

# Spreading Innovations

## A Program for Increasing Access and Optimizing Care

May 2015



A joint effort of CCI and Blue Shield of California Foundation  
with additional funding from Kaiser Permanente

## IMPORTANT DATES

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### Informational Webinar:

11:00am, May 14, 2015

### Proposal deadline:

5:00 pm, June 26, 2015

### Award Announcement:

August 14, 2015

## Frequently Asked Questions

### What do I need to submit?

Please submit the following online through the CCI website by 5:00 p.m. on June 26th:

<http://www.careinnovations.org/programs-grants/grants/>

1. Spreading Innovations [Application Form](#)
2. Spreading Innovations Narrative
3. Spreading Innovations [Budget](#)

### Eligibility Criteria

Clinic corporations, ambulatory care clinics at public hospitals owned and operated by public hospitals (either at the hospital or in the community), and other California-based nonprofit health centers that provide comprehensive primary care services to primarily underserved populations are eligible to apply. Regional clinic consortia and statewide clinic associations are not eligible to apply.

Organizations must be a nonprofit and tax-exempt organization under 501(c)(3) of the Internal Revenue Service Code (IRC) or a governmental, tribal, or public entity. Examples of eligible organizations that comprise the safety net include:

- Free-standing community clinics and health centers
- Ambulatory care clinics which are part of public hospital systems either located in the public hospital or out in the community
- Primary care health centers (including those sponsored by Public Health Departments)
- American Indian Health Centers

Safety Net Innovation Network members from Colorado, Hawaii and Oregon that meet the above criteria are also eligible to apply. Kaiser Permanente will support the participation of these applicants from outside of California in this program.

### Who do I contact for more information?

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(415) 561-7817  
[sarah@careinnovations.org](mailto:sarah@careinnovations.org)

## REQUEST FOR PROPOSALS

# Spreading Innovations: A Program for Increasing Access and Optimizing Care

A joint effort of CCI and Blue Shield of California Foundation, with additional funding from Kaiser Permanente

## Program Background

Two upheavals are poised to change health care, and health systems will need to adapt quickly with dramatic changes in how they deliver care. First, the implementation of the Affordable Care Act has brought increased demand for services, and clinics must design new ways to provide patients with the care they need when they need it.

The second upheaval is a shift towards value-based payments, which will fundamentally alter how care is delivered in safety net clinics—and will create opportunities to implement innovative new models. Clinics are grappling with many questions as they prepare for these changes: How can they reduce costs, improve quality and make sure their services are valuable to patients? How will they manage these organizational changes? How will they ensure they have the workforce needed to operate differently?

Earlier this year, CCI engaged with safety net organizations across California to gather insight into the challenges and opportunities facing clinics as they consider shifting payment models away from fee-for-service to a more capitated (value-based) payment system—and to create a vision of the future after these changes. These healthcare innovators envisioned that instead of care being “delivered” from clinician to patient, it will be co-created by an expanded care team that includes the patient and community at large. Patients will not only be collaborators, they will also be customers who are able to access care when, where and how they want it. All touchpoints—whether physical, digital or social—will be designed from the patients’ perspective.

While the shift toward value-based payment brings many questions, it’s also an exciting opportunity for organizations to pursue projects that improve care but were not reimbursed under the pure fee-for-service payment model. Innovative safety net organizations have begun this work already, and some have successfully implemented projects that provide alternatives to face-to-face visits, use the care team members in new and interesting ways, and expand patients’ options to access services and information and engage in their own care. These organizations have rich resources and knowledge to share with others who are hoping to follow their path to a new model of care.

Over the past 4 years, CCI has been helping safety net organizations develop creative solutions to critical challenges, test and implement new ideas, and disseminate successful projects to other organizations. During this time of rapid change, it’s crucial for organizations to learn from the experience of others and build on their successes. CCI is committed to making sure effective ideas take root—and helping safety net organizations put these innovations into practice without reinventing the wheel.

Our Spreading Innovations program, which began in 2014, presented proven practices that have not yet been widely adopted in the safety net and helped new organizations successfully adapt and implement these practices. This year, CCI will launch a new round of this program to support the dissemination of successful innovations that prepare clinics for a value based payment system as well as improve timely access to care.

