SAFETY NET PARTNERS WORKING TOGETHER TO CREATE PERSON CENTERED HEALTH HOMES:

Lessons Learned from the HHIF Evaluation

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INTRODUCTION

National health reform has renewed attention and focus to supporting innovation in the health care delivery system. Health plans, health care organizations, and providers are rapidly shifting from "usual care" to new solutions to meet the reform challenge, including implementing person-centered health homes (PCHH) as called for under the Patient Protection and Affordable Care Act (ACA). This transformation of the health care delivery system and clinical practices requires complex redesign to achieve health reform's Triple Aim[1] of improved population health outcomes, enhanced patient experience, and lowered overall costs of care. When fully implemented in January 2014, the ACA also expanded health care coverage to a broader population, including people with complex, high cost health care needs, who can benefit from improved care coordination and comprehensive case management.

In 2011, the Center for Care Innovations (CCI), in partnership with The California Endowment, launched the Health Home Innovation Fund (HHIF) to support partnerships among safety net organizations to build patient-centered, integrated systems of care, and explore payment reform options to incentivize and sustain health home implementation. At the core of the HHIF initiative was the vision and expectation for increased collaboration across safety net providers and long-term systems change to improve the health care delivery system for safety net populations.

[1] The Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach for optimizing the health care system. www.ihi.org

Health Home Innovation Fund Goal

The purpose of the HHIF was to provide flexible funding and technical assistance to build capacity across the safety net, with the goal of improving the health of underserved communities, providing better care to individuals and their families, and lowering the cost of care. The HHIF funded multi-stakeholder collaboratives to improve care coordination and integration among safety net institutions and providers to better serve patients, particularly those with complex needs, in the rapidly evolving health care marketplace. These collaboratives involved a range of stakeholders, including regional clinic consortia, health plans, community health centers, hospitals, and other community-based organizations.

The Initiative supported eight regional collaboratives across California with two-year $500,000 grants to facilitate health home transformation. In addition, $200,000 grants were awarded to two collaboratives that focused on specific health home policy-related projects. Over the course of the Initiative, the collaboratives supported clinics in transforming clinical practices, improving care transitions and access across multiple providers and organizations through care/case management and health navigation models, and achieving PCMH recognition.[2]

The HHIF supported:

- Clinic Level Transformation
- Improvements in Care Transitions through Complex Care Management
- PCMH Recognition

[2] PCMH recognition is the most widely used way to transform primary care practices into health homes. PCMH recognized practices are well positioned to access financial incentives from health plans, and federal and state-sponsored pilot programs. Recognized health homes offer value to patients and payers because they can demonstrate capacity to meet nationally recognized standards for care quality. www.ncqa.org

HHIF Grantee Collaboratives

The Health Home Innovation Fund supported 10 geographically diverse collaboratives to facilitate health home transformation (Table 1). The strategies and activities to transform systems of care varied by collaborative, as did the lead organizations, existing infrastructure and capacity, target populations, constellation of partners and number of participating clinics.

A total of 57 clinics participated across the eight fully funded collaboratives. HHIF clinic partners ranged from very small clinics that see fewer than 150 patients annually, to large, multi-site clinic systems with over 100,000 patients seen each year. In addition to the 57 clinic partners, the HHIF collaboratives included eight health plans, nine hospitals, multiple academic institutions, community-based organizations and county departments of public health and social services. (see map, next page)

Table 1: Structure of HHIF Collaboratives

Health Plan Lead	Clinic Consortium Lead	Other Lead*
■ Inland Empire Health Plan (IEHP) ■ Health Plan of San Joaquin (HPSJ)	■ Coalition of Orange County Community Clinics (COCCC) ■ North Coast Clinic Network (NCCN) ■ San Diego Community Clinics Health Network (CCHN) ■ San Francisco Clinic Consortium (SFCC) ■ Health Alliance of Northern CA (HANC)	■ Health Improvement Partnership of Santa Cruz and Central CA Alliance for Health (HIP/CCAH) ■ Redwood Community Health Coalition and Partnership Health Plan (RCHC/PHP) ■ CA School Based Health Centers Association (CSBHCA)

* Entity involving health plan and consortium, or public/private member coalition

The HHIF Collaborative Projects* include:

1. Coalition of Orange County Community Clinics
2. Health Improvement Partnership of Santa Cruz & Central CA Alliance for Health
3. Health Plan of San Joaquin
4. Inland Empire Health Plan
5. North Coast Clinic Network
6. Redwood Community Health Coalition & Partnership Health Plan
7. San Diego Community Clinics Health Network
8. San Francisco Community Clinic Consortium

Targeted Policy Projects:

A. Health Alliance of Northern California (HANC)
B. California School Health Centers Association

** These eight HHIF Collaborative Projects are fully funded.*

Evaluation Approach

The HHIF evaluation used a mixed method, participatory approach to examine key questions concerning the implementation experiences and outcomes achieved across the funded collaboratives and participating clinics. Through collaboration and input from the funder and grantees, the evaluation aimed to document key learnings about the practice and systems transformation process involved in health home implementation.

The evaluation used a range of data sources and data collection strategies, including:

- Monthly check in calls throughout the grant period with grantees to document implementation progress and accomplishments
- Technical assistance check in calls to support quality improvement data tracking
- Site visits, during which the evaluators met with lead agency staff, clinic staff, and collaborative partners
- Quarterly Quality Improvement reports submitted by the grantees to CCI
- Web-based surveys of lead agencies, clinics, and collaborative partners to collect data on implementation progress, systems change, and outcomes
- Local evaluation and grantee progress reports

Key Evaluation Findings

Key evaluation findings are presented in the following five sections:

1. Role of Clinic Consortia and Health Plans in Facilitating PCHH Transformation
2. Fostering Strong Cross-Sector Partnerships & Collaboration
3. Grantee Accomplishments & Outcomes
4. Barriers & Facilitators to Practice and System Transformation
5. Summary of Accomplishments and Lessons Learned

1. Role of Clinic Consortia and Health Plans in Facilitating PCHH Transformation

"Our health plan partner provided excellent leadership in terms of providing tailored support, communicating regularly and frequently, and remaining flexible and supportive of changing needs of the clinic sites."

- Clinic Partner

Practice transformation efforts are supported and motivated by the expectations under health reform, incentives connected to NCQA recognition, and meeting the goals of the Triple Aim. As lead grantee agencies for the HHIF, clinic consortia and health plans played a critical role in supporting and facilitating practice changes at the clinic and cross-system levels. Health plans and clinic consortia are in an ideal position to share best practices and lessons learned related to PCHH transformation across member clinics through existing learning networks and quality improvement efforts. Consortia and health plans support both clinical and operational transformation in the following ways:

- Sponsoring provider trainings on various PCMH components
- Developing agreed upon models and protocols for PCMH implementation across multiple clinics in the network or county
- Developing standardized job descriptions and model components of case management or patient navigation programs
- Enhancing (in come cases centralizing) referral and care coordination systems across partner organizations, including streamlining benefits enrollment, appointment coordination and connections to social services for complex patients
- Developing resources to facilitate PCMH recognition across the network of clinics (e.g., primary care "tool-kit," organizational assessments, assistance with NCQA recognition applications)
- Leveraging multiple grants and initiatives to provide training and technical assistance to providers to increase skills and capacity

Clinic consortia and health plans played a critical role in supporting and facilitating practice changes at the clinic and cross-system levels.

