OPPORTUNITY

In partnership with the California Health Care Foundation (CHCF) and the Blue Shield of California Foundation (BSCF), the Center for Care Innovations (CCI) is launching a Population Heath Learning Network (PHLN). The PHLN aims to improve the health and wellbeing of more than 750,000 Californians by bringing together safety net primary care organizations to strengthen and advance their population health management strategies.

What We'll Provide

Up to 30 organizations will be selected to participate in this two-year network focused on learning, sharing best practices, and taking action to advance population health. This is not a basic or entry level network, but an opportunity to expand and elevate population health activities already underway. Organizations will attend in-person convenings to network with peers and experts in the field. They can also select from a robust array of technical assistance depending on their need, including:

- Access to 1:1 consultations and support from technical experts.
- Online resource center and toolkits.
- Coaching support.
- Virtual learning opportunities.
- Site visits to exemplar and peer organizations.
- Support from CCI's program team.

Organizations will receive between $4,000 and $8,000 (depending on their location relative to the San Francisco Bay Area) to offset travel costs to attend convenings, workshops, and site visits.

In year two, organizations can apply for grants of up to $30,000 to support deeper implementation of one or more population health management strategies tested in year one.

Timeline

The PHLN will run from March 2018 to March 2020.

Key dates:

- **Informational Webinar:** Friday, January 19, 2018 from 12 to 1:30 pm
- **Application Deadline:** Friday, February 9, 2018 at 5 pm
- **Network Participants Announced:** Friday, March 16, 2018
- **Kickoff Webinar:** Tuesday, March 27, 2018 from 12 to 1:30pm
- **First In-Person Convening:** Early May 2018

Eligibility

California-based safety net healthcare organizations that provide comprehensive primary care services to underserved populations are eligible to apply. Organizations must be nonprofit and tax-exempt under 501(c)(3) of the Internal Revenue Service Code (IRC) or a governmental, tribal, or public entity. This includes:

- Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes
- Community clinics, rural health clinics, and free clinics
- Ambulatory care clinics owned and operated by public hospitals
- Indian Health Services Clinics

Regional clinic consortia and statewide clinic associations are not eligible to apply.

Learn More

Join us for an informational webinar on January 19 to hear a detailed description of the network and ask questions. Register for the webinar.

For any other questions, please contact:

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OVERVIEW

Background

Historically, most primary care practices, including health centers, have provided episodic care to individuals who booked appointments or needed emergency care. Practices optimized their workflows and staffing models to address the medical needs of these "active" patients during face-to-face encounters in clinical settings. Over the past two decades, a sea change has swept through health care, forcing organizations to rethink—and reorganize—how they care for their patients and their communities.

Today, primary care organizations aim to proactively manage the health of a defined population of patients that is assigned to them; in California, this is established most often by a Medi-Cal Managed Care Plan. As such, there is a need to use data to identify, segment, and appropriately respond to medical, behavioral, and social needs through effective care interventions. And recognizing that social determinants (health-related behaviors, socioeconomic factors, and environmental factors) account for up to 80 percent of health outcomes, there is also a need to broaden the population health management lens to include understanding the social, political, and cultural context in which patients and their families live and to focus on providing whole-person care.

Such a change requires developing new skills in patient outreach and engagement, adding new roles to care teams, building community partnerships to address social needs, and connecting with patients over email, phone, telehealth and other methods in addition to the traditional office visit.

CCI has more than 17 years of experience grantmaking, designing and implementing high-quality, high-value programs and networks, as well as offering robust technical assistance to safety net organizations and health care systems. Previously, CCI led the Capitation Payment Preparedness Program (CP3) Population Health Program, which prepared organizations for the care delivery changes needed to succeed in a capitated, or value-based payment, environment. Participating organizations made changes such as increasing provider-to-medical-assistant ratios by 50 percent; adding new roles like navigators, panel managers, pharmacists, and behavioral health clinicians to care teams; implementing robust data reports for planned care and outreach; and incorporating alternative encounters like telephone and group visits.

Despite setbacks to California's Alternative Payment Methodology Pilot (APM), market trends indicate value-based payment is on the immediate horizon. Organizations must to prepare for the changes needed to succeed in a value-based environment. Building on our past CP3 Population Health Program, CCI is launching a new network focused on sharing best practices, innovating new care solutions, and advancing the spread of vetted changes that propel organizations towards value-based care and payment models.

Launching a New Network

In partnership with the California Healthcare Foundation (CHCF) and the Blue Shield of California Foundation (BSCF), the Center for Care Innovations (CCI) is launching a Population Heath Learning Network (PHLN). The PHLN aims to improve the health and wellbeing of more than 750,000 Californians by bringing together safety net primary care organizations to strengthen and advance their population health management strategies.

