blue of california foundation

California Health Care Foundation

Dignity Health

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.

- 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

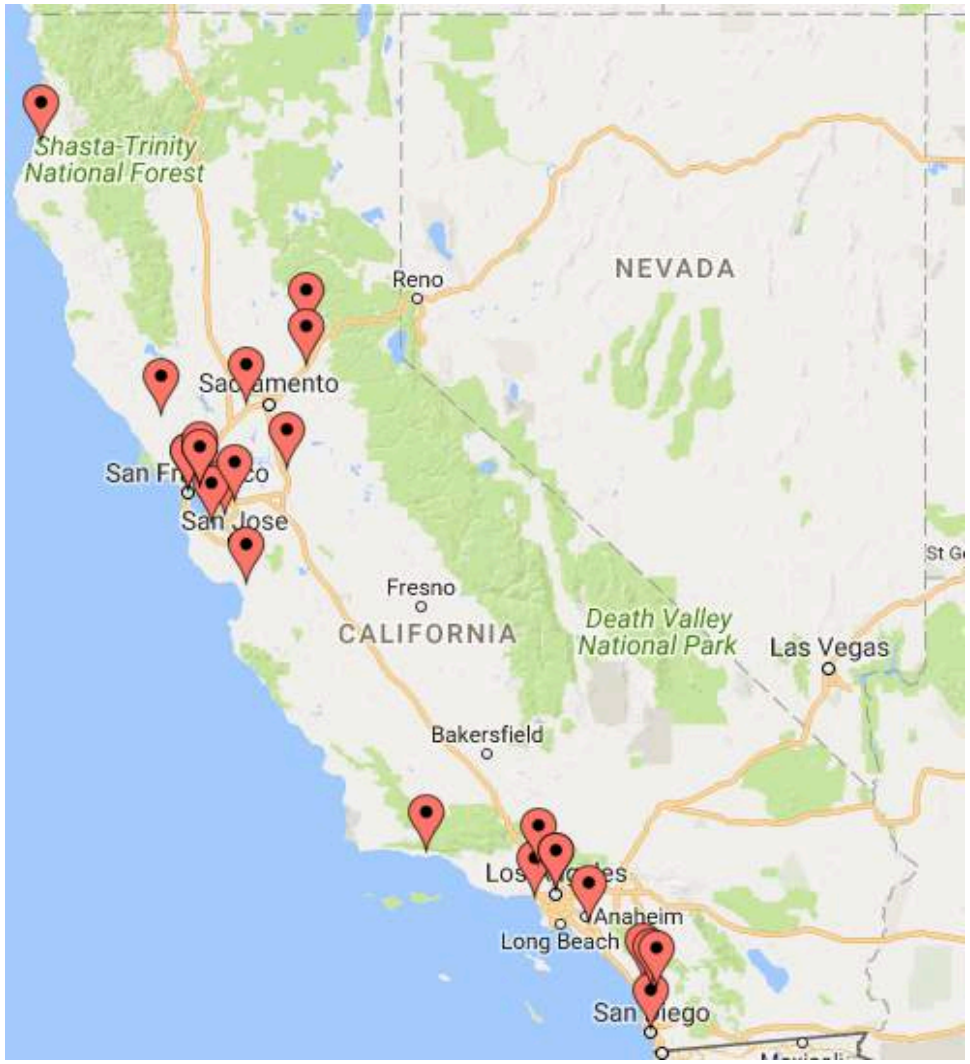
https://bit.ly/PHLNLS3

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

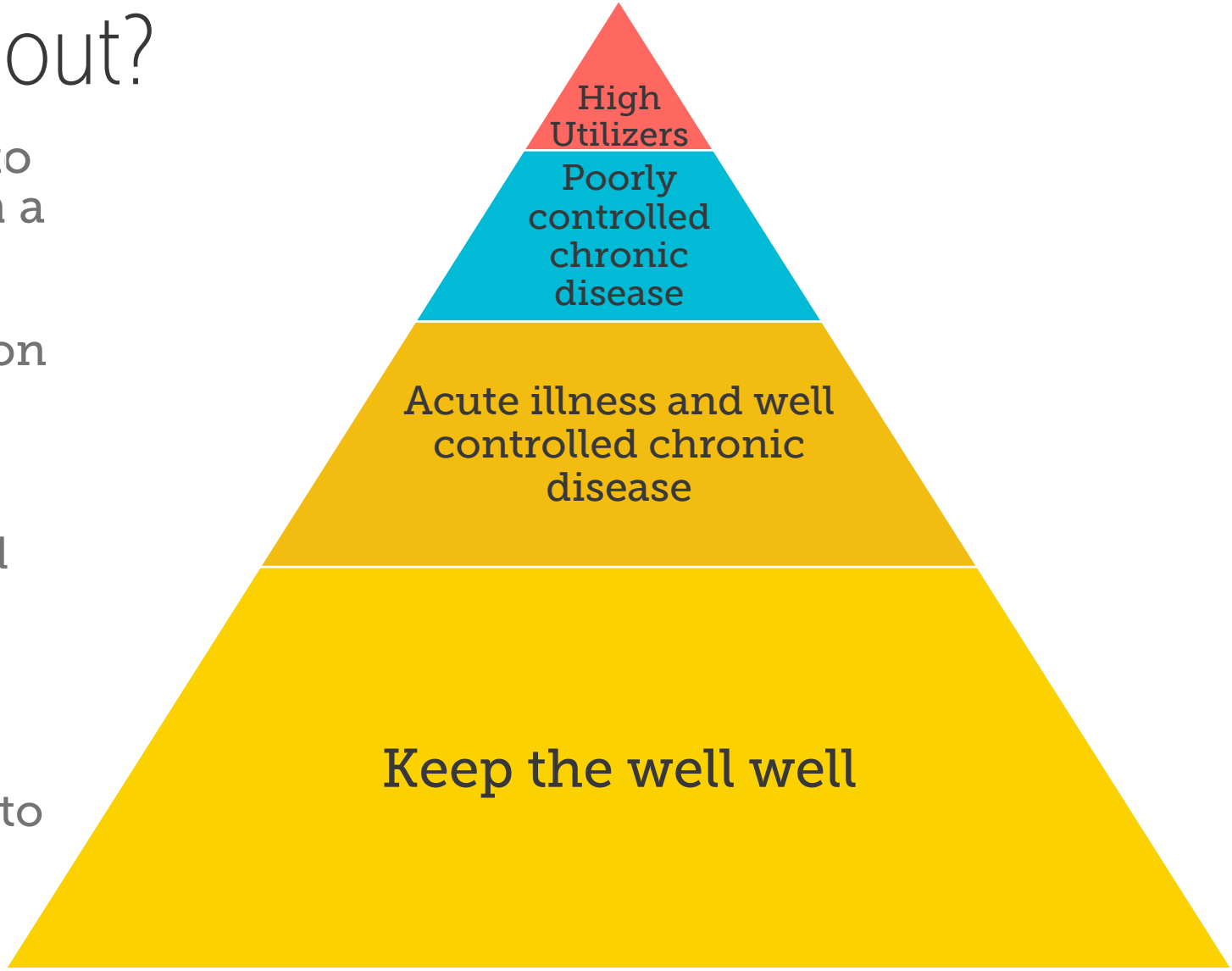
1. Create a peer group for **learning and innovation**
2. Increase the pressure to 'keep up' and accelerate progress **towards a new norm**
3. Adopt and deeply **implement a broad range of changes** critical to high performing population health management
4. **Spread proven changes** to other high-volume 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**



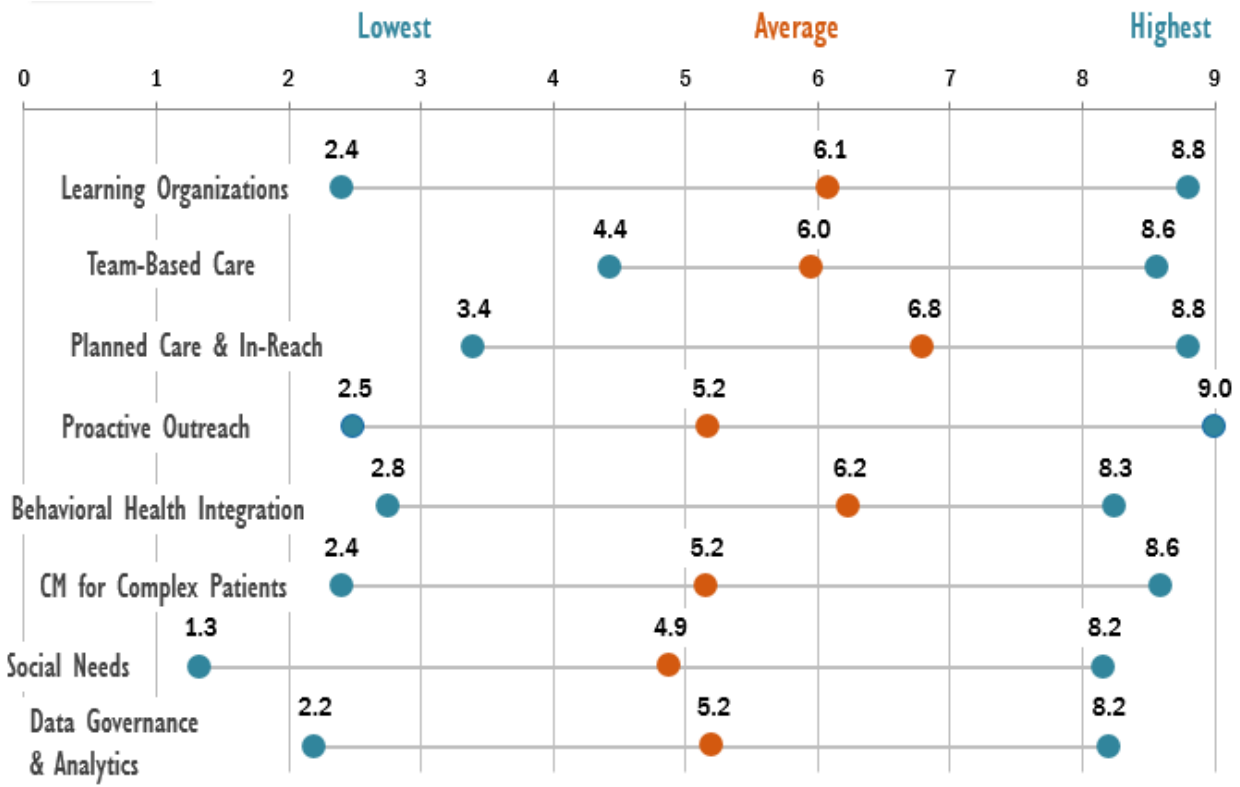
What are we talking about?

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...



