INSTITUTE FOR HIGH QUALITY CARE

Project Planning Toolkit

Prepared for the Local Indigent Care Needs Program

County Medical Services Program

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Introduction

The Local Indigent Care Needs (LICN) Program

The County Medical Services Governing Board (CMSP) has invested in both Planning Project Grants and Implementation Project Grants under their Local Indigent Care Needs (LICN) Program. Through the LICN Program, CMSP seeks to expand the delivery of locally directed indigent care services for low-income uninsured and under-insured adults that lack access to healthcare, behavioral health care, and associated support services in CMSP counties. The principal goals of the LICN Program are to promote timely delivery of necessary medical, behavioral health and support services to locally identified target populations; link these populations to other community resources and support; and, improve overall health outcomes for these target populations.

LICN Planning Project Grantees were selected from a pool of either county or non-profit agency applicants. Each Planning Grantee has submitted a proposed idea or project as well as questions to investigate. The planning period will allow the Planning Grantee to gather and analyze internal and community-based data; consider strategies to address access challenges identified by their environmental scans; and ultimately create an Implementation Project that can be submitted for an Implementation Project Grant funding.

The LICN Planning Toolkit was developed by the Institute for High Quality Care (IHQC), the technical assistance provider for the CMSP LICN program, to support Planning Grantees in designing and creating their Implementation Project Plan.

The LICN Planning Toolkit

The LICN Planning Toolkit is designed to support Planning Grantees, their project managers, and their collaborative partners in creating their Implementation Project Plan. The Toolkit is intended to be an approachable, workbook-stylized guide that offers approaches tailored for LICN Planning Grantees. The chapters and subsections provide a brief summary of the area of focus, and walk the reader through considerations, decision points, and applicable tools that can provide assistance. The Toolkit also provides links to supplementary resources that let the reader explore relevant topics more deeply. A more comprehensive compilation of resources can be found in the LICN Resource Library: *http://IHQC.org/LICN-resource-library/*. The password for accessing the library is **licngrantee**

The Toolkit is structured to sequentially walk the project team through classic steps of a program planning and design process. Recognizing that each Planning Grantee is coming to the planning process at different stages, the project team may not need to cover each section with the same depth and focus. At a minimum, review each chapter and subsection's checklists or considerations summaries. This effort may prompt additional thinking or factors that you have yet to consider.

Finally, the Toolkit includes an Implementation Work Plan template. Chapter 3 reviews each section of this template and provides a crosswalk of the work Plan elements to the CMSP LICN Implementation Program grant submission format and requirements.

About the Institute for High Quality Care (IHQC)

IHQC works to optimize the capacity of California safety net organizations to provide high quality healthcare by advancing their ability to engage and sustain quality improvement initiatives, instilling an organizational culture of quality improvement, and improving their readiness for an expanded role in integrated healthcare delivery environments. IHQC provides tools, trainings and resources for safety net healthcare providers, integrated health delivery systems, and foundations focused on optimizing the health of the communities they serve. To learn more, visit http://IHQC.org/.

IHQC has been engaged by CMSP as the technical assistance provider for the LICN Program.

Chapter 1 – Project Focus

CHAPTER FOCUS

Identify the specific problem(s) you wish to solve, and identify the strengths and gaps that will best equip you address your target population.

SECTIONS

1.1 Community Needs Assessment

1.2 Organization Assessment & Project Partners

1.3 Confirming the Project Focus

TOOLS

- Research & Data Mining
- Root Cause Analysis
- Qualitative Data Collection
- SWOT Analysis
- Priority Matrix

CONSIDERATIONS

- What information do we already have?
- What information is missing? How might we obtain it?
- How do we know we are pursuing the right project?

As a LICN grantee, it is likely that your organization's mission, vision, or values aspire to sustain the health, safety, and quality of life of your community members. However, it may be challenging to determine priorities among several areas you have thought about improving. Prior to generating or selecting ideas about solutions or health interventions, it is critical to start with assessing the "current state." Understanding the factors affecting the community's health that exist both internally and externally to your organization can help you make decisions on how to achieve the biggest impact given the available resources.

Chapter 1 – Project Focus offers a high-level guide to assessing community needs, assessing organizational needs, establishing partnerships, and determining which problem(s) your project intends to solve.

> *"You have to consult with the community, understand and analyze community information, your own and others' observation, and the context of the issue to create an intervention that will actually bring about the changes the community wants and needs."*
>
> *~ Extracted from Community Tool Box*
> *https://ctb.ku.edu/en/table-contents/overview/other-models-promoting-community-health-and-development/preceder-proceder/main.2*

1.1 Community Needs Assessment

Whether you are retrieving existing data or using qualitative methods to discover new insights, teams must be able to *demonstrate that there is an existing need* which their project will purposefully address. Initial exploratory efforts should center on obtaining information and data that paints a picture of:

- ❑ The problem that is trying to be solved, and
- ❑ The population you wish to impact.

This section offers questions that will help you assess the current state of your community.

What does the current environment look like? What are the notable issues or disparities?

Conduct ***Research and Data Mining*** to obtain information about the local community, guided by these prompts:

- ❑ Identify the health-related issues that your community may be experiencing.
  - Consider **health indicators** from a variety of categories like diseases/causes of death, health behaviors, health care access, and social determinants of health (see the *Health Indicators* reference list below).

- ❑ Compare the local community's data with other benchmarks to determine which indicators demonstrate notable disparities and gaps.
  - Much of this research may already have been conducted, and there are several **searchable databases** that can be queried for comparisons (see the *Searchable Databases* reference list below).

- ❑ Note any health indicators or other data that would be interesting to learn about but the data are not currently available.
  - How might the team obtain these data? What "proxy indicators" currently exist that could give you the next-best estimate of the information you seek?

