Population Health Learning Network

December 5, 2019

Convening #3
Our Core Program Team

Megan O’Brien, Senior Manager, CCI
Tammy Fisher, Senior Director, CCI
Dr. Carolyn Shepherd, Clinical Director
Meaghan Copeland, Program Consultant
Our Extended Team

Denise Armstorff
Improvement Advisor & PHLN Coach

Jerry Lassa
Data Matt3rs & PHLN Metrics Guru

Juliane Tomlin
CCI Senior Program Manager & PHLN Coach
Our Presenters Today

Kathryn Phillips, MPH
Senior Program Officer, Improving Access, CHCF

Parinda Khatri, PhD
Chief Clinical Officer, Cherokee Health Systems

Jen Spezeski
Evaluation Lead, JSI
What’s in Store for the Day?

**Connect with peers** to advance your population health management capabilities by sharing best practices and lessons learned across PHLN domains.

Strengthen your **year two projects** by infusing new ways of thinking and problem-solving challenges through peer dialogue and exchange.

Celebrate movement toward building a **culture around population health** management.

Identify **key steps for sustaining and spreading** population health capabilities throughout your organization.

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**Opening Speakers**

**Storyboard Gallery**

**Virtual Site Visits**

**In-Person Affinity Group Time**

**Team Time**

**Celebrate!**
Housekeeping Reminders

Wifi

Parking Validation

Materials
Program Portal Page: Convening Materials

Includes:

- Links to the agenda
- Venue Map
- Contact information for attendees
- Links to the slides & storyboards

PHLN Convening #3

The Population Health Learning Network’s third (and final) convening will be held on December 5th at the Hilton Oakland Airport hotel.

Contents (Click to Jump to Sections):

- Event Information
- Pre-Work
- General Handouts
- PHLN Connections: Virtual Site Visits

PHLN Goal

The PHLN aims to improve the health and wellbeing of more than 1.2 million Californians by bringing together safety net primary care organizations to strengthen and advance their population health management strategies.
PHLN Approach

1. Create a peer group for **learning and innovation**
2. Increase the pressure to ‘keep up’ and accelerate progress **towards a new norm**
3. Adopt and deeply **implement a broad range of changes** critical to high performing population health management
4. **Spread proven changes** to other high-volume FQHCs
5. Test and deploy innovations critical to whole person care: assessing and responding **social needs, behavioral health integration, care management** for vulnerable populations
6. Align population health management strategies toward **value-based care and payment**
What are we talking about?

The work of population health is to maximize health and wellbeing in a defined population by:

- **stratifying** the population based on risk
- **delivering** care management interventions to foster health and wellbeing and to prevent illness and disease
- **engaging** patients, their families, and care teams in care strategies to achieve positive health and wellbeing outcomes
At the Beginning...

Strongest in the domains of:
1. Planned Care & In-Reach
2. Behavioral Health Integration
3. Learning Organizations
4. Team-Based Care

Greater areas of opportunity:
1. Care Management for Complex Patients
2. Social Needs
3. Data Governance & Analytics
4. Proactive Outreach
Our PHLN Destination

Year 1: Spark & Test Ideas

Year 2: Implement & Spread
Progress Toward Our Goal

Figure 7. Majority of participants took meaningful steps, successfully tested, or successfully implemented changes

- We took meaningful steps towards meeting our aim statement:
  - Strongly Agree/Agree: 96%
  - Neutral: 4%

- We successfully implemented changes or interventions from our aim statement:
  - Strongly Agree/Agree: 82%
  - Neutral: 16%

- We successfully tested changes or interventions from our aim statement:
  - Strongly Agree/Agree: 78%
  - Neutral: 22%

84% of participants agreed they had successfully implemented a change as a result of the PHLN.
Outcomes to Date

**Venice:** For nearly 2,000 diabetics, foot exam improved from 69% to 75% and retinal exams improved from 53% to 62%.

**North County:** Improved DM Poor Control (A1c > 9) for over 5,000 diabetics by 3.4% (3 month rolling).

**CMC:** Nearly 14,000 outreach attempts to HPSJ members, resulting in 44% with appointment scheduled, 61% completing appointment and 27% with wellness visits.

