Population Health Learning Network

January 19, 2018

Informational Webinar

blue of california foundation

California Health Care Foundation

CCI CENTER FOR CARE INNOVATIONS

Webinar Reminders

1. Everyone is muted.
   - Press *6 to **mute** yourself and *7 to **unmute**.

2. Remember to chat in questions along the way!

3. Webinar is being recorded, posted on CCI's website, and will be sent out via email.

Agenda

1. Introductions
2. Why Population Health?
3. Network Description
4. Eligibility & Expectations
5. How to Apply
    - Timeline and Important Dates
6. A Word from CHCF
7. Questions & Answers

CCI Program Team

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Design Programs & Networks
Convene People
Work with Experts
Re-Granting

What We Do

CCI Focus Areas

POPULATION HEALTH

- Treating Addiction in the Primary Care Safety Net (TAPC)
- Preventing Heart Attacks and Strokes Everyday (PHASE)
- Transformation Accelerator
- Trauma-Informed Care

TECHNOLOGY SOLUTIONS

- The Technology Hub
- Telehealth

DATA ANALYTICS

- Safety Net Analytics Program (SNAP) – Los Angeles
- Data aggregation project: criminal justice + health (I.D.E.A.)

INNOVATION & DESIGN THINKING

- Innovation Catalyst Program
- Safety Net Innovation Network (SNIN)

COMMUNITY-CENTERED CARE

- Roles Outside Of Traditional Systems (ROOTS)
- iLab: Whole Health

DELIVERY SYSTEM REFORM

- Practice Transformation Initiative (PTI)
- Spreading Solutions That Work
- Population Health Network
- Delta Center - RWJF

How CCI Makes Change

UNDERSTAND THE NEEDS OF THE SAFETY NET

- Start every program by asking the safety net; make it relevant

TEACH SKILLS AND MINDSETS FOR CHANGE

- Catalyst program – design and innovation
- Embed improvement, innovation, leadership, change management into programs

OFFER THE "BEST" EXPERTS & FACULTY

- Provide access to best thinkers and doers in program areas
- Coaches to help move from the ideas to the implementation

APPLIED PROJECTS – NOT JUST THEORY

- All programs have applied projects to make change
- Ability to show impact and change through measurement approach

