Population Health Learning Network

March 19, 2019
Year 2 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 the PHLN newsletter.
Today’s Agenda

1. Welcome & Introductions
2. Reminder: What is the PHLN?
3. Year Two Overview & Support Available
4. Affinity Groups & Projects Overview
5. Communications Tools
6. What’s Next?
7. Q&A
Our CCI Program Team

**Megan O’Brien,**
Senior Program Manager

**Tammy Fisher,**
Senior Director

**Diana Nguyen,**
Program Coordinator
Our Extended Program Team

Dr. Carolyn Shepherd, PHLN Faculty

Meaghan Copeland, Program Consultant
Congratulations!
Social Needs

- L.A. County Dept. of Health Services - Primary Care
- North County Health Services
- Santa Rosa Community Health
- Tri-City Health Center
- Serve the People Community Health Center

Focus Areas

- Access Strategies to Optimize Planned Care & Outreach
- San Francisco Health Network - Primary Care
- Neighborhood Healthcare
- Northeast Valley Health Corporation

Year 2 Project

- Behavioral Health Integration
- L.A. County Dept. of Health Services - Primary Care
- North East Medical Services
- Axis Community Health
- Vista Community Clinic
- Open Door Community Health Centers

Focus Areas

- Data Tools & Reporting to Close Gaps in Care
- Ravenswood Family Health Center
- Venice Family Clinic
- Salud Para La Gente

Care Team Roles

- Risk Stratification
- Community Medical Centers
- Lifelong Medical Care
- Northeast Valley Health Corporation
- Santa Barbara Neighborhood Clinics
- Native American Health Center
- Los Angeles LGBT Center
- La Clinica de La Raza
- CommuniCare Health Centers
What is one thing you are excited about in Year 2?

1. Meeting our goals because it would mean improvement on our clinical measure which equals quality patient care.

2. Implementing!

3. Focusing on a critical need in our organization.

4. Learning from other health centers’ pilot projects.

5. The opportunity to work on PDSA cycles and see results for our efforts.

6. Making progress on our measures, finally pushing forward!
Reminder: What is the PHLN?

Goals & Objectives for the Network
PHLN Goal

The PHLN 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 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 other 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 We Did in Year 1

1. 2-day convenings May 2018 & January 2019
2. Site visits to 6 exemplar organizations
3. 9 virtual sessions including webinars & office hours
4. 2 in-person workshops
5. Completed baseline assessment & quarterly update
6. Launched PHLN Forum
Our PHLN Destination

Year 1:
Spark & Test Ideas

Year 2:
Implement & Spread

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Year 2 Overview

Goals, Expectations, and Support
Year Two of the PHLN: Two Paths

Option 1: Keep Participating in the Network
- Core team attend Convening #3 (December 5, 2019)
- Continue to participate fully in evaluation activities
- Continue to connect & share with other PHLN teams in the network
- Option to participate in other activities (i.e. coaching, access technical advisors, webinars, etc)
- Submit quarterly reports

Option 2: Participate AND Receive Additional $$ and TA Support
- Continue core PHLN activities
- Additional financial support ($30K)
- We’ll ask for extra metric collection & reporting AND also provide you with extra support
Year Two Grant Opportunity

Grants to support project proposals that focus on implementation or spread of one or more population health strategies

1) Build on, strengthen, deepen, or spread ideas that advance your organization’s population health work;
2) Be focused on implementing an idea or strategy tested (partially or fully) in year one of the PHLN.

Not a planning grant or an innovation grant
## Expectations

### Participation in Network Activities & Dedication to Sharing
- Robust usage of the forum
- Present project findings on December 5, 2019 and the final PHLN webinar by the end of May 2020

### Metrics Collection & Progress Reporting
- Define a set of measures with our metrics guru, Jerry Lassa
- Create a measurement work plan to track relevant metrics and milestones with Jerry
- Submit metrics and progress report quarterly to CCI (April 30, 2019; July 30, 2019; October 30, 2019; January 30, 2020; and April 30, 2020)

### Evaluation Activities
- Continue to participate in the full PHLN evaluation activities (conducted by JSI) like the annual survey, endline assessments, interviews, etc.

