Connected Care Accelerator

Background

The COVID-19 pandemic has upended the way California delivers health care. Health care systems completely restructured their services to keep both their patients and employees safe. Federal policymakers acted quickly to expand coverage and payment for virtual care. The California Department of Health Care Services also dismantled previous barriers to telehealth and began requiring Medi-Cal managed care plans to pay providers for telephone and video visits at the same rate as in-person visits.

As a result, many California health care providers rapidly pivoted from in-person visits to remote patient visits. For these organizations, this shift has been transformational, as they've adopted new technology, overhauled workflows, and redefined team member roles.

While there is still a great deal of uncertainty in how patients will engage with the health care system beyond the pandemic, it is clear they won't want to give up their ability to remotely access care. This program will ensure essential data is collected to advocate for more permanent policy changes to sustain telehealth and virtual care into the future.

The Connected Care Accelerator, an initiative of the California Health Care Foundation, has been designed in partnership with the Center for Care Innovations to support organizations in different implementation phases of "virtual care," also commonly known as "telehealth" or "telemedicine." The accelerator has two separate tracks:

- For the **Infrastructure and Spread** track, CHCF will provide $50,000 grants to up to 30 safety net practices to expand and improve virtual care. The support will be tailored to achieve geographic diversity with a focus on safety net providers whose patients are predominantly covered by Medi-Cal, uninsured, and communities of color. The goal of this track is to support early implementation and build the necessary infrastructure to provide virtual care.
- For the **Innovation Learning Collaborative** track, CHCF will provide $100,000 grants and technical assistance to up to 20 safety net practices where the majority of their patients are covered by Medi-Cal and uninsured. This track is designed for organizations further along in their implementation of virtual care approaches and have a committed team to

test, learn, and share best practices.

ABOUT THE INFRASTRUCTURE AND SPREAD TRACK

Made possible by the California Health Care Foundation.

Infrastructure and Spread Track Structure & Core Content

The Infrastructure and Spread track is available to up to 30 health care safety net practices. This track will provide funding to organizations interested in building their infrastructure for telehealth. Selected organizations will have the option to learn about best practices through CCI open webinars, the CCI Academy, and online tools and resources.

Each organization selected for the Infrastructure and Spread track should expect to make the following commitments over this 12-month program:

- Identify a team lead that will be responsible for managing the virtual care efforts at their organization.
- Collecting and submitting quarterly on a standardized set of measures, as well as contributing to sharing stories about the impact of the work.
- Participate in qualitative interviews with the evaluation team, as needed.

Selected organizations have the option to participate in additional CCI webinars and peer-sharing conversations to advance implementation of virtual care.

APPLICATION

Who's Eligible?

We're looking for safety net health care organizations that provide comprehensive primary care services primarily to a substantial percentage of Medi-Cal and uninsured patients. Our goal is to select organizations from across California with the goal of achieving geographic diversity and reaching communities most vulnerable to COVID-19 and may benefit from additional support.

Eligible organizations include:

- Federally qualified health centers (FQHC) and FQHC look-alikes
- Community clinics, rural health clinics, and free clinics
- Ambulatory care clinics owned and operated by public hospitals
- Indian Health Service clinics
- Independent provider care practices

Eligible organizations must meet the following criteria:

- Providers actively use an EMR system.
- The organization serves at least 8,000 unduplicated patients.
- To achieve the program's goal of reaching Medi-Cal and uninsured patients, with a particular emphasis on serving non-white patients known to be more affected by the COVID-19 epidemic, eligible organizations can meet any one of the follow three criteria:
    - Patient population is at least 70 percent Medi-Cal and/or uninsured
    - Patient population is at least 40 percent Medi-Cal and/or uninsured, as well as 20 percent Black
    - Patient population is at least 40 percent Medi-Cal and/or uninsured, as well as 70 percent non-white

If your organization does not meet the above criteria but serves a traditionally hard-to-reach or marginalized community, you may still apply as an exception. Please review the narrative questions for more details.