LEARNING COMMUNITY IS ESSENTIAL

- Learn from others like you about what really works

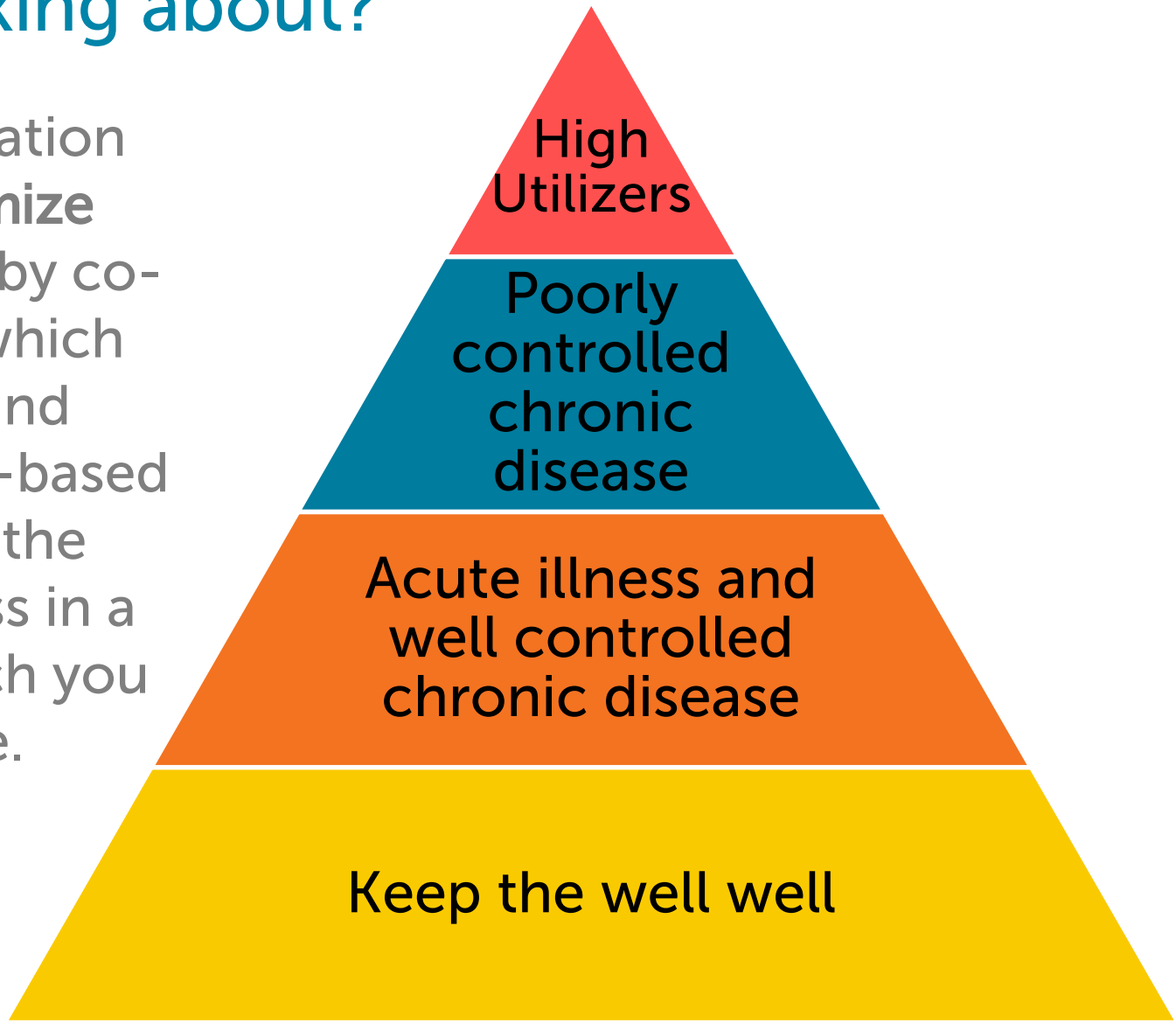
PROVIDE SMALL GRANTS & TRAVEL STIPENDS

- Grants provide focus to change efforts

Why Population Health?

What are we talking about?

The work of population health is to **maximize health and wellness** by co-creating services which deliver primary and secondary evidence-based interventions for the prevention of illness in a population for which you are accountable.



