POPULATION HEALTH LEARNING NETWORK

The PHLN is a two-year offering from the Center for Care Innovations (CCI) that 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 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.

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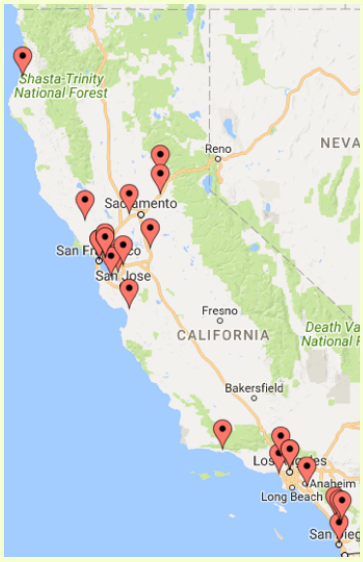
blue of california foundation

25 ORGANIZATIONS

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



1. Axis Community Health
2. Chapa-De Indian Health Program
3. CommuniCare Health Centers
4. Community Medical Centers, Inc.
5. L.A. County Department of Health Services - Primary Care
6. La Clinica de La Raza, Inc.
7. LifeLong Medical Care
8. Los Angeles LGBT Center
9. Native American Health Center
10. Neighborhood HealthCare
11. North County Health Services
12. North East Medical Services
13. Northeast Valley Health Corporation
14. Open Door Community Health Centers
15, Ravenswood Family Health Center
16. Salud Para La Gente
17. San Francisco Health Network- Primary Care
18. San Ysidro
19. Santa Barbara Neighborhood Clinics
20. Santa Rosa Community Health
21. Serve the People
22. Tri-City Health Center
23. Venice Family Clinic
24. Vista Community Clinic
25. Western Sierra Medical Clinic

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

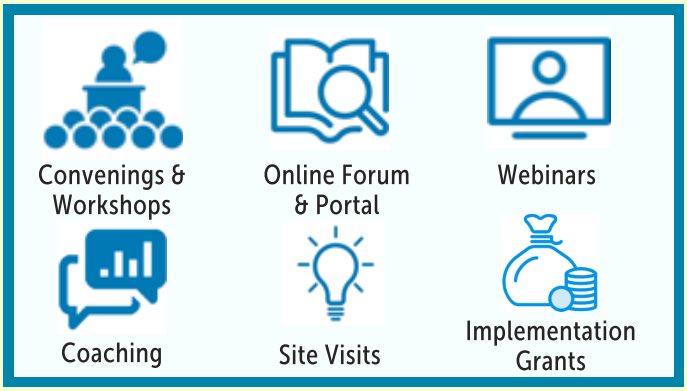
8 CORE CONTENT AREAS

Learning, sharing, and technical assistance are focused on the PHLN's core content.

- 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

The PHLN provides robust technical assistance and support that teams self-select.



- 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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YEAR 2 IMPLEMENTATION GRANTS

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.

Organization	Area Focus	Year 2 Project Focus
Chapa-De Indian Health Program, Inc	Access Strategies to Optimize Planned Care & Outreach	Develop a robust and reliable recall system to move toward advance access scheduling
Neighborhood HealthCare	Access Strategies to Optimize Planned Care & Outreach	Develop a recall and tracking system to improve access
Northeast Valley Health Corporation	Access Strategies to Optimize Planned Care & Outreach	Assist newly assigned members with establishing care through the implementation of NextGen EMSS and Care Messaging Platform Modules, and test out low and high touch methods of engaging active patients with preventative health screenings
San Francisco Health Network-Primary Care	Access Strategies to Optimize Planned Care & Outreach	Increase access and close gaps by conducting proactive, centralized outreach to assigned but unseen members
L.A. County Department of Health Services - Primary Care	Social Needs	Address food insecurity for patients to improve clinical outcomes by linking at least 20% of patients seen who screen positive to appropriate resources
North County Health Services	Social Needs	Identify a SDOH screening tool and assess patients with poor diabetes control, linking them to resources and developing appropriate workflows
Santa Rosa Community Health	Social Needs	Develop workflows, train staff, implement PRAPARE, and create a plan to link patients to needed resources
Serve the People Community Health Center	Social Needs	Implement and integrate PRAPARE screening and develop workflows for identified diabetic patient population
Tri-City Health Center	Social Needs	Use PRAPARE data and patient focus groups to Improve health outcomes in the diabetic patients
Axis Community Health	Behavioral Health Integration	Develop a robust behavioral health registry within EPIC that monitors and tracks key health indicators such as screening scores, allowing the appropriate clinicians to use the data to adjust treatment plan in timely manner
North East Medical Services (NEMS)	Behavioral Health Integration	Increase access to culturally- and linguistically- appropriate behavioral health care for adolescents (ages 12-17) across all NEMS pediatric clinics by applying the adult depression screening process and workflow to our adolescent population
Open Door Community Health Centers	Behavioral Health Integration	Address the underlying causes of poor access to BH services within ODCHC via BH provider education and support, Case Manager training and support, and effective use of data
Vista Community Clinic	Behavioral Health Integration	Improve depression screening in children ages 12-18 from a baseline of 73% to 83% through the initiation of use of the PHQ-A depression screening tool
CommuniCare Health Centers	Care Team Roles	Divide the Patient Services Representative role into two positions (Registration PSR and Team PSR) and test if the division of labor optimizes Care Team function and patient experience
La Clinica de La Raza, Inc.	Care Team Roles	Standardize and optimize the Clinical Office Assistants role and maximize the skills, abilities, and performance of COAs
Los Angeles LGBT Center	Care Team Roles	Re-structure the team-based model to a Core Clinical Care Model, hire 3 new LVN Coordinators, 1 Flow Facilitator, standardize workflows and standing protocols, and implement huddles, and missed opportunities reports
Native American Health Center	Care Team Roles	Add a referral coordinator to a pod, followed by clinical care assistant, float MA, flow MA, and Team RN to each of the care teams
Santa Barbara Neighborhood Clinics	Care Team Roles	Add a new core care team member (panel managers) & also focused on diabetes care management
Ravenswood Family Health Center	Data Tools & Reporting to Close Gaps in Care	Decrease the number of patients whose insurance lapses, by creating a streamlined and effective process for insurance panel management
Salud Para La Gente	Data Tools & Reporting to Close Gaps in Care	Improve data transparency by developing and implementing population health reports for care teams to act on clinical quality improvement (colorectal cancer screening)
Venice Family Clinic	Data Tools & Reporting to Close Gaps in Care	Integrate existing Patient Visit Planning report into NextGen system to increase the ease of use and allow all team members to access the report
Community Medical Centers	Risk Stratification	Develop a structured tiered outreach process (using a roster utility system eMed Apps) to better engage assigned, unseen members
LifeLong Medical Care	Risk Stratification	Improve care coordination services for high risk patients by developing and implementing a risk stratification methodology
Northeast Valley Health Corporation	Risk Stratification	Optimize care management services by testing a risk stratification tool (Chronic Condition Count) and testing a complex care management model focusing on DM patients

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