**NEVHC:** 518 (9%) of 5,800 DM patients assigned to risk tier 3-4 and 1% of those (5 patients) offered services. 454 of 700 (61%) patients received well adolescent exam. 560 of 2,746 (20%) patients received CCS.

**Neighborhood:** Continuity at EVP pilot site improved from 31% to 45%.

**CommuniCare:** Patient continuity improved from 41% to 53% and provider continuity improved from 43% to 55%.
Key Changes We’ve Seen

- Implemented **new care team roles & expanded roles** for non-clinical staff
- Implemented **data reports** to identify missed opportunities and gaps in care
- Tested **risk stratification methods** to align care management
- Tested social needs screening tools and refined workflows
- Created a **behavioral health registry** to manage treatment plans for depression
- Testing and implemented outreach strategies and tools, such as text messaging & phone campaigns
San Francisco Health Network

Figure 1. Patient-level outreach results by age

- n=381
- n=80, 21% scheduled
- n=42, 53% showed

# patients called
# patients scheduled appointment
# patients showed to appointment

12-24 months  | 2-6 years old  | 7-11 years  | 12-19 years old
North East Medical Services

Screened **2,512** patients with PHQ2, **4%** (92) positive

**91%** (86) had same day PHQ9, **58%** (50) positive PHQ 9 score>10

Goal was to have BH f/u on **60%**, **88%** patients (44) had f/u
LA County DHS focused on food insecurity by integrating a screening question into the EHR workflow.
Culture Change

QI Infrastructure
• “…all team members are trained on the PDSA model, understand the metrics they’re accountable for, and have a voice in quality improvement activities.”

Leadership
• “…work together in an innovative way and we’ve had the chance to get to know one another better. This has unified us as leaders.”

Working Differently
• “Becoming part of the PHLN has given us infrastructure, information, and timelines for completing work that we had struggled to prioritize.”

Collaboration
• “Thanks to our participation in the PHLN, we have incorporated human-centered design brainstorming tools and prototyping during team meeting. These tools have transformed the way we collaborate and develop new program ideas.”
Building a Culture of Pop Health

1. Reflect individually on sticky notes (3 mins):
   • What actions has your organization taken toward building a culture of population health management?
   • What have you gained from the PHLN and other initiatives that have helped you in building a culture?

2. Share with your team & prioritize top 1-2 ideas (7 mins).

“Building a culture where everyone is responsible and invested in quality improvement metrics is key to improving population health.”

- Annual Survey Respondent (2018)
Reflections and Looking Ahead
Value Based Payment and Population Health

Parinda Khatri, PhD
Chief Clinical Officer
Cherokee Health Systems

Population Health Learning Network Convening #3
Center for Care Innovations
Oakland, CA
Dec 5, 2019
Good Morning!

Happy to be back in California!
The View on VBP

Current State

Key Elements

Getting Ready
Current State:

VBP Models

- Pay for Performance
- Bundled Payments
- Primary Care Services Payment
- Shared Savings
- Shared Risk
- OTHER MISC
A 50-State Review of Value-Based Care and Payment Innovation

Commissioned by Change Healthcare

StateVBRstudy.com

- 40 states have implemented VBP for 2 years or longer
- 8 are in early stages
- 4 have little to no VBP
- 50% are multi-payor in scope
- 23 states have VBP targets
- 22 states have or planning ACOs
- 16 states have or planning EOCs
Current State: VBP

- F4S Linked to Quality and Value
- APM built on F4S Architecture
- Population Based Payment
Current State: The Need for Speed (?)  
*Hurry Up and Wait!*
Current State: VBP

HELLO
My name is

HOT MESS
WE'RE USED TO BEING THE UNDERDOG. I'M OK WITH THIS.