## Program Overview

CCI, in partnership with Blue Shield of California Foundation and with additional funding from Kaiser Permanente, is launching the second year of the Spreading Innovations Program to spread focused innovations that improve access to care by leveraging technology and care teams more effectively. Clinics that begin adopting practices that give patients more options for how to access the care they need will be best positioned for success in the future. We are supporting the spread of these specific innovations because they are proven methods that have been used effectively outside the safety net as well as by early adopters within the safety net. As more and more safety net providers work to meet the requirements of medical home certification and meaningful use incentives, as well as prepare for a value based payment reimbursement model, we have seen a growing interest in patient portals, telemedicine, and expanded care team models.

This year, CCI has expanded on its **Spreading Innovations** program to include additional innovation options and better support the dissemination of successful ideas. The grant and technical assistance program will support organizations to implement one of the following interventions:

- Co-Visits
- Patient Portal
- Telephone Visits
- Texting Solutions
- Video Collaboration and Instant Messaging

These innovations are already at work in safety net organizations in California and Colorado and are operating successfully. This program will focus on building upon the successes of these early innovators and support the implementation and spread of these innovations more broadly to new organizations.

Through this grant program, grantees will have access to a variety of tools, including technical assistance, peer support and coaching to help them implement their chosen innovation. Grantees will work with host organizations that have already successfully implemented the innovation in order to gain a clear understanding of how to operationalize the project, gain buy-in from key stakeholders, train staff, redesign workflows and build a business case to sustain the innovation over time. While each grantee will need to adapt the innovation to meet the needs of their patients and staff and to fit with their organizational structure, this connection to a host organization will provide grantees with a solid foundation for their projects.

This year, CCI is also launching the **Acceleration Academy**, a virtual learning series that will focus on sharing information and resources on other successful projects in the safety net that have not yet been widely adopted. The purpose of the Acceleration Academy is to speed the adoption of these interventions by sharing best practices and lessons learned from those who have already worked to put them in place. The Acceleration Academy will be open to all healthcare organizations that are interested in implementing changes that will prepare them for a value based payment system.

## Grant Project Profiles

Applicants to the Spreading Innovations grant program will apply to implement one of the following projects at their own organization and will work with a host site to learn how to operationalize the innovation.

1. **Co-Visits** – Host Site: Clinica Family Health Services, CO
2. **Patient Portals** – Host Site: Shasta Community Health Center
3. **Video Collaboration and Instant Messaging** – Host Sites: West County Health Centers and Petaluma Health Center
4. **Telephone visits** – Host Site: Riverside County Health System
5. **Texting Solutions** – In-person meeting on texting strategies and ongoing learning community support

Grantees will visit the innovation host site and participate in group coaching calls with their hosts to learn about the essential components of their project and lessons for successful implementation. They will also have access to a coach, toolkits, training curriculum, videos, and educational materials that can be adapted by the grantee organization.

## CO-VISITS

A Co-Visit based primary care model allows clinics to increase access to primary care same day services while improving sustainability and joy in work. In a co-visit, a nurse does the intake and history for a primary acute care visit. She then invites the medical provider into the patient room to review the chief complaint. The provider verifies history, completes a physical exam (while the nurse scribes this information). The provider does the medical decision making and then hands the patient back to the nurse for patient education and care plan review.

A co-visit replaces a traditional double book and therefore allows the nurse a greater role in patient care, while reducing the time and stress placed on the provider. This has translated into better patient access, more patient face to face time with the nurses, and an increase in billable visits for providers. The increase in patient visits has helped pay for an increase in RN staffing as well as an additional MA on the care team to help with overall flow. [Clinica Family Health Services in Colorado developed this innovative, tightly timed patient hand-off model](#) as part of a larger plan to expand primary care access by ten percent without adding any medical providers.

