Our Core Program Team

Megan O’Brien, Program Manager, CCI
Tammy Fisher, Senior Director, CCI
Diana Nguyen, Program Coordinator, CCI
Dr. Carolyn Shepherd, Clinical Director
Meaghan Copeland, Program Consultant
PHLN Cohort

- 25 organizations from across the state
- 24 month network
- 140 individuals at Convening #1
Make New Connections

• Find someone you don’t know at your table or nearby.
• Introduce yourself
  • Name
  • Organization
• What do you hope to personally get out of the next two days?
What We Heard

• A better **understanding** of Population Health
• Make **connections** with other teams in the network
• Dedicated **team time**
• Develop an **action plan** & concrete goals
• Expand and/or learn new population health **strategies**
• Hear what others are doing & **what’s working**
• **Inspiration**
• Better understanding the PHLN & **network expectations**
• **Share our strengths** with the network
What We Heard

“I’m excited to learn more about where everyone is in terms of population health management and meet other members and clinics part of this initiative.”

“Broader idea of what other health centers have done. Inspiration for the future. Contact numbers (CHCs) for future questions.”

“Inspiration! I always leave the CCI gatherings with renewed motivation to move our change efforts forward.”

“Ideas for improving staff buy-in and how to shift culture to get prioritization of front line staff to do population management work.”

“Concrete to-do’s/roadmap about how to achieve our specific population health goals.”
<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
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</thead>
<tbody>
<tr>
<td><strong>Framework for Population Health</strong></td>
<td><strong>Reflections</strong></td>
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<td><strong>Shift &amp; Share Stations: Peer and Expert Sharing</strong></td>
<td><strong>Learning Labs: Expert and Peer Sharing</strong></td>
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<td><strong>Lunch</strong></td>
<td><strong>Networking Break</strong></td>
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<td>• Co-design Session</td>
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<td>• Optional Chat &amp; Chow, Organized by Role</td>
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<td><strong>Learning Labs: Expert and Peer Sharing</strong></td>
<td><strong>Team Time: Small Commitments</strong></td>
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<td><strong>Team Time &amp; Reflection</strong></td>
<td><strong>Evaluation Activities</strong></td>
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<tr>
<td><strong>Happy Hour &amp; Connections!</strong></td>
<td><strong>Where to Go Deeper</strong></td>
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</tbody>
</table>
Expert Faculty

Carolyn Shepherd
Leibig-Shepherd, LLC

Connie Davis
CMMI

Lori Raney
Health Management Associates

Boris Kalikstein
Pivotal Moment Consulting

Rob Houston
Center for Health Care Strategies, Inc.
Peer Faculty

PHLN Participants
# Convening Passport

## SHIFT & SHARE STATIONS (ROUND 1)

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<tr>
<th>Assessing &amp; Addressing Social Needs</th>
<th>KEY TAKEAWAYS</th>
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Health Care that Works for All Californians
Why Population Health?

Improve the patient’s **experience of care**.
Access, alternative encounters, cultural competence, addressing social needs.

Achieve **better health outcomes** by closing gaps in care.
Initiated by staff per evidence-based guidelines.

**Avoid unnecessary utilization** in the ED and hospital readmissions through coordinated care.

Stabilize or **reduce health care costs**.
Target the right resources to the patients who need it most.

Boost **workplace satisfaction** by optimizing team-based care and ensuring all staff can work to the top of their skill and license.
What are we talking about?

