California Health Care Foundation

blue of california foundation

Dignity Health

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

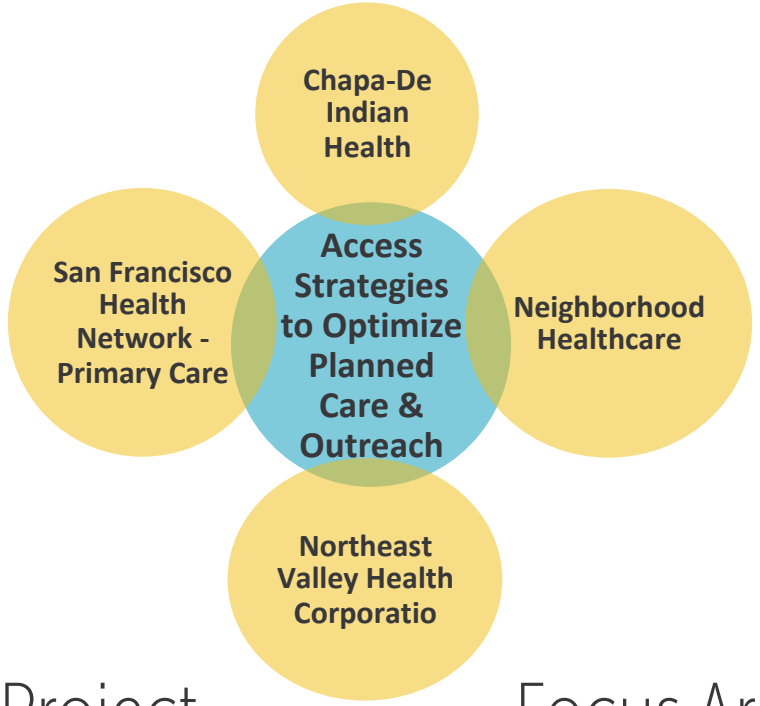
Our Extended Program Team

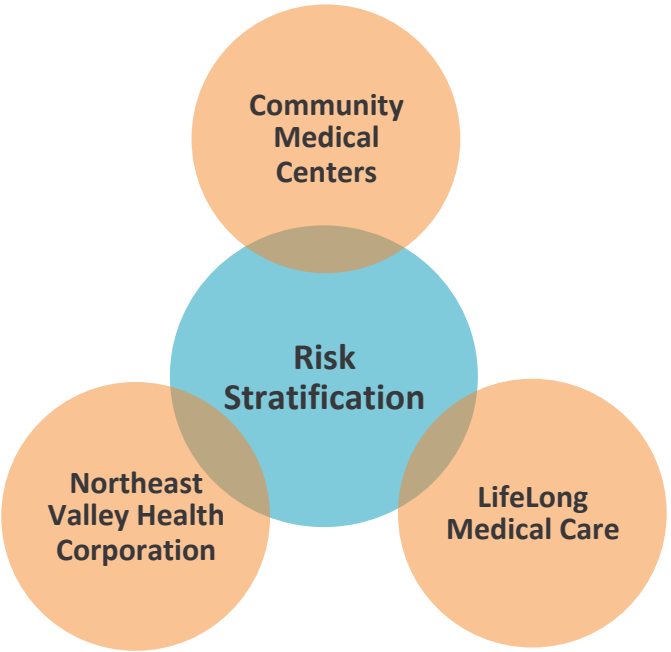
Dr. Carolyn Shepherd,
PHLN Faculty

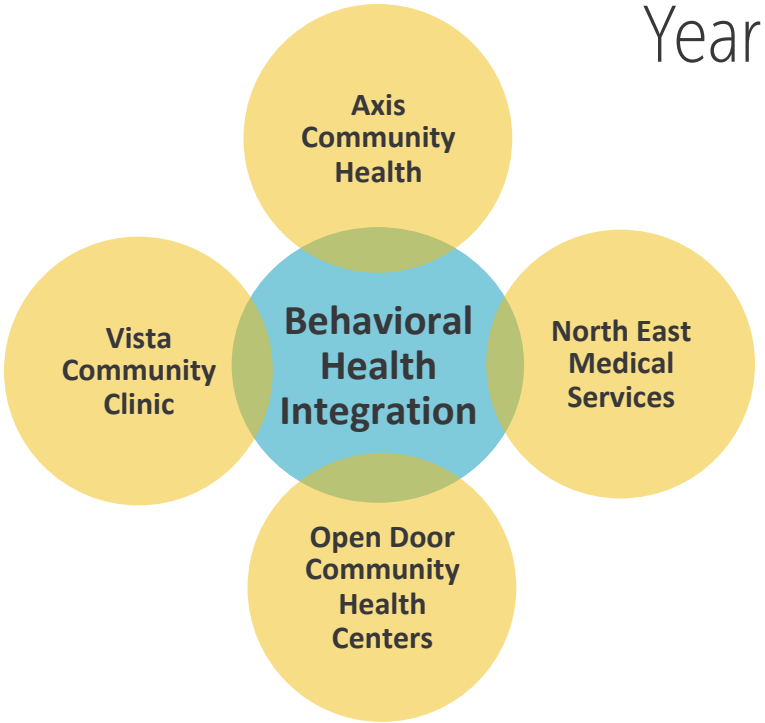
Meaghan Copeland,
Program Consultant

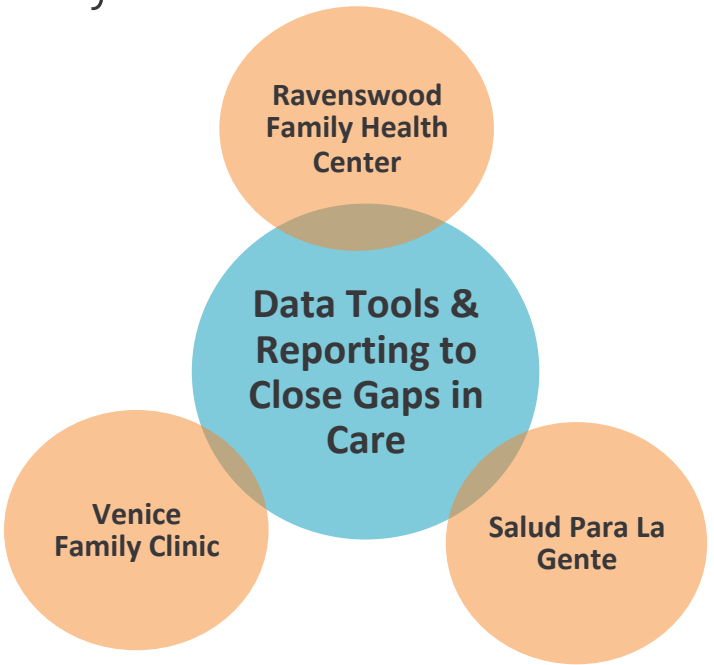