Co-visits work best for patients coming in with minor acute illness or requiring relatively routine care for non-chronic conditions. When a patient seeking a same day appointment arrives for their visit, a nurse takes their patient history and performs any needed in office tests. The provider enters the exam room where the nurse reviews the patient history. The provider reviews any further history, completes a physical exam and decides on an assessment and care plan. The provider also prescribes medications if needed. The nurse explains the assessment and care plan to the patient, goes over warning signs and follow-up, and does any basic education the case requires. She also completes the chart documentation and sends it to the provider for final review and billing.

Clinica found that co-visits required a whole new level of communication within care teams. Nurses and providers are now talking in a much more detailed way about individual patients. This requires creative adjustments to workspaces to accommodate these discussions, as well as the precise timing of the handoff. Both nurses and providers needed training to better work in collaboration to serve the patients' same day needs. This model has met both of its original goals: to increase patient access and to improve work-life sustainability for members of our primary care teams.

You should consider implementing this innovation in your organization if the demand for same day appointments at your clinic is consistently significantly higher than your current capacity, and your providers and nursing staff have expressed interest in expanding care team roles.

Co-Visit grantees will receive \$15,000 to offset staff time spent implementing the Co-Visit model and to pay for travel expenses for the host site visit.

## PATIENT PORTAL

Online portals allow patients to interact with their health information and communicate with providers outside the traditional office visit. Such systems offer powerful benefits: encouraging patients to become more engaged in their own care and helping providers improve efficiency, quality, and access. Successful portals are tailored to the operations of specific community clinics and their unique patient populations. Implementing a patient portal involves several components – technology implementation, marketing, enrollment, training, support and workflow redesign.

Shasta Community Health Center used a multidisciplinary implementation team (including IT, clinical and front office staff) to successfully implement a patient portal across all providers and sites. They pursued portal implementation to improve customer service and reduce their high call volume. Their

current portal functionality includes messaging your care team, appointment request, medication refill request, lab results, and completing patient forms. Shasta opened portal enrollment to their entire patient population to achieve critical mass and realize the greatest operational efficiencies. Initial deployment focused on encouraging acceptance and use by support staff. Shasta created and automated reports for enrollment and use, as well as reports that tracked cycle times to monitor their customer service level.

In a survey done one year after implementation, 84% of patients reported that the portal saved them from calling the health center, and 41% reported that the portal saved them from visiting the health center. This self-reported survey is aligned with published studies that have shown portals to improve efficiency by improving patient flow.

In the first round of our Spreading Innovations program, which began in September 2014, we supported nine organizations to implement patient portals. Of these nine organizations, three have fully implemented, three have partially implemented and three are piloting their portals.

You should consider implementing this innovation in your organization if you have an EHR system with portal functionality and are interested in meeting meaningful use requirements, obtaining patient-centered medical home certification or providing patients with an alternative access point to the care delivery system. To participate in the patient portal implementation grant, grantees will need to commit to implementing at least three functionalities of the portal (messaging your care team is required).

Patient Portal grantees will receive \$25,000 to offset portal related expenses, staff time to support workflow changes and implementation, and for travel expenses for the host site visit.

## TELEPHONE VISITS

Virtual telephone visits are clinical exchanges that occur via telephone between providers and patients. Virtual telephone visits have the potential to:

- Increase patient access
- Decrease hospital readmission rates
- Decrease unnecessary emergency room visits
- Improve patient satisfaction and
- Decrease overall costs of care

Virtual telephone visits offer a convenient alternative for patients who may have difficulty with transportation or with taking time off from work to be seen in the clinic. Virtual telephone visits improve patient access and help with “completing today’s work today.” Virtual telephone visits are appropriate for a wide variety of clinical issues and follow-up items, including but not limited to: discussion of abnormal laboratory or diagnostic test results, medication management, care coordination (including referral management), management of chronic conditions, management of acute conditions (e.g., cough or cold symptoms, simple urinary tract infections, etc.), post-hospital or post-emergency follow-up, preventive care, health education, outreach, and supportive counseling.

[Riverside County Health System has been conducting telephone visits](#) for established patients to talk with their primary care providers. They piloted their telephone visit model in June 2013 with one provider at one clinic site and achieved positive results. Since then they have spread their successful model to 6 clinic sites and have conducted over 10,000 telephone visits. They also integrated the telephone visit with their EHR and developed a toolkit to facilitate the continued spread of their project. Riverside is currently measuring the total number of patient encounters, the reduction in appointment backlog, patient satisfaction, and clinician and staff engagement.

