WELCOME

GREETINGS
HI
HELLO
HOWDY
GLAD YOU'RE HERE
Introduction!

Grassroots volunteer & lay health worker model of care

Care navigation & peer emotional and practical support

Bringing enabling & clinical services into the community
Learning Objectives

Understand the **goals and expectations** of the ROOTS program and learning community.

**Understand your colleagues’ project** goals and key components, challenges, and questions, and where you may be able to learn from them.

Receive **feedback** from your peers and faculty about your own project.

**Clarify and validate** how your data and end-user input led you to your proposed project and the population you will be working with.

**Co-design** with CCI staff the content and support you need to succeed in the ROOTS program.
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00am</td>
<td>Breakfast &amp; Registration</td>
</tr>
<tr>
<td>9:30am</td>
<td>Welcome, Overview, &amp; Intros</td>
</tr>
<tr>
<td>10:10am</td>
<td>Leading Change: One Clinic’s Work to Address SDOH</td>
</tr>
<tr>
<td>11:00am</td>
<td>ROOTS Team Projects Share &amp; Learn, Part 1</td>
</tr>
<tr>
<td>12:45pm</td>
<td>ROOTS Team Project Share &amp; Learn, Part 2</td>
</tr>
<tr>
<td>1:30pm</td>
<td>Role of Data to Address SDOH</td>
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<tr>
<td>2:45pm</td>
<td>Team Time</td>
</tr>
<tr>
<td>3:35pm</td>
<td>Help Us Co-Design the ROOTS Program!</td>
</tr>
<tr>
<td>4:15pm</td>
<td>Wrap Up, Evaluation, &amp; Closing</td>
</tr>
</tbody>
</table>

4:15 – 4:30pm: Wrap Up, Evaluation, & Closing
What We Heard

Strategies for implementation
Data
Innovative ideas
Collaboration with other teams
Best practices
Program expectations
Methods to evaluate success
Coaching
Inspiration
Cultivating a sense of community
Ways to help and support our communities
“An understanding of how best to use these resources to expand our services to the whole person.”

“I hope to hear what others are doing and have done in this space and gain some tips and tools for moving forward in engaging community partners in meaningful ways.”

“I do not know much about the grant yet but I am excited to learn as much as I can!”
Housekeeping
Welcome, Overview of the Day, and Introductions
Mount Bayou Clinic offered

- **Medicine**: medical, pharma, home-based care
- **Nutrition**: farm co-op, food delivery system
- **Built Environment**: clean water, plumbing, housing
- **Education**: GED opportunities
- **Transportation**: school bus company
Funding Changed Focus

- Johnson signs Economic Opportunity Act
- First grant for NHC
- Authority transferred out of OEO
- Services are divided between primary and secondary
- Services limited to people below FPL
- >50 centers
- >100 centers

*Courtesy of Lauren Taylor*
In partnership with Blue Shield of California Foundation, CCI will support 7 organizations in California over 12 months through an innovation collaborative focused on the role of clinics in addressing the social determinants of health.
Key Objectives

- Support and build capacity of clinics to use patients & community-level SDOH data
- Identify sustainable ways to build partnerships to improve health
- Clarify the role of clinics in addressing SDOH and how to integrate these roles into the fabric of the organization
- Identify and develop resources, tools, and lessons to share with the larger safety net health care community
What Makes this Program Different?

This is an innovation collaborative.

We don’t have a single change package.
Co-Design with You

We don’t want to push irrelevant content or expertise

We want you to help design this program

Tell us what you need

Be honest about what does NOT work
A Word from Rishi

Dr. Rishi Manchanda

- Serves as Advisor & Key Thought Partners throughout the program
- Serves as faculty to help cohort navigate specific SDOH related topics
Phases, Milestones & Deliverables
# Program Timeline

<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
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<tbody>
<tr>
<td>Sept</td>
<td>Onsite #1: Oct 5</td>
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<tr>
<td>Oct</td>
<td>Onsite #2: March 8</td>
</tr>
<tr>
<td>Nov</td>
<td>Onsite #3: Aug 9</td>
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<td>Sept</td>
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## Monthly Coaching Calls

