Welcome to Healthcare and Homelessness Pilot Initiative Workshop Day 1!

Mute your audio!

Turn on your video!

Say hi in the chat box! Tell us:

What's something that has made you laugh in the past week?

HEALTHCARE & HOMELESSNESS PILOT INITIATIVE

WORKSHOP 1: DAY 1

HEALTHCARE & HOMELESSNESS

WORKSHOP 1: DAY 1

1

Welcome!

Introductions: Community Solutions

Beth Sandor
Principal

Andi Broffman
Portfolio Lead

Meghan Arsenault
Senior Manager

Anna Bialik
Improvement Advisor

John Gauthier
Project Manager

Introductions: IHI

Aleya Martin
Sr. Project Manager

Catherine Mather
Project Director

Ninon Lewis
Vice President

Catherine Craig
Faculty Coach

Lauran Hardin
Faculty Coach

Agenda: Day 1

Time	Agenda Item
12-12:30PM ET / 9-9:30AM PT	Welcome and Our Journey Together
12:30-1:15PM ET / 9:30-10:15AM PT	Reviewing our Collective AIM
1:15-1:20PM ET/10:15-10:20AM PT	Mini Break/Transition to Breakout 1
1:20-2:30PM ET / 10:20-11:30AM PT	Breakout 1
2:30-2:35PM ET / 11:30-11:35AM PT	Chat Waterfall
2:35-3:05PM ET / 11:35AM-12:05PM PT	**LUNCH BREAK**
3:05-4:20PM ET / 12:05-1:20PM PT	The ‘What’ and ‘Why’ of Quality Data/Breakout 2
4:20-4:50PM ET / 1:20-1:50PM PT	Breakout 3: Wrap Up Team Time
4:45-5PM ET / 1:45-2PM PT	Closing

Agenda: Day 2

Time	Agenda Item
12-12:15PM ET / 9-9:15AM PT	Welcome Back
12:15-1:15PM ET / 9:15-10:15AM PT	Cross Sector Collaboration
1:15-1:30PM ET / 10:15-10:30AM PT	Break
1:30-2:30PM ET / 10:30-11:30AM PT	Quality Improvement and the Theory of Change
2:30-3PM ET / 11:30 - 12PM PT	**LUNCH BREAK**
3-4PM ET / 12-1PM PT	Breakout: Team Time
4-4:45PM ET / 12- 12:45PM PT	Closing

Working Agreements for the Pilot

Share your experiences

Practice "Yes...*and*" vs. "Yes..*but*"

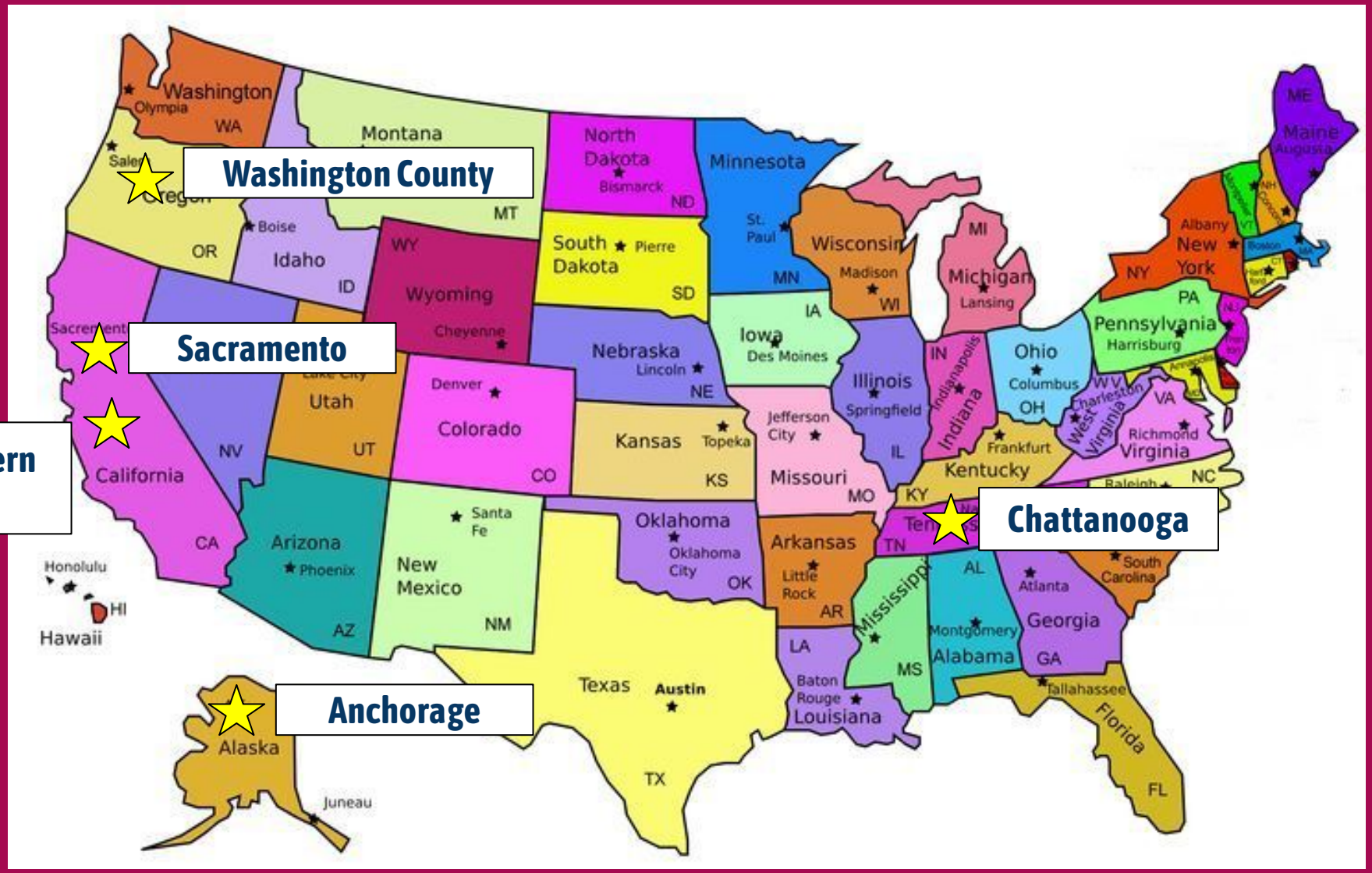
Stay curious

Respect time

Expect to experience varied emotions

Show up, choose to be present

Participating Pilot Teams



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1. Click on 'Participants'

2. Hover over your name and click 'More'

3. Select 'Rename'
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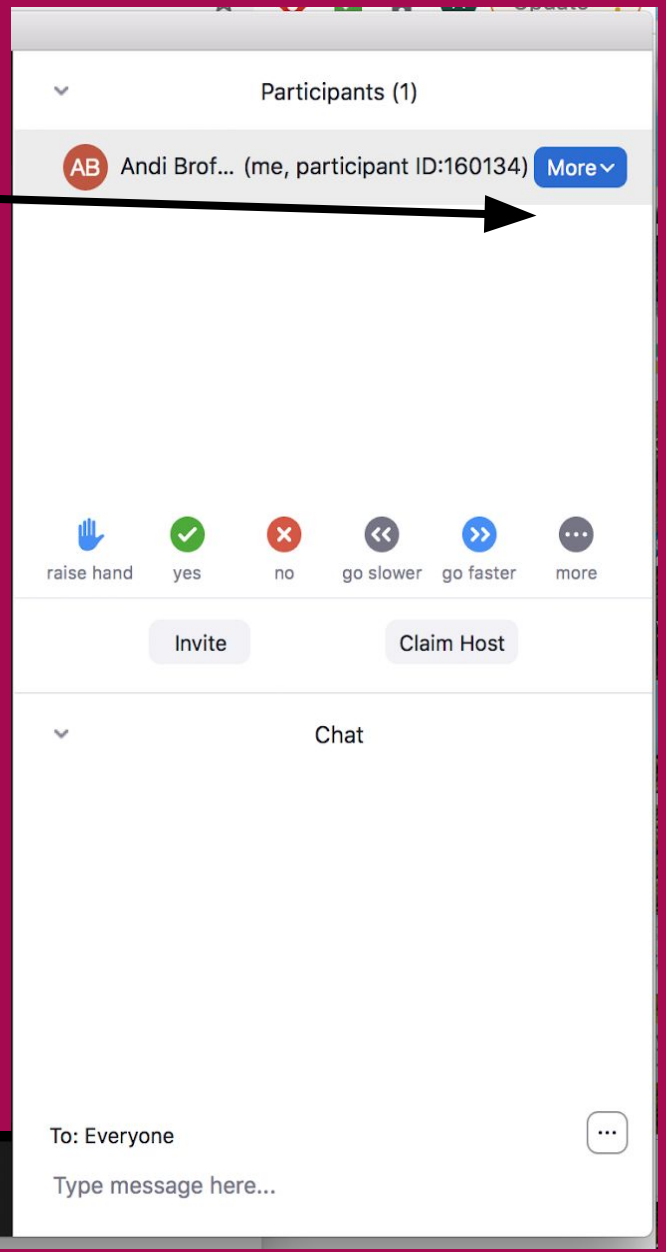

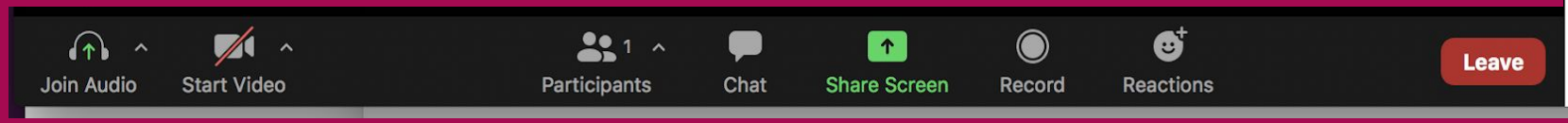

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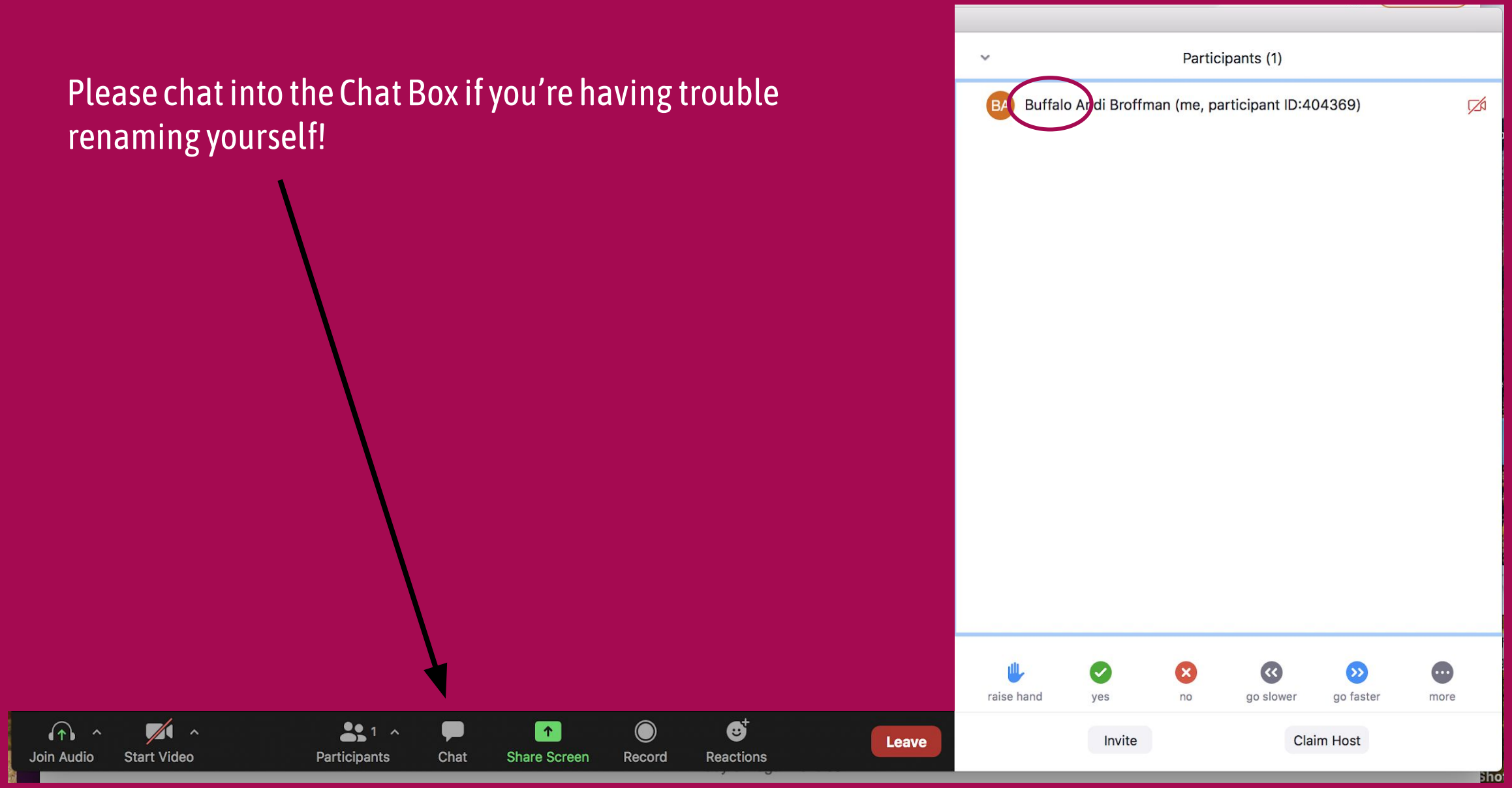

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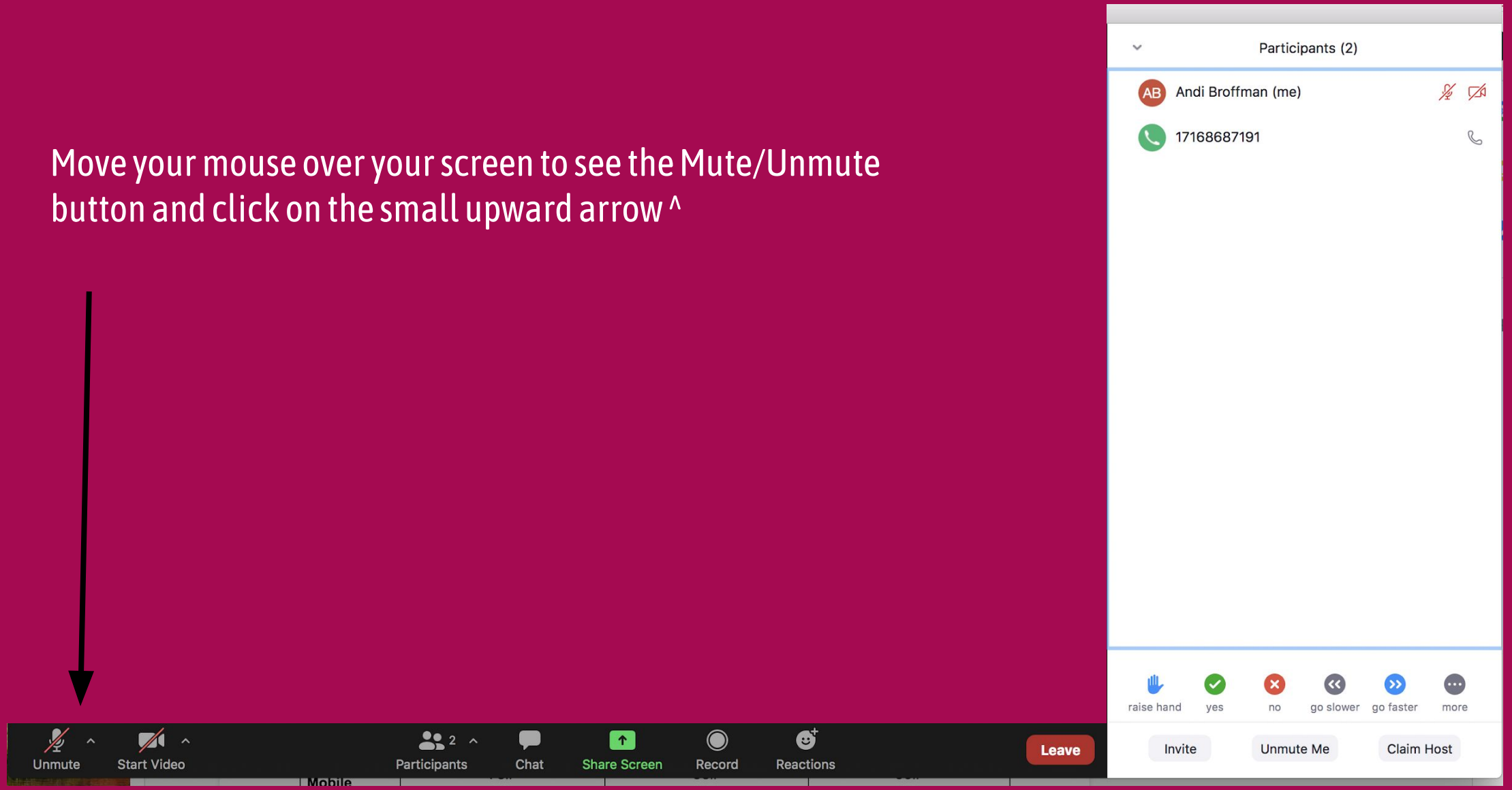

