



# CP3 Population Health Toolkit

FROM VOLUME TO VALUE: SUPPORTING CARE DELIVERY TRANSFORMATION IN THE SAFETY NET

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# Introduction

## Background on CP3

In May 2016, the Center for Care Innovations (CCI) launched a population health management program as part of a larger effort to prepare California's Federally Qualified Health Centers (FQHCs) for planned shifts in reimbursement. The larger effort, known as the Capitation Payment Preparedness Program – also called CP3 – was developed by the **California Primary Care Association** and the **California Health Care Safety Net Institute**.

Within CP3, CCI designed a program to support FQHC participants with two goals: (1) transforming care processes and systems to achieve high-value, quality health care and (2) preparing CP3 sites for the care delivery changes needed to be successful in a capitated or value-based payment model.

## CCI Program Goals and Activities

**VALUE-BASED CARE** Value-based care directly connects how providers are paid for their services with the quality and cost efficiency with which that care is delivered. Value-based care initiatives support the transformation from a payment system based on the quantity of services delivered, to the effectiveness with which care is provided to individual patients and how the health of patient populations is managed.

**POPULATION HEALTH MANAGEMENT** In turn, population health management is driven by the use of data to identify and address the health care needs of a defined population. Population health management focuses on providing evidence-based preventive care, addressing gaps in care and effective management of chronic conditions through a focus on team-based care, patient engagement, and effective use of health information technology tools.

**SHIFT FROM VOLUME TO VALUE** CCI's population health program focused on four components designed to support clinics in moving from volume to value: (1) team-based care, (2) population health management, (3) planned care, and (4) transforming data into meaningful information to support population health management. Program activities included four in-person learning sessions, intensive "learning labs" focused on key elements of value-based care, virtual swap meets to exchange resources, site visits, webinars, and coaching. This toolkit consolidates the tools, resources and learnings of the population health program activities to support other health centers in their journey to value-based care.



▶ See complete infographic.

*“Feeling connected to your workplace is so important. Part of our goal in the transformation process was to establish not just a culture of accountability, but also a culture of joy. As part of this journey, we started a group called The Healer’s Art [based on Rachel Naomi Remen, MD]. We wanted to explore the mission of medicine and moments of awe with our patients. It was profound to be at the same table and share. After, we conducted the Maslach’s Burnout Inventory and actually found some reductions in provider’s burnout score.”*

— COMMUNICARE HEALTH CENTERS  
CP3 PARTICIPANT

To learn more about the program activities and to access webinars and slides, visit the **CP3 Population Health Technical Assistance Program Portal**. In addition, overall lessons learned from the project can be accessed via the **“Moving Toward Value-Based Care: Lessons Learned from CP3”** webinar.

## Program Participants and Faculty

The program had two tracks: The Comprehensive Track and the Low Intensity Track. The content reflected in this toolkit was gathered based on our experiences in the Comprehensive Track. Nine FQHCs from across California participated in the Comprehensive Track. Combined, these nine organizations represented over 31 individual clinics sites. Participants included:

- CommuniCare Health Centers
- LifeLong Medical Care
- Monterey County Clinic Services
- OLE Health
- Ravenswood Family Health Center
- San Mateo Medical Center
- Tiburcio Vasquez Health Center
- Venice Family Clinic
- Vista Community Clinic

CCI wishes to thank program faculty for assistance in designing and leading this project. In particular, CCI would like to thank Dr. Carolyn Shepherd, the project’s clinical director. Dr. Shepherd was formerly the Chief Medical Officer of Clinica Family Health in Boulder, Colorado, and she brought many of the valuable lessons learned in Clinica’s transformation to the program.

# Leadership and Culture

The Leadership and Culture section includes a range of resources designed to support safety-net leaders in designing and implementing transformation strategies. Resources address conceptual issues, such as technical versus adaptive change, and offer practice tools to help community health centers communicate change initiatives and support team functioning.

## Leadership and Change Management

- ▶ **ADAPTIVE CHANGE** Two tools help to inform adaptive change. The first, from Catalyz, describes the differences between technical and adaptive change and provides some examples. The second, created by Ronald Heftiz, is a framework for adaptive leadership. The framework offers a guide to identify and address challenges.
- ▶ **RIDER, ELEPHANT, AND PATH** Catalyz utilizes the Rider, Elephant and Path concepts introduced in *Switch: How to Change Things When Change is Hard* to provide more detail on activities by role. See also a **short video** narrated by Chip Heath, author of *Switch*. In the video, Heath describes the concepts of rider (rational), elephant (emotional), and path (external environment that impacts change).

