



Cal HIVE

Health. Impact. Value. Engagement.

PROGRAM PROSPECTUS

A 2-year California Quality Collaborative (CQC) Improvement Collaborative focused on sustainable virtual care for people with chronic conditions

Begins October 2020

Executive Summary



CQC invites you to join CalHIVE, a 2-year improvement collaborative with a focus on telehealth-enabled care for people with chronic conditions.

OVERVIEW

The COVID-19 pandemic has been tragic for our communities, our patients, and our primary care practices and care teams. Yet, like most tragedies, we strive to make the best of a situation we did not choose. This new world has presented an opportunity to re-design primary care delivery for people with chronic conditions by fully leveraging the capabilities of virtual care.

CQC invites you to join the CalHIVE Network, a collaborative program designed to improve clinical outcomes for patients with chronic conditions and reduce performance variation by leveraging and fully optimizing the tools of virtual health care.

CalHIVE will begin in October 2020 and focus on the California regions of Imperial County, the Inland Empire, and the Central Valley.

The aim of CalHIVE is to:

- Maximize telehealth operations to support sustainable management of chronic conditions
- Adopt a measurement plan for telehealth quality and monitoring
- Improve clinical outcomes and reduce variation within participating organizations for patients with diabetes and asthma

In order to accomplish this aim, the network of participating organizations will:

- Engage 1,500 primary care clinicians in the work of virtual care delivery
- Participate in a collaborative of peers
- Share performance data for a common set of metrics



Executive Summary



COVID-19 Update

Given the unprecedented impact of the public health emergency on health care in addition to shelter-in-place requirements, CQC has made the following changes to CalHIVE:

- Planned for virtual-only meetings and technical assistance in 2020, and will adhere to official guidance regarding travel and in-person meetings for future years
 - Modified the curriculum from focusing on the building blocks of high performing primary care to improving telehealth operations for sustainable management of chronic care
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Over 2 years, program participants will:

- Design and implement efficient, sustainable, and effective virtual care, in balance with in-person workflows
- Apply improvement methodology, including use of aim statements, measures, data-driven improvement, theories for change and change ideas, and conducting Plan-Do-Study-Act cycles
- Engage with peers from other provider organizations and systems in a learning collaborative model

TIMELINE

CalHIVE will begin in October 2020 and last for 2 years, ending September 2022.

PARTICIPATION CRITERIA

This collaborative is designed for organizations within CalHIVE's targeted regions that are committed to improving care in the primary care setting for individuals with chronic diseases through expanding existing telehealth capabilities. Typically these organizations are:

- Health systems with primary care sites
- Independent Physician Associations (IPAs)
- Management Services Organizations (MSOs)
- Large group practices
- Community health centers

CONTACT

For questions or further information, please email Michael Au mau@pbgh.org.



Why Participate?



CalHIVE capitalizes on the wave of change happening across health care in California

- With the COVID-19 pandemic, greater support and adoption of virtual care technology and workflows
 - Increased use of value-based purchasing arrangements
 - Success of recent practice transformation/quality improvement programs
 - Changes to statewide measurement programs
 - Funding from state undertakings
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CalHIVE will improve clinical outcomes for your patients by tackling barriers to the adoption of successful virtual care delivery.

CalHIVE will grow your organization's value to practices through increased support to frontline clinicians.

Improvement in the program is measured by a set of meaningful, outcomes-based, common measures.

CalHIVE's methodology is grounded in the practice perspective & takes a full panel, payer agnostic approach.

The program includes capacity-building of data collection and use for current reporting and future measures.

CalHIVE's system of measurement allows for performance comparison across clinicians, practices, and organizations.

The program includes a unique peer-sharing model for healthy 'co-opetition.'

CalHIVE will focus on chronic condition management that will help participating organizations:

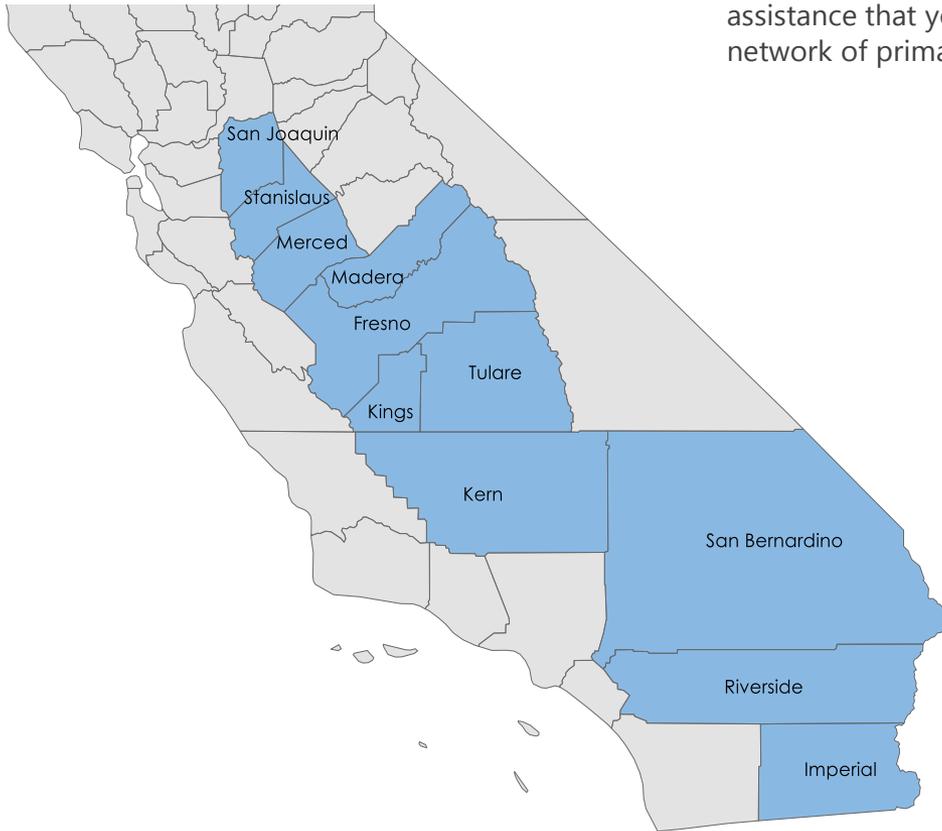
- Improve overall access to care and leverage flexibility of virtual care to help patients proactively manage chronic conditions
- Catch up on deferred care
- Track and proactively outreach to high-risk patients
- Follow-up on complications from deferred care
- Support their network of practices by optimizing care team members to deliver effective virtual patient care
- Improve team-based telehealth in a hybrid virtual and in-person clinical environment
- Address behavioral health conditions that may be preventing patients from managing physical health



Who Should Participate?

CalHIVE will focus on the California regions of Imperial County, the Inland Empire, and the Central Valley.

This improvement collaborative is designed for provider organizations committed to improving care in the primary care setting for individuals with chronic disease by spreading and optimizing existing virtual care operations. CQC deploys a train-the-trainer approach, meaning the project team in your organization participates in the learning collaborative and receives technical assistance that you then implement in your organization and within your network of primary care practices. Typically, participating organizations are:



- **Health Systems with Primary Care**
- **Independent Physician Associations (IPAs)**
- **Management Services Organizations (MSOs)**
- **Large Group Practices**
- **Community Health Centers**



Conditions of Focus

Within CalHIVE's regions (Central Valley, Inland Empire & Imperial County):

- Diabetic and asthmatic patients have poorer outcomes of care than most Californians (red-shaded cells), and as a result, these regions experience:
 - More frequent utilization of the Emergency Department¹
 - More disease related deaths²
- Large performance gaps exist across major payers (Commercial & Medi-Cal)

Measure (Performance Direction)	Product	CA Avg.	Central Valley North	Greater Fresno Area	Kern County	Inland Empire	Imperial County*
Diabetes HbA1c Poor Control > 9% (lower is better)	Commercial HMO	31.3%	30.3%	27.8%	35.2%	32.6%	64.8%
	Medi-Cal Managed Care	34.9%	39.0%	43.0%	32.0%	36.0%	36.0%
Asthma Medication Ratio (higher is better)	Commercial HMO	87.3%	89.2%	92.4%	86.6%	85.7%	81.7%
	Medi-Cal Managed Care	60.7%	61.7%	66.0%	52.0%	55.2%	57.0%

Source: California Regional Health Care Cost & Quality Atlas, Integrated Health Associates (<https://atlas.iha.org>)

Notes: Commercial HMO results for 2018 measurement year. Medi-Cal Managed Care results for 2017 measurement year.