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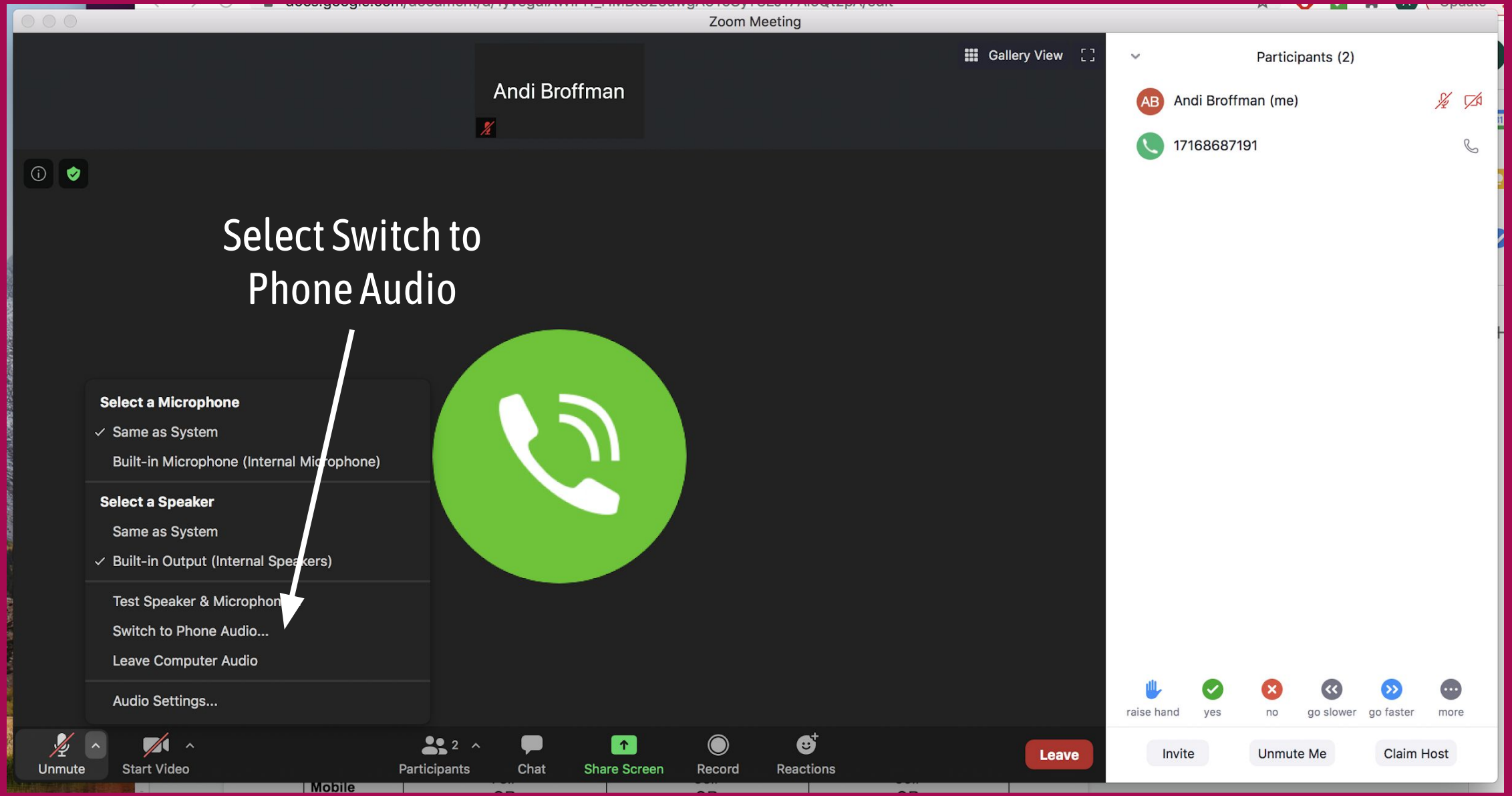

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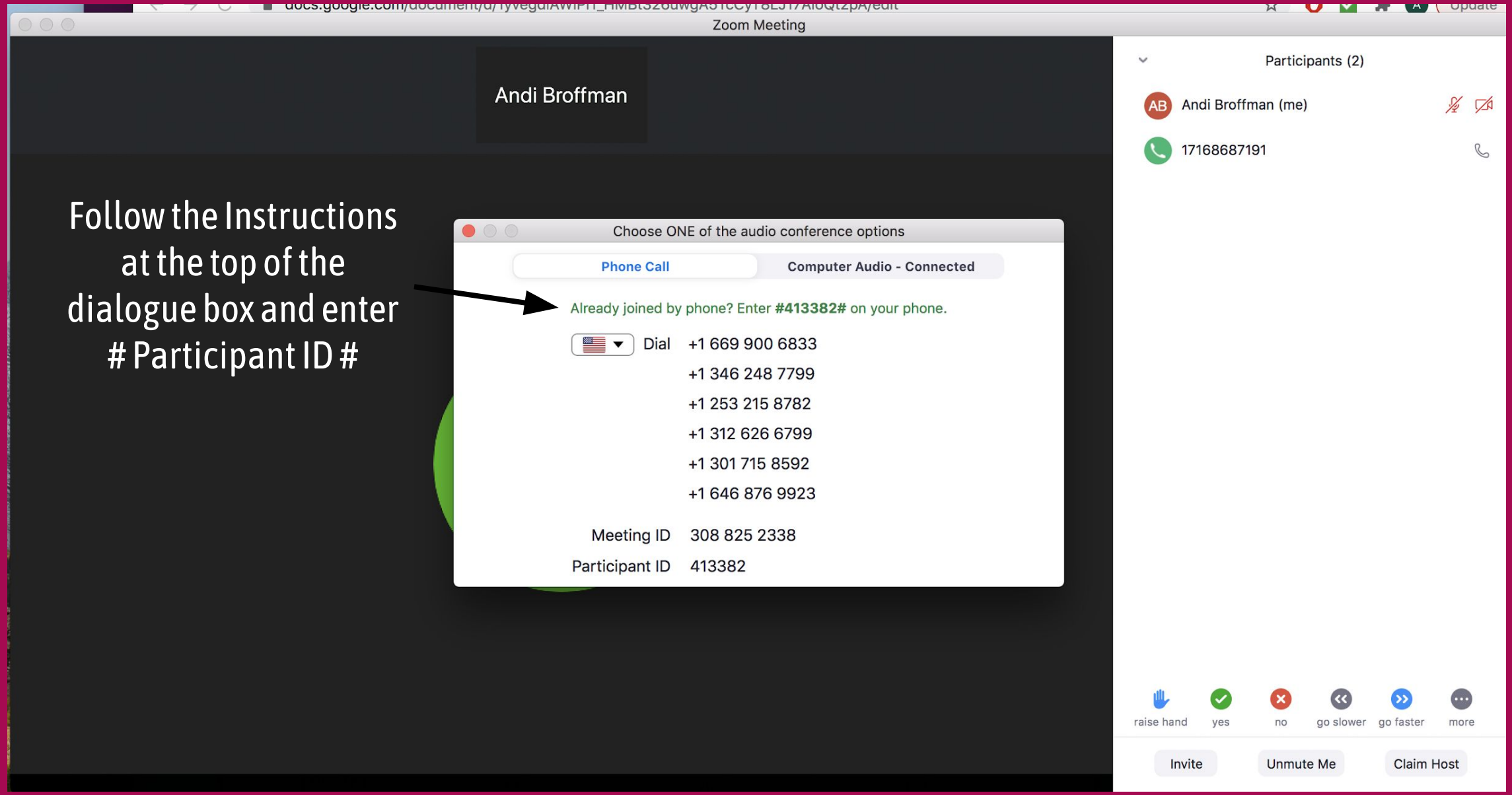
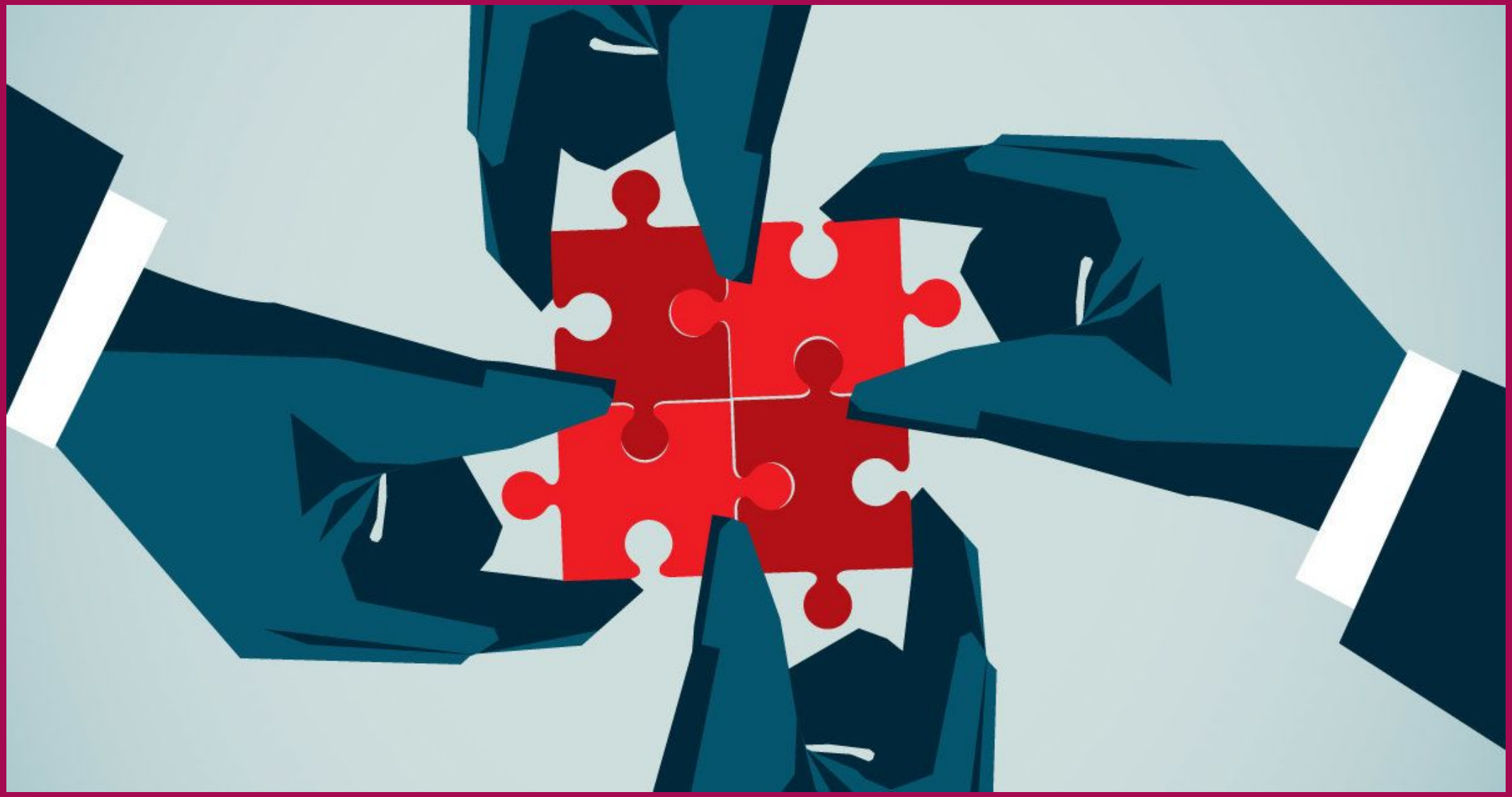


Why now? Why you?



Pilot Initiative Objectives

✔ Prevent, reduce and end chronic homelessness through collaboration with health systems

✔ Identify interventions/ways of working that have the greatest impact;

✔ Make the business case for both the health system and the overall community;

✔ Understand the effects of housing for the health of the chronically homeless population and the impact on healthcare institutions operationally, including the morale of staff as a result of actively participating in problem solving; and

✔ Achieve cost reductions or greater value for funds spent.

Our Journey Together in the Pilot

Kick-Off Call
December 2020

Foundations Phase
December & January 2020

Virtual Workshop 1
January 28 & 29, 2021

Action Period 1
February - May 2021

Virtual Workshop 2
May 2021

Action Period 2
May - October 2021

Workshop 3
October 2021

Action Period 3
October 2021 - May 2022

Workshop 4
May 2022

Action Period 4
May - October 2022

Site Harvesting
October 2022 - January 2023

Kick Off and Foundations Phase

Kick Off Call	Foundations Phase
1. Meet the Pilot Teams and the Pilot Initiative Staff 2. Share the overview of the Pilot Initiative 3. Understand your 'why' for this work 4. Preview the work of the Foundations Phase	1. Continue to build rapport and connections between the homelessness system and the health care system on your Pilot Team 2. Work with your Faculty/Coach through virtual coaching to begin Foundations Phase Work 3. Start a Storyboard to be worked on during Workshop 1

Workshop Objectives

Workshop 1

1. Continue to build relationships between health systems and homelessness systems
2. Review the Pilot Initiative Aim and identify ‘what would need to be true’ to achieve this aim
3. Review Quality Data and Why It’s Important
4. Build on Knowledge of Cross Sector Collaboration
5. Review our Quality Improvement Approach and the Theory of Change for this Pilot
6. Identify your three month milestone - where do we want to be by May?
7. Feel connected as one Pilot cohort

Action Periods: What to Expect

Pilot Team Coaching Calls	All Pilot Site Monthly Calls
Who: Health System representatives Homelessness System Representatives, IHI Faculty Coach, Built for Zero Coach	**Who:** All Pilot Teams: • Health System representatives • Homelessness System representatives • IHI Staff • Built for Zero Staff
What: up to 90 minutes of Pilot Team coaching	**What:** 60 minute group calls to engage in discussions around shared challenges, bright spots, cross team learning and networking
When: Once per month, schedule with your coaches and Pilot Teams	**When:** 4th Wednesday of each month, 3-4PM ET/12-1PM PT Starting February 24th

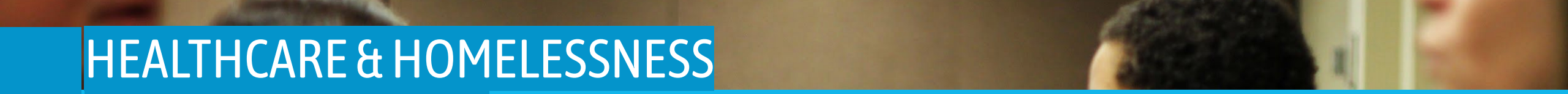
Action Period 1: February through May

As a pilot team…

1. Finalize a 3 month milestone
2. Identify a portfolio of projects from the Theory of Change
3. Participate in Pilot Site coaching calls
4. Participate in All Pilot Site monthly calls
5. Prepare for Workshop 2 (May 2021)

Communities and Coaches

Chattanooga	Sacramento	Bakersfield	Washington County	Anchorage
IHI Faculty Coach: Catherine Craig	**IHI Faculty Coach:** Catherine Craig	**IHI Faculty Coach:** Lauran Hardin	**IHI Faculty Coach:** Lauran Hardin	**IHI Faculty Coach:** Lauran Hardin
BfZ Coach: Anna Bialik	**BfZ Coach:** Anna Bialik	**BfZ Coach:** Anna Bialik	**BfZ Coach:** Anna Bialik	**BfZ Coach:** Anna Bialik



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Our Collective Aim

Pilot Initiative Purpose Statement

Health Systems will make a meaningful, measurable and transformative contribution to ending chronic homelessness in a community

Pilot Initiative Aim

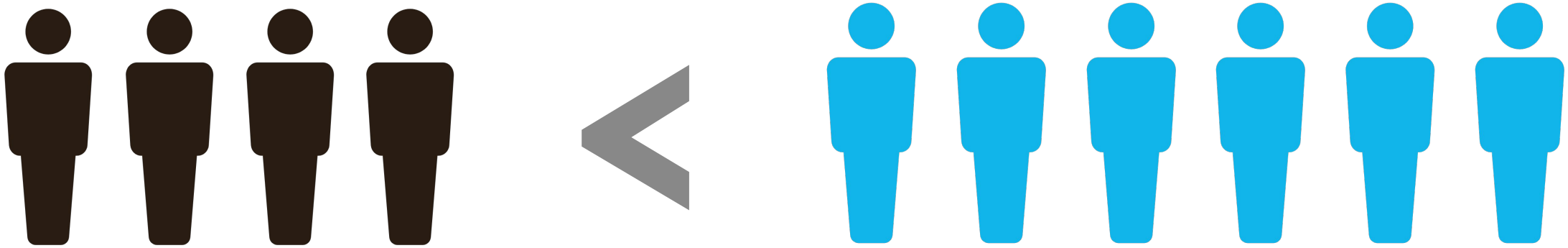
Over the course of the 2 year initiative, Pilot Teams will have made measurable progress toward ending chronic homelessness, with a focus on building racially equitable systems.

Shared Definitions: Chronic Homelessness

Chronic homelessness is defined by the Department of Housing and Urban Development (HUD).

Technical Definition	Spirit of the Definition
People with a disabling condition that: • experienced 1 year or more of continued homelessness • 4 or more episodes of homelessness within 3 years*	People who are experiencing long-term or repeated episodes of homelessness that have complex needs that render them vulnerable

Shared Definitions: Measurable Reduction.



People Currently Experiencing Homelessness

People Experiencing Homelessness at Baseline

Interview: Bakersfield and Functional Zero

Anna Laven
Executive Director
Bakersfield Kern Regional
Homelessness Collaborative

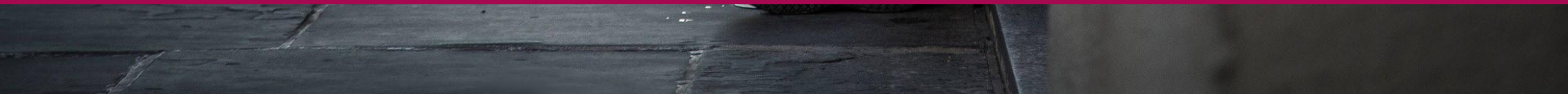
Anna Bialik
Improvement Advisor
Community Solutions
Built for Zero

HEALTHCARE & HOMELESSNESS

WORKSHOP 1: DAY 1

3

Breakout 1



Team Breakouts: Round 1

- We will sort you into breakout rooms with your Pilot Team
  - ***Have you changed your name to include your community?***

- Breakout Options:
  - Complete additional elements of your storyboard ***or***
  - Aim commitment and discussion: what needs to be true to meet the two year aim?