## Communication

- ▶ **STORYTELLING** The Center for Care Innovations presents the webinar “Beyond the Data: Storytelling for Buy-In and Action.” Safety net communications expert, Suzanne Samuel, describes tools and templates to support getting buy-in and inspiring action.
- ▶ **THREE PHASES OF TRANSITIONS** Developed by William Bridges, this model aligns strategies and emotions with transition phases: (1) endings, losing and letting go; (2) neutral; and (3) beginnings.
- ▶ **FIVE COMPONENTS TO EFFECTIVELY COMMUNICATE CHANGE** This tool helps teams define change components and it includes an example of how the tool was used by Clinica Family Health as they implemented advanced access.
- ▶ **COMMUNICATION PLAN** This tool helps organizations track the status, by stakeholder segment, of communicating change initiatives. The tool was adapted from the *Heart of Change Field Guide: Tools and Tactics for Leading Change in Your Organization*.

*“When we first rolled out care teams, we had a lot of trouble spreading from the first clinic to other sites. There was resistance from other sites and we didn’t understand why. Eventually we realized that we needed to do a better job communicating. We needed to reach out to each site’s clinical leadership. CP3’s tool really helped us target messages to different stakeholders — executive leadership, middle line leaders, front line staff. They each needed to understand what the change would mean for them.”*

— SAN MATEO MEDICAL CENTER  
CP3 PARTICIPANT





## Team-Building

- ▶ **TEAM CHECK-IN** This tool, developed by Catalyz, enables teams to gauge each person's energy and mood at the beginning of a meeting.
- ▶ **DEEP T** Catalyz shares this tool, designed to help teams understand each person's depth and breadth of knowledge as the result of determining their "T-shape." The ultimate goal of the Deep T is to mix people with different T-shapes to create diverse and interdisciplinary teams.

## Going Deeper

**CHANGE MANAGEMENT** A three-part series on engaging effectively in practice transformation, led by Wendy Jameson and sponsored by the California Primary Care Association. This series consists of:

- ▶ **Four Strategies for Managing the People Side of Change**
- ▶ **Engaging Effectively in Practice Transformation**
- ▶ **Making Sure Changes Spread and Stick**
- ▶ **ADAPTIVE LEADERSHIP: MOBILIZING FOR CHANGE AND DISRUPTING THE STATUS QUO** This free five-week course is offered by +Acumen, an organization that offers free and low-cost courses for social change-makers.
- ▶ **INTRODUCTION TO HEALTH CARE LEADERSHIP** IHI Open School offers this 75-minute online course that addresses the characteristics of leadership, techniques for persuading different types of people, and effective team functioning. Note: Health professionals and groups must pay an annual fee to listen to IHI Open School courses, however this introductory class can be taken as a free sample of the Open School's offerings.

*“It's important to give all providers the opportunity to be at the table. And for us, the providers most invested in a change weren't always who we expected.”*

— VISTA COMMUNITY CLINIC  
CP3 PARTICIPANT

# Using Data as an Asset

Most health centers have clinical, 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, workflow, and administration.

The resources below provide hands-on tools to assess your organization's data and analytical competencies and to transform data into meaningful, actionable information to drive organizational change.

## Building a Data-Driven Culture

- ▶ **ANALYTICS CAPABILITY ASSESSMENT** CCI offers this assessment, specifically designed for the safety-net setting. It covers three domains: people, process and technology.
- ▶ **BUILDING A DATA-DRIVEN CULTURE FOR POPULATION HEALTH MANAGEMENT** In this webinar, SA Kushinka from CCI and Jerry Lassa from DataMatt3rs share a framework and key capabilities for developing strong data processes and systems to improve care. These short videos are referenced during the webinar:
  - ▶ **"A Public Health Approach to Population Health Management"** (3:44)
  - ▶ **"Right-Sizing Data Governance"** (4:47)
  - ▶ **"Roles in a Data-Driven Organization"** (1:28)



*“As part of our work on empanelment, we first had to spend a lot of time cleaning up our data. This was a huge part of our success. Once we did that, we focused on democratizing the data, including drilling down to share results at the provider level. We sometimes think that people are sensitive about sharing at that level, but we found that it encouraged healthy competition among our providers.”*

— COMMUNICARE HEALTH CENTERS  
CP3 PARTICIPANT



## How Data Can Support Population Management

- ▶ **DATA FOR POPULATION MANAGEMENT** Adapted from a presentation by Dr. Shepherd, this tool outlines how various types of data can support different clinic roles.
- ▶ **TACTICAL APPROACHES TO POPULATION MANAGEMENT** Adapted from a presentation by Boris Kalikstein from Pivotal Moment Consulting, this tool describes the steps to transforming data into action.

