California Health Care Foundation

blue of california foundation

Population Health Learning Network

March 27, 2018

Kickoff Webinar

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 newsletter.

Today's Agenda

1. Welcome
2. Population Health: A Perspective from the Clinic
3. Team Introductions
   - What is your **organizational pop health superpower**? What do you feel you do well as an organization & could potentially help others with?
4. Network Overview: Goals, Structure, & TA Support
5. Preparing for May Convening
6. Questions & Answers

Meet Your Program Staff!

Our CCI Program Team

Megan O'Brien,
Program Manager

Tammy Fisher,
Senior Director

Diana Nguyen,
Program Coordinator

Our Extended Program Team

Dr. Carolyn Shepherd,
PHLN Faculty

Meaghan Copeland,
Program Consultant

Our Focus

We work relentlessly to bring practical innovations to your organization.

We believe the challenges facing the safety net are tremendous opportunities for evolving health and health care.

What We Do Today

CCI transforms care for underserved populations by inspiring, teaching, and spreading innovation among organizations serving patients.

Build Capabilities

Catalyze Innovation

Spread Solutions That Work

Our Six Program Areas

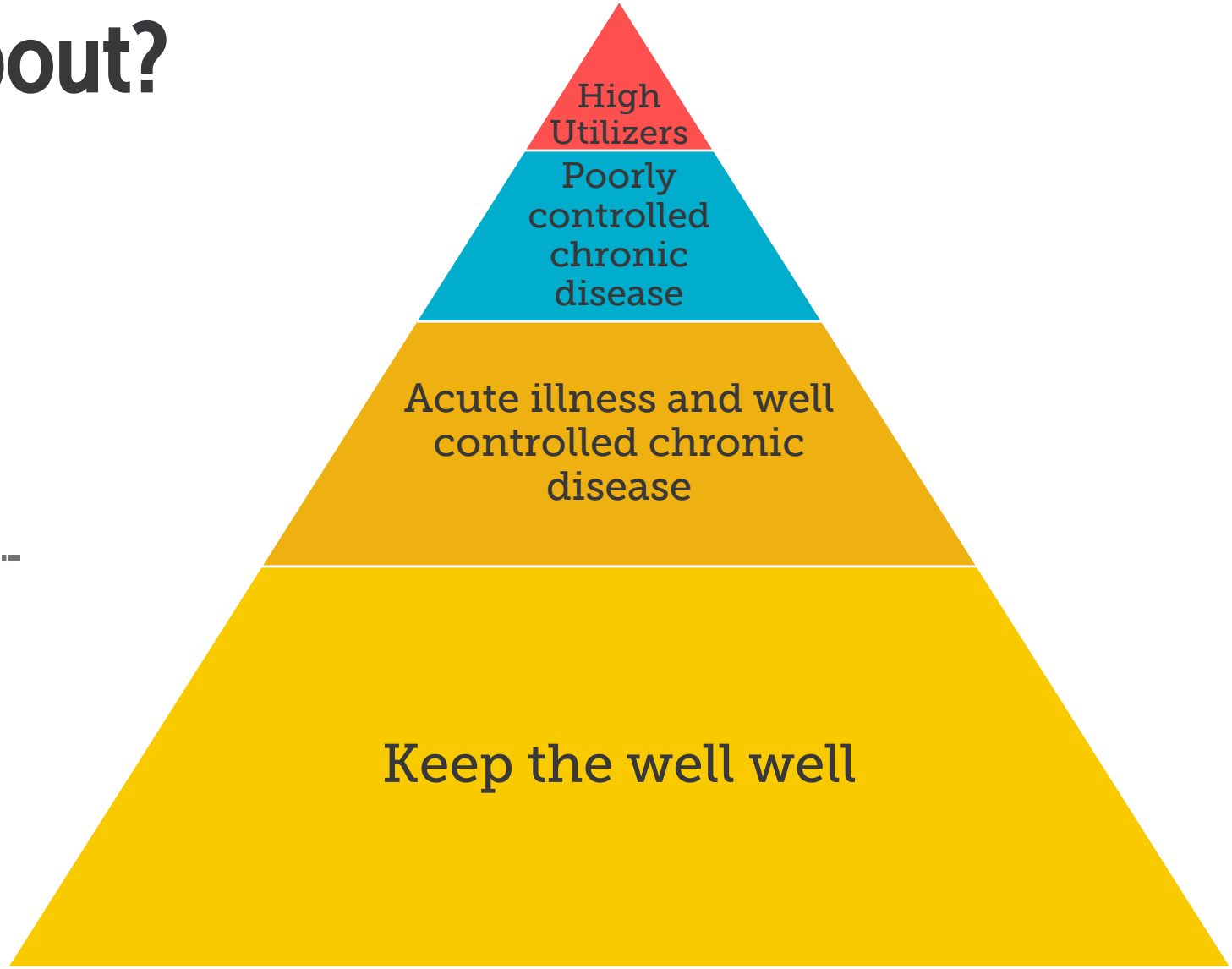
1. Population Health
2. Data Analytics
3. Innovation & Design Thinking
4. Technology Solutions
5. Delivery System Reform
6. Community-Centered Care

Population Health:

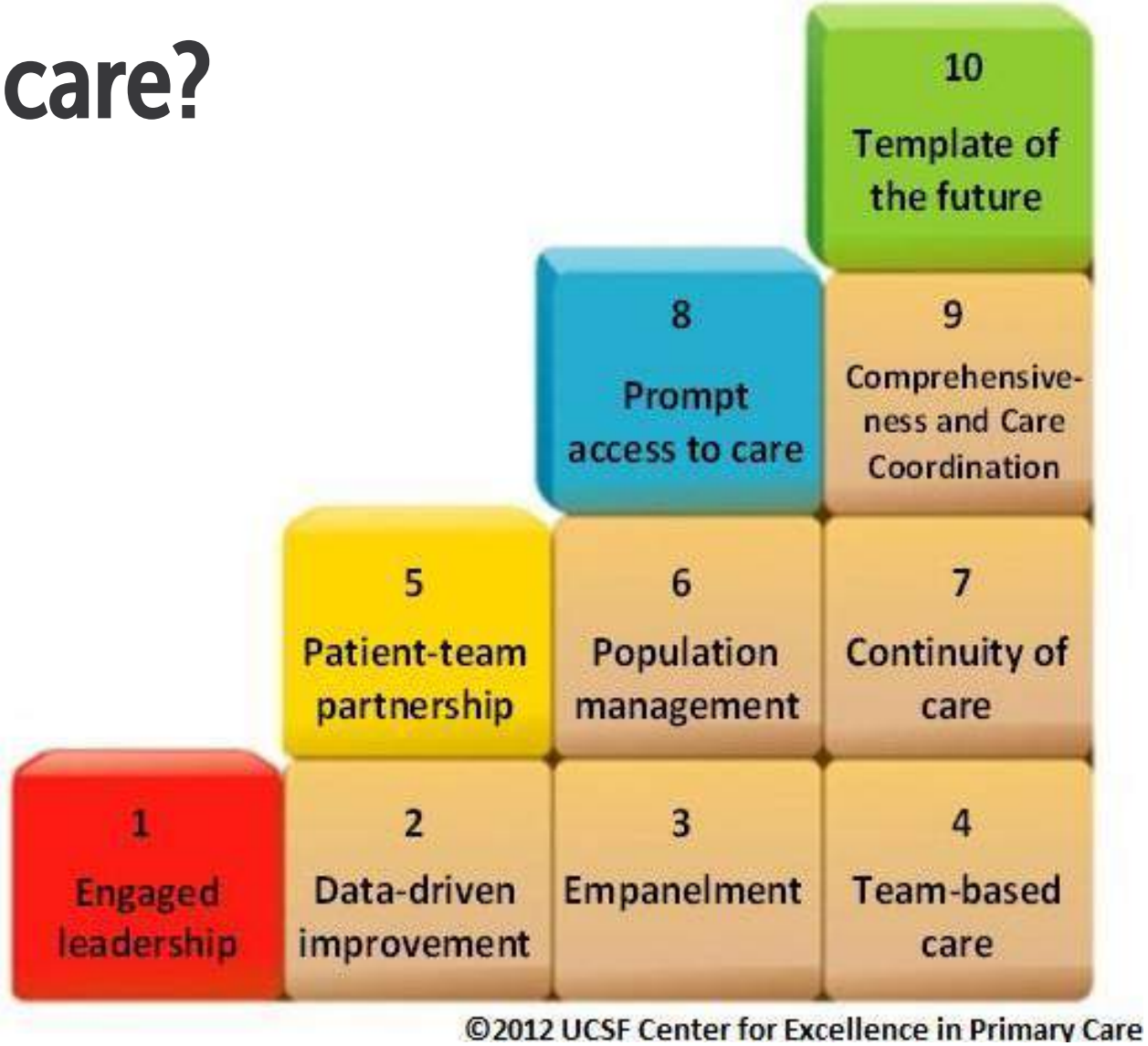
A Perspective from the Clinic

What are we talking about?