Nate Johnson

KEEP CALM AND EMBRACE THE MESS
Innovative Practices: Key Elements

Social and Community Factors
- Transportation
- Food Security
- Housing
- Safety
- Environmental Toxins
- Adverse Experiences

Collaboration & Partnerships
- Team Based Care
- Expanded Workforce
- Payors
- Patients
- Community Based Organizations
- Businesses
- Schools
- Law Enforcement

DATA
- Transparency
- Interoperability
- Sharing
- Analytics
Food as Medicine

Why Food Could Be the Best Medicine of All

By Alice Park | Photographs by Zachary Zavislak for

February 21, 2019

Invited Commentary
April 22, 2019

Food Is Medicine—The Promise and Challenges of Integrating Food and Nutrition Into Health Care

Food As Medicine: It’s Not Just A Fringe Idea Anymore

Why doctors are writing prescriptions for food

Evidence suggests that healthy diets may be effective in helping chronic diseases such as type 2 diabetes, heart disease, and hyper

Food Is Medicine: Providing Medically Tailored Meals to Community Members with Disease-associated Nutritional Risk Supports Stable BMI and Decreased Hospitalization (P12-005-19)

Jule Anne Henstenburg, Claudia Parvanta, Laura Pontiggia, Sue Daugherty, Nicole Laverty
Collaboration & Partnerships

Ride to Health

We have partnered with Gwinnett County Council on Aging to assist households overcome transportation barriers to healthcare services. Eligible households can receive transportation vouchers for physical and behavioral health appointments.

Eligibility criteria:
- Gwinnett County resident
- Household has 2 or fewer vehicles
- Income below 50% of the Area Median Income
- Healthcare services must be located within Gwinnett County

Applications for Ride to Health can be requested in our office at 104 Washington St in Snellville by calling 770-558-7220.

TRENDS IN PAYER-PROVIDER PARTNERSHIPS

- Overall number of product partnerships launched per year
- Partnered product launches by state
- Joint venture or co-branded products as % of total
- Communication of value-based compensation in product announcements
- Partnerships by exchange

Primary Behavioral Health
INTEGRATED CARE
Training Academy
Data Data Data Data Data
MOM!
WE'RE PLAYING HOSPITAL C.F.O. AND TIMMY SAYS HIS ANALYTICS ARE BETTER THAN MINE!
Getting Ready: *Data*

### Descriptive
- Information
- Knowledge

### Prediction
- Insight
- Action

### Prescriptive
- Wisdom
- Optimization

Tailored (e.g. precision medicine) strategy for complexity

- # of patients with chronic health problems
- High Need? Vulnerable? Medically Complex?
Getting Ready: Data Infrastructure

Accurate
Precise

Accessible

Actionable
# Getting Ready: Big Data to Actionable Data

## Amerigroup Quality Measures - Summary by Region

## CHC Needs Assessment & Intervention Guidance

<table>
<thead>
<tr>
<th>CHC Needs</th>
<th>Intervention Guidance</th>
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</table>
| Patient has Chronic Condition                  | • Does the patient see specialists outside CHS?  
|                                                |   • If so, request ROI for each specialist, review upcoming apts, problem-solve and address barriers to attendance.  
|                                                |   • Ask the patient, “How often do you miss your medications?”  
|                                                |   • Problem-solve and address barriers to medication adherence (e.g., can the not afford medication, don’t understand how to take medication, don’t remember to take medication).  
|                                                |   • Encourage healthy diet, activity, and smoking cessation.                           |
| Patient has had no PCP Visit in > 6 months     | • Who is patient’s assigned PCP?  
|                                                |   • If patient is assigned to an outside (non-CHS) PCP, does the patient want to become a CHS primary care patient?  
|                                                |   • If so, add patient to a list of patients needing CHS PCP visits.  
|                                                |   • If patient desires to keep an outside PCP, assist patient in scheduling a visit and problem-solving barriers to attendance.  |
Common Theme in Evidence
Healthcare is about RELATIONSHIPS
RELATIONSHIPS IN THE ORGANIZATION

Clinical

IT

Finance

Operations
RELATIONSHIPS WITH ‘NEIGHBORS’

• CBOs
• PAYORS
• SCHOOLS
• ACADEMIC
• GOVERNMENT
Building the Foundation: PHLN Domains

- Learning Organization
- Team Based Care
- Planned Care/In-Reach
- Proactive Outreach
- Behavioral Health Integration
- Care Management for Complex Patients
- Social Needs
- Data Governance and Analytics
You had the power all along, my dear.

