blue of california foundation

California Health Care Foundation

# Population Health Learning Network

November 5, 2018

## Site Visits Reflection Webinar

# Our Core Program Team

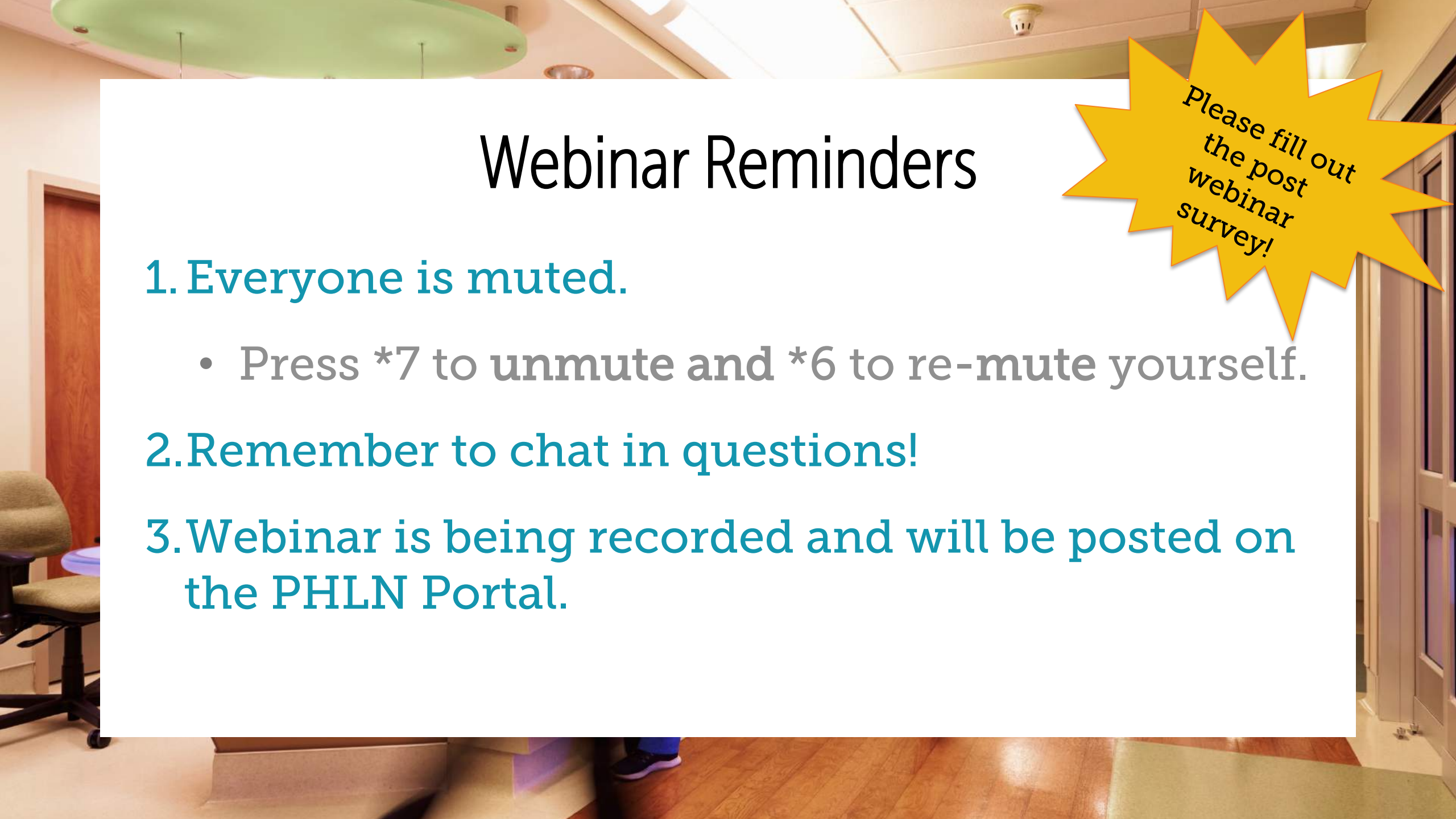
**Megan O'Brien,**
Program Manager, CCI

**Tammy Fisher,**
Senior Director, CCI

**Diana Nguyen,**
Program Coordinator, CCI

**Dr. Carolyn Shepherd,**
Clinical Director

**Meaghan Copeland,**
Program Consultant



# Webinar Reminders

Please fill out the post webinar survey!

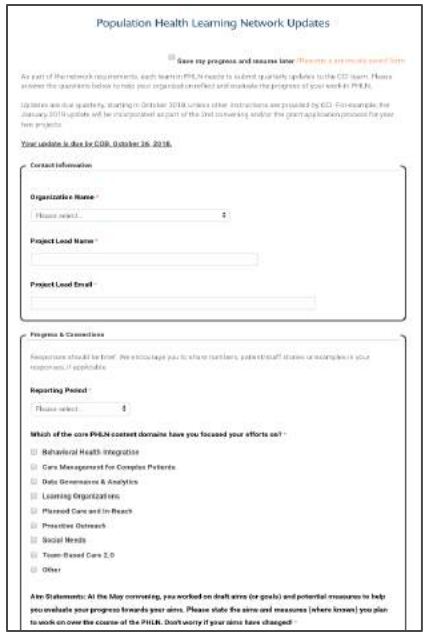
1. Everyone is muted.
   - Press *7 to **unmute and** *6 to re-**mute** yourself.
2. Remember to chat in questions!
3. Webinar is being recorded and will be posted on the PHLN Portal.