Congratulations!

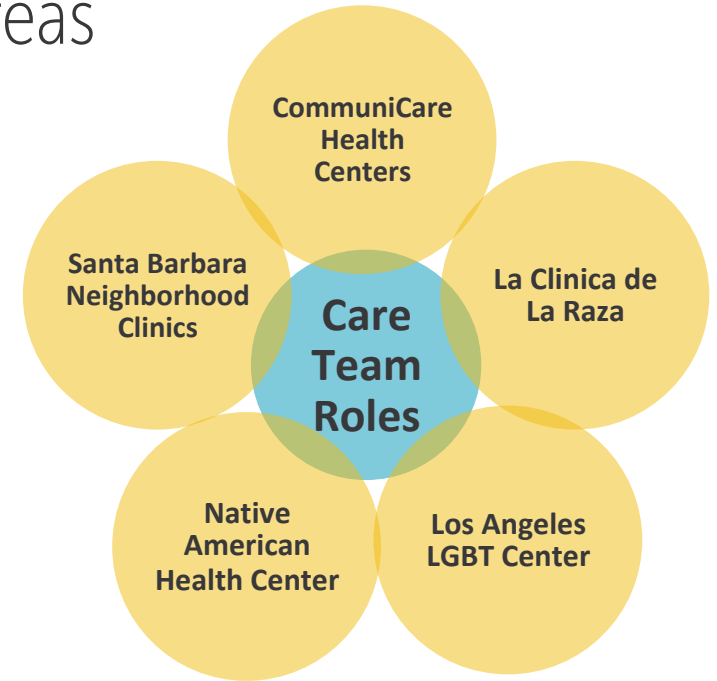
Year 2 Project Focus Areas











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

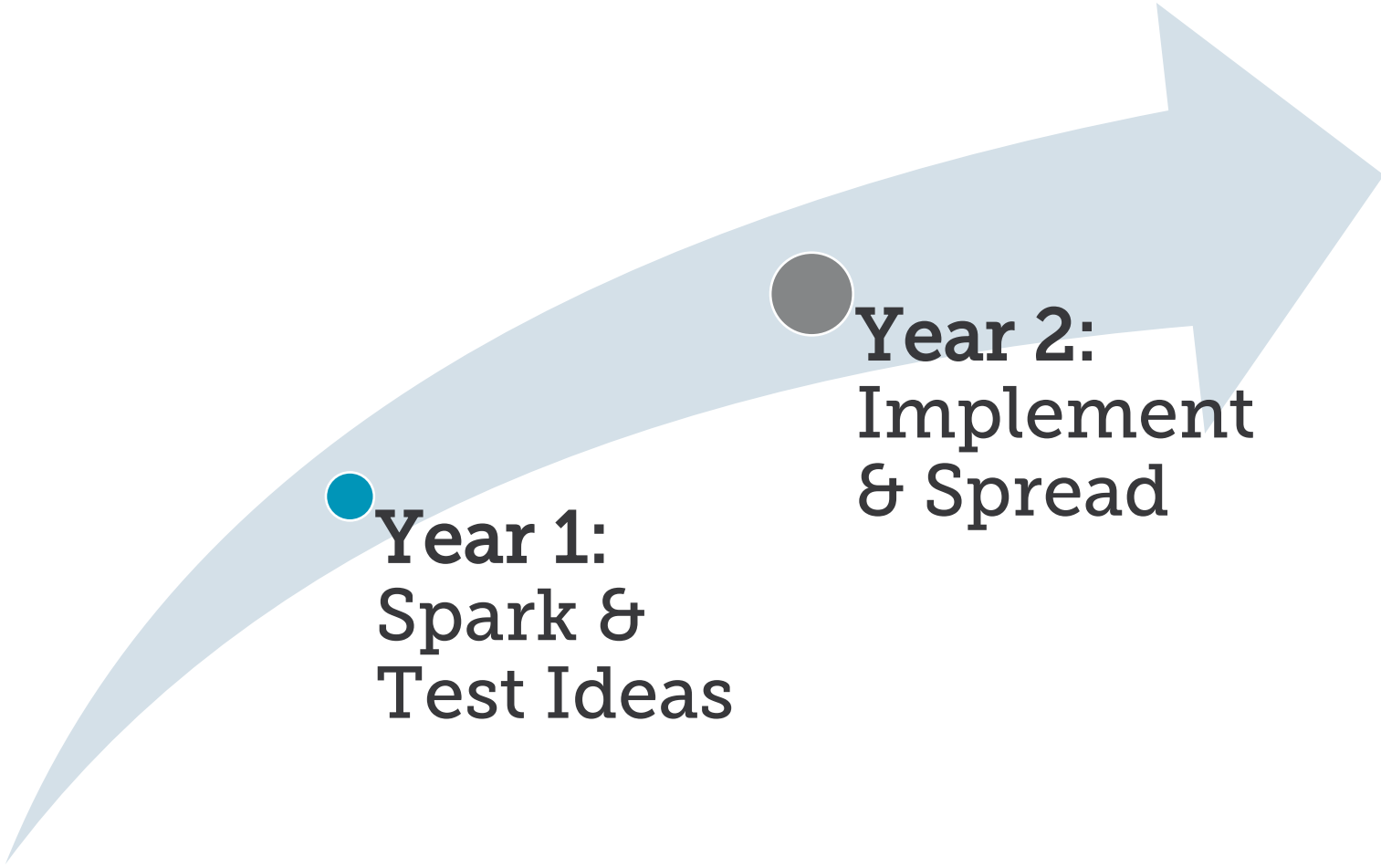
Test and deploy innovations critical to whole person care: assessing and responding **social needs**, **behavioral health integration**, **care management** for vulnerable populations