Measure results are aggregated across Covered California Regions. * Imperial County data also includes results from Inyo and Mono counties

¹ California Health and Human Services Agency Open Data Portal. Asthma ED Visit Rates (LGHC Indicator). <https://data.chhs.ca.gov/dataset/asthma-ed-visit-rates-lghc-indicator-07>. Exported 7/17/2020

² Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database. <http://wonder.cdc.gov/ucd-icd10.html>. Exported 7/17/2020



Approach



CalHIVE builds on more than 10 years of CQC experience deploying high impact programs, many using the improvement collaborative model. CQC uses a systems approach to improvement work, and frameworks developed by organizations such as Institute for Healthcare Improvement³ and UCSF.⁴

CalHIVE will incorporate concepts from the 10 Building Blocks of High-Performing Primary Care,⁵ with adaptations based on our experience over the past 4 years with more than 1,500 small, independent primary care practices. We will work with leading telehealth subject matter experts to adapt these building blocks for use in virtual and in-person clinical settings.

Our approach includes a change package built on the most impactful drivers of change within provider organizations and practices.

Aim

Improve outcomes for Californians receiving care from participating clinicians by 9/30/2022

Sub-Aims

Reduce variation between regions and State

Improve health outcomes for people with diabetes and asthma

Maximize telehealth operations to support sustainable management of chronic conditions

Primary Drivers

Engaged Leadership

Telehealth Operations

Data-driven Improvement

Team-based Care

Patient and Family Engagement

Population Management

³Institute for Healthcare Improvement. How to Improve. <http://www.ihl.org/resources/Pages/HowtoImprove>

⁴UCSF Centers for Excellence in Primary Care. Health Coaching. <https://cepc.ucsf.edu/health-coaching>

⁵Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. "The 10 Building Blocks of High-Performing Primary Care." Ann Fam Med. 2014;12(2):166-171.



System of Measurement & Measurement Set



CalHIVE’s measurement infrastructure will monitor quality and improvements related to the following domains:

- Health Outcomes
- Hospital Utilization
- Behavioral Health

CalHIVE measurement principles

- Selected measures align with multiple reporting or accountability programs
- Measures are payer agnostic
- Support value-based payment mechanisms

Collaborative participants will be required to collect and report data across a suite of measurement domains and performance measures.

- Data will be reported at the clinician level with their associated practice location identified.
- Results will be aggregated at multiple levels of analysis including clinician, practice, provider organization and across the CalHIVE network.
- Performance information will be shared transparently within the program and used to drive improvement efforts.

In addition to reporting clinical data, participants will be required to submit a clinician enrollment file to identify enrolled providers. The enrollment file will identify the clinician and the practice locations where they provided care.

In parallel, participants will conduct bi-annual practice assessments with guidance from faculty to monitor change package implementation and inform care teams about their practice’s strengths and opportunities.

Health Outcomes	Utilization	Behavioral Health
<p>Diabetes</p> <ul style="list-style-type: none"> • HbA1c Poor Control (>9%) • HbA1c Good Control (<8%) • Blood Pressure Control • HbA1c Testing <p>Asthma</p> <ul style="list-style-type: none"> • Asthma Medication Ratio 	<ul style="list-style-type: none"> • Emergency Department Visits 	<ul style="list-style-type: none"> • Screening for Depression and Follow-up Plan* <p>*Anticipated implementation in Q4 2021</p>



Measurement Deliverables & Timeline

During each reporting cycle, participants will submit a clinician enrollment file and clinical data file.

Data Cycle Submission Dates

2020 October – Cycle 1

2021

January – Cycle 2

April – Cycle 3

July – Cycle 4

October – Cycle 5

2022

January – Cycle 6

April – Cycle 7

July – Cycle 8

October – Cycle 9

Clinician Enrollment



Submitted **during onboarding** utilizing a standardized reporting template to identified enrolled clinicians. Data fields include:

- Clinician identifiers (Name, Type 1 NPI)
- Practice identifiers (Name, Location, Type 2 NPI, TIN)

Measurement Data



Measurement data will be reported **quarterly** for all enrolled clinicians utilizing a standardized reporting template. Data will be reported to identified the individual clinician, practice and payer-product mix.

Participants will be required to report on all measures.

Practice Assessments



Practice assessments will be collected at key intervals during the program with each practice completing no more than 3 assessments during the program.

Practice assessments will be populated with practice identifiers information provided in your enrollment file.



Learning Activities

CalHIVE's learning collaborative employs an "all teach, all learn" philosophy, with virtual and in-person convenings throughout the program. At the foundation of all learning events is an evidence-based framework of adult learning principles and methodology, known as Dialogue Education, to maximize engagement through learner-centered design where learners are active decision-makers in their own learning with learning tasks and achievement-based objectives.