# Webinar Agenda

1. Welcome & Housekeeping
2. Where Are We On The PHLN Journey? *Moving beyond sparking ideas.*
3. 6 Team Presentations
   - LA County Dept. of Health Services
   - CommuniCare Health Centers
   - Open Door Community Health Centers
   - Tri-City Health Center
   - Neighborhood Health
   - Venice Family Clinic
4. Open Discussion, Q & A
5. Wrap Up, Next Steps & Evaluation

# THANK YOU!

## Progress Report #1


Population Health Learning Network Updates

Save my progress and resume later

Contact Information

Organization Name *

Please select...

Project Lead Name *

Project Lead Email *

Progress & Connections

Reporting Period *

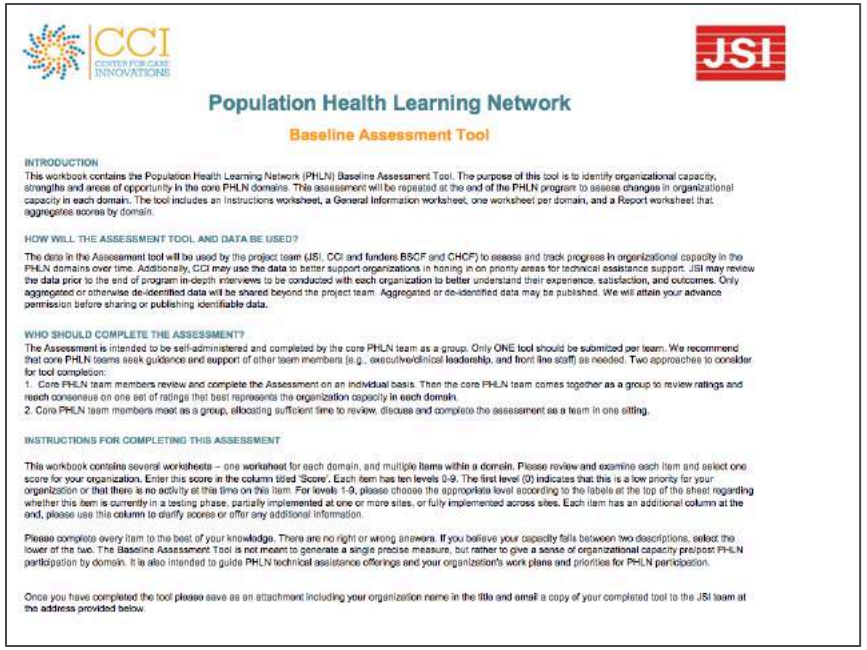
Please select...

Which of the core PHLN content domains have you focused your efforts on? *

- Behavioral Health Integration
- Care Management for Complex Patients
- Data Governance & Analytics
- Learning Organizations
- Planned Care and In-Reach
- Proactive Outreach
- Social Needs
- Team-Based Care 2.0
- Other

Aim Statements: At the May convening, you worked on draft aims (or goals) and potential measures to help you evaluate your progress towards your aims. Please state the aims and measures (where known) you plan to work on over the course of the PHLN. Don't worry if your aims have changed! *

## Baseline Assessment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JSI

Population Health Learning Network

Baseline Assessment Tool

INTRODUCTION

This workbook contains the Population Health Learning Network (PHLN) Baseline Assessment Tool. The purpose of this tool is to identify organizational capacity, strengths and areas of opportunity in the core PHLN domains. This assessment will be repeated at the end of the PHLN program to assess changes in organizational capacity in each domain. The tool includes an Instructions worksheet, a General Information worksheet, one worksheet per domain, and a Report worksheet that aggregates scores by domain.

HOW WILL THE ASSESSMENT TOOL AND DATA BE USED?

The data in the Assessment tool will be used by the project team (JSI, CCI and funders BSCF and CHCF) to assess and track progress in organizational capacity in the PHLN domains over time. Additionally, CCI may use the data to better support organizations in honing in on priority areas for technical assistance support. JSI may review the data prior to the end of program in-depth interviews to be conducted with each organization to better understand their experience, satisfaction, and outcomes. Only aggregated or otherwise de-identified data will be shared beyond the project team. Aggregated or de-identified data may be published. We will attain your advance permission before sharing or publishing identifiable data.

WHO SHOULD COMPLETE THE ASSESSMENT?