Break!
5 minutes, transition to breakouts
come back at 1:20 ET/10:20 PT

Full Group Share Out: Waterfall of Chat

1. In the chat, type **one new thing you learned about your community or Pilot Team** during the breakout
2. Don't hit send, yet!
3. Once everyone has typed their answer into the chat, we'll let you know when to send your answer to the group

Lunch Break!
See you in 30 minutes

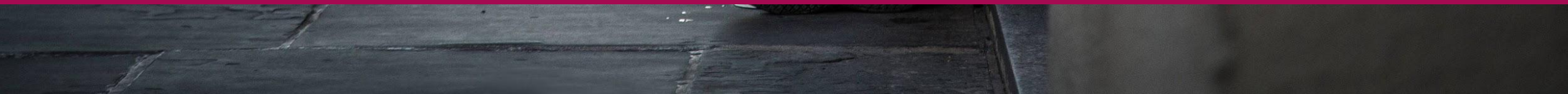
We'll reconvene at 3:05PM ET / 12:05PM PT

HEALTHCARE & HOMELESSNESS

WORKSHOP 1: DAY 1

4

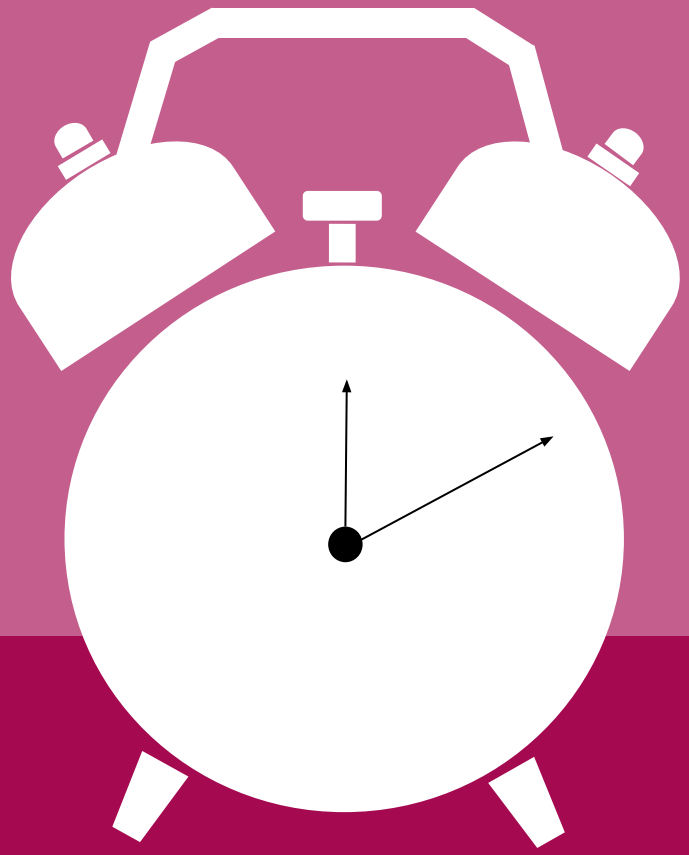
Quality Data in the Homelessness Response System



Comprehensive By-Name Lists

Real-Time Data Designed for Improvement:

Data collected and tracked in a consistent, timely fashion (*as often as possible!*) to help you understand and improve *today's* landscape.



Why We Need Quality Data

A quality by-name list allows a community to collect and track data in a consistent and timely way so that you can:

- See trends in the numbers of individuals becoming homeless
- Understand now people move in and out of the homelessness response system on an ongoing basis
- Have accurate information to set goals to reduce homelessness
- Have accurate information to understand if you are making progress in ending homelessness
- ***Bonus:*** More clearly see the current needs of people experiencing homelessness in your community in real-time to target resources

Targeting Resources for Chronic and Other Vulnerable People

Bonus: More clearly see the current needs of people experiencing homelessness in your community in real-time to target resources

1. There are resources in communities specific for chronic homelessness
2. And, there might be a resource gap for people experiencing long-term homelessness and/or people experiencing homelessness with complex needs that might not meet the definition of chronic
3. This could be a perfect opportunity for Pilot Teams to discuss how health systems can meet resource gaps for that population

Components of a Quality By-Name List

PARTICIPATION & COVERAGE	• All agencies and programs are represented • List tracks all individuals who become homeless • List also includes people sleeping in shelters and on the streets
REAL-TIME UPDATES	• List is updated regularly • As people's status changes, those changes are reflected on the list
PERSON-SPECIFIC	• Each person has a file that includes their name, assessment score, service history, health and housing needs • Each person can be followed through the system from point of becoming homeless

Two Key Indicators of Quality Data

Qualitative
Scorecard/Improvement Framework

Quantitative
Data Reliability

Qualitatively Assessing your List

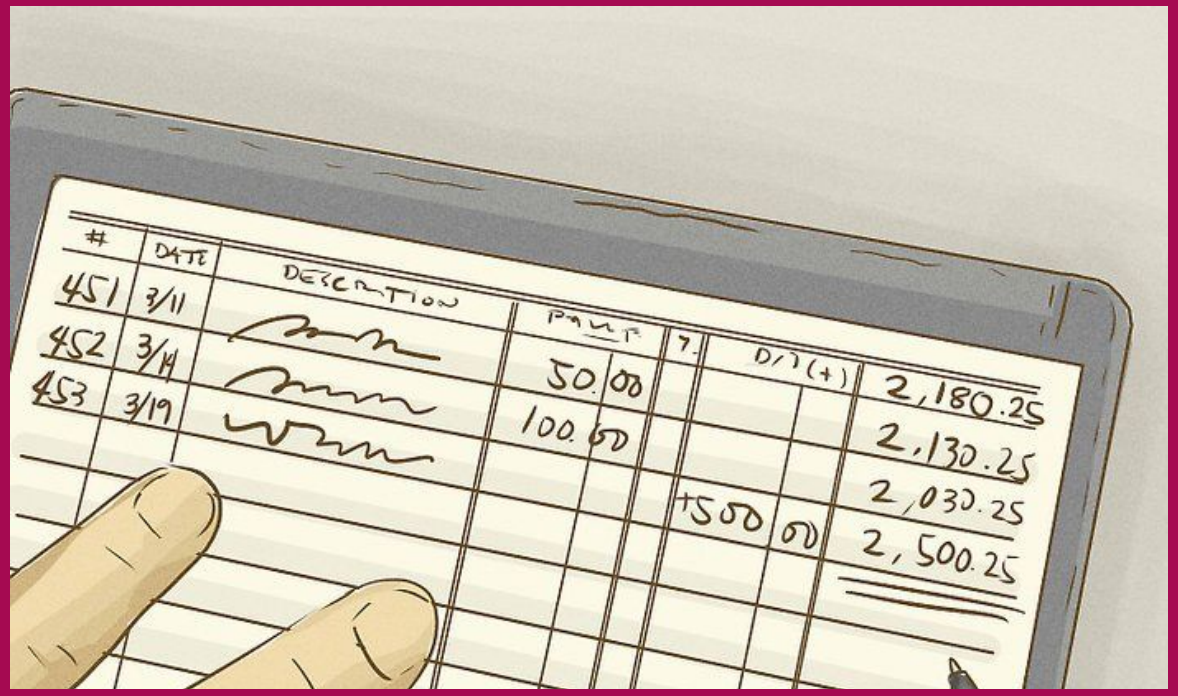
A framework for measuring the quality of your community's data and improvements over time

COMMUNITY PARTICIPATION & COVERAGE	POLICIES & PROCEDURES	DATA INFRASTRUCTURE	
1. Outreach coverage	4. Inactive policy	7. Tracking homeless status	10. Tracking returns to system
2. Providers reporting data	5. Tracking w/o full assessment	8. Unique identifier	11. Tracking outflow
3. Tracking all homeless individuals	6. Timely/accurate data updates	9. Tracking newly identified people	12. Tracking population status
			13. Tracking population status over time

Quantitatively Assessing your List

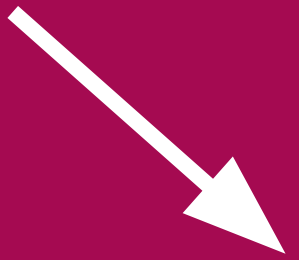
- Inflow/outflow data matches changes in actively homeless number month-to-month

- Combined with a score of 28 (perfect score) on the By-Name List Scorecard, reliable data can provide confidence that your data is good enough to track who is becoming homeless in your community



How Good is Good Enough?

When your 3 month data reliability is at or below 15%



	Actively Homeless Number	3 Mo Outflow	3 Mo Inflow	3 Mo Data Reliability
October 2020	348	38	47	11%

What Data Can a By-Name List Produce?

INFLOW: Newly identified

INFLOW: Returned from housing

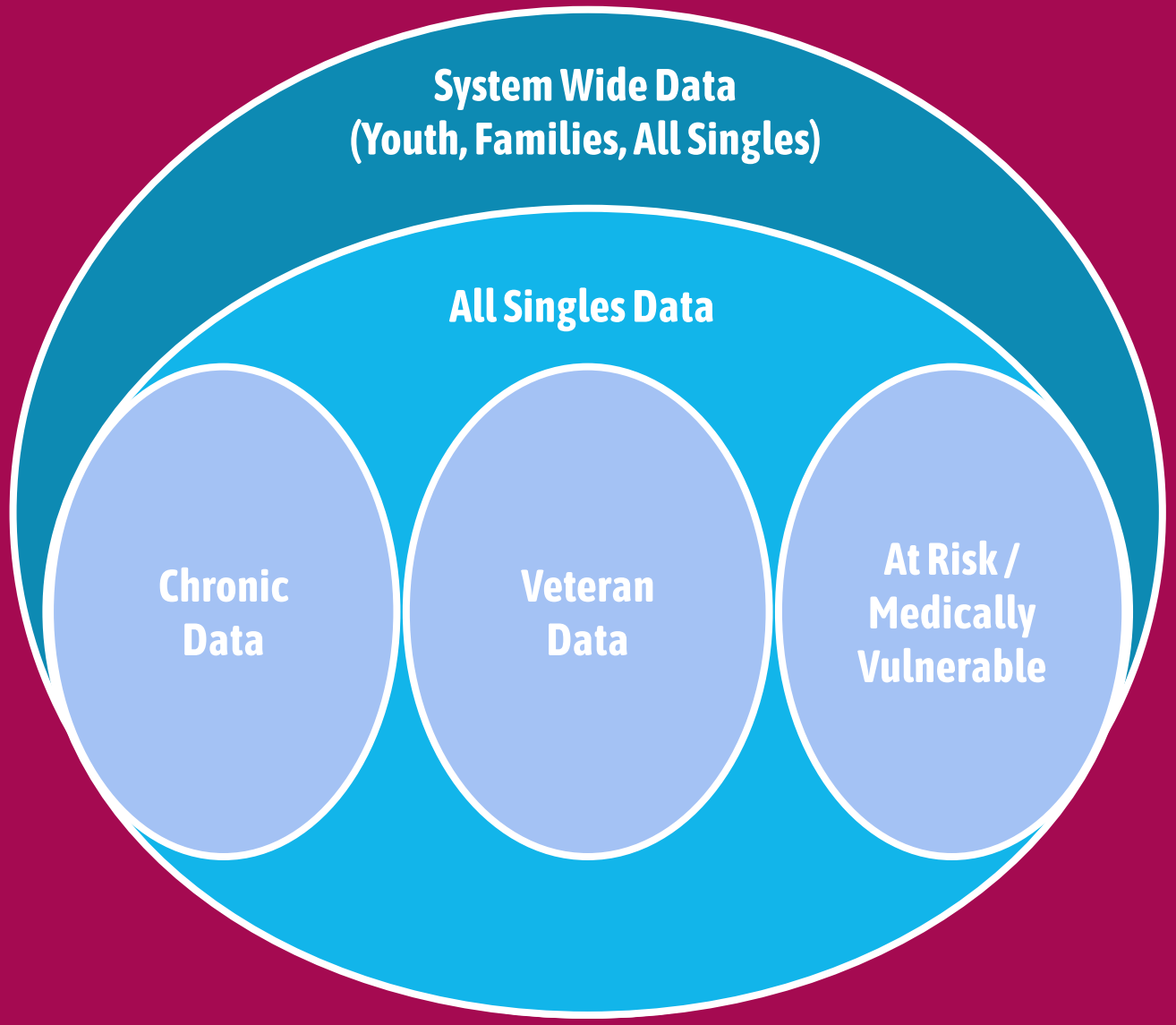
INFLOW: Returned from inactive

OUTFLOW: Housing placements

OUTFLOW: Moved to inactive

OUTFLOW: No longer meets population criteria

Who's On Your By-Name List?



Pilot Initiative Aim

Over the course of the 2 year initiative, Pilot Teams will have made measurable progress toward ending chronic homelessness, with a focus on building racially equitable systems.

Committing to Racial Equity

Why Develop Indicators?

We've heard:

- How important it is to have a concrete, measurable aim
- About challenges in understanding and communicating whether we're making progress
- That it's hard to know if a change actually lead to an improvement
- We aren't sure how to hold the system (and each other) accountable for improvement

Acknowledging Limitations

- This framework intentionally focuses on improvements in the homeless response system and does not include upstream systems that contribute to the overall disproportionality of people of color — particularly Black and Native Americans — experiencing homelessness.
- These measures and indicators do not alone define a racially equitable system, and we encourage communities to determine whether there are additional indicators and measures to incorporate into its work.
- With learning comes improvement. As communities begin measuring and designing toward racially equitable systems, it is likely these indicators will evolve and improve.

Committing to Racial Equity

INDICATORS

SYSTEM DECISION-MAKING POWER

Black, Indigenous, and People of Color (BIPOC) at all levels of the homeless response system have decision-making power to influence the design of the system.

LIVED EXPERIENCE

BIPOC receiving services from the homeless response system have experiences that preserve their dignity and have their needs met in a timely manner.

QUALITY DATA

All people experiencing homelessness have access to the system and are known by name in real-time. Communities accurately collect data around race and ethnicity.

SYSTEM OUTCOMES

Communities close all racial/ethnic disproportionality in housing placements, returns to homelessness, and the average length of time from identification to housing by improving outcomes for BIPOC who experience homelessness.

Quality Data

[Indicator 3] All people experiencing homelessness have **access to the system and are known by name** in real-time. Communities accurately collect data around race and ethnicity.

[Measure(s)]

1. Communities score 100% on the By-Name List (BNL) Scorecard with new racial equity content that aims to ensure data is collected appropriately, of high quality, and complete:
    a. Staff working with, sharing, and communicating race and equity data are **demonstrating best practices to mitigate racial bias** in data.
    b. The data collection process around race and ethnicity fields **respects self-identification** of clients, and best practices to acknowledge the sensitivity around these data points are demonstrated by frontline staff charged with collecting this data.
    c. **Race and ethnicity data is collected for at least 90%** of the individuals on the BNL with high degree of confidence in accuracy.

2. Communities can **visualize and share data disaggregated by race/ethnicity** from their quality BNLs

Quality Data

[Indicator 3] All people experiencing homelessness have **access to the system and are known by name** in real-time. Communities accurately collect data around race and ethnicity.

[Where to Start] Start with your BNL! Look at what % of individuals have race and ethnicity fields completed. Then start unpacking how that data got there (is it a form the individual fills out themself? Are they asked by staff and how? Can they self-identify or are there preset options?

System Outcomes

[Indicator 4] Communities **close all racial/ethnic disproportionality** in housing placements, returns to homelessness, and the average length of time from identification to housing by improving outcomes for Black, Indigenous, and People of Color who experience homelessness.

[Measure(s)]

1. Racial/ethnic disproportionality in housing placement outcomes, returns to homelessness, and the average length of time from identification to housing is **analyzed with an intersectional lens** (considering gender identity, age, and sexual orientation) and documented.

2. **Measurable improvement results in closing the gap** in outcomes for populations experiencing disproportionately worse outcomes in:
    a. Housing placements
    b. Returns to homelessness
    c. Length of time homeless

System Outcomes

[Indicator 4] Communities **close all racial/ethnic disproportionality** in housing placements, returns to homelessness, and the average length of time from identification to housing by improving outcomes for Black, Indigenous, and People of Color who experience homelessness.

[Where to Start] Start by exploring your data and identifying potential disparities in outcomes. Look intersectionally if you can -- not just by race/ethnicity but also by age, gender identity, sexual orientation, and geographic region.

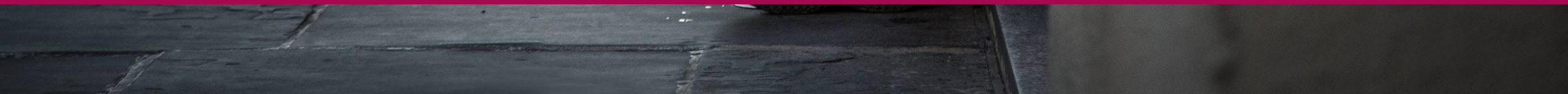
HEALTHCARE & HOMELESSNESS

WORKSHOP 1: DAY 1

4

Breakout 2

3:45pm - 4:15pm ET / 12:45pm - 1:15pm PT



Breakout 2: Data Conversations

Participate in guided discussions about your Pilot Site's
By-Name List Data and other data focused concepts

Break!
5 minutes, stay in breakouts
Come back at 4:20pm ET/1:20pm PT

You'll reconvene in your breakout room

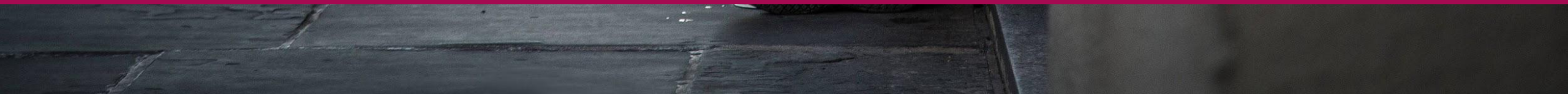
HEALTHCARE & HOMELESSNESS

WORKSHOP 1: DAY 1

4

Breakout 3

4:20 - 4:50 pm ET/1:20 - 1:50pm PT



Breakout 3: Wrap Up Team Time

- Begin or build upon earlier discussion of what would need to be true to meet the pilot initiative aim of making measurable progress toward ending chronic homelessness ***or***

- Continue your data discussions

5

Day 1 Wrap Up

Agenda: Day 2

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12-12:15PM ET / 9-9:15AM PT	Welcome Back
12:15-1:15PM ET / 9:15-10:15AM PT	Cross Sector Collaboration
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3-4PM ET / 12-1PM PT	Breakout: Team Time
4-4:45PM ET / 12- 12:45PM PT	Closing

For Tomorrow

- Review the Theory of Change in preparation for a deep dive and beginning to think about your pilot team's three month milestone and highest leverage strategy areas

- Join us with the Zoom link in your calendar invitation at 12PM ET / 9AM PT

Closing

- Utilize the chat box to tell us one word to describe how you feel after Day 1?