“Often times, the cost savings of the virtual telephone visit is realized outside of the clinic system—by the local community hospital or emergency room and health plan. So, the challenge is ‘How do we demonstrate the value of the telephone visit in our own clinic system?’ The way we are trying to do that

is by measuring our unmet need to show how access actually improves when we use telephone visits. We are also trying to align our diabetes population care program with our telephone visit program at those sites to see if diabetes care improves at sites with the telephone visits. And, we are working closely with our partner health plan. We believe that if we do not do this now, we will not be able to compete as the reimbursement model changes.” Geoff Leung, MD Riverside County Health System

In the first round of our Spreading Innovations program, which began in September 2014, we supported two organizations in their implementation of telephone visits. Of these two organizations, one has implemented phone visits in two of their adult medicine clinics, with plans to expand to additional sites. The second organization has implemented phone visits in their residency and family medicine departments, with plans to expand to their primary care and internal medicine departments. Both have reported high patient and provider satisfaction with telephone visits.

You should consider implementing this innovation in your organization if the overall demand for appointments at your clinic is consistently higher than your current capacity and your patients and providers have expressed interest in new visit models beyond the face-to-face appointment.

Telephone Visit grantees will receive \$15,000 to offset the staff time to implement the phone visit model and for travel expenses for the host site visit.

## TEXTING SOLUTIONS

Safety net organizations in California have developed and implemented a number of models for using text messaging in primary care, including appointment reminders, chronic disease self-management, closing the specialty referral loop and improving transitions from hospitalization to primary care by connecting patients to their care teams. As they have developed their models, they have gained valuable knowledge about how to develop a successful texting program. California safety net organizations have implemented texting projects in these areas:

- **Reminding patients about upcoming appointment:** An existing automated phone appointment reminder system was supplemented with a text message reminder 24 hours before the appointment, which led to a 32% increase in appointment confirmations/cancellations and a 10% drop in their no-show rate. This system integrates with their EHR, allowing cancelled appointments to be opened up in real time.
- **Encouraging patients' self-management of their health:** Health coaches and dieticians work with patients to set self-management goals and send customized text messages to help patients meet them. The bi-directional messages between health coaches and patients are about appointment reminders, educational or motivational. Over the past year, participating patients have begun to work toward their goals with 23% either partially or fully achieving them.
- **Promoting better transitions of care:** To better manage the referral process for non-urgent referrals (appointments that are not required within a 7-day period), a text messaging program was implemented to close the referral loop. Using their EHR's text messaging functionality, they were able to send reminders to patients of external specialist appointment dates and close the referrals.

Grantees pursuing this opportunity are not limited to these models, but will implement a specific use case for texting that is appropriate for their organization. They will also receive funding to participate in a learning community focused on how to establish a successful texting program. Grantees will receive information and resources on crafting messages, engaging patients and increasing response rate, establishing a consent process, ensuring HIPAA compliance, engaging staff, integrating texting into your EHR and tracking metrics.

You should consider implementing this innovation in your organization if you have identified a specific patient need that texting can help solve and your staff have expressed interest in implementing new technology solutions.

Texting Solutions grantees will receive \$10,000 to offset staff time spent implementing a solution, as well as attending the in-person convening, participating in learning community activities, and participating in an evaluation by providing data.

## VIDEO COLLABORATION AND INSTANT MESSAGING

Video collaboration and instant messaging allows primary care teams to move beyond asynchronous communication limited to specific silos of care to seamless communication that allows collaboration within primary care, across health systems, and with community health partners. As the complexity of disease and care coordination increases, teams will need to use a variety of point-of-care communication tools and strategies, such as: instant messaging, presence capability (the ability to know if a person is available), video calls, multi-person video meetings, off-site video collaboration, and shared collaboration platform across health systems.