The Assessment is intended to be self-administered and completed by the core PHLN team as a group. Only ONE tool should be submitted per team. We recommend that core PHLN teams seek guidance and support of other team members (e.g., executive/clinical leadership, and front line staff) as needed. Two approaches to consider for tool completion:

1. Core PHLN team members review and complete the Assessment on an individual basis. Then the core PHLN team comes together as a group to review ratings and reach consensus on one set of ratings that best represents the organization capacity in each domain.
2. Core PHLN team members meet as a group, allocating sufficient time to review, discuss and complete the assessment as a team in one sitting.

INSTRUCTIONS FOR COMPLETING THIS ASSESSMENT

This workbook contains several worksheets – one worksheet for each domain, and multiple items within a domain. Please review and examine each item and select one score for your organization. Enter this score in the column titled 'Score'. Each item has ten levels 0-9. The first level (0) indicates that this is a low priority for your organization or that there is no activity at this time on this item. For levels 1-9, please choose the appropriate level according to the labels at the top of the sheet regarding whether this item is currently in a testing phase, partially implemented at one or more sites, or fully implemented across sites. Each item has an additional column at the end, please use this column to clarify scores or offer any additional information.

Please complete every item to the best of your knowledge. There are no right or wrong answers. If you believe your capacity falls between two descriptions, select the lower of the two. The Baseline Assessment Tool is not meant to generate a single precise measure, but rather to give a sense of organizational capacity pre/post PHLN participation by domain. It is also intended to guide PHLN technical assistance offerings and your organization's work plans and priorities for PHLN participation.

Once you have completed the tool please save as an attachment including your organization name in the title and email a copy of your completed tool to the JSI team at the address provided below.

We'll be using these data: (1) for planning the January convening and activities in 2019; (2) in the Year 2 grant opportunity.


*Spreading Innovations Patient Portal grantee*

# Our Destination

## Year 1: **Spark & Test Ideas**

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

## Year 2: **Seed & Spread Grants**

- **Implement or spread ideas in core PHLN focus areas:** identify something you want to spread, deepen, or something new to help remove a previous roadblock
- **Draft goals, measures, and changes** to help you reach your goals
- **Make the case:** why should we fund your project? How are you advancing population health management capabilities in an impactful way?

# Our Destination

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# Year 1 Activities

1. **May Convening:** Shift & Shares, Learning Labs, & More
2. **Webinars & Virtual Office Hours**: Care Team Structures, Value Based Payment Models, Using Data
3. **Leading Profound Change:** 1 Webinar & 2 In-Person Workshops
4. **6 Site Visits:** Clinica, Southcentral, Cherokee Health, Petaluma, Cambridge Health, La Clinica
5. Monthly Coaching
6. Online Forum & Program Portal

# Our Destination

## Year 1: **Spark & Test Ideas**

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- **Draft goals, measures, and changes** to help you reach your goals
- **Make the case:** why should we fund your project? How are you advancing population health management capabilities in an impactful way?

# Year Two Grant Opportunity

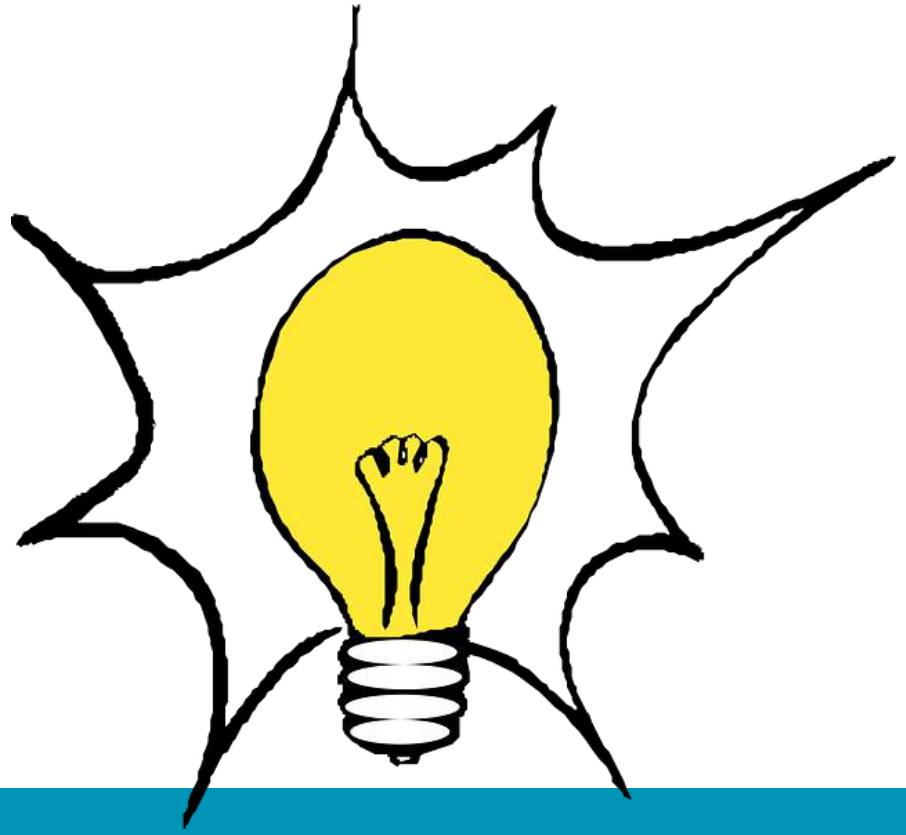
- Grants between $20,000-$30,000
- Support specific project ideas that focus on **deeper implementation** of one or more population health strategies.
  1. Build/strengthen/deepen your work; OR
  2. Approach your work differently with a fresh perspective; overcome challenges you've faced; OR
  3. Pilot or implement a new idea!
- Not fishing for new ideas! Rather, we want to make sure you are aligning and strengthening your work AND advancing your population health capabilities.
- Not competing against other PHLN members.
- This isn't a planning grant; this is an action/implementation grant.