- ❑ Document any findings. Examples might be:
  - *Example County's* top 3 causes of death are heart attack, stroke, and colorectal cancer.
  - *Example County's* unintentional drug overdose rate (15.9 per 100,000) is significantly higher than the national average (11.9 per 100,000).
  - *Example County Health System's* hospital ED readmissions rate is an average of 50% each month.
  - The number of individuals in *Example County* experiencing homelessness increased from 1,375 (4.9%) in 2018 to 2,500 (8.9%) in 2019, and this number has increased at a much faster rate compared to the two neighboring counties.

Health Indicators
Consult a variety of lists to identify health indicators you may wish to explore in your community.

Core Health Indicators (WHO):
https://www.who.int/healthinfo/indicators/100CoreHealthIndicators_2018_infographic.pdf?ua=1

Healthy People 2020 Leading Health Indicators (CDC):
https://www.cdc.gov/nchs/healthy_people/hp2020/hp2020_indicators.htm

Key Indicators of Health (LA County Department of Public Health):
http://publichealth.lacounty.gov/ha/docs/2015LACHS/KeyIndicator/PH-KIH_2017-sec%20UPDATED.pdf

Searchable Databases
A wealth of data and information are available through searchable databases like the following:

National Health Data from the CDC
https://www.cdc.gov/nchs/hus/contents2018.htm
https://www.cdc.gov/socialdeterminants/data/index.htm

Healthy People 2020
https://www.healthypeople.gov/2020/data-search/

California Health and Human Services Agency
https://data.chhs.ca.gov/

California Health Interview Survey Data (CHIS)
https://healthpolicy.ucla.edu/chis/data/Pages/GetCHISData.aspx

Rural Health Information Hub
https://www.ruralhealthinfo.org/data-explorer

Community Health Needs Assessment (CHNA) from Kaiser Permanente
https://about.kaiserpermanente.org/community-health/about-community-health/community-health-needs-assessments

How do we define our target population?

The LICN proposal asks teams to address at least one of the following populations in their project:

- Adults that need follow up specialty services and/or other support services following an inpatient hospital stay
- Adults receiving inpatient hospital care with limited home/community support to facilitate healing and recovery
- Adults with complex health or behavioral health conditions that have housing and/or transportation challenges that impede their ability to obtain necessary health care services
- Adults with health and/or behavioral health conditions released from incarceration
- May narrow into sub-populations:
  - Homeless adults
  - Adults with chronic health or behavioral health conditions
  - Adults in need of pain management support

As your team defines and better understands the project's target population, consider these guiding questions:

- ❑ Apply similar considerations from the previous section to select your target population.
  - E.g. In *Example County*, the number of adults with behavioral health conditions is 2x the state average.
  - E.g. In *Example County*, the number of inpatient hospital visits increased by 25% in the last year.

- ❑ Define the target population once you make a selection.
  - Determine how many individuals are within the group(s) you selected.
  - Identify demographics and other notable characteristics of your target population. Consider gender, age group, race and ethnicity, primary language, sexual orientation, marital status, and/or disability.

- ❑ Define subset populations and/or sample groups, if needed.
  - Is there a particular demographic group that is at higher risk for certain health issues?
  - Based on the organization's current capacity, is it more feasible to identify a pilot group before scaling up to the larger population?

- ❑ Note any critical data that is missing or undefined.
  - How might you obtain this data? What "proxy indicators" currently exist that could give you the next-best estimate of the information you seek?

- ❑ Document Your Findings. Examples might be:
  - *Example County's* Community Hospital reported 800 inpatient visits in January 2020, and of those, there is a total of 600 unique patients. Of those patients, 75% were male, 80% were over the age of 55, and 60% noted experiencing housing insecurity

What are the factors impacting our target population's health outcomes?

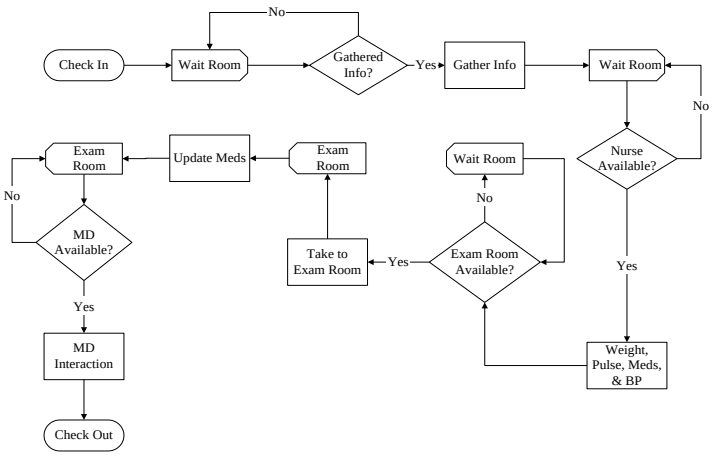
Looking beyond the data, teams should apply a variety of methods to better understand their target population's experiences and further contextualize the data and demographics. These efforts can help uncover any real or perceived gaps in services or resources, which will be critical to informing your intervention design and theory of change (explored in Chapter 2).

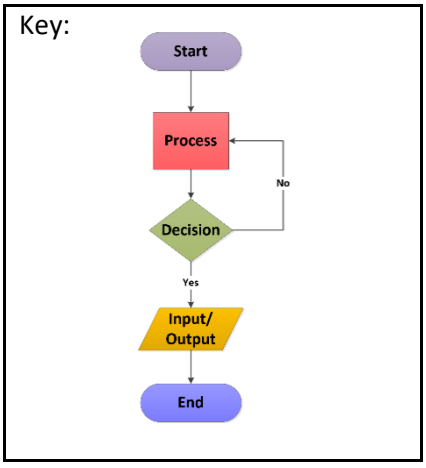
Start with leveraging some ***Root Cause Analysis*** approaches to better understand the underlying issues and challenges that impact health outcomes and disparities.

