# Population Health Learning Network

January 24, 2019

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.

# Year Two of the PHLN: Two Paths

## Option 1: Keep Participating in the Network

- -Core team attend Convening #3 (December 5, 2019)
- -Continue to participate fully in evaluation activities
- Continue to connect & share with other PHLN teams in the network
- -Option to participate in other activities (i.e. coaching, access technical advisors, webinars, etc)
- -Submit quarterly reports

## Option 2: Participate AND Receive Additional $$ and TA Support

- -Continue core PHLN activities
- - Additional financial support ($30K)
- -We'll ask for extra metric collection & reporting AND also provide you with extra support

# Year Two Grant Opportunity

26 grants of $30,000 each to support project proposals that focus on implementation or spread of one or more population health strategies

1) Build on, strengthen, deepen, or spread ideas that advance your organization's population health work;

2) Be focused on implementing an idea or strategy tested (partially or fully) in year one of the PHLN.

Not a planning grant or an innovation grant

This opportunity is not competitive. We expect to issue awards to all participants who meet established criteria. You may submit proposals for up to two separate grants.

# What Makes a Strong Proposal

- Connection of the proposed project to at least **one core content areas covered in the PHLN**;
- Connection of proposed project to your **overall aims** developed in year one;
- **Scope of the project and feasibility** given the grant resources and 12-month timeline;
- **Plan for tracking** incremental **progress and impact** of the project on patients, organization operations, efficiency, and/or costs; and
- Ability of the proposed project to **be sustained** beyond the grant timeline.
- Demonstration that the proposed project will **help advance or accelerate your organizations' population health capabilities**.
- A designated **project lead** who has actively participated in PHLN-related activities.

# Example Project Ideas

1. Adding a **new role** to your organization's core **care team.**
2. Developing and implementing a **suite of new population health-related data reports** to support in-reach and/or outreach processes across your organization.
3. Developing and implementing a **registry for behavioral health** with care team roles and workflows.
4. Implementing a new or revamped **alternative visit** such as a group visit, flip visit, or telephone visit.
5. Implementing a **social needs screening protocol, tool, or workflow**.
6. Revising and/or implementing a **new algorithm for stratifying patients** who might benefit from complex care management.

# Expectations

**Continue Participation in Network Activities & Dedication to Sharing**

- Present project findings on December 5, 2019 and the final PHLN webinar by the end of May 2020

**Evaluation and Metrics Collection & Progress Reporting**

- Define a set of measures and with the help of CCI's program evaluator
- Create a measurement work plan to track relevant metrics and milestones
- Submit metrics quarterly (April 30, 2019; July 30, 2019; October 30, 2019; January 30, 2020; and April 30, 2020)
- Continue to participate in the full PHLN evaluation activities

**Affinity Groups & Forum Usage**

- Be matched in triad affinity groups based on the areas in which you are doing work.
- Check in at least quarterly (preferably through the PHLN online forum) to share progress and help overcome challenges experienced

# Important Dates and Timeline

- **Application Launch**: Thursday, January 17, 2019
- **Application Deadline:** Friday, February 8, 2019
- **Grants Announced:** By Friday, March 1, 2019
- **Kickoff Webinar:** Tuesday, March 19, 2019
- **End of Grant**: Friday, February 28, 2020


 

# How to Apply

Applicant organizations must submit the following materials:

1. Application Form
2. Response to Application Questions
3. Proposed Budget

**All materials must be received by 5 PM PST on Friday, February 8.**

All questions should be submitted through the PHLN forum at: https://forum.careinnovations.org/

CCI will be hosting two, 30-minute Q&A sessions:

- Friday, January 25 at 12pm: https://zoom.us/j/4155614444
- Thursday, January 31 at 12pm: https://zoom.us/j/4155614444

# Set Up for Success: Tips for Selecting Year 2 Measures

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John Snow, Inc.

1.24.19

# For Year 2 projects, you will…

- Define a set of measures.
- Create a measurement plan.
- Track and report on your measures.

# Why collect data?

# Collecting data helps to…

- Track progress
- Understand what's working (or not) and why
- Make improvements
- Understand successes
- Communicate with others

# What is important to measure?

# Two Measurement Mantras

Measure what matters.

Measure what you can change.