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 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

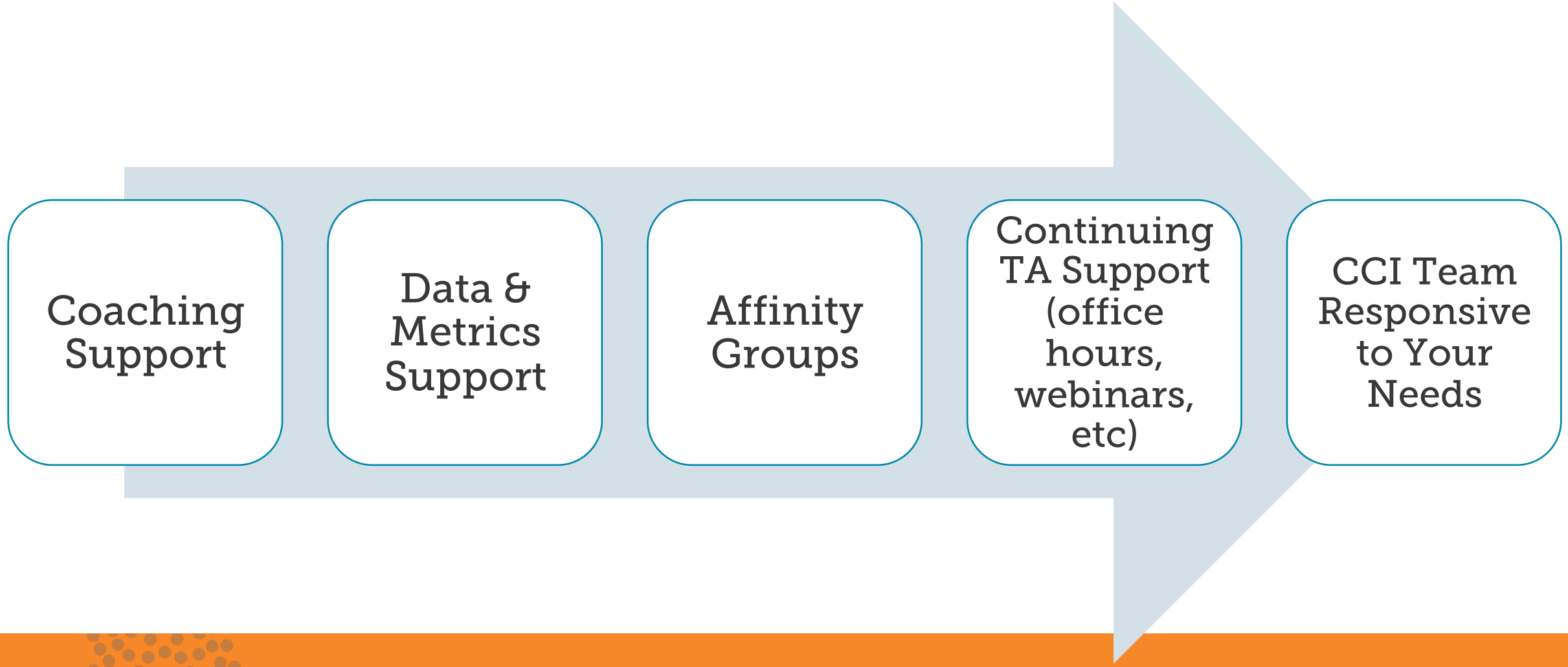
Expectations

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



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

jerry.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 module 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)