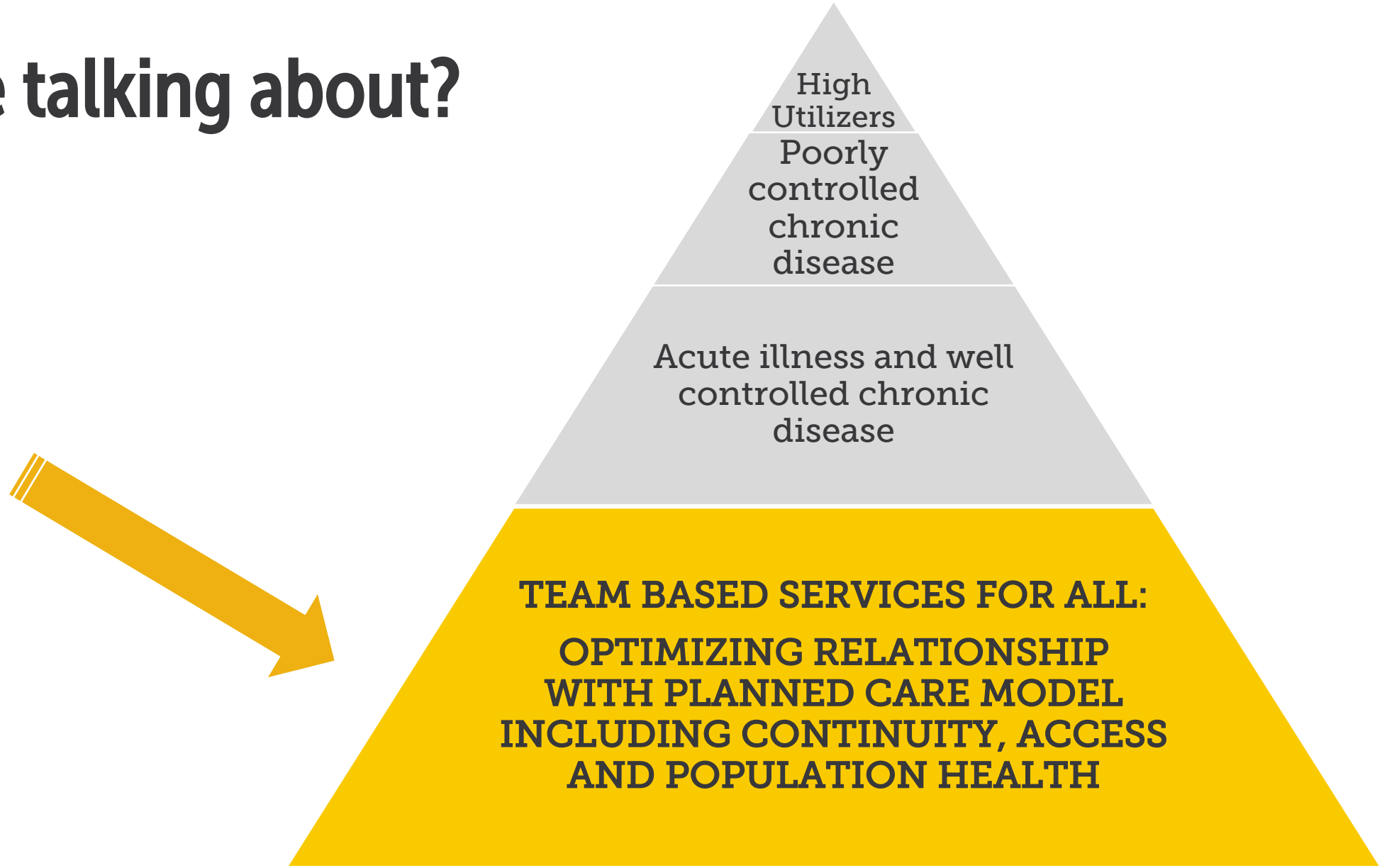
The work of population health is to **maximize health and wellness** by co-creating services which deliver primary and secondary evidence-based interventions for the prevention of illness in a population for which you are accountable.



Why population health care?



Who are we talking about?



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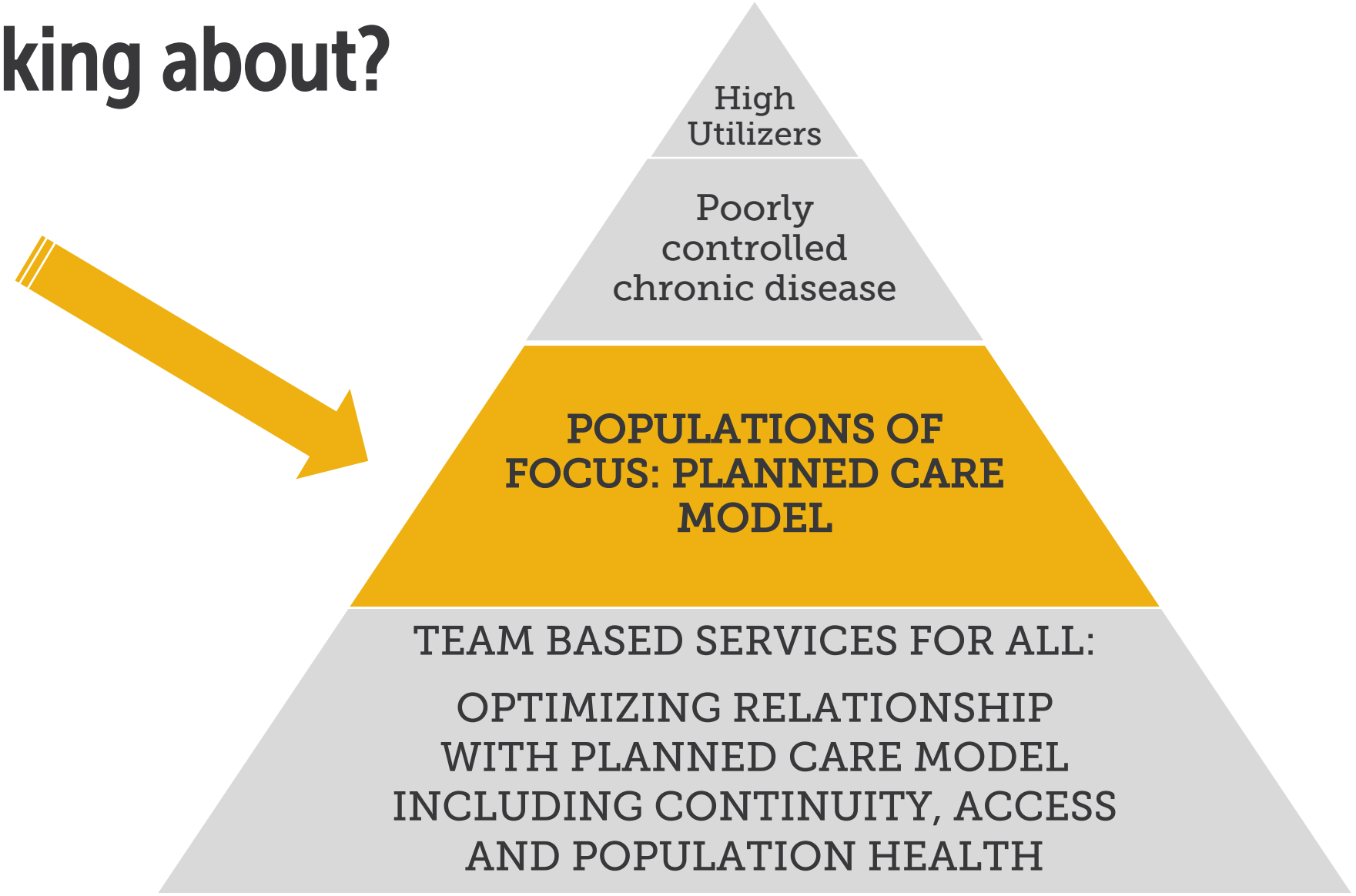
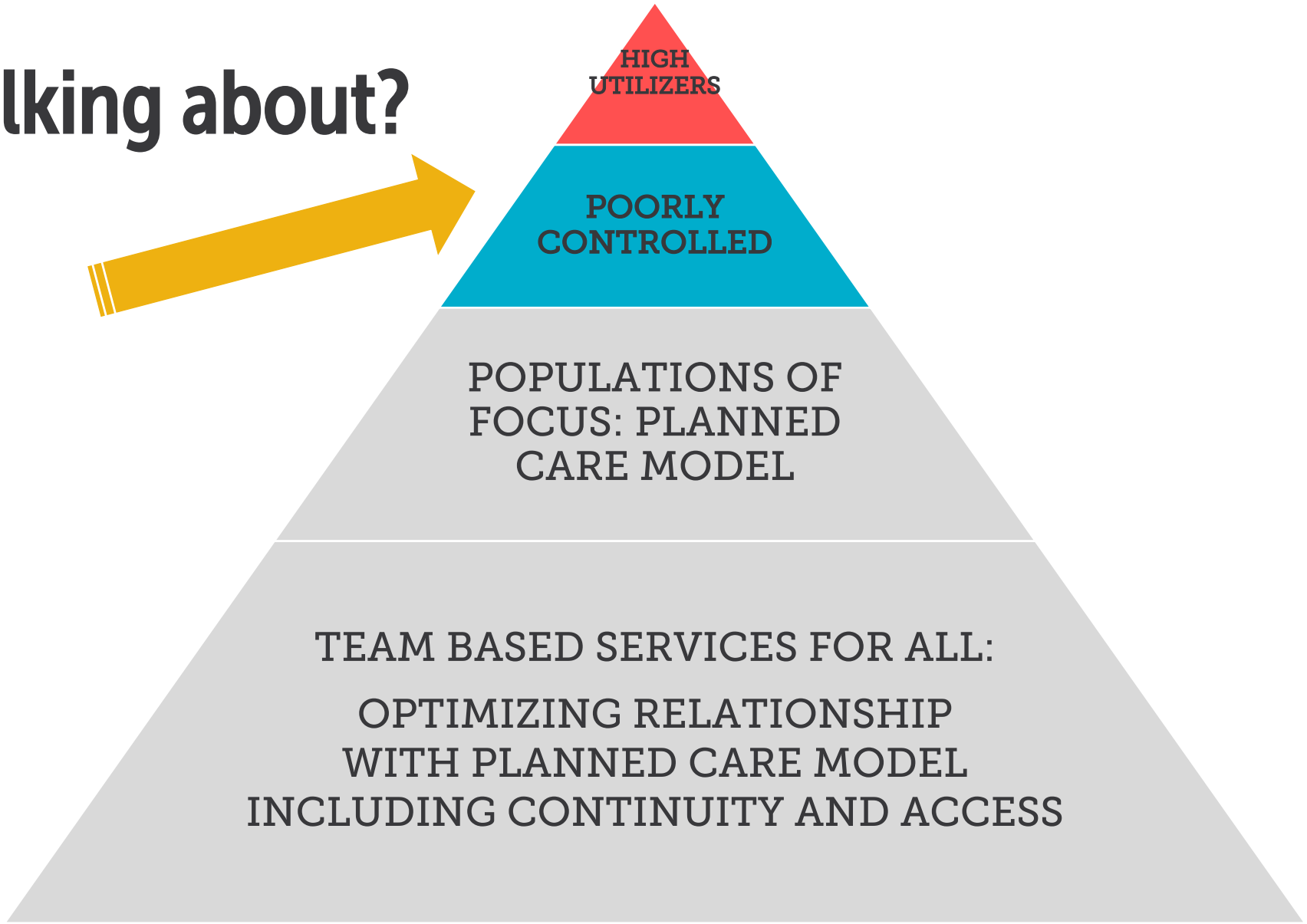