Thank you for your attention. Any questions?
Health Care that Works for All Californians

The California Health Care Foundation is helping low-income Californians get the health care they need.
Implications for California

• **VBP has taken root:**
  • In 2017, 59% of all healthcare payments were through VBP arrangements and 35% of payments were through sophisticated VBP models such as shared savings, downside risk, and population-based payment.

• **Major advantage:** Successful experience with PRIME, WPC, GPP (Waiver 2020 components)
  • Big changes can be made!
  • Experimentation: Required to have 60% of patients attributed to APMs by 2020

• **Major barrier:** Fragmented financing systems, behavioral health, physical health

• **Unknown:** Potential of the CalAIM process, “modernizing Medi-Cal”
  • Focus on population health & wellness; identify and mitigate social determinants of health and reduce disparities and inequities
  • Striving to improve alignment and coordination
  • Goal is to reduce per-capita cost
Another driver?
Patients notice the dysfunction of our current payment model

CHCF Listening to Low-Income Consumers Project, NORC, early results of focus groups, statewide survey 2020
• Patients were aware of encounter-based payment and they felt the consequences
• Many told stories of being asked to “come back in” for test results because it was the “only way the provider could get paid”

In Their Words: Consumers’ Vision for a Person-Centered Primary Care System, Nov 2019, Community Catalyst Center for Consumer Engagement
• Consumers welcome a broader conversation with their primary care provider, not just focused on their medical treatment, but exploring the needs of the whole person.
• Consumers resonated with the concept of a “one-stop shop” where they could receive a wide variety of services under one roof, including medical services, mental health treatment and counseling, and social services.

“They’re so busy, they don’t have the time to actually check you out. Right? Let alone to talk to you about food and your house and everything else. They’re lucky if you can get down to what you’re in there for.” Pennsylvania participant
Questions?
Q&A: States to learn from

**State-led APMs**
- Colorado (capitated)
- Oregon (capitated)
- Washington (capitated)
- Arizona (rate adjustment)

**Medicaid ACO – Shared Savings**
- Massachusetts (C3)
- Minnesota (FQHC Urban Health Network)
Q&A: PRIME

• Includes 21 PHCS and some district and municipal hospitals
• $3.26 billion federal investment
• Key capabilities:
  • Quality improvement infrastructure and mindset (LEAN), 50-60 metrics
    ✓ Year-over-year performance improvement targets – 10% gap closure between current performance and 90th percentile
    ✓ Must be above 25th percentile to receive payment
    ✓ Performance above 90th percentile must be maintained
  • Proactive outreach & patient engagement
  • Data analytics, risk stratification, predictive modeling
  • Partnerships & collaboration
  • Integration

To learn more: https://safetynetinstitute.org/membersupport/primesupport/
Q& A: What do we see in Medicaid; specifically aimed at FQHCs?

- **Pay-for-Performance**: FQHCs are financially rewarded for meeting pre-defined performance benchmarks on quality measures for patient satisfaction, resource use, health outcomes, or health care costs. FQHCs receive an incentive payment outside of the PPS rate from the health plan and/or the independent physician associations (IPA).
  - Many examples; Partnership Health Plan

- **Risk-Based Capitation**: Providers receive a prospective per member, per-month (PMPM) payment to cover a range of services (e.g., primary care), with payment contractually linked to quality metrics. This model typically applies to large provider organizations with patient panels large enough to bear the medical risk.
  - Health Care LA, IPA

- **Shared Savings (Upside-Only)**: Providers that succeed in keeping costs below a total cost of care benchmark keep a percentage of the savings. The shared savings payment is made retrospectively, contingent upon quality performance.
  - Inland Empire Health Plan

- **Virtual ACO with Shared Savings**: Health plans and FQHCs can come together to build a virtual ACO that would address total cost of care.
  - AltaMed Health Services

- **Bundled Payments (Upside-Only)**: FQHCs would receive an all-inclusive payment for a specific scope of services to treat an “episode of care” with a defined start and end point.