As the payer, health plans are in a unique position to support and incentivize practice changes within clinics and other providers in their network. Specifically, health plans can:

- Provide additional funding to support clinic strategies for practice transformation, case management and care coordination
- Offer clinics financial incentives through "pay for performance" quality improvement efforts and PCMH recognition
- Share utilization and cost data with clinic partners to assess the return on investment of PCMH interventions
- Catalyze changes across their network such as discharge coordination processes and communication protocols between hospitals and safety net clinics

2. Fostering Strong Cross-Sector Partnerships and Collaboration

"As a result of the HHIF collaborative, clinics are much more likely to reach out directly to the health plan or community-based organizations for resources. This work, and primary care transformation demands outreach with partners, and the work of this collaborative fueled clinic self-confidence in conducting outreach and networking to improve patient care and services."

- Clinic Consortia Representative

Practice transformation and implementation of complex care management programs at the clinic level was greatly accelerated by the cross-sector partnerships, which provided greater access to needed resources, expertise, and data. A community approach to creating health homes requires involvement of multiple cross-sector stakeholders, such as health plans, hospitals, community clinic consortia, primary care clinics, and other safety net providers, to create coordinated systems that support person-centered care. HHIF partners worked collectively to address issues related to ACA implementation and develop strategies to meet the needs of their communities – emphasizing a spirit of collaboration over competition.

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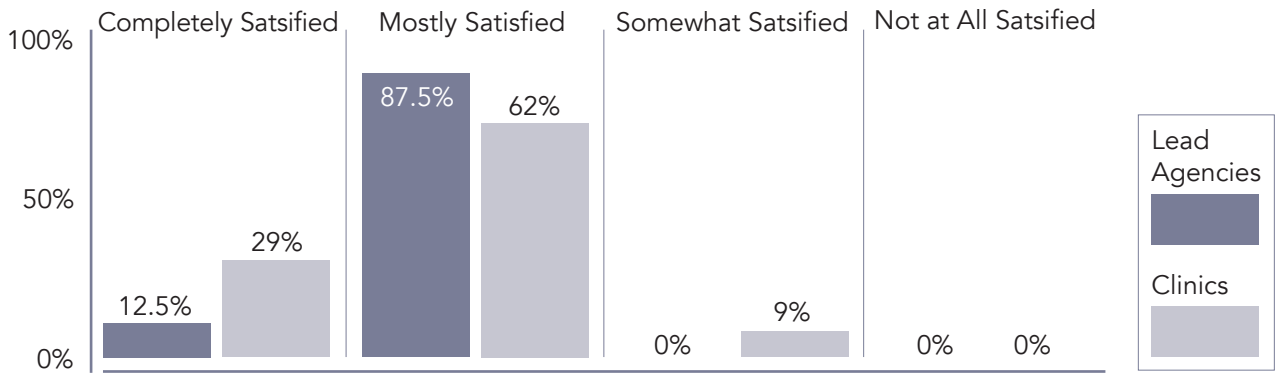
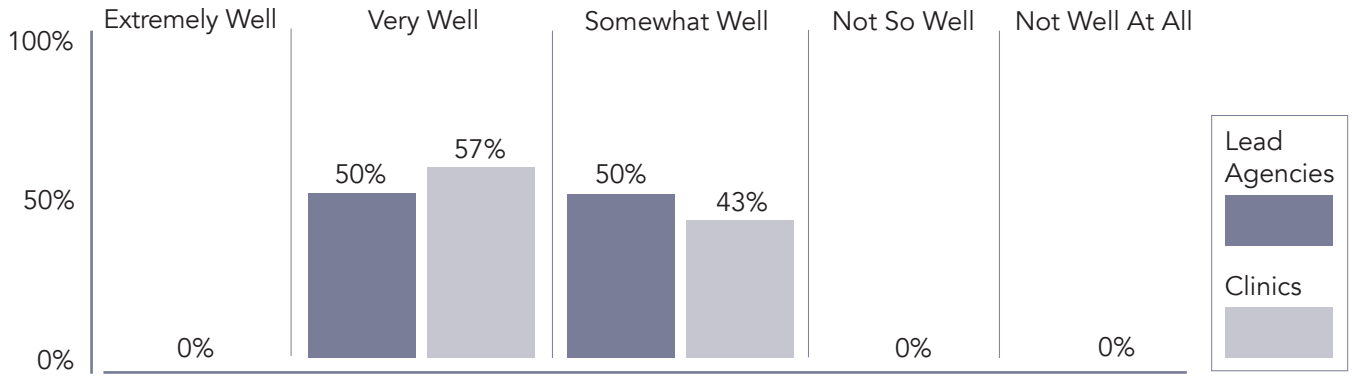
Overall, clinic partners and lead agencies felt the collaborative approach worked well and provided increased opportunities for connection, joint activities and sharing best practices. Most expressed an interest in leveraging this experience to bring in additional partners (hospitals, other clinics, community agencies) to broaden the work and resources available to the populations served. In the final HHIF survey, grantees rated their overall experience participating in the HHIF collaborative and how well the partners worked together to carry out activities and connect multiple services, programs or systems. (See graphs below)

Overall Satisfaction with HHIF Collaborative Experience:



How well the partners worked together as a collaborative to carry out activities and connect multiple services, programs or systems:



Facilitators of strong leadership and collaborative partnership:

When engaging in cross-sector work, it is important to have a strong leader that is skilled at acknowledging the presence of independent organizational agendas and diverse stakeholder interests, while maintaining a unified vision for the broader community. Consortia, health plan and clinic partners involved in the HHIF initiative identified several key factors associated with effective leadership and a strong collaborative partnership, including:

- Buy-in from all partners on shared vision and goals
- Bring all parties together early and often to maintain continuity of the work and establish an identity of each organization working together as part of a larger effort
- Clearly define roles, expectations, responsibilities
- Open and honest communication where all ideas are welcome
- Efficient use of time and resources across the partner organizations
- Establishing trust and responsibility across partners for developing solutions and taking action
- Flexibility with changing needs across partner organizations and policy changes under health reform
- Lead agency working with partners to advocate and apply for continued funding

> *"Participating in the HHIF collaborative moved our PCMH strategic objective from the drawing board to practical application and has resulted in sustainable practice management changes that will extend beyond the demonstration period."*
>
> *- Health Center*

3. Grantee Accomplishments and Outcomes

Through strong cross-sector partnerships, grantees worked to create health care delivery systems that support person-centered care. Grantee collaboratives made accomplishments in the following strategic areas to support health home transformation:

- Implementing core PCHH components at a clinic level
- Cross-system care coordination and case management for complex patients
- Implementing or enhancing health IT, sharing data and building capacity to demonstrate outcomes

Clinical level practice changes to achieve core PCHH components. HHIF grantees and participating clinics engaged in a variety of activities to achieve health home transformation and ultimately build capacity to meet the requirements for PCMH[3] recognition from an accrediting body.[4] Grantees utilized resources such as external consultants,[5] practice coaches, and trainings for providers to facilitate changes in clinical and operational practice.