There is ample evidence supporting the implementation of population health management approaches in primary care. A strong focus on population health management allows organizations to:

- Target the right resources to the patients who need it most.
- Provide better access to care through alternative encounters, such as phone visits.
- Improve the patient's experience of care.
- Achieve better health outcomes by closing gaps in care.
- Boost workplace satisfaction by optimizing team-based care and ensuring all staff can work to the top of their skill and license.
- Reduce emergency department utilization and hospital readmissions through coordinated care.
- Stabilize or reduce health care costs.

Up to 30 organizations in California will be selected to participate in this two-year network focused on learning, sharing best practices, and taking action to advance population health.

Over the two-years in the network, organizations will commit to attending three in-person convenings and also select from a robust array of technical assistance and support depending on their needs in managing population health. This can include consultations from experts, capability-building trainings and webinars, site visits to peers and exemplars, and 1:1 customized coaching on core content areas listed below. Travel grants between $4,000 and $8,000 will also be provided to all participants to offset costs to attend in-person convenings and site visits.

In year two, participating organizations can apply for grants of up to $30,000 to support deeper implementation of one or more population health management strategies tested in year one. Grants will be made through a competitive application process.

Network Structure & Core Content

Organizations interested in participating in the PHLN must be able to demonstrate an aptitude and commitment for advancing their population health management strategies and tactics. Participants will be expected to enter the network with the following core capabilities in place:

- A team-based model of care implemented in most sites;
- Empanelment processes with most patients empaneled to a clinician or care team;
- Data infrastructure that includes processes around data governance, validation, and data reporting to facilitate clinical decision making at the point of care; and
- A strong quality improvement culture where changes are tested, measured, and evaluated for implementation or spread.

The network provides an opportunity to enhance existing capabilities and to develop new capabilities (e.g., more sophisticated data reporting skills) through peer sharing and learning from exemplars within and outside of California.

Organizations must be committed to networking with peers and will be expected to proactively share strategies, challenges, and best practices with one another. While customized technical assistance and coaching will be available, the emphasis of this network will be sharing and spreading ideas and best practices among peers — not didactic teaching from experts. Lastly, organizations should enter the network with a clear commitment to spread what they learn internally (from one site to another) and to participate in project-end activities intended to share lessons beyond the network.

Required activities are three, 1.5 daylong in-person convenings to enable peer sharing and learning from healthcare and non-healthcare faculty. Participants will be able to access supplemental support through webinars, site visits, expert consultants, and coaching based on their specific needs, capabilities, and goals. Learning, sharing, and technical assistance will be focused on the PHLN's core content:

1. **Leadership and Change Management:** Understanding adaptive and technical challenges. Communicating around large change initiatives. Clarifying leadership roles and how leaders work together to provide integrated care.
2. **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 across organization.
3. **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.
4. **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.
5. **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.
6. **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.
7. **Social Needs:** Screening and prioritizing nonmedical needs. Building internal systems, referral processes, and effective partnerships with community organizations to respond to identified needs.

Additional capability-building workshops and webinars will be offered in year one. Participants will be able to opt out of these workshops and webinars if they participated in the CP3 Population Health Comprehensive Track Program, a comparable CCI program, and/or demonstrate high aptitude when applying to the network. Topics include:

- **Quality Improvement and Human-Centered Design:** Setting aims and measures. Using PDSA cycles. Identifying changes through innovation and user-centered design approaches. Change management.
- **Leveraging Data as an Asset:** Data governance, stewardship, and using data to drive clinical and operational decisions.
- **Team-Based Care with Behavioral Health Integration 1.0:** Understanding the spectrum of behavioral health integration, components of integrated care, and populations served. Building the team, including roles and relationships, practice space, communication, screening, warm handoff, and treatment plan.
- **Access and Panel Management:** Using data regularly to manage supply and demand, panel size, risk adjusting panels, access to care, using alternative visits.

In year two, we'll offer grants of up to $30,000 to support specific project ideas that focus on deeper implementation of one or more population health strategies. Example project ideas could include experimenting with health plans to offer coordinated care transition plans, developing complex care management programs for high risk patients, and building relationships with community partners to facilitate streamlined referrals to address social needs. Organizations will be eligible to apply for and receive more than one grant award.

In early 2019, organizations will submit a specific project — including goals, draft metrics, and planned activities — to be considered for the grant. Each project will be evaluated and participants should expect to provide additional data to support this evaluation. Qualifying organizations will be those that successfully participated in year one of the PHLN by attending convenings, participating in evaluation activities, and facilitating a peer connection through a site visit or webinar.

INSTRUCTIONS

Who Is Eligible?

California-based safety net healthcare organizations that provide comprehensive primary care services to underserved populations are eligible to apply. Organizations must be nonprofit and tax-exempt under 501(c)(3) of the Internal Revenue Service Code (IRC) or a governmental, tribal, or public entity. This includes:

- Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes
- Community clinics, rural health clinics, and free clinics
- Ambulatory care clinics owned and operated by public hospitals
- Indian Health Services Clinics

Regional clinic consortia and statewide clinic associations are not eligible to apply.