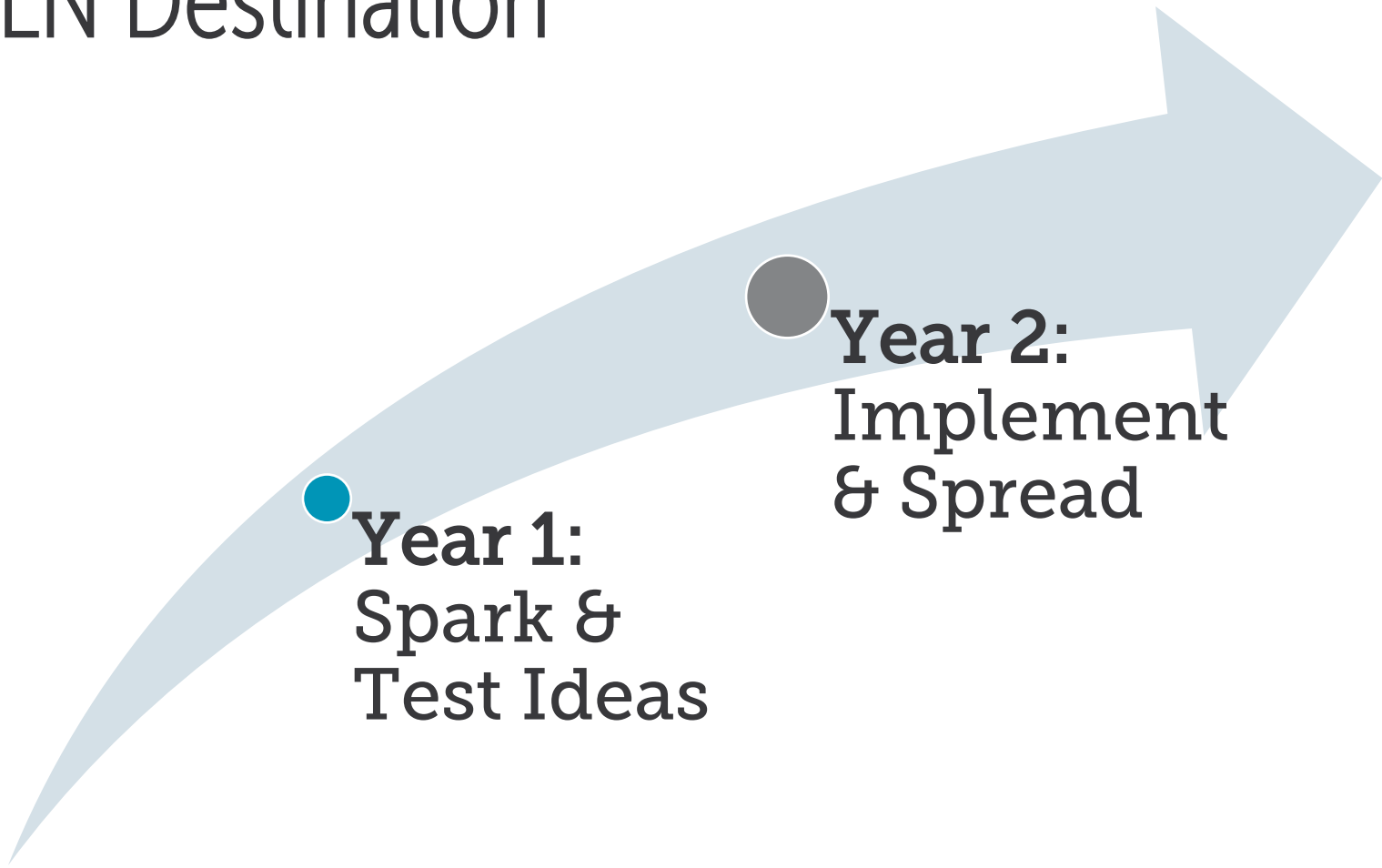
Strongest in the domains of:

1. Planned Care & In-Reach
2. Behavioral Health Integration
3. Learning Organizations
4. Team-Based Care

Greater areas of opportunity:

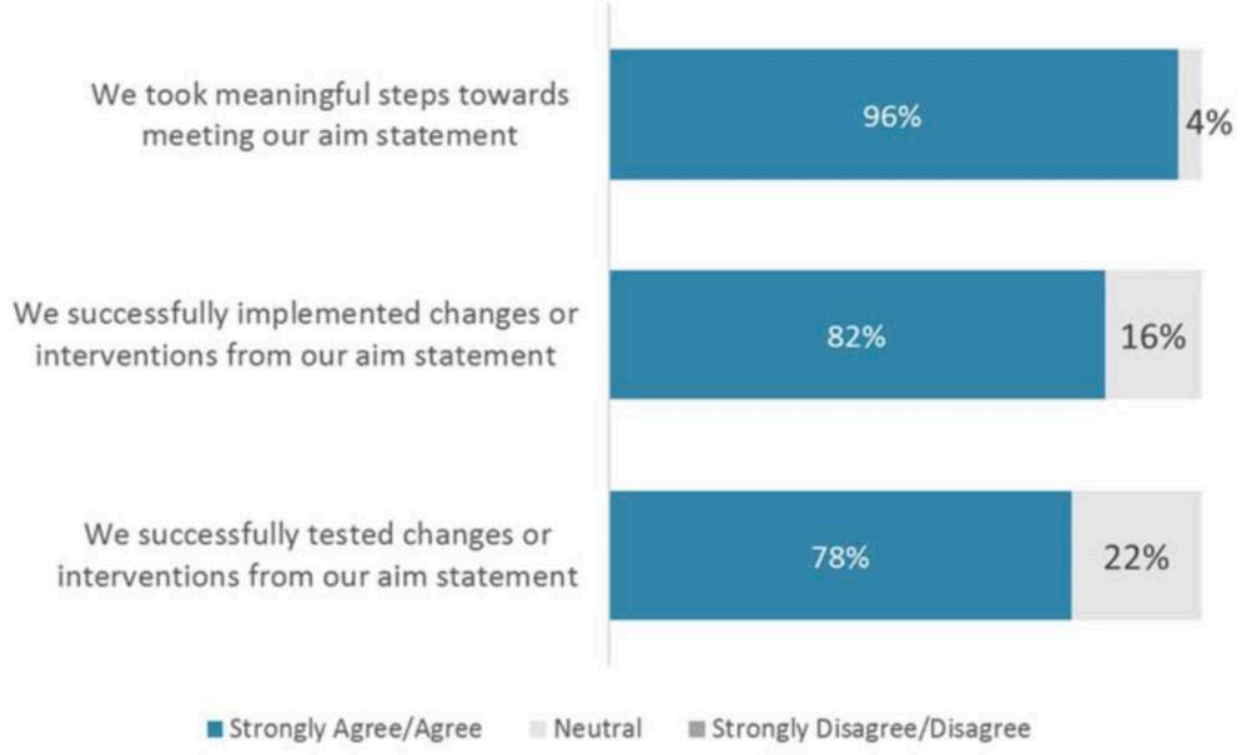
1. Care Management for Complex Patients
2. Social Needs
3. Data Governance & Analytics
4. Proactive Outreach

Our PHLN Destination



Progress Toward Our Goal

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



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

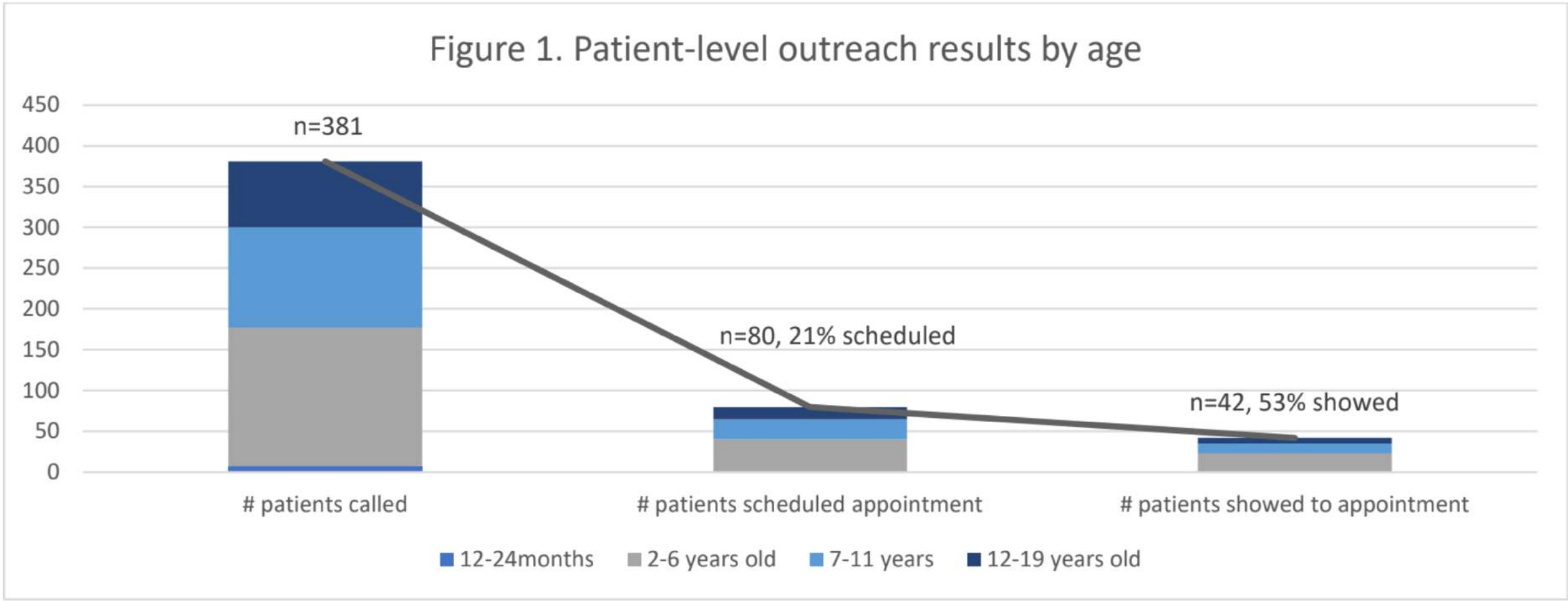
Tested **risk stratification methods** to align care management

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



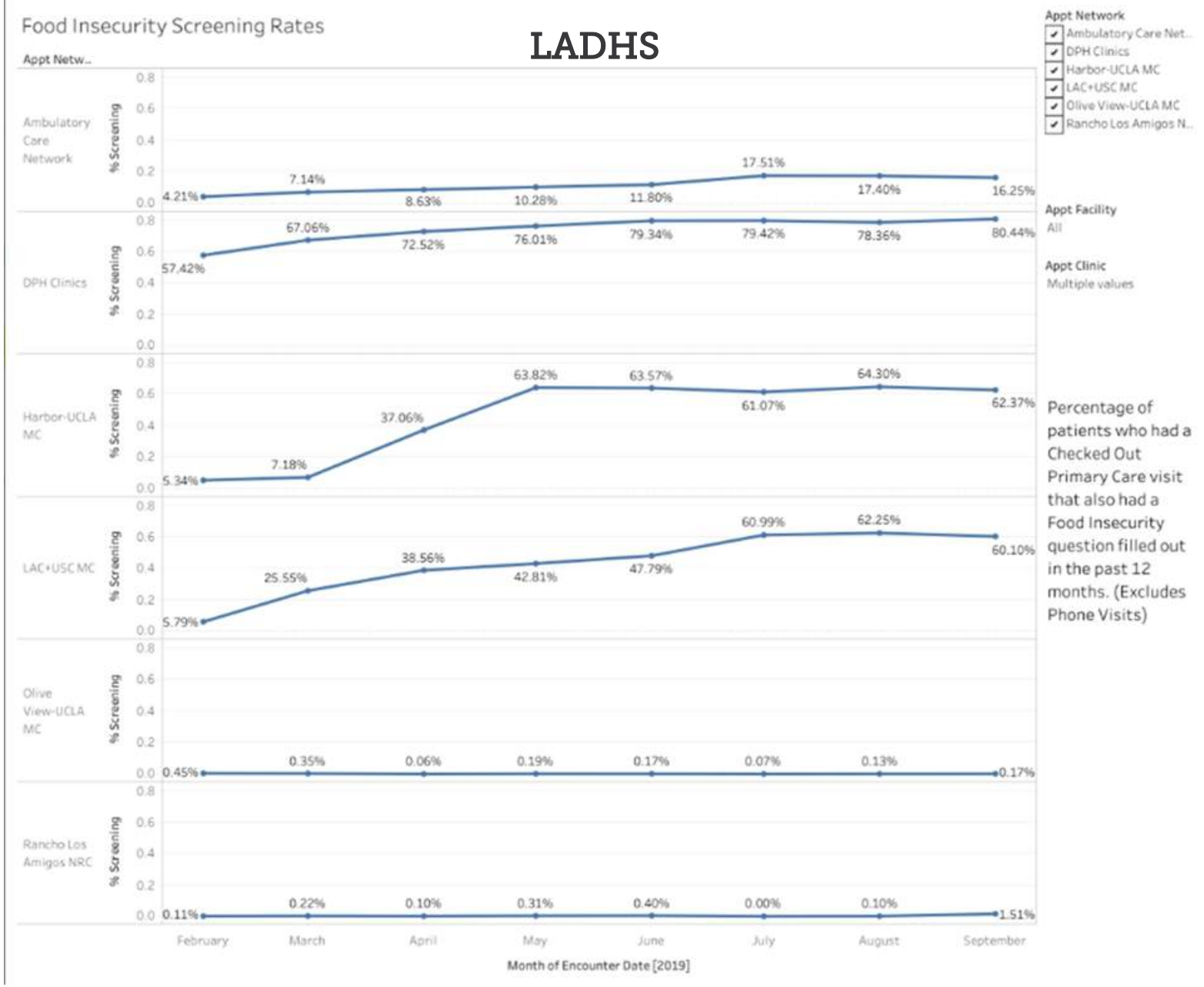
North East Medical Services

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

Population Health Learning Network
North East Medical Services (NEMS)