The work of population health is to **maximize health** 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.
Figure 1. Six Foundational Concepts of Pathways to Population Health

1. Health and well-being develop over a lifetime.

2. Social determinants drive health and well-being outcomes throughout the life course.

3. Place is a determinant of health, well-being, and equity.

4. The health system needs to address the key demographic shifts of our time.

5. The health system can embrace innovative financial models and deploy existing assets for greater value.

6. Health creation requires partnership because health care only holds a part of the puzzle.

What creates health? How can health care engage?
Portfolios of Work

P1: Physical and/or Mental Health
P2: Social and/or Spiritual Well-being
P3: Community Health and Well-being
P4: Communities of Solutions

Equity
Population Management
Community Well-being Creation
1. Physical and/or Mental Health

| Patient empanelment and care management |
| Access                               |
| Relationship/continuity              |
| Evidence based practice              |
| Risk stratification                  |
| Discharge/transfer procedures        |
| Behavioral Health Integration        |
| Patient/family partnerships          |
| Performance improvement              |
| Community partnerships               |
2. Social and/or Spiritual Wellbeing

- Identify key social and spiritual drivers of health
- Develop community partnerships
- Screen for social and spiritual needs and connect individuals to community resources
- Track improvements for the defined population
What We’re **Not** Covering

### 3. Community Health and Well-Being
- Health care organizations working together with community partners to improve specific health and well-being outcomes for a place-based population
- Covered in our ROOTS & iLab programs

### 4. Community of Solutions
- Health care organizations actively engaging in contributing to the long-term, overall well-being of the community as part of their mission and responsibility
- Potentially future programming at CCI
“Sometimes you get a lot of ideas flowing and it is hard to stay on track.”
Our Destination

Year 1: Spark & Test Ideas

- Align ideas with organizational priorities: how do ideas fit into your population health goals?
- Strengthen work: where are you stuck, what do you want to make better?
- Get support from your leadership: identify priority areas, get excitement and resources for new ideas
- Find a place to try ideas out: assign a team to work on ideas
- Start working differently: disrupt your system, create prototypes and pilots
- Measure and learn: capture just enough data to know if these new ideas are working

Year 2: Seed & Spread Grants

- Implement or spread new ideas in core PHLN focus areas: identify something new or something you want to make better
- Draft goals, measures, and changes to help you reach your goals
- Make the case: why should we fund your project? How are you advancing population health management capabilities in an impactful way?
Network Core Features & Expectations

**Attend Three Convenings**
- Bring a dedicated & continuous team

**Evaluation & Updates**
- Participate fully in surveys, assessments, etc.
- Sharing quarterly updates

**Share & Learn with Peers**
- Organize & facilitate peer connections, thru in-person & virtual opportunities
- Active sharing during convenings & webinars
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coaching</td>
<td>Coaching support helps your team stay on track with telephonic check-ins, helps you translate your work into actionable changes that you can test and measure, connects you to resources and experts, and works with you to identify and problem-solve around challenges your facing in your work. Coaching calls can be scheduled on an ongoing basis or ad-hoc.</td>
</tr>
<tr>
<td>Faculty Consultations</td>
<td>Faculty have content expertise. They can share information on the “what” and the “how.” If you have specific questions about content presented in a learning session, or want guidance on an area you’re experiencing challenges, schedule ad-hoc time with faculty. Consults will be provided in 30-minute increments. See the back for more information about our faculty experts.</td>
</tr>
<tr>
<td>Site Visits</td>
<td>Site visits are full-day, on-site learning opportunities to get guidance, ideas, and inspiration from an organization outside the PHLN with an overall strong population health management approach and has exceptional expertise in 1 or 2 focus areas of our content domains. Site visits will occur between August – October 2018. Confirmed organizations include: (1) Southcentral Foundation (AK); (2) Petaluma Health Center (CA); (3) Clinica Family Health (CO); (4) La Clinica (OR); (5) Cherokee Health Systems (TN); (6) Cambridge Health Alliance-Union Square Family Health (MA).</td>
</tr>
<tr>
<td>Peer Exchanges</td>
<td>Virtual interactions with peers you’d like to learn from. This could be a 1:1 exchange or a group exchange addressing a specific topic area or multiple topics. Reach out directly to another team to schedule or contact CCI for assistance.</td>
</tr>
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</table>
Goals & Changes: Team Discussions

In your teams, discuss questions, capture answers:

• What are your organization’s goals around population health?