1. Brainstorming Activities (approaches for facilitating a brainstorming session are further detailed in Chapter 2)
   - ***Featured Tool: Fishbone Diagram*** – Also known as a "cause and effect" diagram. It is a root-cause analysis tool that visually shows the relationship between an observed problem (an "effect") and the possible "causes" influencing it. Explore this Featured Tool on the following page.

   - "5 Whys" – An exercise that explores the underlying causes of a problem. Ask "why" something is happening; then, for the reason you identify, ask why that happens. Repeat this process at least 5 times.

2. Process/Workflow Mapping and Analysis
   - ***Process Flow Mapping*** – This exercise provides a picture of a process in its current state, showing in what order certain tasks or activities of a process are performed. Once you have mapped out the current state, identify pain points, gaps in care, or areas that need improvement.

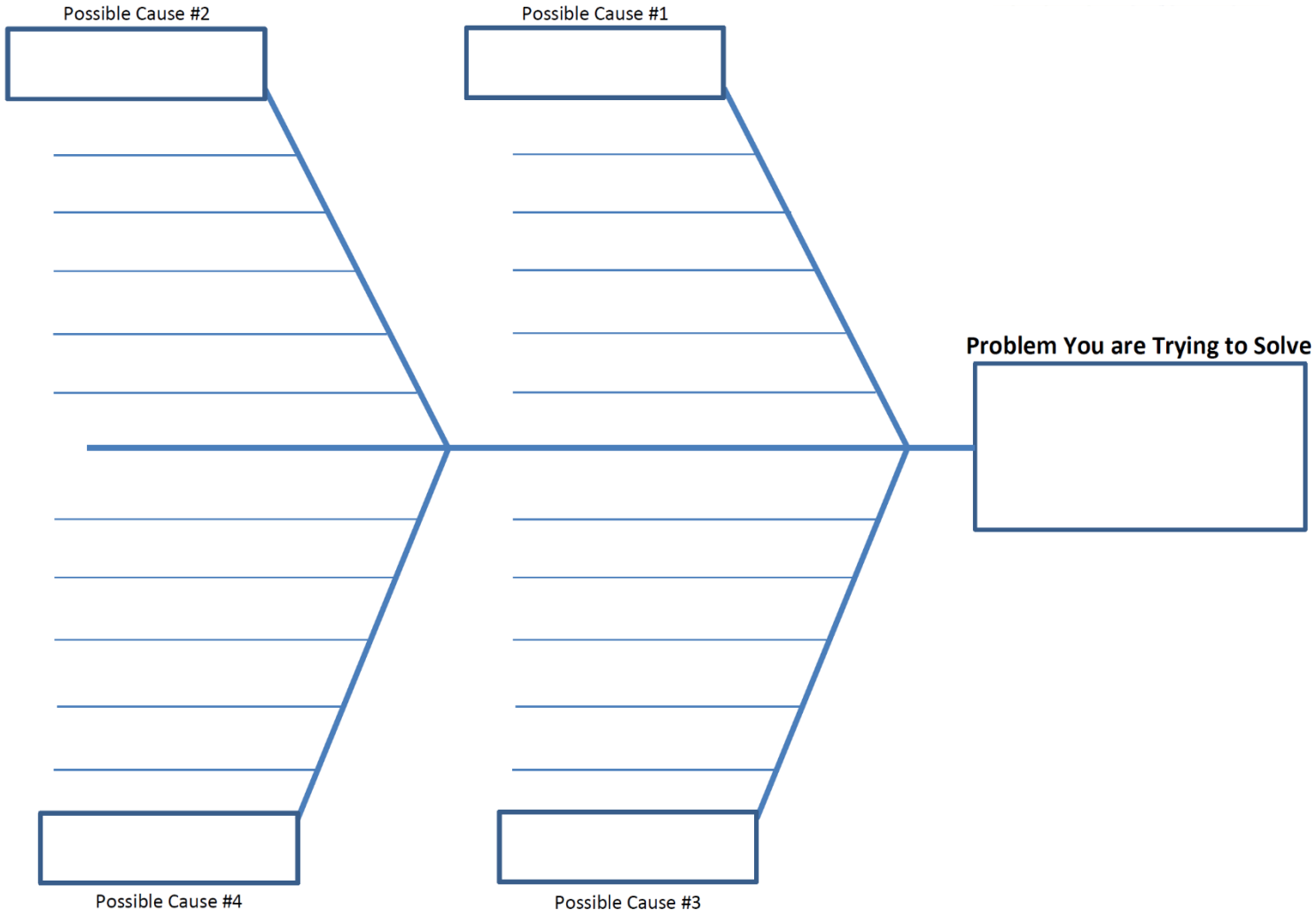




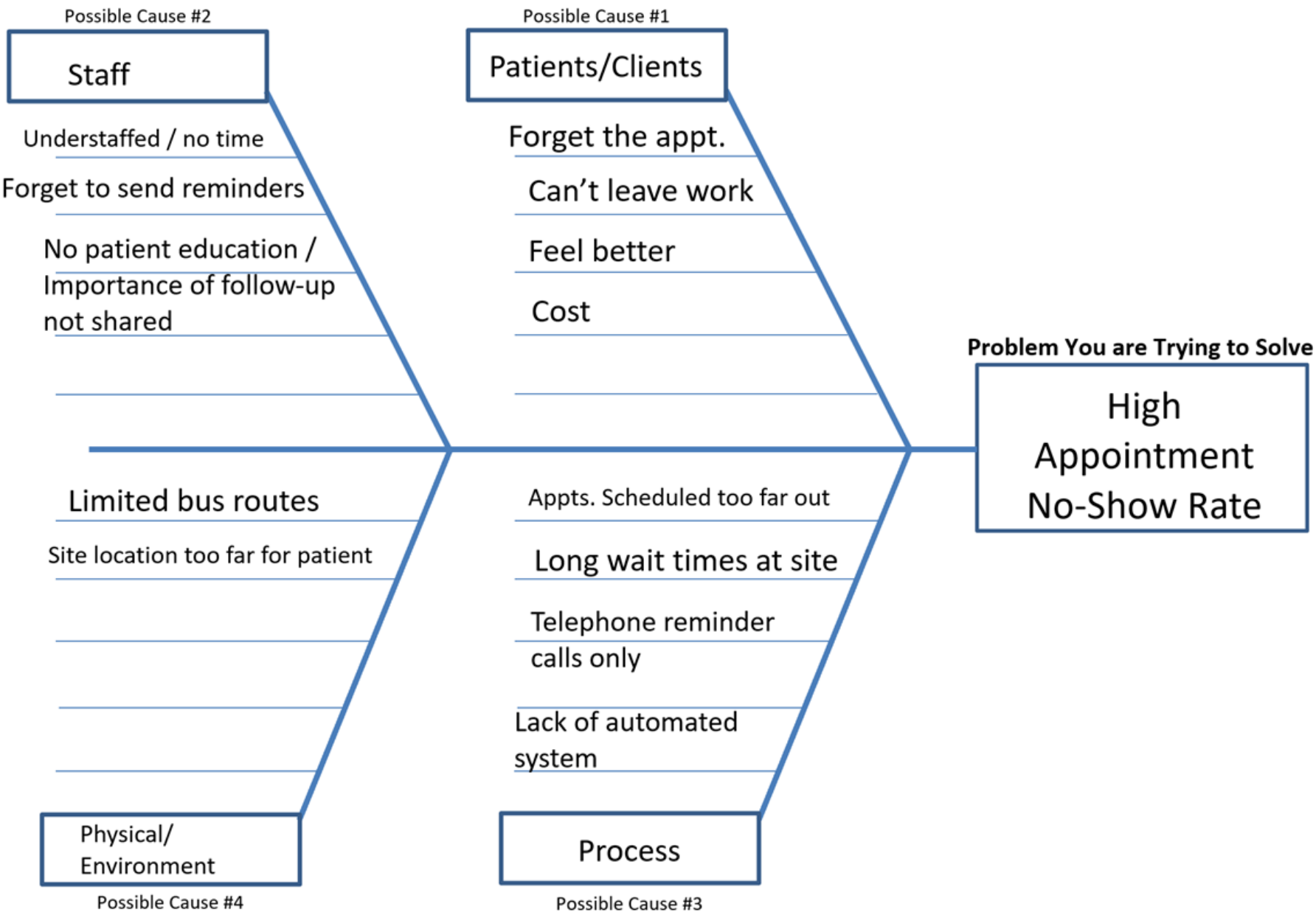
   - ***Journey Mapping and Empathy Mapping*** – These exercises, when used in tandem with process mapping, allow the planner to gain a deeper understanding of how a patient/client might experience a specific service or interact with one or more organizations.
     – Journey Mapping Guide example: https://www.ideou.com/blogs/inspiration/use-customer-journey-maps-to-uncover-innovation-opportunities
     – Empathy Mapping Template example: http://gamestorming.com/empathy-map/

Featured Tool: Fishbone Diagram

1) Start by stating the problem in the “head” box.