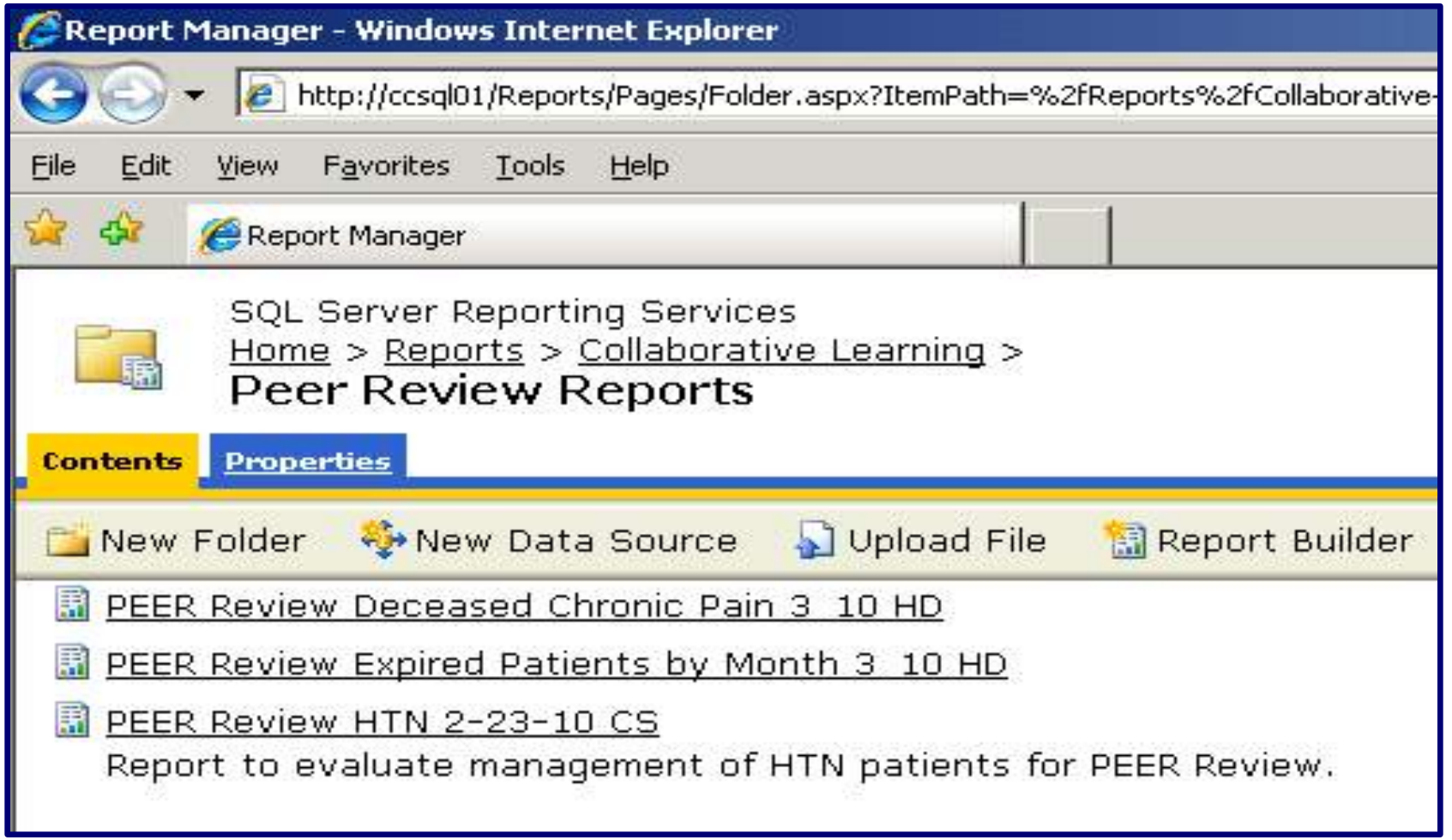
Who are we talking about?