- Kickoff Webinar #1: Sept 14
- Content Webinar #2: Dec 7
- Content Webinar #3: April 5
- Content Webinar #4: June 7

## Site visits

- Idea Sharing Webinar #1: Nov 16
- Idea Sharing Webinar #2: Feb 1
- Idea Sharing Webinar #3: May 3
- Idea Sharing Webinar #4: Jul 12
# Program Curriculum Phases

<table>
<thead>
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<th>PHASE</th>
<th>TIMEFRAME</th>
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<tbody>
<tr>
<td>Phase 1: Data &amp; Inquiry</td>
<td>09/17 - 12/17</td>
</tr>
<tr>
<td>Phase 2: Development, Management, and Co-Design</td>
<td>01/18-04/18</td>
</tr>
<tr>
<td>Phase 3: Developing Next Steps for Action</td>
<td>05/18-08/18</td>
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Applied Project
Program Expectations & Metrics

Participate in Overall ROOTS Evaluation

- As examples of successful models and changes through case studies
- Interviews with evaluators
- Willingness to participate and share lessons learned beyond program

Project Metrics

- Work with the SIREN team to develop project specific metrics
Milestones & Deliverables

**Milestone Set 1** - Team Build, Data Review, Formalize Project Target Population and Target Need, Consider Potential Staff and Community Partners

- **Finalize Project Charter: November 2017**

**Milestone Set 2** - Design Project Workflow and Marketing, Initiate Metrics, Start Project Operations

- **Develop partner agreements: April 2018**

**Milestone Set 3** - Analyze Progress, Redesign, Formalize Sustainable Operations

- **Participate in sharing lessons learned, August-October 2018**

Are these the right milestones?
Evaluation & Coaching
Goal: Ensure learnings from the program are identified and recorded:

1. Did participation in the program improve your clinics’ capacity and commitment to addressing patients’ SDOH?
2. What projects were most successful and why?
3. What challenges did you face in implementing your projects and how did you address them?
4. What ROOTS program activities were most helpful?
5. Did participation in this program improve your patients’ SDOH and/or health outcomes?
Evaluation

- Baseline project lead interviews: Oct-Nov 2017
- Baseline provider *(and patient)* surveys: Nov-Dec 2017
- Mid course in-person interviews: Feb-Apr 2018
- Follow-up provider *(and patient)* surveys: Sep-Oct 2018
- Follow-up project lead interviews: Sep-Oct 2018
- Collection of site-specific process and outcome metrics: Sept-Oct 2018
- Throughout: *Surveys to gauge satisfaction with program sessions, and one-on-one evaluation TA.*
Program Components: Coaching

- Helps with **troubleshooting** and assists teams in advancing project
- Monitors your **experience** of the program
- Conducts **monthly team meetings**
- Hosts “**Ideas in Action**” Webinars
- Connects you with **additional resources** and informs CCI of additional needs
Introductions:

Get to know your fellow ROOTS participants!
Mad Tea Party
1. Introduce yourself to the person facing you.
2. Answer the question on the screen.
3. Then your partner does the same.
4. When you hear the CHIME the person in the right lane rotates to the right.
5. You have a total of 1 minute for *both of you!*
What is your favorite movie (or at least one you liked)? Why?
Why is addressing social determinants of health important to you?
What animal best describes you?
What do you do to self-care?
Why is collaboration so damn hard?
What is the most far off place you’ve lived?
Why did you get into health care?
What is one thing you love about working where you do?
Where is your favorite vacation spot (and why)?
Why will today be great?
Leading Change: One Clinic’s Work to Use Data to Address SDOH
Roots Mission

The mission of Roots Community Health Center is to eliminate Oakland’s health disparities by:

• Providing **culturally responsive**, comprehensive healthcare, behavioral health, and wraparound services

• Identifying and addressing root causes of illness and suffering

• Emphasizing **self-sufficiency** and **community empowerment**
History

• 501(c)3 organization founded in 2008 to address wide disparities in health outcomes for East Oakland residents with a particular focus on those of African descent.