• What are the key changes you believe will help you reach your goals?
Example

Population Health Goals
- Improve health outcomes for assigned patients
- Improve access to care
- Improve the patient experience

Alternative visits
1. Nurse co-visits
2. Telehealth for SUD services

Information systems
1. Integrate social needs data
2. Optimize population health data tool

Community partnerships
Develop partnership with CBO on high social need area

Complex care management
Optimize complex care program

Outreach
1. Reconcile assigned patient list
2. Outreach for patients that haven’t established care

Develop conditions for co-visits; Develop workflow for co-visits

Revise social needs survey

Set up meeting with food pantry – shared vision?

Revise algorithm for identifying top 5% patients

Call patients on health plan list; document outcome
Shift & Share
11:15am-1:10pm
Program Portal Page: Convening Materials

GENERAL HANDOUTS – PARTICIPANT PACKETS

- Agenda
- Venue Map
- Connect with Members of Your Network!
- Convening Faculty Biographies (coming soon!)
- Convening Passport
- Team Time Worksheet
- Technical Assistance Overview & Faculty Introductions
- Evaluation Overview for PHLN
- Convening Evaluation Survey – Day 1 & 2

SHIFT & SHARE: RELATED RESOURCES

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>PRESENTER(S)</th>
<th>RESOURCES</th>
</tr>
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<tbody>
<tr>
<td>Alternative Visits</td>
<td>Carolyn Shepherd, Leiby-Shepherd, LLC</td>
<td>Diabetes Group Visit Flow/Example</td>
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<tr>
<td></td>
<td>Marco Angulo, Serve the People</td>
<td>Group Visit Flow Worksheet: Download word document</td>
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<td></td>
<td></td>
<td>Diabetes Group Visits Curriculum (STP)</td>
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<td>Group Visits Confidentiality Agreement (STP)</td>
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<td>Spanish Group Visits Form (STP)</td>
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<td>Rx Form (STP)</td>
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<tr>
<td>Assessing and Addressing Social Needs</td>
<td>Jessica King, Northeast Valley Health Corporation</td>
<td>NEMHC Food Insecurity Algorithm</td>
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<td>NEMHC Food Rx Guide</td>
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<tr>
<td>Complex Care Management</td>
<td>Brian Gan and Matt Mitchell, Central City Concern</td>
<td>Tailoring Care: A Population Segmentation Framework</td>
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Shift & Share Activity

• Opportunity to quickly learn from peers in tangible, practical ways
  • 4 topic areas, or “shift & share” stations,
  • 2-3 presenters per station
  • 2 rounds
• Each presenter will share a brief presentation using a storyboard or other visual method
• You will have a chance to ask questions
• Each group will have a facilitator

Round 1: 11:15 – 12:05
• Sharing & Conversation, QA
  • What do you have to add to the conversation?

Round 2: 12:15 – 1:05
• Sharing & Conversation, QA
  • What do you have to add to the conversation?
<table>
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<tr>
<td><strong>Group 2: Complex Care Management (Boardroom II)</strong></td>
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<td>• LifeLong Medical Care</td>
<td>• Tri-City Health Center</td>
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<tr>
<td><strong>Group 3: Alternative Visits (Pacific Room)</strong></td>
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<tr>
<td>• Serve the People Community Health Center</td>
<td>• Santa Rosa Community Health Centers</td>
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<td>• Western Sierra Medical Clinic</td>
<td><strong>Group 4: Using Data for Population Health Management (Boardroom III)</strong></td>
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<td>• Leibig-Shepherd, LLC</td>
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<td>• Open Door Community Health Centers</td>
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<td>• Southcentral Foundation</td>
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<td>• San Ysidro Health</td>
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Registration & Meals:
Foyer

Main Room:
International Ballroom

Breakout Rooms:
- Pacific Room
- Boardroom II
- Boardroom III
Pre-Lunch Reminders
1:10pm-2:10pm
Three Options

Chat & Chow: Tables Organized by Roles

Special PHLN Co-Design Session *Invite Only

On Your Own
Co-Design Participants: Thank You!

