The PHLN is a two-year offering from the Center for Care Innovations (CCI) that aims to improve the health and well-being of more than 1.2 million Californians by bringing together safety net primary care organizations to strengthen and advance population health management strategies. The PHLN runs from March 2018-March 2020.

The PHLN was developed in recognition that achieving the triple aim—exceptional patient outcomes, experience, and lower costs—takes time and requires organizations to continuously improve their care teams, care processes, and systems, with each new iteration being responsive to changes in their patients’ needs and preferences and their payers’ reimbursement models. Population health management helps community health centers to deliver more efficient, cost-effective care that meets the needs of patients. It also equips organizations with the skills and data to target resources where disparities in care are greatest.

25 ORGANIZATIONS

There’s a potential to impact over 1.2 million patients served by the 25 PHLN organizations.

Teams include 3-5 individuals representing senior & management positions, and those responsible for leading and managing population health activities.

8 CORE CONTENT AREAS

- Behavioral Health Integration
- Social Needs
- Complex Care Management
- Team-Based Care 2.0
- Learning Organizations
- Data Governance & Analytics
- Planned Care
- Proactive Care to Close Care Gaps

TECHNICAL ASSISTANCE

- Network Model - focused on peer learning and exchange
- Independent evaluation of impact and learning underway by JSI, Inc.; results available in 2020
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Organizations were eligible to apply for year two implementation grants of $30,000 each to support implementation or spread of population health strategies tested in year one. Project periods last from March 1, 2019-February 28, 2020.

Evaluation results and case studies from the implementation grants will be made available in the summer of 2020.