# An evaluation framework


**Outcomes:** How do we define success from the project now, six months from now, and one year from now?

**Measures:** What will you see if the project resulted in any changes?

**Data Collection Strategies:** What data can we collect to understand if change took place or the project was successful?

# Types of measures

**Process measures** reflect steps that lead to an outcome.

**Outcome measures** reflect the results of a process or practice.

# What is realistic to measure?

Why is the speedometer stuck on 35?

The car only collects speed data once a year.

freshspectrum.com

# Consider stakeholders

Who is a stakeholder?

How will we engage stakeholders and build their support?

Remember: Stakeholders need incentives to engage in the process of data collection, data entry, and data interpretation.

# Consider timeframe

Keep your logic model in mind – what will occur in 3 months, 6 months, 12 months,  or more?

Remember process measures!

# Consider availability of data

What data are available?

How timely are the data?

What data collection strategies exist?

Where are the gaps?

# Consider feasibility of data collection

What is reasonable to collect?

What resources are available?

What training is needed?

# Consider how data will be used

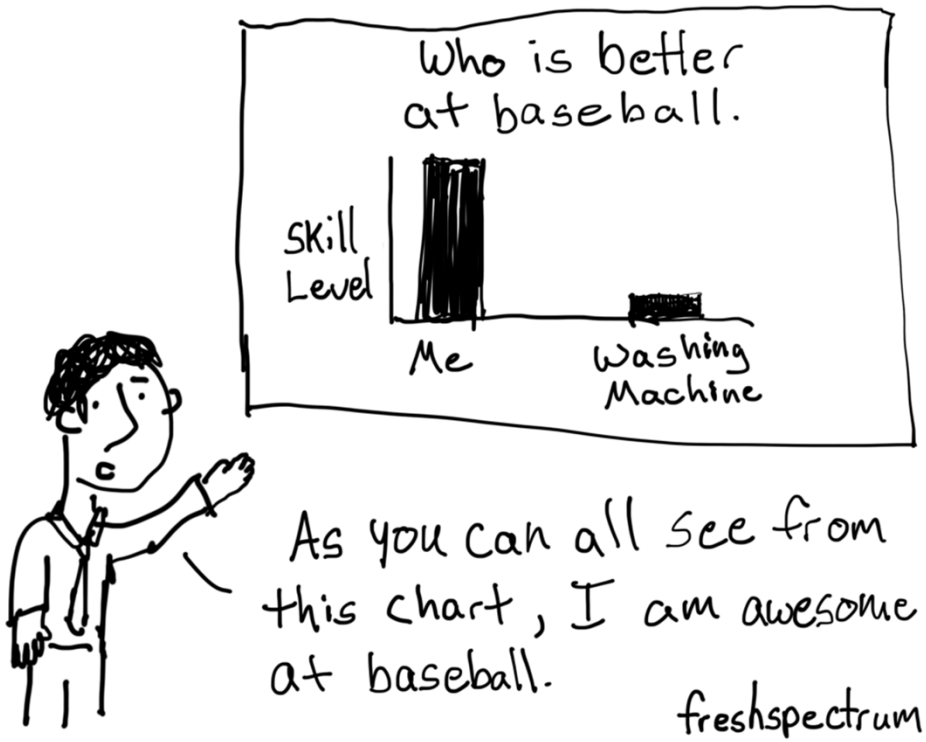
Who is the audience?

How will we review the data and act on it?

# Summary of considerations

- Stakeholders
- Timeframe
- Availability of data
- Feasibility of data collection
- Use of data

# How can we avoid common pitfalls?



# Sample Year 2 projects

- Adding a **new role** to the care team.
- Developing **new data reports** to support in-reach and outreach processes
- Implementing a **registry for behavioral health** with care team roles and workflows.
- Implementing a new or **revamped alternative visit**
- Implementing a **social needs screening** protocol, tool, or workflow.
- Revising and implementing a new **algorithm for stratifying patients** who might benefit from complex care management.

# Strong Measures – Easy, right?

**Example 1**: Have a documented curriculum to teach staff how to make data-driven decisions by the end of year 1 of the PHLN.