• Began as a volunteer, mobile operation, targeting those with high barriers to access: men in transitional housing, drug rehabilitation and at-risk fathers.

• Developed as a model in the areas of quality, accessibility, community/cultural responsivity, efficiency and physician leadership.

• Moved into our East Oakland location in 2011 and became a licensed community clinic in 2013
Roots’ Model: Whole Health

- Integrated
- Empowerment
- Navigation
- Care

Whole Health

Ongoing
CARE is at the center

ROOTS community health center
CARE

- Prioritizes those with the greatest needs
- Focuses on transitions
- Meets people where they’re at

Physical Health Care
Behavioral Health Care
Street Medicine
Housing
Immigration (I693)
CARE

We are seeing first-hand the impacts of multi-generational poverty, trauma, racism and stress
  - Prioritizing those most impacted, while
  - Identifying & addressing root causes

Goals:
  - Move individuals from Crisis ➔ Stability ➔ Prosperity
  - Identify, test and scale upstream interventions for improved community health
NAVIGATION  building agency

Hiring from the Community
- Support from those with shared lived experience

The right tools to achieve goals
- Assessing and Addressing Barriers / Social Determinants of Health

Exercising the right to
- access benefits
- receive appropriate services
NAVIGATION

- Life Assessment & Plan
- Barrier Removal
- Benefits Enrollment
- Education & Training
- Career & Job Readiness
- Homeless Services
- Reentry Services
Reentry Navigation  A Continuum of Care

Healthy Measures
Focus on chronically ill inmates, pre- & post-release

• Curriculum in 7 state prisons
• Full-time Navigator in Santa Rita Jail
• Lived experience reentry Navigators trained as CHWs link chronically ill reentry individuals to care
EMPOWERMENT
Empowerment is the foundation
Individuals – Families – Organizations – Businesses - Community

Advocacy
Research & Evaluation
Leadership Development
Base Building/Coalition Building

Economic Empowerment
Workforce Development
Pipeline Programs
Social Enterprise
Fiscal Sponsorship/Business Incubation
Consolidations (mergers & acquisitions)
Research and Evaluation

• Establishes and builds our expertise
• Provides a powerful advocacy platform
• Improves public accountability
ADVOCACY

Increasing our Impact

Our motivation:
Accomplishing our mission requires broad policy and systems change.

Our Assets:
- Content expertise → Experience, Research, Evaluation
- Credibility with the community and policymakers alike
- A growing base of clients/patients who access us regularly
Information to Action  *Example*

- We identified the greatest barrier to good health for our community: *poverty itself*

- Barriers to employment: Low educational attainment, limited work experience/training, criminal background, limited soft skills, high unemployment rate/down economy

- *Solution:*
  - Education & training that meets the needs of community members and employers alike
  - Self-sustaining enterprise to create ongoing training opportunities and increasing permanent positions
Information to Action

• “Repeat utilizers” of General Assistance are overwhelmingly African American (73% compared to 60% of total GA).
• Largest group of repeat utilizers was African American men (50% compared to 36% of total GA)
• # of New GA recipients follows unemployment rate
• # repeat utilizers stays stable despite unemployment rate
• Many repeat utilizers have criminal background as a barrier to employment
Information to Action  *Social Enterprise*

Creating opportunity for those who have been disconnected from the workforce

*Emancipators Initiative*
- On-the-job training
- Whole health support
- Work experience at Clean360

*Clean360*
- Roots’ soap making social enterprise
- Generating unrestricted revenue
- Developing employer partnerships
- Advocating for responsible procurement
Information to Action **OUR Project**  
*Leadership Development, Advocacy, Systems Change and Evaluation*