Examples could include:

- Adding a new role to your core team
- Developing & implementing a new data report
- Developing & implementing a new outreach protocol
- Implementing group or flip visits
- Implementing a social needs screening protocol or tool
- Revising & implementing a new care management algorithm

# This grant is for YOU!

# Reflections & Ideas from the Site Visits



# Site Visit Evaluation Data

1

## Clinica Family Health

- 4 teams, 12 individuals
- Overall Experience: 4.8

2

## Southcentral Foundation

- 5 teams, 11 individuals
- Overall Experience: 4.8

3

## Cherokee Health Systems

- 5 teams, 12 individuals
- Overall Experience: 4.9

4

## Petaluma Health Center

- 6 teams, 16 individuals
- Overall Experience: 4.9

5

## Cambridge Health Alliance

- 5 teams, 12 individuals
- Overall Experience: 4.6

6

## La Clinica

- 5 teams, 12 individuals
- Overall Experience: 4.9

# What You Said

"I really appreciate learning about all different workflows to integrate Behavioral Health and Primary Care."

"This was an eye-opening and very helpful visit. Your health center [Southcentral] is inspirational!"

"Every single presentation was great. The clinic tour was very inspirational."

"Seeing the value of care teams and how it creates an environment and workforce that exudes excellence in care."


1
2
3
Defining Aims & Prioritizing the Work
Moving into Action
Ready to Start Implementing

# Site Visits


La Clinica
October 16
Petaluma
Health Center
September 26
Clinica Family
Health
September 6
Cherokee Health
Systems
September 19
Southcentral
Foundation
September 13
Cambridge
Health Alliance
October 11
New Hampshire
Vermont
Massachusetts
Rhode Island
Connecticut
New Jersey
Delaware
Maryland
Washington, D.C.
West Virginia
Oregon
Montana
North Dakota
Minnesota
Wisconsin
Michigan
New York
Pennsylvania
South Dakota
Wyoming
Iowa
Illinois
Utah
Colorado
Kansas
Missouri
California
Kentucky
Virginia
Tennessee
North Carolina
Arizona
New Mexico
Oklahoma
Arkansas
South
Carolina
Alabama
Mississippi
Georgia
Texas
Louisiana
Florida
Alaska
Hawaii

# Key Questions to Keep In Mind

What remaining questions do you have?

What's getting you stuck?

What else do you need to get moving?

# Clinica Family Health
# Site Visit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# Clinica Family Health

## Site Visit Agenda Topics:

- The Patient-Centered Journey: Team-Based Care Model
- Care System Design and Implementation
- Behavioral Health and Accountable Care
- Improved Office Efficiency: How Physical Space Supports Team-Based Care
- Improved IS Design: Data-Driven Decision-Making

**Agenda and other resources:**
https://www.careinnovations.org/phln-portal/activities/site-visits-2018/#clinica

## Site Visit: Clinica Family Health

# Los Angeles Department of Health Services

Site Visit Attendees:

- Jagruti Shukla, Director Primary Care, LAC+USC Medical Center
- David Campa, Director, Primary Care, L.A. County Dept. of Health Services
- Dennis Wong, Medical Director of Primary Care

# Key Takeaways

- Healing takes place in the context of a relationship and you need continuity to develop the relationship (reflected in the care team model)
- The structural design of a health center has tremendous impact on team interactions
- "Our model of Behavioral Health is not a couch and a fan"
- It is critically important to have access to timely, meaningful, and transparent data and reports

# Bringing Back Takeaways

- Each PHLN team member will report back to the entire team on the key learnings from the site visit at our monthly PHLN call.
- The PHLN team will then present specific recommendations to the LA DHS Primary Care Work Group (PCWG) for feedback and approval.
- The PHLN team and PCWG will develop the next step and action plan on the recommendations.

# Taking Action

Key Learning:

Group visits have benefits beyond increased efficiency/ access, such as mutually beneficial patient relationships, group dynamics, staff satisfaction, etc.

Plan:

Develop Group Visit strategy for our PCMHs

- Consider inviting Judy Troyer from Clinica to do 1-day Group Visit Training with us.

# Connecting to Our PHLN Goal(s)

Our PHLN goal(s):

1. Develop a Population Health mission statement, vision, and goals for L.A. County DHS Primary Care.
2. Optimize Population Health data, tools, and technology.
3. Include all stakeholders (with a focus on patients) in our Population Health efforts.