Key implementation activities included:

Patient Empanelment: Empanelment, or the assignment of patients to specific providers or a care team, is a foundational element to PCHH and enables population management by changing practice responsibility from the care of individual patients to proactive and planned care for a population of patients.

Team-Based Care: Team-based care is an approach for delivering patient-centered, coordinated care to panels of patients where clinicians work with a small group of medical assistants (MAs) who have enhanced responsibilities and clearly defined roles for patient care.[6] Specific patient care tasks are assigned to the team members with the most appropriate training to perform them well.

Panel Management: Panel management is the use of panel data to promote proactive population-based care and performance improvement processes. It is a critical component in improving access to care and conducting proactive outreach to engage patients who need to come in for care.

3. The term PCMH (Patient Center Medical Home) is used in this report when referring to recognition from a national accrediting body. All other references are to PCHH (Person Centered Health Home), which is a broader term reflecting an emphasis on the whole health needs of the individual, and aligns with the intent to the HHIF initiative.

4. Clinics involved in HHIF sought PCMH recognition from various accreditation bodies including the National Committee for Quality Assurance (NQCA), Accreditation Association for Ambulatory Care (AAAHC) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

5. Grantees contracted with state and national experts, including Health Team Works, Qualis, UCSF Center for Excellence in Primary Care, Stanford Patient Self-Management Programs, Coleman and Associates, and CPCA PCHH Practice Transformation coaches.

6. Safety Net Medical Home Initiative- Elevating the Role of the Medical/Clinical Assistant: Maximizing Team-Based Care in the Patient-Centered Medical Home. August 2011.

Use of Data & Technology for Quality Improvement: Quality Improvement (QI) strategies rely on routine data collection and performance measurement to identify areas for improvement and change. Electronic health record systems (EHR) and registries, are essential components of health homes, supporting service delivery, care coordination, quality improvement, outcome tracking and cost analyses.

PDSA Cycles: The PDSA cycle is a scientific method used for action-oriented learning. Implementing PDSA cycles is another strategy to improve clinic operations, workflow and care quality. Implementing rapid-cycle, "small tests" and applying lessons learned helped clinics implement longer-term change strategies.

Patient Centeredness: Patient-centered care is at the heart of the PCHH model of care delivery. Patient-centered interactions are characterized by an increase in patients' involvement in decision-making, care, and self-management.[7] Self-management education and support increases patients' problem-solving skills and confidence in managing their health problems. [8] Patient-centeredness also elevates a focus on the patient experience, a key component of the Triple Aim.

Clinic Level Outcomes

As shown in Table 2, over the course of the Initiative, the 57 clinics made significant progress in practice transformation by implementing key components of the PCHH.

Table 2: Implementation Progress by Clinics on Core PCHH Components (n=57 clinics)

PCHH Component	Clinic Activities	% of Clinics Pre-HHIF	% of Clinics Post-HHIF
Empanelment	Empanelled at least a sub-set of patient population	50%	91%
	Empanelled all patients		58%
Team-Based Care	Use care teams	42%	84%
	Use huddles routinely	35%	79%
Panel Management	Use panel management	23%	58%
Use of Data/Technology for Quality Improvement (QI)	Develop and use QI plans	56%	81%
	Conduct PDSA cycles as part of QI work	49%	79%
Patient-Centeredness	Involved patients in PCHH transformation activities		25% very involved
PCMH Recognition		0%	40%

7. Wagner EH, Coleman K, Reid RJ, Phillips K & Sugarman JR. Guiding Transformation: How Medical Practices can become Patient-Centered Medical Homes. The Commonwealth Fund, New York. Feb 2012.

8. Bodenheimer T, Lorig K, Holman H & Grumbach K. Patient Self-Management of Chronic Disease in Primary Care. JAMA Nov 2002, 288(19):2469-2475.

Patient Empanelment

Nearly all (91%) participating clinics empanelled patients by the end of the funding period. Empanelment is fundamental to practice transformation and PCHH consultants recommend this as an important starting point for health home implementation.

Team-Based Care

The percentage of clinics using team-based care doubled from 42% to 84% by the end of the grant period. Across the HHIF clinic sites, physicians embraced the strengths of a team-based care model. They recognize that inter-professional teams embedded in primary care are more effective in addressing the needs of complex patients. Furthermore, team-based care is positively correlated to provider satisfaction.[9] Team composition varied across clinics; however, most clinic teams were comprised of a primary care provider, RN, medical assistant, and front desk staff. Some clinics implemented dedicated "teamlets", where primary care providers work consistently with the same medical assistant each shift. To meet the needs of complex patients, other providers on the team can include a behavioral health provider, health educator, registered dietician nutritionist, and benefits enrollment specialist.

Panel Management

The percentage of clinics using panel management increased significantly from 23% to 58% over the grant period, although the robustness of this practice varies widely and tends to be incremental in nature. Grantees tend to start with a sub-set of patients (e.g., condition or payer specific) prior to managing or conducing outreach for the entire clinic population. Most common conditions and patient populations targeted for ongoing panel management:

- Diabetes
- Cancer screens (Colorectal, mammograms, cervical)
- Hypertension
- Asthma
- Depression
- Obesity

Panel management duties expanded and elevated the role of the Medical Assistant and improved health home team culture. A significant outcome of implementing panel management commonly reported across the clinics is the elevated and expanded role of the medical assistant (MA). Clinics reported a positive culture shift as MAs accepted greater responsibility for managing their panel of patients. Changes and additions to job responsibilities, such as panel management and patient outreach, enhanced job satisfaction and feelings of empowerment. Many MAs reported they felt they were an important member of the care team with a distinct role and opportunities for job growth, which had a positive effect on MA retention for some clinics.

> *"All clinic sites across our system are collecting and entering diabetes data into the electronic registry, but not all clinic sites have taken the next step of managing and reaching out to patients based upon that registry data."*
>
> - Clinic Consortium

9. See individual grantee profiles in the appendix staff satisfaction findings. Specifically, in the SFCCC collaborative, evaluation findings from the Center for Excellence in Primary Care found a strong correlation between designated provider teams and improved satisfaction.

Quality Improvement

The percentage of clinics using QI plans increased 25 percent (from 56% to 81%). Through routine monitoring of QI data, some clinics were able to demonstrate clinical improvements with specific patient populations over the course of the grant. Other clinic sites may not have demonstrated improvement on specific QI indicators, but they did learn QI techniques and became more comfortable extracting data from their EHR for this purpose. Grantees reported that collecting data and interpreting findings was useful in raising awareness of the need to use data to guide clinical interventions. Recognizing there is an important link between staff satisfaction and patient experience of care, many grantees (68%) examined how clinic transformation activities affected provider and staff satisfaction as part of their QI efforts.