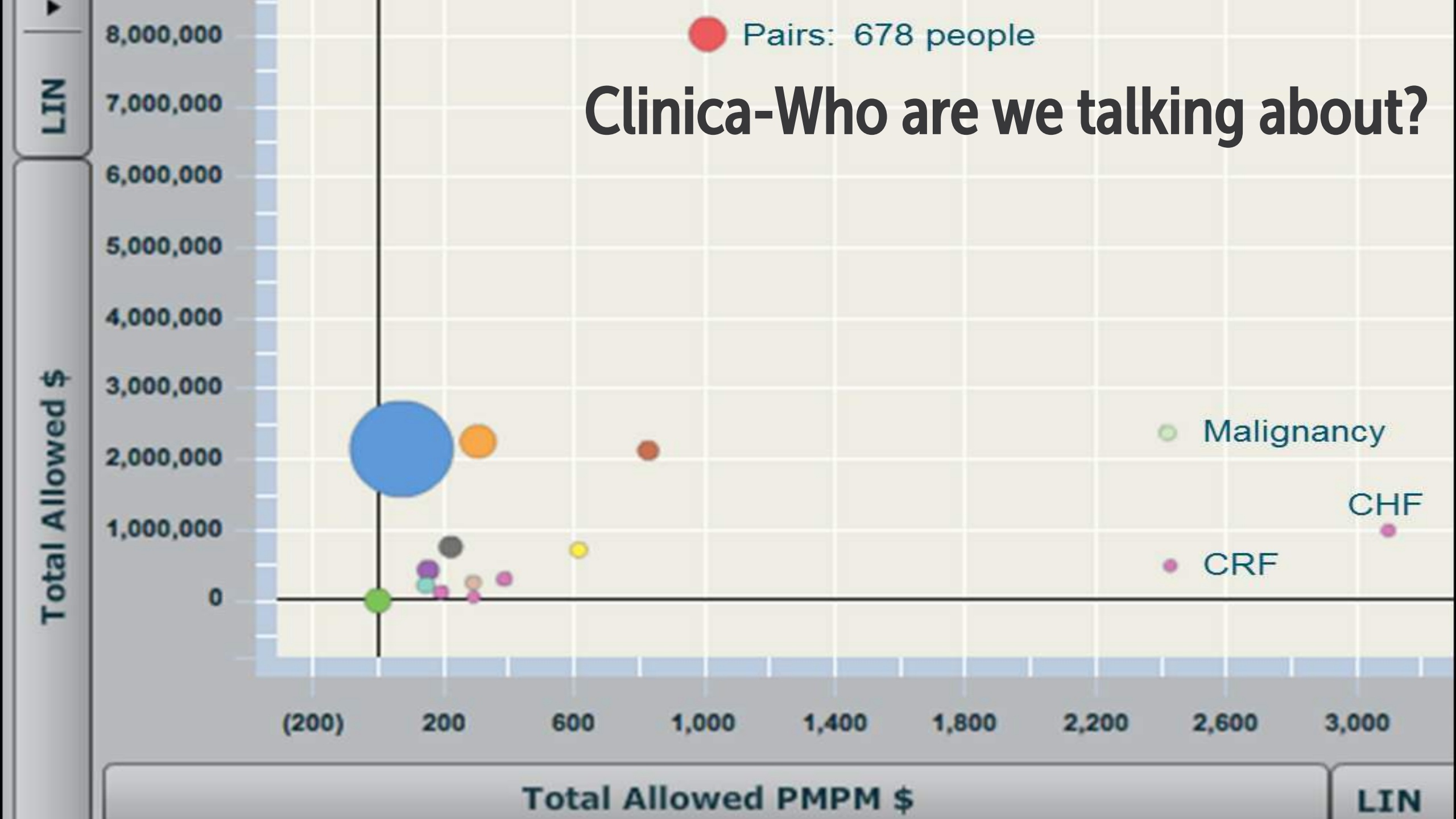
- Diabetes
- Asthma
- Depression
- Prenatal patients
- Chronic Pain
- ADHD
- Anticoagulation
- Hypertension

Who are we talking about?



Clinica Chronic Pain Patients Review




Pairs: 678 people
Clinica-Who are we talking about?
Malignancy
CHF
CRF
Total Allowed $
8,000,000
7,000,000
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
0
(200)
200
600
1,000
1,400
1,800
2,200
2,600
3,000
Total Allowed PMPM $
LIN
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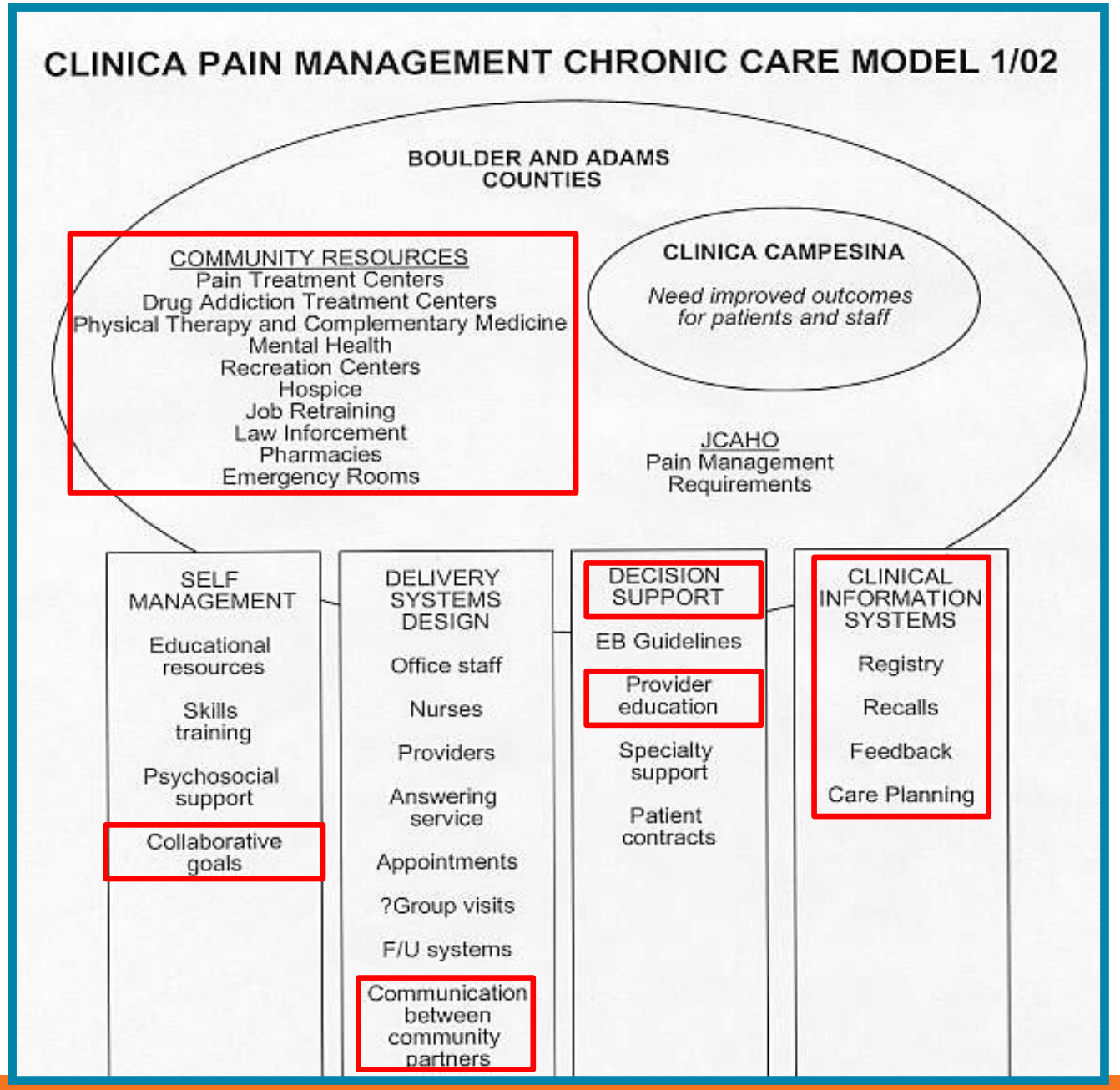
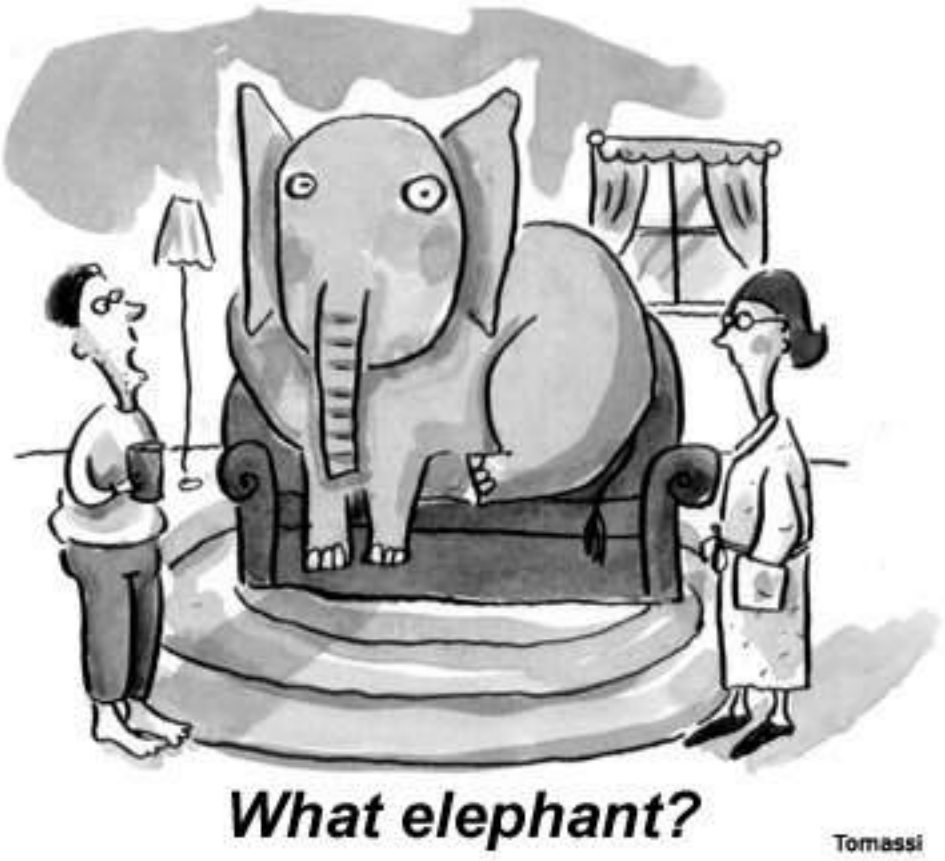
Where to start?

