Population Health Learning Network – Year 2 Project Focus Areas

L.A. County Dept. of **Health Services - Primary**

Address food insecurity for patients to improve clinical outcomes by linking at least 20% of patients seen who screen positive to appropriate resources

Social Needs

North County Health Services

Identify a SDOH screening tool and assess patients with poor diabetes control, linking them to resources and developing appropriate workflows

Serve the People Community Health Center

Implement and integrate PRAPARE screening and develop workflows for identified diabetic patient population

Tri-City Health Center

Use PRAPARE data and

patient focus groups to

Improve health

outcomes in the

diabetic patients

Santa Rosa Community

Develop workflows, train staff, implement PRAPARE, and create a plan to link patients to needed resources

Axis Community Health

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

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

Behavioral

Health Integration

Open Door Community Health Centers

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

North East Medical Services

Increase access to culturallyand linguisticallyappropriate 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

Venice Family Clinic

Chapa-De Indian Health

Develop a robust and reliable recall system to move toward advance access scheduling

San Francisco Health **Network - Primary Care**

Increase access and close gaps by conducting proactive, centralized outreach to assigned but unseen members

Access Strategies to **Optimize**

Planned Care & Outreach

Northeast Valley Health Corporation

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

Ravenswood Family **Health Center**

Decrease the number of patients whose insurance lapses, by creating a streamlined and effective process for insurance panel management

Data Tools & Reporting to **Close Gaps** in Care

Integrate existing Patient Visit Planning report into NextGen

system to increase the ease of use and allow all team members to access the report

Salud Para La Gente

Improve data transparency by developing and implementing population health reports for care teams to act on clinical quality improvement (colorectal cancer screening)

Community Medical Centers

Develop a structured tiered outreach process (using a roster utility system eMed Apps) to better engage assigned, unseen members

Risk Stratification

Northeast Valley Health Corporation

Neighborhood

Healthcare

Develop a recall and

tracking system to

improve access

Optimize care management services by testing a risk stratification tool (Chronic Condition Count) and testing a complex care management model focusing on DM patients

LifeLong Medical Care

Improve care coordination services for high risk patients by developing and implementing a risk stratification methodology

CommuniCare Health Centers

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

Care Team

Roles

Santa Barbara **Neighborhood Clinics**

Add a new core care team member (panel managers) & also focused on diabetes care management

La Clinica de La Raza

Standardize and optimize the Clinical Office Assistants role and maximize the skills, abilities, and performance of COAs

Native American Health Center

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

Los Angeles LGBT Center

Re-structure the teambased 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