### Affinity Groups
- Be matched in affinity groups based on the areas in which you are doing work.
- Check in at least quarterly (preferably through the PHLN online forum) to share progress and help overcome challenges experienced
Important Grant Reminders

• **Timeline & End of Grant:** Friday, February 28, 2020 **NOT** December 31, 2019

• **Scope Revisions:** If your team was asked to make revisions to your scope or key activities in the announcement email, please work with your coach to do so and resubmit to CCI by 3/31/19.

• **Metrics & Measurements:** All teams who received grant awards will be expected to track and report progress and this activity will be supported through regular contact with Jerry Lassa.
Setting You Up for Success in Year Two

Coaching Support
Data & Metrics Support
Affinity Groups
Continuing TA Support (office hours, webinars, etc)
CCI Team Responsive to Your Needs
PHLN Coaches

Dr. Carolyn Shepherd  
Principal  
Leibig-Shepherd, LLC

Denise Armstorff  
Quality Improvement & Leadership Consultant  
Armstorff Consulting

Lori Raney  
Principal  
Health Management Associates

Juliane Tomlin  
Senior Manager, Practice Transformation, CCI

For more information about the coaches, visit the PHLN Support Portal:  
https://www.careinnovations.org/phln-portal/faculty-coaches/
What Does My Coach Do?

• Your coach is a mentor and guide for your team. Think of them as a thought partner.

• Your coach can help you think through:
  • specific population health goals and aims
  • your ideas to PDSA and planning for PDSAs
  • measures to track success
  • strategies for managing change and engaging team members in QI work

• Connect you to other PHLN teams, technical assistance and other support that CCI can offer.

• Keep you accountable for what you want to accomplish and in moving your work forward.
Elements of Coaching

- Monthly phone calls
- In between communication via email
- Your whole PHLN team or a smaller group from your team can join coaching calls
- 6 months to start (March 2019-August 2019)
## Key Considerations

### Frequency & Consistency
- Meet virtually with your coach during a mutually agreed upon time each month.
- If you need to reschedule or cancel, please give your coach as much advanced notice as possible.

### Agenda Setting
- Your team should set the agenda ahead of time for your coaching calls.
- Agenda items could include updates on your progress, challenges you’d like to trouble shoot, teams or faculty you’d like to be connected to, etc.

### Improvement Tools
- Your coach will suggest using a variety of different improvement tools to help guide and structure your work. The expectation is that your team will be open to trying out recommendations in between coaching calls, and report back during the calls. These tools could include driver diagrams, logic models, etc.

### Feedback
- We’ll be including a question in the quarterly progress reports about coaches.
- Please feel comfortable providing your coach with real-time feedback about what’s working, what’s not, and what could be better.
- You can also reach out to your team’s CCI PHLN pointperson if you have any questions or concerns about coaching.
Metrics & Measurement Support: Jerry Lassa

ejerry.lassa@datamatt3rs.com

About Jerry:

• Statistician and QI professional with over 25 years’ experience
• Leadership roles at an academic medical center, two community health centers, and an HCCN
• Analyst, coach and faculty on various California state-wide data initiatives from 2011-2018:
  • Aligning QI in CA Clinics for MU
  • CA Statewide Data Management Strategy
  • CA Comparative Analytics Project
  • Regional Information for Shared Excellence
  • Practice Transformation Initiative (TCPI)
  • Safety Net Analytics Program (Data-driven culture, Data Governance)
• Teaches statistics at Northwestern University (over 20 years, omg)
• Loves In-N-Out

What he can help your team with:

• Developing strong measures that align with your AIM statements (he can provide group and/or 1:1 coaching to strengthen measures for data collection and monitoring over time).

• Developing an Excel template (run charts or other visual display of trended data) to document your measures and view data over time.