Thanks and see you tomorrow!

HEALTHCARE & HOMELESSNESS PILOT INITIATIVE

WORKSHOP 1: DAY 2

HEALTHCARE & HOMELESSNESS

WORKSHOP 1: DAY 2

1

Welcome Back!

Welcome to Healthcare and Homelessness Pilot Initiative Workshop Day 2!

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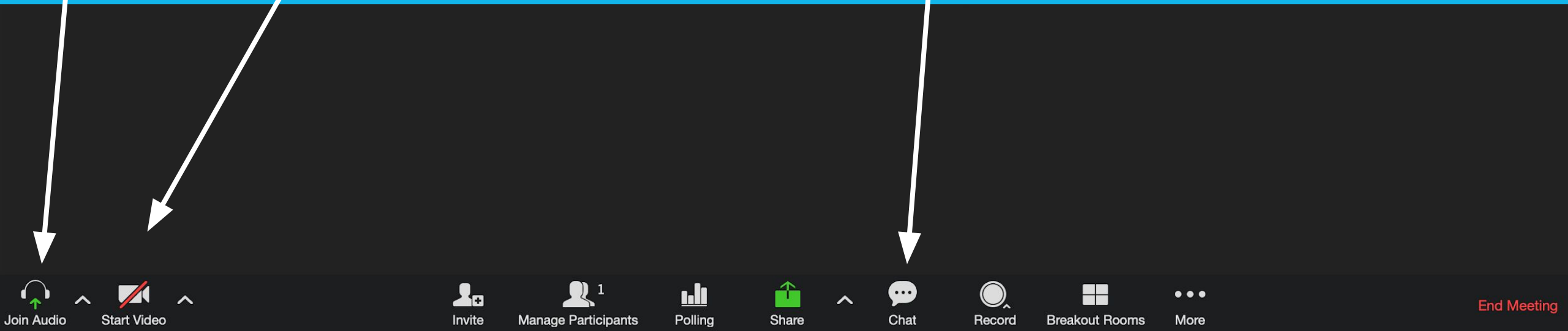
Turn on your video!

Say hi in the chat box! Tell us:

What's something that has made you laugh in the past week?



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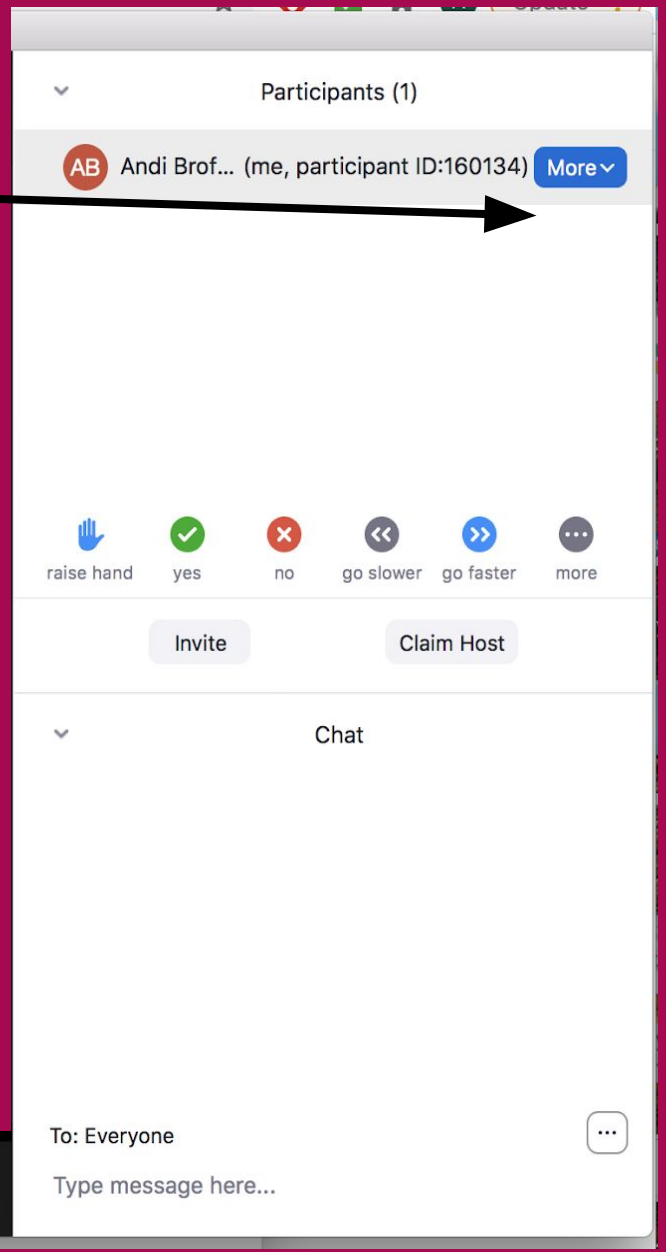

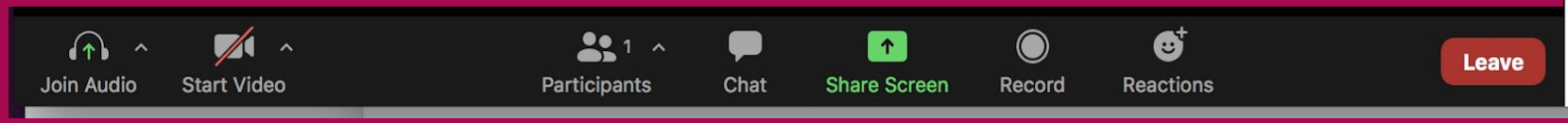

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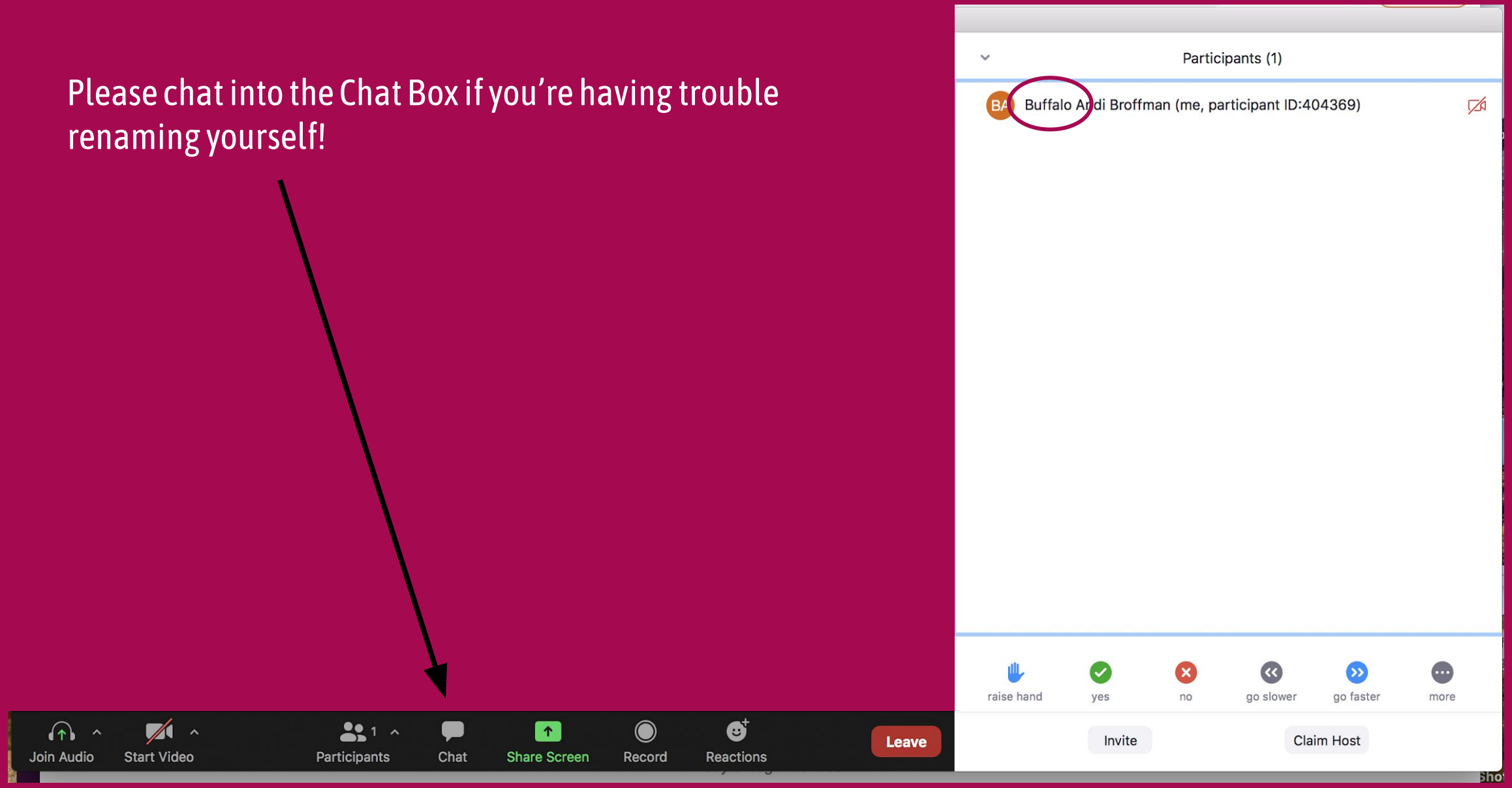

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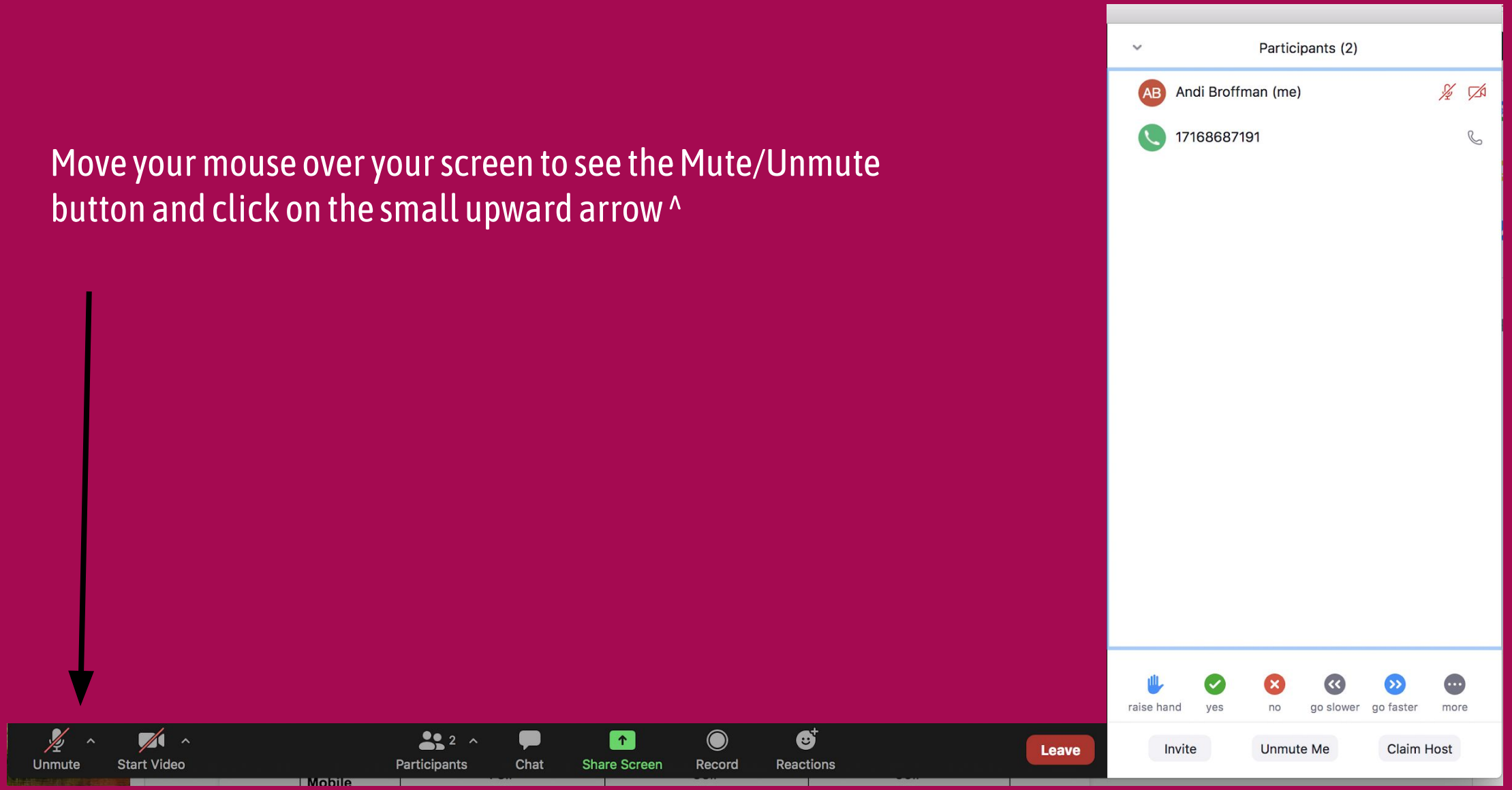

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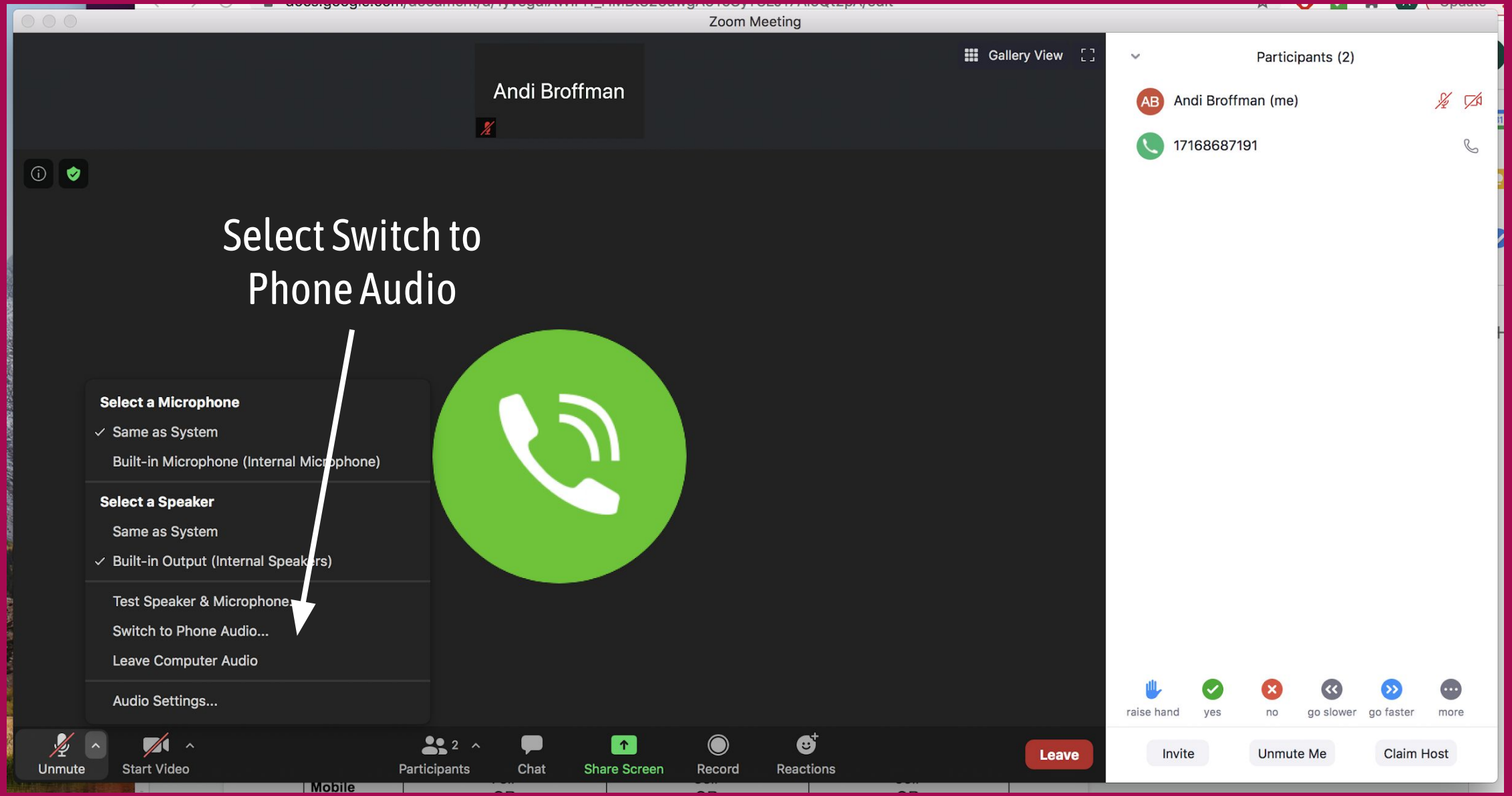
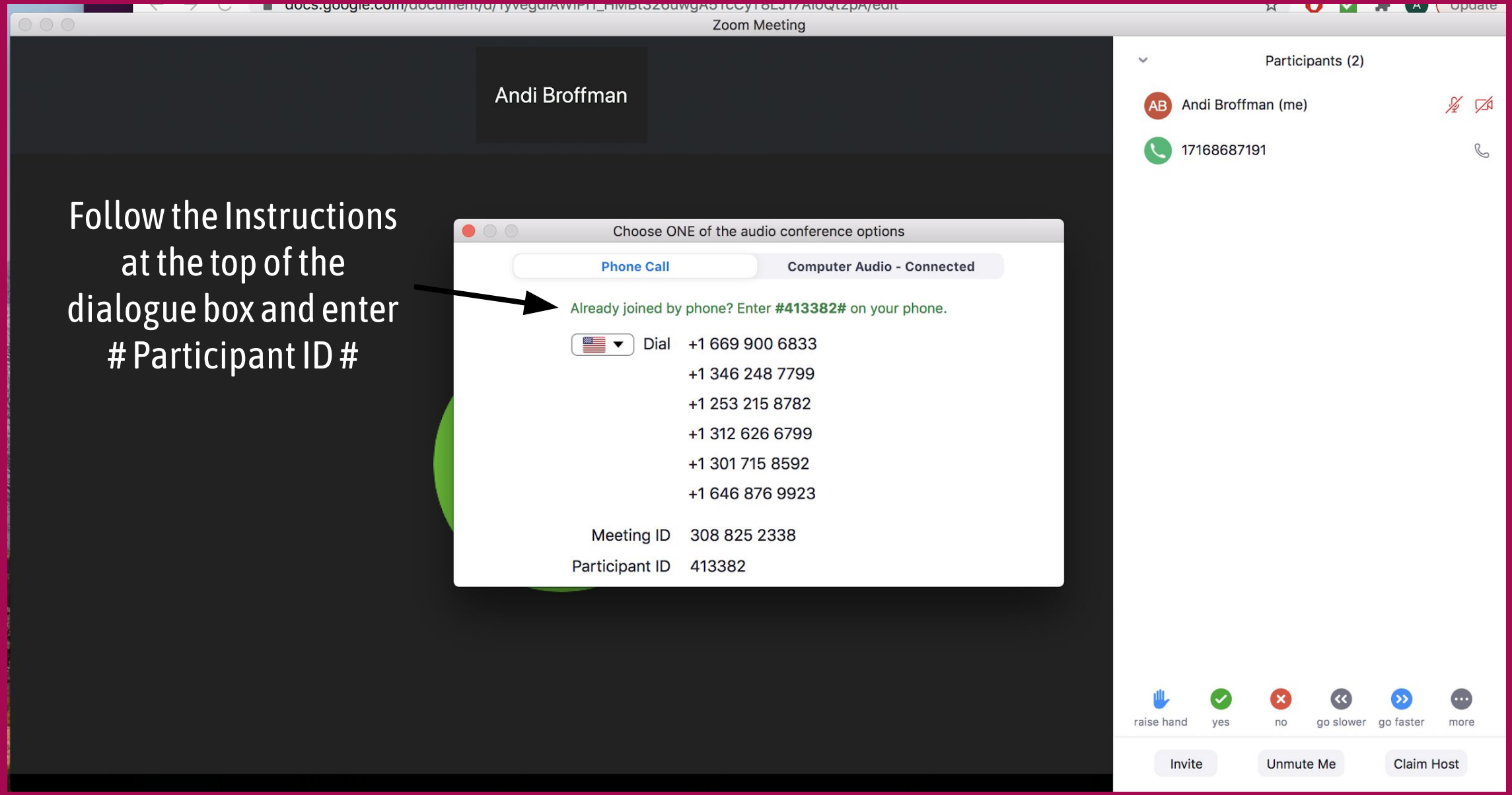