- 6 month Leader Fellowship for 15 Formerly Incarcerated individuals
- facilitated by lived experience Roots staff
- Resulting Toolkit includes key considerations/recommendations, co-created by Roots and Fellows, including: organizational self-assessment of readiness to launch a reentry engagement process and development of a reentry engagement plan/process

This ground work formed the basis for our state & local advocacy efforts  
➢ (e.g., SNAP E&T, 1400 Jobs, public procurement)
Key Lessons

• Assume nothing!
  ➢ Listen to what the data is telling you...and take it further

• Those closest to the problem are closest to the solution
  ➢ Invest in the experts: those with shared lived experience to those you want to reach

• Everyone doesn’t have to do everything
  ➢ Assess your org honestly and prepare to partner

• Accept that this work typically requires broader community change
  ➢ Assess your willingness and define your strategy to engage in policy & systems change
Visit us online at rootsclinic.org

Main Clinic & Headquarters
9925 International Blvd., # 5
Oakland, CA 94603
510-777-1177

Roots South Bay
1898 The Alameda
San Jose, CA 95126
408-490-4710

Pediatrics Clinic
2700 International Blvd., #11
Oakland, CA 94601
510-533-1246

Social Enterprise – Clean 360
212 E. Regent Street
Inglewood, CA 90301
510-431-3606

Social Enterprise – Clean 360
4107 Broadway
Oakland, CA 94611
510-451-0570

Follow us on Social Media
@RootsEmpowers
Break & Stretch! (15 minutes)
ROOTS Team Projects Sharing & Learning, Part 1
Presentation

Create a 5-7 minute presentation, making sure to address the following questions:

What are you **most passionate about** related to the ROOTS program or your teams’ project?

Describe your **project’s key components**, including: *What are the goals? What social determinant or social need are you focused on? Who is your target population and why did you select this population? What key partners do you plan to engage?*

What do you need **to succeed** with your project?

What is one **obstacle** you anticipate encountering?

What is one **question** you have for your peers or faculty?
ROOTS Cohort

1. Asian Health Services
2. LAC+USC Medical Center, Primary Care Adult Clinics
3. LifeLong Medical Care
4. Northeast Valley Health Corporation
5. Petaluma Health Center Inc.
6. St. John’s Well Child and Family Center
7. West County Health Centers
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Lunch (45 minutes)
ROOTS Team Projects Sharing & Learning, Part 2
### Presentation

Create a 5-7 minute presentation, making sure to address the following questions:

<table>
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<th>Answer</th>
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Social Determinants of Health

WHERE TO FIND DATA, WHAT TO USE IT FOR, AND HOW
Loretta Khangura, MPH, BSN, RN, CHTS-CP, VP Practice Transformation

With the unofficial title of “Data Poet,” Loretta has been a nurse for 30 years. With an MPH from Johns Hopkins University in 2013, she has decades of experience in Public Health, Primary Care and Healthcare Analytics. She has worked in governmental public health, home health, hospitals, and the population healthcare IT industry. She has been a Perinatal Program Manager, QI Director, and Director of Population Health in FQHCs. Loretta works with clinical organizations and providers across the country to provide business intelligence to improve clinical processes and outcomes. Loretta’s passion is playing with data to tell stories and solve every-day problems to improve health.
Objectives

➢ Identify data that informs the most pressing issues in SDoH in your area.
➢ Discuss strategies for data-informed prioritization of SDoH interventions.
➢ Share strategies for integrating your data sets with external data sets to:
  ☐ Inform interventions
  ☐ Identify external partners
  ☐ Define intervention success metrics
Be thinking about…

What data do we have to understand our population and their SDoH needs?

What data do we need to track project progress and anticipated impacts.
What data did you use?

❖ What sources of data did you use to help you determine what your project would look like?

❖ What worked well? What kind of data did you wish you had access to?
Who has data of interest?