<table>
<thead>
<tr>
<th>Organization</th>
<th>Participant Name</th>
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<tbody>
<tr>
<td>Ravenswood</td>
<td>Erika Simpson</td>
</tr>
<tr>
<td>Community Medical Centers</td>
<td>Alyssa Arismendi-Alvarez</td>
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<tr>
<td>North County</td>
<td>Cathy Sakansky</td>
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<tr>
<td>Axis</td>
<td>Afsheen Islam</td>
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<tr>
<td>Chapa-De</td>
<td>Brandon Bettencourt</td>
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<tr>
<td>SFDPH</td>
<td>Henry Rafferty</td>
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<td>CommuniCare</td>
<td>Evan Priestley</td>
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<td>LA LGBT</td>
<td>Claudia Alvarez</td>
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Faculty Pitches

Key Considerations for Designing Your Organization’s Social Needs Strategy
Connie Davis & Kelly Reily
Pacific Room

What it Means to Be a Learning Organization
Mike Hirst & Karen McIntire
Int’l Ballroom

Continuum of Data
Boris Kalikstein
Boardroom III

Tailoring Care: Delivering the Right Intervention to the Right Patients
Dr. Brian Chan & Matt Mitchell
Boardroom II
Registration & Meals:
Foyer

Main Room:
International Ballroom

Breakout Rooms:
- Pacific Room
- Boardroom II
- Boardroom III
Lunch
1:10pm-2:10pm
Learning Labs

2:10-4:40pm
Learning Labs

Key Considerations for Designing Your Organization’s Social Needs Strategy
Connie Davis & Kelly Reily
Pacific Room

What it Means to Be a Learning Organization
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Continuum of Data
Boris Kalikstein
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Tailoring Care: Delivering the Right Intervention to the Right Patients
Dr. Brian Chan & Matt Mitchell
Boardroom II
Registration & Meals: Foyer

Main Room: International Ballroom

Breakout Rooms:
- Pacific Room
- Boardroom II
- Boardroom III
Team Time for Action Planning
4:10-4:40pm
## SHIFT & SHARE STATIONS (ROUND 1)

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Team Time

• Reflect on the Shift & Shares and Learning Labs you participated in & share with your team (using your Convening Passport):
  • What were the **key takeaways**?
  • What do you think you could **bring back and try out and/or tweak** at your organization?

• How did what you learn today tie in with the goal & changes you discussed at the beginning of the day?
Reflection & Wrap-Up
4:40-5:00pm
What We Heard

• A better **understanding** of Population Health
• Make **connections** with other teams in the network
• Dedicated **team time**
• Develop an **action plan** & concrete goals
• Expand and/or learn new population health **strategies**
• Hear what others are doing & **what’s working**
• **Inspiration**
• Better understanding the PHLN & **network expectations**
• **Share our strengths** with the network
What’s in Store for Day 2?

- Learning Labs
- Networking Break
- Team Time: Small Commitments
- Evaluation Activities
- Where to Go Deeper
Learning Labs

Optimizing Data Tools & Technology for Population Health Management
Mike Hirst & Karen McIntire
Boardroom III

Strategies for Effective Behavioral Health Integration
Dr. Lori Raney
Int’l Ballroom

Complex Care Management: A Diabetes Case Study
Erin Kirk & Holly Herrera
Boardroom II

Team-Based Care 2.0: Getting to the Template of the Future
Dr. Carolyn Shepherd
Pacific Room
Day 1 Evaluation

Population Health Learning Network Convening #1
Day 1 Evaluation

Please share your thoughts about the convening below. Your feedback will help us improve the quality of the PHLN. All responses will be kept confidential and only be presented in summary form.

Day 1: Impressions

Please indicate the degree to which you agree or disagree with the following:* (Select one response per row)

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not applicable</th>
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I gained new ideas by participating in the learning sessions. This could include understanding and application of best practices, tools and resources.