What we learned during the site visit will help us achieve our goals by providing concrete examples of how a Population Health program is organized, including the use of data and tools for outreach and care gap closure, and how patient-centered, comprehensive care can be accessible to the whole population.

# Southcentral Foundation Site Visit


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# Southcentral Foundation

## Site Visit Agenda Topics:

- Southcentral Foundation: Nuka System of Care Overview
- Data Services: Data Management and Data Services Dept.
- Primary Care & Integrated Care Teams: Workflows, Roles and Performance Indicators

**Agenda and other resources:**
https://www.careinnovations.org/phln-portal/activities/site-visits-2018/#southcentral

# Site Visit: Southcentral Foundation

## CommuniCare Health Centers


**Site Visit Attendees:**

- **Evan Priestley**, Director of Health Promotion and Wellness
- **Aileen Barandas**, Chief Quality Officer

# Key Takeaways

- Takeaway #1: Share the work of data prioritization and create visibility to requests, it will help highlight when more resources are needed.
- Takeaway #2: Create a sense of private practice within a large organization with well-defined teams and attention to how appointments are made.
- Takeaway #3: Commitment to workforce development showcases unique investment in professional development and depth of training for all employees.

Southcentral Foundation Site Visit

# Bringing Back Takeaways

- Formal presentation to executive leadership team.
- Presentation to Health Promotion and Wellness Department staff.
- Shared notes on shared drive.
- Shared notes and key takeaways on PHLN Forum online.

# Taking Action

One idea we are trying (or want to try out) that we walked away from the site visit with is...

Pilot Program at Salud Clinic:

- Care team structure, co-location and scheduling.
- Update to the Patient Services Representative (PSR) position to split the role
  - Role 1: front reception and phones
  - Team PSR: builds relationship with patient panel, panel management, scheduling. Physically sits in the back office with the care team.

# Connecting to Our PHLN Goal(s)

Our PHLN goal(s):

- SDOH Governance and Infrastructure
- Team-based care 2.0

What we learned about on the site visit will help us achieve our goal(s):

- Relationship is the product of the business
- Create visibility for the work being done
- Care team structure: Form follows function

# Cherokee Health Systems
# Site Visit


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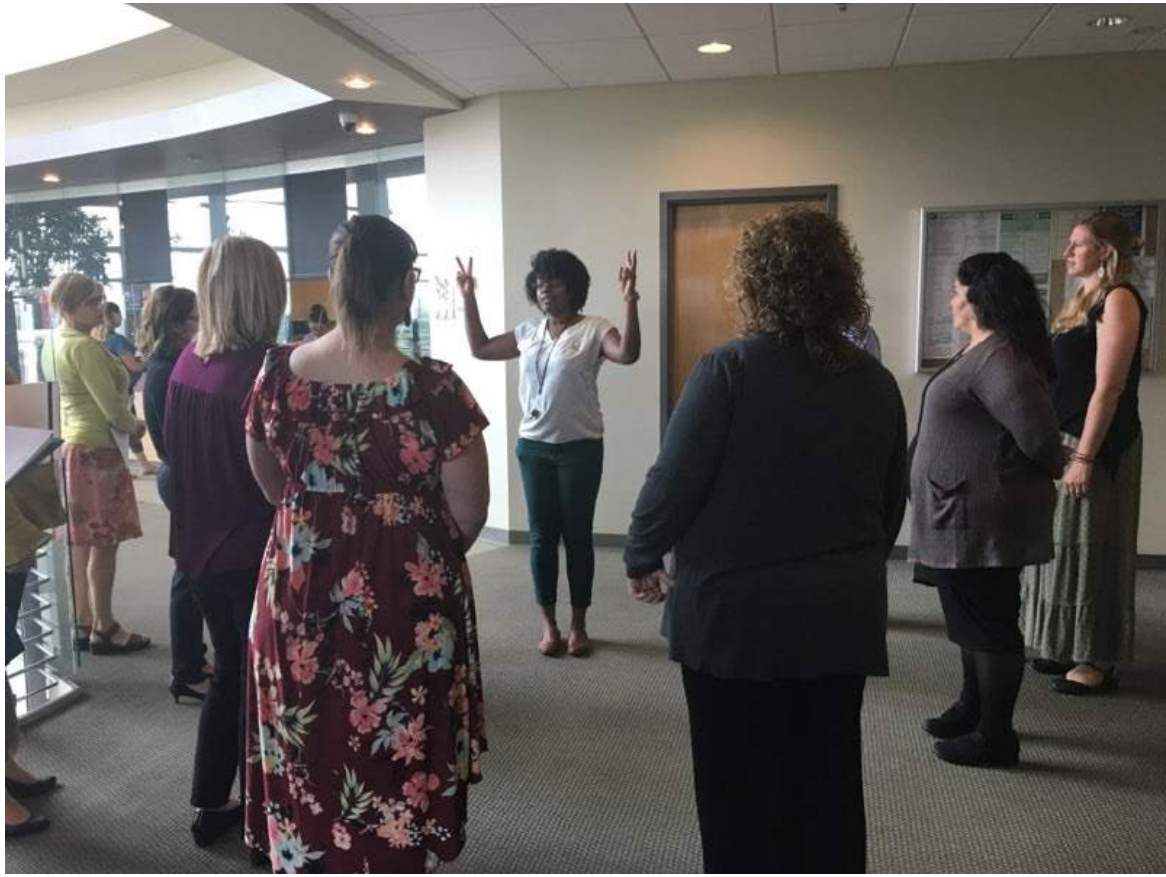
# Cherokee Health Systems