Example QI Indicators collected by HHIF Grantees:

- Diabetes (A1c)
- Blood Pressure
- Adult BMI
- Tobacco use rates
- Depression (PHQ-9)
- Show rate
- Flu vaccine rates
- PCP Continuity
- Provider satisfaction
- 30 Day hospital readmissions (hospital transition program)
- Cancer screening rates
- Adolescent well-care exams
- Insurance status
- Third next available appointment (Access measure)
- Community Referrals
- Enabling services (transportation, food, housing assistance)

PDSA Cycles

The percentage of clinics using PDSA cycles increased from 49% to 79%. In an effort to improve access to care, create organizational efficiencies and enhance communication and coordination, clinics tested a wide array of practice change activities.

Examples of PDSA Cycles Tested by Clinics:

Improve Access

- Dedicated outreach efforts to improve childhood immunization and mammography screening rates
- Reduce no show rates using front desk clerks to call patients and confirm appointments
- Implemented telephone visits and walk-in appointments
- Increased in-house lab work in-house to decrease the number of referrals for simple procedures

Improved Communication and Care Coordination

- Obtained cervical cancer screening records from outside agencies for shared patients
- Medication reconciliation and documentation in EHR
- Implemented flagging system to improve communication among providers and medical assistants about patients, which also reduced cycle time
- Co-located appointment scheduler and advice line nurse to enable early consultation with patients and reducing the need for in-person appointments, in many cases

Patient Centeredness & Patient Experience of Care

Although clinics expressed a commitment to demonstrate improvements in patient experience, progress on this key PCHH component was limited. Many clinics expressed the need to stabilize operational changes before engaging patients for feedback on experience of care. Few clinics exceeded the Federally Qualified Health Center standard licensure requirements for 51% consumer representation on their Board and conducting annual satisfaction surveys (e.g., Consumer and Group Consumer Assessment of Healthcare Provider and Systems). Some clinics with greater patient involvement established Consumer Advisory Boards, elicited patient feedback on quality initiatives through surveys or focus groups or used patient feedback to inform PDSAs. Four grantees, (HPSJ, NCCN, CCHN, and COCCC) conducted specific, patient centered activities aimed at increasing the level of patient involvement. Examples include:

"It is important to keep the patient's end goals in mind. When considering practice change activities and making decisions, administrators need to ask the question, 'How does this advance patient-centered health care in our community?'"

– Clinic CEO

- Implementing the Stanford Patient Self-Management model
- Including patients on clinic quality improvement teams
- Developing web-based portals to increase patient access to health information, involvement in preventative services and self-management activities
- Conducting telephone interviews with patients about satisfaction with clinic PCMH activities and operational changes
- Sharing direct patient quotes and feedback with clinic leadership
- Vetting PCMH brochures and clinic educational materials with patients to ensure consistent and clear messaging around team-based care and new PCMH model of care

Grantee Highlight: North Coast Clinic Network

Recognizing that patient-centeredness involves more than a primary care focus within a confined physical clinic setting, one collaborative (NCCN) worked to integrate a wellness and prevention focus in the PCHH approach by promoting access to community gardens on-site at clinics, hosting nutrition classes, hosting mobile cancer screening events to reach rural areas and incorporating patient-centered principles into the architectural design of new clinic sites (e.g., indoor-outdoor waiting rooms, multi-use spaces for exercise, and cooking classes at the clinic).

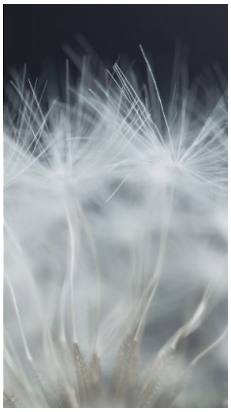
NCQA Recognition

40% of the clinics applied for NCQA PCMH recognition and, of these, 48% received at least a Level 1 rating from NCQA by the end of the grant. Transforming clinical and operational practices within clinics to achieve PCMH recognition was an important priority of the collaboratives as they worked to build health homes in the eight communities. The Health Resources and Services Administration (HRSA) recommends that community health centers pursue Patient-Centered Medical Home (PCMH) recognition in an effort to "demonstrate their leadership as providers of high-quality care."[10] NCQA's PCMH recognition is currently the most widely adopted model for transforming primary care practices into medical homes, and involves a rigorous practice transformation, documentation and application process taking an average of 24 months to complete. An additional three clinics applied for and received PCHH recognition from another accreditation source, such as JCAHO or AAAC.

NCQA PCMH 2011 Standards

Levels

- PCMH 1: Enhance Access and Continuity
- PCMH 2: Identify and Manage Patient Populations
- PCMH 3: Plan and Manage Care
- PCMH 4: Provide Self-Care Support and Community Resources
- PCMH 5: Track and Coordinate Care
- PCMH 6: Measure and Improve Performance



"It's important for clinics to understand the difference between concrete requirements for PCMH recognition and what it really means for clinic operations because the transformation process costs time and money. Practice change has to be about system and culture change, not just checking boxes on the application for certification."

- Clinic CEO

10. www.hrsa.gov

Cross System Care Coordination and Case Management for Complex Patients

A key component of the PCHH model,[11] includes targeted efforts to address the needs of high risk, high cost patients. Individuals with complex, chronic conditions are a critical subset of the safety net population and require tailored interventions. No single system of care can address the range of needs of a complex population to achieve the desired goals of improving the health of the population and reducing overall costs of care.

"We leveraged our partnership with hospitals, clinics and behavioral health resources to enhance and ensure care coordination across the systems. Bringing these partners to the table on a regular basis was beneficial not only to the evolution of our HHIF care transitions program, but to the safety net system as a whole."

- HIP

An important HHIF strategy is the cross-system collaborative approach that promoted the establish-ment of strong partnerships across the safety net. This collective approach to identify a shared target population and develop treatment interventions established a sense of collective accountability across the partners for meeting the Triple Aim goals.

As Table 3 shows, over the course of the Initiative, there were significant changes in the number of clinics implementing care management, navigation, and self management supports, which are activities associated with more advanced PCHH practices to address the needs of complex populations. The number of clinics offering integrated behavioral health services also increased.

Definitions and Distinctions between Care Coordination and Care Management

Care Coordination: The goal of care coordination is to improve the appropriateness, timeliness, and efficiency of clinical decisions and care, thereby improving the overall quality of health care. Care coordination involves the transfer of information across providers to establish accountability for each aspect of a patient's overall care.

Care Management: The goal of care management is to improve patients' functioning and health status, and enhance care coordination, eliminate service duplication, and reduce utilization of costly medical services, such as ER and hospital readmissions.

Complex Care Management: Complex care management is a more intensive intervention that targets the most complex, high acuity patients with multiple chronic medical conditions, limited functional status, psychosocial needs, and other social concerns.