What Makes a Strong Applicant

CCI is interested in attracting organizations that will succeed in the network, meaning that they have a readiness for change and the infrastructure in place to make it happen. We are counting on applicants to honestly access their capabilities, strengths, and weaknesses when applying. This is not a basic or entry level network, but an opportunity to expand and elevate population health activities already underway.

Preference will be given based on the following desired criteria, though organizations do not need to meet all of these benchmarks to apply:

- Serve at least 10,000 unduplicated patients per year.
- Established and defined care teams.
- An electronic health record that has been in practice for at least one year.
- Most patients empaneled to clinicians and/or care teams.
- Some data infrastructure in place. For example, data governance is established and data validation processes are in place for at least three clinical measures.
- Financial organizational stability to allow teams in the network the time and resources to test and make care delivery changes, with or without payment mechanisms in place.
- Health information technology capacity. For example, use of a population health reporting tool.
- Actively working on care delivery transformation efforts in at least four PHLN core content areas.

Our Expectations

This network is intended to be flexible and responsive to the needs of participants, so we ask each organization to act as a partner in shaping the network by committing to the following:

1. **Engaged Leadership:** Successful organizations will require leadership that is committed to engaging in care delivery changes to support high-quality health care.

2. **Continuity & Dedicated Team:** At least three individuals are required to be committed to the learning network to promote continuity, with a maximum of five members per organization participating in core network activities (e.g., in-person convenings and evaluation interviews). The team should include:

    - At least one senior leader with decision making authority and who is responsible for communicating information up and down the organization; and
    - Two management level staff that have a significant role in your organization's population health management efforts and may manage care teams responsible for executing population health activities.

Other organization staff will be able to participate in other network offerings, such as workshops and webinars as desired.

3. **Participation in Network Activities & Dedication to Sharing:** Team members are expected to fully participate in network activities, and share lessons learned by presenting examples of project successes and challenges at learning sessions and in other opportunities.

4. **Evaluation:** Teams are expected to provide feedback to CCI and network evaluators to refine and improve the network content and delivery methods through activities like quarterly surveys, phone interviews, and onsite visits. Participants will also be asked to complete an assessment at the beginning and end of their time in the network. Year two grantees are expected to work closely with an external evaluator to identify metrics, collect data, and share stories about impact of the work.

5. **Organize and Facilitate Peer Connections:** Teams are expected to participate on at least two in-person visits to peer organizations in the PHLN or exemplar organizations located in California or elsewhere in the US. Teams are also expected to a host an organization to visit their site or facilitate a virtual peer exchange with at least one other organization in the PHLN to exchange best practices and challenges on specific topics.

6. **Desire to be Care Delivery Transformation Leader:** Teams in the network should be excited to take a lead in building cultures of care delivery transformation in their organizations, want to share and learn from peers about challenges and best practices, and strive toward being a "bright spot" in California around this work.

How to Apply

STEP 1: ATTEND INFORMATIONAL WEBINAR (OPTIONAL)

Interested organizations are encouraged to participate in an informational on Friday, January 19, 2018 from 12 to 1:30 pm to hear a detailed description of the network and ask questions. Please register here.

STEP 2: APPLY ONLINE

Your application must be submitted online by **5:00 pm on Friday, February 9, 2018.**

Applications should include the following:

1. Application Submission Form
2. Response to Application Questions
3. Tax Status Documentation

4. Letter of Leadership Support

Application Questions

Please limit responses to a maximum of five pages, using at least 11-point font and 1-inch margins.

1. What are your organization's key motivations for participating in the PHLN?

2. Have you completed an assessment of your organization's capabilities, strengths, and improvement areas in delivering primary care? Examples of evaluations include CPCA's Alternative Payment Methodology (APM) readiness assessment, Improving Primary Care (LEAP) Assessment, and the 10 Building Blocks of Primary Care Assessment (BBPCA). Please share in which areas/domains your performance was strongest and which areas demonstrate your biggest opportunities for improvement.

3. What are your top three priorities related to population health management?

4. How does advancing your organization's population health management capabilities align with your organization's strategic plan?

5. What are the unique contributions your organization could make to the PHLN?

6. Describe two successes or lessons learned that you could share with others in the network.

7. What technical assistance and support would be most helpful to push your population health activities forward?

8. Organizations must appoint a "Core Network Team" to participate in the PHLN. At least three individuals should be committed to the learning network to promote continuity, with a maximum of five members per organization. Who will you include on your team? Please list the name, title, and project responsibilities of each member of this core team.

Next Steps

CCI and our network partners will review proposals. Between February 9 and March 16, follow-up emails or calls may be used to clarify application questions or gather additional information.

Our intent is to select an engaged group of organizations that have strong leadership commitment, experience implementing care delivery transformation changes in their organizations, and are willing to teach and learn from their peers. The selection

process will seek to achieve geographic diversity of participants across the state of California.

Acceptance into the PHLN will be announced via email on **Friday, March 16, 2018**.