- Start with an AIM
- Develop a driver diagram using the planned care model as a framework
- Prioritize PDSAs for testing population health process changes



The California FQHC payment pilot…on hiatus



How are we going to change?

CarePlanner

?

5/24/2013 4:40:14 PM

Person Nbr	Patient Name	PCP/ Status	Phone Number	Age/ DOB	Gender	Last Visit	ACO
		PCP: Lomonaco McLean, Jennifer **Status:** Active **Payer:** Medicaid FQHC		48 Year(s)	F	05/22/2013 Lomonaco McLean, J **CarePlan Rvw:**	X

Alerts

Past Due - Diabetes Visit
Past Due - Diabetes Eye Exam
Past Due - LDL (Cholesterol) Lab
Past Due - Needs Review of Pain Contract
Past Due - Pain Needs Review of Patient Health Questionnaire (PHQ)
Past Due - Pain Needs Review of Functional Assessment Score
Due Now - Microalbumin
Abnormal Body Mass Index - was 57.12 on 05/08/2013
ACO Care Team Score is 5

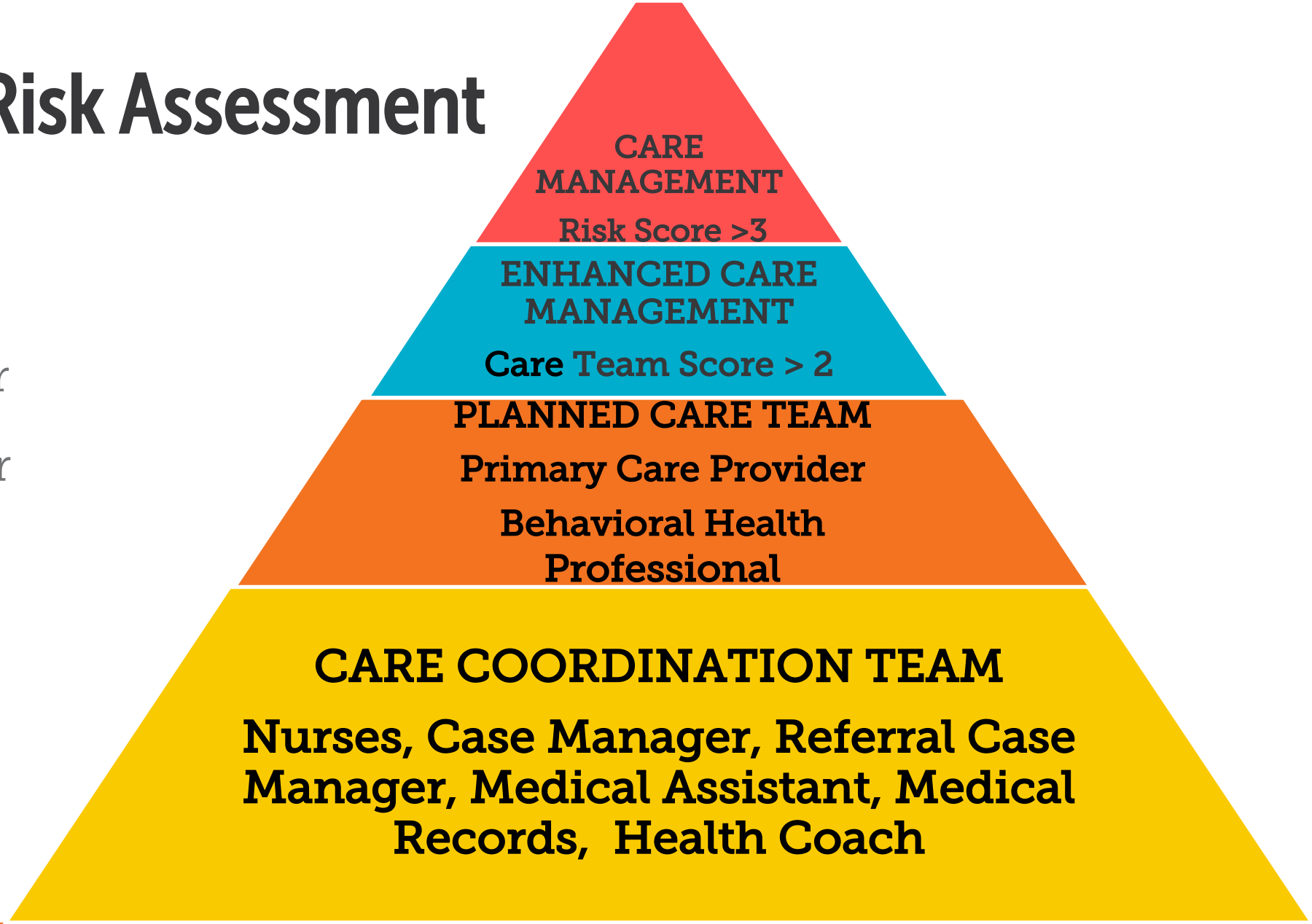
Appts

Active Problem List

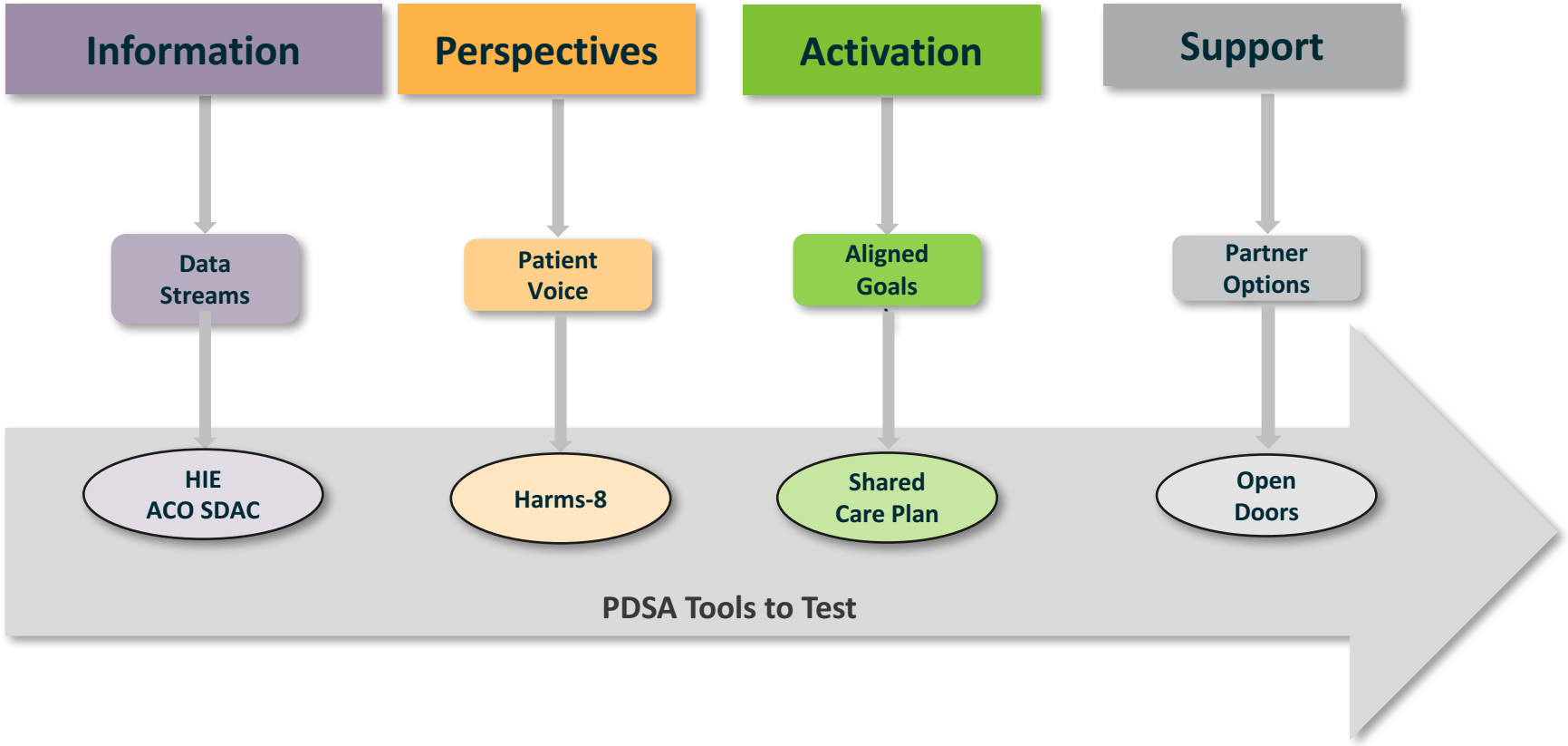
05/08/2013 - OSA (obstructive sleep apnea) - 327.23
12/14/2012 - Borderline personality disorder - 301.83
12/14/2012 - GAD (generalized anxiety disorder) - 300.02
/2012 - Leg pain - 729.5
/2012 - Major depressive disorder, recurrent e withou - 296.33
/2012 - Panic disorder with agoraphobia - 300.21
/2012 - Post traumatic stress disorder (PTSD) - 1
/2012 - Suicide attempt - E958.9
/2012 - Gastroparesis - 536.3
/2012 - Constipation - 564.00
/2012 - Morbid obesity - 278.01
/2012 - Opiate dependence - 304.00
/2012 - DVT (deep venous thrombosis) - 453.40
/2011 - Atrial Septal Defect, Ostium secundum - 745.5A
/2010 - Abuse, amphetamine, episodic - 305.72
/2010 - Irritable bowel syndrome - 564.1
/2009 - Asthma Persistent - 493.20
/2008 - Diabetes II, uncomplicated - 250.00
/2008 - Hepatitis C, chronic viral, w/o hepatic coma - 070.54
05/02/2008 - intrauterine fibroids - 615.1
05/02/2008 - Migraine - 346
05/02/2008 - Seizures, convulsions, other - 780.39
05/02/2008 - Tobacco abuse - 305.1

Clinica Health Risk Assessment

- HRA Scores:
- 57% = 1 or greater
- 13% = 3 or greater
- 5% = 4.5
- 1% = 5