Table 3: Case

Activity	% of Clinics Pre-HHIF	% of Clinics Post-HHIF
Provide care management	32%	58%
Provide patient navigation services	19%	63%
Provide self-management support	56%	79%
Provide integrated behavioral health services	40%	63%

11. Qualis Safety Net Patient Centered Medical Home Initiative (http://www.qualishealth.org/healthcare-professionals/safety-net-medical-home-initiative).

Three HHIF grantees[12] focused their grant activities on intensive care management, health navigation or complex care management interventions for low-income, complex, chronic patients. Although each program implemented different strategies to address the needs of this complex population, all three programs shared several core elements that facilitated program implementation.

Essential Components of Complex Care Management Programs:

- A tested and replicable process to appropriately identify high-risk patients and conduct outreach based on risk/need
- Multidisciplinary teams with medical, behavioral health, social services, and benefits advocacy expertise and skills to match patient needs
- Well-trained care managers in a broad spectrum of topics (e.g., motivational interviewing, care transition models, advanced care planning, health literacy, patient activation measures, trauma informed care, cultural competency)
- Patient involvement in goal setting and care planning
- Smaller caseloads
- Providing care in homes and community settings
- Health coaching to promote prevention and self-care practices
- Provider supports to mitigate burnout
- Information exchange across providers and systems
- Performance measures are consistent with the scope of the intervention and reflect care manager duties
- Financial incentives are aligned with quality care

Complex Care Management Outcomes. Clinics made important changes to cross-system care management processes to improve patient outcomes reduce emergency department (ED) use and lower inpatient hospitalization rates – resulting in lower costs for participating managed care plans. They created and refined referral tracking and notification systems with hospitals, improved referrals and care coordination with specialty providers, including behavioral health, and established cross-system communication protocols to improve care coordination of shared patients. Grantees also improved patient satisfaction and experience through education on navigating the system of care more effectively.

12. RCHC/PHC, SFCCC and HIP used HHIF grant funding to pilot test complex case management or health navigation models. Additional information on each of these pilot programs is available in the grantee specific case profiles in this report and in the "Strategies and Models for Complex Case Management" brief available at www.desertvistaconsulting.com

Health IT Systems and Data Sharing

> *"We send clinical data to the Network on a quarterly basis and they create dashboards that show our data over time for our individual health centers. We have goal lines and national and state benchmarks so that we can see how we are performing in relation to the rest of the state and the country. These dashboards are displayed and discussed at our quarterly QI meetings."*
>
> *– Health Center Representative of NCCN*

Health IT systems, including electronic health record systems (EHR) and registries, are essential components of health homes, supporting service delivery, care coordination, quality improvement, outcome tracking and cost analyses. Clinics with limited IT infrastructure (no EMR or registry) experienced significant barriers in moving toward the PCHH. At a minimum, these data systems support clinical and billing functions in the clinics, but increasingly the clinics used them to assess population health and to facilitate care coordination, particularly transitions between hospitals and clinics.

Over the course of the HHIF, the percentage of clinics with a functional EHR or population health management system (registry) increased from 54 to 70 percent. Clinics used data from registries and EHRs to identify patients in need of care and ongoing management, and to track clinical and operational quality metrics related to the Triple Aim. Many clinics also enhanced health information exchange capabilities across their networks to target patients and share data across health plans, clinics, and hospitals to improve service delivery coordination.

Data sharing increased across the safety net providers. To support their HHIF project goals, grantees increased the frequency with which there was routine data sharing among the collaborative partners. Prior to HHIF, cross-system data sharing was limited or where there were opportunities for data sharing (e.g., between health plan and clinic providers), engagement was low. During HHIF project implementation, partners were more proactive about data sharing and interpretation of findings, as opposed to having "passive access" to data from another provider system. Examples cited by the grantees of new, proactive data sharing practice include:

- **Health Plan to Clinic:** Health plan partners share data with clinics such as care-based incentive data, clinic specific performance data on HEDIS measures, hospital, ER and inpatient utilization and cost data information. Health plans provide data through Provider Report Cards on a monthly basis and provide opportunities for clinics to share best practices. Rather than giving "passive" access to these clinic level reports through a portal, some health plans created customized, user-friendly reports that were easy to interpret, and actively disseminated them to administrators and providers to facilitate discussions of data trends across the collaborative.
- **Hospital to Clinic:** Where strong relationships and MOUs are in place, hospitals provide information on patients admitted to hospitals and emergency departments, including discharge summaries, with clinic or health plan partners. In two HHIF collaboratives (COCCC, HIP), clinics or provider teams have direct access to hospital data systems or utilization management providers that facilitate "warm handoffs" between the hospital/ER and clinics to facilitate care coordination.

- **Clinic Consortia to Clinics:** Clinic Consortia use data analytic tools to develop dashboards and share data with clinic members through peer network meetings and facilitate sharing of best practices across clinics. This not only eased the reporting burden on clinics but also demonstrated the value of consortia as a trusted QI resource. One grantee (NCCN) developed capacity as a technical assistance provider to clinics by providing onsite coaching on EHR data mapping and teaching clinics how to generate outcome reports from their own systems.

- **County Departments to Clinics:** County departments of public health and social services have agreements in some regions to share data with clinics (SF, NCCN) to promote quality improvement efforts or expedite enrollment, eligibility determination and access to needed social services.

Lead agencies – health plans and clinic consortia alike – made significant progress in building data analytics capacity to demonstrate outcomes. An important cultural shift related to using data for clinical decision-making and outcome monitoring needed to occur in the clinics as part of health home transformation. Over the course of the grant period, lead agencies made significant progress in supporting this culture change and building data analytics capacity in clinics. Recognizing that many clinics, at least initially, lacked in-house capacity to analyze, interpret, and use data, the health plans and clinic consortia collected and integrated data from participating clinics. They also created and shared reports with clinic leaders and staff regarding performance metrics and patient outcomes to support on-going quality improvement.

> Health home transformation requires an important shift in organizational culture to using data for clinical decision-making and outcome monitoring.

Lead agencies also supported the clinics in identifying and tracking Triple Aim outcomes over the course of the funding period, specifically:

Population health: All of the participating clinics collected data on clinical outcomes, at least for a sub-set of patients with specific chronic diseases (e.g., diabetics, CVD). More than two-thirds (68%) demonstrated improvements in patient clinical outcomes in their quarterly quality improvement reports.

Patient Experience: All of the HHIF grantees selected patient satisfaction as their patient experience measure. FQHCs and community clinics are required to collect this information under state and federal guidelines for licensure, so there were ample baseline data available 42% of the clinics demonstrated measurable improvements in patient satisfaction.