2) Next, think of 4-6 possible categories of causes to populate the “body” of the fish. Common categories include individual perceptions, beliefs, and behaviors, physical infrastructure, resources/supportive services, or policies.
3) Fill out the “fishbones” by listing the specifics within each cause that may be contributing to the problem.
4) Tip: You may want to use a “5 Whys” approach to help you dive deeper into the underlying causes of the problem. Ask “why” a problem is happening…then, for the reason you think it is happening, ask why that happens…repeat this process at least 5 times.



Sample Fishbone Diagram



3. Observation
    - ***Gemba Walks to "Go See, Ask Why, Show Respect"*** – This activity originates from Lean/Six Sigma methodology and involves directly observing one or more activities within a process and inquiring of the people involved with those activities about what is working and what is challenging.
        – Visual guide example to conducting a Gemba walk: https://leanbluesky.com/2017/03/17/the-gemba-walk/

4. "Market Research" and Other Qualitative Research Strategies
    - ***Surveys, Polls, and Questionnaires*** – Distribute a set of questions to a broad audience to obtain a high volume of feedback in a short amount of time.
    - ***Key Informant Interviews*** – In-depth, one-on-one conversations with stakeholders and subject matter experts, such as patients/clients, staff, partners, or other relevant community members.
    - ***Focus Groups*** – Gather a small, diverse group of people to engage in a guided discussion around a selected topic. This approach can yield rich information, but is often complex and time-intensive to conduct.
    - Worksheets for designing and conducting these approaches can be found in the LICN Resource Library.