### TOOLS FOR DATA VISUALIZATION

- ▶ **“Tableau in Action.”** In this webinar, Dr. Jason Cunningham and Dana Valley from West County Health Centers discussed how their health center put data visualization into action with Tableau.
- ▶ **“Design Thinking for Data Visualization.”** This webinar features Andrew Frueh, the Director of User Experience from Health Catalyst. He discusses the importance of data visualization, commonly accepted presentation rules, and how to effectively create visualizations.

## Going Deeper

CCI developed the **Data-Driven Culture website** to provide safety-net clinics with a range of tools to support the effective use of data. Available tools and resources include those to facilitate the development of a data strategy and data governance, build an effective data services department, implement data and improvement tactics, and engage the clinic team.

*“Now that we have all this data, we want to develop a process to leverage it at all levels, including the front desk, across our MA staff, among providers. We want to get our data out to everybody.”*

— VISTA COMMUNITY CLINIC, CP3 PARTICIPANT



# Building and Strengthening the Care Team

High-performing primary care relies, in part, on organized care teams that share responsibility for the health of their patient panel. The resources below will assist community health centers in identifying who should be on their care team and at what level (e.g., core team, extended team), how to structure the team and define roles, and methods to support care teams. Also included are specific examples of how the care team can work together on activities such as referral management, standing orders, and improving access.

Care team resources are organized around two concepts: (1) models for building the care team, including role definitions, ratios of providers to patients, and sample workflows and (2) approaches to supporting teamwork, including tools to support high-functioning teams

## Building the Care Team

▶ **RATIOS** The Multnomah County Health Department shares the care team ratios used in the Oregon APM.

### RESOURCES TO BUILD AND OPTIMIZE CARE TEAMS, INCLUDING:

- ▶ **“Share the Care.”** Exercise from the UCSF Center for Excellence in Primary Care
- ▶ **Orientation template.** Worksheet for new medical staff from Clinica Family Health
- ▶ **Team definition exercise.** Three levels: core team, extended team and affiliated team
- ▶ **HEALTH CENTER ROLES** Community Health Centers in Connecticut shares a model for pods, role definitions for medical assistants, and various activities for RNs, including complex care management.
- ▶ **JOB DESCRIPTION EXAMPLES** Clinica Family Health provides position descriptions for a range of clinic staff, including administration/operations, behavioral health, case managers, and providers.
- ▶ **COMPETENCY ASSESSMENTS** Clinica Family Health shares tools used for performance assessments by clinic role.

*“All our care teams have one hour of administrative time available per week for dedicated ‘team time.’ Teams have flexibility as to how they use this time. One team focused on preparing the curriculum for group visits, another spent the time optimizing their use of our electronic health record. It’s always challenging to take time out of the clinical day — there is an inherent tension between productivity and providing this time — but we worked with site leadership on the planning and it’s been very popular.”*

— MONTEREY COUNTY HEALTH DEPARTMENT  
CP3 PARTICIPANT



*“The most laborious part of provider engagement is ironing out the workflow within the dyad. One person has to ‘own’ the process and revise it as input is received from all those involved.”*

— LIFELONG MEDICAL CARE  
CP3 PARTICIPANT

## Doing the Work: Critical Care Team Functions

- ▶ **TEAM-BASED CARE WORKFLOW** Indicates which person on the care team is responsible for various components of care (e.g., medication refills, test results, point of care testing, etc.).
- ▶ **DEFINING TASK WORK** Key tasks for standard work functions of primary care. This includes assessing performance, building and maintaining effective teams, using rapid cycle tests of change, and making new or improved functions sustainable.
- ▶ **STANDING ORDERS** Dr. Shepherd describes Clinica’s process to adopt standing orders.
- ▶ **IMPROVING ACCESS AND REFERRAL MANAGEMENT** Dr. Shepherd, formerly of Clinica Family Health, outlines how a care team can work together to improve access and referral management.