Sample topic areas of learning activities shown here will be introduced in specific sequencing and others will have continuous activity throughout the duration of the program. Some activities focus on topics relevant to all teams and others focus on special topics.

CalHIVE Learning Modalities:

- Live webinars with experts and peers
- On-demand recorded videos and tools
- Program website
- Network of peers
- In person meetings (when safe to do so)

Engaged Leadership

- Aim statement development
- Storytelling
- Frameworks for leading change
- Adaptive leadership
- Humble inquiry

Virtual Population Management for Chronic Disease

- Empanelment
- Continuity of care
- Population management
- Care coordination
- Transitions of care
- Behavioral health integration

Patient Engagement

- Collecting real-time feedback
- Motivational Interviewing
- Shared Decision-Making

Data Driven Improvement

- Data systems to collect information related measures
- Data shared widely and transparently
- Updated data and actionable data displays

Team Based Care and Virtual Workflows

- Virtual care team roles for hybrid clinical settings (virtual and in-person)
- Standing orders
- Virtual workflows, including virtual / in-person clinical decision analysis
- Health coaching

Telehealth Operations

- Billing, reimbursement, documentation & strategy
- Successful tools practices



Technical Assistance



Key Curriculum Dates

2020

- September 30:
Memorandum of Understanding signed
- October - December: Program Launch
 - Individual needs assessments and goal setting with assigned Improvement Advisor
 - Data collection for reference periods

2021

- Q1 CalHIVE Learning Kickoff
- Ongoing peer learning + skills training
 - Monthly Improvement Adviser meetings
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Technical assistance includes the learning activities described on the previous page as well as support provided through other modalities such as an in-depth needs assessment, dedicated improvement advisor and data insights discussions.

Comprehensive Needs Assessment	<ul style="list-style-type: none">• Virtual dialogue with the participating organization and CQC teams, detailing the current state of:<ul style="list-style-type: none">✓ Centralized services available to practices✓ Leadership, resources and strategic alignment✓ Telehealth technology & processes✓ QI capabilities✓ Data and performance✓ Org structure and staffing✓ Practice relationships and opportunities
Improvement Advisor	<ul style="list-style-type: none">• Monthly (or more) calls• Coaching for teams and leaders• Development of practice engagement plans• Technical skill-building specific to the team's needs• Sustainability planning (including post-COVID planning)
Data Insights	<ul style="list-style-type: none">• Data analysis calls/video conferences as-needed• Identification of gaps in data systems and capabilities• Performance analysis across your network to identify biggest opportunities• Education on telehealth quality measures



Expectations of Participating Organizations



Senior Leadership Support

Dedicated Project Resources

Improvement Team

Dedicated Support for Measurement and Data

Existing Telehealth Infrastructure

To succeed in CalHIVE, participating organizations will need to exhibit certain characteristics and requirements as described below.

- **Senior Leadership Support:** Participating teams must have the explicit support and engagement of their senior leadership. To optimize program impact, the collaborative should be a recognized priority supported by each organization's senior leadership. CQC faculty will convene the senior leaders periodically and dedicate time to discuss leadership issues.
- **Improvement Team:** The multidisciplinary improvement team usually consists of 4 to 6 members who represent a range of stakeholders, including clinical care, operations, executive leaders, patients and their families, community partners, and payers. Teams that include patients and family members have demonstrated quicker, more focused efforts.
- **Dedicated Project Resources:** The organization's identified senior leader for the collaborative should appoint a project leader who will oversee the day-to-day activities of the team and is provided the time, resources, and accountability to succeed. We estimate this project leader will need to dedicate 20 to 40 percent of time to this work.
- **Dedicated Support for Measurement and Data Infrastructure:** Because of the challenges of securing consistent and accurate data, a data and measurement lead should be designated. CQC faculty will convene the measurement leads from each team via periodic coaching calls to work through common measurement challenges and to share learnings.
- **Existing Telehealth Infrastructure:** To ensure that participants are able to focus on scaling and optimizing virtual care workflows, organizations should have a telehealth product they see using long-term.



Learn More & Enroll



To learn more, contact:

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There are no fees to participate in this collaborative, due to the generous funding provided by CVS Aetna and the California Health Care Foundation (CHCF).

If you are interested in joining CalHIVE, reach out to our CQC team and we will schedule a call with your organization to answer your questions and determine if this program is the right fit for your organization.

We anticipate finalizing the participant organizations by September 30th, to begin collaborative activities in October 2020.