Synthesize Our Findings

Once the team has gathered enough information to understand the community needs, review and compare your findings to generate a short-list of your best options. Consider factors like:

- ❑ Opportunities to impact upstream factors (e.g. systematic, environmental, and social influences)
- ❑ Total volume of individuals who could be impacted by your project
- ❑ Populations that demonstrate the greatest health disparities
- ❑ Populations that are historically underserved, disenfranchised, stigmatized, etc.
- ❑ Topics and issues that are important to the community
- ❑ Likelihood or feasibility of reaching a certain population

Document your notes in a template like this ***Community Needs Assessment Findings*** table:

Finding/Theme	Data/Count	Source & Date	Notes (Why is this important? What is surprising?)
Example: *Hospital readmissions are more likely to be experienced by patients >55years old. They are more likely to have complex health issues, and more likely to be experiencing homelessness.*	*About 100 readmissions on average each month in 2019*	*2019 NCHS Hospital Data 2015 Health Care for the Homeless Survey*	*Target population is likely elderly, need to account for transportation/mobility barriers.*

1.2 Organization Assessment and Project Partners

The project planning process includes reviewing, understanding, and aligning the current priorities, drivers, and capacities for the Lead Agency, as well as the Project Partners. The tools in this section will help you assess your organization's "current state," strengths to build upon, and gaps to fill. Your findings will further inform how you prioritize project ideas and can facilitate how you build support and engagement from key stakeholders.

What Is Our Organization's "Current State?"

With a better understanding of how the larger environment is affecting the health of your target population, consider applying similar approaches to conduct a "needs assessment" of your organization's internal processes. At the end of this process, the planning team should be able to confirm that there is some sort of problem, gap, or discrepancy within the system, and identify underlying causes to these issues.

- ❑ Consider any questions, curiosities, or assumptions about your patient/client population, processes, or systematic structures that you would like to understand further.
- ❑ ***Research*** and review your quality or performance data.
- ❑ Apply ***Root Cause Analysis*** tools to help you identify potential areas of improvement within your organization.
- ❑ Note any data that you want to learn more about but the information is not currently available.
    - How might you obtain this data? What "proxy indicators" currently exist that could give you the next-best estimate of the information you seek?
- ❑ Document your findings.

What Are Our Current Priorities?

- ❑ Consider the following questions:
    - What are the current organizational priorities? Are they aimed at improving internal processes, addressing the needs of patients/clients, or a mix of both?
    - Which priorities are being addressed with active projects and/or projects planned for the future?
    - How are our resources/time distributed across these priorities and projects? (extensive/high, moderate, or minimal/low)
    - How will the response to COVID-19 impact these priorities and projects?
- ❑ Document your answers in a template like this ***Project Inventory*** table.

Project	**Brief Description of Project** (Change ideas, key activities, goals, etc.)	**Current Status** (Planned, Active, Completed)	**Time/Resource Dedication** (High, Med, or Low)	**Other Notes** (Considerations that may impact our project)
Example: Improve hospital readmission rates	*Rolling out new case manager follow-up protocols.*	*Active (Started Jan. 2020)*	*Medium*	*Expected to complete project by Dec 2020; hiring freeze will likely delay recruitment of 2nd case manager*

Identify Organizational Strengths and Gaps

Reflect on your organization's capacity in service delivery and project management by reviewing the ***LICN Program Needs and Skills Assessment*** completed by your planning team. Which areas scored the highest? Which areas scored the lowest? Identify strengths that should be leveraged, and gaps that should be addressed over the course of your LICN project. You can document your highlighted responses in a template like this ***Needs and Skills Assessment Results*** table:

	Highest Scoring Items	Lowest Scoring Items
Project Team and Staffing	- -	- -
Data Availability	- -	- -
Program Design	- -	- -
Partnerships	- -	- -
Program/Organizational Capacity	- -	- -
Familiarity/Expertise with Specific Topics and Tools	- -	- -

A ***SWOT Analysis*** is also a helpful exercise to reflect on the organization's strengths and gaps. SWOT stands for Strengths, Weaknesses, Opportunities, and Threats. This framework can help teams map out the positive aspects and challenging areas *internal* to their project team or organization, as well as the facilitating and deterring factors that exist *externally,* and can potentially influence their project's impact.

This tool can also help you identify what type of partnerships to form – who can help you bolster strengths, capitalize on opportunities, fill any gaps among weaknesses, and better equip you to address any threats? A SWOT Analysis worksheet is provided in the next page, and you can learn more here: https://www.health.state.mn.us/communities/practice/resources/phqitoolbox/swot.html

Featured Tool: SWOT Analysis Worksheet

Use the template below to brainstorm the Strengths, Weaknesses, Opportunities, and Threats that would affect your project.

	Helpful	Harmful
Internal	**Strengths** ***Team* characteristics that help achieve outcome/ goals** (e.g. staff skills/capabilities that contribute to success; existing management/team leadership; support for area of focus; resources that are accessible – time, funding, staff, systems, facilities, infrastructure) •	**Weaknesses** ***Team* characteristics that hinder achievement of outcome/goals** (e.g. staff skills/capabilities not yet present; lack of management/team leadership; lack of support/buy in from key stakeholders; missing resources) •
External	**Opportunities** ***Environmental* factors that facilitate success** (e.g. health plan priorities/interests; funding sources; external partnerships and collaborations; social, cultural, and technological factors that you could leverage, such as the increase in social media use) •	**Threats** ***Environmental* factors that prevent success** (e.g. uncertainty of current health policy; withdrawing funding sources; impacted projects as a result of diverted resources; social, cultural, and technological factors that could put your project efforts at risk) •

Following the SWOT analysis, consider:

- Which strengths you can use to your advantage to address/minimize weaknesses.
- How your team could take full advantage of the opportunities.
- How realistic are the threats, and how you might plan for/address those threats.