Given the program goal of equitably expanding statewide access to virtual care delivery, organizations that have already received telehealth grant funding from HealthNet in the last four months are not eligible to apply.

Statewide associations and regional clinic consortia are also not eligible to apply.

What Makes a Strong Applicant?

1. **High Proportion of Medi-Cal or Uninsured Patients:** Successful applicants will meet the eligibility requirements; preference will be given to organizations that serve an even higher proportion that the minimums described above.

2. **Organization Serves a Unique Population or Need in Their Community:** Preference will be given to organizations that provide needed care for a greater share of patients of color in their community and/or non-English speaking groups.

3. **Data and IT Systems in Place:** Successful applicants will have basic data and IT systems in place with the ability to track patient-level data. Data reporting for this program will build upon existing standard data collection reports.

Our Expectations

This track is intended to be flexible to the needs of participants, so we encourage each organization to leverage the offerings by committing to the following:

1. **Data Reporting and Evaluation Activities:** Teams are expected to work closely with an external evaluator to collect and submit data at the beginning, mid-point and end of the program on a standardized set of measures, as well as progress reports to share stories about the impact of the work. This program will ensure essential data is collected to advocate for more permanent policy changes to sustain telehealth into the future.

   (See **Appendix A** for a current draft description of the measures.) The finalized definitions of program measures, including detailed specifications, will be shared during the accelerator's kickoff webinar. The evaluation team will work with individual organizations about how best to pull and report data.

2. **Patient and Community Involvement:** Successful organizations will involve patients' and community members' perspectives and experiences in plans to implement virtual care services, taking into account disparities in virtual care access across certain patient populations.

3. **Participation in Program Activities:** Organizations are encouraged to participate in ongoing webinars and discussions in the CCI Academy. These resources are not required for selected participants. Organizations may be asked to share lessons learned by presenting examples of their project successes and challenges with the larger program.

How to Apply

STEP 1: WATCH THE INFORMATIONAL WEBINAR (OPTIONAL)

Register for our Informational Webinar on Tuesday, June 9th at 1pm to hear a more detailed description of the program and listen to some questions and answers.

STEP 2: APPLY ONLINE

Your proposal and budget must be submitted online by Friday, June 19, 2020 by 5pm.

Applications should include the following:

1. Application Submission Form
2. Application Narrative: Includes responses to the five questions listed below.
3. Budget Template
4. Tax Status Documentation

Application Narrative Questions

Please limit your entire response to a maximum of three pages, using at least 11-point font and 1-inch margins.

1. **Overall Goals:** Why is your organization interested in participating in this program? How do you intend to use the grant funds?

2. **Virtual Care Delivery Experience:** What virtual care delivery tools have you started using since the beginning of the COVID-19 pandemic (i.e., phone visits, video visits, patient portal, text messaging, etc.)?

3. **Participation:** Who in your organization is leading your telehealth infrastructure efforts? What is their role and how do you intend to spread learnings and practices within your organization?

4. **Data Reporting Capabilities:** Please describe your current ability to collect and report on patient-level data regarding visit modality (i.e., in-person, phone, video). Please describe how you would collect data quarterly by visit type and if you could report this data by race/ethnicity?

5. **For organizations that do not meet all of the outlined criteria and serve traditionally hard-to-reach or marginalized communities (250 words or less):** Please describe the community your organization uniquely serves and how they and your organization is being affected by COVID-19. Include details about which criteria your organization does not meet and why (e.g., this practice has two full-time providers that serve 6,000 patients total). We will only select participants from this group if we are unable to achieve our health equity goals from applicants who meet the full criteria.