Cost: While all eight collaboratives set goals of demonstrating reduced costs, by the end of the grant period only three had the capacity to generate any cost related data. These three collaboratives (HPSJ, RCHC/PHC and SFCCC), received data through the participating health plans, as well as a hospital partner, in one case. Across the three collaboratives, cost data were only available for a very small sub-set of patients (e.g., health plan members with specific chronic conditions in select clinic sites or health plan members participating in targeted case management pilots projects). Due to the short-term duration of the funding period, patients associated with these cost data only received program services for a brief time period - less than one year - which created challenges for interpreting cost implications and calculating the return on investment. Despite these limitations, all three grantees demonstrated reduced costs as a result of their interventions.

4. Facilitators and Barriers to Practice Transformation

Building a stable foundation for health home transformation and clarifying roles and expectations across partner organizations in a collaborative requires significant time and focused attention. Transformation within the safety net system of care requires changes in: provider and staff behavior, attitudes and service delivery, clinic operations, cross-system communication and collaboration, policy and financing. The following section discusses some of the factors that facilitated or created challenges to health home transformation across the HHIF sites.

Facilitators of Practice and System Tranformation

Flexible Funding to Support Innovation. Flexible grants provide safety net organizations with an important source of funding to support pilot programs, conduct experiments in service delivery and leverage and compliment other transformation initiatives. HHIF grantees were encouraged to use funding to convene stakeholders in strategic planning, identify gaps in the systems of care, enhance provider skills through training, test innovative concepts, and gather evidence to demonstrate the effectiveness of community-wide collaboration. In the reality of scarce resources, many grantees interpreted "innovation" as funding services and interactions with patients that are not billable in the medical reimbursement model, but are inherently valuable and critical to improving overall health.

Working in Partnerships across the Safety Net and Collaborative Learning. Progress on practice transformation and implementation of complex care management programs at the clinic level was greatly accelerated by the cross-sector partnerships, which provided greater access to needed resources, training, expertise, and data. In addition to deepening and broadening relationships across HHIF collaborative partners, grantees also benefitted from statewide learning sessions and opportunities promoted by the funder. The funder sponsored and convened forums that linked grantees to national leaders and experts in the field as well as provided opportunities for peer learning and information exchange through statewide convenings, training webinars and technical assistance on data collection and outcome measurement.

> Transformation within the safety net system of care requires changes in: provider/staff behavior, attitudes and service delivery, clinic operations, cross-system communication and collaboration, policy and financing.

Leadership Commitment and Readiness for Change. Collaboratives were tasked with the difficult responsibility of creating a unified vision for transformation across participating partners, including health plans, clinics, and hospitals that may have different levels of motivation, buy-in and readiness for the change process. Engaged leadership and commitment across partners provided strong and sustained support for implementation of the PCHH care model. Strong project champions- clinic, medical director

"The external consultants provided managed disruption that challenged entrenched work patterns, offered new ideas that promoted a higher functioning organization, and held health centers accountable to changes to which they committed."

– Health Plan representative

or health plan leaders, were critical in bringing together the right composition of partners, maintaining momentum and encouraging buy-in regarding data collection, sharing and QI activities.

Use of External Consultants. As part of the HHIF, grantee lead agencies were encouraged to engage external consultants to accelerate their health home transformation work. Nearly all (7 of 8) used external consultants to support and facilitate practice transformation. Of those, more than half found them to be "essential"(14%) or "very helpful" (43%) to the transformation process. Interestingly, three-quarters of the clinics that responded to a post-initiative survey reported that the external consultants were "essential" (44%) or "very helpful" (31%).

All of the lead agency grantees indicated that they would recommend external consultants to other collaboratives or stakeholders interested in health home transformation. External consultation and coaches provided grantees and clinics with content expertise in the PCHH model and created external accountability to work plan goals. External consultation and coaching led to significant improvements to grantees' proposed intervention, work plan objectives and outcome measures.

Eight ways in which external consultants were most helpful to grantees:

- Provided content expertise and training in key components of PCMH 1) empanelment, 2) care team development, 3) health coaching, 4) panel management, 5) advanced access planning, 6) population management were cited as most beneficial to the transformation process.
- Helped clinics redesign the patient visit process and workflows in real time, in the clinic setting with existing resources.
- Served as a neutral third party suggesting changes and improvements based on expertise and insight from working with other clinic sites/ systems.
- Held clinics accountable to activities, changes and meaningful deadlines for action to expedite the change process in a way that would have taken much longer without this external "push."
- Provided structured process to assess clinic readiness for PCMH recognition, made recommendations for clinics on where to focus transformation activities.
- Provided resources and tools to assist clinics in building Quality Improvement infrastructure.
- Introduced evidence based practices (e.g., Motivational Interviewing) to providers and staff at all levels of the organization (mid-level practitioners, health navigators, medical assistants, front desk personnel).
- Routinely assessed participating clinic progress and provider satisfaction, and fed back findings to inform implementation.

Barriers and Challenges to Practice and System Transformation

Health IT and Data Sharing. Collaboratives that included clinics without sufficient HIT capacity and infrastructure were at a disadvantage in implementing core PCHH components, tracking Triple Aim outcome measures and sharing data with other providers. Approximately 30% of the participating clinics did not have functioning EHRs or registries over the course of the grant period.

Data analysis was a challenge for clinics that lacked dedicated staff time and sufficient IT expertise that incorporates clinical and technical knowledge. Capacity for health information exchange (HIE) was limited and created barriers for sites trying to advance care coordination efforts across multiple health care systems. Additional challenges included data lags in claims and utilization data across providers (primary care clinics, hospitals), which affect routine quality improvement monitoring. Accessing "real time" data on ER visits and hospital admissions to support care management is another barrier experienced by programs targeting reductions in high-cost, high utilization patients.

> Developing alternative payment strategies while simultaneously trying to understand the myriad of coverage and reimbursement changes resulting from ACA implementation was a significant challenge.

Testing and Implementing Alternative Payment Reforms. Developing systems to reform payment is challenging in the rapidly shifting environment of national and state health reform. For the majority of projects, payment reform discussions remained in the early stages of development.

Grantees experienced numerous challenges testing and implementing alternative payment reforms, including:

- Having limited access to critical cost data related to services which is essential to building the business case
- Defining "shared savings" across the collaborative partners (for example, while care management yields savings in ED visits and hospitalizations, there is not a direct link between accrued savings on the hospital side and sustained or new funding for care management in the clinic)
- Understanding the myriad of coverage and reimbursement changes resulting from ACA implementation (e.g., Medi-Cal expansion population, mental health and substance abuse parity requirements, transition of rural counties to managed care)

While most stakeholders involved in the HHIF intended to work on payment reform, they are awaiting sufficient data on clinical outcomes for patients and clear evidence of cost savings before they can commit to a new financing or reimbursement structure. Initial financing reform efforts did not evolve beyond maximizing "pay for performance" and quality improvement incentives at the clinic level. Grantee partners were less successful in their efforts to pilot test and demonstrate effectiveness of shifting from a Fee-For-Service to case rate reimbursement structure.

