PATH Collaborative Planning & Implementation (CPI)

Welcome! The Southwest Collaborative Planning Meeting will be starting shortly.

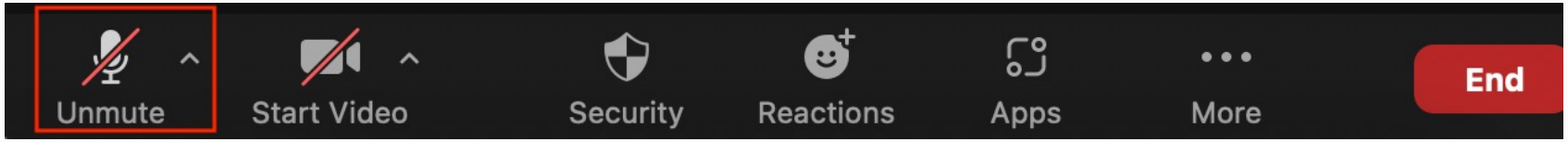
Thursday, February 22, 2024

POPULATION HEALTH
INNOVATION LAB
A Program of the PUBLIC HEALTH INSTITUTE

This event is being recorded.

The slides and recording will be available after the event at **pophealthinnovationlab.org/projects/PATH**

Please mute your microphone and video during the presentation.



PATH – Collaborative Planning & Implementation (CPI)

Southwest Collaborative Planning Meeting

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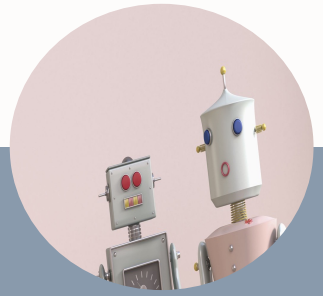
Thank you to our sponsors!

Welcome!

Roll Call
Please rename yourself as *Name, Organization* and share in the chat.

Chat Check-In
Name a new partner in your network you just started working with!!



Participation Eligibility
Vendors and salespeople must remove themselves from this collaborative.

AI meeting tools restricted.

Hybrid Housekeeping

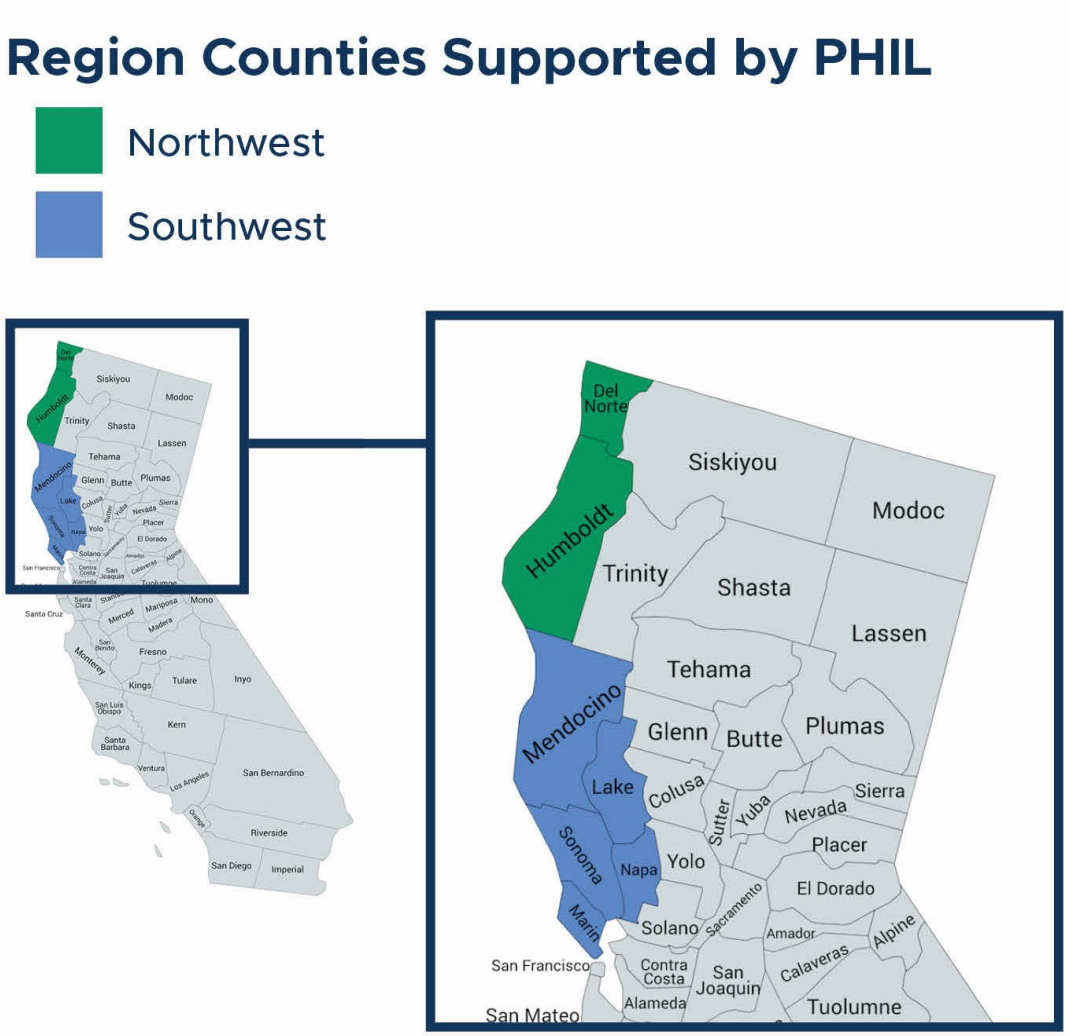
Virtual Attendees:

- Feel free to use the chat feature and hand raise function
- Please mute your microphone while others are sharing
- We will conclude the virtual portion of the meeting around 1:30 pm

In-person Attendees:

- Restroom location
- Exits
- Lunch will start around 12:30 pm

Collaborative Planning & Implementation Overview



CPI collaboratives will work together to identify, discuss, and resolve CalAIM implementation issues.

- Learn more about the PATH CPI initiative here.
- Catch up with us! Find meeting minutes, Readiness Roadmap Resources, and registration links on the PHIL website.

Agenda for Today

- Welcome, Framing, and Check-in
- Local Organization Spotlight
- Reflecting and Refining the Intentions and Objectives for the Northwest Collaborative
- Ecosystems of Care in the Context of CalAIM: Presentation & Activity
- [In-Person] Crowdsourcing for CalAIM Collective Impact: Open Space Peer Networking
- Wrap-up & Evaluation