Building Strategic Partnerships

Designing and implementing a program aimed at solving complex problems requires multi-sector collaboration. Your organization likely has existing partnerships and collaborations that can be leveraged to support your LICN project, but you will need to expand these partnerships or identify new partners to increase your project's impact for your target population. The ***Practical Playbook*** from the California Accountable Communities for Health Initiative (CACHI) offers a detailed approach to forming partnerships, but you may generally consider the following when engaging partners.

- ❑ Select who should be included as a partner organization.
    - Who are our current partners?
    - What other partnerships need to be formed? ***Asset Mapping*** is one tool that can guide the brainstorming process, and can help you think creatively about other sectors, industries, or institutions that may be doing similar work. The Advancement Project - Healthy City Community Research Lab offers an extensive toolkit for community asset mapping here: https://www.communityscience.com/knowledge4equity/AssetMappingToolkit.pdf

- ❑ Identify the connections on which the partnership should be based.
    - How are our organizations aligned?
    - Which aspects of our current or prospective partners' mission, values, and services align in meeting the needs of our potential target population?
    - What other goals, drivers, and needs should we be aware of among our partner organizations?

- ❑ Determine the mutual benefits of the partnership.
    - How will you *mutually* support each other's strengths?
    - How will you *mutually* address each other's gaps?

- ❑ Meet with your partners to establish expectations.
    - Who will be involved, and in what capacity? Considerations for individual roles and responsibilities are explored further in Chapter 3.
    - How will we share and exchange activities, staff, and/or data?
    - The California Health Care Foundation offers a comprehensive guide and toolkit to building a shared culture among community partnerships: https://www.chcf.org/wp-content/uploads/2019/10/BuildingSumGreaterPartsIntegrationCommunityHealth.pdf

- ❑ Complete Letters of Commitment or Memoranda of Understanding to formalize the partnership and include with your LICN Implementation Grant proposal submission.

- ❑ Document your process with a table like this ***Partner Organization Inventory*** template:

Partner Organization	**Areas of Alignment**	**Gaps they can help us fill**	**Gaps we can help them fill**	**Contact Information** (Name, Role, Email, Phone)	**Notes** (e.g. potential risks/conflicts of interest, meeting plans, action items, etc.)

1.3 Confirming the Project Focus

Through your work thus far, you have gained extensive knowledge about the "current state," and you have likely identified several issues that could be addressed through the LICN program. By identifying the existing health issues, the populations demonstrating the greatest need, gaps in service, and other systematic challenges, your planning team should have a better sense of which problems, if addressed, would result in the greatest impact on your patients/clients and your organization. This section provides considerations to help you generate your short-list of topics and ultimately confirm your project's focus.

Select Your Project's Area(s) of Focus

Before advancing to generating solutions, confirm the focus of your project, and leverage all the information you compiled from your exploratory efforts to make a case for why you are pursuing a certain direction. If the planning team finds it challenging to make a selection, consider using a simple **2x2 *Priority Matrix*** to organize and rank your options. A detailed description of a more complex multi-factor priority matrix is also described in Chapter 2.

Suggested factors for assessing priority:

- Severity of issue for your community
- Degree to which staff are empowered to create change
- Innovation (How novel would the potential program be?)
- Alignment with organization's strategic goals
- Alignment with partner organizations' strategic goals
- Bandwidth/resource availability
- Engagement/Interest (of community, staff, or other key stakeholders)
- Feasibility in a 3-year period

Communicate With Your Partners and Other Key Stakeholders

You have likely included your partners and key stakeholders throughout this exploratory process, but you may still need to obtain confirmation or approvals from the project's senior leadership. To help build buy-in among your colleagues and stakeholders, it is helpful to formally communicate your project focus once a decision is made. Keep communication channels open and allow others to share their initial reactions, additional curiosities or questions, and suggestions for anything that should be further assessed or reviewed.

Chapter 2 – Theory of Change

CHAPTER FOCUS

Creating a Project Map that defines the activities and changes that will be tried to reach the project's goals.

SECTIONS

2.1 Generating Ideas - Best Practices and Group Brainstorming

2.2 Prioritizing and Organizing Your Ideas

2.3 Creating Your Project Map

TOOLS

- Best Practice Log
- Group Brainstorming
- Priority Matrix
- Driver Diagram
- Logic Model

CONSIDERATIONS

- What interventions might work for our project?
- How to we visually represent how project from activities lead to impact?
- What can we measure to track our project's impact?

When planning a project or initiative, articulating the project's *Theory of Change* helps to focus and scale project activities, to define the relationship of these activities to the outcomes, and to frame opportunities for evaluation of the effort. Articulating and/or mapping a *Theory of Change* also provides an opportunity to think through multiple changes and activities that might lead to the desired outcomes. The process lets the project team and collaborative partners be creative – considering how promising practices from similar efforts could be applied as well as brainstorming new changes that might work.

Chapter 2 – Theory of Change – provides approaches and tools for Generating Ideas, Creating a Project Map, and Identifying Your Project Measures.

> *"Theory of Change is essentially a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context. It is focused in particular on mapping out or "filling in" what has been described as the "missing middle" between what a program or change initiative does (its activities or interventions) and how these lead to desired goals being achieved."*
>
> ~ Extracted from https://www.theoryofchange.org/what-is-theory-of-change/

2.1 Generating Ideas - Best Practices and Group Brainstorming

In this next phase of the project planning and design efforts, teams should invest time in researching promising practices and brainstorming activities, changes, and/or interventions to consider for your LICN project. This "Generating Ideas" section will walk through a series of activities to guide teams or collaborative partners through this process, including:

- ❑ Research what has already been tried and tested at your organization and/or in your community
- ❑ Identify and log best practices (both internally to your organization and externally in similar organizations or systems)
- ❑ Engage in group brainstorming to discuss potential improvement ideas

Research Best Practices

Goal: Understand what others – similar organizations, projects, your peers and colleagues – have already tried and tested. Note which changes have worked well, which haven't worked well, and why.