**Example 2:** Have a care coordinator integrated into all campuses by Dec 31, 2020.

**Example 3:** By May 31, 2019, 95% of pts with a DM ICD-10 code will have been evaluated by an Access Navigator for insurance eligibility (including PRUCOL, Medi-Cal, etc.).

# Pitfall #1: Lack of clarity

**Pitfall:** Measures/goals are not clear to everyone on the team

**Solution:** Write goal so that someone who hasn't been involved in the project will understand what you mean.

## Original

Reach 8,000 patients by 2020.

## Improved

Increase provision of tobacco screening to new and existing patients during preventive care visits from 82.2% to 87% of patients by 2020.

# Pitfall #2: Jumping to outcome measures

**Pitfall:** Measures are solely focused on outcomes without an initial assessment of process

**Solution:** Ensure you have measures that indicate whether your team has taken the planned actions that would lead to the improvement as well as measuring the ultimate result.

## Original

Increase tobacco screening for adults 18 and older from 87% to 89%.

## Improved

**Process measures**

- EHR template adapted to simplify clinical decision prompt
- Training completed for 100% of medical assistants on tobacco screening
- Designate a data steward from each care team to ensure data collected is accurate, complete and timely

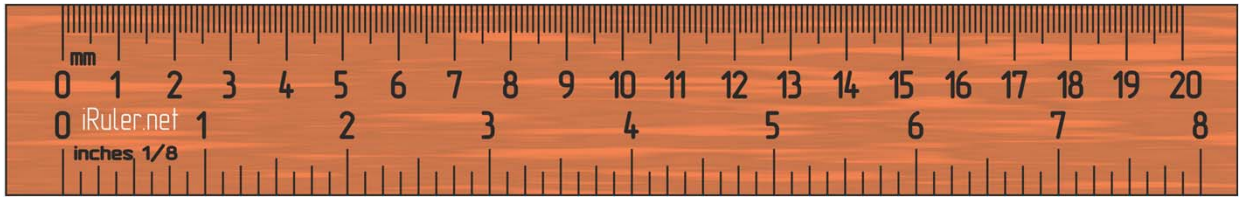
**Outcome measure**

Documentation of tobacco screening increased from 87% to 89% of patients 18 and older.

# Pitfall #3: Aims that can't be measured

**Pitfall:** Aims are so aspirational that it is unclear when you will have achieved success, or how you will know you have achieved success

**Solution:** Translate how aims are written so that success is defined in a way that is measurable.



## Original

Pursue quality metrics for IBH and explore what their role is in population health

## Improved

Create a quality measurement plan for IBH that includes

- Defining the quality measures of interest for pop health
- Determining which patient populations should be reviewed for these quality measures
- Ensuring consistent documentation of the quality measures
- Defining the timeframe for review of quality measures (Measure-trend PHQ scores over time, comparing score at intake vs. Score after d/c from counseling)

Create a dashboard for monitoring all measures with provider and site drill down

# Pitfall #4:Timing of results

**Pitfall #4:** Choosing outcomes to measure that may take longer to observe than what is realistic in the measurement period.

**Solution:** Consider how long it will take to see the changes, and what changes will be observable at the points in time you plan to measure

# Original

- Pilot Chronic Care Management program and measure the number of patients enrolled in the program and number who have received services.
- Improve cervical cancer, colorectal cancer screening rates and smoking cessation/intervention rates by involving staff and look for QI opportunities.

# Improved

- Define the care model process (before the visit, during the visit, after the visit, between visits) for target population
- Pilot  Chronic Care Management program by June 2020.
- Measure data on the number of patients enrolled by October 2020.
- Measure the number of patients receiving services as of January 2020
- Among those enrolled, measure the number of cervical cancer, and colorectal cancer screenings and smoking cessation/interventions in June 2021.

# Takeaways

Use measurement as a tool to support your team in marking and celebrating success.

Choose measures that are realistic in terms of

- time to collect the data,
- time to observe the results,
- **meaningful to your team!**

# Next Steps and Support

- PHLN Portal: https://www.careinnovations.org/phln-portal/
- PHLN Forum: https://forum.careinnovations.org/
- PHLN program team and coaches
- Year 2 Office Hours on 1/25 and 1/31 at noon
- Jerry Lassa: jerry.lassa@datamatt3rs.com

# Questions?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