Zoom: Connect Your Name to Your Phone Number



Agenda: Day 1 Review

Time	Agenda Item
12-12:30PM ET / 9-9:30AM PT	Welcome and Our Journey Together
12:30-1:15PM ET / 9:30-10:15AM PT	Reviewing our Collective AIM
1:15-1:20PM ET/10:15-10:20AM PT	Mini Break/Transition to Breakout 1
1:20-2:30PM ET / 10:20-11:30AM PT	Breakout 1
2:30-2:35PM ET / 11:30-11:35AM PT	Chat Waterfall
2:35-3:05PM ET / 11:35AM-12:05PM PT	**LUNCH BREAK**
3:05-4:20PM ET / 12:05-1:20PM PT	The 'What' and 'Why' of Quality Data/Breakout 2
4:20-4:50PM ET / 1:20-1:50PM PT	Breakout 3: Wrap Up Team Time
4:45-5PM ET / 1:45-2PM PT	Closing

Quick debrief

What's squared away?

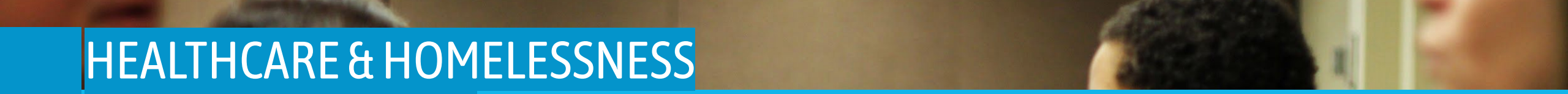
What do you really understand?

What's still going around in your head?

What do you still not understand?

Agenda: Day 2

Time	Agenda Item
12-12:15PM ET / 9-9:15AM PT	Welcome Back
12:15-1:15PM ET / 9:15-10:15AM PT	Strengthening Partnerships and Cross Sector Collaboration
1:15-1:30PM ET / 10:15-10:30AM PT	Break
1:30-2:30PM ET / 10:30-11:30AM PT	Quality Improvement and the Theory of Change
2:30-3PM ET / 11:30 - 12PM PT	**LUNCH BREAK**
3-4PM ET / 12-1PM PT	Breakout: Team Time
4-4:45PM ET / 12- 12:45PM PT	Closing



HEALTHCARE & HOMELESSNESS

WORKSHOP 1: DAY 2

2

Strengthening Partnerships and Cross Sector Collaboration

Health System Faculty Coaches

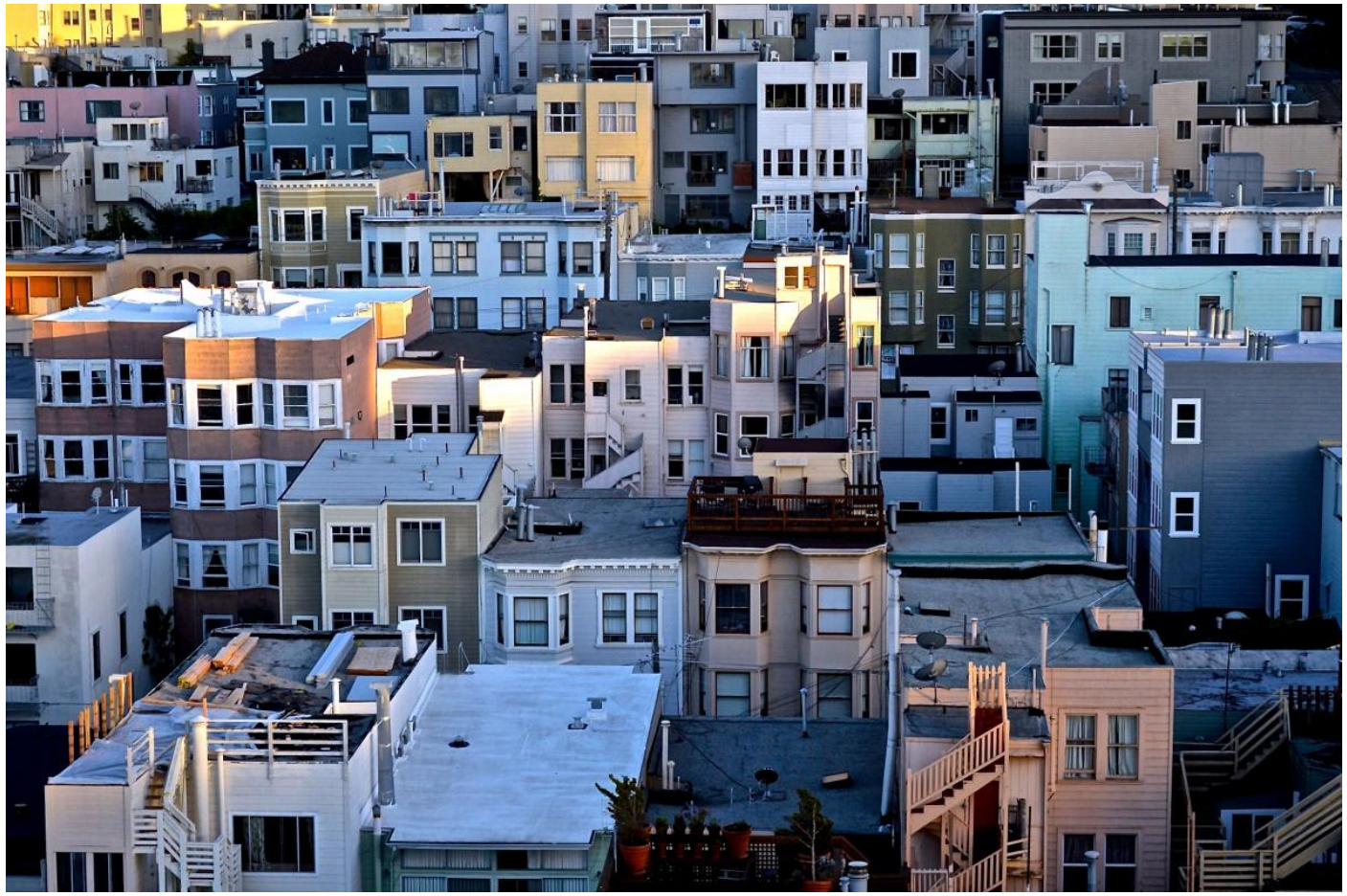
Catherine Craig, MPA
MSW,
IHI Faculty,
Triple Aim Initiatives and
Population Health

Lauran Hardin MSN, CNL, FNAP, FAAN
Senior Advisor
The National Center for Complex Health and Social Needs

Lesson objectives

- Articulate the urgency around cross sector partnerships
- Learn about governance structures that have supported other communities
- Create and strengthen an asset map of resources for complex populations

Why partner?



The promise of effective partnership

- Triple Aim outcomes for whole population – Equity!
- Joy in work and staff well-being

Key methods:

- Coordinate care with patients and community providers
  - Case conferences
- Align strategic missions
- Identify and address systemic obstacles
- Develop shared funding models

From partnership to population health

- Moving from partnering with 1 or 2 providers around an urgent health need…

- … to shaping a system of care that produces outcomes in population health

Project Restoration

Partnership Examples

Case Study Project Restoration Target Population: Cross-sector High Utilizers

- ✔ Community-wide ecosystem design for individuals who are high utilizers of two or more community agencies.
- ✔ Cross-sector Community Collaborative
- ✔ Countywide process improvements

An Ecosystem to Address Complexity

CONTINUUM OF SERVICES

Cross-Sector Community Collaborative

Shared Data and Asset Mapping

Community Specific Targeted Interventions

Process Improvements to Change Root Cause

Early partnership activities

- Understand each organization's role in impacting community health
- Establish projected scale of the partnership
- Search out existing community meetings that discuss health or housing
- Partner to identify trusted, informal local leaders
- Review existing community data (police, EMS)
- Support each other's funding efforts
- Test collaborating around 1-2 individuals

ED and Up teams

Partnering with local police departments, group homes, schools, pediatricians, primary care providers, crisis clinics, etc…

- Audit of ED visits from group homes to identify (in+) appropriate ED use, collaborate with group homes needing support
- NAMI classes at children's hospital
- Co-design with crisis clinic a new triage process from ED to crisis center
- Co-locate representative from partner organization in our ED
- ED leaders attends partner agency's community events to meet leaders, seed further collaboration
- ED leaders participate actively in local community coalitions

Including learning who in community is leading in an area and entrust that group, ie:

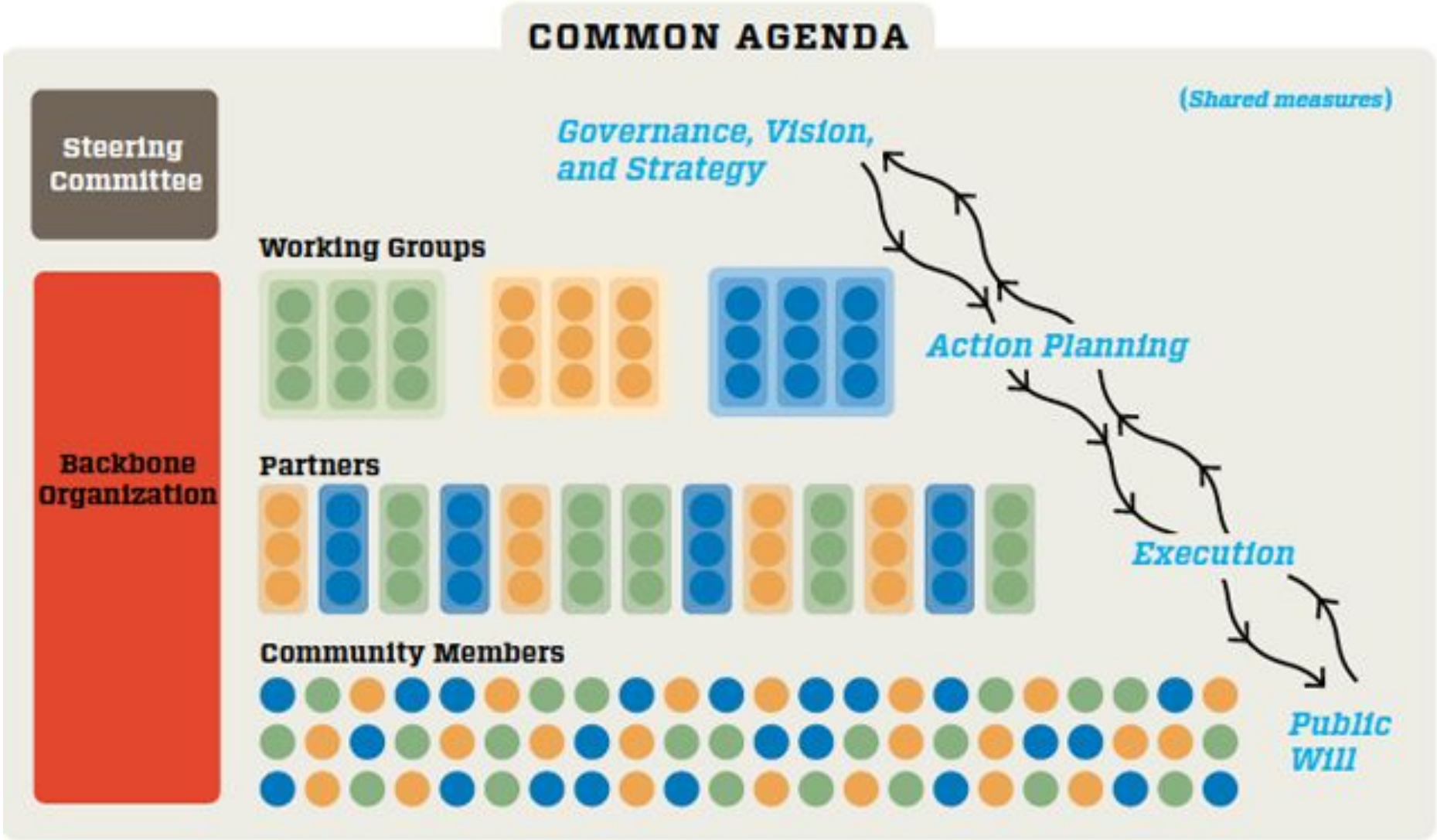
- Health system handed over Mental HealthCare Plans to community providers already doing this: VOA and police

Chat waterfall

- Tell us about a partnership you are proud of!
- What are you looking forward to accomplishing with partners?

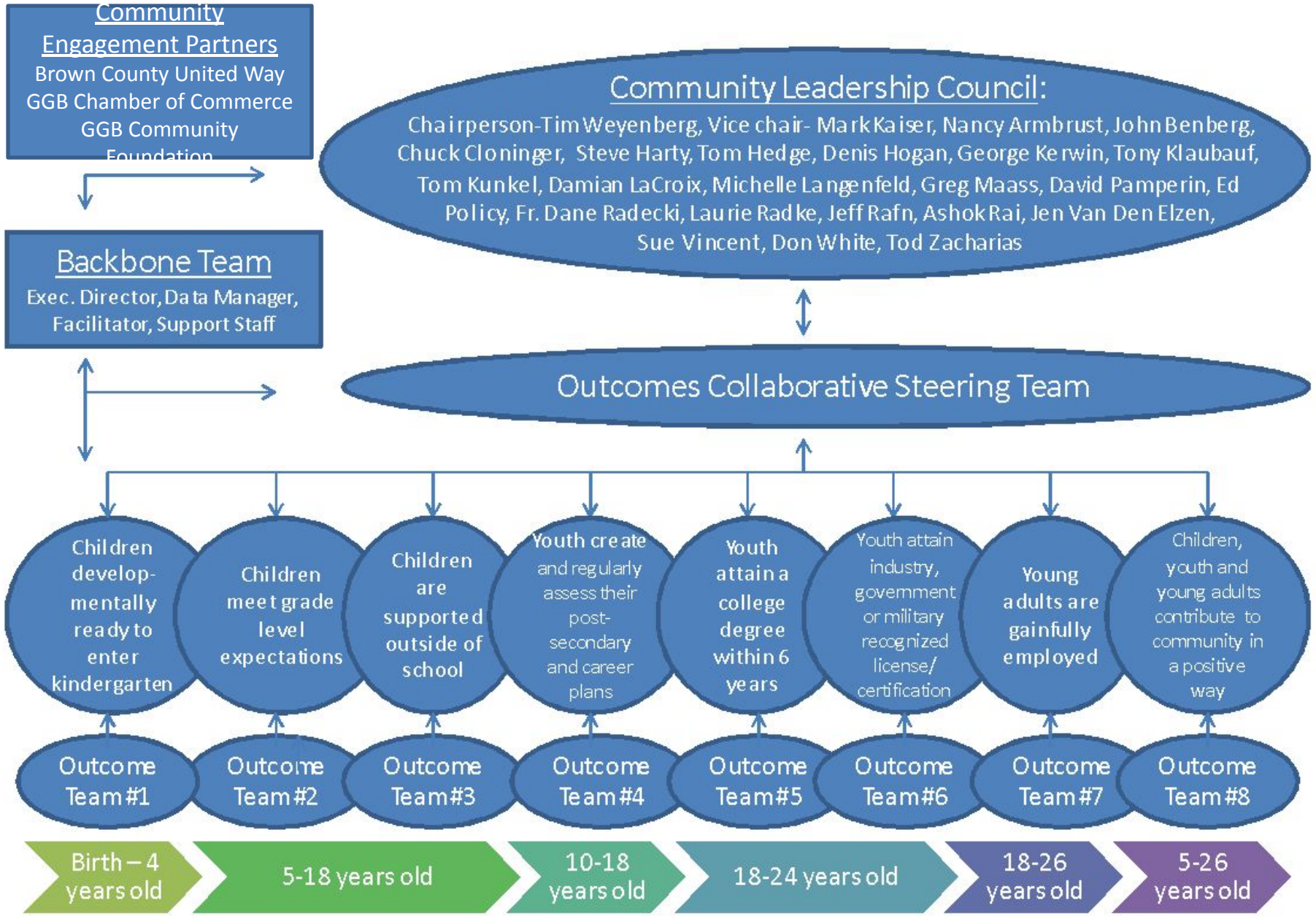
Developing Governance Structures

Cascading Levels of Collaboration



Achieve Brown County

Community Accountability



Pueblo Triple Aim Coalition

- High Level Policy and Governing Board: Pueblo Triple Aim Corporation
  - High Level Community Support
- Advisory Council: Pueblo Triple Aim Steering Committee
  - "Boots on the Ground"
- Ad-Hoc Committees: Portfolio Specific
  - Deal with shorter-term, single issue needs

Chat waterfall

- What governance structures are you considering?
- Questions?