Objectives

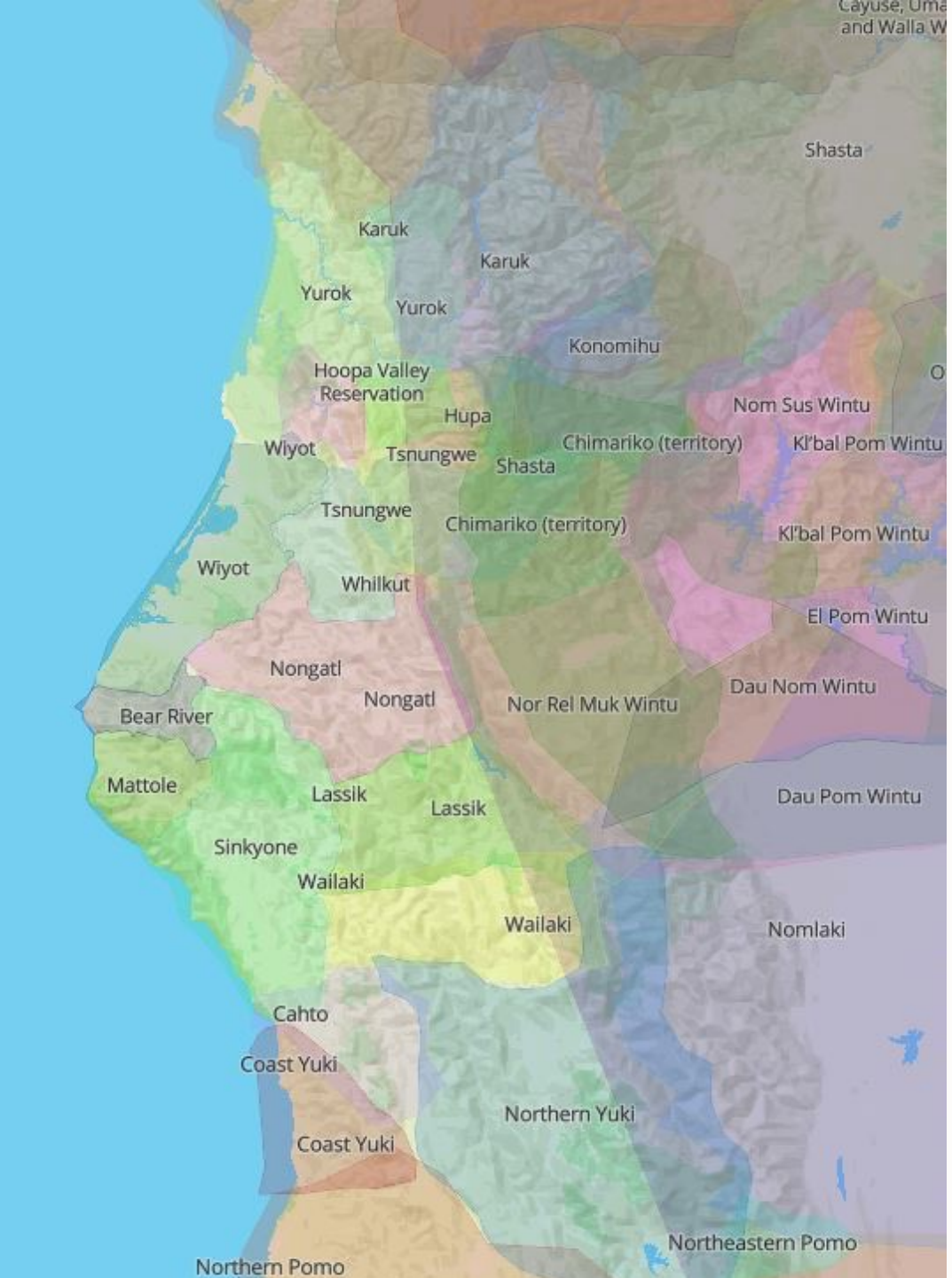
1. Strengthening the capacity of regional CPI participants through empowering them with information, tools, and new perspectives to inform their work.
2. Increasing participant engagement in the overall intention for and objectives of the regional PATH CPI Collaborative work.
3. Increasing participant understanding of the Ecosystems of Care framework within a CalAIM context.

Land Acknowledgment

The Population Health Innovation Lab team respectfully acknowledges that we live and operate on the unceded land of Indigenous peoples throughout the U.S.

We acknowledge the land and country we are on today as the traditional and treaty territory of the Native American, Alaska Native, and Tribal nations who have lived here and cared for the Land since time immemorial. We further acknowledge the role Native American, Alaska Native, and Tribal nations have today in taking care of these lands, as well as the sacrifices they have endured to survive to this day.

Photo by Ralph (Ravi) Kayden on Unsplash



Whose Land Are We On?

Today, despite displacement and hardships, Southern Pomo, Wappo tribes, Granten Rancheria and Me-Wuk tribes persist here in Santa Rosa.

Commitments to Community Inclusivity

Be Present, Brave, and Curious

- Encourage different opinions and respectful disagreement
- Embrace conflict which can deepen our understanding
- Acknowledge the risk speakers take, and value the privilege to learn from one another
- Make use of opportunities to connect person-to-person

Create An Inclusive Space

- Invite the unheard voices
- Take responsibility for our own voices (make space)
- Resist the temptation to only witness the dialogue (take space)

Invite Anti-Racist Dialogue

- Be aware we all have a bias that may impact action; biases are learned and can be unlearned.
- Address racially biased systems and norms
- Recognize the vast and varied lived experiences participants have with racism.
- Be intentional about power dynamics and how you exercise your privilege
- Avoid defensive responses when people speak from lived experiences with racism

Be Accountable

- Foster awareness of unrepresented community members not "in the room" *
- Respect each other's time - participate fully and prepare for each activity
- Commit to actions that move items beyond discussion *
- Practice patience and persistence – we cannot solve everything in a single conversation and will revisit topics that require additional discussion

Commitments Courtesy of: Community Health Worker & Promotor Workforce Development Resource Library — Health Leads. (2023, June 29). Health Leads. https://healthleadsusa.org/communications-center/resources/community-health-worker-promotor-workforce-development-resource-library/

Elevating the Expertise of Local Partners

Local approaches to pain points and solutions in the ECM and CS implementation journey.

Welcome:

Local Mendocino CalAIM Collaborative

Heather Criss & Megan Van Sant

Reflecting and Refining the Intentions and Objectives for this Collaborative

Alignment, Shared Intent, and Improvement

Sense-Making

"The cognitive and communicative processes through which humans understand, describe, and relate to phenomena"

Privilege

Limitations

Ability

History

Locality

Motivations

Bias

Interest

Capacity

Perspectives

Priorities

Drivers

Quote from: https://journals.sagepub.com/doi/10.1177/1609406921998907

STRATEGIES TO EFFECTIVELY COLLABORATE FOR ECM AND COMMUNITY SUPPORT EXPANSION

CURRENT ENVIRONMENT

- Policy is constantly changing
- DHCS is transforming Medi-Cal through various initiatives, including CalAIM.
- Such initiatives, including the Providing Access and Transforming Health (PATH) initiative, have complex and unique roll-outs.
- Regional providers have variable levels of capacity and interest to implement Enhanced Care Management and Community Supports.
- Organizations are working with new external partners and new systems
- Siloed approaches to implementing CalAIM

KEY ELEMENTS

- Shared Vision & Goals
- Shared Knowledge
- Engagement and Retention
- Testing and Innovation
- Gap Identification and Solution