Strategy	Expected Outcome (Quantitative)	Measure	Notes	Goal	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Cumulative Total
Strategy #1: Improve Existing Depression Screening Process	A	PHQ-2s administered	Starting 7/1/2019, we updated the reporting logic in order to better parallel the ways in which we measure our organizational goals. For this measure, we refined the reporting logic to only count PHQ-2's given to unique patients. As a result, the numbers from March 2019 to June 2019 have slightly changed.	2850	242	253	291	420	478	524	304	**2512**
	B	PHQ-2 red flags	Starting 7/1/2019, we updated the reporting logic in order to better parallel the ways in which we measure our organizational goals. For this measure, we refined the reporting logic to exclude "false positive" PHQ-2 red flags, defined as patients who have positive PHQ-2's but score under 5 for PHQ-9. As a result, the numbers from March 2019 to June 2019 have slightly changed.	125	10	12	13	10	25	13	9	**92**
	C	PHQ-9s completed	Starting 7/1/2019, we updated the reporting logic in order to better parallel the ways in which we measure our organizational goals. For this measure, we refined the reporting logic to only count PHQ-9's that were administered on the same day of the PHQ-2 screening. As a result, the numbers from March 2019 to June 2019 have slightly changed.	95	8	10	13	10	23	13	9	**86**
					66.67%	100.00%	66.67%	100.00%	93.75%	87.50%	100.00%	**88.00%**
Strategy #2: Connect Patients to Appropriate Behavioral Health Services	A	BH followup within 90 days of positive PHQ-9	Starting 7/1/2019, we developed the reporting logic in order to capture the data for this measure and applied it retroactively in order to calculate a cumulative percentage.	60% of positive PHQ-9 screenings	(2/3)	(6/6)	(6/9)	(6/6)	(15/16)	(7/8)	(2/2)	(44/50)

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

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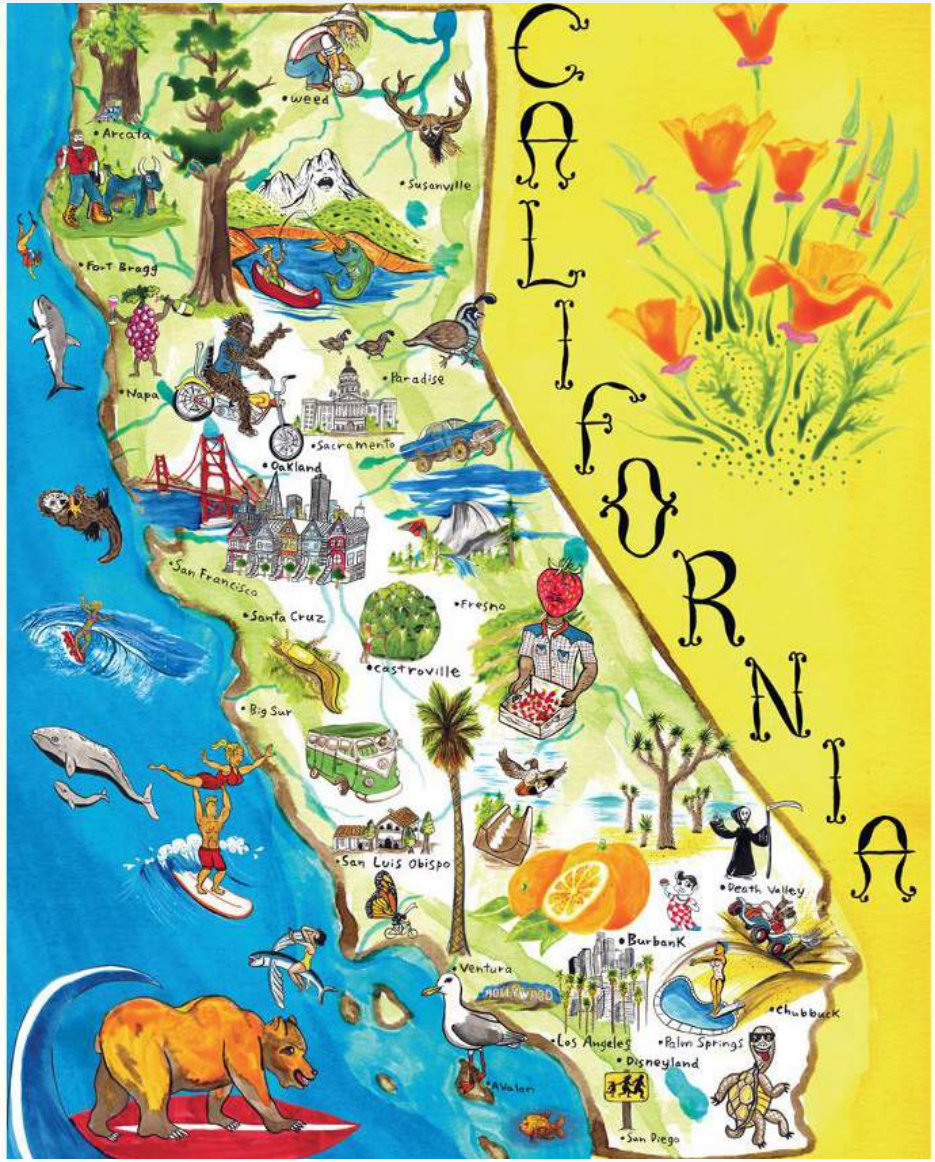
Good Morning!

Happy to be back in California!



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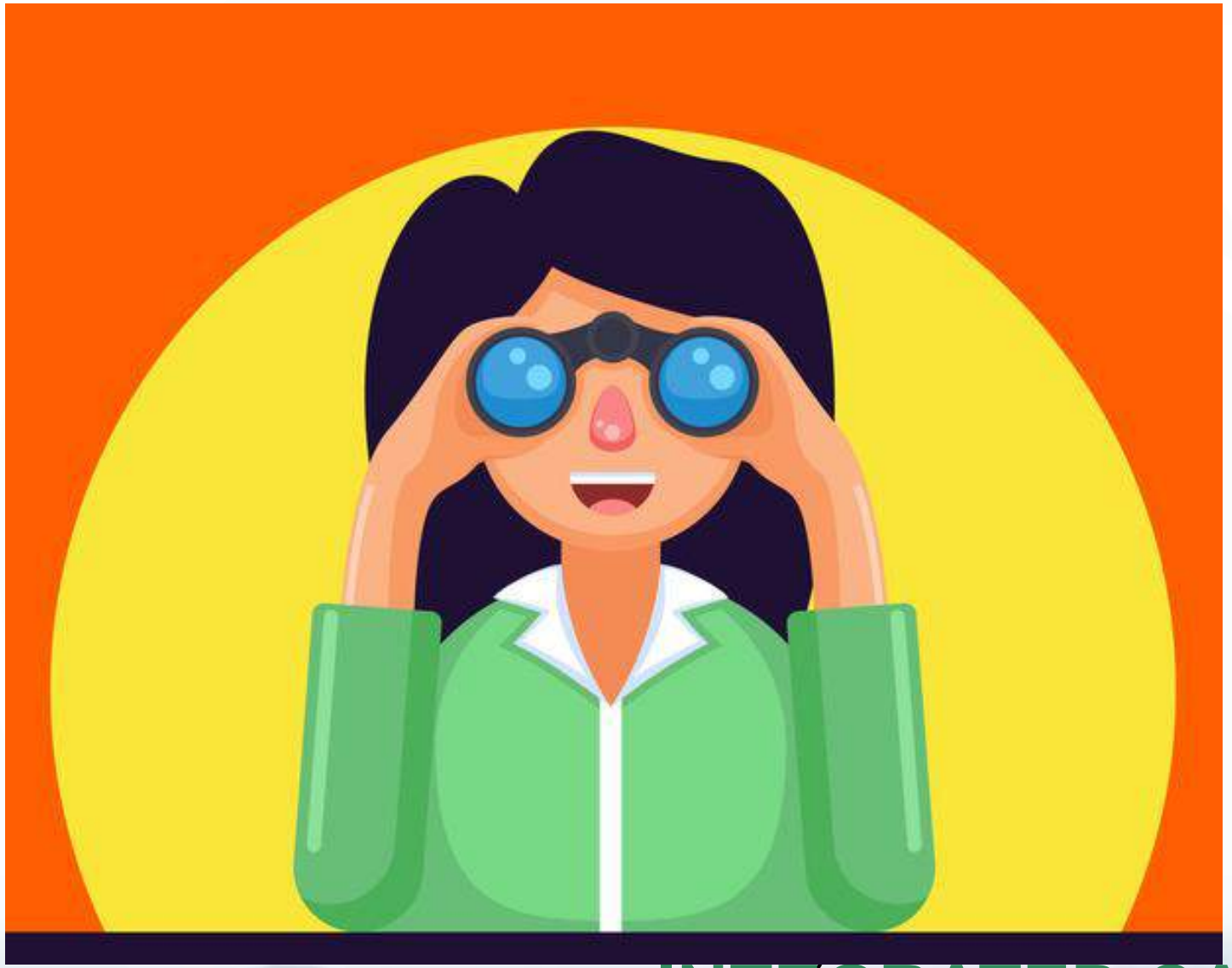
The View on VBP

Current State

Key Elements

Getting Ready



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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