❖ Health Departments
❖ Cities
❖ Counties
❖ EHR
❖ HRSA/UDS
❖ Foundations
Health Department Publications and Reports

❖ Alameda
➢ http://ac-hcsa.maps.arcgis.com/apps/MapSeries/index.html?appid=c7eac040d44e47939d94bbad80ab630e

❖ Los Angeles
➢ http://publichealth.lacounty.gov/yrhealth.htm

❖ Sonoma

Interactive Map of Persistent Poverty
Law Enforcement

- [https://communitycrimemap.com/](https://communitycrimemap.com/)
- [https://www.neighborhoodscout.com/](https://www.neighborhoodscout.com/) Income, house cost, crime and more
- [https://www.crimereports.com/](https://www.crimereports.com/)
- [https://www.crimemapping.com/home](https://www.crimemapping.com/home)
Food Security

- **Interactive, by county** – [http://map.feedingamerica.org](http://map.feedingamerica.org)
Built Environment and Transportation


- Partners for Livable Communities [http://livable.org/](http://livable.org/) Great resources
  - [http://livable.org/storage/documents/reports/AIP/City_Leaders_Institute_scorecard_only.pdf](http://livable.org/storage/documents/reports/AIP/City_Leaders_Institute_scorecard_only.pdf)
  - City Leaders Institute on AGING IN PLACE. Template for community scorecard.

- Interactive bike route mapper [http://www.calbike.org/maps_routes](http://www.calbike.org/maps_routes)


- Where can you get with public transportation? [https://www.mapnificent.net/](https://www.mapnificent.net/)
Housing

❖ Housing Affordability vs Income
   https://www.huduser.gov/portal/maps.html

❖ LI rental housing
   http://apps.urban.org/features/rental-housing-crisis-map/

❖ Urban Institute – Multiple data visualizations
   https://www.urban.org/data-viz

❖ U Iowa affordability
   http://ppc.uiowa.edu/housing/affordability
Block Group Data Outlines
https://www.huduser.gov/portal/maps/cn/home.html

The mapping tool is populated by a large amount of data. After clicking these polygon guides, please wait for data to load before clicking on additional buttons. Also, after clicking "DRAW" you have to re-enable the optional layers if you need them as a guide to draw your shape.
Census Tract Data Outlines

https://www.huduser.gov/portal/maps/cn/home.html
Government

- https://www.udsmapper.org/
- https://datawarehouse.hrsa.gov/Tools/MapTool.aspx Interactive map of HRSA data
- https://dnav.cms.gov/
- https://wonder.cdc.gov/ look for data “atlas” for maps
  - Has a “Run Hotspot Analysis” button.
- http://www.countyhealthrankings.org/ Has good SDoH data, but only by county. Great interactivity.
  Data downloads that you can integrate into your own models.
- BRFSS data files that can be used in your own GPS maps
  - https://www.cdc.gov/brfss/gis/gis_maps.htm
- CDC Drug overdose death rates
  - https://www.cdc.gov/drugoverdose/data/statdeaths.html
fun links

- https://www.census.gov/popclock/
- http://www.worldometers.info/
- http://www.worldlifeexpectancy.com
- http://www.cityhealthdashboard.com/ (Limited, but will expand to cities with populations >70,000 in 2018)
- http://www.jchs.harvard.edu/research/interactive-maps
  interactive housing studies maps
Prioritizing SDoH Focus

Quantitative

Objective

Generalisable

Numbers

Qualitative

Subjective

Not Generalisable

Words
Considerations

QUANTITATIVE
❖ Internal Population Data
❖ Community Data
❖ Available Resources

QUALITATIVE
❖ Care Team Passion
❖ Patient Feedback/ Stories
❖ Existing Partnerships
❖ Organizational Alignment
Bringing power to the table

❖ Are you geo-mapping?
❖ Be part of the conversation
❖ Bring the power of your data to the table
❖ Show others how the issues your clients face fit into the broader picture
❖ Influence local policy decisions
Define and Measure Success

❖ How do you define success?
❖ What data do you need to measure that?
Additional Resources/References

❖ Accountable Health Communities Model
   https://innovation.cms.gov/initiatives/ahcm