Capacity Building

Relationship Buiding

Collaborative Systems Improvements

Long Term Results

TEAM

CPI Participants
PHIL

MCPs

PCG/ DHCS

Collaborative Supports

Monthly and Pop-Up Convenings

Office Hours and Technical Assistance

Workgroups

Peer-to-Peer Learning

Resource Hub

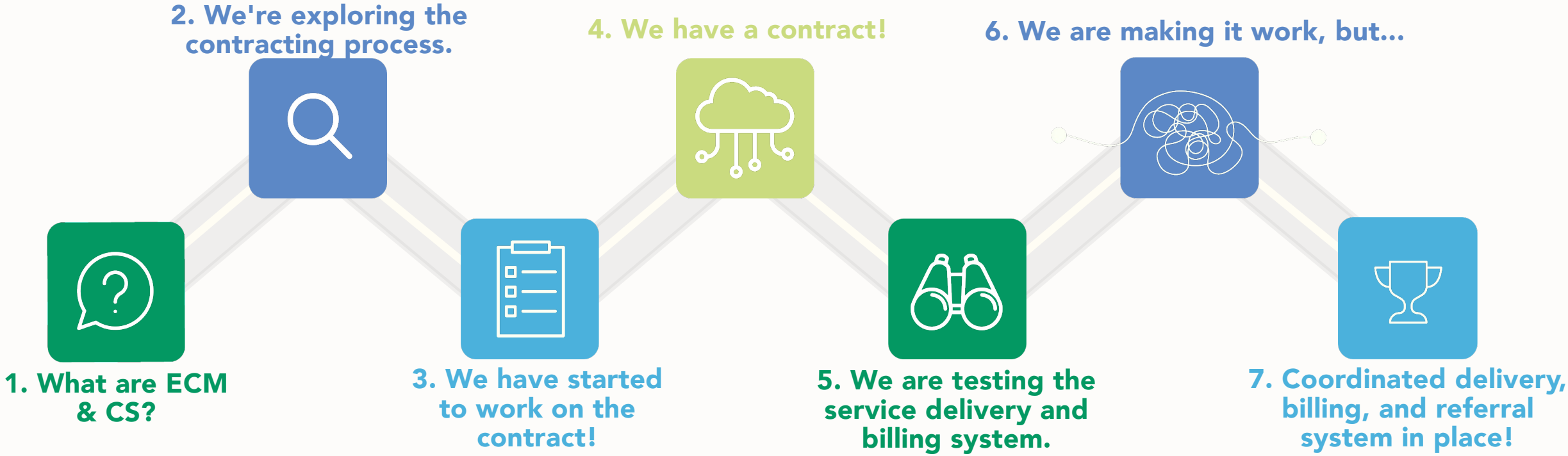
Skill Building and Training Hub

Short Term Results

Resource compilation
Increase peer networks
Gap identification
Unbiased convening space for learning and sharing
Increased partnerships
Increase alignment in CalAIM participation

Reflecting on our Aim Statement for 2023

The PATH Collaborative Planning and Implementation (CPI) initiative will **support the advancement of CPI participants at least one step along the Readiness Roadmap towards successfully implementing Enhanced Care Management (ECM) and Community Supports services** within the Medi-Cal delivery system through collaborative solutions that expand CPI participants' capacity and infrastructure needed to move towards an equitable, coordinated, and accessible Medi-Cal system by Dec 31, 2023.



Refining Our Aim Statement for 2024

By December 31, 2024, the PATH Collaborative Planning and Implementation (CPI) initiative will have **improved access to contracted providers by helping increase the number of providers, increasing enrollment for members who are eligible for Enhanced Care Management and Community Supports** in our contracted counties. *This CPI will facilitate this by supporting the progression of CPI participants along the Readiness Roadmap to effectively integrate Enhanced Care Management (ECM) and Community Supports services within the Medi-Cal system.*

STRATEGIES TO EFFECTIVELY COLLABORATE FOR ECM AND COMMUNITY SUPPORT EXPANSION

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Increase alignment in CalAIM participation

Long Term Results

Increased access to and enrollments into CalAIM ECM/CS (Increase providers, increase in clients enrolled)
Increase in utilization of services in the region

Partnership HealthPlan of California Presentation

Updates on CalAIM implementation

Ashley Peel
Program Manager, ECM

Kaiser Permanente

Updates on CalAIM implementation

Vanessa Davis
Director, Medicaid

Policy Debrief:

MCP Transition, Screenings & Assessments Birth Equity PoF Timely Payments, Claims, Encounters, Billing

Policy Debrief: MCP Transition, Screenings & Assessments

Intent DHCS is simplifying screening and assessment tools as part of the PHM and clarifying screenings and assessments required for member's impacted by the MCP transition.

Source PHM Policy Guide

Health Information Form (HIF)/Member Evaluation Tool (MET)

Will still be required to be completed within 90 days of enrollment for new/transitioning members. However, DHCS is clarifying that:

- MCPs may contract with providers for HIF/MET. If contracted, the provider is responsible for following up on positive screening results. If not contracted, the MCP must follow up on positive screening results.
- Initial Health Appointment(s) results that are completed and shared back with the MCP within 90 days of enrollment would fulfill the HIF/MET requirement and, thus, the federal initial screening requirement.

Individual Health Appointment

- Individual Health Education Behavior Assessment (IHEBA)/Staying Healthy Assessment (SHA) are eliminated, but IHAs remain.
    - Receiving MCPs must ensure that a member has an Initial Health Appointment(s) within 120 days of their transition.
    - IHA is does not needed within 120 days if the member's PCP determines that the member's medical record contains complete information, was updated in the last 12 months and PCP documents findings in the member's record.

Policy Debrief: MCP Transition, Screenings & Assessments

Intent DHCS is simplifying screening and assessment tools as related as part of the PHM Policy. and clarifying screenings and assessments required for member's impacted by the MCP transition.

Source PHM Policy Guide

Health Risk Assessment (HRA) is required for Seniors and Persons with Disabilities (SPD)

- For transitioning members who have no HRA record and meet the definition of "high risk" per guidance outlined in the CalAIM: PHM Policy Guide and APL 22-024.
- For transitioning members who are authorized to receive Long-Term Services and Supports (LTSS):
  - Receiving MCPs may rely on HRAs conducted by the previous MCP on or after January 1, 2023.
  - Receiving MCPs are required to conduct another HRA if the last HRA last was done prior January 1, 2023.
  - Receiving MCPs are required to conduct another HRA if the member experienced:
    - A significant change in health status
    - A change in level of care
    - A change in risk

Policy Debrief: Birth Equity Launch

Intent Decrease poor birth outcome disparities through Birth Equity ECM services for four groups who have historically poor birth outcomes and disparities based on the CDPH's most recent State public health data (including the Prenatal Care Dashboard and Pregnancy-Related Mortality Dashboard).

Source DHCS 01.17 Presentation and DHCS Birth Equity Webinar 02.02

Birth Equity Population of Focus (Launch January 2024)

Includes *Black, American Indian, Alaska Native, Pacific Islander* Adults and Youth who:

- Are pregnant or are postpartum (through 12-month period past the last day of pregnancy); and
- Are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality

Others Eligible for Birth Equity Services

Other pregnant and postpartum Medi-Cal Managed Care members may be eligible for Birth Equity ECM services, if they meet the criteria of another.

When Determining Eligibility

MCPs should make their best effort to reconcile discrepancies in available data. In cases where:

- Data discrepancies cannot be resolved, the MCP should rely on the member's self-identification of racial and ethnic groups.
- MCP/DHCS has missing or different data, the MCP should rely on the member's self-identification of racial and ethnic group.
- Members who self-identifies with multiple race/ethnic groups should receive Birth Equity services if one of the self-identified groups meets the eligibility criteria.

Policy Debrief: Birth Equity Launch cont'd

Intent Decrease poor birth outcomes and disparities through Birth Equity ECM services for four groups who have historically poor birth outcomes and disparities based on the CDPH's most recent State public health data.

Source DHCS 01.17 Presentation and DHCS Birth Equity Webinar 02.02

Birth Equity ECM Provider Requirements

While DHCS encourages MCPs to contract with POF specific service providers, there are no different or additional requirements for ECM providers who will serve the Birth Equity Population of Focus.

Community Referrals

DHCS expects MCPs to source most ECM and Community Supports referrals from the community. For Birth Equity this may include organizations such as Women, Infants and Children (WIC) and women and family shelters, as well as:

Other Programs and Services	Provider Types (clinical/non-clinical)
• Comprehensive Perinatal Services Program • California Perinatal Equity Initiative • Black Infant Health • Indian Health Programs • American Indian Maternal Support Services • Tribal Social Services Agency • Providers/CBOs Serving Pacific Islanders	• OBGYN & Family Medicine offices • Behavioral health providers • Hospitals • Doulas, Midwives, Promotoras • Maternal Home Visiting providers • Community Health Workers (CHWs) • Community Health Representatives

Policy Debrief: Timely Claims Payments

Intent To remind MCPs of federal and state claims payment requirements, as well as encourage MCPs to go beyond minimum requirements, to the extent feasible, for timely payment of claims to sustain providers and ensure member access to care.