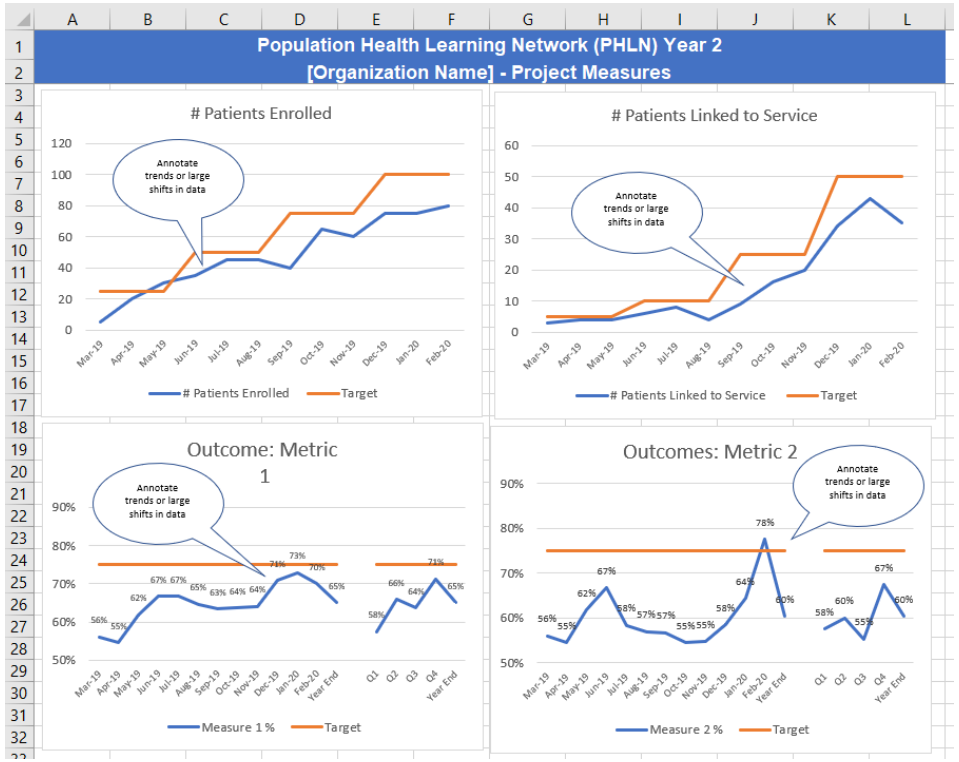
Quarterly Activity and Measure Status

Population Health Learning Network (PHLN) Year 2
[Organization Name] - Quarterly Report

#	Milestone/Measure/Metric	Target Date / Value	Quarterly Status 4/30/19	7/30/19	10/30/19	1/30/20	Year End Status	Notes
	Milestones (Key Activities)							
1	Inventory/assess current screening (e.g., PRAPARE) and linkage protocols	4/15/2019	Complete					
2	Develop/refine screening and linkage protocols, tools, workflows	4/30/2019	80%					
3	Develop/refine care team roles	4/30/2019	90%					
4	Establish/validate referral resources (internal, community partners)	5/15/2019						
5	Incorporate screening tool documentation and workflows into EHR	5/31/2019						
6	Develop/refine reports, workflows for following up and tracking referrals and linkages	6/30/2019						
7	Train staff on new protocols, workflows, system	7/15/2019						
8	Pilot new screening protocol, assess, refine as needed	8/1/2019						
9	Spread	10/1/2019						
10	Measure, monitor process and outcomes measures, refine screening and linkage as needed	Ongoing						

Scorecard format

Dashboard Format



Monthly monitoring of measure trends

Metrics & Measurement Support: Jerry Lassa

After today's webinar...

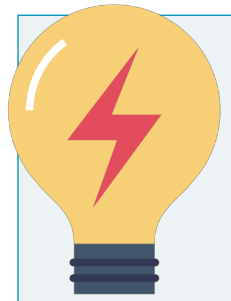
Jerry will email Project Leads to set up time in the next few weeks to discuss your proposed metrics.

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.

Affinity Groups & Projects Overview

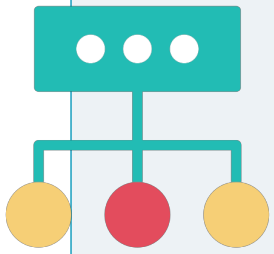
What is an Affinity Group?

Year 2 PHLN Affinity Groups



Purpose

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



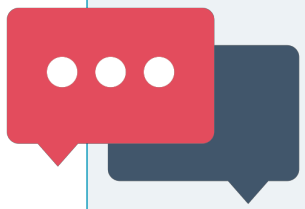
Structure

- 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 groups
- 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

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

Risk Stratification

Community Medical Centers, Inc.	Central	Develop a structured tiered outreach process (using a roster utility system eMed Apps) to better engage assigned, unseen members
LifeLong Medical Care	Bay Area	Improve care coordination services for high risk patients by developing and implementing a risk stratification methodology
Northeast Valley Health Corporation	Los Angeles	Optimize care management services by testing a risk stratification tool (Chronic Condition Count) and testing a complex care management model focusing on DM patients

Access Strategies to Optimize Planned Care & Outreach

Neighborhood HealthCare	San Diego	Develop a recall and tracking system to improve access
Chapa-De Indian Health Program, Inc	Central	Develop a robust and reliable recall system to move toward advance access scheduling
San Francisco Health Network-Primary Care	Bay Area	Increase access and close gaps by conducting proactive, centralized outreach to assigned but unseen members
Northeast Valley Health Corporation	Los Angeles	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

Data Tools & Reporting to Close Gaps in Care

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

Care Team Roles

CommuniCare Health Centers	Central	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
Los Angeles LGBT Center	Los Angeles	Re-structure the team-based model to a Core Clinical Care Model, hire 3 new LVN Coordinators, 1 Flow Facilitator, standardize workflows and standing protocols, and implement huddles, and missed opportunities reports
Native American Health Center, Inc.	Bay Area	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
La Clinica de La Raza, Inc.	Bay Area	Standardize and optimize the Clinical Office Assistants role and maximize the skills, abilities, and performance of COAs
Santa Barbara Neighborhood Clinics	Central Coast	Add a new core care team member (panel managers) & also focused on diabetes care management

Behavioral Health Integration

Axis Community Health	Bay Area	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
Vista Community Clinic	San Diego	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
North East Medical Services (NEMS)	Bay Area	Increase access to culturally- and linguistically- appropriate behavioral health care for adolescents (ages 12-17) across all NEMS pediatric clinics by applying the adult depression screening process and workflow to our adolescent population
Open Door Community Health Centers	Far North	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