Transferring training knowledge to practice. Trainings and webinars introduce concepts, but do not necessarily convert to organizational or practice changes. Buy-in from front line clinic staff and the methods used to enable front line staff to adopt the transformation require multiple strategies, training formats, patience, and time. It is important to maintain a strong connection between project leadership and the front line teams implementing the work to ensure that training and technical supports are reaching the front line workers. Clinic leadership is faced with the challenge of balancing staff release time for training while knowing that time away from patient care results in delays for patients and lost revenue for clinics. During times of fiscal constraints, it is challenging for organizations to commit dedicated resources for transformation at the clinic operational level – especially when training attendance does not readily lead to immediate and visible change.

Balancing concurrent health reform activities. Clinic and collaborative partners experienced pressure and "change fatigue" associated with concurrent quality improvement and practice transformation efforts taking place in local health care systems. Health plans and clinic systems are working to implement practice improvements while addressing the needs of many newly insured patients who are sicker with more complex psychosocial needs than existing patients. Negotiating time and attention to grant activities given the competing demands to prepare for health reform implementation was a significant challenge across the collaboratives.

Having a "customer service" orientation in health care is new for many FQHCs and offers both challenges and enormous promise for clinics that want to compete in the new health care marketplace.

Keeping the patient at the center of the PCHH. Collaborative partners struggled to define, document and measure patient experience in a robust and meaningful way. For most grantees, innovative measures for patient experience continue to be an area for ongoing technical assistance. Patient outreach and engagement in care is also an area where clinics experienced difficulties. Once clinics are more comfortable with changes in clinic operations, they are faced with the challenge of how to truly partner with the patient in their care and empower them to take responsibility for self-management goals. Having a "customer service" orientation in health care is new for many FQHCs and offers both challenges and enormous promise for clinics that want to compete in the new health care marketplace and be responsive to the needs of the communities they serve.

Lack of robust behavioral health resources. When working with complex populations, providers across the system need to expand access to non-primary care services, including mental health and substance use treatment, benefits counseling, specialty care, social services and community supports. HHIF projects that implemented complex case management and health navigation pilots expressed the need for greater access to behavioral health services in order to appropriately care for a high-risk, high-cost population. Many communities have service gaps in this area, which created challenges for case managers trying to connect patients to needed mental health, substance use and social services.

Long-term sustainability. Without local, hands-on sustainability plans, some clinics found it challenging to maintain changes they implemented. Consultants provide expertise and tools that produce short-term results, but supporting sustainable change requires a more robust strategy that addresses infrastructure issues and organizational culture (e.g., capacity for HIE, leadership support, reimbursement and financing issues). Dedicated time and commitment from the clinics to carry the work forward through ongoing committees, staff training, or evaluation activities is needed for sustainability. Funders can help by assisting grantees by building sustainability planning into grant objectives and offering assistance prior to grant sunset.

5. Summary of Accomplishments & Lessons Learned by HHIF

Over the course of the HHIF, many accomplishments and important lessons learned were identified that can inform safety net partners and funders interested in advancing this work. The collective experiences of the grantees – both successes and challenges – produced lessons in the areas of PCHH transformation, care coordination, complex care management, quality improvement, and outcome measurement. HHIF implementation accomplishments and lessons learned are summarized below in Table 4.

Table 4: Accomplishments and Lessons Learned from the Health Home Innovation Fund Initiative

PCHH Transformation

Accomplishments:

- Clinics advanced in implementing multiple components of the PCHH model of care – empanelment, team-based care, panel management, and use of data for QI. Nearly half of all HHIF clinics that applied received NCQA PCMH recognition.
- Clinics shifted the delivery system culture to team-based care by using staff to the top of their licensure, expanding the role of the medical assistant, and growing a culture of "these are our patients" and "we are responsible and accountable for their experiences and outcomes." The shift to care teams improved provider and patient satisfaction with PCMH implementation.
- Clinics developed and advanced a culture of quality improvement and increased their capacity to use data to inform clinical care and operational processes.
- Consortia and health plan partners leveraged HHIF funds to expand training, capacity building and TA efforts related to PCMH recognition to other clinics in the network.

Lessons Learned:

Building Capacity for Transformation

- Clinic consortia, health plans, external consultants, and practice coaches play important roles in supporting clinic level transformation through training, skill building, data and resource sharing, and disseminating best practices.
- The infrastructure - time, resources, and culture change - needed to transform practices to a patient-centered focus is significant. Systems changes take time. It is challenging to develop and stabilize a program, strengthen and solidify partnerships, and demonstrate clinical and cross-system outcomes in a two-year period.

- Adequate staff and resources must be dedicated to transformation from start to finish. Dedicate substantial time to the process each week no matter what else is going on in the clinic and proactively manage change fatigue and staff resistance to change in job roles, responsibilities and care model.

Sustaining Culture Change

- Transformation to PCHH is most successful and sustainable when motivated by a deep desire to effectively care for patients, rather than by simply meeting the criteria of a PCMH application.
- Effective care teams need to be interdisciplinary, non-hierarchical and consistent. Teams also need leadership support, a clear division of labor and roles for team members, frequent opportunities for communication and feedback, clear clinical and administrative processes to support teamwork, and implementation of PDSA cycles to understand success and failures in team functioning.
- To maximize investments in training, technical assistance and external coaching, clinics need to not only attend the training sessions, but also continue to grow in-house expertise through leadership and professional development of existing staff.
- Change is difficult to sustain. Leadership needs to follow up on the implementation of new policies and procedures through ongoing monitoring and regular audits.

Areas for Further Development

- **Prevention:** Prevention needs to be a focus for more than preventing ER visits and hospital readmissions. If safety net health systems are going to move from volume-based to value based care there needs to be a culture shift from reactive health care interventions to proactive health care solutions.
- **Peer Learning:** Clinics value and benefit from convening with other clinic peers to discuss clinic workflows, data collection, referral protocols and operational processes and learn from each other.
- **Customer Service Orientation:** While partial implementation of PCHH components can lead to improvements in patient satisfaction and experience, customer service remains the number one training needed and requested by clinics. Team members and clinic staff need to be customer (patient) oriented, have high health literacy, and the capacity to translate medical information to patients, and successfully engage and activate patients.

Complex Care Management, Care Coordination & Health Navigation

Accomplishments:

- Increased knowledge of the needs of and care management strategies for complex patients (e.g., services, provider skills and expertise, engagement, length of service etc.), which can inform other statewide efforts for Medi-Cal expansion and complex care management. Providers and health plans enhanced their understanding of the needs of the low-income, newly insured population and how to work across the system to address these needs.
- Enhanced collaboration between the health plans, clinics, hospital, and clinic consortia in the design, implementation and evaluation of complex case management and hospital transition programs.

- Demonstrated, with early results, trends toward return on investment and potential cost savings, reduced ED and hospital utilization, and improved patient outcomes.