## Site Visit Agenda Topics:

- Clinical Model of Integration: Structure, Roles and Process
- Population Health Management: Assessments and Measurements
- Integrated Care of Addiction
- Population Health Management: Care Coordination
- Integration and Population Health: Leadership, Strategy and Culture



**Agenda and other resources:**
https://www.careinnovations.org/phln-portal/activities/site-visits-2018/#cherokee

# Site Visit: Cherokee Health Systems

## Open Door Community Health Centers


Site Visit Attendees:

- Linda D'Agati, Chief Quality Improvement Officer
- Holly Scaglione, Health Resources Manager
- Ramona Pantoja, Back Office Manager, Clinical Support

# Key Takeaways

- Takeaway #1: BH services are provided in an efficient, evidence-based and high-volume manner.
- Takeaway #2: BH Integration requires many BH providers with some specialization.
- Takeaway #3: BH providers develop a panel of patients/ caseload.

# Bringing Back Takeaways

How did you (or how are you planning to) share your learnings with your team and other stakeholders?

We met with a multidisciplinary group including FP physicians, psychiatry, BH clinicians, case managers, an AOD counselor and administrative staff during which we assessed the current status of our BH and CM services. Then we discussed many of the CHS visit takeaways. The group's response to those learnings will be summarized and used to help decide which ideas we should test now or consider for in the future.

# Taking Action

One idea we are trying (or want to try out) that we walked away from the site visit with is...

Develop an educational curriculum about BH and CM services to share with new and established providers/ employees. The process of doing this will force us to clearly describe our BH program and the result, we hope, will be reduce confusion, improve efficiency and reduce inappropriate duplication of services.

# Connecting to Our PHLN Goal(s)

## Our PHLN goal(s):

BH staff will use evidence-based practices and work to their highest level of licensure/scope.

## What we learned about on the site visit will help us achieve our goal(s) by:

Giving us many ideas as well as inspiration to more fully integrate our medical and behavioral health care.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# Petaluma Health Center
# Site Visit


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# Petaluma Health Centers

Petaluma Health Center

## Site Visit Agenda Topics:

- Team Structure and Functions
- Actionable and Accessible Data + Informatics
- Quality Improvement: Infrastructure and Improvement Processes
- Social Determinants of Health and Digital Tools

**Agenda and other resources:**
https://www.careinnovations.org/phln-portal/activities/site-visits-2018/#petaluma

# Site Visit: Petaluma Health Center

## Tri-City Health Center


**Site Visit Attendees:**

- **Ryan Tanglao,** BSN, RNPh, Quality Program Management Coordinator
- **Phyllis Pei,** Director of Clinic Support Services
- **Tam Nguyen,** PhD, Former Behavioral Health Director

# Key Takeaways

- Care team structure
- Staff huddles
- Structured SDOH

Petaluma Health Center Site Visit

# Bringing Back Takeaways

We are able to meet with our Senior Management Team and present our experience when it comes to PHC structured communication to staff, care team, data management system, SDOH, and structured patient advisory groups.

Petaluma Health Center Site Visit

# Taking Action

Ideas we are trying (or want to try out) that we walked away from the site visit with are the following:

1. Partner with Behavioral Health management to incorporate SDOH for risk stratification and empanelment
2. Structure our care team
3. Revisit Provider Incentive Program
4. Co-design boot camp classes with patients

# Connecting to Our PHLN Goal(s)

What we learned about on site visit will help us achieve our goal(s) by:

1. Encouraging care teams to confirm with TCHC goals, mission, and vision to provide comprehensive and patient-centered care
2. Strengthening our staff communications through team huddles
3. Streamlining care coordination

# Cambridge Health Alliance Site Visit


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# Cambridge Health Alliance

## Site Visit Agenda Topics:

- Overview of CHA: Care Teams, Leadership, and Population Health Management
- Care Team Structures and Functions
- Pharmacotherapy at CHA: Pharmacist Integration
- Social Determinants of Health: Staff Training and Culture Change
- SDOH and Community Partnerships
- IT at CHA: Using EPIC

**Agenda and other resources:**
https://www.careinnovations.org/phln-portal/activities/site-visits-2018/#cha


# Site Visit: Cambridge Health Alliance

## Neighborhood Healthcare


**Site Visit Attendees:**

- Melissa Bishop, Medical Director of Quality
- Melissa Barajas, Director of Quality and Population Health

# Key Takeaways

## Takeaway #1 - Co-management Model

- 1 MD: 1 PA: 1 RN : 1-2 MAs together manage a large panel of patients
- MD «paneled provider» provides chronic care, PA «practice support provider» provides urgent care