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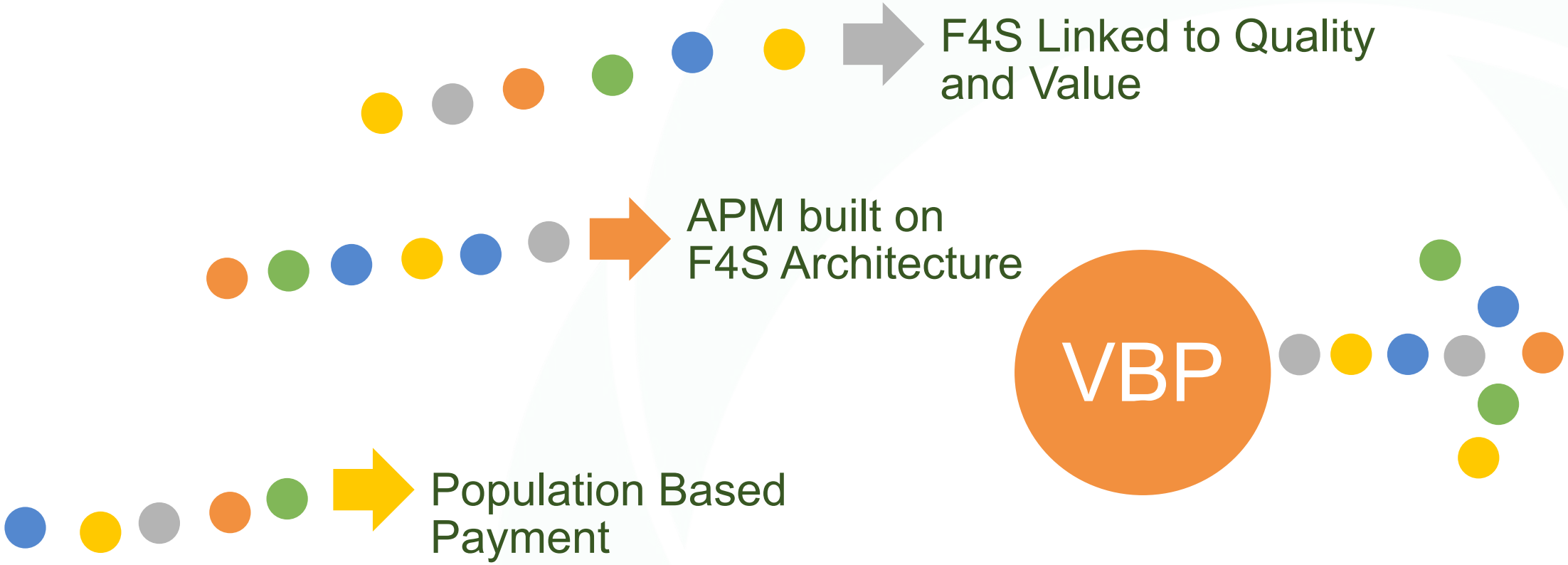
Current State: The Need for Speed (?)

Hurry Up and Wait!



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Current State: VBP

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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 c
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

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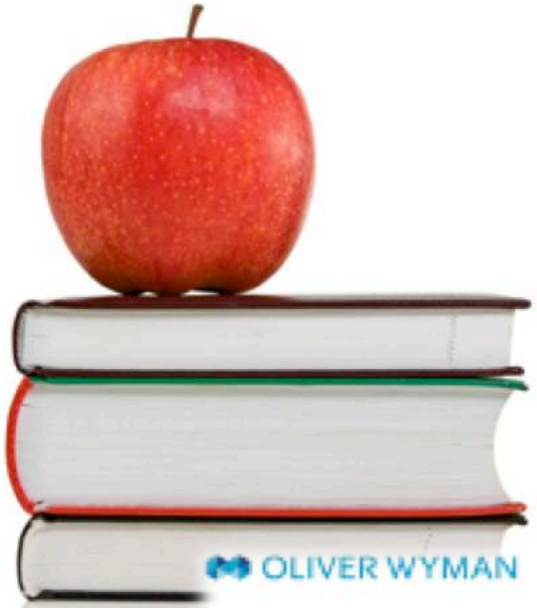
Collaboration & Partnerships



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Data Data Data Data

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Getting Ready: *Data*

# of patients with chronic health problems

Descriptive

- Information
- Knowledge

High Need?
Vulnerable?
Medically Complex?

Prediction

- Insight
- Action

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

Prescriptive

- Wisdom
- Optimization

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Getting Ready: Data Infrastructure

Accurate
Precise

Accessible

Actionable

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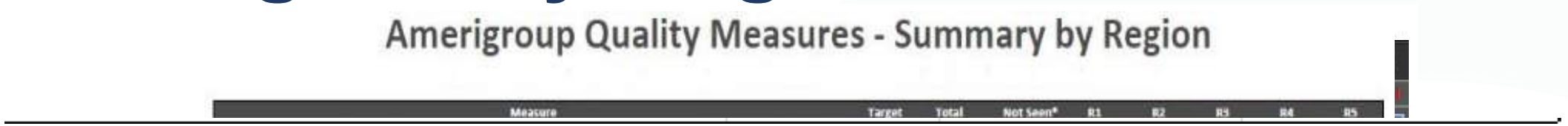
Getting Ready: Big Data to Actionable Data



CHC Needs Assessment & Intervention Guidance

CHC Needs	Intervention Guidance

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

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Healthcare is about *RELATIONSHIPS*

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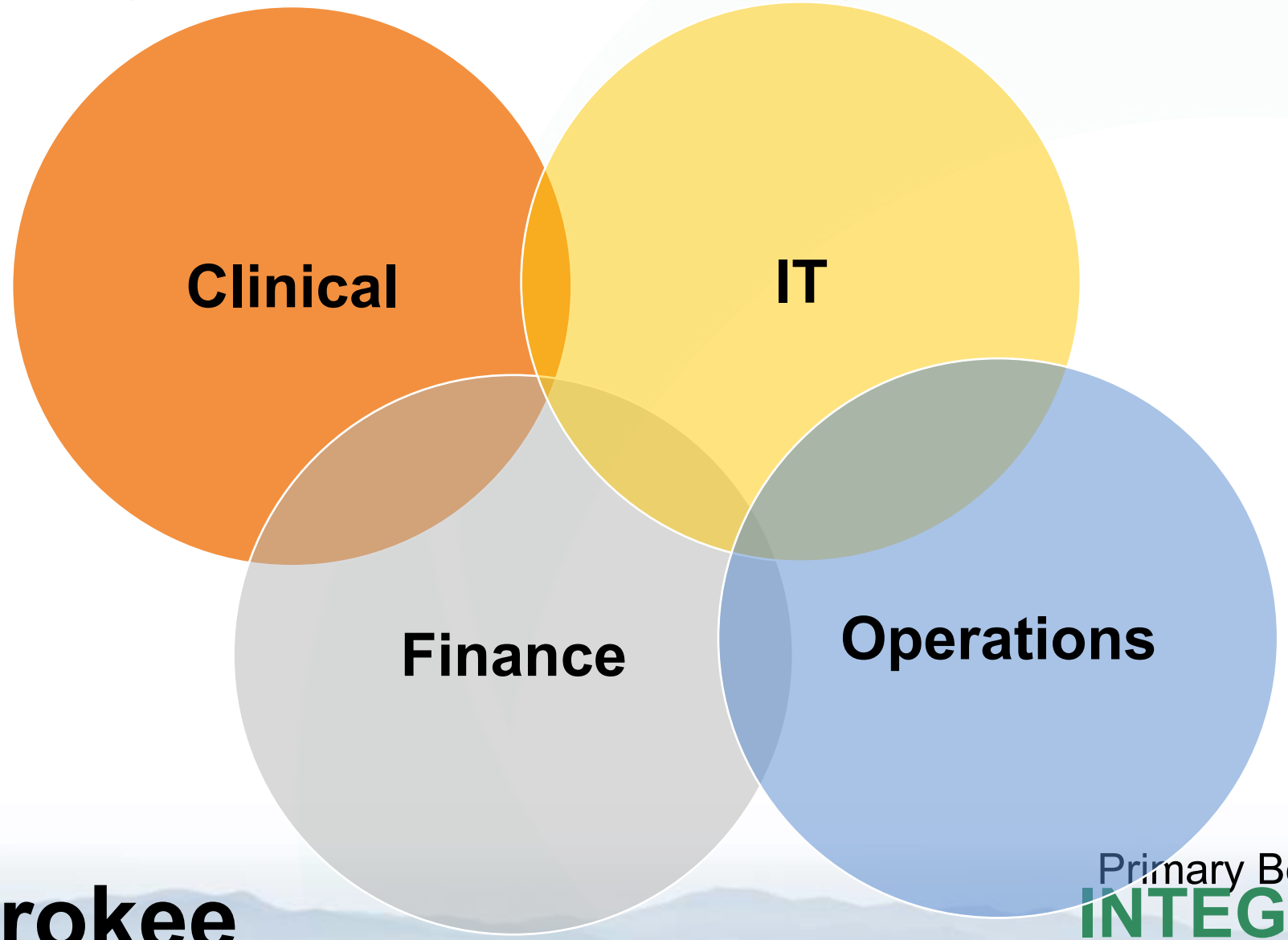
RELATIONSHIPS IN THE ORGANIZATION



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RELATIONSHIPS WITH ‘NEIGHBORS’

- CBOs
- PAYORS
- SCHOOLS
- ACADEMIC
- GOVERNMENT

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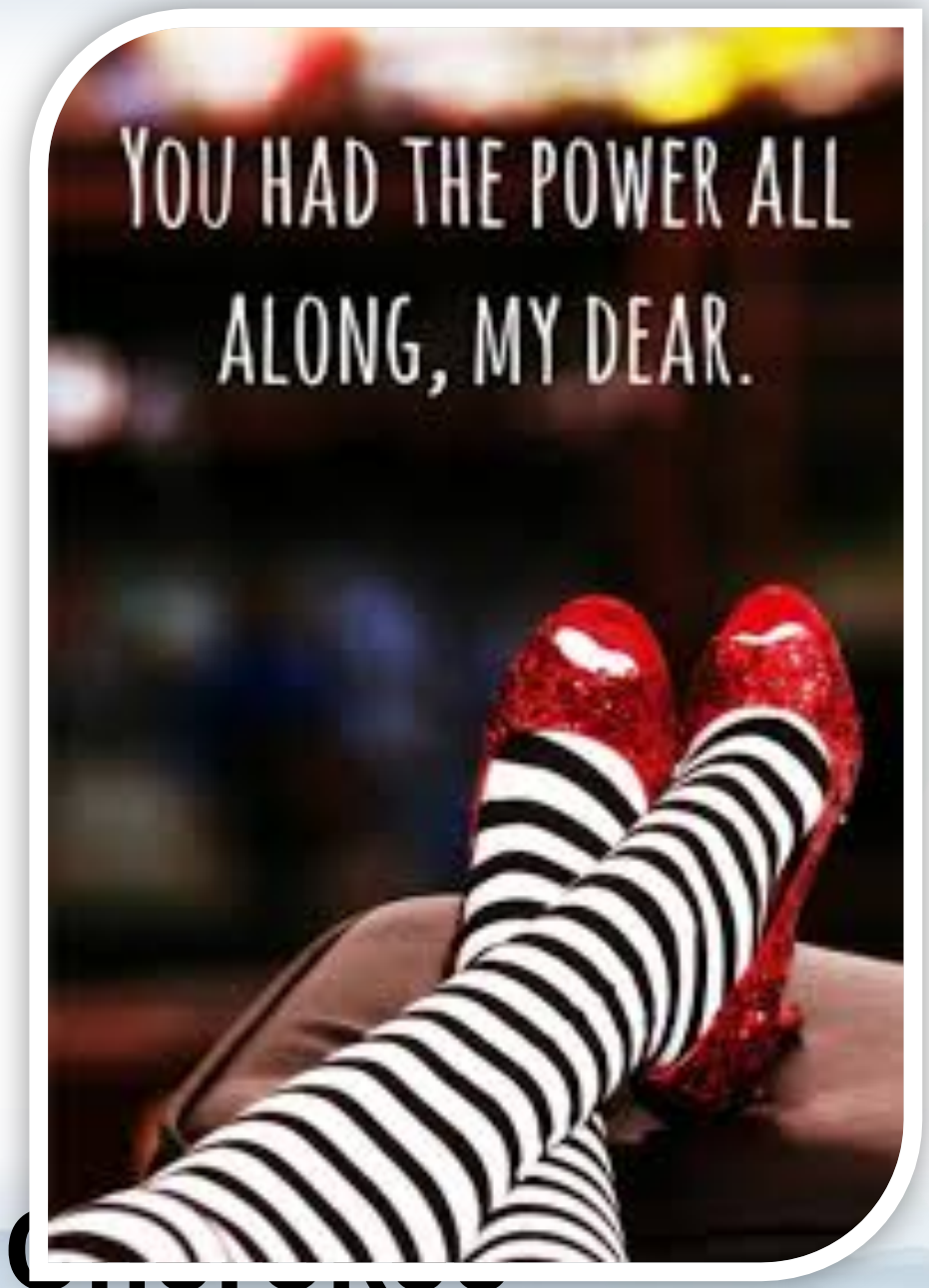
Building the Foundation: PHLN Domains

- ✓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



?