Source DHCS ALL PLAN LETTER 23-020 (REVISED) 10.12.2023

Claims payment Timeline

- Federal Medicaid mandates that 90 percent of all clean claims from practitioners be paid within 30 days of the date of receipt and 99 percent of all clean claims be paid within 90 days of receipt.
- MCPs must pay clean claims within 30 calendar days of receipt and encourages MCPs to go beyond the minimum requirements, if feasible, for claims payment to support and sustain providers so members have access to care.
- If the MCP contests a portion of a claim, it must reimburse any uncontested portions within the statutory timeframes.
- If the MCP contests or denies all or a portion of a claim, it must specify the reason(s) within the statutory timeframes.
- If the MCP needs additional information to complete the claim, it must specify the reason within the statutory timelines.

Delegated Adjudication of Claims

- If delegated to a subcontractor for emergency services, the MCP must forward at least **95 percent** of misdirected claims to the subcontractor within **10** Working Days of receipt.
- If delegated to a subcontractor for non-emergency services, the MCP must forward at least **95 percent** of misdirected claims to the subcontractor ***or*** send denial notice and instructions to provider the within **10** Working Days of receipt.

Policy Debrief: Timely Claims Payments cont'd

Intent To remind MCPs of federal and state claims payment requirements, as well as encourage MCPs to go beyond minimum requirements, to the extent feasible, for timely payment of claims to sustain providers and ensure member access to care.

Source DHCS ALL PLAN LETTER 23-020 (REVISED) 10.12.2023

Other Claims, Encounters, Billing and Invoicing Requirements

- If an MCP does not pay a clean claim within **45** Working Days of receipt, it will owe the Provider 15 percent interested per annum beginning on the first day after a **45** Working Day period.
- Although not required, DHCS expects that MCPs will adhere to timely payment requirements regardless of whether a provider's claim, bill, invoice, or equivalent encounter is tied to a State Directed Payment (SDP).
- MCPs must ensure that Provider Manuals have current policies and procedures (P&Ps) on clean claims submissions, as well as billing and invoicing processes for providers that are unable to submit claims via e-file format.
- MCPs must ensure that all Providers are provided education and training on billing, invoicing, and clean claims submission protocols. This includes encounter submission for those not billed on a fee-for-service basis.
- Training must start within **10** Working Days and be completed within **30** Working Days, after new provider has "active status".

Break Time!

5-10 minutes to grab lunch

Ecosystems of Care Framework

Understanding the Why, What and How

Stefani Hartsfield
Hartsfield Health Systems Consulting

From Silos to Systems

Our experience has taught us that better outcomes for the population we serve will not be accomplished by any single health system, community-based organization, or social service agency. It will take organizations, systems, agencies, and residents working together across a community in a coordinated, interdependent ecosystem.

From Care Coordination To Ecosystems Of Care | Health Affairs Forefront. (2024).

Individual Complexity and Systemic Complexity

Individual Holistic Care

- Person-centered
- Equitable
- Cross-sector
- Team-based
- Data-driven

- Requires trusting relationships and connection from the individual being served and among providers.

- Seeks to improve the health and well-being of a relatively small group of individuals who require multi-layered, intensive supports to a stable wellbeing status.

Systems Level Holistic Care

- Define a shared identity, which requires shared language
- Agreed standards of practice (workflows)
- Voices of leadership and people with lived experience working together.
- Increased possibility for change

- Requires trusting relationships and connection among the organizations.

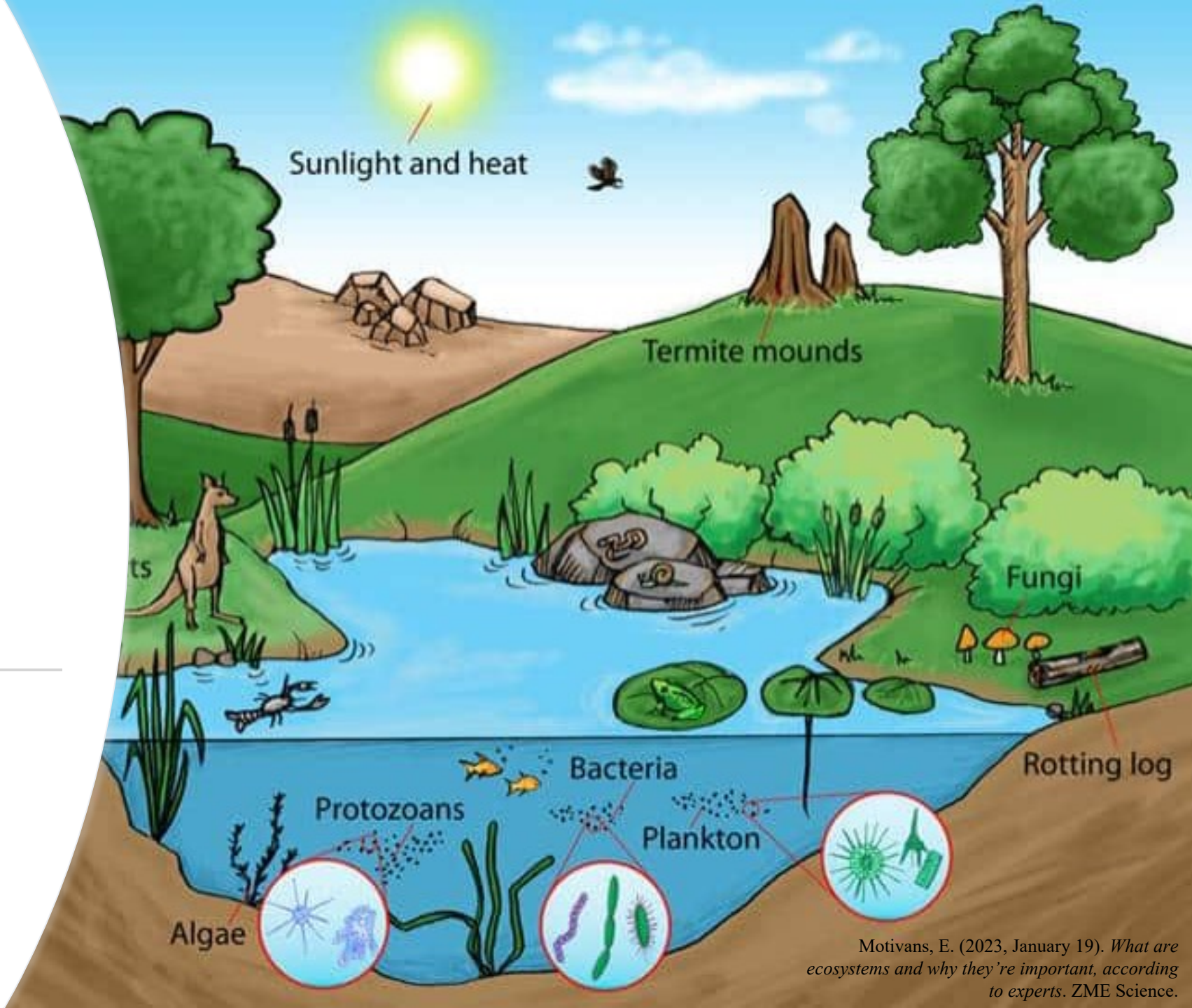
- Addresses the root causes and drivers of poor health.

An ecosystem includes all the living things (plants, animals and organisms) in a given area, interacting with each other, and with their non-living environments (weather, earth, sun, soil, climate, atmosphere). In an ecosystem, each organism has its own niche or role to play.

an. (2024). *What is an ecosystem?* The Australian Museum

Ecosystems

Traditional Ecosystem View



Motivans, E. (2023, January 19). *What are ecosystems and why they're important, according to experts*. ZME Science.