Key Dates:

June 1, 2020	Request for Applications Opens
June 9, 2020	Informational Webinar
June 1 - 19, 2020	Application Period
June 19, 2020	Application Due, 5pm PST
July 15, 2020	Accelerator Acceptances Announced
August 13, 2020	Accelerator Kickoff Webinar

Next Steps

CCI and CHCF will review applications. Our intent is to select a group of up to 30 safety net health care organizations interested in building their infrastructure for telehealth and virtual care. The cohort will be announced via email by **Wednesday, July 15, 2020.**

ABOUT THE INNOVATION LEARNING COLLABORATIVE

Made possible by the California Health Care Foundation, with additional funding from the Blue Shield of California Foundation.

Background

As health care providers shift from addressing coronavirus-related emergency care to the whole spectrum of patients' needs, there are a number of opportunities to innovate and learn together. Health care providers caring for the most vulnerable populations in our communities need to design a sustainable infrastructure and approach to safely care for all patients using telehealth and digital tools.

Patients accessing primary care and behavioral health services in safety net systems may experience additional digital barriers and challenges to accessing care. Population health approaches, team structures, and internal operations must to be adapted to ensure that patients served by safety net health systems aren't left behind; additional support is needed to ensure disparities aren't exacerbated by limited literacy skills, the availability of internet-enabled devices, limited broadband, and lack of support for patients to fully engage in their health care.

There is no clear playbook and a limited evidence base for how to make these fundamental changes in safety net health care systems. However, with any new challenge, we believe the answers will emerge from our community of providers who are willing to innovate, test, and learn from each other.

Innovation Learning Collaborative Structure & Core Content

The goal of the Innovation Learning Collaborative is to provide a testing ground and support for organizations to rapidly design, test, and share solutions to effectively care for patients using virtual care strategies. The lessons and best practices developed by participants will lay

important groundwork for strengthening telehealth throughout California's health care safety net. Over the course of this 12-month learning collaborative, participants will join one of three learning cohorts, each aimed at strengthening and sustainably integrating virtual care into the standard of care.

The objectives of the learning collaborative are to:

- Identify the biggest challenges and opportunities to strengthen population health management, build virtual care teams, and engage patients who face digital barriers to care.
- Identify and test virtual care delivery changes to better understand the infrastructure, data, staff, and skills necessary to support these changes.
- Uncover and document the best practices to effectively manage patient populations remotely.
- Share best practices and bring successful changes to scale.

We will select up to 20 health care safety net organizations in California to participate in a virtual innovation learning collaborative. We will provide an array of support and technical assistance including:

- Virtual peer learning convenings,
- Monthly webinars featuring experts in the field,
- Monthly virtual "office hours" with experts,
- Site visits to exemplar organizations, which are likely to be virtual, and
- Educational resources and tools.

An external evaluator will support the collection of data and stories to ensure we assess the overall impact of the learning collaborative and advocate for long-term policy changes to sustain virtual care.

Each organization selected for the Innovation Learning Collaborative should expect to make the following commitments:

- Identify a core project team that will be responsible for leading the testing, implementation, and learning for the organization. At minimum, this team should consist of at least four members including clinical, administrative, and operational leads. No more than six team members total.
- Ensure that the selected team will participate in all of the core activities (i.e., virtual meetings, testing and implementation of solutions, and evaluation activities).
- Actively participate in at least one of the three cohorts, described below.
- Commit to testing changes and sharing learnings with peers and the safety net community.
- Submit quarterly reports on metrics your organization will collect throughout the program.

- Participate in qualitative interviews with the evaluation team, as needed.
- Be willing to share your experiences and learning with others in the safety net.

Participating organizations will select at least one of the following cohorts. The descriptions below outline the type of issues the teams will tackle in these breakout groups. However, the specific activities and focus areas will be co-designed with accepted applicants.

Cohort 1: Sustaining Virtual Care Teams

Organizations participating in this cohort will uncover and rethink how virtual care teams:

- Deliver primary care services to vulnerable populations.
- Collaborate and effectively communicate with other members of their care team.
- Effectively and efficiently carry out workflows and protocols (e.g., huddle, chart prep, manage the patient experience, etc.)
- Support patients virtually to effectively use digital and virtual tools.
- Identify and define new roles for care team members.

