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

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Our Extended Program Team

Dr. Carolyn Shepherd,  
PHLN Faculty

Meaghan Copeland,  
Program Consultant
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?

TEAM BASED SERVICES FOR ALL:
OPTIMIZING RELATIONSHIP WITH PLANNED CARE MODEL INCLUDING CONTINUITY, ACCESS AND POPULATION HEALTH
Who are we talking about?

High Utilizers

Poorly controlled chronic disease

POPULATIONS OF FOCUS: PLANNED CARE MODEL

TEAM BASED SERVICES FOR ALL: OPTIMIZING RELATIONSHIP WITH PLANNED CARE MODEL INCLUDING CONTINUITY, ACCESS AND POPULATION HEALTH
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

Report Manager - Windows Internet Explorer

SQL Server Reporting Services
Home > Reports > Collaborative Learning > Peer Review Reports

New Folder  New Data Source  Upload File  Report Builder

PEER Review Deceased Chronic Pain 3 10 HD
PEER Review Expired Patients by Month 3 10 HD
PEER Review HTN 2-23-10 CS
Report to evaluate management of HTN patients for PEER Review.
Clinica - Who are we talking about?
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?
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

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Expected Visits per 1000 patients/Year</th>
<th>Clinica Actual Visits per 1000 patients/per year</th>
<th>% Variance Actual vs Expected</th>
<th>% RCCO Variance</th>
<th>Clinica Adjusted Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Improvement ER Visits</td>
<td>906.7</td>
<td>829.9</td>
<td>(8.5%)</td>
<td>1.4%</td>
<td>(9.9%)</td>
</tr>
<tr>
<td>% Improvement Imaging Services</td>
<td>425.7</td>
<td>281.8</td>
<td>(33.8%)</td>
<td>(5.8%)</td>
<td>(28%)</td>
</tr>
<tr>
<td>% Improvement 30 Day Readmits</td>
<td>13.1</td>
<td>9.1</td>
<td>(30.5%)</td>
<td>1.2%</td>
<td>(31.8%)</td>
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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
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
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
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?
<table>
<thead>
<tr>
<th>Institution</th>
<th>Description</th>
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<tbody>
<tr>
<td>Community Medical Centers, Inc.</td>
<td>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 <strong>integrating “member” data</strong> with our patient data into our EHR, so we can develop more effective population health strategies to meet community needs.</td>
</tr>
<tr>
<td>Tri-City Health Center</td>
<td>We provide a wide <strong>range of enabling services</strong> to our patients.</td>
</tr>
<tr>
<td>Northeast Valley Health Corporation</td>
<td><strong>Data driven organization</strong>; with staff, leaders and providers engaged in quality improvement</td>
</tr>
<tr>
<td>La Clínica de La Raza, Inc.</td>
<td>La Clínica’s superpower is the ability to <strong>leverage the Care Team</strong> to improve clinical quality.</td>
</tr>
<tr>
<td>Ravenswood Family Health Center</td>
<td>We are the <strong>“Data Driven Decision Makers”</strong>. Staff that are committed to using data to introduce ideas to improve efficiency and effectiveness of the care we provide to our patients.</td>
</tr>
<tr>
<td>CommuniCare Health Centers</td>
<td>Our team’s super power is having <strong>access to data to inform our decision making</strong>. 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).</td>
</tr>
<tr>
<td>San Ysidro Health</td>
<td>Our data to <strong>show improved health outcomes</strong>!</td>
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<tr>
<td>Axis Community Health</td>
<td>Our <strong>care team structure</strong> 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.).</td>
</tr>
<tr>
<td>Native American Health Center, Inc.</td>
<td>Our population health superpower is a <strong>medical group visit called “Diabetes Care Day,”</strong> 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.</td>
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<tr>
<td>Neighborhood HealthCare</td>
<td><strong>Teamwork!</strong></td>
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<tr>
<td>Organization</td>
<td>Description</td>
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<tr>
<td>North East Medical Services (NEMS)</td>
<td>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.</td>
</tr>
<tr>
<td>Open Door Community Health Centers</td>
<td>Our Population Health Superpower is our team-based care. We might also say it's our use of data or intensive case management program.</td>
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<tr>
<td>Salud Para La Gente</td>
<td>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.</td>
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<td>San Francisco Health Network- Primary Care</td>
<td>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.</td>
</tr>
<tr>
<td>Santa Rosa Community Health</td>
<td>Our superpower is “flexibility – when disaster strikes, all staff step in to fill the gaps so no patient is left behind”</td>
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<tr>
<td>Serve the People Community Health Center</td>
<td>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.</td>
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<tr>
<td>Venice Family Clinic</td>
<td>Our ability to use data from Azara healthcare, i2i Population Health and Nextgen to reduce gaps in care and improve care.</td>
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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!
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

Capability-Building Workshops & Webinars*

Access to 1:1 consultations and technical experts

Site visits to exemplar & peer organizations

Coaching

Support from CCI Team

Toolkits, resources and pre-recorded webinars

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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.


**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

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

**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.

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

**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.
Core In Person Opportunities: Convenings & Site Visits

- **Convening #1**: May 23-24, 2018, Oakland, CA
- **Convening #2**: January 16-17, 2019, LA, CA
- **Convening #3**: December 4-5, 2019, Bay Area, CA

Site visits to exemplar orgs.

Site to site peer connections

Capability-Building Trainings*

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
- Access to Technical Assistance
- Release Year 2 grant opportunity, Select Projects
- Final evaluation activities

*Orgs can request exemptions from participation.
Communication Tools

- Monthly Newsletter (Sent out first Tuesday each month)
- Calendar invites for big events
- CCI Program Portal Page
HELLO, NETWORK MEMBERS!

This website is a support center for the use of Population Health Learning Network (PHLN) participants. Program updates, report due dates, resources, and more will be posted to this website.

For more information about PHLN, please visit the program page. This website is managed by Center for Care Innovations.

https://www.careinnovations.org/phln-portal/
Program Portal Page: Overview

**PHLN Timeline**

<table>
<thead>
<tr>
<th>KEY DATES</th>
<th>Date</th>
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<tbody>
<tr>
<td>Kickoff Webinar</td>
<td>March 27, 2018</td>
</tr>
<tr>
<td>In-Person Convening</td>
<td>May 23 and 24, 2018</td>
</tr>
<tr>
<td>Webinar: Blended Methodology</td>
<td>September 20, 2018</td>
</tr>
<tr>
<td>Workshop: Blended Methodology</td>
<td>October 18, 2018</td>
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<td>In-Person Convening</td>
<td>December 4 and 5, 2019</td>
</tr>
</tbody>
</table>
Program Portal Page: Meet Your Network

- Axis Community Health
  Pleasanton, CA

- Chap-A-De-Indian Health
  Auburn, CA

- CommunityCare HealthCenters
  Davis, CA

- Community Medical Centers, Inc.
  Stockton, CA

- Health Services

- La Clinica
  Oakland, CA

- LifeLong Medical Care
  Berkeley, CA

- Los Angeles LGBT Center
  Los Angeles, CA
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

In-Person Convening #1. May 23 & 24

Register here

Register here by May 1st. Event details included on registration page.

NEW RESOURCES

PHLN Info: View the recording and

Informational Webinar: 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.
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.
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
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
Thank you!

For questions contact:

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Diana Nguyen
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diana@careinnovations.org