Day 1: Shift & Share Station #2 (11:10 – 1:10)

Which Shift & Share Station did you attend first? (Select one)
- Assessing & Addressing Social Needs
- Complex Care Management
- Alternative Visits
- Using Data for Population Health Management

Day 1: Shift & Share Station #2 (11:10 – 1:10)

Please rate the first Shift & Share Station you attended:

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Day 1: Shift & Share Station #2 (11:10 – 1:10)

Which Shift & Share Station did you attend second? (Select one)
- Assessing & Addressing Social Needs
- Complex Care Management
- Alternative Visits
- Using Data for Population Health Management

Day 1: Shift & Share Station #2 (11:10 – 1:10)

Please rate the second Shift & Share Station you attended:

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Day 1: Reflections

Please share your thoughts below so we can best tailor the PHLN to meet your needs.

Thinking about Day 1 of the convening, what sessions or other aspects of the day were most valuable to you?

What could we have done differently or better?

Is there anything else you would like to add?
Happy Hour & Networking Reception
5:00-6:00pm
Reflections & Overview
8:30-9:00am
Gallery of Insights

• What were some of your insights or a-ha moments from Day 1?
  • Spend 5 minutes capturing your thoughts on sticky notes.
  • Share with your tables.
  • Post notes on the ”Gallery of Insights” Chart.
What’s in Store for Day 2?

- Learning Labs
- Networking Break
- Team Time: Small Commitments
- Evaluation Activities
- Where to Go Deeper
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<tr>
<td>Grab a stamp for the session you attended!</td>
<td></td>
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<tr>
<td><strong>Assessing &amp; Addressing Social Needs</strong></td>
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<td>La Clinica de La Raza</td>
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<td>L.A. County Dept of Health Services</td>
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<td>Salud Para La Gente</td>
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<td><strong>Complex Care Management</strong></td>
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<td>OHSU Family Medicine at Richmond</td>
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<td>Lifelink Medical Care</td>
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<td><strong>Alternative Visits</strong></td>
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<tr>
<td>Serve the People Community Health Center</td>
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<tr>
<td>Western Sierra Medical Clinic</td>
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<tr>
<td><strong>Using Data for Population Health Management</strong></td>
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<tr>
<td>North East Medical Services</td>
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<tr>
<td>Pivotal Moment Consulting</td>
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<tr>
<td>Santa Barbara Neighborhood Clinics</td>
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</table>
Faculty Pitches

Optimizing Data Tools & Technology for Population Health Management
Mike Hirst & Karen McIntire
Boardroom III

Strategies for Effective Behavioral Health Integration
Dr. Lori Raney
Int’l Ballroom

Complex Care Management: A Diabetes Case Study
Erin Kirk & Holly Herrera
Boardroom II

Team-Based Care 2.0: Getting to the Template of the Future
Dr. Carolyn Shepherd
Pacific Room
Learning Labs
9:00-11:00am
Learning Labs

- **Optimizing Data Tools & Technology for Population Health Management**
  - **Mike Hirst & Karen McIntire**
  - **Boardroom III**

- **Strategies for Effective Behavioral Health Integration**
  - **Dr. Lori Raney**
  - **Int’l Ballroom**

- **Complex Care Management: A Diabetes Case Study**
  - **Erin Kirk & Holly Herrera**
  - **Boardroom II**

- **Team-Based Care 2.0: Getting to the Template of the Future**
  - **Dr. Carolyn Shepherd**
  - **Pacific Room**
Registration & Meals:
Foyer

Main Room:
International Ballroom

Breakout Rooms:
- Pacific Room
- Boardroom II
- Boardroom III
Networking Break
11:00-11:30am
Team Time
11:30-12:00pm
## Convening Passport