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

CCI Affinity Group Contact Person

Affinity Group	CCI Point of Contact
1. Assessing for and Addressing Social Needs	Megan
2. Risk Stratification	Michael & Meaghan
3. Access Strategies to Close Gaps in Care	Carolyn
4. Data Tools & Reporting to Close Gaps in Care	Tammy
5. Care Team Roles	Juliane
6. Behavioral Health Integration	Diana & Lori

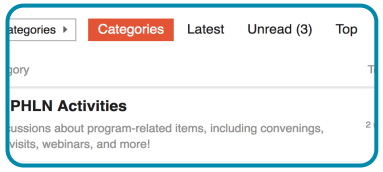
Communication Tools

Overview of Tools

Monthly Newsletter

Calendar invites for big events

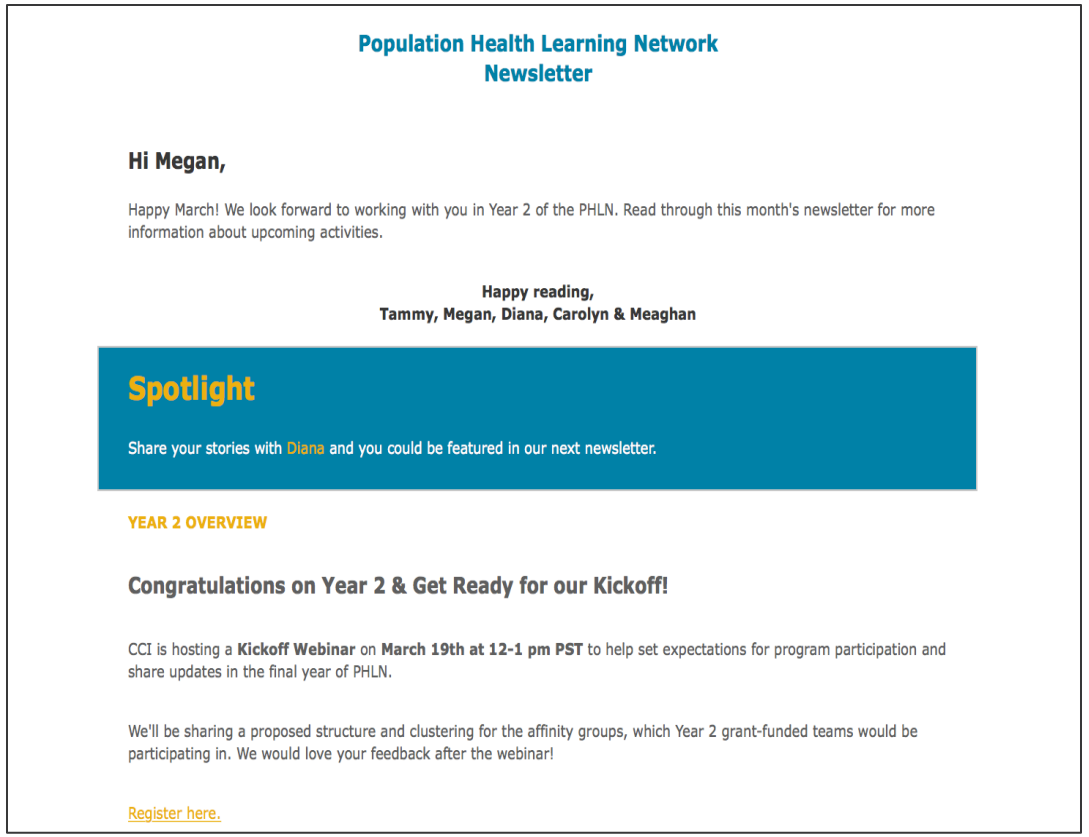
CCI Program Portal Page



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



Population Health Learning Network
Newsletter

Hi Megan,

Happy March! We look forward to working with you in Year 2 of the PHLN. Read through this month's newsletter for more information about upcoming activities.

Happy reading,
Tammy, Megan, Diana, Carolyn & Meaghan

Spotlight

Share your stories with Diana and you could be featured in our next newsletter.

YEAR 2 OVERVIEW

Congratulations on Year 2 & Get Ready for our Kickoff!

CCI is hosting a **Kickoff Webinar** on **March 19th at 12-1 pm PST** to help set expectations for program participation and share updates in the final year of PHLN.

We'll be sharing a proposed structure and clustering for the affinity groups, which Year 2 grant-funded teams would be participating in. We would love your feedback after the webinar!

Register here.

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

STAY UP-TO-DATE!