Other organizations or collaborative efforts may already have had successes with interventions similar to your project's focus. In order to not "reinvent the wheel," research what promising practices already exist for your effort. Consider what worked in these cases, what didn't, and what the specific conditions for the effort were. Often these promising practice cases offer precautions to avoid – saving you time to focus your efforts. Many of these best practices have been documented and shared on websites like the **Rural Health Information Hub** (https://www.ruralhealthinfo.org/success) and the **National Health Care for the Homeless Council** (https://nhchc.org/clinical-practice/homeless-services/best-practices/).

You may also find that others in your organization or your partners have spent some time and effort on this project. Take note of these internal efforts – talk to those who may have been actively involved in those efforts to learn what was tried, what worked, and what challenges were encountered along the way.

Document your findings in a table like a ***Best Practices Log***, detailed on the next page.

Featured Template: Best Practices Log

Create an inventory of "best practices" or "evidence-based practices" to assess these change ideas/interventions. Consider what would work well for your organization, and what would be challenging and/or need to be tailored if you adopted that change.

Change Concept	**Change Ideas**	**What would work well for our organization?**	**What would be challenging? What would we need to tailor for our organizations? Other considerations?**	**Reference**
Example: Team Based Care & creating high-functioning care teams	*Example:* Creating Team Agreements "Share the Care" Models Expanding team huddles to include behavioral health specialist and case managers			https://cepc.ucsf.edu/why-share-care http://improvingprimarycare.org/team/behavioral-health-specialist

Group Brainstorming

Goal: Engage in ***Group Brainstorming*** to explore what the promising practices identified would look like if implemented at your organization/community; what it would take to roll this out; and what other "out of the box" ideas could be considered for the defined project.

Your team, partners, and key stakeholders probably have some ideas about how to proceed with your project, to improve access to services, or to address common challenges. Bring this group together for a brainstorming session. To make the most of this brainstorming session, consider applying one or more techniques like nominal group technique, post-it note/dot voting, and affinity diagrams.

Brainstorm to Answer:

- What are 2-3 examples of changes being implemented in similar settings/organizations or patient/client populations?
- Why would these work well for our patients, clients, or organizations?
- What would be challenging for us?
- What might we need to redefine or tailor to meet our specific needs?

Fundamentally, brainstorming should be set in an environment and with processes that promote input and ideas from everyone. All voices and all ideas are gathered – promoting creativity without judgment or modification. You are looking for quantity at this point.

The ***Nominal Group Technique*** (https://en.wikipedia.org/wiki/Nominal_group_technique) provides a 4-step framework for idea generation, narrowing, and prioritization that promotes input from everyone. The steps are:

- ❑ **Individual Idea Generation:** Have people generate ideas on their own (silently to themselves or ask them to come to a meeting with 5-10 ideas).
- ❑ **Combine Ideas:** With a "round robin" or similar process, each person shares one idea at a time. **No critiquing or debating ideas at this point.
- ❑ **Group Discussion:** Consider groups of ideas listed and have the group discuss.
- ❑ **Ranking/Voting:** Leverage a prioritization technique like dot voting or a relative priority or ranking matrix (see next section for prioritization techniques).

Affinity Diagrams (https://asq.org/quality-resources/affinity) offer another grouping and narrowing technique that helps to optimize brainstorming sessions. All of the ideas are written on sticky notes and then sorted by themes. Similar ideas are clustered together and additional related ideas are attached to the group. The process is especially helpful when you are trying to sort through a large number of ideas.

2.2 Prioritizing and Organizing Your Ideas

After identifying and collecting change ideas, teams should focus next on prioritizing and organizing these ideas – selecting those that could bring the greatest impact to your project and to your community. This Prioritizing and Organizing Your Ideas section reviews two tools to help:

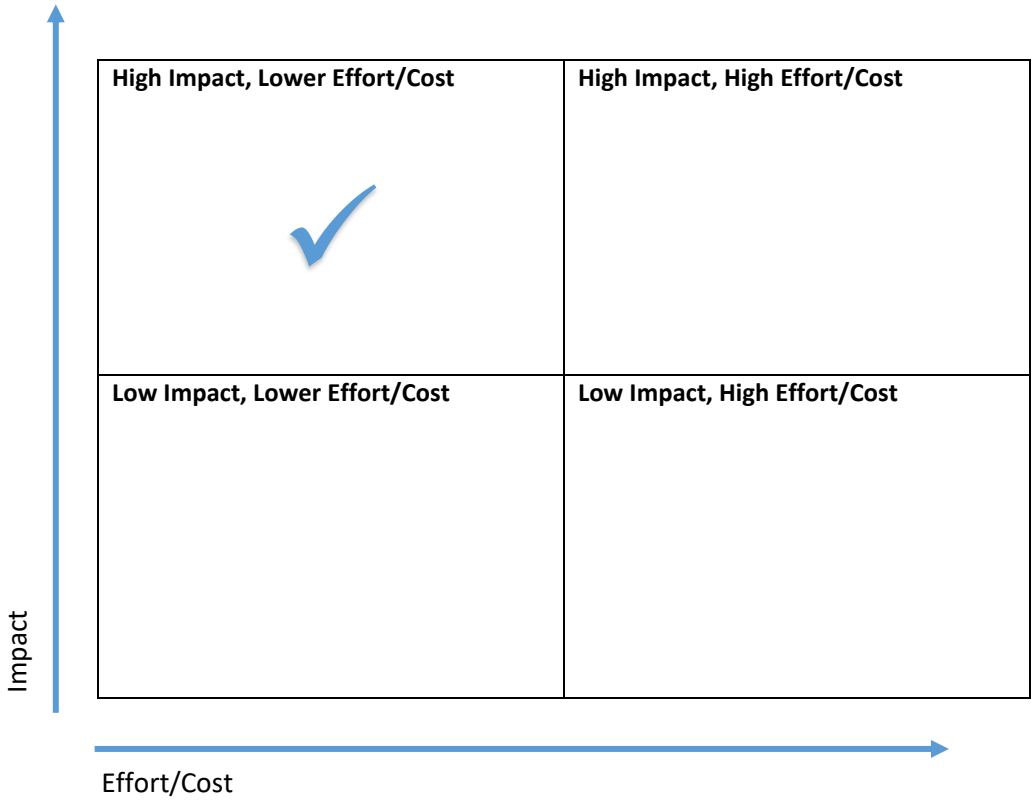
- Prioritize these improvement or implementation ideas, identifying the projects that could have the greatest impact on our target population.
- Organize changes and implementation ideas into a diagram linking activities to goals in support of the project aim.