Cohort 2: Population Management

Organizations participating in this cohort will uncover and rethink ways multidisciplinary care teams:

- Coordinate interventions for patients with chronic conditions (e.g., diabetes, cardiovascular disease, etc.)
- Proactively reach out to patients for preventive services.
- Approach planned care and in-reach.
- Stratify and tailor care to sub-populations (e.g., patients in need of prenatal care, behavioral health services, etc.)
- Leverage remote monitoring devices, as well as approaches to manage data and patient needs.
- Manage care for complex patients, including addressing social needs.

Cohort 3: Engaging Patients with Digital Barriers

Organizations participating in this cohort will focus on ways to engage patients in a virtual setting by creatively testing new ways to provide:

- Interpreter services and culturally responsive care for limited English proficient patients.
- Support to patients with limited technical abilities or experience.
- Outreach and connection to homeless patients.

- Connectivity to patient populations with limited access to technology, broadband and Wi-Fi.
- Services tailored to older adult populations that may experience additional technological challenges.

APPLICATION

Who's Eligible?

We're looking for health care safety net organizations that provide comprehensive primary care services primarily to at least 8,000 unduplicated patients. Medi-Cal and uninsured patients must make up **at least 50 percent** of the organizations' total patient population. We'll select organizations across the state with the goal of achieving geographic diversity and reaching communities most vulnerable to COVID-19.

Qualifying organizations include:

- Federally qualified health centers (FQHC) and FQHC look-alikes
- Community clinics, rural health clinics, and free clinics
- Ambulatory care clinics owned and operated by public hospitals
- Indian Health Service clinics
- Independent provider care practices

Statewide associations and regional clinic consortia are not eligible to apply.

What Makes a Strong Applicant?

1. **Prior Experience and Desire to Expand Virtual Care Capabilities:** Successful applicants should currently provide telehealth via phone and video to patients at the time of applying. Organizations must possess a strong understanding of innovation and performance improvement methods, and they must be ready to measure and test changes throughout this learning collaborative. Grant funds should be used to enhance ability to provide virtual care.

2. **Clear Vision of How to Sustain the Efforts in This Program:** Successful applicants will demonstrate keen understanding of existing challenges and articulate how they intend to further spread or enhance virtual care capabilities within their organization beyond this grant funding opportunity.

3. **Data, IT, and QI Systems in Place:** Successful applicants will have data, IT, and QI systems in place with the ability to track patient-level data and make improvements to telehealth approaches based upon the data. Data reporting for this program will build upon existing standard data collection reports.

Our Expectations

This learning collaborative is intended to be flexible and responsive to the needs of participants, so we ask each organization to act as a partner in shaping the program by committing to the following:

1. **Leadership Buy-In:** Successful organizations will require leadership that is committed to testing and implementing innovative virtual care delivery approaches. It will also require leaders to understand the importance of using innovation and performance improvement to spread telehealth practices across the organization and willingness to leverage organizational resources to operationalize such changes. We expect strong leadership support from the Chief Medical Officer and Chief Operating Officer at a minimum, as demonstrated through the letter of leadership support.

2. **Patient and Community Involvement:** Successful organizations will involve patients' and community members' perspectives and experiences in their plans to implement telehealth services, taking into account disparities in telehealth access across certain patient populations.

3. **Continuity and a Dedicated Team:** At least four individuals (and no more than six) are required to commit to the core program team to promote continuity and participate in core activities (i.e., webinars and evaluation activities). The team should include:
    - At least one senior leader who can ensure protected time for team members to participate in learning collaborative activities, as well as lead change within their organizations. This individual should also have decision-making authority to move telehealth efforts forward;
    - A clinical champion that has a significant role in your organization's telehealth efforts;
    - At least one frontline staff or provider who can inform and lead the operational and clinical implementation within the organization; and
    - A data or IT staff that can help to manage data and metrics collection and reporting.