Ecosystems of Care

An ecosystem of care is a local network of organizations, sectors, fields, and/or professions working collectively to address the root causes of poor health among individuals with complex health and social needs.

The National Center for Complex Health and Social Needs | CHCS Center for Health Care Strategies, Inc. | Institute for Healthcare Improvement

Blueprint for Complex Care - Camden Coalition. (2023, November 20). Camden Coalition. https://camdenhealth.org/resources/blueprint-for-complex-care/

Advancing Equity

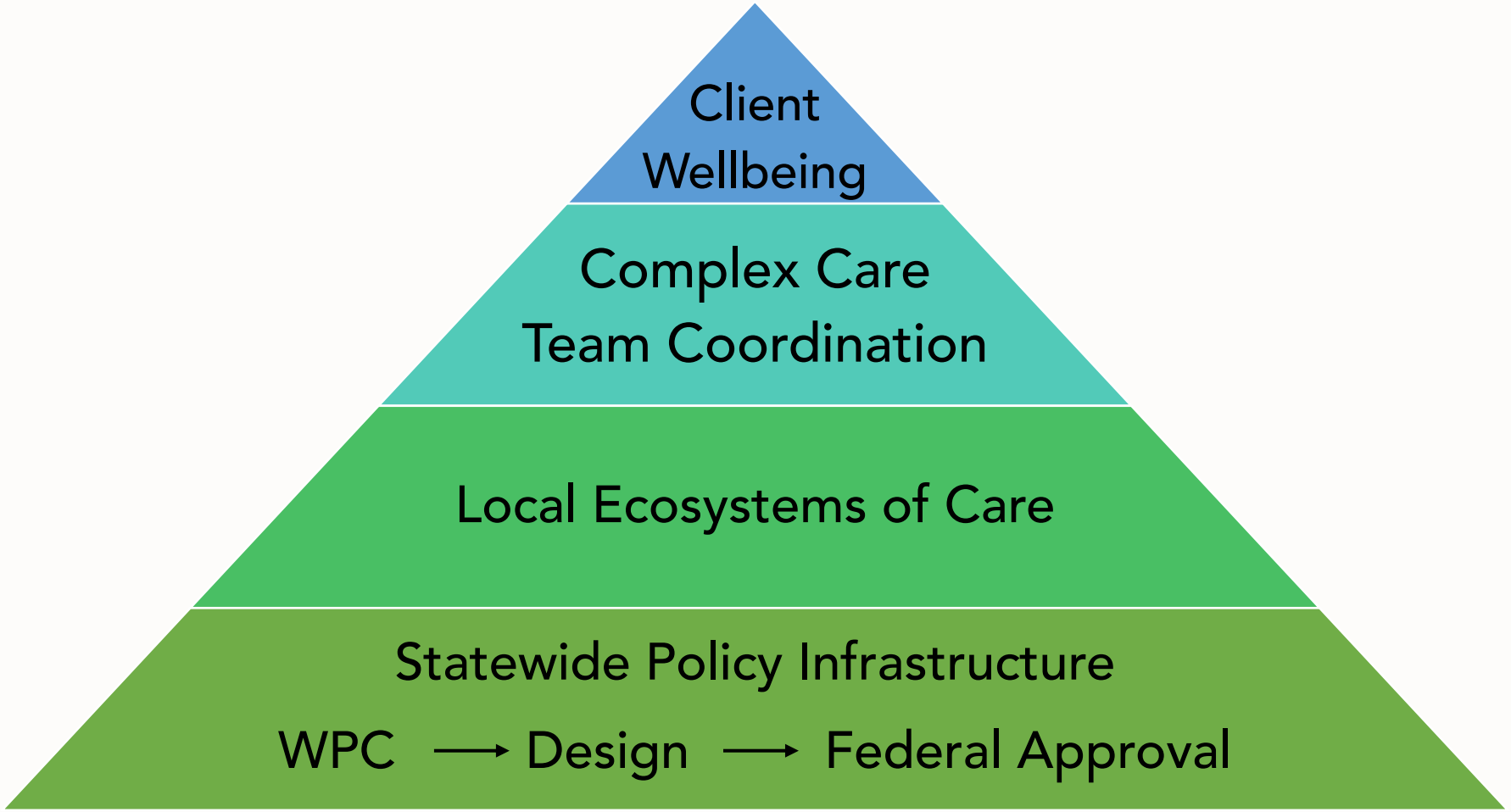
How can Ecosystems of Care help in advancing equity?

- With time, care and intentionality
- Streamline financing models that sustain care across sectors
- Create space for non-traditional provider organizations to have voices in the health continuum conversation.
- Continue to redesign the health delivery systems that fail to meet the needs of the population they serve by including the social care providers at equal value.
- Through building ecosystems of care that enhance cross cross-sector partnerships and elevate marginalized voices, the intention encourages health systems to share power with members of the community.