Why Population Health?

Improve the patient's **experience of care**.

Access, alternative encounters, cultural competence, addressing SDOH.

Achieve better health outcomes by **closing gaps in care**.

Initiated by staff per evidence based guidelines.

Avoid unnecessary utilization in the ER and hospital readmissions through coordinated care.

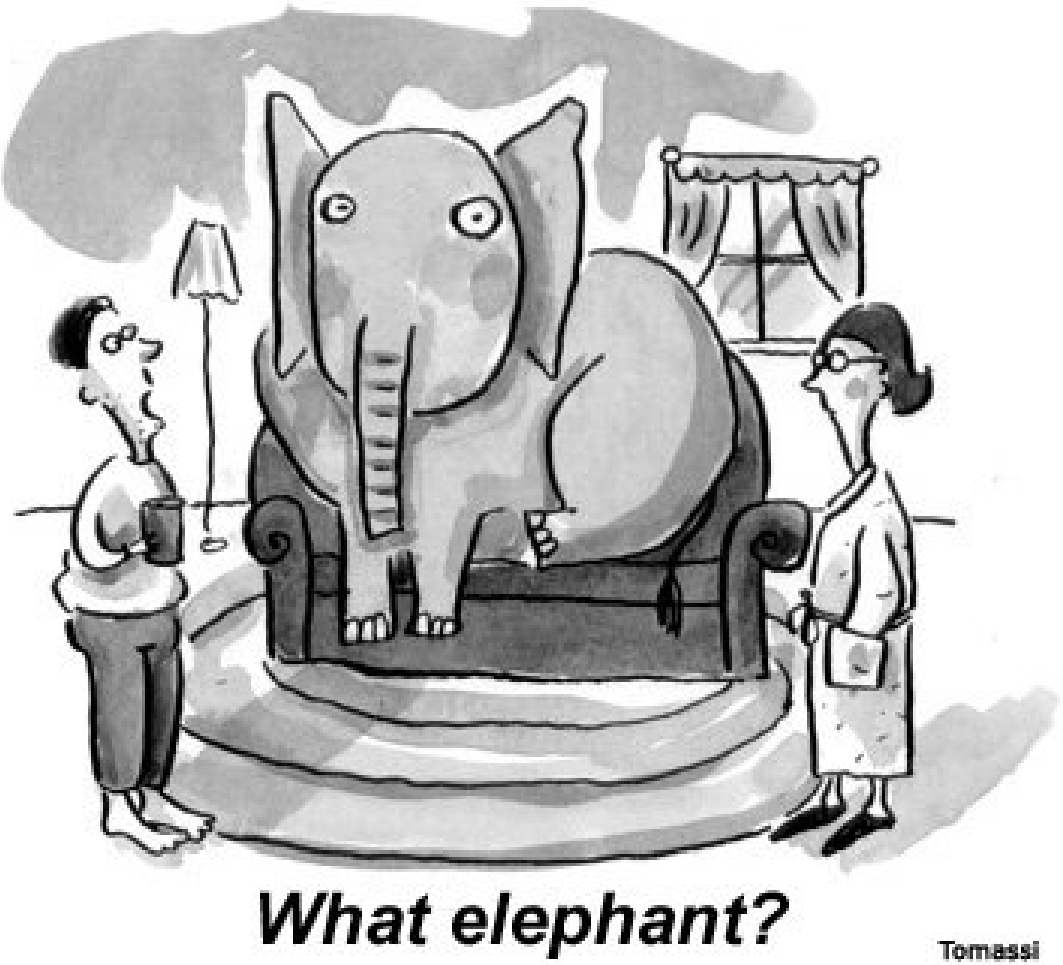
Stabilize or reduce health care **costs**.