• Over the course of the project, he’s available via email and phone to answer questions about monitoring of measures including data collection, populating the Excel template and interpreting measure progress.

• He’ll be collaborating with PHLN faculty in working with teams to monitor measure progress during coach check-in calls, group forums, and/or 1:1 calls.
Common Themes Across Proposals

Commonalities/differences

- Many commonalities in activities and measures both within and across affinity groups (next slide)

- Differences due to teams at different starting points (e.g., beginning vs. refining screening, risk strat., protocols)

- Differences due to more or less process/technology change (e.g., new vs. change in use of EHR, PHM, data viz tool)

Process/technology changes:

- New EHRs: Lifelong-NG/eCW to Epic; SFHN-eCW to Epic; La Clinica de La Raza-NG to Epic; Axis-NG to Epic

- Using new feature in EHR: NEVHC-assessing use of NG’s Enrollment Management and text messaging modules; Venice-integrating existing Patient Visit Planning report into NG

- New/change in use of PHM: NEVHC using new CCC module in i2iTracks; La Clinical de La Raza assessing new PHM system

- New/change in use of data/viz tool: Lifelong and Axis to use Tableau
Common Themes Across Proposals

**Key Activities**

1. Inventory/assess current approach
   - screening (e.g., PRAPARE) and linkage protocols
   - risk stratification
   - in/outreach protocols
   - care team roles
   - Med/BH referral protocols
2. Develop/refine approach and care team roles
3. Incorporate new approach into EHR/PHM documentation and workflows
4. Develop/refine reports
5. Train staff
6. Pilot new approach
7. Spread
8. Measure, monitor, refine as needed

**Process Measures**

- # and % patients
- screened, assigned to risk tiers, in-outreached, Referred to BH
- # and % patients
- linked, with services offered/administered, scheduled for appointment, Followed-up
- # and % care team members trained
- No show rate
- TNAA

**Outcomes Measures**

- Patient experience
- Staff satisfaction
- Health outcomes/QIP measures
- Acute care utilization (ER, hospitalization)
Tracking Templates (As Needed)

Quarterly Activity and Measure Status

Dashboard Format

Scorecard format

Monthly monitoring of measure trends
Metrics & Measurement Support: Jerry Lassa

Jerry will email Project Leads to set up time in the next few weeks to discuss your proposed metrics.

All teams who received grant awards will be expected to track and report progress and this activity will be supported through regular contact with Jerry.

After today’s webinar...
Affinity Groups & Projects Overview
What is an Affinity Group?

affinity group

a group of people linked by a common interest or purpose.
Year 2 PHLN Affinity Groups

Purpose

• Connect with peer organizations working on similar project areas in order to share challenges, wins, and accelerate progress.

Structure

• Each affinity group has between 3-5 organizations.
• CCI will suggest groups depending on year 2 project proposal. Let us know by March 26: *is there a more appropriate affinity group for your team?*
Year 2 PHLN Affinity Groups

Basic Ask

• Check in at least quarterly over the next year (so 4 times) to update your peers about your progress, challenges, ask questions. But the sky’s the limit in how you choose to work together!
• But the sky’s the limit in how you choose to work together!

Ways to Check In

• Use the forum; Diana will create threads for each affinity group.
• Set up a virtual meeting or call.
• Exchange updates via email.
• Set up an informal, virtual office hour and invite other PHLN teams.
• Organize in person meetings or site visits (CCI can help with travel costs!)
Core Areas of Focus for Year 2

1. Social Needs
2. Risk Stratification
3. Access Strategies to Optimize Planned Care & Outreach
4. Data Tools & Reporting to Close Gaps in Care
5. Care Team Roles
6. Behavioral Health Integration
## Social Needs