THANK YOU FOR YOUR ATTENTION

ANY QUESTIONS?

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California Health Care Foundation

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


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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/

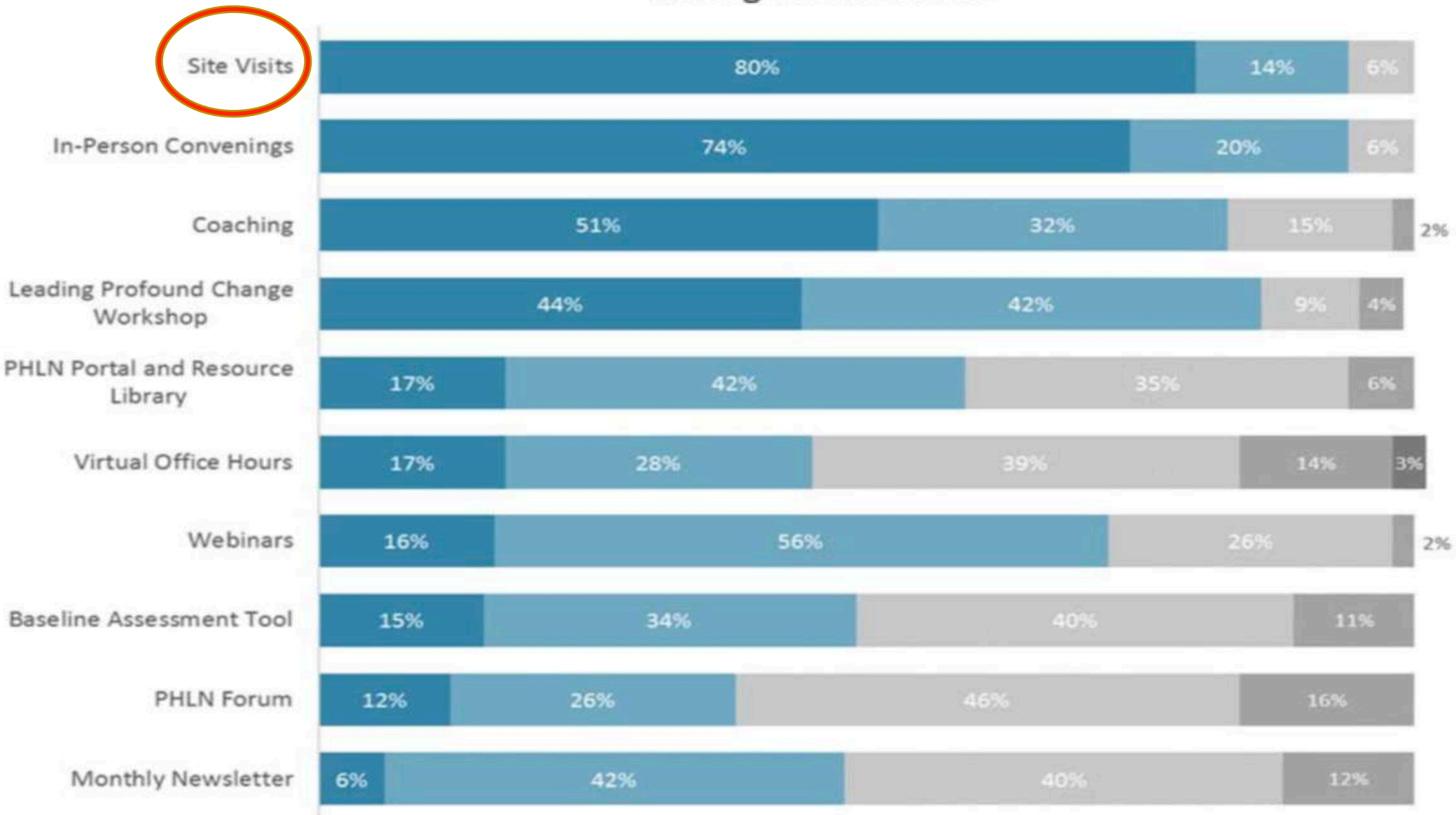
Q& A: What do we see in Medicaid; specifically aimed at FQHCs?

- **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

PHLN Connections: **Virtual Site Visit #1**

Figure 3. PHLN Activities helped teams to make progress on population health management efforts



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."

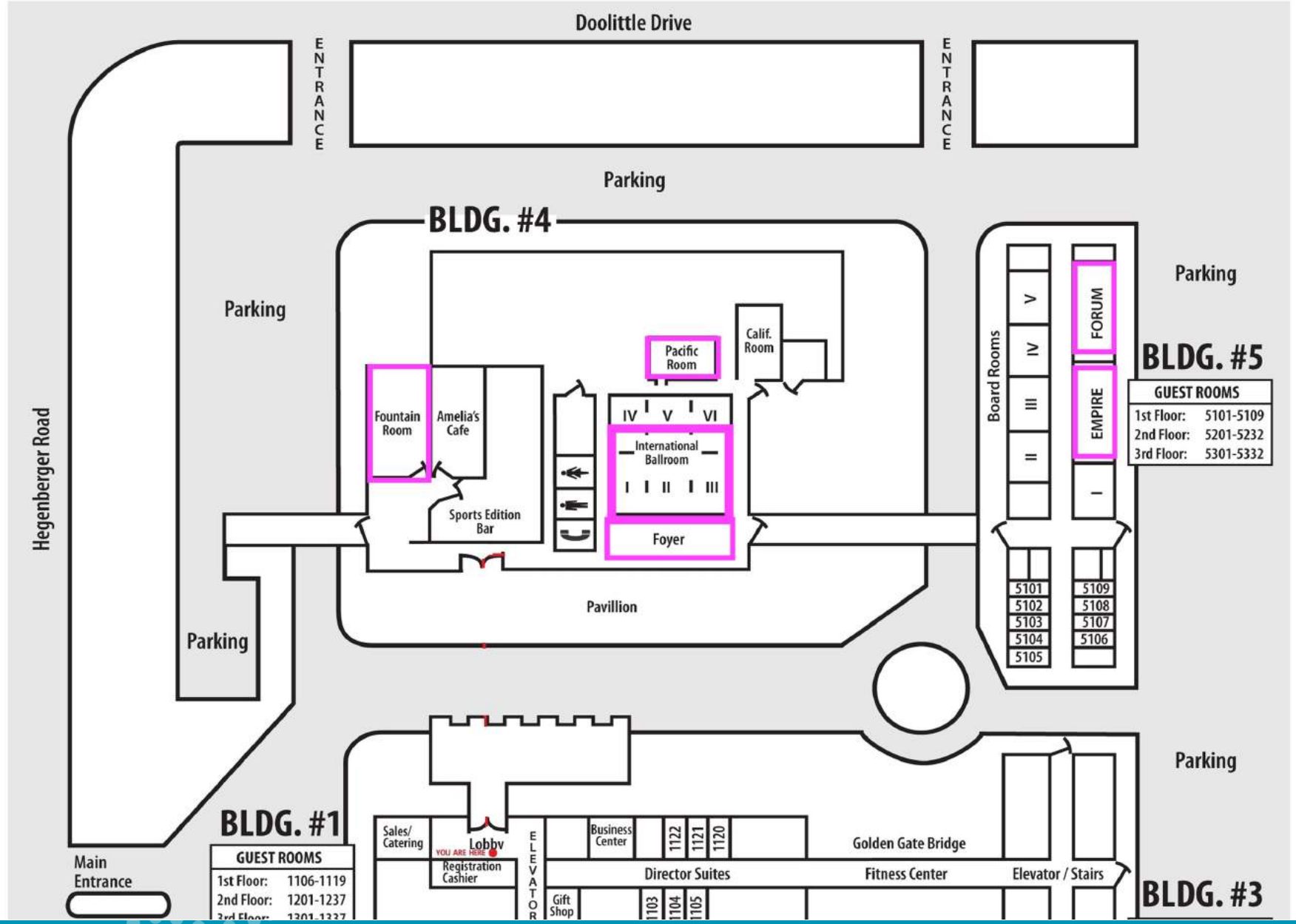
Sharing Lessons Learned from the PHLN: Storyboard Gallery

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

MAIN Room Facilitator: Megan	• **Teams:** Serve the People, Neighborhood, NEMS, CommuniCare, & Venice
FOUNTAIN Room Facilitator: Tammy	• **Teams:** Santa Rosa, NEVHC, LA LGBT, & SPLG
EMPIRE Room Facilitator: Carolyn	• **Teams:** LA County, CMC, Axis, Santa Barbara, & Ravenswood
FORUM Room Facilitator: Denise	• **Teams:** North County, SFHN, Vista, LifeLong, & NAHC
PACIFIC Room Facilitator: Jerry	• **Teams:** Tri-City, Chapa De, Open Door, La Clinica