Target the right resources to the patients who need it most.

Boost **workplace satisfaction** by optimizing team-based care and ensuring all staff can work to the top of their skill and license.

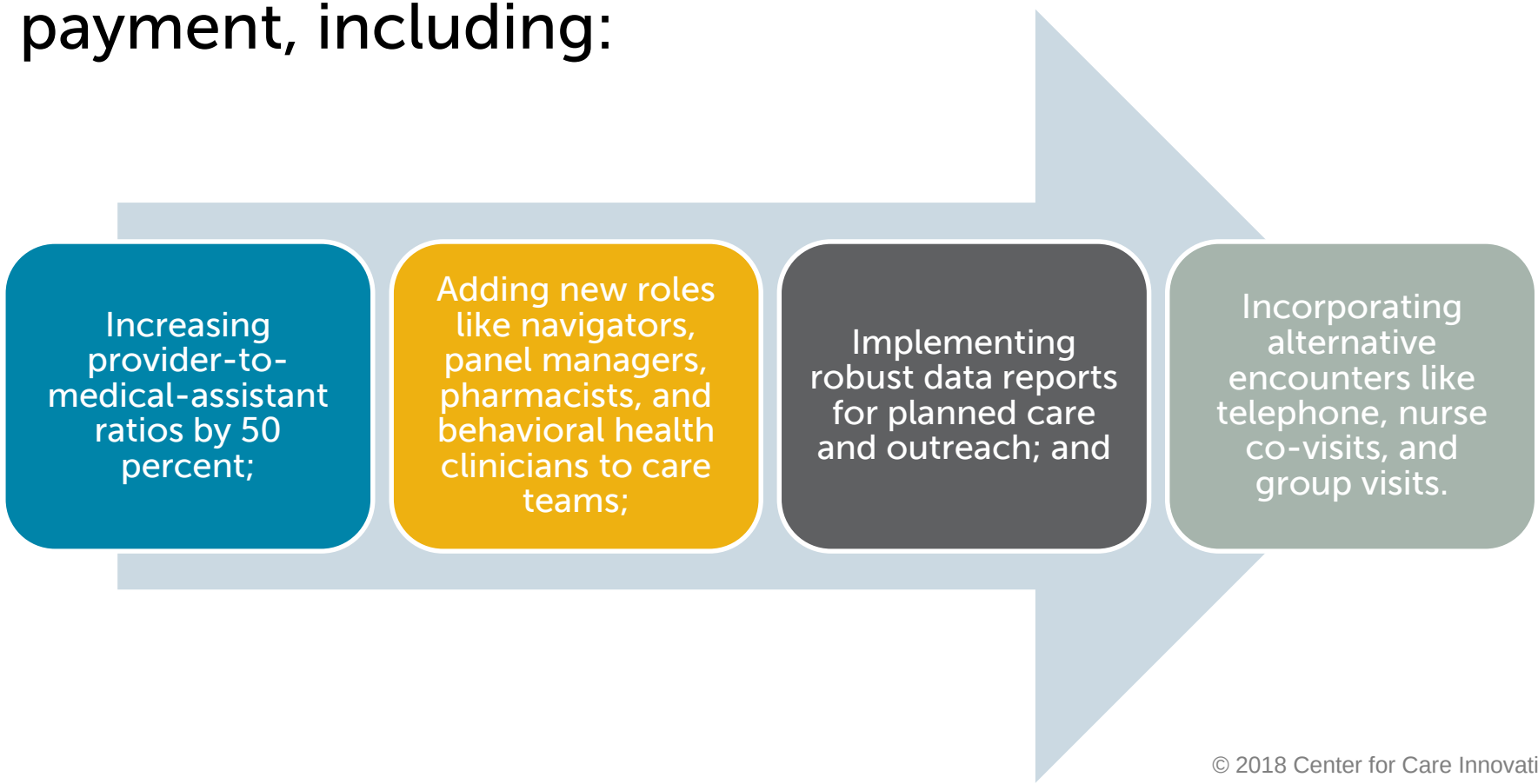
The FQHC Payment Pilot

On hiatus….



CCI's Past Population Health Success

CP3 Population Health Program spurred organizations to make changes in advance of payment, including:



Tiburcio Vasquez Health Center Inc.

Caleb Sandford, MBA
Chief Operations Officer
Tiburcio Vasquez Health Center

"These are things we need now regardless of payment reform, and they're things that we'll need if we do payment reform, [these are] things we'll need if the payment structure changes and everyone goes back to being uninsured, and they are things we need to keep providing good care."

- COO, TVHC

Network Description

PHLN Goal

The PHLN aims to improve the **health and wellbeing** of more than **750,000 Californians** by bringing together **safety net** primary care organizations to strengthen and advance their **population health management strategies**.

Key Objectives

- Create a peer group for learning and innovation
- Increase the pressure to ‘keep up’ and accelerate progress towards a new norm
- Effectively get organizations to adopt and deeply implement a broad range of changes critical to high performing population health management
- Spread proven changes to more high-volume FQHCs
- Test and deploy innovations critical to whole person care: assessing and responding social needs, behavioral health integration, care management for vulnerable populations
- Align population health management strategies toward value-based care and payment

Network Overview

Up to 30 CA-based organizations

Two-year network focused on learning, sharing best practices, and taking action to advance population health

Travel grants between $4,000 and $8,000

In year two, grants of up to $30,000 to support deeper implementation

Requirements:

1. Attend three in-person convenings
2. Participate in evaluation activities
3. Share & learn with peers

Network Highlights

Core capabilities in place for participating organizations:

- A **team-based model** of care implemented in most sites;
- **Empanelment processes** with most patients empaneled to a clinician or care team;
- **Data infrastructure** that includes processes around data governance, validation, and data reporting to facilitate clinical decision making at the point of care; and
- A strong **quality improvement culture** where changes are tested, measured, and evaluated for implementation or spread.

The network provides an opportunity:

- to *enhance* existing capabilities
- to develop new capabilities through peer sharing
- to enable learning from exemplars within and outside of CA
- to problem solve around common challenges

Content Domains

Leadership and Change Management: Understanding adaptive and technical challenges. Communicating around large change initiatives. Clarifying leadership roles and how leaders work together to provide integrated care.

Team-Based Care 2.0: Delivering patient-centered care through redefining and experimenting with team roles and alternative visits, creating access and managing population health in a value-based care and payment environment. Standardizing care teams.

Planned Care and In-Reach: Gauging patients' needs and delivering timely services and support, with an emphasis on leveraging technology, data tools for clinical decision making, and patient engagement strategies.

Proactive Outreach: Displaying and engaging the care team in using data, as well as the data systems for analytics and reporting. Partnering with health plans for data exchange. Considering risk stratification to enable effective outreach.

Content Domains

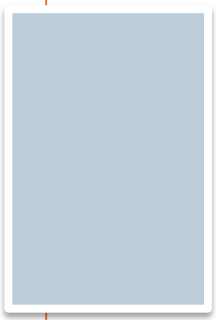
Behavioral Health Integration: Bringing behavioral health and somatic medicine together at the care team level to better detect illness, improve overall health outcomes, create a better patient experience, and reduce suffering.

Care Management for Complex Patients: Identifying high-risk patients. Defining interventions for patients based on strata. Integrating behavioral health. Building community partnerships. Managing hospital transitions.

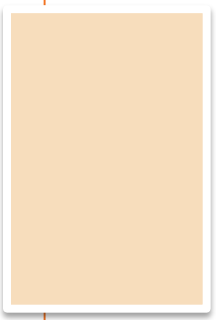
Social Needs: Screening and prioritizing nonmedical needs. Building internal systems, referral processes, and effective partnerships with community organizations to respond to identified needs.