## Supporting Teamwork

- ▶ **FRAMEWORK FOR TOUGH CONVERSATIONS** Catalyz shares the Nonviolent Communication Model (also called Compassionate or Collaborative Communication). It’s a four-step framework for talking through a difficult situation focusing on self-empathy, empathy, and honest self-expression.
- ▶ **GROUPS VERSUS TEAMS** Catalyz defines the difference between groups and teams and offers a TRIZ exercise around working agreements.

## Going Deeper

- ▶ **COMPREHENSIVE LEARNING SESSION 1** Review the entire slide deck and all **handouts** for “CP3 Population Health Management Training” that introduced many of the above concepts and tools.
- ▶ **CREATING PATIENT CENTERED TEAM-BASED PRIMARY CARE** The Agency for Healthcare Research and Quality offers a white paper on team-based primary care.

# Panels

Empanelment is foundational for managing population health. It is the process of assigning patients to primary care providers and care teams so that their care is better coordinated and managed by a team that knows them and can address important care gaps. The tools below are designed to support the empanelment process, including:

- Assigning patients to providers and care teams;
- Calculating demand and supply to determine panel sizes;
- Adjusting panel size based on the impact of age, gender, and other variables (e.g., seasonal fluctuations);
- Identifying and closing care gaps.

Many of these resources were developed as part of CCI's three-part empanelment series. Links to webinars and materials are included below.

## Empanelment

- ▶ **BACKGROUND** Read more about the value of empanelment, variables that impact panel size, and how to assess demand and capacity.
- ▶ **SIZE EXAMPLE** Virginia Garcia Memorial Health Center provides their approach to panel size and scheduling, as used in the Oregon APM.
- ▶ **FOUR-CUT METHODOLOGY** The four-cut methodology is a process used to assign patients to providers based on utilization patterns. This tool includes a description of the methodology and an example of how it can be used.
- ▶ **CALCULATING PANEL SIZE** Three tools support empanelment, including a formula to calculate the correct panel size, a narrative explanation of how to calculate demand and supply, and a list of panel adjustments factors by age and gender.
- ▶ **BALANCE** A number of factors that contribute to balancing panels, including the average visits per patient and per year, total clinical hours, target panel sizes, and more. All this is laid out in an easy to use tool.

*“We designed a simple, no frills empanelment process. Our IT staff used the 4-cut method to auto assign all patients who had been seen in the last 12 months. This initial list was probably about 70% accurate. Then our panel manager ran a daily audit of appointments, comparing the patient’s assigned PCP against the provider they actually saw. Where a mismatch was identified, the panel manager reviewed the patient’s appointment history and then determined which provider should be their PCP. Since January, between 80% and 90% of our patients had visits scheduled with their assigned provider.”*

— TIBURCIO VASQUEZ HEALTH CENTER  
CP3 PARTICIPANT



## Panel Maintenance and Management

- ▶ **MANAGING DEMAND** Developed by Petaluma Health Center, this series of tools will help to manage weekly and short-term demand for appointments. The tools also describe the demand considerations of new patients.

**POLICY / REPORT EXAMPLES** Clinica Family Health shares the following internal protocols, policies and reports:

- ▶ **Appointment types, scheduling rules, and definitions.** A protocol for oversight, timeliness and management of appointment setting. The protocol also defines various appointment types and lengths.
- ▶ **New patient scheduling and panel size management**
- ▶ **Report example.** A report used to track the panel size of providers across this multi-site system.
- ▶ **CONSIDERATIONS IN OPTIMIZING EMPANELMENT** This narrative describes the various issues that can impact empanelment, including no shows, unfilled appointments, seasonal demand fluctuation, and variations in provider practice style.
- ▶ **MEDICAL ASSISTANT (MA) PANEL MANAGEMENT SUMMARY** To learn more about the role that MAs can play, read this summary of Community Health Center's approach to MA Panel Management.

## Going Deeper

- ▶ **EMPANELMENT SERIES** CCI hosted a three-part webinar series on empanelment. **Series 1.0, Part 1: "The Need to Belong"** (54:52) addresses why panels are important to patient-centered care, how to begin, special circumstances to consider, and reports that support empanelment. **Series 1.0, Part 2: "There's No Room"** (59:14) addresses factors impacting panel size, how to use the four-cut method, and continuity reporting. **Series 2.0: "Leveraging Empanelment to Improve Access"** (1:02:00) addresses metrics for measuring access to care and strategies to reduce demand and increase supply.
- ▶ **EMPANELMENT: ESTABLISHING PATIENT-PROVIDER RELATIONSHIPS** The Safety Net Medical Home Initiative released this implementation guide which addresses pre-empanelment work, panel size analysis tools, ongoing monitoring and adjustment, and case studies.