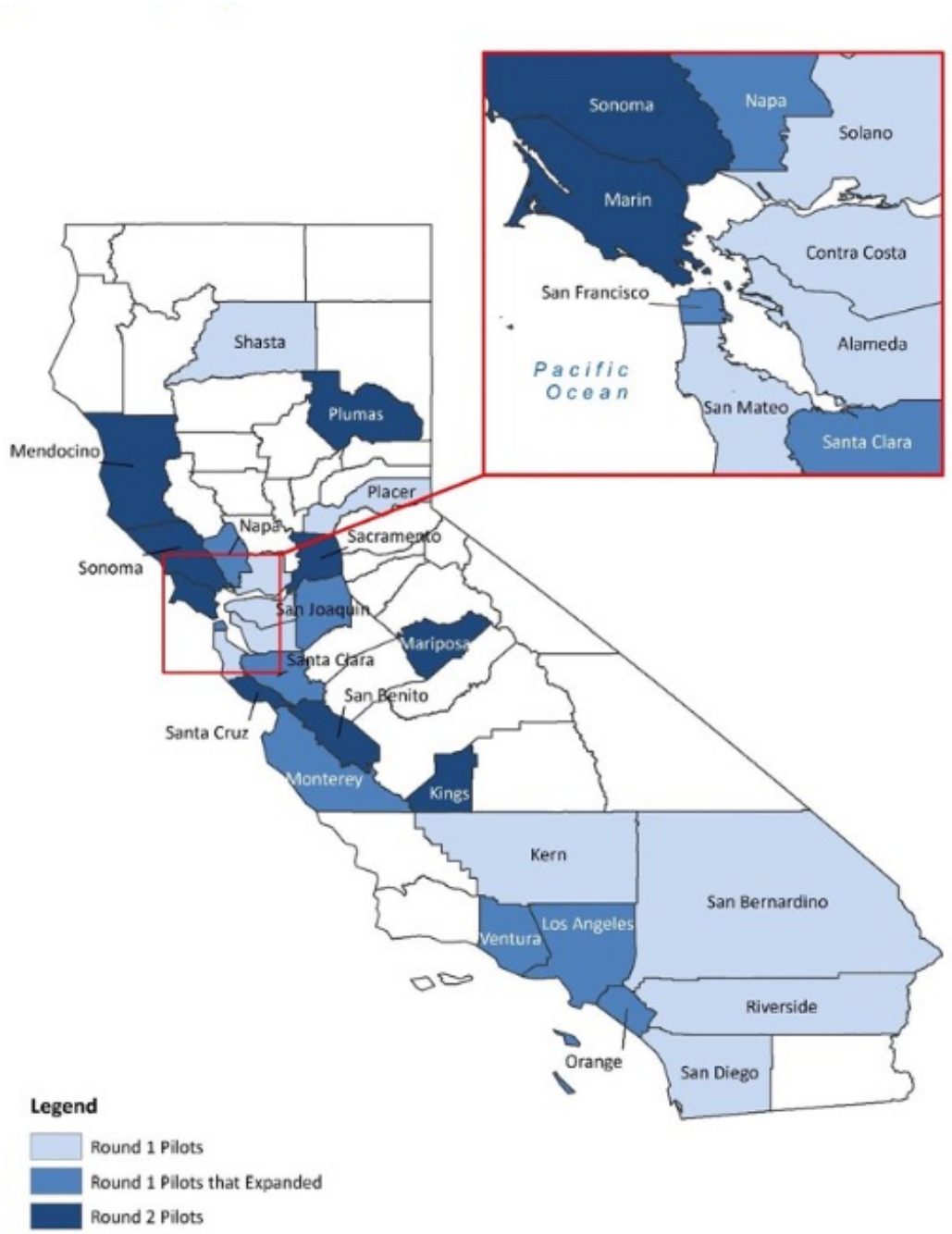
Building the Medi-Cal Ecosystem

*The California Advancing and Innovating (CalAIM) Initiative seeks to transform and align all elements of Medi-Cal into a **standardized, simplified system** focused on helping enrollees live healthier lives.*

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES



Whole Person Care Lead Entity Map



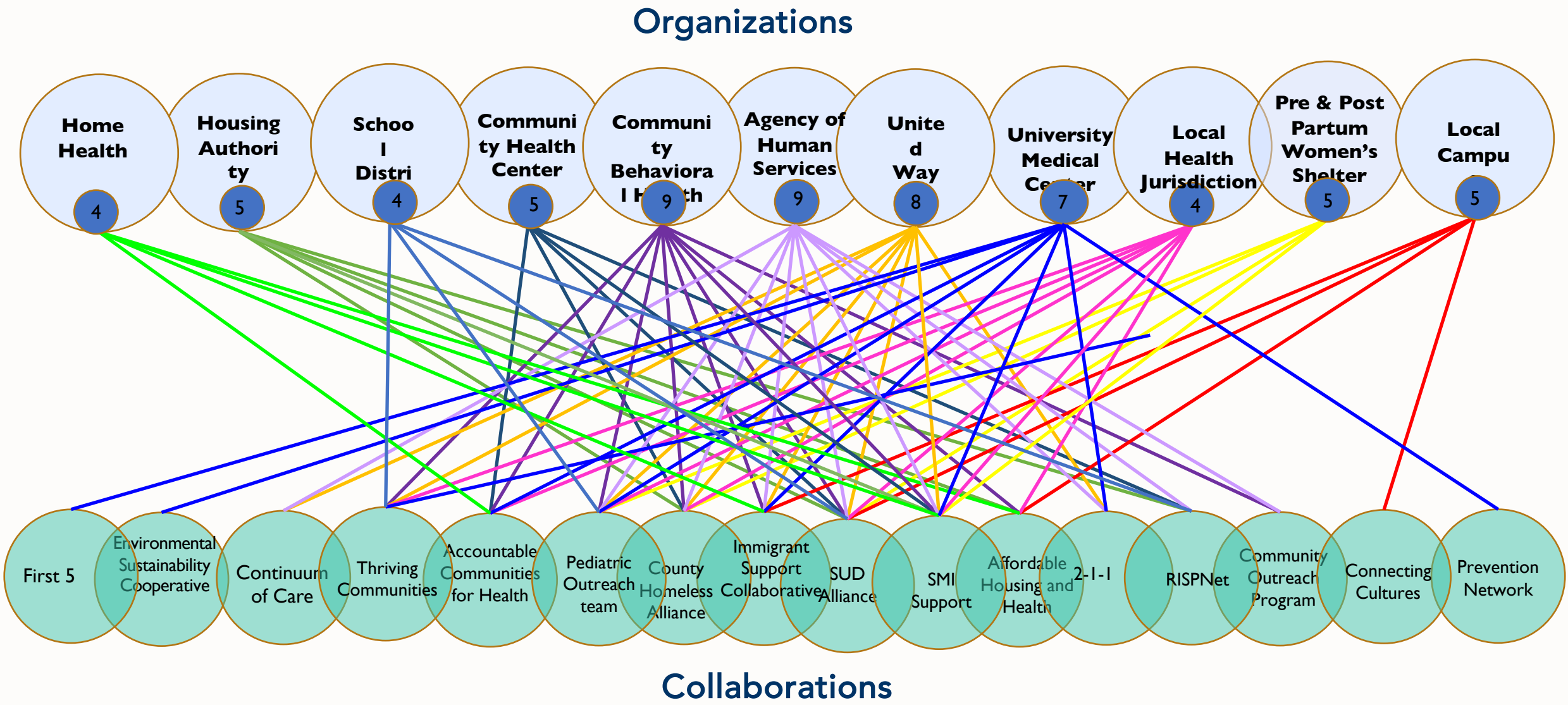
Final Evaluation of California's Whole Person Care (WPC) Program.

CalAIM as an Ecosystem of Care

1. Identify and manage comprehensive needs through whole person care approaches and social drivers of health.
2. Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.
3. Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.

How Does It Apply?