[West County Health Centers and Petaluma Health Center have been using video collaboration](#) with WebEx as their primary video interface and WebEx Connect as an enhanced communication platform. Their activities include:

- Video Warm Hand-Off:** Provider (or other staff) virtually brings support staff into the office visit with a patient to introduce them prior to a future visit or interaction. They are using the video warm hand off to: introduce an RN care manager to discuss goals for a future home visit; introduce behavioral health staff to demystify the visit and begin to set a common agenda for the next visit; and to introduce the dental team to reduce a patient’s fear about their future dental visit.
- Real-Time Office Collaboration:** Provider in the office with a patient wants to bring in staff to have a dynamic discussion or collaboration. They are using video for providers to: discuss complicated referral questions with referral staff; consult with pharmacy technicians on formulary alternatives; discuss complex social stressors identified in the office visit with an RN care manager; discuss new information identified in the office visit that may impact pending disability paperwork with an access coordinator; and to bring a provider into a health coach’s visit with a patient to provide clinical insight and to bill as a 99212.
- Multi-person Collaboration:** During an office visit, they are using real-time video to conduct meetings to: discuss complex social concerns with a patient, medical provider, RN care manager, and social worker; discuss treatment options and the need for complicated prior authorization for medications that are not on the insurance formulary with a patient, medical provider, specialist, and pharmacy tech; and discuss end-of-life wishes prior to establishing an advance directive with a patient, medical provider and off-site family members.
- Off-Site Video Collaboration:** In this intervention staff are remote and connect to the provider or other staff via a video connection. They have been using video to: connect an RN care manager who is conducting a post discharge hospital transition home visit with a medical provider; connect remote support staff and patient at an education visit to the provider for clinical support and billing; to bring in RN triage or a medical provider for video evaluation when an outreach worker has identified a clinical concern with a homeless client; and to connect an RN care manager who is doing homeless outreach visits or home health visits to an access coordinator to sign the patient up for insurance or food stamps.

“We’re bringing technology that’s ready to use, out of the box, and affordable into the healthcare space and effectively using relationships and extending those relationships through collaboration and communication using technology.” Jason Cunningham, MD West County Health Centers



In the first round of our Spreading Innovations program, which began in September 2014, we supported two organizations to implement video collaboration projects. Of these two organizations, one has implemented Lync, an instant message platform with video capability, at two sites for 119 staff. They have sent over 23,000 messages and have plans to expand to 5 more sites in the coming months. The second organization is piloting a video collaboration system to connect staff across multiple sites for consults to determine the need for referrals. Both organizations have reported high provider satisfaction.

You should consider implementing this innovation in your organization if your patients and providers have expressed interest in alternative visit models.

Video Collaboration and Instant Messaging grantees will receive \$25,000 to offset the cost of equipment, start-up connection fees, staff time to implement and for travel expenses for the host site visit.

## Acceleration Academy

CCI is committed to spreading best practices that can speed up the transformation of care in the safety net by helping organizations learn from each other and adopt effective interventions without having to reinvent the wheel. We do this by convening clinical leaders to share ideas, collaborate and innovate together, and through our grant programs. We are also interested in reaching a broader group of organizations to share information on a variety of successful projects underway in the safety net. The Acceleration Academy will offer a virtual learning series to highlight working solutions and share resources to enable wider adoption. The Acceleration Academy will be open to all healthcare organizations that are interested in implementing changes that will prepare them for a value based payment system.

The Acceleration Academy will offer virtual learning series on a number of topics, including:

- **Group Visits:** Group visits enable care teams to meaningfully engage with patients in a more efficient way, improve access and outcomes, and motivate behavior change. In this webinar series, we will highlight successful models and share implementation resources.
- **Social Determinants of Health:** While safety net health care providers have become leaders in providing high quality, culturally competent care, their efforts alone will never be enough to create and sustain healthy communities. How can health care organizations identify the social and environmental factors that affect the health of their patients? How can they build relationships and work with their communities to solve problems? In this webinar series, we will highlight successful models and share resources to assist organizations interested in starting this important work.
- **Remote Monitoring:** For people with chronic disease, it is critical for them to stay in close communication with their care team. Remote monitoring allows providers to be able to monitor patients' care by leveraging data from devices and other technologies in patient's homes and proactively reach out before a patient requires emergency care.
- **Peer Support models:** Promotoras, Community Health Workers, and peers can be critical members of the care team. People living with chronic conditions need more than medical treatment from their health care providers; they need support in sustaining complex self-care behaviors. Peer support interventions can be a meaningful approach to provide patients this assistance.