Clinica PDSAs on Tools for Potentially Preventable Visits



Opportunities for Knowledge Transfer Through the PHLN

Clinica Tested and Implemented System Changes

- Diabetes
- Prenatal patients
- Asthma
- Depression
- Chronic Pain
- ADHD
- Anticoagulation
- Hypertension

- Algorithm of care
- Decision support
- Registry outreach
- Alternative visits
- Patient engagement
- Decrease variation
- Measure outcomes
- Improve over time

Track Performance

Performance Measure	Expected Visits per 1000 patients/ Year	Clinica Actual Visits per 1000 patients/per year	% Variance Actual vs Expected	% RCCO Variance	Clinica Adjusted Performance
% Improvement ER Visits	906.7	829.9	(8.5%)	1.4%	**(9.9%)**
% Improvement Imaging Services	425.7	281.8	(33.8%)	(5.8%)	**(28%)**
% Improvement 30 Day Readmits	13.1	9.1	(30.5%)	1.2%	**(31.8%)**

What we are talking about…Population Health!

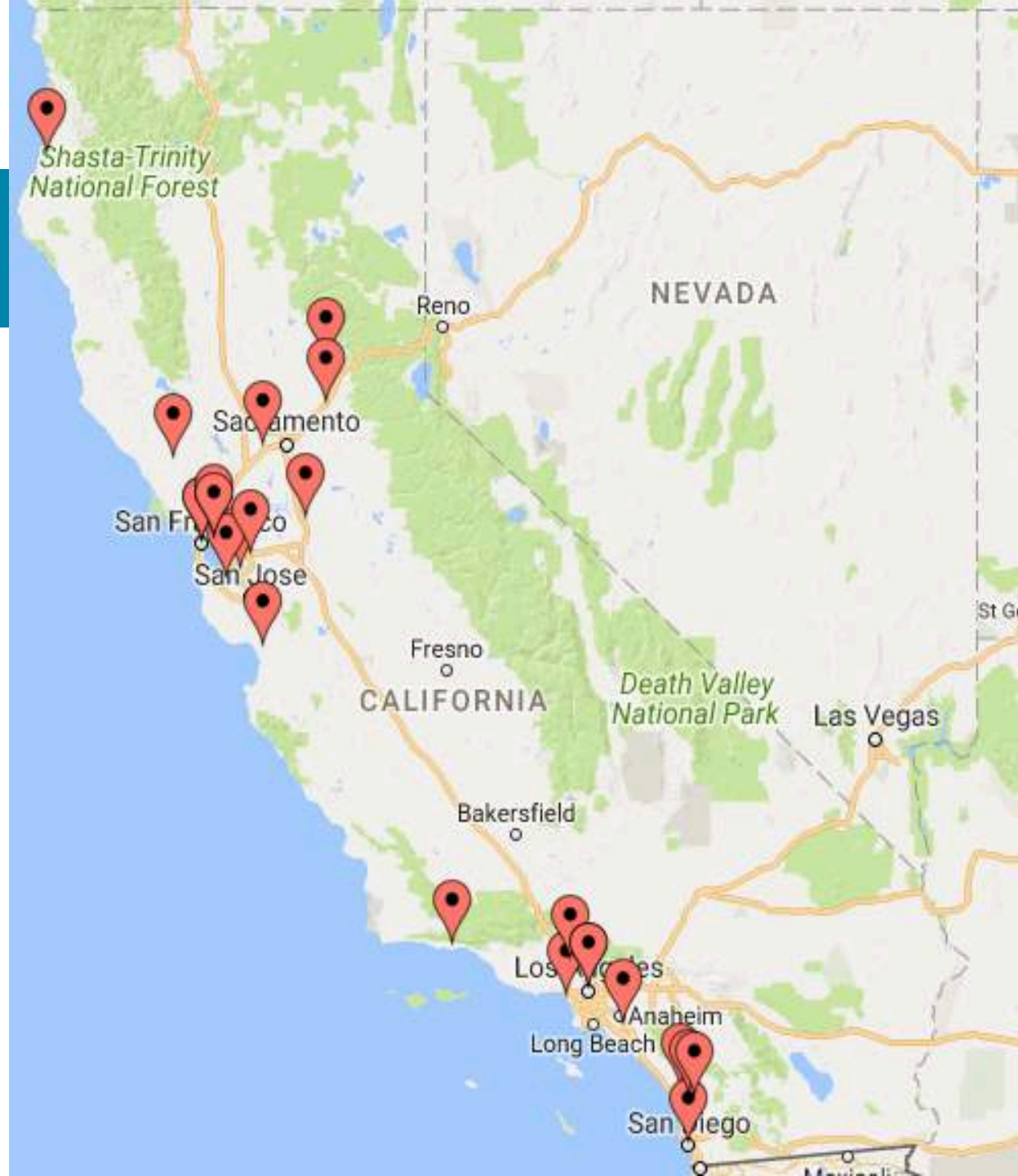
1. Develop high functioning care teams
2. Identify important sub-populations
    - High volume, high cost, high risk
3. Ensure evidence based care
    - Collect data and examine detailed characteristics of the sub-populations
    - Develop criteria for when to take action
    - Select and train population management staff
    - Create processes to remind pts & teams when work is due
4. Track and improve performance measures
5. Develop care coordination/care management competencies

Network Participants

Team Superpowers & Introductions

PHLN Cohort

25 organizations from across the state of CA were selected to participate in a 24 month network.



PHLN At-A-Glance

Type of Organizations
- 21 FQHCs
- 2 FQHCs/ Indian Health Services
- 1 FQHC Look-a-likes
- 1 Ambulatory Clinic

Employees
- 623 average
- Range from 50-2,789

Sites
- 12 average
- Range from 1-48

Patient Population
- 48,000 average
- Range 11,988-164,233

EHR
- 13 NextGen
- 6 eCW
- 1 Cerner
- 1 EPIC
- 2 Intergy
- 2 Other (All Scripts, Axeium)

Making Connections

CCI Team Selfie

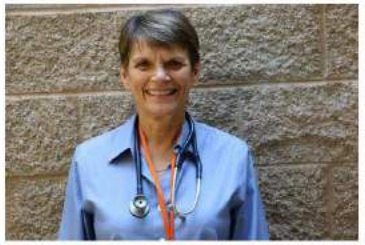
Axis Community Health

CommuniCare Health Centers

La Clinica de la Raza, Inc.