# Planned Care

Planned Care consists of a set of intentional steps designed to gauge patients' needs, and deliver timely services and supports to meet those needs. The components of planned care include assessing and tracking patient's health status, providing evidence-based preventive care, effective management of chronic conditions, and leveraging tools and technology to improve efficiency (i.e., through clinical decision support, patient tracking). The tools in this section are designed to support planned care activities, such as managing the referral process, implementing standing order sets, optimizing the care team to support planned care activities, patient registries, etc.

## Implementing Planned Care

- ▶ **PLANNED CARE MILESTONES** Understand the key activities involved in implementing planned care by following the milestones described in this tool. They include coordinating outreach and in-reach, core team huddles, care plan development, and self-management support.
- ▶ **FOUR ACTION STEPS** These steps describe the components that support planned care, designed around assessing performance, building effective care teams, conducting rapid cycle tests of change, and improving standard work functions.
- ▶ **REFERRAL MANAGEMENT** Learn the components of designing and implementing a process to manage referrals, including internal and external referrals, and standardizing information exchange.

## Standing Orders

- ▶ **LESSONS LEARNED** This tool describes the lessons learned by Clinica Family Health as they implemented standing orders.
- ▶ **SET EXAMPLES** Access a range of standing orders sets, including those for planned care, diabetes, nurse appointments, and other conditions.
- ▶ **PROTOCOLS** Procedures for nursing visits, medication refills and dispensing, and vaccines, among others.

*“When implementing planned care, we recommend standardizing the pre-visit planning process. Develop a checklist for MAs that includes everything they need to prepare for each day. That way, the MA can make sure they have what they need for each patient. The checklist also really improves our huddles.”*

— TIBURCIO VASQUEZ HEALTH CENTER  
CP3 PARTICIPANT





## Huddles

- ▶ **DAILY HUDDLE CHECKLIST** Virginia Garcia Memorial Health Center in Oregon provides a checklist of activities for their daily huddle.

## Registries

- ▶ **OUTREACH CARE PLANNER** Review two examples of how registries can support planned care outreach and closing the loop.
- ▶ **OUTREACH WORKFLOW** Understand Clinica Family Health's approach to using registries, focusing on assigning action steps to clinic staff and providing clear criteria about next steps.

## Going Deeper

- ▶ **HEALTHY HUDDLES** The UCSF Center for Excellence in Primary Care offers a range of tools to support implementing huddles, including **"Healthy Huddle Warm Up Tool,"** designing a huddle, preparing staff, and how to follow-up on issues addressed in the huddle.
- ▶ **IMPLEMENTATION GUIDE** The Safety Net Medical Home Initiative offers the implementation guide *Organized, Evidence-Based Care: Planning Care for Individual Patients and Whole Populations*. The guide introduces the chronic care model as the foundation to explore planned care, decision support, and care management.
- ▶ **PLANNED CARE: ACTION STEPS** "Primary Care Team Guide" describes action steps to implement planned care. Steps include assigning care delivery components to specific staff, using protocols and standing orders, and other components central to planned care.
- ▶ **10 BUILDING BLOCKS OF HIGH-PERFORMING PRIMARY CARE** *The Annals of Family Medicine* published this seminal article, which addresses foundational components of primary care, including data-driven improvement, team-based care, and empanelment.
- ▶ **CHRONIC CARE MODEL** *Health Affairs* "Evidence on the Chronic Care Model in the New Millennium" explores the evidence that supports the effectiveness of the chronic care model.

# Expanding Access

Alternative or “nontraditional” visits expand a clinic’s capacity to care for patients beyond the traditional face-to-face encounter. Both telephone visits with providers and shared medical appointments offer additional opportunities to provide support for patients, as well as to enhance the role of other members of the care team.

Similarly, patient portals facilitate access to health care information and serve as an important tool in providing patient-centered care. Portals can include a range of features, such as secure email, appointment making, access to test results, and more.

Resources in this section address the elements of planning for both alternative visit types (e.g., designing the visits, establishing workflows, coding and documentation) and developing patient portals.

## Telephone Visits

► **DEFINITIONS, CODING, AND DOCUMENTATION** San Mateo Medical Center details the components that a telephone visit must include and offers guidance regarding coding and documentation.