PHLN Support Portal

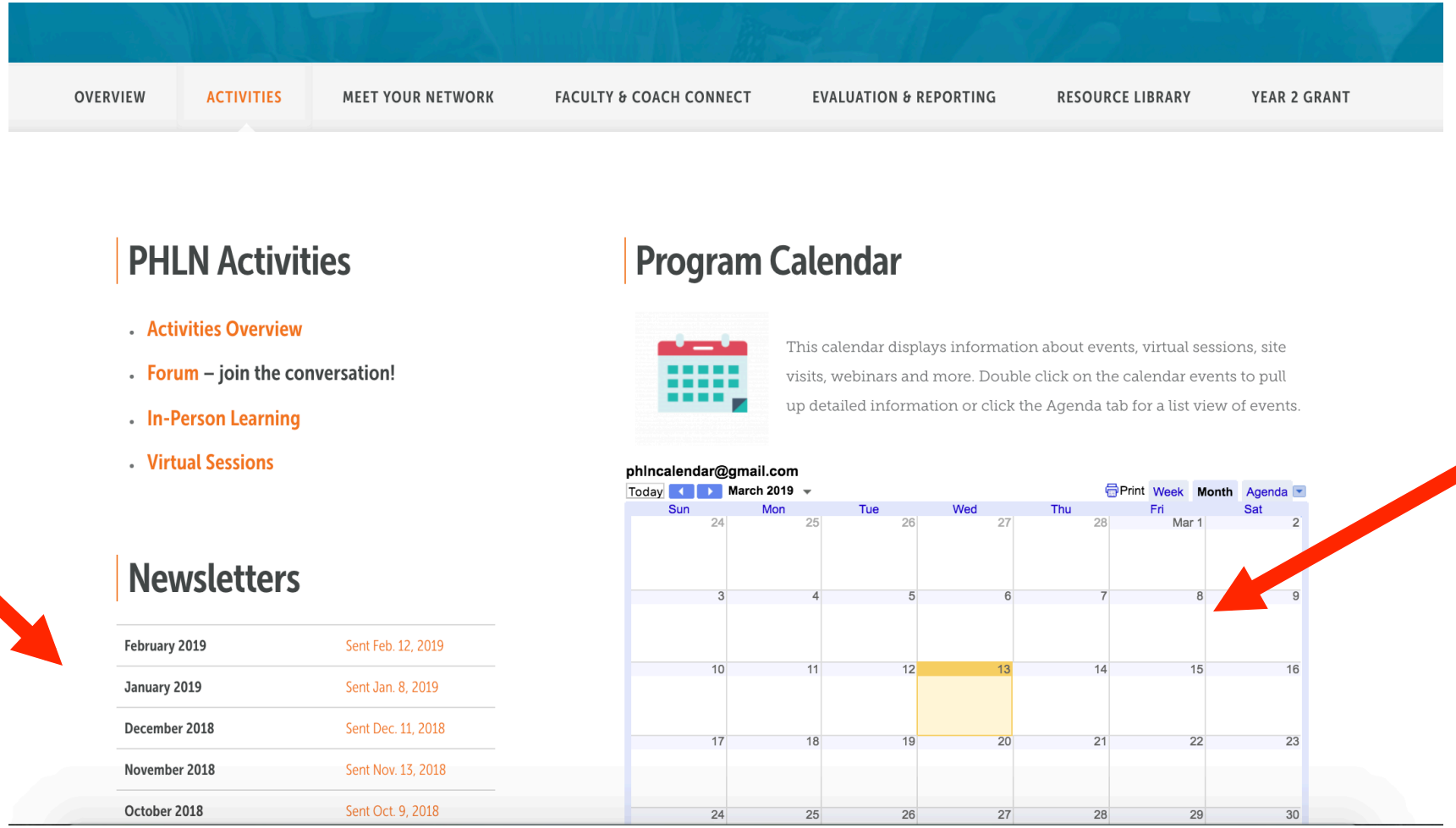
OVERVIEW | ACTIVITIES | MEET YOUR NETWORK | FACULTY & COACH CONNECT | EVALUATION & REPORTING | RESOURCE LIBRARY | YEAR 2 GRANT

HELLO, NETWORK MEMBERS!

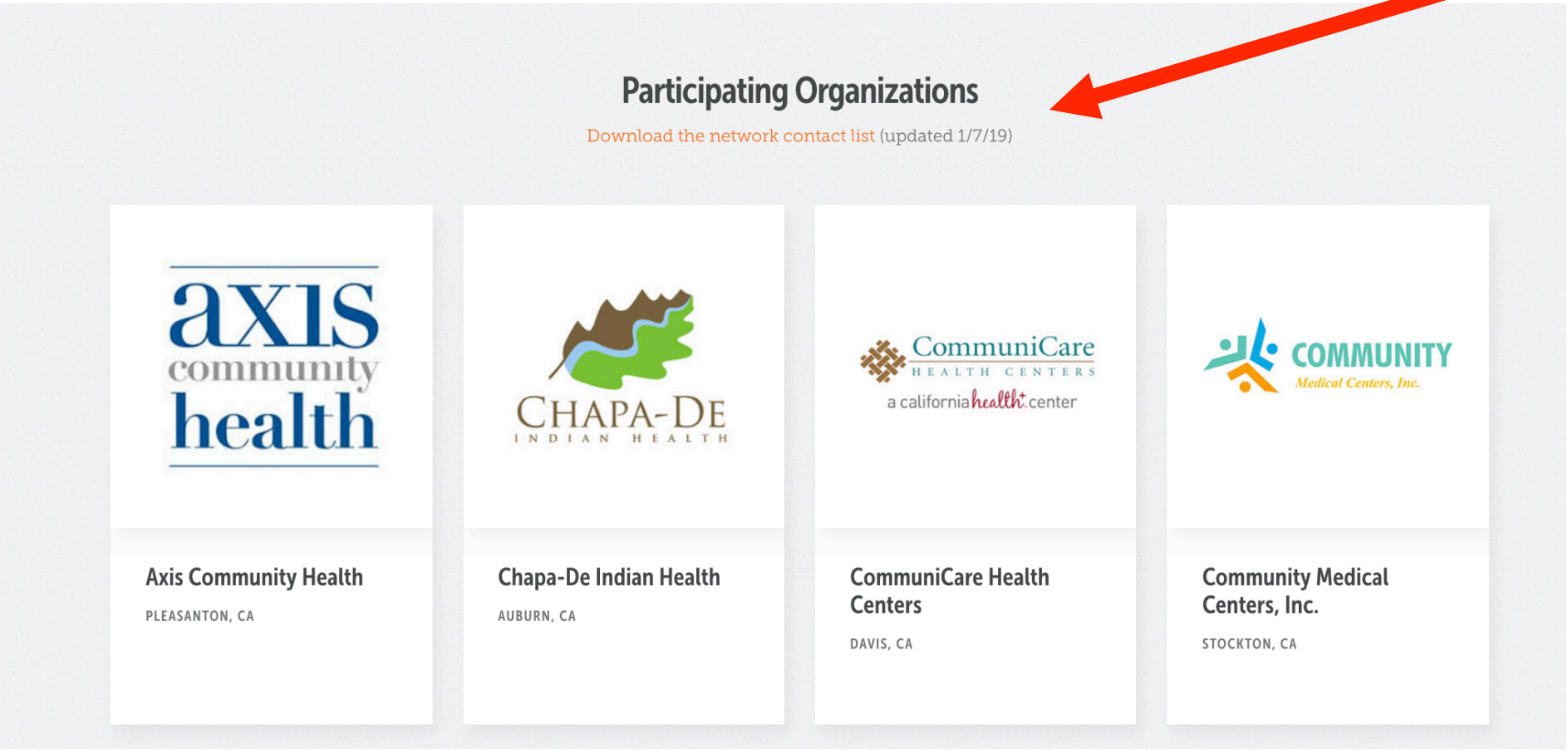
This website is a support center for the use of **Population Health Learning Network** (PHLN) participants. Program updates, report due dates, resources, and more will be posted to this website.