Mapping Assets

Asset Mapping

What are the resources for Complex Patients in your area?

Social Needs Resource Platforms

Aunt BERTHA
CONNECTING PEOPLE AND PROGRAMS

UNITE US

Collective alerting and shared care planning platforms: increasing interoperability across organizations

collectivemedical

Purpose Impact Network Resources Culture

Closing the communication gap with healthcare collaboration software

Collective
support th
needs car

Returr

PATIENTPING

Who We Help How We Help Who We Are

PINGS

Healthcare's First and Most Advanced E-Notifications System

Pings deliver real-time notifications whenever your patients experience care events—whether they are at a hospital, ED or post-acute (SNF, LTACH, HHA, IRF, hospice)–Pings allow you to scale how you manage your patient populations. Pings can be embedded within your existing workflow systems or used natively through our web and mobile user experience.

carequality

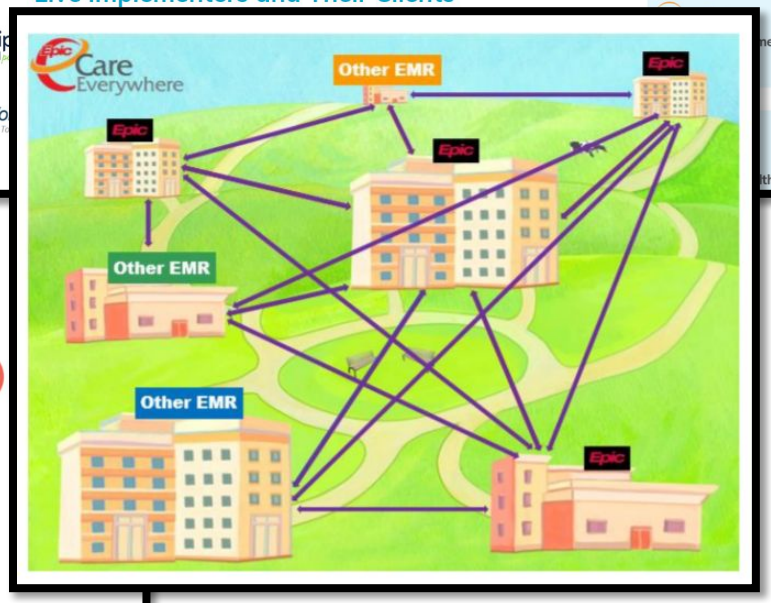
Our Community What We Do Get Involved Resources Blog Wiki

Carequality Interoperability Framework Adopters

The adopters of the Carequality Interoperability Framework – and their clients – benefit from accelerated, less costly health data sharing agreements, because they no longer need to develop one-off legal agreements between individual data sharing partners.

commonwell HEALTH ALLIANCE
- Cerner
- Brightree
- Evident
- Greenway Health
- Meditech

Live Implementers and Their Clients



First Rule of Partnerships

- **Learn what exists around you**

Assess patient needs & local resources

Do not recreate existing services!

Do leverage existing community coalitions

In your organization:

- Where do target population patients come in from?
  - Identify high rates of (in+)appropriate referrals
  - Test ways to support appropriate referrals
- What community organizations do patients report feeling connected to or supported by?
  - Does triage or intake collect this information?

Develop inventory of community collaboration across the organization

- Community Health Needs Assessment
- Community Benefit
- Chaplaincy
- Public Health
- Participation in community coalitions
- Departments serving same target population

Stakeholder Analysis

Mapping/inventory of people who:

- Are final decision makers or are opinion leader that can impact the outcome
- Must ratify or who can veto the decision
- Must be consulted prior to the decision being made
- Have expertise crucial to realizing the desired outcomes or experience in the situation we seek to change
- Will be affected by the outcome
- Must implement or live by the changes
- Will need to be informed of the changes

Stakeholder Analysis

A. Key Stakeholders	B. Impact	C. Current Level of Support	D. Issues, Wins and Mindset	E. Stakeholder Strategy and Comments
• Key stakeholders (or stakeholder group)	• Rate each stakeholder according to their impact in helping or hindering the change effort • 3 = critical • 2 = very important • 1 = somewhat important	• Assess each stakeholder's current or anticipated level of support: • - = opposed • 0 = Neutral • + = Favorable • ? = Unknown	Identify issues that are important to each stakeholder. What would be a "win" for them/this organization? What would influence them to support the change? What do they need?	• Who could help influence this stakeholder • What approach might work? • How might you proceed if you don't win their support?

Chat waterfall

Tell us about your asset map

Tools and Resources

Pathways Assessment Tool

- http://www.pathways2pophealth.org/act.html
  and a paper version:
- http://www.pathways2pophealth.org/files/P2PH-Compass_Assessment-Tool-4.17.pdf
- Consider sharing this full assessment with hospital leadership, particularly those involved in population and community health efforts

Resources

- **Hardin, L.,** Trumbo, S., Murray, V. (November, 2019). What Matters Most in driving Cross-Sector Partnerships for Complex Populations. Enduring webinar Better Care Playbook. https://www.bettercareplaybook.org/_blog/2019/30/what-matters-most-driving-cross-sector-partnerships-complex-populations

- **Hardin, L., Trumbo, S. & Wiest, D. (October 2019).** *Cross-sector collaboration for vulnerable populations reduces utilization and strengthens community partnerships.* **Journal of Interprofessional Education and Practice.** https://doi.org/10.1016/j.xjep.2019.100291

- **Asiedu-Frimpong, M. & Hardin, L. (November 2019).** *Using Asset Maps to match Community Supports for patients with Complex Care Needs.* **IHI Better Care Playbook.** Blog and practical play https://www.bettercareplaybook.org/_blog/2019/1/using-asset-maps-match-community-supports-patients-complex-care-needs-interview-camden

Resources for further exploration

- The Playbook: Who are people with complex needs?
- Play: Conduct a Three-Part Data Review to Understand Patient Needs
- Play: Identify Patients with Qualitative and Quantitative Criteria
- 10 Questions to Better Understand and Serve Your Complex Population
- Effective Care for High-Need Patients: Opportunities for Improving Value, Outcomes, and Health
- Segmenting High-Need, High-Cost Patients: A Video Presentation
- The CHRONIC Care Act of 2018: Advancing Care for Adults with Complex Needs
- Using Data to Better Serve the Most Complex Patients: Highlights from NGA's Intensive Work with Seven States
- Persistence and Drivers of High Cost Status among Dual Eligible Medicare and Medicaid Beneficiaries

Inspiring Videos

- https://vimeo.com/196441233 2-Min Video Introduction on Complex Care
- https://vimeo.com/242605956 5-Min Video What is Complex Care?
- Project Restoration https://www.youtube.com/watch?v=5ltCGJTofrM
- ONEHealth Model Memphis https://www.youtube.com/watch?v=jH8fjqqvYjk&feature=youtu.be&list=PLC3uOjwmHMrxlcZRrJ54Wx9UWoUSobLyj

Break!
15 minutes

See you at 1:30PM ET/10:30AM PT

HEALTHCARE & HOMELESSNESS

WORKSHOP 1: DAY 2

3

Quality Improvement, Theory of Change & Project Portfolios

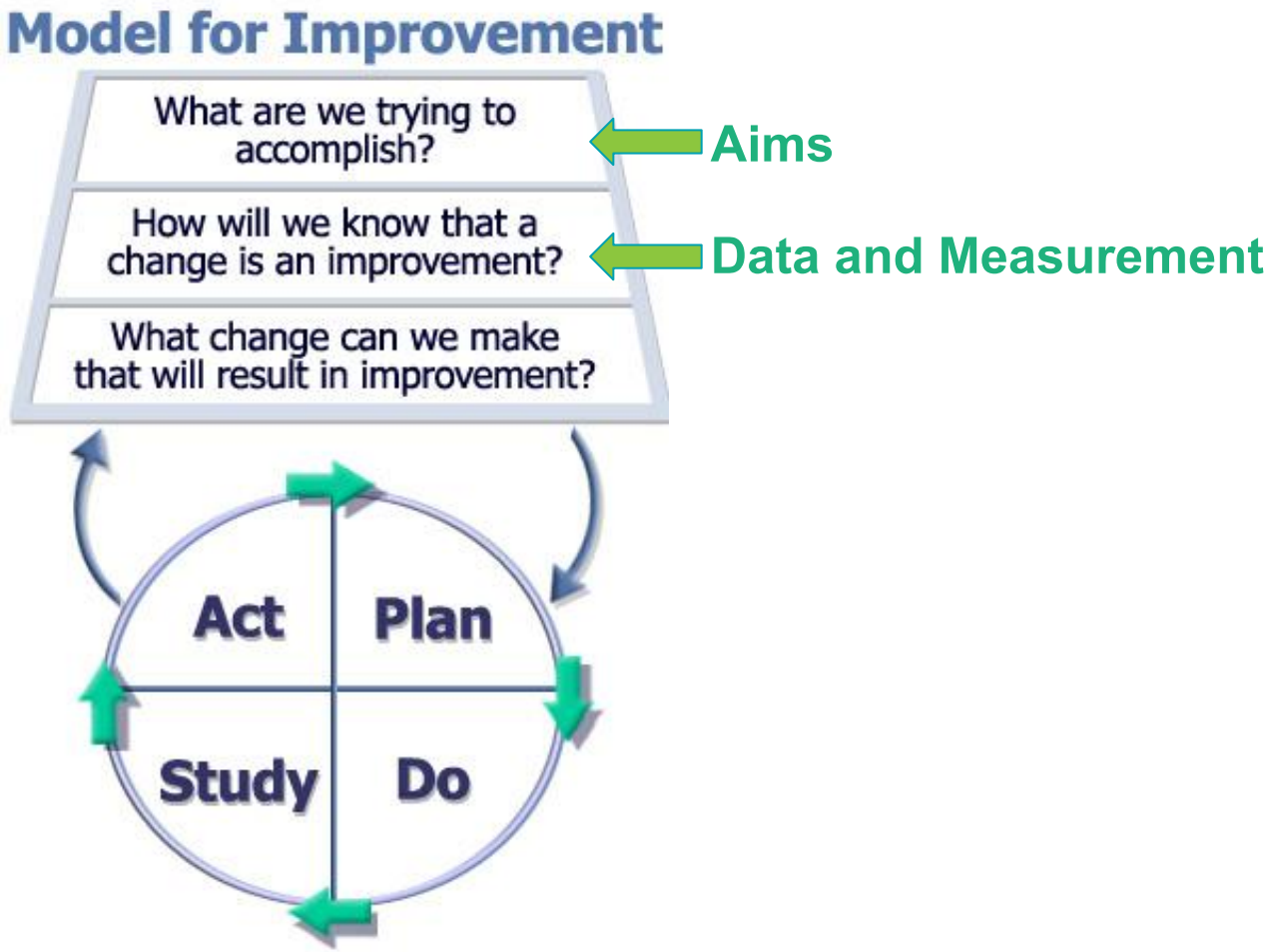
Institute for Healthcare Improvement

Theories of Change & Assembling A Portfolio Of Interventions & Investments

A Model for Learning & Change

Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd Edition). San Francisco, California, USA: Jossey-Bass Publishers; 2009.

A Model for Learning & Change



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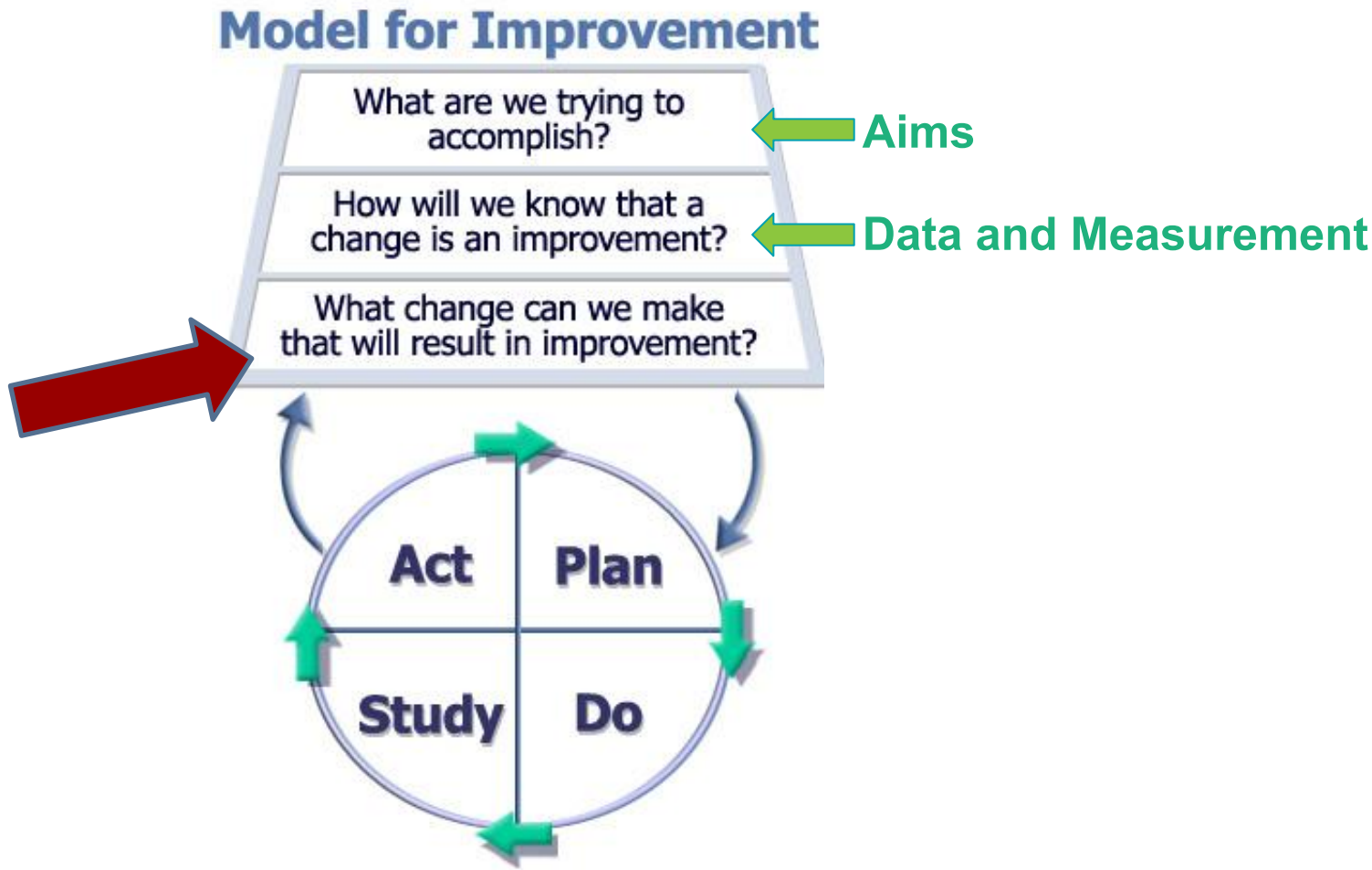