In addition to engaging clinic experts and consultants in this series, CCI will seek speakers from outside the safety net to provide a fresh perspective on engaging in these projects. These sessions will be recorded and shared publicly on the CCI website.

## What We're Looking For

- **Engaged Leadership** – Successful projects will require leadership to commit staff time and to support infrastructure and cultural changes necessary to implement the focused innovation. We would like you to select an executive sponsor for the project to help ensure organizational commitment to identifying resources and devoting time to implementation.
- **Dedicated Project Team** – Teams will need to allocate sufficient staff time to successfully implement their projects and include either a member of the leadership team or linkage to leadership to communicate the outcomes of their work. In addition to naming an executive sponsor, teams should designate a day-to-day project lead. The project lead will spend approximately 1 day per week on the project (though this may vary depending on the phase of the project).
- **Clear Measurement Plan** – Teams will need to define a set of measures and create a measurement plan at the beginning of their project to track the rate of adoption and the impact of the intervention. CCI will be monitoring adoption rates across grantees through periodic reporting. Since these innovations are new in the safety net setting, we are interested in building the evidence of their effectiveness to share more broadly with the field.
- **Commitment to Sustainability and Alignment with Strategic Priorities** – Most of these innovations currently do not have a specific billing code associated with providing this service. However, we expect this barrier to be reduced with the coming changes to the payment system. Many organizations currently sustain these services by connecting them to strategic priorities and goals or other incentive programs (i.e. pay for performance, PCMH certification, Meaningful use, etc.). We are looking for organizations with a commitment to sustaining these services over the long-term through a clear alignment with strategic priorities.

## What We'll Provide

Grantees will receive funding to offset staff time, travel costs for visiting the host site and implementation costs for the project. Grants and support will range from \$10,000 - \$25,000 according to the capital needs of the project and level of complexity in implementation. The funding amount for each innovation is outlined in the project profiles.

In addition to grant funds, grantees will also have access to:

- The innovation host organization to help support implementation. This includes a 1 day site visit to the host organization and follow up group coaching calls.
- Toolkits and resources to support implementation
- Biweekly coaching support from an implementation coach
- A program evaluator to help grantee organizations define measures, develop a measurement plan and assess impact of the innovation on the organization
- An active peer learning community of grantees implementing similar innovations

## Eligibility

Clinic corporations, ambulatory care clinics at public hospitals owned and operated by public hospitals (either at the hospital or in the community), and other California-based nonprofit health centers that provide comprehensive primary care services to primarily underserved populations are eligible to apply. Regional clinic consortia and statewide clinic associations are not eligible to apply.

Organizations must be a nonprofit and tax-exempt organization under 501(c)(3) of the Internal Revenue Service Code (IRC) or a governmental, tribal, or public entity. Examples of eligible organizations that comprise the safety net include:

- Free-standing community clinics and health centers
- Ambulatory care clinics which are part of public hospital systems either located in the public hospital or out in the community
- Primary care health centers (including those sponsored by Public Health departments)
- American Indian Health Centers

Safety Net Innovation Network members from Colorado, Hawaii and Oregon that meet the above criteria are also eligible to apply. Kaiser Permanente will support the participation of these applicants from outside of California in this program.

## How to Apply

Interested organizations are encouraged to participate in an informational webinar on Thursday, May 14, 2015 at 11:00am.

Dial-in: **866.740.1260**  
PIN Code: **5617817**  
Register: <https://cc.readytalk.com/r/jcsl5wvinmtx&eom>

Your proposal and budget must be submitted online to CCI by June 26<sup>th</sup> at 5:00pm:

[Apply here: http://www.tfaforms.com/371978](http://www.tfaforms.com/371978)

Please use size 11pt font or larger and margins no smaller than 1 inch when writing your 6 page maximum narrative.

Proposals will be reviewed by CCI and an external review committee and awards will be announced August 14.

