patient may be appropriate for care management services and whether providers can bill using Medicare's Chronic Care Management codes. Click to view PDF.

▶ [Click to view PDF.](#)

## Risk Stratification

Risk stratification is one method of understanding the needs of a patient population. While each organization may develop its own specific methodology, at its core, risk stratification relies on a range of patient data (e.g., utilization, clinical, cost) to organize patients into categories that represent their levels of risk. This section offers insight into several organizations approaches to risk stratification.

### SLIDE PRESENTATION: RISK STRATIFICATION AND CARE COORDINATION

La Clinica outlines their approach to risk stratification and care coordination. For patients with complex care needs, La Clinica creates care plans, supports patients in establishing self-management goals for preventive and chronic illness care, and creates action plans to help manage flare-ups.

▶ [Click to view PDF slides.](#)

### SLIDE PRESENTATION: POPULATION HEALTH MANAGEMENT BIO-PSYCHO-SOCIAL ASSESSMENT

Cherokee Health Systems introduces the biopsychosocial algorithm they use to quantify patient complexity. The presentation includes sample reports, a patient dashboard, and more information on workflows.

▶ [Click to view PDF slides.](#)

### ACTION GUIDE: RISK STRATIFICATION FOR POPULATION HEALTH MANAGEMENT

The National Association of Community Health Centers describes the what, why, and how of risk stratification.

▶ [Click to view PDF.](#)

### HANDOUT: RISK MODEL

Petaluma Health Center created this one-page depiction of their risk stratification model. It assigns point values to various elements of a patient's health (e.g., body mass index, tobacco use, chronic conditions, emergency department utilization).

▶ [Click to view Risk Model PDF.](#)

For more context on how Petaluma Health Center uses risk stratification as part of its overall population health management approach, see their slide presentation on Planned Care and Population Management.

▶ [Click to view slide presentation PDF.](#)



# Social Needs

Social needs, also referred to as social determinants of health, are non-medical factors that impact a patients' overall health and wellness. Resources in this section address building internal systems to identify social needs, developing effective partnerships with community-based organizations, and establishing referral processes to connect patients to resources. This section is organized into three subsections: Designing a Social Needs Strategy; Screening and Identification; and, Connecting to Resources.

## Designing a Social Needs Strategy

Developing a comprehensive approach to social needs is an important component of an organization's overall approach to PHM. Effectively addressing social needs requires organizations to build awareness of how these factors impact a patient's health, understand the specific needs of their population, available resources, and the best ways to connect patients to those resources.

### SLIDE PRESENTATION: KEY CONSIDERATIONS IN DESIGNING YOUR ORGANIZATION'S SOCIAL NEEDS STRATEGY

The Centre for Collaboration, Motivation, & Innovation defines the social determinants of health and identifies key resources to developing a strategy to address social needs.

▶ [Click to view PDF slides.](#)

### SLIDE PRESENTATION: CARE NEEDS SCREENING AND SOCIAL DETERMINANTS OF HEALTH

The Cambridge Health Alliance describes their approach to addressing their patients' social needs. The slides provide useful context for addressing social factors and the screening/referral processes.

▶ [Click to view PDF slides.](#)

### SLIDE PRESENTATION: IDENTIFYING AND ADDRESSING SDOH IN COMPLEX POPULATIONS

Petaluma Health Center outlines their approach to addressing social determinants, screening for social needs, and how to use data to inform partnerships with community organizations.

▶ [Click to view PDF slides.](#)



Credit: SDI Productions



### CASE STUDY: L.A. DEPARTMENT OF HEALTH SERVICES, BAY AREA COMMUNITY HEALTH

The Los Angeles Department of Health Service (LADHS) and Bay Area Community Health-- share how they addressed social determinants as part of their participation in PHLN. LADHS focused on addressing food insecurity while Bay Area Community Health focused on routine screening and connecting patients to resources. Both organizations also describe changes made as a result of the COVID-19 pandemic. Learn more about the work they did in this case study.

▶ [Click to view webpage.](#)

## Screening and Identification of Needs

Understanding each patient's individual circumstances and needs is the first step in connecting them to care. There are a range of tools available to screen patients. The resources in this section will help you learn more about these tools and the implementation process at three health centers.

### TABLE: SOCIAL NEEDS SCREENING TOOLS COMPARISON

The Social Interventions Research and Evaluation Network (SIREN) at UCSF summarizes characteristics of various social needs screening tools, including intended population or setting, social health domains, and the number of questions addressing each domain.

▶ [Click to view webpage.](#)

### VIDEO: TRI-CITY HEALTH CENTER USING THE PRAPARE TOOL TO IDENTIFY SDOH

Bay Area Community Health (formerly Tri-City Health Center) recounts how they implemented the PRAPARE tool to identify social determinants in Diabetes Group Management classes.