Aims

Data and Measurement

Build a Portfolio of Interventions and Investments

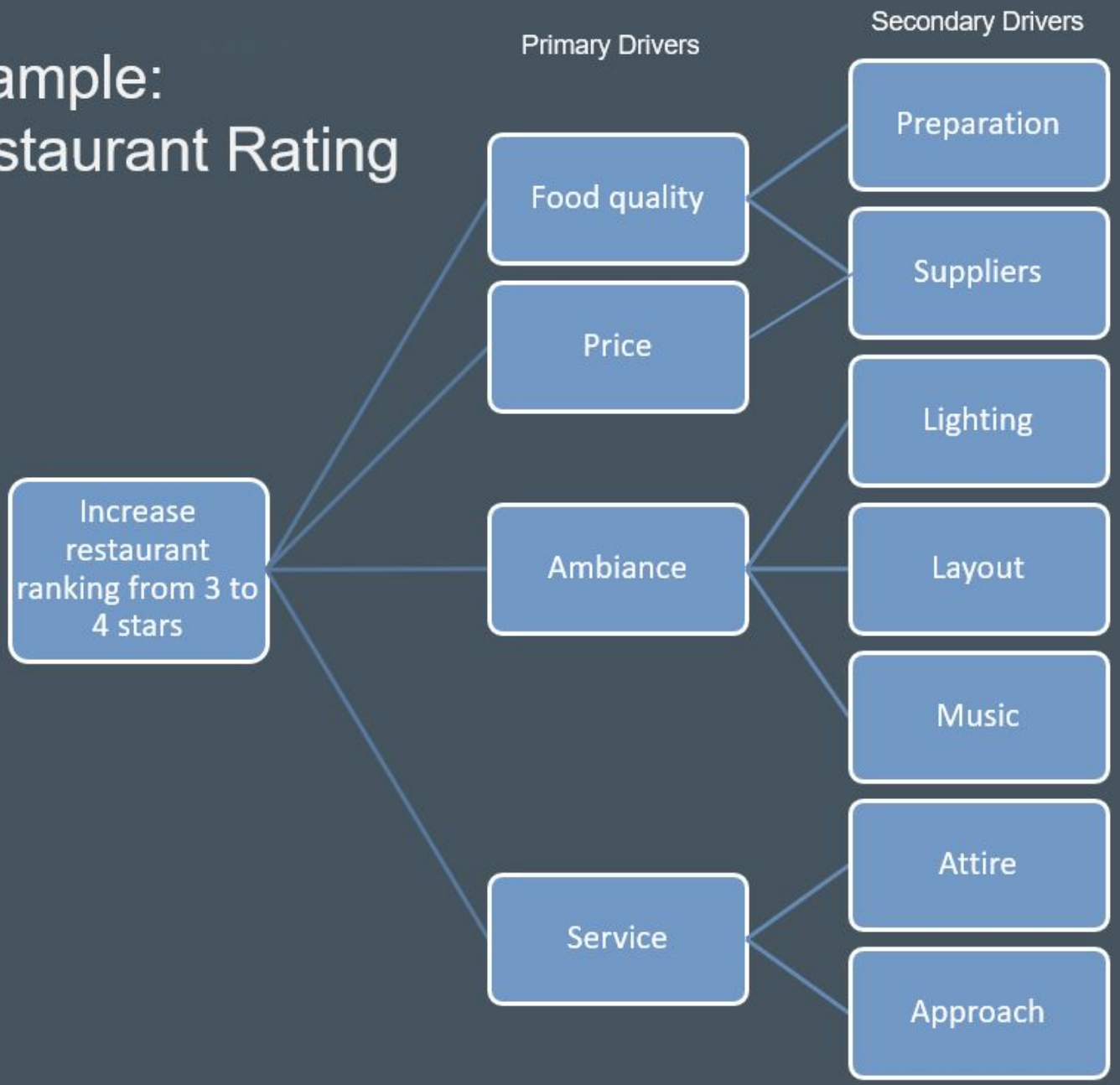
Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd Edition). San Francisco, California, USA: Jossey-Bass Publishers; 2009.

Creating a Theory of Change to Drive Results

Beyond an aspirational aim

- Effective change requires a theory of how you will achieve the goal
- There are endless pathways to improvement, how does your team/organization/community think you'll get there
- Driver diagrams are one way to make the theory explicit and allow others to buy-in or share their theory

Example: Restaurant Rating



Driver Diagram: How to Develop

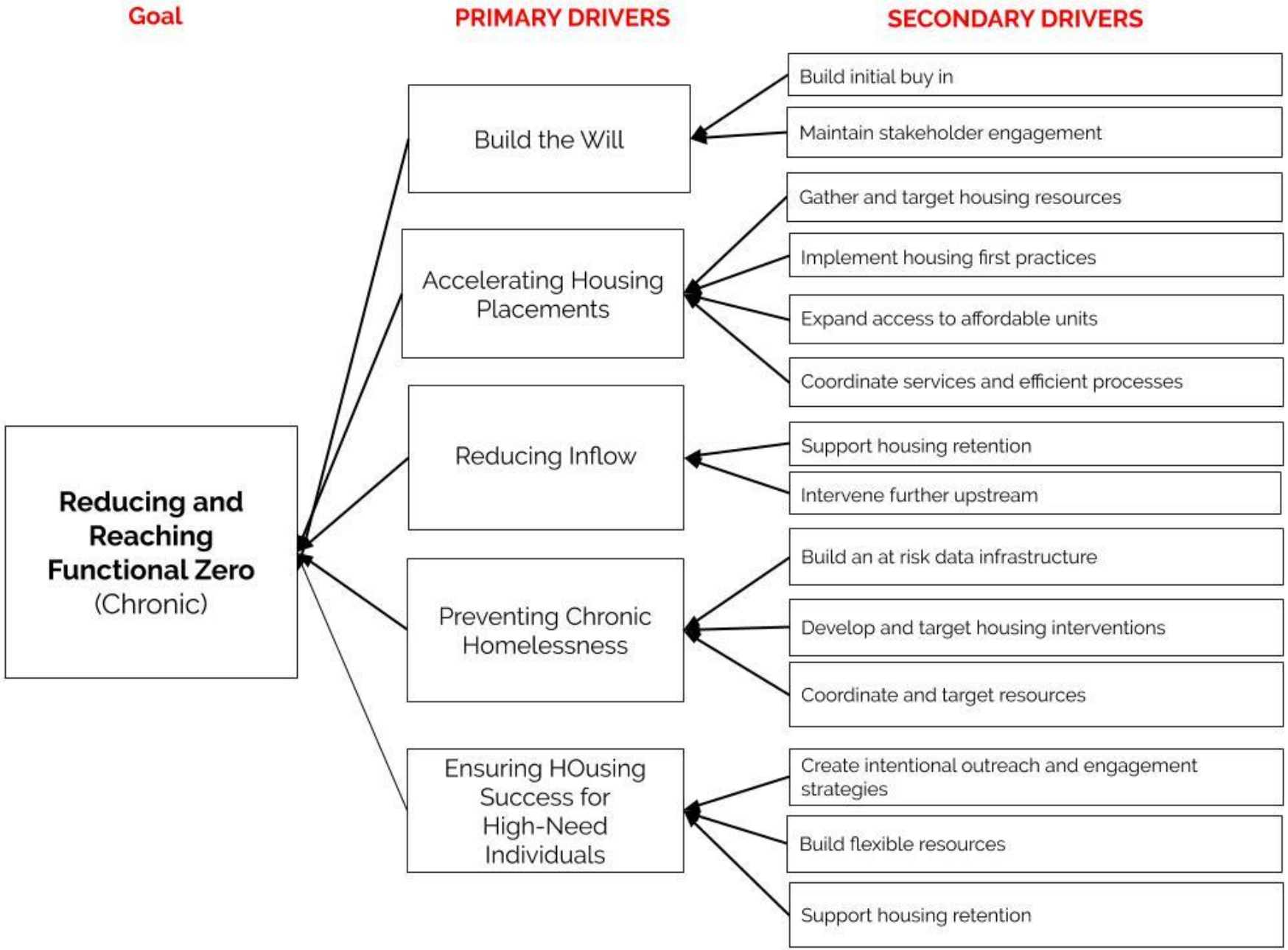
1. Gather expertise: expert meeting, literature review, interviews
2. Identify key structures, processes, norms that must change to achieve the aim
3. Elicit change ideas that have worked
4. Experts inform specific aim

Remember:

- Best working theory to date and revise as you learn!
- Include what is necessary and sufficient
- Creates a shared language and mental model

"Disclaimer: Probably wrong and definitely incomplete."

- Tony Bryk, President of the Carnegie Foundation for the Advancement of Teaching


Goal
PRIMARY DRIVERS
SECONDARY DRIVERS
Reducing and Reaching Functional Zero (Chronic)
Build the Will
Build initial buy in
Maintain stakeholder engagement
Accelerating Housing Placements
Gather and target housing resources
Implement housing first practices
Expand access to affordable units
Coordinate services and efficient processes
Reducing Inflow
Support housing retention
Intervene further upstream
Preventing Chronic Homelessness
Build an at risk data infrastructure
Develop and target housing interventions
Coordinate and target resources
Ensuring HOusing Success for High-Need Individuals
Create intentional outreach and engagement strategies
Build flexible resources
Support housing retention

COMMUNITY SOLUTIONS

PURPOSE: Health care organizations will make a meaningful, measurable, and transformative contribution to end chronic homelessness across a community with a focus on building racially equitable systems.

COMMITMENT: Build Sustained Belief in and Commitment to Ending Chronic Homelessness at the Population Level

WITHIN THE HEALTH SYSTEM

- Establish this work as a strategic priority that aligns to a broader journey towards population health and well-being and an "anchor mission" for the health system in the community
- Identify and engage key internal leaders to champion the effort and sustain their belief in the goal and the path to achieving it
- Identify and articulate the levers and roles for the health system to address homelessness, from physical and mental health services to community benefit and relations in order to believe in the opportunity and obligation
- Build a case using relevant data that resonates with health system leaders and links ending chronic homelessness to health, cost, and quality outcomes

TOGETHER WITH THE COMMUNITY

- **Create and sustain buy in for shared population level aim, timeline and measurement framework**
- Build trust and partnership with housing/homeless system partners, relevant government actors as well as key mainstream agencies
- Develop, tap into and/or refine existing ongoing community-wide communications strategy and infrastructure
- Build a case using relevant data that resonates with health system leaders and links ending chronic homelessness to health, cost, and quality outcomes

GOVERNANCE: Establish shared language and mechanisms for collaboration, measurement and governance

WITHIN THE HEALTH SYSTEM

- **Establish clear internal oversight, project management, measurement, and reporting structure from line staff to leadership that includes internal measures to align and integrate efforts**
- Identify leaders at different levels of the health system who will engage in internal and external efforts
- Reframe how people experiencing homelessness are perceived, treated and talked about within the health system at all levels
- Develop and implement a longitudinal internal communications strategy and infrastructure that builds and sustains will for local, regional and national health system staff

TOGETHER WITH THE COMMUNITY

- Build capacity and capability to partner with people with lived experience as key stakeholders in the improvement process
- Work with cross-sector stakeholders (including public health) to map assets and levers for the most appropriate role for health care
- Use population needs and community assets data to create and pursue a common policy platform on the local/regional level
- Commit to the shared goal of ending chronic homelessness and create a path toward achieving it
- Create clear and simple language and shared definitions for key terms and concepts across sectors
- Tap into and add to governance and decision-making mechanisms that align with existing coordinated efforts to end

HOUSING PLACEMENTS: Increase housing placements and retention rates for those experiencing chronic homelessness

WITHIN THE HEALTH SYSTEM

- **Understand and optimize the health system's role in the identification to housing placement process so that people don't fall through the cracks between steps in the process**
- Invest organizational funds in housing unit and subsidy gaps for high utilizers of the health system
- Focus organizational assets (funds, people, infrastructure, policies etc) to fill community-wide service and provider gaps

TOGETHER WITH THE COMMUNITY

- Engage in improvement of the identification to housing placement process
- Develop data-sharing mechanisms to target and prioritize high utilizers of the health care system that are on the By-Name list
- Identify and close community-wide housing unit and subsidy gaps
- Identify and close community-wide service and provider capacity gaps

FINANCING: Establish and build upon financial mechanisms aligned to reducing and ending chronic homelessness

WITHIN THE HEALTH SYSTEM

- **Map current funding mechanisms for care delivery within the health system to identify ways to fund coordinated service delivery and fill provider gaps (e.g., 1115 Medicaid Waiver; MSSP participation)**
- Develop internal policy and practice to align allocation of Community Benefit, foundation, and/or Corporate Social Responsibility funds
- Track organizational investments against monthly metrics for reducing, ending or sustaining an end to chronic homelessness
- Quantify and project financial value to the institution associated with savings (productivity, utilization, resources) for achieving the aim

TOGETHER WITH THE COMMUNITY

- **Build, tap into, refine and/or add to the community-wide mechanism for multi-stakeholder flexible funding to incentivize achieving and sustaining an end to chronic homelessness**
- Quantify the economic and social value of getting to and sustaining an end to homelessness across the community
- Develop and implement strategies/tools to support reinvestment/reallocation of cost savings into upstream solutions

INFLOW: Prevent the inflow of individuals into chronic homelessness

WITHIN THE HEALTH SYSTEM

- **Invest organizational funds in housing, services and/or navigation gaps for patients at risk of experiencing homelessness**
- Improve early identification and support of patients at risk of homelessness to reduce their inflow into homelessness

TOGETHER WITH THE COMMUNITY

- Understand and overcome barriers (e.g. privacy barriers) to data-sharing across housing & homelessness and health care systems
- Work with key community partners in building an "At Risk" list and data/measurement infrastructure
- Identify and close community-wide service, provider capacity, housing units and subsidy gaps
- Create an integrated pathway to connect at-risk individuals with diversion/prevention resources
- Identify, understand and work to eliminate institutional and systems barriers (including structural racism)

How do we use one in practice?

- Keep front and center to your work (visually)
- Put in pencil, not pen
  - Update your theory as you learn
  - Select regular points to review
- Tie changes and projects to drivers
- Use to track progress
- Share to communicate and engage others

Building a Portfolio of Projects, Interventions, and Investments to Achieve Your Aim

Portfolio: Definitions

- A hinged cover or flexible case for carrying a collection of loose papers
- The diversified collection of securities held by an investor designed to spread risk
- For our purposes:
  - The set of projects, investments, and capacities that together will achieve results for and with your population

Why have a Portfolio of work?

Diversity & Integration

The new and improved system requires new ideas from a variety of places.

Manage Complexity

For complex adaptive change such as this, we are working on multiple processes in different parts of the system.

Interdependence & Alignment

No single initiative, change idea, or set of unaligned projects will likely be enough to produce population-level results.

Parsimony

With so many opportunities for improvement, the urge to set too many goals and under-resource them will be strong.

Embracing a Portfolio Approach

- Portfolios depend on understanding your population and how it is segmented.
- Your portfolio will be informed by a broad view of what you and other partners can do (consider the whole system).
- Your portfolio represents your best theory of what will lead to results. It can and should be rebalanced as you learn more about your population.
- There's a lot in your portfolio already.

Attributes of an Effective Portfolio of Projects and Investments

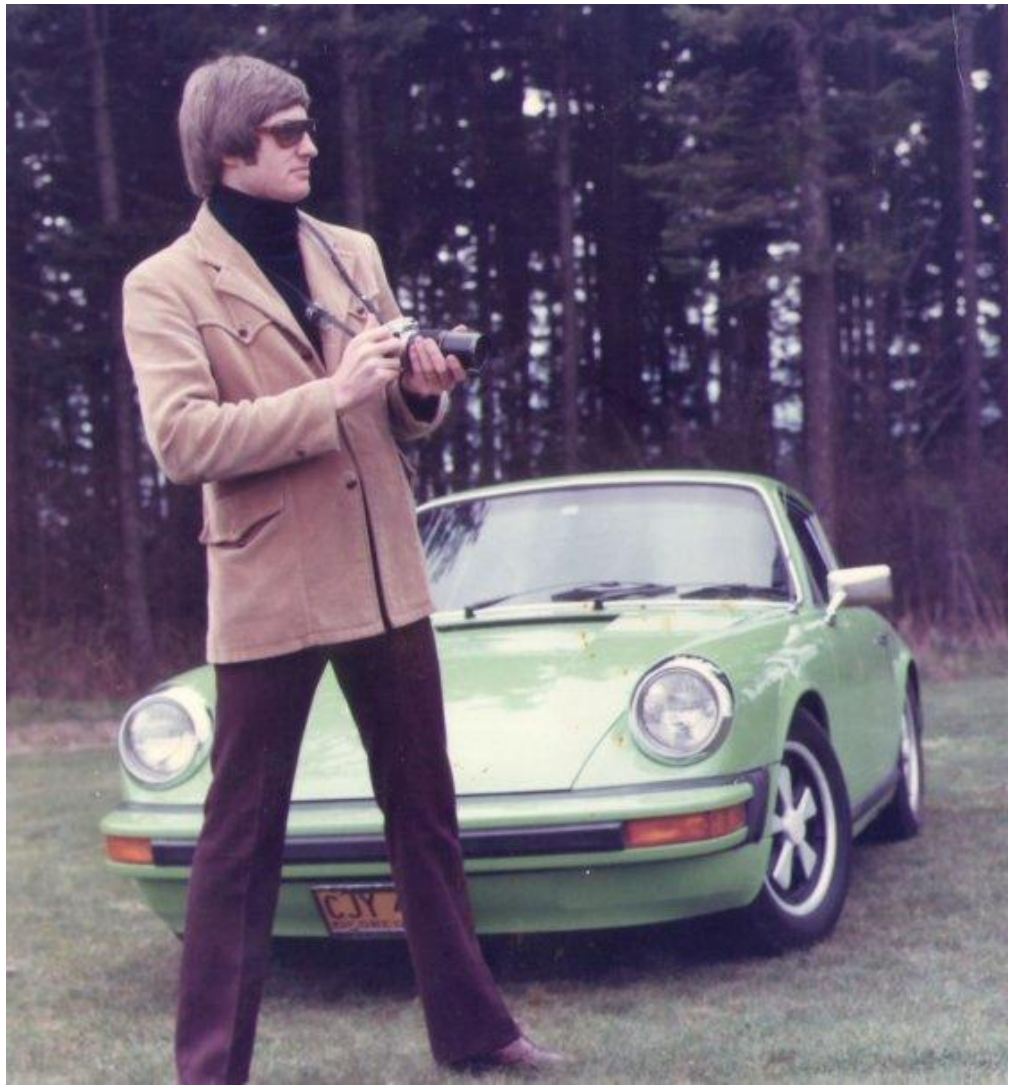
- Risk matches the goals
- Diversified
  - Long term, short term, big bets, quick wins, both improvement projects as well as investments (in capacity, data, etc.)
- Periodically rebalanced with new insights

Meet Greg J. Lewis* - full-time mixed-media fine artist of 49 years, based in Portland, Oregon.

*Also, my dad.