To learn more: Center for Health Care Strategies, Inc. Accelerating Value-Based Payment in California’s FQHCs: Options for Medicaid Health Plans. [http://www.chcs.org/media/CA-VBP-FQHC-Report_041619.pdf](http://www.chcs.org/media/CA-VBP-FQHC-Report_041619.pdf)
PHLN Connections: Virtual Site Visit #1
Figure 3. PHLN Activities helped teams to make progress on population health management efforts

- Site Visits: 80% (14% in-person, 6% other)
- In-Person Convenings: 74% (20% other, 6% virtual)
- Coaching: 51% (32% in-person, 15% other, 2% virtual)
- Leading Profound Change Workshop: 44% (42% in-person, 9% other, 4% virtual)
- PHLN Portal and Resource Library: 17% (42% in-person, 35% other, 6% virtual)
- Virtual Office Hours: 17% (28% in-person, 39% other, 14% virtual, 3% in-person)
- Webinars: 16% (56% in-person, 26% other, 2% virtual)
- Baseline Assessment Tool: 15% (34% in-person, 40% other, 11% virtual)
- PHLN Forum: 12% (26% in-person, 46% other, 16% virtual)
- Monthly Newsletter: 6% (42% in-person, 40% other, 12% virtual)
Role of Networking & Connection

“...having those connections provides the ability to learn what other organizations do best, who to contact when there are questions or challenges and learnings from their shared challenges.”

“We don’t have to create the wheel ourselves. We can take a look at other health centers’ prototypes and see what might work in our setting.”
Sharing Lessons Learned from the PHLN: Storyboard Gallery
Storyboard Activity

• Opportunity to share & learn about what other teams outside your affinity group did this past year
• Each team will share a presentation (up to 15 minutes) using a storyboard
• As the listener, you’ll be asked to listen & share:
  • What experiences or lessons learned do you or your organization have to offer that relates to the work presenting team?
  • What are your responses to the questions that the team is asking?
  • What is something you’d like to learn more about?
• Each group will have a facilitator
# Team Assignments

<table>
<thead>
<tr>
<th>Room</th>
<th>Teams</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAIN Room</td>
<td>Teams: Serve the People, Neighborhood, NEMS, CommuniCare, &amp; Venice</td>
<td>Megan</td>
</tr>
<tr>
<td>FOUNTAIN Room</td>
<td>Teams: Santa Rosa, NEVHC, LA LGBT, &amp; SPLG</td>
<td>Tammy</td>
</tr>
<tr>
<td>EMPIRE Room</td>
<td>Teams: LA County, CMC, Axis, Santa Barbara, &amp; Ravenswood</td>
<td>Carolyn</td>
</tr>
<tr>
<td>FORUM Room</td>
<td>Teams: North County, SFHN, Vista, LifeLong, &amp; NAHC</td>
<td>Denise</td>
</tr>
<tr>
<td>PACIFIC Room</td>
<td>Teams: Tri-City, Chapa De, Open Door, La Clinica</td>
<td>Jerry</td>
</tr>
</tbody>
</table>
Venue Map

Registration & Meals:
Foyer

Main Room:
International Ballroom

Breakout Rooms:
• Pacific Room
• Fountain Room
• Empire (Bldg 5)
• Forum (Bldg 5)
15 Min Break & Storyboard Gallery Starts at 11am
Lunch
12:30pm-1:30pm
Affinity Groups
1:30-2:30 pm
Affinity Group Time

1. Social Needs

2. Risk Stratification

3. Access Strategies to Optimize Planned Care & Outreach

4. Care Team Roles

5. Behavioral Health Integration

Use time for a round robin of updates, plan to work on next, & asks of others
Venue Map

Registration & Meals: Foyer

Main Room: International Ballroom

Breakout Rooms:
- Pacific Room
- Fountain Room
- Empire (Bldg 5)
- Forum (Bldg 5)
Break
2:30-2:50 pm
PHLN Connections: Virtual Site Visit #2
Spreading & Sustaining Population Health Innovations

Dr. Carolyn Shepherd
Spreading and Sustaining PHLN Innovations

It’s not the innovation that matters most...
What’s the Problem?