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

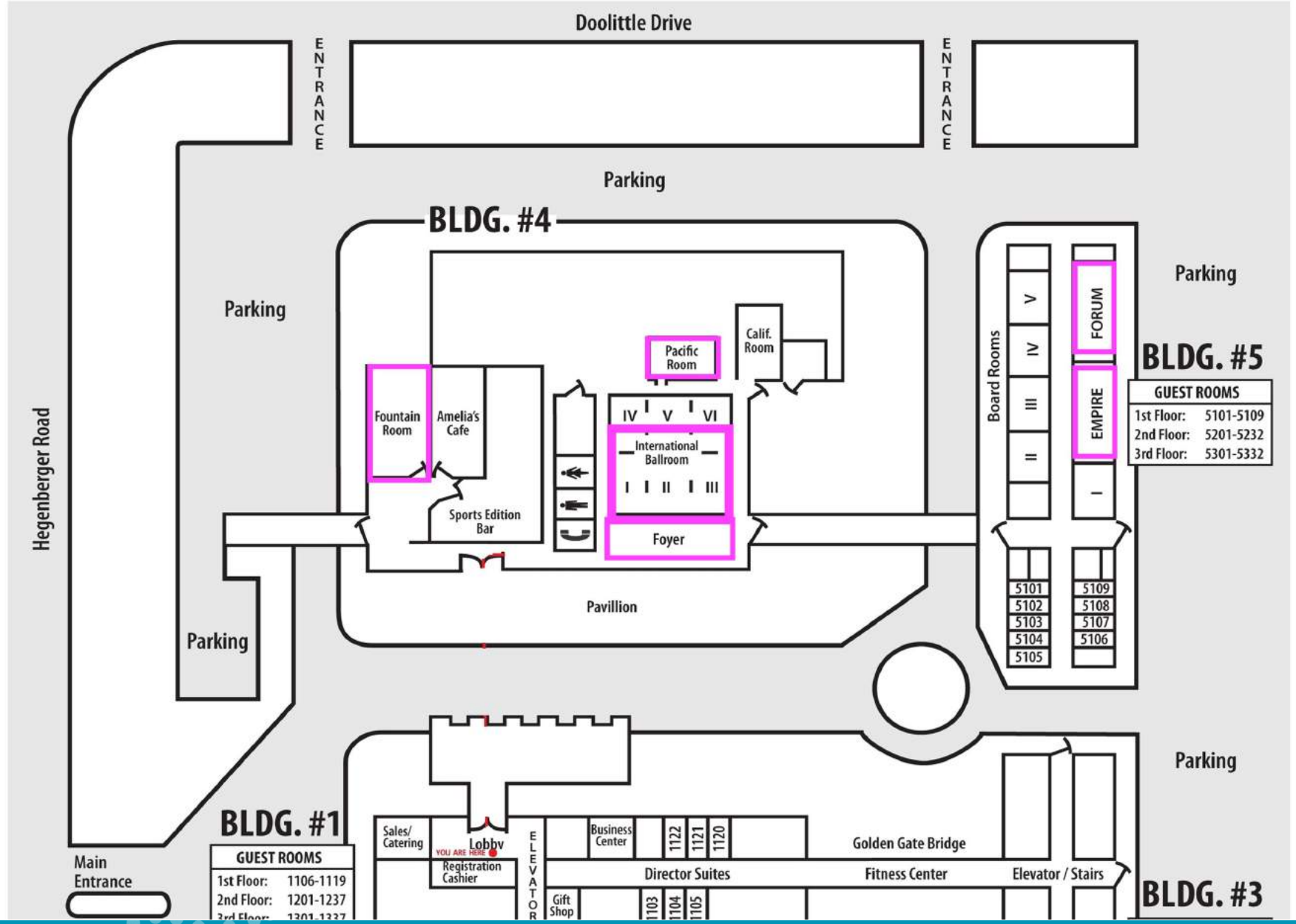
2. Risk Stratification

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

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International Ballroom

Breakout Rooms:

- Pacific Room
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- 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

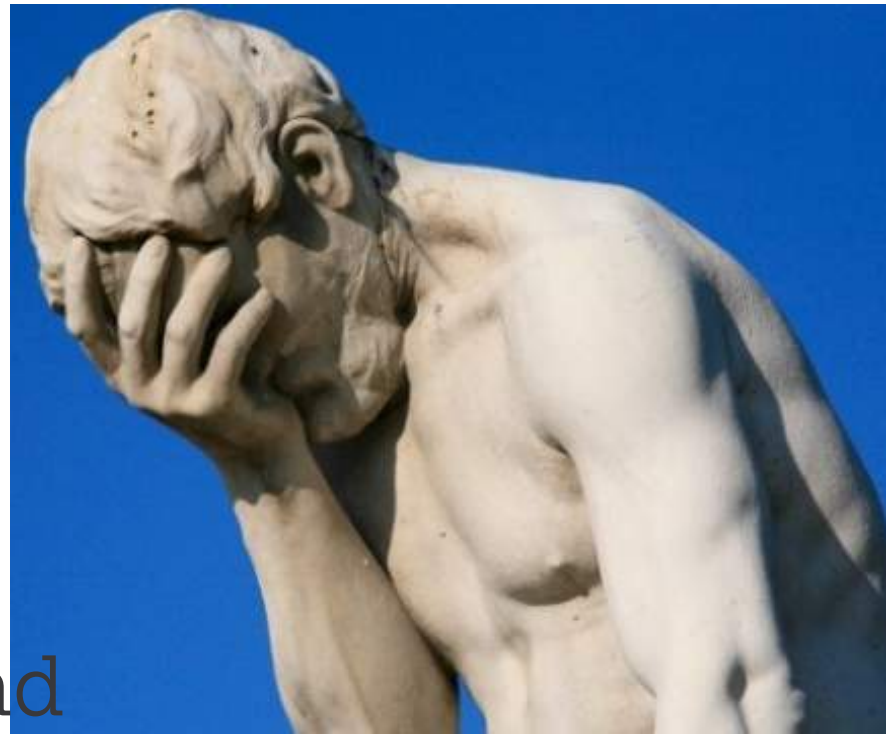
It's not the innovation that matters most...

...it's what happens after the innovation.

Dr. Rob Reid, SNMHI, Univ of Toronto

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

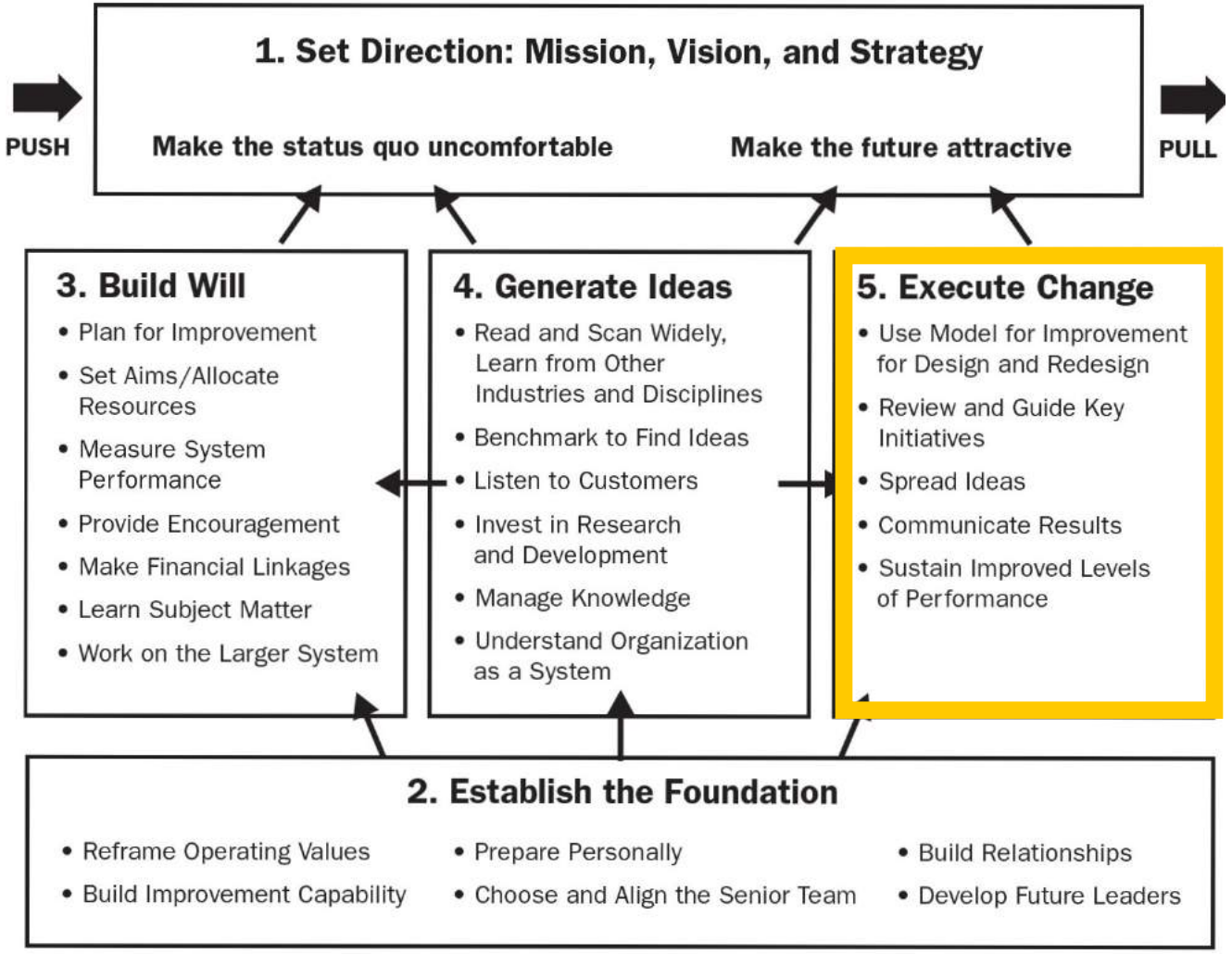


Adapted from: Lloyd R. Applying the Science of Improvement to Daily Work. Chicago: HRET; 2012.

What Happens After?

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

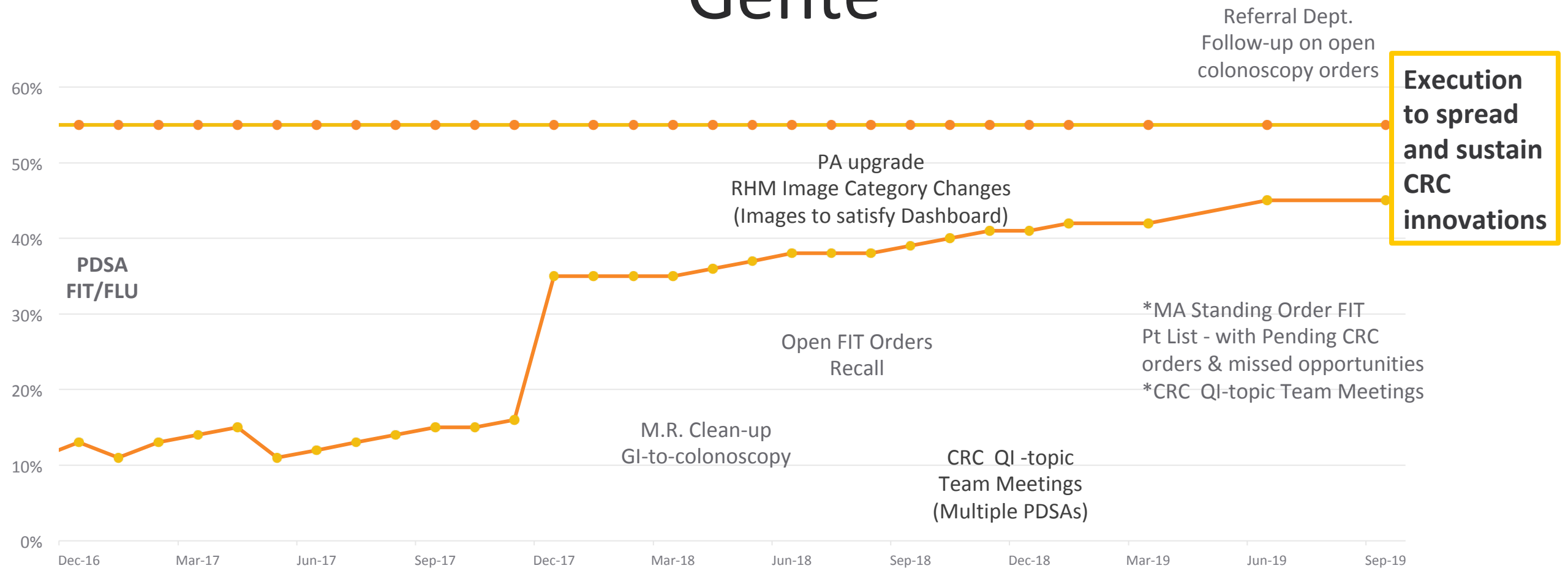
IHI Leadership Framework for Improvement



Adapted from Reinertsen JL, Bisognano M, Pugh MD. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition).* Cambridge, Massachusetts: Institute for Healthcare Improvement; 2008.