## Proposal Questions

Please answer the following questions in 6 pages or less using at least 11 point (non-narrow) font and at least 1 inch margins.

1. Which innovation are you selecting to implement in your organization and how will you tailor the project to meet your organization's needs? Please include enough detail so those not involved in developing the project can understand the project design and how it will be implemented in your organization.
2. **Texting Solutions and Video Collaboration Applicants Only:** Please describe the specific use case that you will be using texting or video for in your organization (e.g. texting appointment reminders, video warm handoffs, etc.).
3. If you have begun implementation of your project, please describe where you are in the process. Please provide enough detail so we can understand your stage of development.
4. What is the problem or issue the selected innovation would address? Describe how the problem or issue is relevant to the needs of your patient population and your organization's strategic priorities.
5. Who is on your implementation team and why were they selected? How will leadership be involved with and support your project? Please provide the names of the executive sponsor and the day-to-day project leader.
6. Describe your organization's experience with the adoption or implementation of other innovations or interventions. What worked well and what would you improve?
7. What resources will you need to implement the selected innovation (e.g. funding, expertise, technology or other outside partner)?
8. Please describe how you will evaluate the impact of your program (include metrics you would be interested in tracking). Who will be responsible for collecting the data? Also, please explain how (and to whom) you would make a case to sustain these services after the 12-month grant if they prove to be valuable.
9. Please describe any challenges you anticipate in the implementation and how CCI could help support any outstanding concerns.
10. **Patient Portal Applicants Only:** If you are planning on implementing a large technology project during the grant period (e.g. EHR implementation or upgrade), please describe how you plan to manage competing priorities and complete your project within the grant timeline.

## Selected Sources

### CO-VISITS

<http://www.careinnovations.org/innovation-spotlight/in-the-incubator-flip-visits/>

<https://vimeo.com/96777975>

### PATIENT PORTALS

<http://www.chcf.org/patient-portals>

“Use of the Refill Function Through an Online Patient Portal is Associated With Improved Adherence to Statins in an Integrated Health System”: <http://www.ncbi.nlm.nih.gov/pubmed/24374412>

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MeasuringImpactPatientPortals.pdf>

Seth Emont, “Measuring the Impact of Patient Portals: What the Literature Tells Us,” California HealthCare Foundation, May 2011, <http://www.chcf.org/publications/2011/05/measuring-impact-patient-portals>

### TELEHEALTH

[http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2009/Jul/1283\\_McCarthy\\_Group%20Health\\_case\\_study\\_72\\_rev.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2009/Jul/1283_McCarthy_Group%20Health_case_study_72_rev.pdf)

<http://www.americantelemed.org/docs/default-source/policy/examples-of-research-outcomes---telemedicine%27s-impact-on-healthcare-cost-and-quality.pdf>

[http://www.careinnovations.org/uploads/Texting\\_for\\_Better\\_Care\\_Project\\_Final\\_Report\\_3.21.14.pdf](http://www.careinnovations.org/uploads/Texting_for_Better_Care_Project_Final_Report_3.21.14.pdf)



## A joint effort of

**Center for Care Innovations (CCI)** partners with health care safety net providers to help them transform care for underserved populations. CCI is a vital source of ideas, best practices and funding to support the adoption and spread of innovations to improve health, reduce costs and improve the patient experience of care. By bringing people and resources together, we accelerate innovations for healthy people and healthy communities.

[www.careinnovations.org](http://www.careinnovations.org)



Blue Shield of California Foundation is an Independent Licensee of the Blue Shield Association

**Blue Shield of California Foundation (BSCF)** is committed to making health care effective, safe and accessible for all Californians, particularly underserved people, and to ending domestic violence. BSCF believes safety and access to health care are fundamental rights of everyone and that ensuring Californian's health and safety requires the involvement of individuals, employers and government agencies.

[www.blueshieldcafoundation.org](http://www.blueshieldcafoundation.org)



**Kaiser Permanente** is committed to helping shape the future of health care. Founded in 1945, Kaiser Permanente has a mission to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. Kaiser Permanente is dedicated to care innovations, clinical research, health education and the support of community health.

[www.kp.org/share](http://www.kp.org/share)