- Innovation project too big
- Driven by one zealot
- Expect heroics
- Fail to test at scale
- No process reliability
- Require innovators to spread
- Stop checking the measures

1. Set Direction
2. Establish the Foundation
3. Will
4. Ideas
5. Execution

IHI Leadership Framework for Improvement

   - Make the status quo uncomfortable
   - Make the future attractive
   - Plan for Improvement
   - Set Aims/Allocate Resources
   - Measure System Performance
   - Provide Encouragement
   - Make Financial Linkages
   - Learn Subject Matter
   - Work on the Larger System

2. Establish the Foundation
   - Reframe Operating Values
   - Build Improvement Capability
   - Prepare Personally
   - Choose and Align the Senior Team
   - Build Relationships
   - Develop Future Leaders

3. Build Will
   - Read and Scan Widely, Learn from Other Industries and Disciplines
   - Benchmark to Find Ideas
   - Listen to Customers
   - Invest in Research and Development
   - Manage Knowledge
   - Understand Organization as a System

4. Generate Ideas
   - Use Model for Improvement for Design and Redesign
   - Review and Guide Key Initiatives
   - Spread Ideas
   - Communicate Results
   - Sustain Improved Levels of Performance

5. Execute Change

Salud Para La Gente
Colorectal Cancer Screening

Referral Dept.
Follow-up on open colonoscopy orders

Execution to spread and sustain CRC innovations

PDSA FIT/FLU

PA upgrade
RHM Image Category Changes
(Images to satisfy Dashboard)

Open FIT Orders Recall

M.R. Clean-up
GI-to-colonoscopy

CRC QI-topic Team Meetings
(Multiple PDSAs)

*MA Standing Order FIT Pt List - with Pending CRC orders & missed opportunities
*CRC QI-topic Team Meetings


0%  10%  20%  30%  40%  50%  60%
Key Execution Domains

Communication
- Vision, information gathering and sharing, networking

Infrastructure
- Policies, processes, resources like staffing, space, equipment

Measurement
- Adoption, sustaining and re-evaluation

Leadership
- Formal leaders and informal leaders
Who Leads on Spreading and Sustaining Innovations?

Executive Leadership

Management Leadership

Team Leadership

Strategic Spread and Sustaining

Tactical Spread
LA LGBT Colon Cancer Screening Rates Planning for Spread and Sustaining Improvements
IHI-
From Improving to Sustaining

PHLN Aim: Enroll 1000 by 12/31/19

![Graph showing patients enrolled per month from January 2018 to November 2019. The graph indicates fluctuations in enrollment with a total enrollment of 948 as of 11/18/2019. The target is to enroll 1000 by the end of the year.]
Quality Control Tool for Quality Control

Number of Patients Eligible to Bill for CCM per Month

- **Good**: Over 300
- **Average**: 101-299
- **Low**: 100 or less

- Yellow: Average
- Green: Good
- Red: Low

Execute!

Communication

Infrastructure

Measurement

Leadership

It’s not the innovation that matters most, it’s how effectively you sustain and spread the innovation.
<table>
<thead>
<tr>
<th>Key Area</th>
<th>Questions to uncover possible conflicts</th>
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<tbody>
<tr>
<td>Work design and infrastructure</td>
<td>Are clear roles and responsibilities explicit and aligned with the new PHLN processes?</td>
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<tr>
<td></td>
<td>Are the roles and responsibilities flexible enough to allow people to adjust to the new ways of doing things?</td>
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<tr>
<td></td>
<td>Does the work environment infrastructure encourage sustaining the change?</td>
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<tr>
<td>Demands from managers</td>
<td>Are the new PHLN expectations clear to managers?</td>
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<tr>
<td></td>
<td>Do they understand what's new, changed or not required anymore?</td>
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<tr>
<td></td>
<td>Are they clear about their boundaries?</td>
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<tr>
<td>Performance measurement</td>
<td>Do performance measures track desired PHLN behaviors?</td>
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<tr>
<td>Recognition systems</td>
<td>What gets noticed by leaders and influencers in the organization?</td>
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<tr>
<td></td>
<td>What gets mentioned in formal and informal situations?</td>
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<td>On what achievements and conditions are promotions based?</td>
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<tr>
<td></td>
<td>Do employees value current means of recognition?</td>
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<tr>
<td>Goal setting</td>
<td>Are individual goals consistent with overall PHLN objectives?</td>
</tr>
<tr>
<td>Skills and competencies</td>
<td>What new skills and competencies are needed for PHLN innovations?</td>
</tr>
<tr>
<td></td>
<td>What skills and competencies are now redundant?</td>
</tr>
<tr>
<td>Management systems</td>
<td>Do management systems measure the elements of PHLN innovation we wish to pay attention to?</td>
</tr>
<tr>
<td></td>
<td>Have new processes been introduced? How will they be measured?</td>
</tr>
<tr>
<td>Communication processes</td>
<td>What new information and feedback needs to circulate freely?</td>
</tr>
<tr>
<td>Relationships</td>
<td>Is the new PHLN working environment creating new patterns of interaction among individuals and departments?</td>
</tr>
<tr>
<td></td>
<td>How can these be supported?</td>
</tr>
<tr>
<td>Leadership</td>
<td>Does leadership continue to support and communicate the urgency for the PHLN changes?</td>
</tr>
</tbody>
</table>