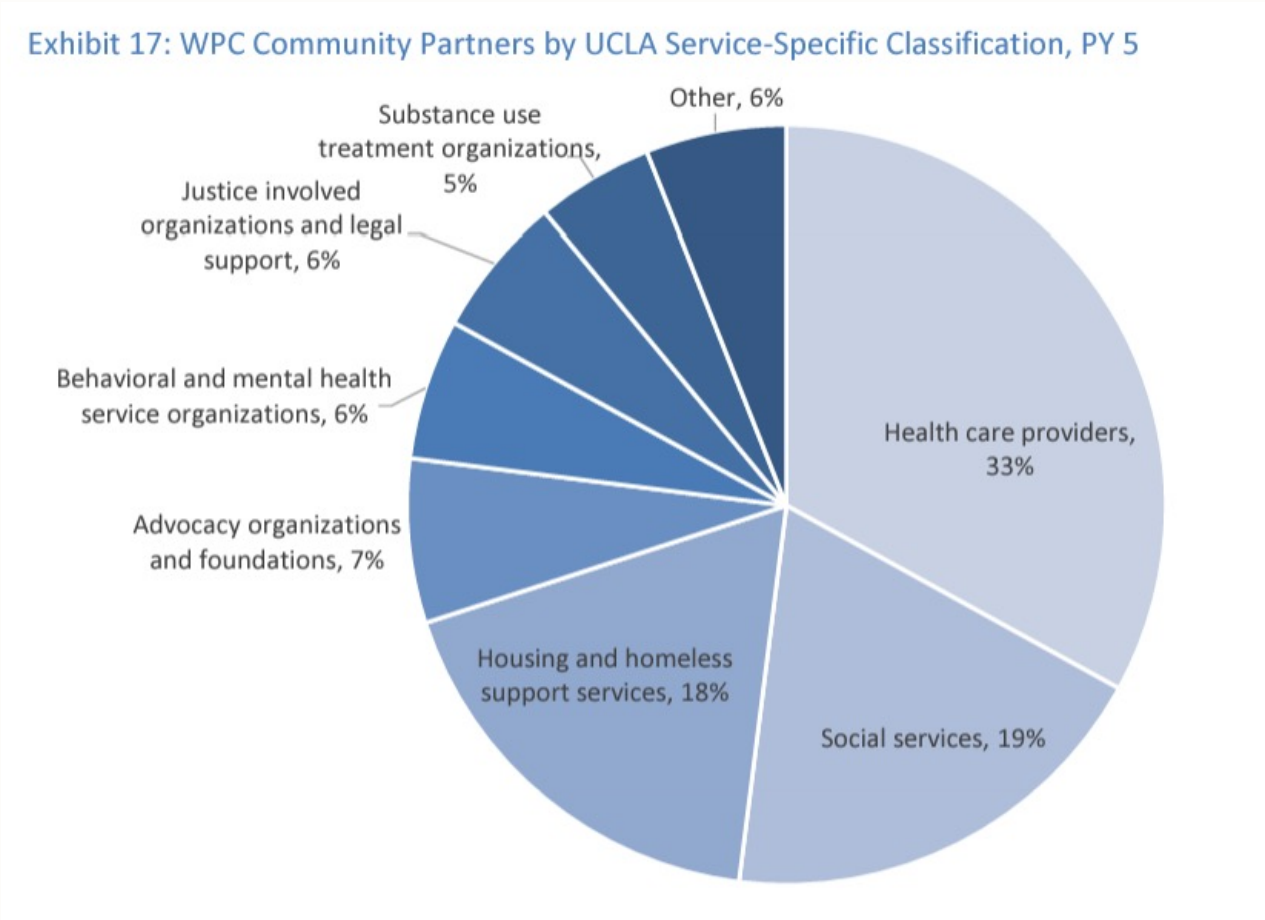
Network Assessment



Whole Person Care Learning

Dimensions of Whole Person Care

Ecosystem Resulting



Tobey, R., Maxwell, J., & Cantor, J. (2015). *An Opportunity to Move from Coverage to Whole-Person Care.*

Final Evaluation of California's Whole Person Care (WPC) Program.

Transition to CalAIM Ecosystems

ALAMEDA COUNTY CARE CONNECT ECOSYSTEM

YOUR COUNTY ECOSYSTEM

Alameda. (2023, July 25). *Alameda County Whole Person Care | AC Care Connect*. Accareconnect

Key Recommendations

DHCS Policy Initiated	Local Care Ecosystem
Develop core competencies and practical tools	Strengthen local cross-sector partnerships through clear definitions and structure.
Develop quality measures for complex care programs	Value the leadership of people with lived experience
Leverage alternative payment models to promote flexible and sustainable funding	Engage allied organizations and healthcare champions through strategic communication and partnership
Identify research and evaluation priorities	Create a field coordination structure that facilitates collective action and systems-level change
Promote expanded public investment in innovation, research, and service delivery	Enhance and promote integrated, cross-sector data infrastructures
Foster peer-to-peer connections and learning dissemination	

Defining Our Ecosystems

Tips for defining your Ecosystem of Care:

1. Analyze local and regional systems in terms of functions rather than actors.

2. Strengthen the enabling environment

3. Weighing the benefits of Standardization and Local Flexibility

Questions?

For more information on Ecosystems of Care:

- Blueprint for Complex Care - Including assessments of strengths and weakness of system and recommendations for best practices.
- The Better Care Playbook – For People with Complex Needs
- Incorporating Community-Based Organizations in Medicaid Efforts to Address Health-Related Social Needs - Key State Considerations

Thank you for joining us!

Our hybrid programming will end as we transition to our small group activity.

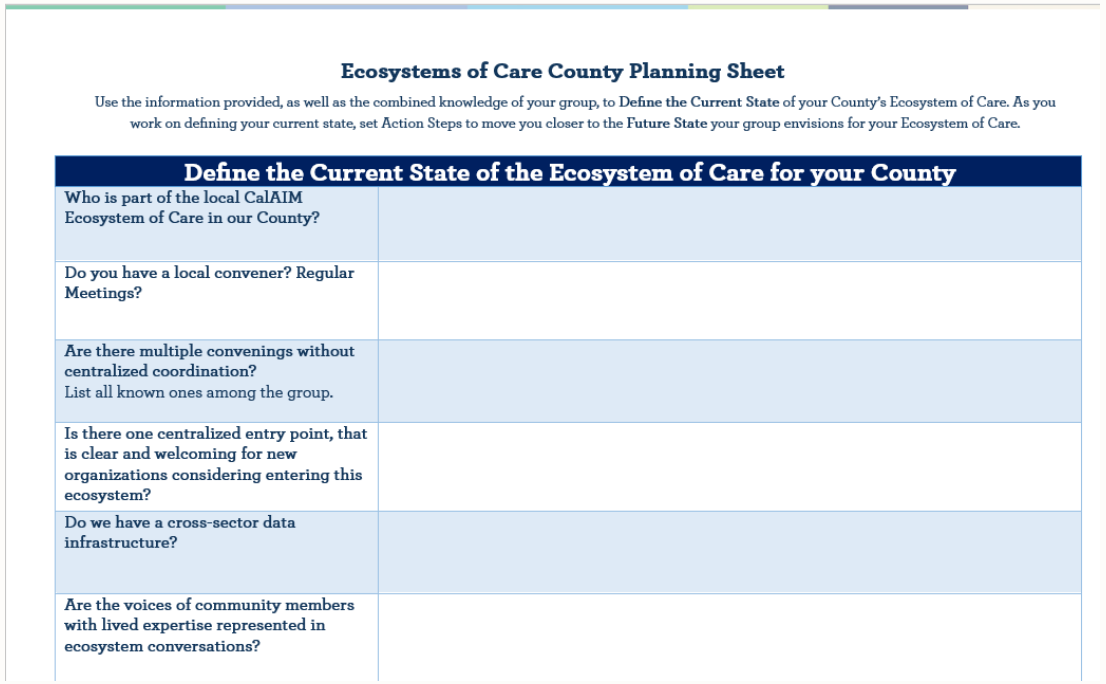
Defining Local Ecosystems of Care

Activity

Assessing Current State

- Move to County Tables
  - Virtual to County Breakout Rooms
- Use the information provided AND the knowledge in the group to:

Define the Current State of your County's CalAIM Ecosystem of Care



Ecosystems of Care County Planning Sheet

Use the information provided, as well as the combined knowledge of your group, to **Define the Current State** of your County's Ecosystem of Care. As you work on defining your current state, set Action Steps to move you closer to the **Future State** your group envisions for your Ecosystem of Care.

Define the Current State of the Ecosystem of Care for your County	
Who is part of the local CalAIM Ecosystem of Care in our County?	
Do you have a local convener? Regular Meetings?	
Are there multiple convenings without centralized coordination? List all known ones among the group.	
Is there one centralized entry point, that is clear and welcoming for new organizations considering entering this ecosystem?	
Do we have a cross-sector data infrastructure?	
Are the voices of community members with lived expertise represented in ecosystem conversations?	

- Please choose a Recorder and a Voice to capture and represent the groups work.

Envision Future Actions

- **Last 10 Minutes**
- Decide what small actions members of the group can commit to accomplish by the March PATH Collaborative!
- Record the:
  - What
  - Who
  - By When
  - Support Needed
- Be Ready to Share!

Envision the Future State Actions we commit to accomplish by the March PATH Collaborative!					
What can we do to fill these gaps?	Responsible Person	With Whom	By When	Support from PHIL Team	MCP or DHCS information
Ex: Invite friend from Dept. of Corrections to join next meeting.	*Jessica*	*N/A*	*2/29/24*	*Does our county have a JI capacity building grant? Who holds it?*	*Who at partnership is working with the JI providers?*
Ex: What avenues exist to compensate community members with lived expertise for participation?	*Tammy*	*Alyssa*	*3/15/24*	*What resources are others using – can you ask statewide? Resource:*	
What else is needed to strengthen convening, data, or other infrastructure to support the local Ecosystem of Care?					

Harvest

- Share a highlight from what you just learned?
- What is an action you will take in response?

Overview of Open Space Technology

Networking Activity

What is Open Space Technology (OST)?