▶ [Click to view video.](#)

### TRAINING MANUAL: PRAPARE TOOL

La Clínica de La Raza developed this resource to document their process of implementing the PRAPARE tool.

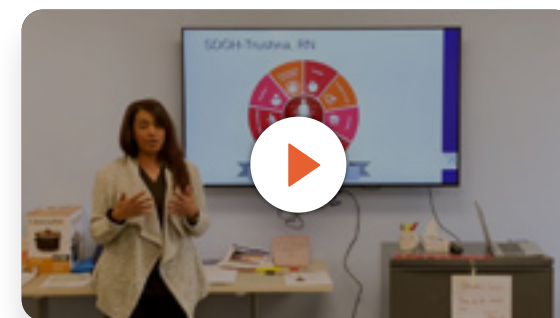
▶ [Click to view PDF.](#)

### EXAMPLE TOOL: PRAPARE CUSTOMIZATION

Santa Rosa Community Health provides examples in English and Spanish about how their organization customized the PRAPARE tool to meet their patients needs.

▶ [Click to view PDF in English/Spanish.](#)

▶ [Click to download Word in English/Spanish.](#)



“

*We've developed a specific role for coordination around anything SDOH related...They strategize with management, clinical teams, and patients. That was a huge step to develop the role, it was the support system for sustaining our efforts.*

## Connecting to Resources

Developing referral pathways is an important step to connecting patients to services and standardizing processes. This section includes two examples of referral pathways and resources related to social needs.

### WORKFLOW: SDOH PATHWAY

Salud Para La Gente mapped out each step of the referral process for patients who are being connected to social services and supports in the community.

▶ [Click to view PDF.](#)

### WORKFLOW AND RESOURCE GUIDE: FOOD INSECURITY

Northeast Valley Health Corporation documented the algorithm, screening, and referral process for patients ages 12-17 years with food insecurity. They also developed a Food Rx Guide which includes a list of resources for free groceries, background on nutrition and food safety, and recipes.

▶ [Click to view algorithm workflow PDF.](#)

▶ [Click to view Food Rx Guide PDF.](#)



Credit: monkeybusinessimages

# Data & Analytics

Most health centers have clinical, utilization, financial, and administrative data at their fingertips. But effectively leveraging these data to drive business and clinical decision-making requires a concerted effort to align strategy in many areas: technology, analytics, business processes, workflows, and administration. The resources in this section include tools to assess an organization's data and analytical competencies and to transform data into meaningful, actionable information to effectively drive organizational change.

## VIDEOS & TOOLS: BUILDING A DATA DRIVEN CULTURE – A VIDEO LEARNING SERIES

This five-part series offers a comprehensive take on transforming organizations to efficiently and effectively use data. Major topics addressed include: defining relevant terminology and understanding the major tools, setting a strategy and tackling the big questions, engaging your team and managing organizational change, tactics and technical issues, and case studies of analytics in action.

▶ [Click to view learning series website.](#)

## SLIDE PRESENTATION: THE CONTINUUM OF DATA

Boris Kalikstein of Pivotal Moment Consulting outlines the key elements of a data strategy, how to differentiate between information and data, and the hallmarks of mature data organizations.

▶ [Click to view PDF slides.](#)

## SLIDE PRESENTATION: OPTIMIZING DATA TOOLS & TECHNOLOGY FOR POPULATION HEALTH MANAGEMENT

Southcentral Foundation shares their approach to using data tools and technology, beginning with how they transform research into action. They also define four layers of data interoperability, identify key success factors, and share their assessment process.

▶ [Click to view PDF slides.](#)

## WEBINAR: DATA-DRIVEN POPULATION HEALTH MANAGEMENT

Community Medical Centers, Inc., Open Door Community Health Centers, and Salud Para La Gente each describe a project related to improving the use of data within their respective organizations. Each outlines their approach, outcomes, successes, and lessons learned.

▶ [Click to view recording and slides.](#)

## HANDOUT: WEATHER REPORT

A data "Weather Report" graphic lists key questions that can indicate when data analysis has gone too far.

▶ [Click to view Weather Report PDF.](#)

## HANDOUT: DATA GOVERNANCE

This handout describes an approach to data governance, including key considerations and activities.

▶ [Click to view PDF.](#)

“

*Even though I feel that we weren't successful in being able to procure data on a regular basis, it did help move our organization in a positive direction. Now we are more metric aware. Now are more comfortable with trying and failing and trying again.*

### WORKSHEET: METRIC CHAMPION TEMPLATE

La Clinica developed this template to support teams in improving performance. The worksheet is designed around a single metric and defines a number of considerations for teams to consider in making improvements. La Clinica also provides an example of a completed worksheet.

- ▶ [Click to view PDF.](#)
- ▶ [Click to download Word.](#)
- ▶ [Click to view example worksheet PDF.](#)