## Takeaway #2 – Access

- Schedule opens 28 days out
- No visit rules
- Does not pre-book follow ups, instead sets a recall timeframe through EPIC that auto contacts patient asking to schedule their follow up visit
- New patient appointment available within 1 week

Cambridge Health Alliance Site Visit

# Key Takeaways

## Takeaway #3 – Portal Use

- 90% Portal enrollment
- Every member of team encourages patient to sign up and use portal.
- Team relies heavily on portal for patient communication

## Takeaway #4 – Integrated Clinical Pharmacists

- 1 clinical PharmD per every 10k patients (18 total, in all clinic sites)
- High risk/complex patient consults
- Warm handoff from PCP, referred to by PCP as "medication specialist"
- Quarterly reports on A1c and HTN: Baseline value prior to PharmD visit compared to latest value within quarter
- COPD "rescue kit" – steroid and antibiotic. Decrease ER/hospital utilization

Cambridge Health Alliance Site Visit

# Bringing Back Takeaways

How did you (or how are you planning to) share your learnings with your team and other stakeholders?

SDOH resource list loaded into EHR and printed with each visit summary - small change, easy to implement

Open Access scheduling – large change will take significant planning and resources to implement but will improve access, patient satisfaction/retention and solve numerous downstream challenges

Cambridge Health Alliance Site Visit

# Taking Action

One idea we are trying (or want to try out) that we walked away from the site visit with is...

Centralize abnormal cancer screening tracking and follow-up. Assign RN to handle this.

Cambridge Health Alliance Site Visit

# Connecting to Our PHLN Goal(s)

## Our PHLN goal(s):

Use technology to improve patient access and experience

## We will move toward implementation of:

- open access scheduling
- tele-visits
- tech-based between visit communication utilizing portal and texting

Cambridge Health Alliance Site Visit

# La Clinica
# Site Visit

LA CLINICA
AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL

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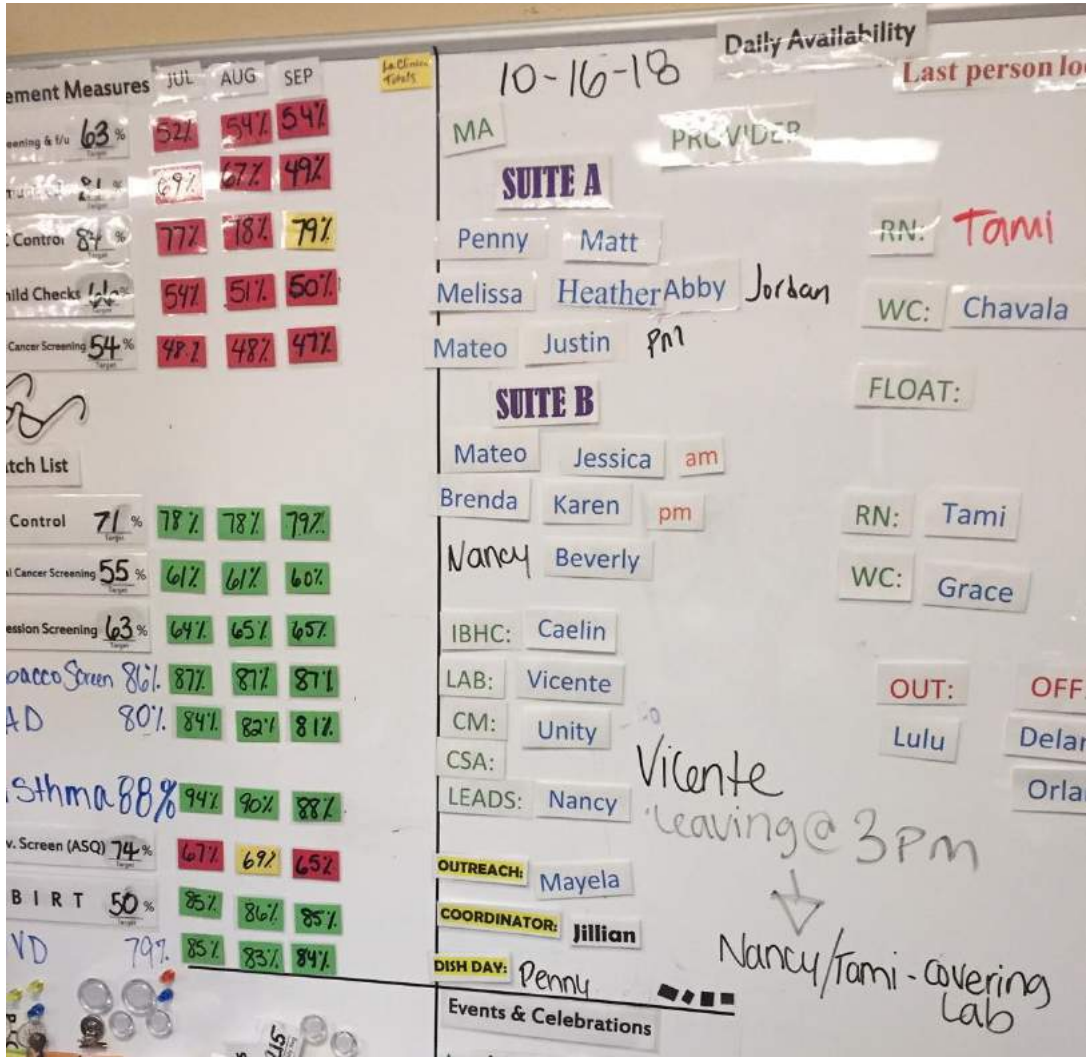
# La Clinica