### SHIFT & SHARE STATIONS (ROUND 1)

<table>
<thead>
<tr>
<th>Key Takeaways</th>
<th>Things I Want to Try at My Organization</th>
<th>Personal Next Steps</th>
</tr>
</thead>
</table>
| **Assessing & Addressing Social Needs**  
  - La Clinica de La Raza  
  - L.A. County Dept of Health Services  
  - Salud Para La Gente | | |
| **Complex Care Management**  
  - OHSU Family Medicine at Richmond  
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  - Serve the People Community Health Center  
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| **Using Data for Population Health Management**  
  - North East Medical Services  
  - Pivotal Moment Consulting  
  - Santa Barbara Neighborhood Clinics | | |

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**Convening Passport**  
Center for Care Innovations  
Population Health Learning Network  
May 23-24, 2018
Team Time

• Reflect on the Shift & Shares and Learning Labs you participated in & share with your team (using your Convening Passport):
  • What were the **key takeaways**?
  • What do you think you could **bring back and try out and/or tweak** at your organization?

• How did what you learn today tie in with the goal & changes?
TOP THREE GOALS FOR YEAR ONE
Reflect on the last two days, what have you observed, learned, your AHA moments! Be as specific as possible. This is an exercise to help you clarify your goals and vision; you are not committing to anything. Think about the specific topics you want to work on, the skills, tools, infrastructure and/or capacity you may want to develop.

1. 

2. 

3. 

4. 

5. 

ACTION TOWARDS YOUR GOALS
Define 3 to 5 activities or actions you need to take to achieve these goals. Ruthlessly prioritize!

1. 

2. 

3. 

4. 

5.
Working Lunch

12:00-12:30pm
Evaluation Plan & Activities
12:30-12:50pm
Where to Go Deeper & How?
12:50-1:30pm
I Like, I Wish, I Wonder

• What I like about the network ______________________

• What I wish could be different ______________________

• What I wonder about and still need to better understand ______________________

1. Spend 5 minutes capturing your thoughts on sticky notes.
   1. Yellow: I like
   2. Green: I wish
   3. Pink: I wonder

2. Share with your tables.
3. Organize sticky notes on the flip chart paper.
## Technical Assistance

<table>
<thead>
<tr>
<th>Coaching</th>
<th>Coaching support helps your team stay on track with telephonic check-ins, helps you translate your work into <strong>actionable changes</strong> that you can test and measure, connects you to <strong>resources and experts</strong>, and works with you to identify and <strong>problem-solve</strong> around challenges you’re facing in your work. Coaching calls can be scheduled on an ongoing basis or ad-hoc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty Consultations</td>
<td>Faculty have content expertise. They can share information on the “what” and the “how.” If you have specific questions about content presented in a learning session, or want guidance on an area you’re experiencing challenges, schedule ad-hoc time with faculty. Consults will be provided in 30-minute increments. See the back for more information about our faculty experts.</td>
</tr>
<tr>
<td>Site Visits</td>
<td>Site visits are full-day, on-site learning opportunities to get guidance, ideas, and inspiration from an organization outside the PHLN with an overall strong population health management approach and has exceptional expertise in 1 or 2 focus areas of our content domains. Site visits will occur between August–October 2018. Confirmed organizations include: (1) Southcentral Foundation (AK); (2) Petaluma Health Center (CA); (3) Clinica Family Health (CO); (4) La Clinica (OR); (5) Cherokee Health Systems (TN); (6) Cambridge Health Alliance-Union Square Family Health (MA).</td>
</tr>
<tr>
<td>Peer Exchanges</td>
<td>Virtual interactions with peers you’d like to learn from. This could be a 1:1 exchange or a group exchange addressing a specific topic area or multiple topics. Reach out directly to another team to schedule or contact CCI for assistance.</td>
</tr>
</tbody>
</table>
Expert Support

**Boris Kalikstein |** Pivotal Moment Consulting
I can provide deeper support in:
- Technology and analytic design for population health
- Implementation of Advanced Access principles
- Data driven decision making
- Value based reimbursement