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Rosa Community Health</td>
<td>Bay Area</td>
<td>Develop workflows, train staff, implement PRAPARE, and create a plan to link patients to needed resources</td>
</tr>
<tr>
<td>Serve the People Community Health Center</td>
<td>Los Angeles</td>
<td>Implement and integrate PRAPARE screening and develop workflows for identified diabetic patient populations</td>
</tr>
<tr>
<td>North County Health Services</td>
<td>San Diego</td>
<td>Identify a SDOH screening tool and assess patients with poor diabetes control, linking them to resources and developing appropriate workflows</td>
</tr>
<tr>
<td>Tri-City Health Center</td>
<td>Bay Area</td>
<td>Use PRAPARE data and patient focus groups to Improve health outcomes in the diabetic patients</td>
</tr>
<tr>
<td>L.A. County Department of Health Services - Primary Care</td>
<td>Los Angeles</td>
<td>Address food insecurity for patients to improve clinical outcomes by linking at least 20% of patients seen who screen positive to appropriate resources</td>
</tr>
</tbody>
</table>
## Risk Stratification

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Medical Centers, Inc.</td>
<td>Central</td>
<td>Develop a structured tiered outreach process (using a roster utility system eMed Apps) to better engage assigned, unseen members</td>
</tr>
<tr>
<td>LifeLong Medical Care</td>
<td>Bay Area</td>
<td>Improve care coordination services for high risk patients by developing and implementing a risk stratification methodology</td>
</tr>
<tr>
<td>Northeast Valley Health Corporation</td>
<td>Los Angeles</td>
<td>Optimize care management services by testing a risk stratification tool (Chronic Condition Count) and testing a complex care management model focusing on DM patients</td>
</tr>
</tbody>
</table>
## Access Strategies to Optimize Planned Care & Outreach

<table>
<thead>
<tr>
<th>Neighborhood HealthCare</th>
<th>San Diego</th>
<th>Develop a recall and tracking system to improve access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapa-De Indian Health Program, Inc</td>
<td>Central</td>
<td>Develop a robust and reliable recall system to move toward advance access scheduling</td>
</tr>
<tr>
<td>San Francisco Health Network-Primary Care</td>
<td>Bay Area</td>
<td>Increase access and close gaps by conducting proactive, centralized outreach to assigned but unseen members</td>
</tr>
<tr>
<td>Northeast Valley Health Corporation</td>
<td>Los Angeles</td>
<td>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</td>
</tr>
</tbody>
</table>
## Data Tools & Reporting to Close Gaps in Care

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ravenswood Family Health Center</td>
<td>Bay Area</td>
<td>Decrease the number of patients whose insurance lapses, by creating a streamlined and effective process for insurance panel management</td>
</tr>
<tr>
<td>Salud Para La Gente</td>
<td>Bay Area/Central Coast</td>
<td>Improve data transparency by developing and implementing population health reports for care teams to act on clinical quality improvement (colorectal cancer screening)</td>
</tr>
<tr>
<td>Venice Family Clinic</td>
<td>Los Angeles</td>
<td>Integrate existing Patient Visit Planning report into NextGen system to increase the ease of use and allow all team members to access the report</td>
</tr>
</tbody>
</table>
## Care Team Roles

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>CommuniCare Health Centers</td>
<td>Central</td>
<td>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</td>
</tr>
<tr>
<td>Los Angeles LGBT Center</td>
<td>Los Angeles</td>
<td>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</td>
</tr>
<tr>
<td>Native American Health Center, Inc.</td>
<td>Bay Area</td>
<td>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</td>
</tr>
<tr>
<td>La Clinica de La Raza, Inc.</td>
<td>Bay Area</td>
<td>Standardize and optimize the Clinical Office Assistants role and maximize the skills, abilities, and performance of COAs</td>
</tr>
<tr>
<td>Santa Barbara Neighborhood Clinics</td>
<td>Central Coast</td>
<td>Add a new core care team member (panel managers) &amp; also focused on diabetes care management</td>
</tr>
</tbody>
</table>
### Behavioral Health Integration

<table>
<thead>
<tr>
<th>Organization</th>
<th>Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis Community Health</td>
<td>Bay Area</td>
<td>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</td>
</tr>
<tr>
<td>Vista Community Clinic</td>
<td>San Diego</td>
<td>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</td>
</tr>
<tr>
<td>North East Medical Services (NEMS)</td>
<td>Bay Area</td>
<td>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</td>
</tr>
<tr>
<td>Open Door Community Health Centers</td>
<td>Far North</td>
<td>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</td>
</tr>
</tbody>
</table>
Next Steps?