Additional Technical Assistance Available

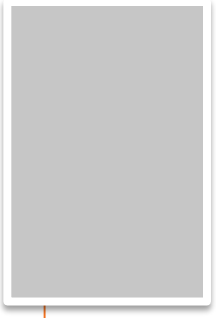
Optional Trainings & Webinars



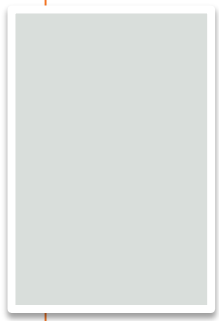
Quality Improvement and Human-Centered Design: Setting aims and measures. Using PDSA cycles. Identifying changes through innovation and user-centered design approaches. Change management.



Leveraging Data as an Asset: Data governance, stewardship, and using data to drive clinical and operational decisions.



Team-Based Care with Behavioral Health Integration 1.0: Understanding the spectrum of behavioral health integration, components of integrated care, and populations served. Building the team, including roles and relationships, practice space, communication, screening, warm handoff, and treatment plan.



Access and Panel Management: Using data regularly to manage supply and demand, panel size, risk adjusting panels, access to care, using alternative visits.

Year Two Grant Opportunity

- **Grants of up to $30,000**
- Support specific project ideas that focus on **deeper implementation** of one or more population health strategies.
- Orgs. will be eligible to apply for and receive more than one grant award.
- Qualifying orgs. will be those that **successfully participated in year one** of the PHLN by:
  1. Attending convenings
  2. Participating in evaluation activities
  3. Facilitating a peer connection through a site visit or webinar

- Examples could include:
  - Experimenting with **health plans** on new payment models for services such as care transitions programs.
  - Developing **complex care management programs** for high risk patients.
  - Building relationships with **community partners** to facilitate streamlined referrals to address social needs.

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Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020

Core In Person Opportunities: Convenings & Site Visits

- Convening #1 (Q2 2018)
- Site visits to exemplar orgs. (Q3 2018 – Q4 2018)
- Convening #2 (Q1 2019)
- Site to site peer connections (Q2 2019 – Q3 2019)
- Convening #3 (Q4 2019)

Capability-Building Trainings*

*Required, but orgs could request exemptions.

- CCI Blended Methodology Training (Q2 2018 – Q3 2018)
- Team-Based Care Training (Q3 2018 – Q4 2018)
- Data Capability Training (Q4 2018 – Q1 2019)

Key Program Activities

- Release RFA, Info Webinars, Select Cohort, Kickoff Webinar (Q1 2018)
- Release grant opportunity, Select Projects (Q2 2019)
- Final evaluation activities (Q2 2020)
- Access to Technical Assistance (Q2 2018 – Q1 2020)

Eligibility & Expectations

Target Audience

20-30 organizations in CA

Clinics that have demonstrated a commitment to **delivering high-quality, comprehensive care** and a commitment to **experiment and learn** with others

What We're Looking For

Preferred Criteria

Serve at least 10,000 unduplicated patients per year.

Established and defined care teams.

An electronic health record that has been in practice for at least one year.

Most patients empaneled to clinicians and/or care teams.

Some data infrastructure in place. For example, data governance is established and data validation processes are in place for at least three clinical measures.

Financial organizational stability to allow teams in the network the time and resources to test and make care delivery changes, with or without payment mechanisms in place.

Health information technology capacity. For example, use of a population health reporting tool.

Actively working on care delivery transformation efforts in at least four PHLN core content areas.

Eligibility

California-based safety net healthcare organizations that provide comprehensive primary care services to underserved populations are eligible to apply.

Organizations must be nonprofit and tax-exempt under 501(c)(3) of the Internal Revenue Service Code (IRC) or a governmental, tribal, or public entity.

Examples include:

- Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes
- Community clinics, rural health clinics, and free clinics
- Ambulatory care clinics owned and operated by public hospitals
- Indian Health Services Clinics

How to Apply

How to Apply

Applicant organizations must submit the following materials:

1. Application Form
2. Response to Application Questions
3. Tax Status Documentation
4. Letter of Leadership Support

All materials must be received by 5 PM PST on Friday, February 9.

Important Dates and Timeline

Application Deadline
Friday, February 9th at 5pm

Network Participants Announced
Friday, March 16, 2018

Kickoff Webinar
Tuesday, March 27 from 12-1:30pm

1st In-person Convening
Early May 2018

A Word from CHCF

California Health Care Foundation

HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

Kathryn E. Phillips,
Senior Program Officer,
Improving Access

blue of california foundation

Carolyn Wang Kong,
Senior Program Officer

Press *7 to unmute or type in your questions.

Thank you!

For questions contact:

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