Schedule a call: boris@pivotalmomentconsulting.com

**Connie Davis |** The Centre for Collaboration, Motivation, & Innovation
I can provide deeper support in:
- Relationship-based care to achieve population health goals
- Supporting patients in health behavior change (motivational-interviewing based skills)
- Shared and informed decision making
- Chronic disease management and complex care

Schedule a call: connie.davis@centreCMI.ca

**Carolyn Shepherd |** Leibig-Shepherd, LLC
I can provide deeper support in:
- Optimization of care teams
- Transformation change in safety net clinics
- Spread & sustainability of change
- Improving access to ambulatory care

Schedule a call: carolynmshepherd@gmail.com

**Lori Raney |** Health Management Associates
I can provide deeper support in:
- Readiness assessment and model design for integrated care
- Implementation training for all members of the integrated team
- Practice coaching for launch and sustaining integrated care
- Financing integrated care

Schedule a call: traney@healthmanagement.com
Team Reflection

Where do we need to go deeper & what support do we need?
# Team Time Worksheet

Use this worksheet to help you plan your next steps after this convening. Reference your Convening Passports as needed. Please write legibly; CCI will be collecting this worksheet and emailing your team a scanned copy after the convening.

## TECHNICAL ASSISTANCE NEEDS

Please select which TA you believe will help your team. Under each box that you have selected, provide concrete details about your TA needs (e.g., specific topic, content expert that you’d like help from).

- Coaching:
- Faculty Consultations:
- Site Visit:
- Peer Exchange:
- Capability-Building Workshops/Webinars:
- Other:

## GOING DEEPER

In which content areas do you want to go deeper?

- Learning Organizations
- Team-Based Care 2.0
- Planned Care and In-Reach
- Proactive Outreach
- Behavioral Health Integration/Integrated Care
- Care Management for Complex Patients
- Social Needs

## NETWORK CONNECTIONS

Please share which organizations you’d like to connect with after the convening and for what reasons.
Wrap-Up: Evaluation & What’s Next
1:30-2:00pm
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: Meet Your Network

Axiss Community Health
PLEASANTON, CA

Chapa-Di Indian Health
AUBURN, CA

CommuniCare Health Centers
DAVIS, CA

Community Medical Centers, Inc.
STOCKTON, CA

L.A. County Department of Health Services - Primary Care
LOS ANGELES, CA

La Clinica de La Raza
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

<table>
<thead>
<tr>
<th>Webinar: Program Kickoff. March 27, 12-1:30pm</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Register here.</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>In-Person Convening #1. May 23 &amp; 24</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Register here by May 1st. Event details included on registration page.</strong></td>
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</tbody>
</table>

### New Resources

<table>
<thead>
<tr>
<th>PHLN Informational Webinar</th>
</tr>
</thead>
<tbody>
<tr>
<td>View the recording and download the slides.</td>
</tr>
</tbody>
</table>
### Program Portal Page: Convening Materials

#### General Handouts - Participant Packets

- Agenda
- Venue Map
- Connect with Members of Your Network!
- Convening Faculty Biographies (coming soon!)
- Convening Passport
- Team Time Worksheet
- Technical Assistance Overview & Faculty Introductions
- Evaluation Overview for PHLN
- Convening Evaluation Survey – Day 1 & 2

#### Shift & Share: Related Resources

<table>
<thead>
<tr>
<th>Topic</th>
<th>Presenters</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative Visits</td>
<td>Carolyn Shepherd, Leiby-Shepherd, LLC</td>
<td>Diabetes Group Visit Flow Example</td>
</tr>
<tr>
<td></td>
<td>Marco Angulo, Serve the People</td>
<td>Group Visit Flow Worksheet, Download word document</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetes Group Visits Curriculum (STPI)</td>
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<td></td>
<td></td>
<td>Group Visits Confidentiality Agreement (STPI)</td>
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<td></td>
<td></td>
<td>Spanish Group Visits form (STPI)</td>
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<tr>
<td></td>
<td></td>
<td>Rx Form (STPI)</td>
</tr>
<tr>
<td>Assessing and Addressing Social Needs</td>
<td>Jessica King, Northeast Valley Health Corporation</td>
<td>NEVHC Food Insecurity Algorithm</td>
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<td></td>
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<td>NEVHC Food Rx Guide</td>
</tr>
<tr>
<td>Complex Care Management</td>
<td>Brian Chan and Matt Mitchell, Central City Concem</td>
<td>Tailoring Care: A Population Segmentation Framework</td>
</tr>
</tbody>
</table>
What’s Next?