• The CCI affinity group point of contact will send out a doodle to schedule a virtual check-in/call in April 2019.

• After that, it’s up to your affinity group to figure out how best to communicate & when!

• But other ways that CCI can help (if requested):
  - Schedule calls
  - Invite experts to join calls
  - Join calls and take abbreviated minutes
  - Track down resources
  - Facilitate calls
<table>
<thead>
<tr>
<th>Affinity Group</th>
<th>CCI Point of Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assessing for and Addressing Social Needs</td>
<td>Megan</td>
</tr>
<tr>
<td>2. Risk Stratification</td>
<td>Michael &amp; Meaghan</td>
</tr>
<tr>
<td>3. Access Strategies to Close Gaps in Care</td>
<td>Carolyn</td>
</tr>
<tr>
<td>4. Data Tools &amp; Reporting to Close Gaps in Care</td>
<td>Tammy</td>
</tr>
<tr>
<td>5. Care Team Roles</td>
<td>Juliane</td>
</tr>
<tr>
<td>6. Behavioral Health Integration</td>
<td>Diana &amp; Lori</td>
</tr>
</tbody>
</table>
Communication Tools
Overview of Tools

- Monthly Newsletter
- Calendar invites for big events
- CCI Program Portal Page
- Forum
Monthly Newsletter

• Sent out the second Tuesday of each month

• Includes:
  • Team Spotlights (send to Diana!)
  • What’s Trending on the Forum?
  • Activities & Key Dates
  • Resources

Not getting the monthly newsletter? Contact Diana at diana@careinnovations.org.
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.

https://www.careinnovations.org/phln-portal/
Program Portal Page: Action Items & Activities

PHLN Activities

- Activities Overview
- Forum – join the conversation!
- In-Person Learning
- Virtual Sessions

Newsletters

<table>
<thead>
<tr>
<th>Month</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2019</td>
<td>Sent Feb. 12, 2019</td>
</tr>
<tr>
<td>January 2019</td>
<td>Sent Jan. 8, 2019</td>
</tr>
<tr>
<td>December 2018</td>
<td>Sent Dec. 31, 2018</td>
</tr>
<tr>
<td>November 2018</td>
<td>Sent Nov. 15, 2018</td>
</tr>
<tr>
<td>October 2018</td>
<td>Sent Oct. 9, 2018</td>
</tr>
</tbody>
</table>

Program Calendar

This calendar displays information about events, virtual sessions, site visits, webinars and more. Double click on the calendar events to pull up detailed information or click the Agenda tab for a list view of events.

phincalendar@gmail.com

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Program Portal Page: Meet Your Network

Participating Organizations

Download the network contact list (updated 1/7/19)

Axis Community Health
PLEASANTON, CA

Chapa-De Indian Health
AUBURN, CA

CommuniCare Health Centers
DAVIS, CA

Community Medical Centers, Inc.
STOCKTON, CA
Evaluation & Reporting

CONTENTS:

- What’s Due/Upcoming: Quarterly Report Due 2/18 (if you aren’t applying for Year 2 grant)
- Quarterly Progress Report Submission Form
- PHLN Logic Model
- Overview of PHLN & Engagements Stats
- JSI, Inc. Evaluation Team
The resources below are designed to help your team and organization with the following topics:

- **Learning Organizations**: Understanding adaptive and technical challenges. Communicating around large change initiatives. Clarifying leadership roles and how leaders work together to provide integrated care.

- **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.