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

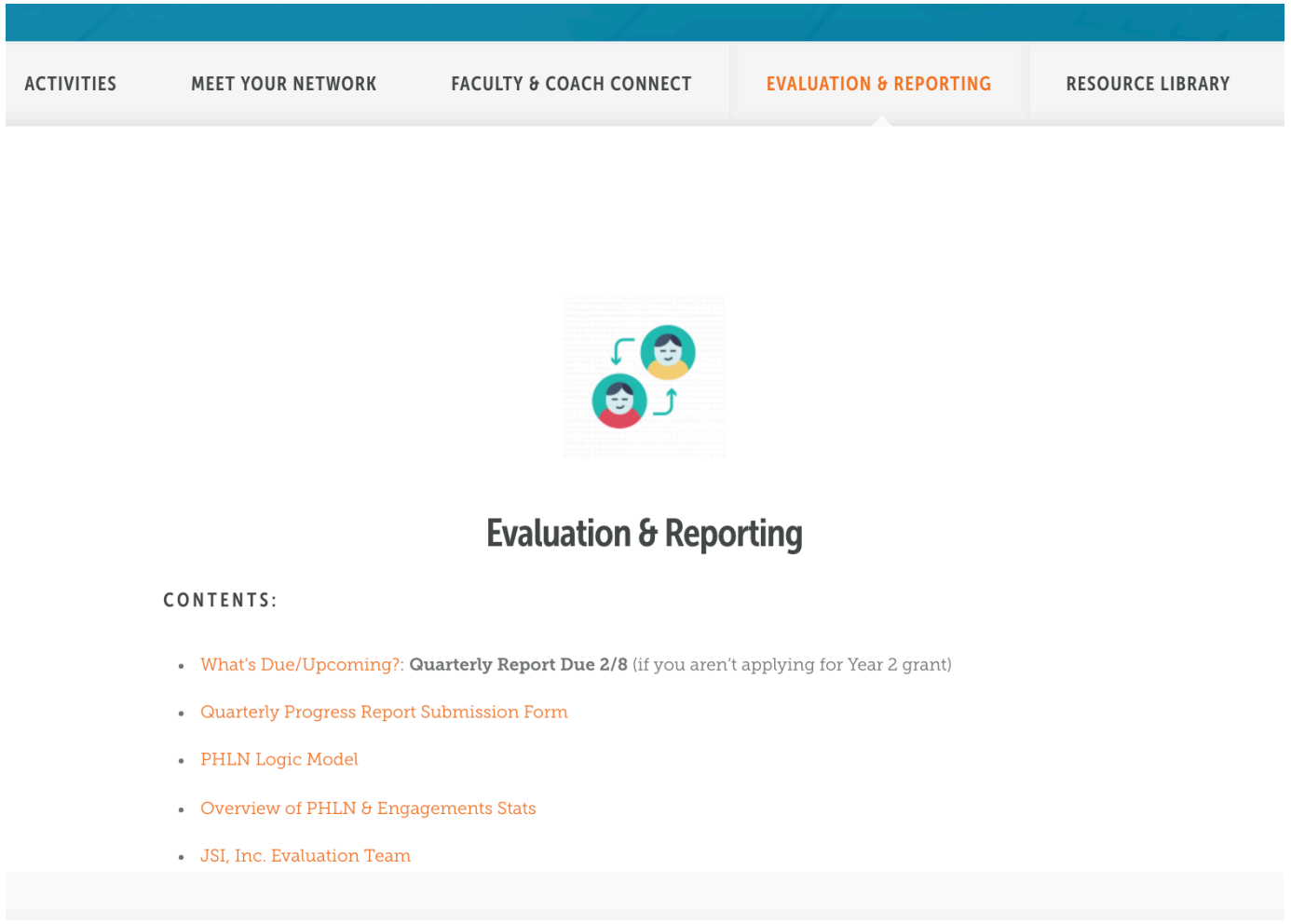
Program Portal Page: Action Items & Activities