Salud Para La Gente

Colorectal Cancer Screening



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

Strategic Spread and Sustaining

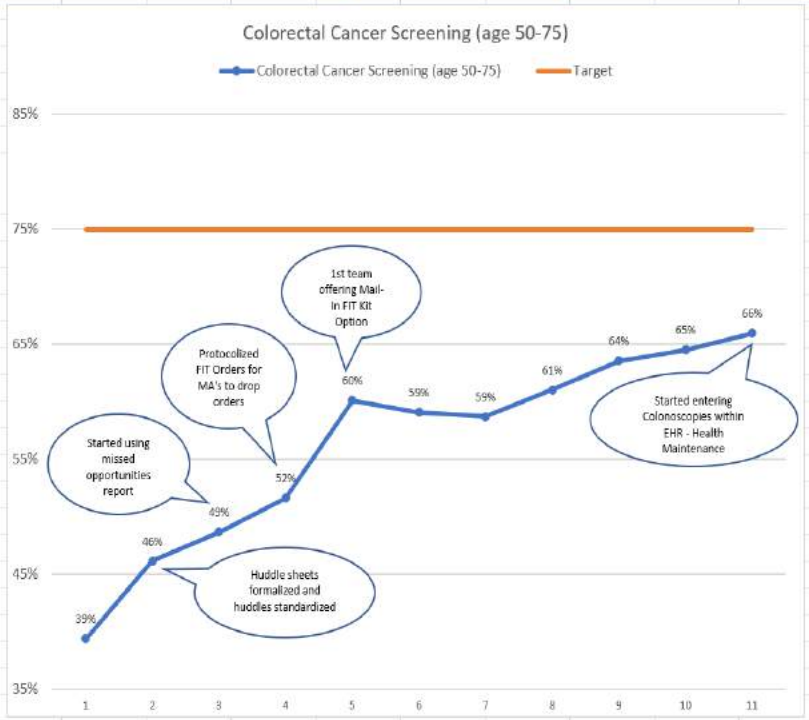
Management Leadership

Tactical Spread

Team Leadership

LA LGBT Colon Cancer Screening Rates
Planning for Spread and Sustaining Improvements

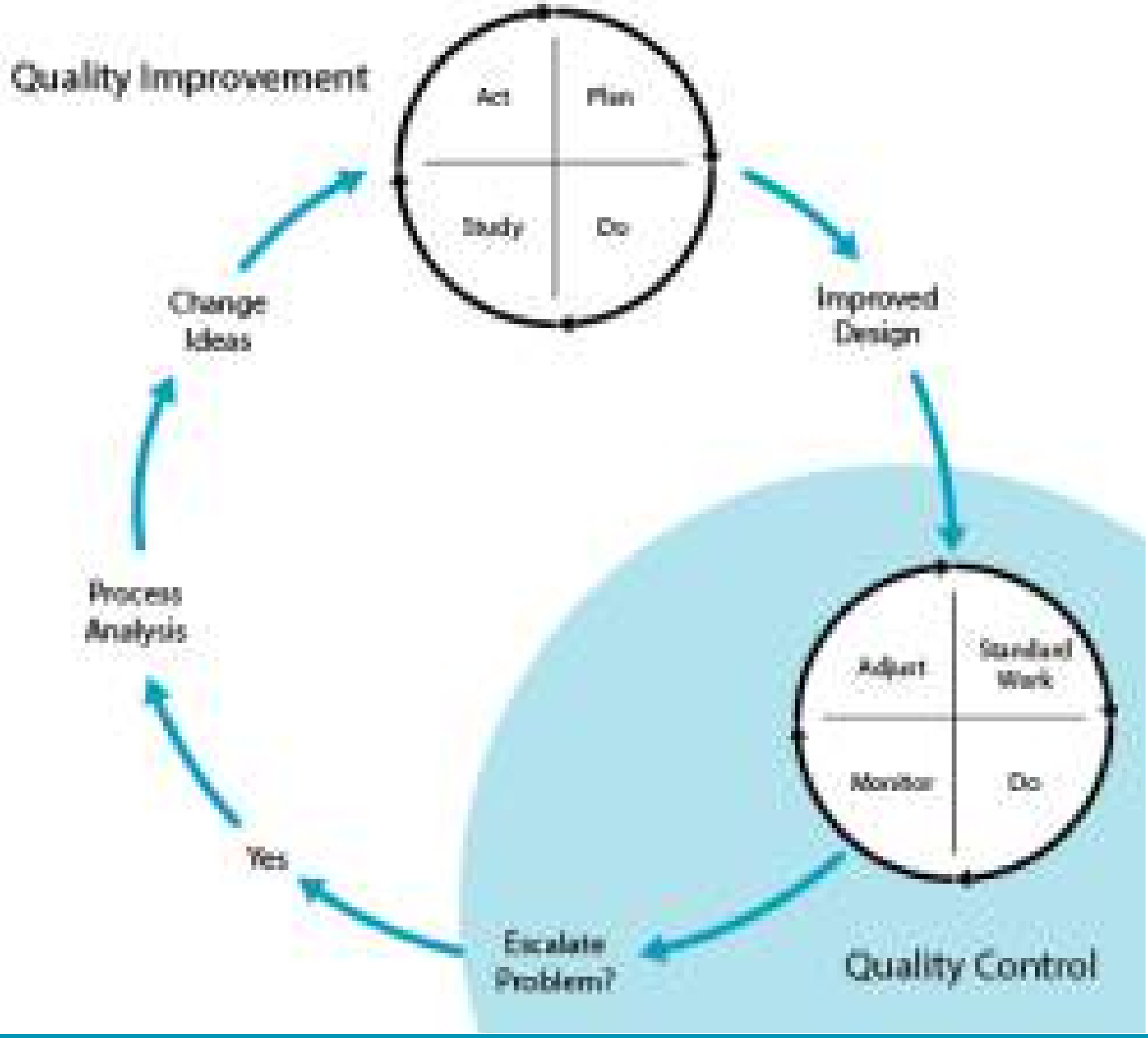
Population Health Learning Network (PHLN) Year 2
Los Angeles LGBT Center - Project Measures



Monthly tracking strongly e Monthly tracking strongly encouraged!

	Key Activity/Milestone	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
1	All new staff recruited (LVN Coordinators, Flow Facilitator)	NS	NS	NS	IP	IP	C					
2	Core Clinical Care Model (CCCM) new team roles implemented	NS	NS	NS	C							
3	Huddle tool and missed opp report report in use	NS	IP	IP	IP	C						
4	Implemented standing protocols for MA's to discuss and drop in FIT KIT orders.	NS	IP	IP	C							
5	Implemented FIT KIT Mail in Option - 1 Team	NS	NS	NS	NS	IP	IP	IP	C			
6	Conducted a pilot to do follow up calls instead of a text reminder to all our patients who received a FIT KIT and had not returned it.	NS	NS	NS	NS	IP	IP	IP	C			
7	Pilot Text Reminders Post receiving Fit Kit	NS	NS	NS	NS	IP	IP	IP	IP	C		
8	Pilot mail CRS FIT Kits to patients that do not have an upcoming clinic visit	NS	NS	NS	NS	NS	NS	NS	NS	IP	IP	IP
9	Implement the Mail-In Fit Kit option for patients - with 2 additional teams	NS	NS	NS	NS	NS	NS	NS	NS	NS	IP	IP
10	Pilot Nurse Manager entering Colonoscopy results into Health maintenace within EHR	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	IP
11	Implement the Mail-In FIT Kit option for patients - with all teams	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
	MILESTONE STATUS KEY:	NS=Not started, IP=In process, C=Complete										
		NS	IP	IP	C							
	PROCESS METRIC											
1	# Patients who got CRS via Fit Kit with mail in option (age 50-75)	0	0	0	0	6	20	11	18	13	28	17
	# Patients who returned their Fit Kit via mail in option (age 50-75)	0	0	0	0	3	14	4	7	7	11	6
	# Patients who returned their Fit Kit via mail in option after 1 F/U Call (age 50-75)	0	0	0	0	0	0	6	0	0	0	0
	% Rate of CRCS Achieved with Mail in Option	**0%**	**0%**	**0%**	**0%**	**50%**	**70%**	**90%**	**39%**	**54%**	**39%**	**35%**

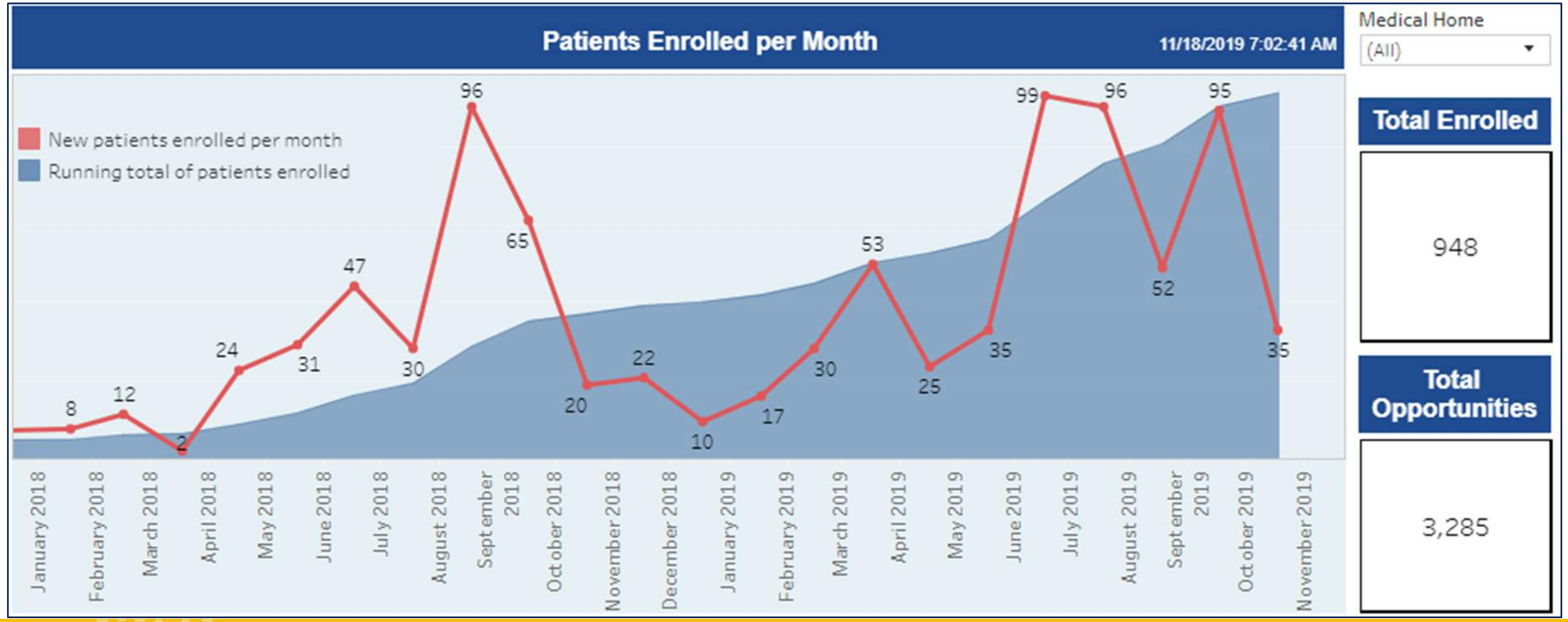
IHI-
From Improving to Sustaining



Scoville R, Little K, Rakover J, Luther K, Mate K. *Sustaining Improvement*. IHI White Paper. Cambridge, Massachusetts Institute for Healthcare Improvement; 2016.