Community Medical Centers, Inc.

Dr. John Okemah
Medical Director



Bonnie Trinclisti, FNP
Director, Clinical Operations

Valerie Arnold
Health Information Systems Project Manager

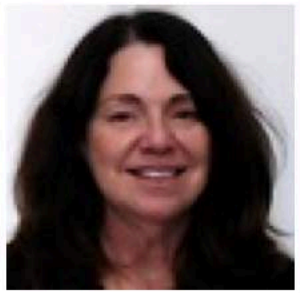
Sandra Tavel
Communications Manager

NATIVE AMERICAN HEALTH CENTER
Serving the community since 1972

Native American Health Center

NEMS NORTH EAST MEDICAL SERVICES

NORTH EAST MEDICAL SERVICES
東 北 醫 療 中 心
a californiahealth center



North East Medical Services (NEMS)

Open Door Community Health Centers

Ravenswood Family Health Center

Salud Para La Gente

Santa Rosa Community Health

Serve the People Community Health Center

San Francisco Health Network

San Ysidro Health

Cruz, Alyssa
LVN

Tam Nguyen, Ph.D.
Behavioral Health Director

Phyllis Pei
Director of Clinic Support...

Ryan Tanglao, BSN, MAN
Quality Program Manage...

Spencer Wong
Physician

Tri-City Health Center

Venice Family Clinic

North East Valley Health Corporation

Neighborhood Healthcare

Team Introductions

1. What is your organizational pop health **super power & why?**
2. What do you feel you do well and could potentially help others with?

Community Medical Centers, Inc.	Our population health superpower is that we recognize and understand that population health is a whole lot more than serving only our patients. We are actively working towards **integrating "member" data** with our patient data into our EHR, so we can develop more effective population health strategies to meet community needs.
Tri-City Health Center	We provide a wide **range of enabling services** to our patients.
Northeast Valley Health Corporation	**Data driven organization**; with staff, leaders and providers engaged in quality improvement
La Clinica de La Raza, Inc.	La Clínica's superpower is the ability to **leverage the Care Team** to improve clinical quality.
Ravenswood Family Health Center	We are the "**Data Driven Decision Makers".** Staff that are committed to using data to introduce ideas to improve efficiency and effectiveness of the care we provide to our patients.
CommuniCare Health Centers	Our team's super power is having **access to data to inform our decision making**. We have recently built a team (programmer, data analyst, EHR lead, and CQO) who have implemented the use of Relevant, a web-based database that pulls data from our EHR in close to real time (once every 24 hours).
San Ysidro Health	Our data to **show improved health outcomes**!
Axis Community Health	Our **care team structure** and process is our strongest power. We implemented care teams with the incorporation of "visit planners" since 2013. We've refined our daily huddle report through i2i to easily identify gaps in care and alerts that need to be cleared. In addition, a recent superpower has been the development of a provider incentive program which displays a monthly dashboard report of their performance. The color-coded report triggers providers and their care teams to run reports on vulnerable populations, use motivational interviewing techniques to engage these patients to come in to get needed care (DM, HTN, Cancer Screenings etc.).
Native American Health Center, Inc.	Our population health superpower is a **medical group visit called "Diabetes Care Day,"** which we hold quarterly to ensure our diabetic patients are maintaining and improving their care. We have devised a patient passport for that day, where the patient can track each station visited and receive an incentive if they've visited all the stations. Please see attached Patient Passport. Our Accreditation body—the Accreditation Association for Ambulatory Health Care, as well as the Indian Health Service have adopted this passport as an example of a best practice.
Neighborhood HealthCare	**Teamwork!**

North East Medical Services (NEMS)	Our superpower and drive to serve our patients comes from **our team of amazing NEMS staff**! Our compassionate and hardworking staff educates community members and provides quality health services in a culturally and linguistically sensitive manner to our patient population.
Open Door Community Health Centers	Our Population Health Superpower is our **team-based care**. We might also say it's our use of data or intensive case management program
Salud Para La Gente	Our **collaborative spirit and teamwork**: in the past two years, we have rolled out several new services including integrated behavioral health, telehealth services, chiropractor services--all of which requires a lot of collaboration and teamwork between different departments (Operations, Referrals, Billing, Medical, Data Systems). We have created several different workgroups which are multidisciplinary in order to overcome the natural tendency to work in silos.
San Francisco Health Network- Primary Care	Our city's commitment and network's dedication to ensure access for Healthy SF (uninsured) and Medicaid populations, in combination with our **experience using data/registries to outreach** to diverse safety net patients to achieve high quality preventive and chronic care.
Santa Rosa Community Health	Our superpower is **"flexibility** – when disaster strikes, all staff step in to fill the gaps so no patient is left behind"
Serve the People Community Health Center	Serve the People's population health superpower is **our service delivery model** designed for uninsured patients. Our service delivery model offers a range of **integrated care** to include integrative and alternative healthcare services. Our integrative program includes our Naturopathic clinic and Yoga Therapy. We also offer alternative points of access. Our team-based interdisciplinary approach is further supported by our Health Scholars Program. **The Health Scholars** assist us in addressing social determinants of health and ensuring we have the support to connect patients to the care they need to maximize their visits.
Venice Family Clinic	Our **ability to use data** from Azara healthcare, i2i Population Health and Nextgen to reduce gaps in care and improve care.

LA County

Our ability to track a large, diverse population across a vast geographic area in a uniform manner, while also honing in on the unique needs of specific populations, using our electronic population management platform which contains a robust empanelment algorithm, patient registries, data analytics, and a complex care management solution.

We now have the data and tools, in addition to an expanding PCMH team structure, that allow us to launch and track widespread preventive health campaigns, utilize various patient outreach methods, and create interdisciplinary practice protocols for superhuman population health!

Vista Community Clinics

- VCC's population health super power is a team-based care model focusing on relationship with various stakeholders, such as Patients, health plans, outreach, care team, Care Coordinators and the quality team.
  - The Population health team work very closely with health plans to identify gaps in care, to target patients with certain specific diagnoses and to outreach population in need of care based on their social determinants of health. We connect them with the right care teams. Our patients are paneled to PCP's care team and ensure that there is consistent pairing of MAs and PCPs. Each care team has 1 Provider, 1 ½ MAs and a PSR.
  - Our chronic and high risk and high cost utilizing patients are linked with care coordinators who also work on their own panel to actively engage with these patients.
  - Finally, the data analyst who is part of the quality/compliance team provides the data based on clinical quality measures and goals set by our leadership team for the Providers, which directly affects the patient's outcome.

Lifelong Medical Care

Our superpower is our Patient Centered Scheduling Pilot & Rollout Plans.

- Since Patient Centered Scheduling implementation we've seen a significant decrease in our TNAA ranging between 7-14 days! This has been a huge transition for providers, front desk staff, etc!

Network Descriptions

Goals, Objectives, Highlights, & Key Features

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**

What Makes this Different?

Not tied to payment methodology.

This is a network not a learning collaborative.

We have only a few in-person sessions; need to stay connected virtually.

Focused on learning & sharing, not didactic teaching.

Network Expectations

Attend Three Convenings

- Bring a dedicated & continuous team

Evaluation

- Participate fully in surveys, assessments, etc.

Share & Learn with Peers

- Organize & facilitate peer connections, thru in-person & virtual opportunities
- Active sharing during convenings & webinars

Additional Technical Assistance Available

Content Domains

Learning Organizations: Understanding adaptive & technical challenges. Communicating and managing change around large-scale initiatives. Clarifying leadership roles and how leaders work together to provide integrated care. Using prototypes and small tests of change to continuously improve and innovate solutions.

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/Integrated Care: 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.

Optional Trainings & Webinars

CCI Blended Methodology Training: October 18, 2018

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

Data Capability Training : June 20, 2019

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

Team-Based Care Training: March 14, 2019

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.

Archived webinars & toolkits available for use

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.

CCI CENTER FOR CARE INNOVATIONS

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
May 23-24, 2018
Oakland, CA

Site visits to exemplar orgs.

Convening #2:
January 16-17, 2019
LA, CA

Site to site peer connections

Convening #3:
December 4-5, 2019
Bay Area, CA

Capability-Building Trainings*

*Orgs can request exemptions from participation.