Lessons Learned:

Program Development – Staffing and Service Needs

- Individuals with complex, chronic conditions are an important subset of the safety net population and require tailored interventions to coordinate care, better manage their health, and improve their quality of life. It is critical to use data to understand the needs of this population to ensure matching the "right services for the right population."
- High risk patients with complex, chronic illness need access to a range of medical, behavioral health, and enabling services to improve engagement in treatment, utilization patterns, and clinical outcomes.
- Complex care management program staff need experience working with a high-risk population with multiple chronic medical conditions and psychosocial needs and be able to implement a multi-systemic, multi-modal approach.
- Before implementing complex care management programs, ensure that clinics use care teams and panel management to support the care coordination and management activities that will be required by this high need population.
- Develop a stepped or tiered approach to care based on acuity level, including clear disenrollment criteria.

Program Implementation and Sustainability

- Care coordination with complex patients takes time – both in terms of engagement of the population in interventions and demonstrating impact. Care coordination and case management requires a balance between providing enough assistance to make a difference and working within limited resources.
- Align outcome expectations and incentives with the scope and responsibility for the complex care management intervention. For example, clinic based providers have less influence over hospital length of stay, which requires additional collaboration between the health plan and hospital providers in the network.
- Safety net partners (clinics and managed care plans) need to work together to demonstrate program impact and assess the return on investment (ROI) for complex care management programs. Clinics and providers understand the range of intervention components implemented with the target population and health plan partners have access to service utilization and cost data. Both sets of information are required to fully understand what's necessary for program implementation and sustainability.

Quality Improvement and Outcome Measurement

Accomplishments:

- Culture shift on the part of clinic leadership and staff to use data for clinical decision-making, including a focus on measurement, applying data and sharing results for ongoing quality improvement. Clinics built

capacity to focus on tracking clinical outcomes, improving operational efficiencies and understanding how operational changes/improvements influence patient outcomes..

- Increased capacity to collect and share quantitative data on patient utilization, costs, and outcomes of care cross-system to improve care coordination and patient transitions.
- Health plans built capacity to create customized, user-friendly reports for clinics to interpret and apply to improvement activities, and engage in quality improvement discussions with peer clinics.
- Clinic consortia and health plan partners provided infrastructure to examine data across member clinics, easing the burden of reporting and serving as a resource to develop dashboards, implement data validation procedures, and provide education and training.

Lessons Learned:

Staff and Health IT Capacity

- A blend of clinical and IT expertise is needed for QI and practice transformation. Providers that are engaged in using data, understanding the metrics being tracked, and evaluating improvements have very high levels of buy-in and support for a culture of quality improvement because they can see the impact of their work.
- Health IT is critical to advance PCHH transformation and care coordination efforts, and facilitate care transitions between hospitals and clinics.
- To facilitate and maximize care coordination and hospital transitions, safety net providers need to move toward HIE that "pushes" data to organizations that need the information rather than relying on a process that "pulls" data out of a clinical information. The latter approach requires significant workflow changes where clinics and providers log into another CIS to look for shared patients at certain intervals rather than having a notification system that alerts providers. Providing "access" to another organization's clinical information system is often not enough to facilitate care coordination and ensure appropriate transitions in care.

Using Data to Make the Case for Transformation

- Have a strong data-collection plan that is clearly defined and consistent among collaborating partners and establish realistic expectations and timelines. Planning for data exchange, analysis and validation processes within a single organization or across systems often takes longer than expected.
- Share data in a timely fashion so partners can see the impact of their efforts over time and make operational and clinical adjustments as needed. Frequent and relevant data sharing increases provider buy-in to quality improvement and measurement efforts.
- Developing the business case for PCHH implementation and complex care management programs falls to the payers (MCOs). The process is complex and requires significant investments in time for data validation and analysis. The data validation process is critical for ensuring the reliability and validity of data extracted from clinics that is necessary to advance the business case.
- Clinics need to develop a keen understanding of the total cost of services they provide in order to effectively participate in payment reform discussions and evaluate alternative payment strategies.

CONCLUSION & RECOMMENDATIONS

Overall, the collaboratives funded through the Health Home Innovation Fund showed ample evidence of progress in advancing PCHH transformations at the clinic level and across the care delivery system. Grantees made less progress in the areas of developing alternative payment strategies, addressing patient experience and expanding the concept of prevention to include wellness and the social determinants of health. The grantees varied in terms of their activities and approaches to build capacity to support and promote practice transformation, but all of the programs benefited greatly by implementing the work as a collaborative involving multiple safety net system partners. The work conducted over the two-year grant period built important relationships and infrastructure to support the further expansion of PCHH and care coordination in the participating communities.

> *"Of critical importance is having a sustainability plan for how to continue the work and maintain the changes once the consultants depart. Without a means of continuing lessons learned, the old organizational practices and inertia eventually take over."*
>
> - Consortia Representative

The HHIF facilitated linkages across safety net partners to align priorities such as PCHH recognition, preparation for ACA implementation and Medi-Cal expansion, building a strong QI infrastructure, and using data to inform clinical practice and enhance care coordination efforts for complex populations. The current policy context accelerated buy-in to the PCHH model at the clinic level as expectations under health reform strongly encourage providers to expand efforts related to cross-system data sharing, communication, care coordination and outcome measurement. This reform environment is also essential for sustaining the practice transformation accomplishments of the HHIF grantees now and in the future for all safety net providers.

Recommendations to Sustain and Advance Health Home Transformation

1. Leverage the findings, lessons learned, and resources of the HHIF collaboratives through dissemination to DHCS and other stakeholders planning and, ultimately, implementing ACA section 2703 pilots. Resources from the HHIF collaboratives that are valuable to safety net providers include: training curricula, PCMH toolkits, adapted job descriptions, and patient engagement brochures.
2. To continue supporting clinics through practice transformation, health plans and clinic consortia need to continue in their roles providing ongoing training, technical assistance, practice coaching and learning community opportunities for clinic members.

3. Embed health home activities in health plan Quality Improvement Programs to support and incentivize transformation activities. Clinics and Medi-Cal Managed Care plans need to continue to collaborate and expand care-based incentive programs to move clinic providers from volume to value based care.

4. Strengthen the evidence for cost savings based on specific interventions implemented and tested during HHIF by continuing to collect and analyze claims data. Payment reform needs to expand beyond monetary incentives for achieving PCMH recognition or improvements on quality metrics to demonstrate the potential return on investment of alternative payment strategies.

5. Encourage statewide dialog, guidance, and leadership on payment reform implementation to stimulate and support changes at the local level.

6. Recognize that clinics serve clients from a mix of reimbursement sources, as well as the uninsured. Efforts to influence practice transformation and reform payment practices need to be universal and not specific to certain sub-groups to truly transform the system.

7. Enhance clinic-based behavioral health services to meet the needs of the expanded Medi-Cal population, the increase in covered behavioral health services and SBIRT expectations for all Medi-Cal providers.

8. Continue to improve cross-system data sharing capacity between health plans, clinics, hospitals, county mental health departments, and social service agencies to track patients who cross multiple service systems and demonstrate the effectiveness of coordination.

9. Invest more attention and resources to addressing and improving patient experience to address this component of the Triple Aim and better understand the impact of transformation activities on patients.