► **WORKFLOW EXAMPLES** Two workflows provided by San Mateo Medical Center outline processes for scheduling telephone visits initiated by a patient and phone visits conducted by either a provider or a nurse.

► **TOOLKIT** San Mateo Medical Center offers a toolkit to design telephone visits. It includes definitions for visits, sample guidelines, and scheduling workflows and protocols.



*“When we developed our process for phone visits, we worked to engage all our stakeholders. It wasn’t limited to providers and scheduling. We needed to educate our coding teams to make sure visits were being captured and with our finance team to work on payment. We also had to engage our patient service associates to correctly schedule the visits. Even our EHR team needed to be engaged. It takes a village and you have to engage everyone at the outset.”*

— SAN MATEO MEDICAL CENTER  
CP3 PARTICIPANT



*“CP3 was instrumental in helping us plan our 3-month pilot for telephone visits. We used San Mateo Medical Center’s toolkit and the details were really valuable. In particular, we appreciated the workflow diagrams, information on coding and billing and the scripts.”*

— VENICE FAMILY CLINIC  
CP3 PARTICIPANT

## Group Visits

- ▶ **TYPES AND ESSENTIAL ELEMENTS** Two types of group visits — access groups and continuity groups — are described here, as well as the key components of group visits.
- ▶ **PLANNING FORM** Community health centers can use this resource to begin planning for shared medical appointments (e.g., group visits). The form describes more than 25 different elements that should be addressed in planning.
- ▶ **VISIT FLOW** This planning sheet summarizes the components of a group visit, including the number and type of staff needed, frequency and duration of the visits (for provider and patient), the number of appointment slots used, and processes to document the visit.
- ▶ **CONFIDENTIALITY AGREEMENT EXAMPLE** Sample patient-facing agreement for use in group visits.
- ▶ **BILLING** Brief guidelines on billing for group visits.

## Patient Portals

- ▶ **BACKGROUND** Shasta Community Health Center Chief Information Officer Charles Kitzman summarizes the key components of developing patient portals. This tool is adapted from this **presentation**.
- ▶ **IMPLEMENTATION** Developed by Charles Kitzman for CCI’s Spreading Innovations program, this presentation details the experience of Shasta Community Health Center in implementing a patient portal.
- ▶ **WORK PLAN TEMPLATE** Created by Jim Meyers as part of CCI’s Spreading Innovations program, this detailed work plan template is based on 16 elements that are common to launching and administering a portal.

## Going Deeper

- ▶ **ALTERNATIVE VISIT WEBINARS** CCI hosted a two-part series to support the implementation of alternative visit types. **Part 1** (57:15) featured a speaker from OCHIN who discussed the definitions of meaningful alternative visits and how workflows can evolve with value-based care. **Part 2** (1:07:42) included speakers from San Mateo Medical Center, Shasta Health Center, and Clinica Family Health who showcased efforts around implementing telephone visits, patient portals, and shared medical appointments (e.g., group visits).
- ▶ **TELEPHONE VISITS** Access all the materials provided by San Mateo Medical Center as part of the program's learning lab addressing telephone visits. Materials include a description of the journey to design and launch telephone visits, additional workflows, and other tools.
- ▶ **GROUP VISITS** Clinica Family Health shares a range of resources to support the implementation of group visits. Materials include the process for Clinica to use group visits, various design and planning tools, and outcomes.

**LEARNING LAB** As part of the population health program, CCI hosted a learning lab addressing many facets of technology-enabled care. Access the slides below:

- ▶ **Home INR Monitoring: Using Patient Portal to Engage Patients and Gather Data**
- ▶ **CP3 Population Health Management (entire day's sessions)**
- ▶ **CALIFORNIA HEALTH CARE FOUNDATION PATIENT PORTALS RESOURCE CENTER** Tools to support the three phases of adoption, including planning, implementation, and optimization.

### CCI SPREADING SOLUTIONS THAT WORK PATIENT PORTAL WEBINARS:

- ▶ **Workflows** (1:00:39)
- ▶ **Increasing User Engagement** (1:00:24)
- ▶ **Minor Access and Issues** (58:08)

*“Our goal was to conduct 500 telephone visits. In less than two years we’ve had more than 5,000 visits. It’s become integrated into our provider workflow.”*

— SAN MATEO MEDICAL CENTER  
CP3 PARTICIPANT



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