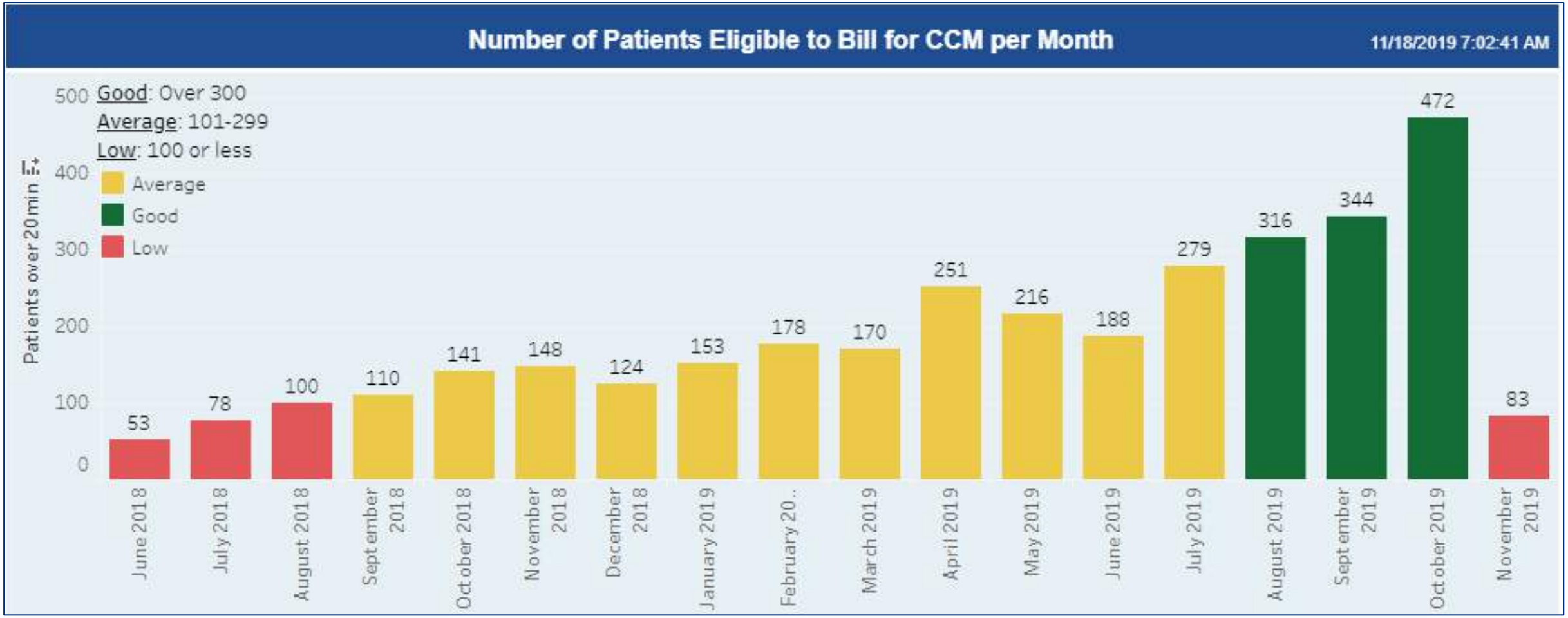
PHLN Aim Enroll 1000 by 12/31/19

LifeLong Medical Care
Health Services For All Ages
a californiahealth+ center



Quality Control Tool for Quality Control

LifeLong Medical Care
Health Services For All Ages
a californiahealth+ center



Execute!

- Communication
- Infrastructure
- Measurement
- Leadership

Sustaining PHLN Innovations-Monitoring Key Organizational Areas

Key Area	Questions to uncover possible conflicts	Yes or No	Possible actions:
Work design and infrastructure	• Are clear roles and responsibilities explicit and aligned with the new PHLN processes?		
	• Are the roles and responsibilities flexible enough to allow people to adjust to the new ways of doing things?		
	• Does the work environment infrastructure encourage sustaining the change?		
Demands from managers	• Are the new PHLN expectations clear to managers?		
	• Do they understand what's new, changed or not required anymore?		
	• Are they clear about their boundaries?		
Performance measurement	• Do performance measures track desired PHLN behaviors?		
Recognition systems	• What gets noticed by leaders and influencers in the organization?		
	• What gets mentioned in formal and informal situations?		
	• On what achievements and conditions are promotions based?		
	• Do employees value current means of recognition?		
Goal setting	• Are individual goals consistent with overall PHLN objectives?		
Skills and competencies	• What new skills and competencies are needed for PHLN innovations?		
	• What skills and competencies are now redundant?		
Management systems	• Do management systems measure the elements of PHLN innovation we wish to pay attention to?		
	• Have new processes been introduced? How will they be measured?		
Communication processes	• What new information and feedback needs to circulate freely?		
Relationships	• Is the new PHLN working environment creating new patterns of interaction among individuals and departments? How can these be supported?		
Leadership	• Does leadership continue to support and communicate the urgency for the PHLN changes?		

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

For more information…

1. Scoville R, Little K, Rakover J, Luther K, Mate K. *Sustaining Improvement*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. http://www.ihi.org/resources/Pages/IHIWhitePapers/Sustaining-Improvement.aspx

2. Nolan T. *Execution of Strategic Improvement Initiatives to Produce System- Level Results.* IHI White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2007. www.ihi.org/resources/Pages/IHIWhitePapers/ExecutionofStrategicImprovementInitiativesWhitePaper.aspx

3. Phillips J, Hebish LJ, Mann S, Ching JM, Blackmore CC. Engaging frontline leaders and staff in real-time improvement. *Joint Commission Journal on Quality and Patient Safety.* 2016 Apr;42(4):170-183.

4. Swenson S, Pugh M, McMullan C, Kabcenell A. *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs.* IHI White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2013. www.ihi.org/resources/Pages/IHIWhitePapers/HighImpactLeadership.aspx

5. Hayes CW, Batalden PB, Goldmann D. A "work smarter, not harder" approach to improving healthcare quality. *BMJ Quality and Safety.* 2015 Feb;24(2):100-102.

6. Kotter, John P. 2012 Leading Change. Boston, MA: Harvard Business Review Press

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.

Digging deeper: rich insights

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:

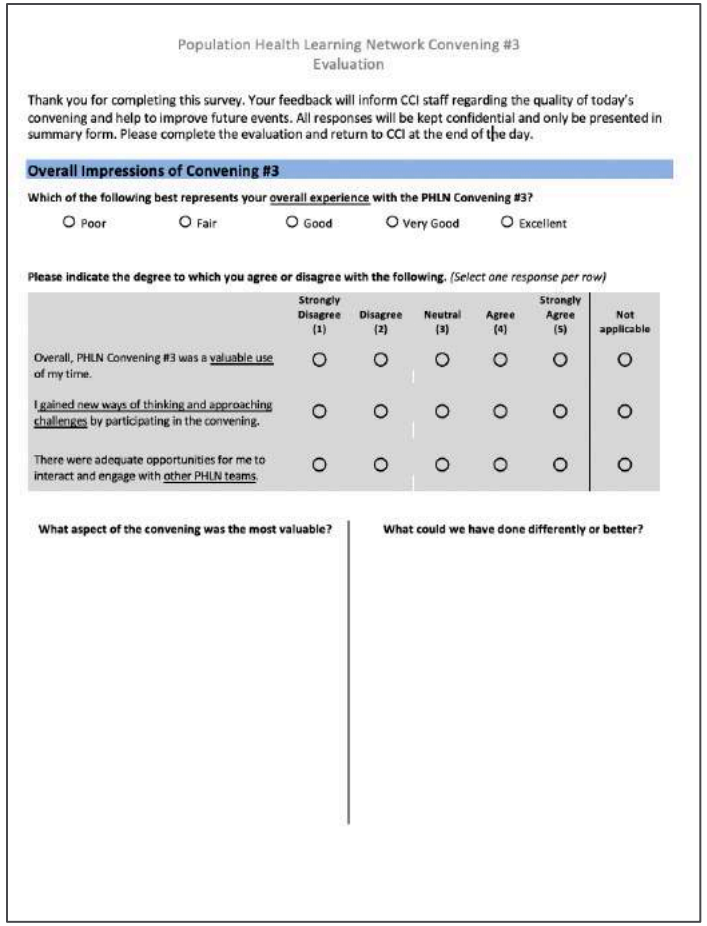
jenette_spezeski@jsi.com

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

Evaluation



Population Health Learning Network Convening #3
Evaluation

Thank you for completing this survey. Your feedback will inform CCI 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 experience with the PHLN Convening #3?

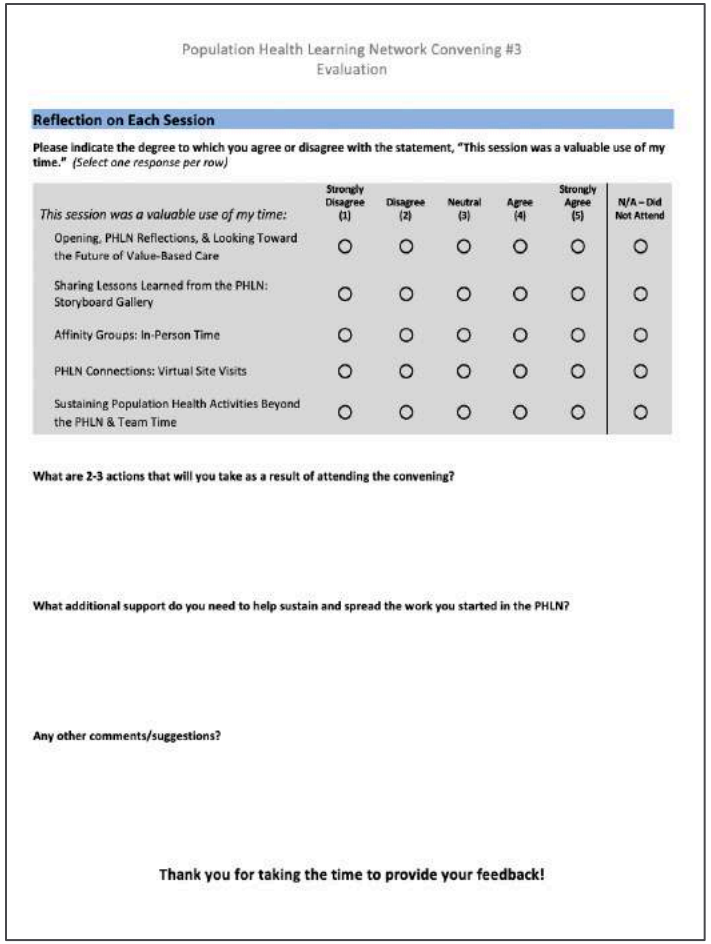
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

Please indicate the degree to which you agree or disagree with the following. *(Select one response per row)*

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	Not applicable
Overall, PHLN Convening #3 was a valuable use of my time.	○	○	○	○	○	○
I gained new ways of thinking and approaching challenges by participating in the convening.	○	○	○	○	○	○
There were adequate opportunities for me to interact and engage with other PHLN teams.	○	○	○	○	○	○

What aspect of the convening was the most valuable?

What could we have done differently or better?



Population Health Learning Network Convening #3
Evaluation

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)*

This session was a valuable use of my time:	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	N/A – Did Not Attend
Opening, PHLN Reflections, & Looking Toward the Future of Value-Based Care	○	○	○	○	○	○
Sharing Lessons Learned from the PHLN: Storyboard Gallery	○	○	○	○	○	○
Affinity Groups: In-Person Time	○	○	○	○	○	○
PHLN Connections: Virtual Site Visits	○	○	○	○	○	○
Sustaining Population Health Activities Beyond the PHLN & Team Time	○	○	○	○	○	○

What are 2-3 actions that will you take as a result of attending the convening?

What additional support do you need to help sustain and spread 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:

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