1:1 Connections

• Connect core faculty for 1:1 support through 30 or 60 minute calls

• CCI will schedule faculty office hours with core faculty

• Reach out to other organizations in PHLN you want to connect with & share resources

Site Visits

• Will be scheduled between August-October 2018

• 6 exemplar organizations have been selected

• Each organization can send 2-3 individuals

• Travel costs are expected to come out of your award stipend
Site Visits

1. Cherokee Health Systems
2. LA CLINICA
3. Southcentral Foundation
4. CLINICA
5. Petaluma Health Center
6. CHA Cambridge Health Alliance
To-Do’s

CCI
• All materials will be posted to network portal
• Next newsletter: June 5
• Will send out information about site visits
• Will email teams a copy of your team time worksheet

PHLN Teams
• Finalize goals & changes
• Communicate goals & changes with others in your organization
• Think about what you’d like to get out of a site visit
• Visit & use the PHLN portal, and be in touch about TA needs
Day 2 Evaluation

Population Health Learning Network Convening #1
Day 2 Evaluation

Day 2: Other Sessions
Please rate the other sessions you attended: (select one response per row)

<table>
<thead>
<tr>
<th>Session</th>
<th>Not at all useful (0)</th>
<th>Not too useful (1)</th>
<th>Somewhat useful (2)</th>
<th>Very useful (3)</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Networking Break</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Team Time: Small Commitments</td>
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<tr>
<td>Evaluation Plan &amp; Activities</td>
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<td>0</td>
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<tr>
<td>Where to Go Dinner &amp; Nite</td>
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Day 2 Reflections
Thank you for your feedback. Your insights are invaluable.

Thinking about Day 2, what sessions or other aspects of the day were most valuable to you?

What could we have done differently or better?

Overall Impressions
Which of the following best represents your overall experience with the PHLN Convening #1 (Days 1 and 2)?

<table>
<thead>
<tr>
<th>Quality</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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</table>

Please indicate the degree to which you agree or disagree with the following:* (select one response per row)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neutral (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am confident in my ability to apply content from the learning sessions to my work and to share back with my colleagues.</td>
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<tr>
<td>I gained new skills by participating in the learning sessions. This could include understanding and application of best practices, tools, and resources.</td>
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<td>0</td>
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<tr>
<td>There were adequate opportunities for me to interact and engage with other presentees and presenters.</td>
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Day 2: Learning Lab (9:00 – 11:00)
Which learning lab did you attend? (select one)

<table>
<thead>
<tr>
<th>Lab</th>
<th>Not at all useful (0)</th>
<th>Not too useful (1)</th>
<th>Somewhat useful (2)</th>
<th>Very useful (3)</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
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<td>0</td>
<td>0</td>
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<tr>
<td>Strategies for Effective Behavioral Health Integration</td>
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<td>Complex Case Management: A Diabetes Case Study</td>
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<tr>
<td>Team Based Care 2.0: Refining the Template of the Future</td>
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</table>

Please rate the Learning Lab you attended:

<table>
<thead>
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<th>Learning Lab</th>
<th>Not at all useful (0)</th>
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<tbody>
<tr>
<td>Day 2 Evaluation</td>
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</tbody>
</table>
CCI
CENTER FOR CARE INNOVATIONS

Questions?
Thank you!

For questions contact:

Megan O’Brien
Value-Based Care Program Manager
Center for Care Innovations
mobrien@careinnovations.org

Diana Nguyen
Program Coordinator
Center for Care Innovations
diana@careinnovations.org