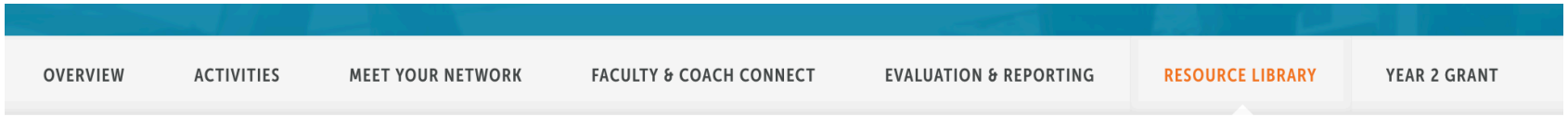
Program Portal Page: Meet Your Network



Program Portal Page: Evaluation & Reporting



Program Portal Page: Resource Library

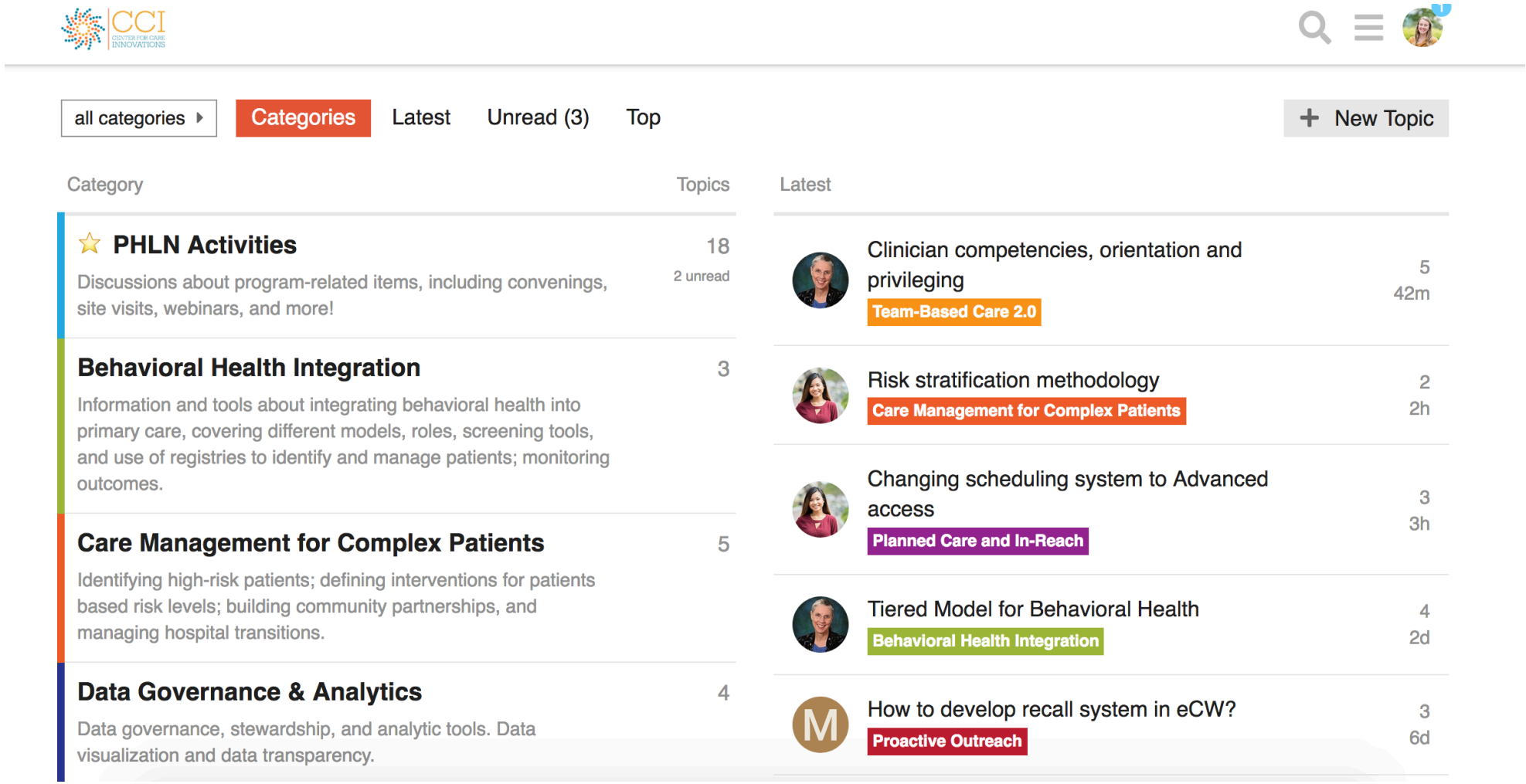


The resources below are designed to help your team and organization with the following topics:

- **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.
- **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 non-medical needs. Building internal systems, referral processes, and effective partnerships with community organizations to respond to identified needs.

PHLN Forum

https://forum.careinnovations.org/



What's Next?

Leading Profound Change Webinar Series

Webinar Series Overview

Date	Webinar Topic	Webinar Summary
January 30, 2019	Brainstorming Techniques	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.
March 12, 2019	Empathy and Journey Maps	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!
May 14, 2019	Prototyping	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.
July 9, 2019	PDSA	Each of us is unique in how we go about leading change and it shows up in what phase of the PDSA cycle we seem to like the best. It's easy to get stuck in the part that makes us most comfortable. Tammy Fisher, from CCI, will share a treasure chest of real-world approaches and stories to help rev up your PDSA cycles for the greatest impact.
September 10, 2019	Leveraging Multiple Tools to Address Primary Care Issues	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.
November 12, 2019	Leading Profound Change: Clinic Experiences	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.

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)

To-Do's

CCI

- ❑ Email connection to affinity group teams
- ❑ Post the recording and webinar slides on CCI portal
- ❑ Send out newsletter in April with link to recording
- ❑ Grant letters and checks will be mailed on March 31

PHLN Teams

- ❑ If you haven't yet, set up a time to meet with your coach.
- ❑ Once an email is sent out, connect with Jerry re: your metrics.
- ❑ Work with your CCI contact person to schedule your first affinity group quarterly check-in.
- ❑Use the forum!


CCI
CENTER FOR CARE
INNOVATIONS
Questions?

Thank you!

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