- **Behavioral Health Integration**: 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 non-medical needs. Building internal systems, referral processes, and effective partnerships with community organizations to respond to identified needs.
What’s Next?
# Leading Profound Change Webinar Series

## Webinar Series Overview

<table>
<thead>
<tr>
<th>Date</th>
<th>Webinar Topic</th>
<th>Webinar Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 30, 2019</td>
<td>Brainstorming Techniques</td>
<td>Brainstorming is a team-based approach to generating ideas rapidly. Sounds easy enough but few of us have ever really been in a good brainstorm. Learn specific techniques for stretching your creative ideas, getting participation from everyone (not just those with the loudest voice), how to sort through the chaos and cue up the group for some action.</td>
</tr>
<tr>
<td>March 12, 2019</td>
<td>Empathy and Journey Maps</td>
<td>In this session, we will learn some concrete ways to help build it for our patients and our own staff through the use of two tools you can use immediately in your work life... or your personal life!</td>
</tr>
<tr>
<td>May 14, 2019</td>
<td>Prototyping</td>
<td>Prototyping is the phase of work many believe is the most intimidating. Find out about the real benefit to rapid prototyping and some clear approaches to using it as a way to really refine your ideas quickly and cheaply.</td>
</tr>
<tr>
<td>July 9, 2019</td>
<td>PDOSA</td>
<td>Each of us is unique in how we go about leading change and it shows up in what phase of the PDOSA cycle we seem to like the best. It’s easy to get stuck in the part that makes us most comfortable. Tammy Fisher, from CC, will share a treasure chest of real-world approaches and stories to help rev up your PDOSA cycles for the greatest impact.</td>
</tr>
<tr>
<td>September 10, 2019</td>
<td>Leveraging Multiple Tools to Address Primary Care Issues</td>
<td>We will map out a few more tangible approaches to tie together many of the skillsets and mindsets we have learned throughout this program. They will be demonstrated in the context of how they might look in a primary care setting to help bring it home.</td>
</tr>
<tr>
<td>November 12, 2019</td>
<td>Leading Profound Change: Clinic Experiences</td>
<td>We will share our own experiences...what we tried, what didn’t go so well, what surprised us and what tips we have to give to one another. Hear from your peers and jump into the conversation on the fly with questions and examples of your own. This session will tap into the wisdom of the crowd.</td>
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Year 2 Activities (So Far)

**Activities**
(all optional except convening #3)

- **March 25** at 12:30pm: PHLN Virtual Office Hours: Petaluma Health Center. [Register here.](#)
- **April 16** at 12:00pm: PHLN Virtual Office Hours: LifeLong Medical Center. [Register here.](#)
- **December 5**: Convening #3

**Evaluation**

- **March 28**: Year 1 Annual Survey released. Survey due by April 12th.
- **April 30**: Progress Report Due.
- **July 30**: Progress Report Due.
- **October 30**: Progress Report Due.
- **January 30, 2020**: Progress Report Due.
- **April 30, 2020**: Final Progress Report Due.
- **Spring 2020**: Wrap up evaluation with JSI (baseline assessment, conversations, and annual survey)
<table>
<thead>
<tr>
<th><strong>To-Do’s</strong></th>
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<tbody>
<tr>
<td><strong>CCI</strong></td>
</tr>
<tr>
<td>- Email connection to affinity group teams</td>
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<tr>
<td>- Post the recording and webinar slides on CCI portal</td>
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<tr>
<td>- Send out newsletter in April with link to recording</td>
</tr>
<tr>
<td>- Grant letters and checks will be mailed on March 31</td>
</tr>
<tr>
<td><strong>PHLN Teams</strong></td>
</tr>
<tr>
<td>- If you haven’t yet, set up a time to meet with your coach.</td>
</tr>
<tr>
<td>- Once an email is sent out, connect with Jerry re: your metrics.</td>
</tr>
<tr>
<td>- Work with your CCI contact person to schedule your first affinity group quarterly check-in.</td>
</tr>
<tr>
<td>- Use the forum!</td>
</tr>
</tbody>
</table>
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