## Site Visit Agenda Topics:

- Team Based Financials
- Partnerships with CCOs and Payor
- Risk Stratification and Social Determinants of Health
- Social Determinants of Health Model and Tools
- Team-Based Improvement: Dashboards

**Agenda and other resources:**
https://www.careinnovations.org/phln-portal/activities/site-visits-2018/#laclinica



# Site Visit: La Clinica

## Venice Family Clinic

**Site Visit Attendees:**

- Meghan Powers, Director of Quality Improvement
- Jonathan Vargas, Population Health Coordinator
- Ariel Peterson, Director of Program Management

# Key Takeaways

- Organizational + Care Team Structure
- Risk Stratification + Care Coordination
- Team Based Financials

# Bringing Back Takeaways

How did you (or how are you planning to) share your learnings with your team and other stakeholders?

VFC site visit team will be presenting at an upcoming operational managers meeting.

Hoping to start a discussion about how various department (outside of QI) can learn from site visits.

# Taking Action

One idea we are trying (or want to try out) that we walked away from the site visit with is...

- Explore ways we can use our current staff in a function similar to La Clinica's "prevention and engagement" specialists
- Consider SharePoint as a way keep staff informed about committee and workgroup activities
- Build feedback loops into data/reporting. (managers provide context for performance, informing higher level reports to the Board, etc.)

# Connecting to Our PHLN Goal(s)

Our PHLN goal(s):

- Define "population health" for VFC and how it relates to our other programs/departments.
- Explore risk stratification.
- Engage care team members in population health management.
- Improve (proactive) management of prenatal care/patients

What we learned about on the site visit will help us achieve our goal(s) by:

Process for applying and validating their risk stratification model

# Key Questions to Keep In Mind

What remaining questions do you have?

What's getting you stuck?

What else do you need to get moving?

# What's Next & Reminders

## Webinars & Convenings

- **November 8 Workshop:** Leading Profound Change Workshop – Los Angeles
- **November 19 Webinar:** Cherokee Health Systems NextGen Demo
- **December 11 Webinar:** Sharing Updates & Progress
- **January 16-17, 2019:** In-Person Convening #2 in Los Angeles

## Reminders & Asks

- Co-Design the January Session with us!
  - We'll include a link with key questions on the forum!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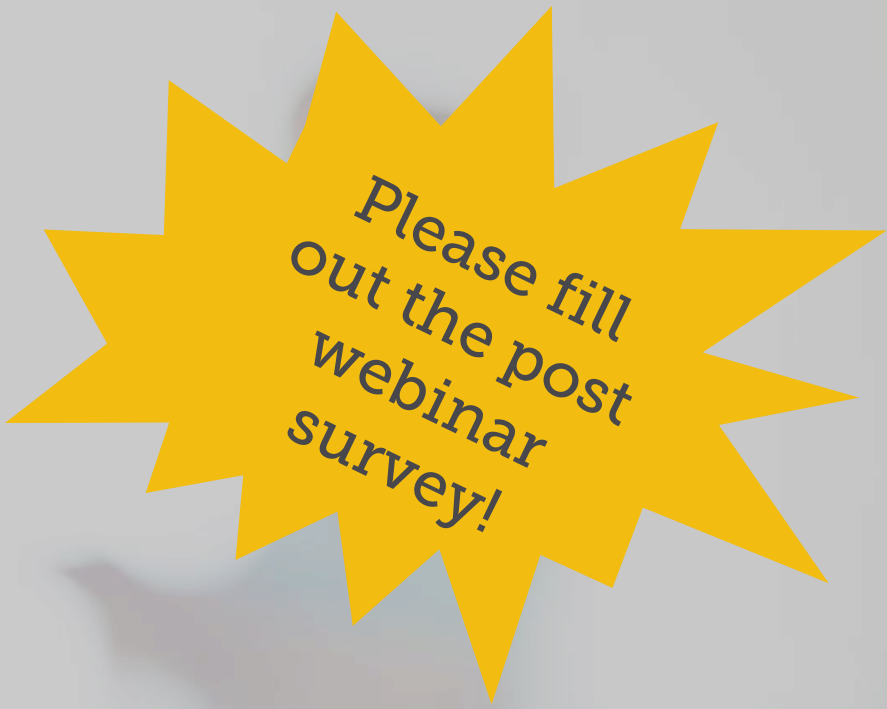
Questions?

# Thank you!

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