What Greg Lewis had to say about portfolios

- *“My portfolio is my articulation to the world of what my best work is at any point in time. But my portfolio changes based upon what I want to accomplish. I wouldn’t present my old graphic design work to someone who wants to see my large-scale installation work. Portfolios always come from purpose. Always.*
- *I have 49 years worth of work to choose from, but my articulation should be parsimonious. I keep only 5-7 projects in my portfolio at any given time.*
- *And I always come back to my portfolio – it evolves as my point of view as an artist evolves and comes more into focus. As I move closer to what I want to accomplish.”*



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A Sample Health Care Population Health Portfolio

- Population:
  - Full Scale – 1450; Segmented - 400 Elders Enrolled in Managed Medicare Product
- The Challenge:
  - To improve screening for fall risk and increase health care proxies for frail elderly population, while increasing patient satisfaction and reducing acute admissions and ER utilization
- Methods Used to Get To Know Their Population:
  - Explored information from its electronic medical record (EMR)
  - Surveys
  - Conversations with patients
  - Discussing patients' needs in care plan meetings and tabulating this information in order to aggregate it

…which led to a portfolio of projects

Goals Based on Insights

- **Extend the Medical Appointment**
- **Standardize Care in the Areas that Matter Most**
- **Expand Social Supports in Transportation, Food and Medication, and EOL Planning**

- Redesign of complex primary care clinics (incl. extension of the medical appointment from 15 mins. to 45 mins.)
- Fall prevention bundle
- Advanced care planning
- Weekly care plan meetings w/ local community organizations to help match the local resources with the needs of particular patients and establish reliable referral processes
- Engaged social workers and psychiatric nurses from the community's physical therapy and occupational therapy programs as part of the care team.
- Chronic disease management classes offered by the local branch of the National Association of Area Agencies on Aging
- Visiting nurses who conduct home safety evaluations

Health System-Led

- Redesign of complex primary care clinics (incl. extension of the medical appointment from 15 mins. to 45 mins.)
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Jointly-Led

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- Advanced care planning
- Weekly care plan meetings w/ local community organizations to help match the local resources with the needs of particular patients and establish reliable referral processes
- Engaged social workers and psychiatric nurses from the community's physical therapy and occupational therapy programs as part of the care team.
- Chronic disease management classes offered by the local branch of the National Association of Area Agencies on Aging
- Visiting nurses who conduct home safety evaluations

Community Agency Partner-Led

- Redesign of complex primary care clinics (incl. extension of the medical appointment from 15 mins. to 45 mins.)
- Fall prevention bundle
- Advanced care planning
- Weekly care plan meetings w/ local community organizations to help match the local resources with the needs of particular patients and establish reliable referral processes
- Engaged social workers and psychiatric nurses from the community's physical therapy and occupational therapy programs as part of the care team.
- Chronic disease management classes offered by the local branch of the National Association of Area Agencies on Aging
- Visiting nurses who conduct home safety evaluations

Overall Aim: Achieve functional zero by June 30, 2021

Outcome Measure: # of active homeless (veteran or chronic)

PORTFOLIO AREA 1: INFLOW

Process Measure:
1) Rate of Individuals touched by your diversion efforts that don't get added to your by-list ; 2) % of inflow that is returned from housed

- Project: Reliably implement diversion screening for every person that presents at an access point.
  - Measure: % screened
- Project: Standardize diversion screening tool
  - Measure: # of access points implementing the standardized assessment tool
- Project: Increasing frequency of after care for rapid re-housing
  - Measure: % individuals returned from rapid rehousing
- Project: Keep people within PSH
  - Measure: % of people falling out of permanent supportive housing
- Project: Increase case managers focused on retention support
  - Measure: % of people falling out of permanent supportive housing

PORTFOLIO AREA 2: OUTFLOW: PROCESS

Process Measure: Length of time to house

- Project: Improve match to housing resource process
  - Measure: Length of time to house
- Project: Reduce unsheltered homelessness
  - Measure: # of people connected to shelter
- Project: Decrease time between assessment and getting on the BNL
  - Measure: Time to get on the BNL
- Project: Improve process for approval from public housing authority
  - Measure: Time to PHA approval

PORTFOLIO AREA 3: UNIT GENERATION

Process Measure: # of units generated; Move-Ins

- Project: Improve quality of landlord engagement meetings
  - Measure: Follow-up survey; # of these landlords' units rented
- Project: Free up PSH units
  - Measure: Positive exits from PSH
- BARRIER BUSTER: PHA Set Aside of Mainstream Vouchers
  - Measure: # of vouchers set aside
- INFRASTRUCTURE: Real Estate Development
  - Measure: # of permanent supportive housing units created

PORTFOLIO AREA 4: CAPACITY

- Project: Data Clean Up
  - 3 Month Project
- Project: Build QI Capability in Agency Staff
  - 4 Month Project; # of changes tested

PORTFOLIO AREA 1:
INFLOW

Process Measure:

1) Rate of individuals touched by your diversion efforts that don't get added to your by-list
2) % of inflow that is returned from housed

Project: Reliably implement diversion screening for every person that presents at an access point.

- Measure: % screened

Project: Standardize diversion screening tool

- Measure: # of access points implementing the standardized assessment tool

Project: Increasing frequency of after care for rapid re-housing

- Measure: % individuals returned from rapid rehousing

Project: Keep people within PSH

- Measure: % of people falling out of permanent supportive housing

Project: Increase case managers focused on retention support

- Measure: % of people falling out of permanent supportive housing

A Sample Pilot Site Portfolio

Commitment	Create list of datasets that would be good for in the system and with the community (including CHNA)
	Share CoC case conferencing/case management infrastructure to illustrate supports available in community that provide more than physical healthcare
Governance	Outline savings to healthcare system and tie that to internal messaging
	Understand what measurement systems currently exist and where the health system might support or tap into those systems (e.g., health system using HMIS data, support for data collection)
Housing Placements	Utilize a screening tool to identify patients experiencing housing instability/literal homelessness
	Co-create process map and identify pain points/bottlenecks with people with lived experience
Financing	Partner with local Community Development Financial Institution (CDFI) efforts
	Pursue collaborative funding opportunities such as grant opportunities, affordable housing opportunities etc.
Inflow	Document patients that meet disability criteria for chronic homelessness at first point of contact and document date homelessness
	Create an integrated pathway to connect at-risk individuals with diversion/prevention resources

Within the health system

Together with the Community

What is Already in Your Portfolio(s)?

- To start, what work is going on now?
  - What projects/interventions/investments are you already engaging in? *(For the health system, think about clinical services, community benefit, and population health efforts)*
  - Are there projects/interventions that align with your population health and homelessness system goals?
  - Where is there opportunity to redesign services for your population?
  - Where is there opportunity to better coordinate services and supports for the population?
  - Where are areas where you need to build capacity to support the population?

Key Points So Far…

- *Portfolios depend on understanding your population and how it is segmented.*
- *Your portfolio will be informed by a broad view of what you and other partners can do (consider the whole system).*
- *Your portfolio represents your best theory of what will lead to results. It can and should be rebalanced as you learn more about your population.*
- *There's a lot in your portfolio already.*
- Use a driver diagram or logic model to show how the portfolio hangs together.
- You can annotate with system and project measures.

Moving from Insights to Action - Part 1

- What is already in our portfolio (both the health system and the CoC)?
- What is already happening elsewhere within the community to support this population?
- Where are there gaps?
- Where can we redesign, better align, coordinate, and build capacity?

Moving from Insights to Action - Part 2

- Review the Health Care & Homelessness Pilot Initiative Change Package
  - Note the strategies and actions you're already engaging in
  - Note which strategies and actions could be high leverage for you
  - Note which strategies and actions you do NOT have the levers for and rule them out

HOUSING PLACEMENTS: Increase housing placements and retention rates for those experiencing chronic homelessness

WITHIN THE HEALTH SYSTEM

- Understand and optimize the health system's role in the identification to housing placement process so that people don't fall through the cracks between steps in the process
- Invest organizational funds in housing unit and subsidy gaps for high utilizers of the health system
- Focus organizational assets (funds, people, infrastructure, policies etc) to fill community-wide service and provider gaps

- *Clearly articulate health systems role in the ID to housing placement process and Identify and train appropriate staff to engage in progressive engagement with patients who are homeless or at risk of homelessness*
- *Co-create process map and identify pain points/bottlenecks with people with lived experience*
- *Utilize a screening tool to identify patients experiencing housing instability/literal homelessness*
- *Connect hospital data on people experiencing housing instability/homelessness with CES access points/community BNL and share report with housing experts*
- *Review patient utilization data by race/ethnicity, gender, age to see where there may be opportunities to address specific barriers to subpopulations such as immigration status, language, gender*
- ***Look at geographic location (neighborhood, census tracts, etc) to help get work and investments***
- *Celebrate successes along the ID to housing continuum (ex: like: VI-SPDAT)*
- *Include discharge planning in ID to housing placement process*

- *Create housing preferences for specific populations (at-risk of chronic, chronic, etc.)*
- ***Track utilization rates of those prioritized for housing to determine/show benefit of housing as a social determinant of health.***

- *Conduct a gaps analysis to understand where to focus organizational assets*
- *Create housing preferences for specific populations (at-risk of chronic, chronic, etc.)*
- *Place housing navigators, community health workers, resource nurses, or any number of "navigator positions" that can be deployed to assess and refer patients for SDOH needs in hospitals*
- *Include hospice care within Permanent Supportive Housing (PSH)*
- *Create a long term care assisted living facility that is housing first and has staff trained in medical care and also assertive, progressive engagement*
- *Use medical students/interns to staff some of the housing facilities that need specific healthcare services (opportunity for them to learn and will be less expensive)*
- *Optimize and deliver adequate mental health service*
- *Use health system real estate to create additional, targeted housing*

TOGETHER WITH THE COMMUNITY

- Engage in improvement of the identification to housing placement process
- Develop data-sharing mechanisms to target and prioritize high utilizers of the health care system that are on the By-Name list
- Identify and close community-wide housing unit and subsidy gaps
- Identify and close community-wide service and provider capacity gaps

- *Develop mechanisms/MOUs to support cross sector data sharing and practice*
- *Create process map and identify pain points/bottlenecks with people with lived experience*
- *Include discharge planning in ID to housing placement process*
- *Co-create process for identifying high utilizers of medical system and prioritize these individuals for housing*
- *Embed mental health savvy case managers/navigators in the ID to housing process*
- *Increase and facilitate flow of communication and information sharing between hospital case managers and homeless system case managers.*

- *.To be added with learning*

- *Conduct gaps analysis*
- *Create asset map of housing resources dedicated to coordinated housing placement system, baseline delta between supply & demand*
- *Advocate for dedicated subsidies from Public Housing Authority*
- *Invest in master leasing of existing units*
- *Invest in the near-term and long term development of new affordable housing units & advocate for the protection & preservation of existing affordable housing*
- *Convene and incentivize landlord community to dedicate market units*
- *Include other affordable housing strategies such as land trusts, innovative housing (tiny homes, shipping containers), etc.*

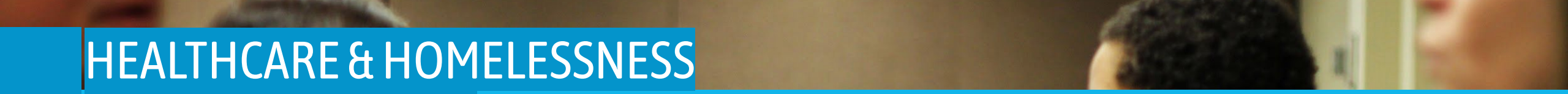
- *Conduct gaps analysis & determine a process for who is best positioned and how to close the community service and provider gaps*
- *Have internal team work with community board members to help understand link between homelessness and health; they use a "social influencer of health"*
- *Co-locate mental and physical health services within permanent supportive housing*
- *Actively tie health system efforts on mental health, substance use disorders, and SDOH screening to reductions in chronic homelessness*

Pilot Team Breakouts

- **Reflect together on your learning thus far and begin to take an inventory of potential interventions and investments**
  - What is already going on (in our health system and through the CoC's efforts)?
  - Where might there be gaps?
  - What could be in our portfolio of 5-8 interventions and investments?
- **Use the change package to start conversation!**
- **We will come back together to debrief**

Break!
See you in 30 minutes

We'll reconvene at 3:00PM ET / 12:00PM PT



HEALTHCARE & HOMELESSNESS

WORKSHOP 1: DAY 2

4

Team Time

Options for Discussion [40 minutes]

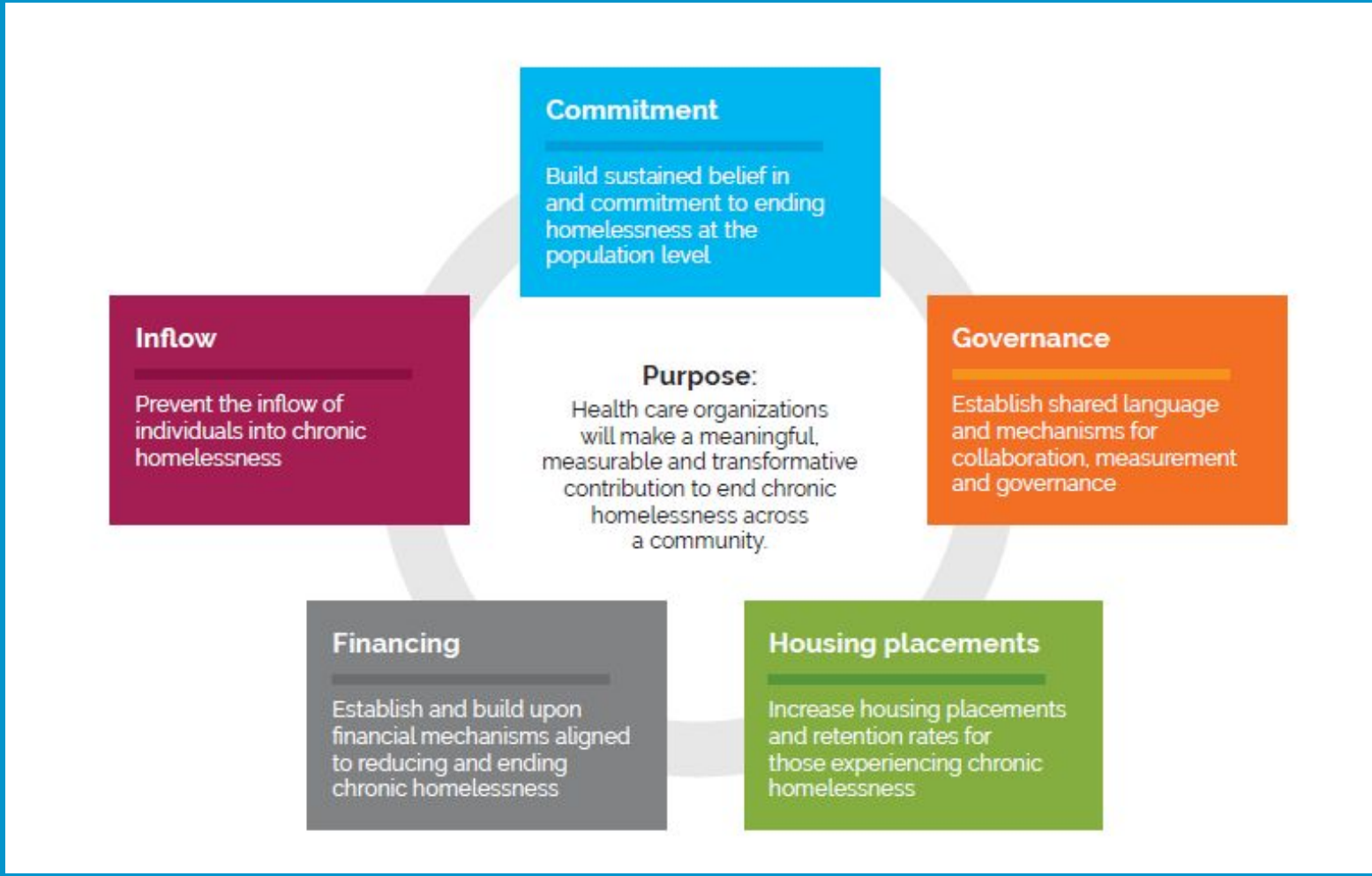
- Select your milestone - where do you want to be by May? (templates on next slide)
- What else do you need to know before selecting pillars?
- What are the highest leverage pillars for your pilot team?
- What projects are a part of your portfolio?

3 Month Milestones Templates

By **Workshop 2 (May 2021)**, our Pilot Site will:

- ***Build our Pilot Teams, identify day to day leads for this initiative and schedule our monthly coaching calls***
- ***Make progress on having quality All Singles data***
- Select our portfolio of projects in high leverage pillars (process mapping)
- Document the work of projects we are already doing in service of reducing chronic homelessness

A Roadmap for Collaboration



HEALTHCARE & HOMELESSNESS

WORKSHOP 1: DAY 2

5

Wrap up and Closing

Closing Conversations

Kedar Mate
President & CEO
Institute for Healthcare Improvement

Rosanne Haggerty
President & CEO
Community Solutions

The Pilot: What Comes Next

Action Periods: What to Expect

Pilot Team Coaching	All Pilot Site Monthly Calls
Who: Health System representatives, Homeless System Representatives, IHI Faculty Coach, Built for Zero Coach	**Who:** All Pilot Teams: • Health System representatives • Homeless System representatives • IHI Staff • Built for Zero Staff)
What: up to 90 minutes of Pilot Team coaching	**What:** 60 minute group calls to engage in discussions around shared challenges, bright spots, cross team learning and networking
When: Once per month, schedule with your coaches and Pilot Teams	**When:** 4th Wednesday of each month, 3-4PM ET/12-1PM PT Starting February 24th

Action Period 1: February through May

As a pilot team…

1. Finalize a 3 month milestone
    a. Identify a portfolio of projects from the Theory of Change
2. Participate in Pilot Site coaching calls
3. Participate in All Pilot Site monthly calls
4. Prepare for Workshop 2 (May 2021)

Closing:

- Share with us in the chat box:
    - One high leverage idea you'd like to test with your team in this Action Period
    - One thing you think makes your Pilot Team strong because of this collaboration?