CCI Blended Methodology Training:
October 18, 2018

Team-Based Care Training:
March 14, 2019

Data Capability Training :
June 20, 2019

Key Program Activities

Release RFA, Info Webinars, Select Cohort, Kickoff Webinar

Release Year 2 grant opportunity, Select Projects

Final evaluation activities

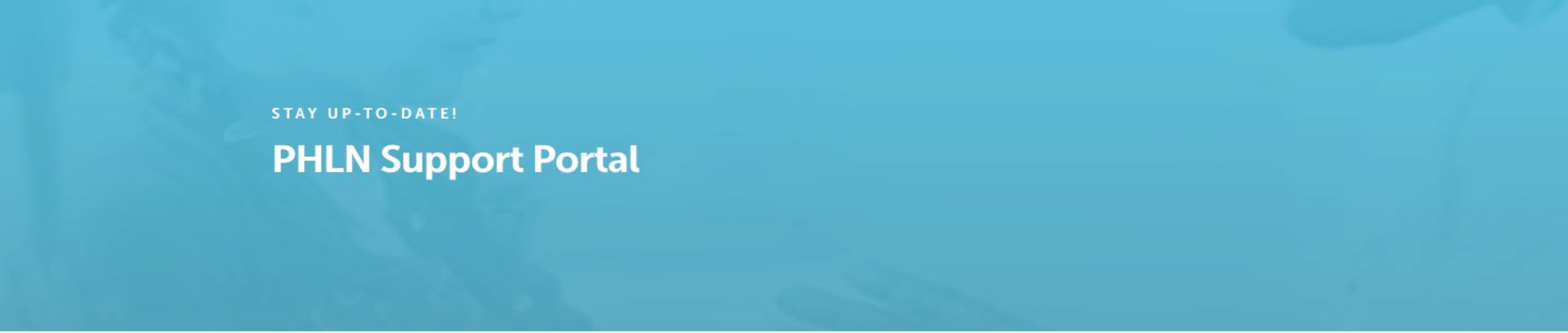
Access to Technical Assistance

Communication Tools

Monthly Newsletter (Sent out first Tuesday each month)

Calendar invites for big events

CCI Program Portal Page



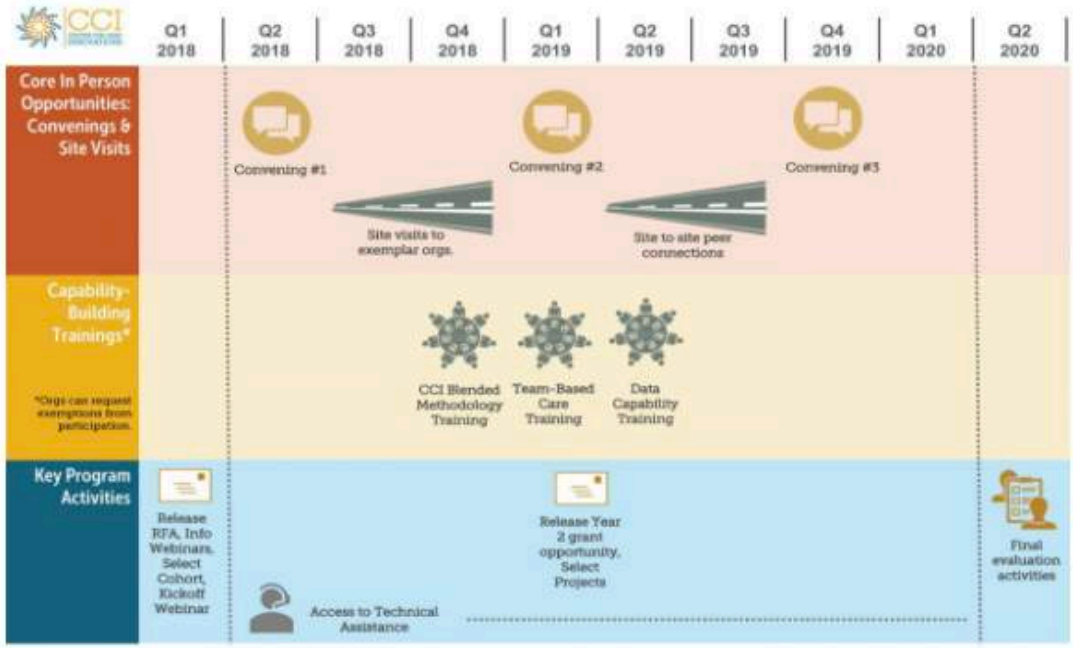
https://www.careinnovations.org/phln-portal/

Program Portal Page: Overview

PHLN Timeline

KEY DATES

Kickoff Webinar	March 27, 2018
In-Person Convening	May 23 and 24, 2018
Webinar: Blended Methodology	September 20, 2018
Workshop: Blended Methodology	October 18, 2018
In-Person Convening	January 16 and 17, 2019
Workshop: Team-Based Care	March 14, 2019
Workshop: Data Capability	June 20, 2019
In-Person Convening	December 4 and 5, 2019



Click to enlarge: PHLN Roadmap

Program Portal Page: Meet Your Network

Program Portal Page: Action Items & Activities

Action Items

Read below for all the most current program announcements, reminders, and newly posted resources. Be sure to bookmark this page and check back regularly so that you don't miss a thing!

ANNOUNCEMENTS & REMINDERS

Webinar: Program Kickoff. March 27, 12-1:30pm	Register here.
In-Person Convening #1. May 23 & 24	Oakland, CA Register here by May 1st. Event details included on registration page.

NEW RESOURCES

PHLN Informational Webinar	View the recording and download the slides.

Program Portal Page: Resource Library

Leadership & Change Management

How to Rally Your Team Around an Idea: CCI describes seven key steps to building support around an idea.

Leading Change Without Being Offensive: CCI offers thoughts about how to make change at an organization when that means disrupting what others hold dear.

Set Your Strategy – Chapter 2 Building a Data Driven Culture: These series of videos offer insights from thought leaders on how senior executives can tackle the big questions of making data use a central part of their organization's strategy and goals.


CCI
CENTER FOR CARE
INNOVATIONS
Questions?

May Convening

Location, Objectives, Faculty, & Pre-Work

Location & Details

When/Where

- Wednesday, May 23 (from 10-6pm) & Thursday, May 24 (from 8-2pm)
- Hilton Oakland Airport Hotel
- **Register at:** https://www.eventbrite.com/e/population-health-learning-network-session-1-tickets-44167727863

Who Should Attend

- Each organization should plan to send the core team participating in the PHLN network.
- Due to the size of the cohort, we are asking that each organization limit their attendance to five team members.

Session Objectives

- Identify **population health management topics** most pressing to participants for best practices and lessons learned;
- Take a **deep dive into the areas** of addressing social needs, behavioral health integration, complex care management, alternative visits, becoming a learning organization, and using data, technology, and tools for population health management;
- **Map potential bright spots** for future programming;
- Identify **specific challenges or technical assistance** needed to improve your population health capabilities; and
- Make sure you leave the convening with **commitments, next steps, and a buddy** to report to over the next 60 days.

Agenda

Topics Covered:

- Addressing social needs,
- Complex care management,
- Working with hospitals to manage care transitions, Alternative visits,
- Using data, tools, and technology for Population Health Management,
- Becoming a learning organization

Key Faculty

Dr. Carolyn Shepherd,
Former CMO at Clinica

Connie Davis
Co-Director at Center for Collaboration, Motivation, and Innovation

Lori Raney
Principle, Health Management Associates

Boris Kalikstein
Pivotal Moment Consulting

Key Faculty

Southcentral Foundation

Winding Waters
A Non-Profit Community Health Center

CENTRAL CITY CONCERN
HOMES HEALTH JOBS

OHSU

Key Faculty

CCI will be reaching out to your teams based on your identified superpower to make requests for you to share during the May convening.

Next Steps

For CCI & PHLN Teams

To-Do's

CCI

- ❑ Email an Excel spreadsheet with team contact information
- ❑ Post the recording and webinar slides on CCI portal
- ❑ Send out newsletter on April 3 with link to recording & registration link for the May session
- ❑ Travel stipend checks will be mailed on March 30

PHLN Teams

- ❑ Confirm team roster with Diana
- ❑ Send selfie and superpower to Diana if you haven't done so already
- ❑ Register to attend May session in EventBrite
- ❑ Bookmark the PHLN portal page
- ❑ Be open and ready to be asked to share what you are working on


CCI
CENTER FOR CARE
INNOVATIONS
Questions?

Thank you!

For questions contact:

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