Adapted from: The Heart of Change Field Guide Dan S. Cohen
For more information...


PHLN Connections:
Virtual Site Visit #3
Wrap-Up: Evaluation & What’s Next
4:30-5:00pm
What’s Next?

**PHLN Activities**

- **Monthly Newsletter** (until March 2020)
- **Coaching** (through end of January 2020)
- **Program Portal & Forum**
- **Affinity Group & Listservs** (CCI support ends in February 2020)
- **Evaluation Activities** (through April 2020)
PHLN Evaluation Activities:
Today – March 2020

PHLN Convening #3
Oakland, CA
12.05.19
Evaluation Overview
Your Feedback Was Used To…

• Identify strengths and areas of opportunity
• Expand features that you liked
• Guide content for learning opportunities
• Lift up successes and lessons learned
Upcoming Evaluation Activities
Final Feedback Survey

- Survey goes live: February 3, 2020
- Survey closes: February 28, 2020
- 1 response per team member

Endline Assessment

- Assessment goes live: March 2, 2020
- Survey closes: March 27, 2020
- 1 response per team

These may look familiar...
PHLN Reflection Conversations

• 30-60 min. conversations about your perspective on the PHLN and what comes next (e.g., sustainability, future opportunities for population health management).
• All conversations will take place Jan.–Mar.
• 1 per team

Case Study Interviews

• 1-2 hour conversations with your team to examine your journey implementing your Year 2 project.
• Only a subset of teams will be asked to participate.
• Interviews will take place in Jan.–Mar.
Routine Reporting

- No progress report for January 2020 (cancelled)
- Final report & budget reconciliation due to CCI by April 30, 2020

Wrapping everything up
Contact Information:

jenette_spezeski@jsi.com

Acknowledgements: This work is made possible with the support of the Center for Care Innovations, California HealthCare Foundation, and the Blue Shield of California Foundation.
Next Up:

• Thank you for helping us learn
• Experience with PHLN informed strategy
• Continue pushing for payment reform
• Study primary care spend and advocate for greater investments in primary care
• “Advancing Primary Care Collaborative,” Fall 2020 (pending Board approval)
  • Behavioral health integration
  • Social risk factors that impact health
Evaluation

Population Health Learning Network Convening #3 Evaluation

Thank you for completing this survey. Your feedback will inform our staff regarding the quality of today’s convening and help to improve future events. All responses will be kept confidential and only be presented in summary form. Please complete the evaluation and return to CCI at the end of the day.

Overall Impressions of Convening #3

Which of the following best represents your overall impression of the PHLN Convening #3?

- Poor
- Fair
- Good
- Very Good
- Excellent

Please indicate the degree to which you agree or disagree with the following. [Select one response per row]

What aspect of the convening was the most valuable? What could we have done differently or better?

Reflection on Each Session

Please indicate the degree to which you agree or disagree with the statement, “This session was a valuable use of my time.” [Select one response per row]

What are 3-5 actions that will you take as a result of attending the convening?

What additional support do you need to help sustain and expand the work you started in the PHLN?

Any other comments/suggestions?

Thank you for taking the time to provide your feedback!
Happy Hour & Networking Reception

Feel free to stay until 6:00pm
Thank you!

For questions contact:

Megan O’Brien
Senior Program Manager
Center for Care Innovations
mobrien@careinnovations.org

Meaghan Copeland
Program Consultant
Center for Care Innovations
meaghan@careinnovations.org