4. **Participation in Program Activities:** Team members are expected to fully participate in program activities including all virtual learning sessions, site visits, one in-person convening in 2021, and monthly calls with faculty and experts. Teams will be asked to complete defined pre-work assignments for virtual and in-person sessions and will be asked to work on multiple changes in the organization to advance team-based care, population health management, and/or engaging patients. Participants will also share lessons learned by presenting examples of their project successes and challenges.

5. **Data Reporting and Evaluation Activities:** Teams are expected to work closely with an external evaluator to collect and submit data at the beginning, mid-point and end of the

program on a standardized set of measures, as well as progress reports to share stories about the impact of the work. This program will ensure essential data is collected to advocate for more permanent policy changes to sustain telehealth and virtual care into the future.

(See **Appendix A** for a current draft description of the measures.) The finalized definitions of program measures, including detailed specifications, will be shared during the program's kickoff webinar. The evaluation team will work with individual organizations about how best to pull and report data.

How to Apply

STEP 1: WATCH THE INFORMATIONAL WEBINAR (OPTIONAL)

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STEP 2: APPLY ONLINE

Your proposal and budget must be submitted online by **Friday, June 19, 2020 by 5pm.**

Applications should include the following:

1. Application Submission Form
2. Application Narrative**:** Includes responses to the seven questions listed below.
3. Budget Template
4. Tax Status Documentation
5. Letter of Leadership Support: This letter should demonstrate organizational commitment to implement or expand upon virtual care capabilities and collect data as needed. This includes dedicated time for the core team to fully participate in program activities and implement changes at the clinical and organizational level. The letter should be submitted by either the Chief Medical Officer, Chief Operating Officer, or Chief Executive Officer.

Application Narrative Questions

Please limit your entire response to a maximum of five pages, using at least 11-point font and 1-inch margins.

1. **Overall Goals:** Why is your organization interested in participating in this learning collaborative? What do you want to learn through this collaborative?

2. **Cohort Preference:** Which of the three cohorts (sustaining virtual care teams, population management, engaging patients with digital barriers) is/are most relevant to your goals? Please describe why this is critical for your organization's success. What are the biggest challenges you hope to address?

3. **Virtual Care Experience:** Please describe your experience with virtual care including modalities of care, whether you are using other virtual tools (portals, texting, phone apps), and what you have learned about the challenges and opportunities for implementing telehealth and virtual care in your organization. If you have successful virtual shifts in care, please share an example.

4. **QI Experience:** Please describe a clinical or operational improvement project you implemented in your organization. What data (outcome measure, processes measures, qualitative measures) did you collect and how often? What is an example of one change you made based on what you learned from the tests and/or data?

5. **Data Reporting Capabilities:** Please describe your current ability to collect and report on patient-level data regarding visit modality (i.e., in-person, phone, video). Please describe what tools or instruments you utilize to collect patient and provider experience and whether you have included any questions about virtual care. Please describe how you would collect data quarterly by visit type and if you could report this data by race/ethnicity?

6. **Site Selection:** What site will you test virtual care practices and why did you select this particular site? What are key characteristics about that site (e.g., patient demographics, number of providers, and prior virtual care capabilities) that fit the program goals?

7. **Budget Narrative:** Please describe how you would use the $100,000 grant to advance your virtual care program. For example, will the funding be used to train staff, purchase equipment, or support patients?

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August 13, 2020	Program Accelerator Kickoff Webinar

Next Steps

CCI and CHCF will review applications. Our intent is to select an engaged group of up to 20 health care safety net organizations that are committed to testing new virtual care approaches and will leverage this support to advance their efforts. The acceptances will be announced via email by **Wednesday, July 15, 2020.**

Appendix A: Connected Care Accelerator Measures

The purpose of the Connected Care measures is to support teams in understanding their progress in implementing telehealth over the course of the program, assess differences in utilization by payer type and race/ethnicity, and to understand how screening and response practices are advancing across the learning collaborative participants. This information will also be helpful in making a case to sustain these services into the future.