- Open Space Technology (OST) is a methodology of hosting events and group conversations around a central topic where participants create the agenda themselves.
- The process is designed to be highly participatory, inclusive and collaborative and can be with groups ranging in size from 5 to over 1000.
- Participants are in full control of their experience and the outcome of the session – collectively they create the agenda

How does Open Space Technology work?

- **Set a Conversation Theme**
  - The theme helps to focus discussion and to inspire participation
  - Today's Open Space theme is *ECM and Community Supports Implementation*
- **Create the Agenda and Marketplace**
  - Participants are invited to identify topics related to the theme they want to discuss
  - Not everyone needs to put forward a topic
  - The participants that suggest themes are the hosts of the conversations
  - You do **NOT** have to be an expert of the topic – it should be something you want to discuss with others
- **Break into groups by the topics related to the Theme**
  - Participants will choose which topic they are interested in discussing and go the relevant group
- **Follow the OST Roles and Principles**

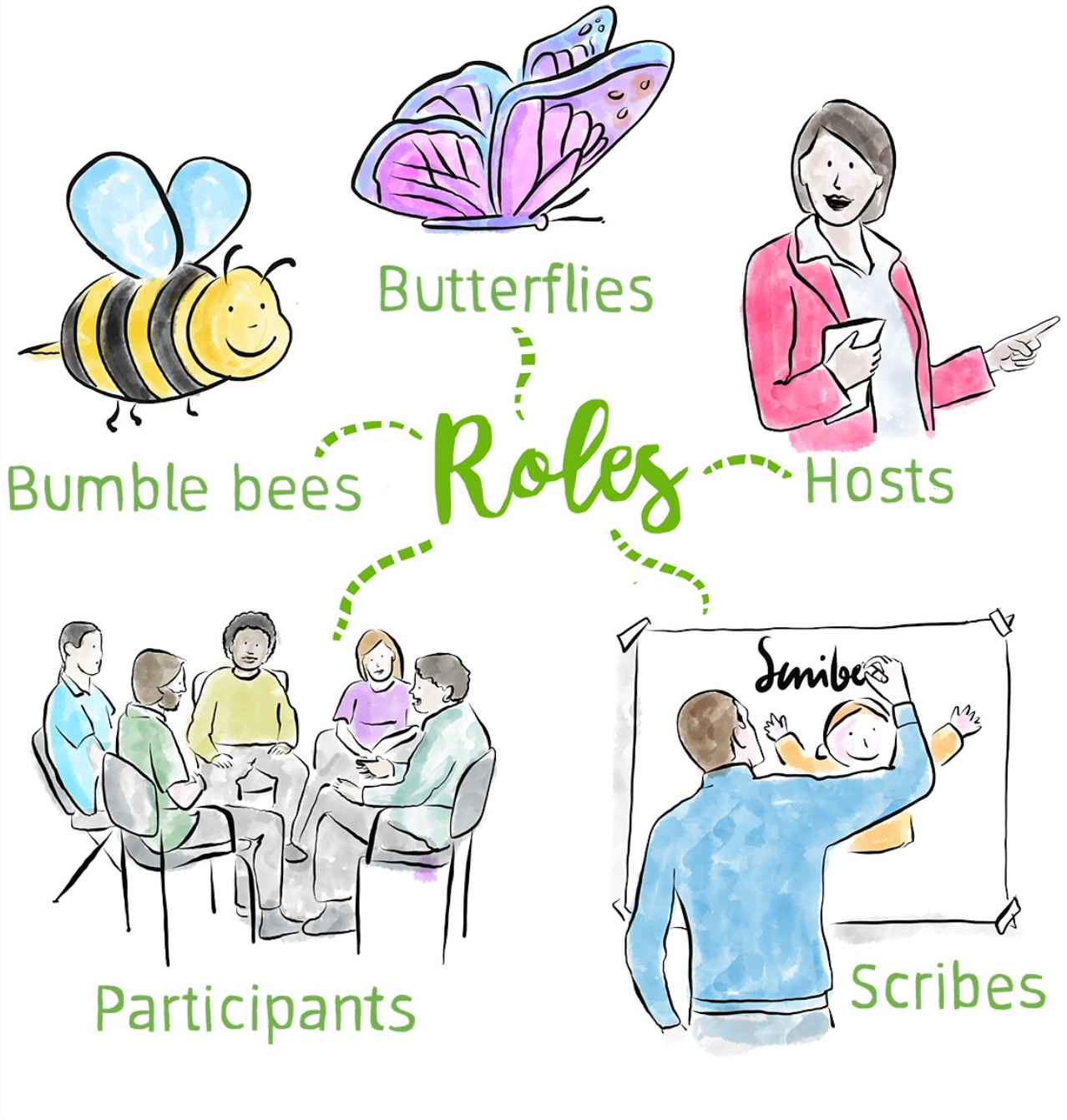
4 Principles and 1 Law

4 Principles of Open Space

- Whoever comes are the right people
- Whenever it starts its the right time
- Whatever happens is the only thing that could have
- When its over its over

The Law of Two Feet

IF AT ANY TIME YOU FIND YOURSELF IN ANY SITUATION WHERE YOU ARE NEITHER LEARNING NOR CONTRIBUTING, USE YOUR TWO FEET.



Open Space Roles

- The host is always the person that proposed the topic of discussion and does not change during a round of conversation.
- You can play one role or in some cases, start in one role and switch to another!

Questions

Open Space Marketplace:

What conversations about ECM and Community Supports implementation do you want to have?

Group Worksheet

- Topic
- Host
- Conversation Participants
- Key Question or Inquiry
- 3 Takeaways for Report Out
- Any Next Steps

Open Space Technology Note Taking Template	
Topic:	
Host:	
Conversation Participants:	
Key Question or Inquiry:	
3 Takeaways for the Report Out:	
What is needed next and any next steps?	

Updates and Upcoming Events

Upcoming PATH CPI Events

Our next CPI regional meeting is virtual. He will see you online!

- NW: Tuesday, March 19 from 1:00 pm – 2:00 pm*
- SW: Wednesday, March 20, 2024 from 1:00 pm – 2:00 pm*

*Timing may be extended to 2:30, based off of January's feedback

PATH CPI Office Hours:

- Monday, February 26 from 1:00 pm – 2:00 pm
- Wednesday, March 13 from 12:00 pm – 12:00 pm
- Monday, March 25 from 1:00 pm – 2:00 pm

Upcoming PATH Events

TA Marketplace Vendor Fair

When? Thursday, February 29 at 9:00 am

What is it? The Vendor Fairs are an opportunity for vendors to pitch their organization and services to potential TA recipients and encourage utilization of the TA Marketplace.

Who should join? TA recipients and organizations interested in learning more about the TA Marketplace—including how to apply to receive free services—are invited to attend.

Upcoming Partnership HealthPlan Events

PHC Roundtables:

- If you were unable to attend the last **ECM RoundTable** and would like the **Chat Q&A**: Please let Vicki, Lynn, or the PHIL team know and one of us will get those out to you. (See slide Appendix for more details)
- Register for the monthly ECM Roundtable
- Register for Community Supports Provider Roundtable

Post-Event Evaluation

To continue improving our work as your CPI Facilitator, PHIL kindly asks that you complete this brief survey. Your feedback ensures quality improvement and will inform planning and activities through the evolution of the collaborative.

https://bit.ly/48qekYF

Thank You!

Feel free to contact our PATH CPI team

Tammy Chandler
PATH CPI Policy & Quality Improvement Manager
tchandler@phi.org

Kathryn Stewart
Director of Learning and Action
kastewart@phi.org

Sue Grinnell
Director of PHIL
sgrinnell@phi.org

Jessica Sanchez
Program Associate
jsanchez2@phi.org

Stefani Hartsfield
Consultant
stefani@hartsfieldhealth.com

For general inquiries, please feel free to email path@pophealthinnovationlab.org


Thank you!