❖ Comparing unemployment with population change
   https://www.arcgis.com/apps/MapSeries/index.html?appid=6aab740eb5f146d0bbc073185aa726cb


❖ Poverty and student absenteeism
   https://www.arcgis.com/apps/MapSeries/index.html?appid=7f567623f36744dda5ad339aba32aca2
   The data notes here give some good examples of how to document what you are using and how it is presented.
A sample

- http://baltimore.maps.arcgis.com/apps/MapSeries/index.html?appid=7c85a6d5b958496d863e738234373934

- Aging population for Maine http://harvard-cga.maps.arcgis.com/apps/StorytellingSwipe/index.html?appid=06c855a8779c41b5aed56b3329ad86c7#
Break & Stretch! (15 minutes)
Team Time: What are you learning & What are your next steps?
Team Time

1. Teams will have time to work on the worksheet.
2. Session faculty will be available to consult on a 1:1 basis and discuss individual team needs.
3. Each team will have 1 minute to report out next steps.
# Project Team Planning Worksheet

<table>
<thead>
<tr>
<th>Applied Project Title</th>
<th>Goal</th>
<th>Anticipated Impacts</th>
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**Organization Name: ___________________________**

**Next Steps**

**Challenges to Overcome**

### The Team
- Who should be the core team (Team Leader, Clinical Lead, Admin Lead)?
- Who are the best champions (Providers, Staff, C-suite, Board)?

### The Data
- What data do we have to understand our population and their SDOH needs?
- What data do we need to track project progress and anticipated impacts?

### The Need
- How do we determine the target population and SDOH need that that best fits this applied project?
- How are we leveraging data and conversations with our community and patients?

### The Partner
- Who might be a community partner?
- How do we pick the partner?
- Does the partnership need to be formalized to work? How?
Help us Co-Design the ROOTS Program!
How Might We?

• **How Might We** best support you in developing internal systems, workflows, and mindsets to address SDOH?

• **How Might We** best support you to succeed in your project?

• **How Might We** best support you in Learning from your peers and others in the field?

1. Brainstorm as many ideas as possible, write on sticky notes
2. Compare with a partner and add any additional ideas
3. Post stickies on the wall
Evaluations & Closing
## Program Timeline

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<td><strong>Onsite #2:</strong> March 8</td>
<td><strong>Onsite #3:</strong> Aug 9</td>
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<td><strong>Monthly Coaching Calls</strong></td>
<td><strong>Site visits</strong></td>
<td><strong>Kickoff Webinar #1:</strong> Sept 14</td>
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<td><strong>Content Webinar #2:</strong> Dec 7</td>
<td><strong>Content Webinar #3:</strong> April 5</td>
<td><strong>Content Webinar #4:</strong> June 7</td>
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<td><strong>Idea Sharing Webinar #1:</strong> Nov 16</td>
<td><strong>Idea Sharing Webinar #2:</strong> Feb 1</td>
<td><strong>Idea Sharing Webinar #3:</strong> May 3</td>
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<td><strong>Idea Sharing Webinar #4:</strong> Jul 12</td>
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What’s Next?

Idea Sharing Webinar
Nov. 16, 2017 @12pm

ROOTS Program Newsletters

Content Webinar
Dec. 7, 2017 @12pm

Site Visits
Stay tuned for information!
To-Do’s

CCI

- Email an Excel spreadsheet with team contact information
- Post the slides on CCI website & send follow up newsletter

ROOTS Teams

- Meet with coach
- Project lead meet with evaluation team
- Complete Project Charter (by November 17)
- Participate in 11/16 Idea Sharing Webinar
- Participate in 12/7 Content Webinar
Future TA Requests

4. Technical Assistance
Help us help you learn! If you come across faculty or technical assistance providers that you think would be beneficial to your project and/or our ROOTS cohort, let us know! Please click the link below to submit a request to CCI if you have any specific technical assistance support needs.
Q & A
Thank you!

For questions contact:

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