The Connected Care measurement approach will collect a mix of qualitative and quantitative data from all participating organizations. The measures described in the tables 1-2 below will be used across all participating organizations. Learning Collaborative participants will be required to report on measures in tables 2 and 3.

Table 1. Evaluation methods

Data type	Description
Clinical data reporting*	Reporting from all participating organizations on key quantitative metrics related to utilization of telehealth (see Table 2). Reporting would be required three times during the initiative (a) Beginning which also includes pre-Covid data, b) after 6 months, c) and at end of program.
Participant interviews	Reflective interviews will be conducted to collect qualitative data on progress and lessons related to telehealth implementation, facilitators and barriers, care team experiences with providing virtual care. Interviews may include: ● Interviews with key leaders at each participating organization at mid-point and the end of the learning collaborative ● Interviews with front line staff from a sample of organizations (e.g., clinicians, other members of the care team)
Provider/staff survey	Survey will be conducted with a small sample of providers and staff to assess provider/staff experience with delivering care virtually.
Learning collaborative activities	ONLY for Learning Collaborative: Post-event surveys will be conducted to understand satisfaction with the activity and how future offerings can be improved.

Table 2: Clinical Data Reporting (both tracks)

Measure description	Required numbers to report (3 times during initiative): Report 1 (Pre-COVID and beginning of program); Report 2 (after 6 months); Report 3 (at end of program)
Distribution of primary care visits by visit type	• Total number of primary care encounters since last report • Number of face-to-face encounters in primary care • Number of phone encounters in primary care • Number of video encounters in primary care
Patients reached by telehealth in primary care	• Total number of patients seen for primary care since last report • Number of patients seen for primary care with at least one face-to-face encounter • Number of patients seen for primary care with at least one phone encounter • Number of patients seen for primary care with at least one video encounter
Distribution of behavioral health visits by visit type provided by own credentialed staff	• Total number of behavioral health care encounters since last report • Number of face-to-face behavioral health encounters in their clinic • Number of behavioral health phone encounters • Number of behavioral health video encounters
Patients reached by telehealth in behavioral health	• Total number of patients seen by behavioral health since last report • Number of patients seen by behavioral health with at least one face-to-face encounter • Number of patients seen by behavioral health with at least one phone encounter • Number of patients seen by behavioral health with at least one video encounter

Utilization of telehealth by payer type	• Number of primary care telehealth encounters (video) by payer type:
	  ○ Commercial
	  ○ Medi-Cal FFS/MC
	  ○ Medicare FFS/MC
	  ○ Other payer (e.g., VA)
	  ○ Uninsured (self-pay, free care, county indigent care)
	• Number of primary care encounters (phone) by payer type:
	  ○ Commercial
	  ○ Medi-Cal FFS/MC
	  ○ Medicare FFS/MC
	  ○ Other payer (e.g., VA)
	  ○ Uninsured (self-pay, free care, county indigent care)

Table 3: Clinical Data Reporting (for Learning Collaborative only)	
Distribution of specialty care visits (not including BH) by visit type	• Total number of behavioral health care encounters since last report • Number of face-to-face behavioral health encounters in their clinic • Number of behavioral health phone encounters • Number of behavioral health video encounters
Patients reached by telehealth in specialty care (not including BH) by visit type	• Total number of patients seen by behavioral health since last report • Number of patients seen by behavioral health with at least one face-to-face encounter • Number of patients seen by behavioral health with at least one phone encounter • Number of patients seen by behavioral health with at least one video encounter
Utilization by race & ethnicity for primary care and BH visits	• Overall race/ethnicity distribution of patient population • Race/ethnicity distribution of patients who have at least one face-to-face visit • Race/ethnicity distribution of patients who have at least one phone visit • Race/ethnicity distribution of patients who have at least one video visit
Utilization by age for primary care & BH visits	• Overall age distribution of patient population • Age distribution of patients who have at least one face-to-face visit • Age distribution of patients who have at least one phone visit • Age distribution of patients who have at least one video visit