Priority Matrix

Goal: Identify the change ideas, or project themes, that will have the largest impact and the highest likelihood of success.

After gathering promising practices and brainstorming new approaches that may work, leveraging a ***Priority Matrix*** can help determine which change, improvement, idea and/or theme should be chosen for this LICN project. It can also be used to help prioritize which ideas should be implemented first.

The easiest way to do this is a simple ***2x2 Priority Matrix*** (e.g., an impact/effort matrix), like the one shown below. In this example, *Impact* reflects how much of an effect the idea/theme would have on the project, the target population, and/or the community. *Effort/Cost* reflects how much effort, time, resources, and/or expense the idea/theme would cost to implement. Teams are usually encouraged to prioritize ideas that are projected to have the highest impact and lowest effort/cost.



If there are other important factors the team, partners, and/or stakeholders believe should be considered in weighing and prioritizing change ideas, use a ***Multiple Variable Priority Matrix***. While you can use as many factors as you want, try to limit these to 5 factors.

Project Idea/ Theme	Factor #1	Factor #2	Factor #3	Factor #4	Factor #5	Total Score
					=	
					=	

Suggested "Scoring" System:
Provide a "score" for each factor using a 1 to 5 scale, with 5 being the most favorable or having the most positive impact.

Factors you may consider:

- Patient/Client outcomes
- Total number of patients/clients impacted by the project
- Partnership collaboration
- Availability of resources to implement
- Finance (costs and/or revenue increases)
- Staff capacity/time to implement
- Confidence that the change/idea will be effective. Project is realistic.
- Are you and your team engaged/excited to take on this project?

Example – Multi-Factor Priority Matrix

Project Idea/ Theme	Patient Outcomes	# of Patients impacted	Costs	Staffing/ Resources available	Realistic in Current Environment	Total Score
Comprehensive case management and care coordination for high risk, complex patients	5	2	2	2	3	**14**
Transitions of care for patients seen in the ED to primary care; connected with care coordinator to facilitate follow-up appointments	4	3	4	4	5	**20**
Mobile Van	3	5	2	2	1	**13**

Driver Diagrams

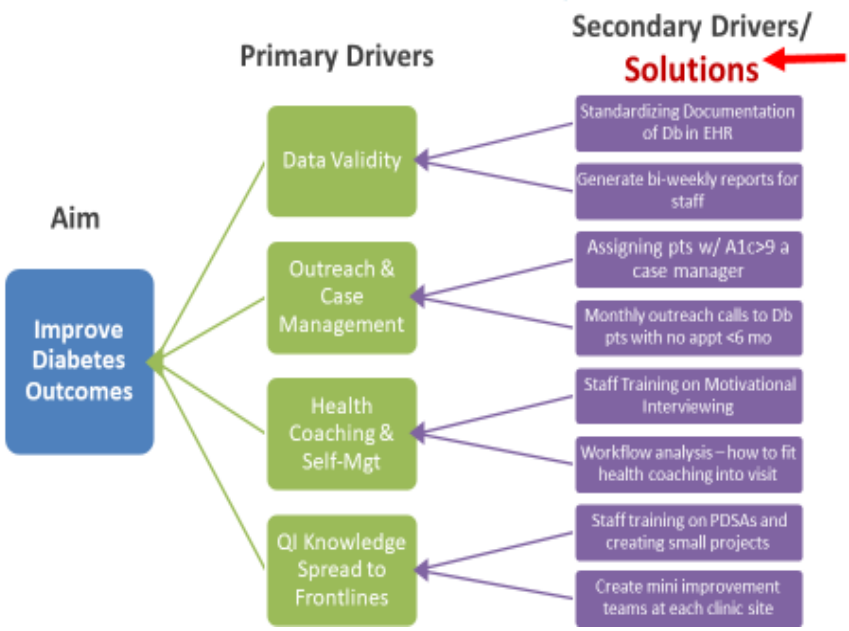
Goal: Cluster and organize the priority changes for the project; create a distinction between larger scale goals versus activities; and illustrate how activities lead to the goals and ultimately the project's impact or aim

A Driver Diagram is a simple visual layout that displays the "drivers" that will lead to the project aim. The first is the project aim – a short statement about what the team is trying to accomplish (e.g., see example). Moving to the right, the next column of boxes are called the primary drivers.

Primary drivers are the higher level themes that must be addressed in order to accomplish the aim. In this example to the right, this project's primary drivers are: data validity, outcomes and case management, health education and self-management, and building QI knowledge with frontline staff.

Continuing to the right, the secondary drivers provide more context for what it will take to make the primary driver work. Secondary drivers are more concrete, approachable project activities or change ideas.

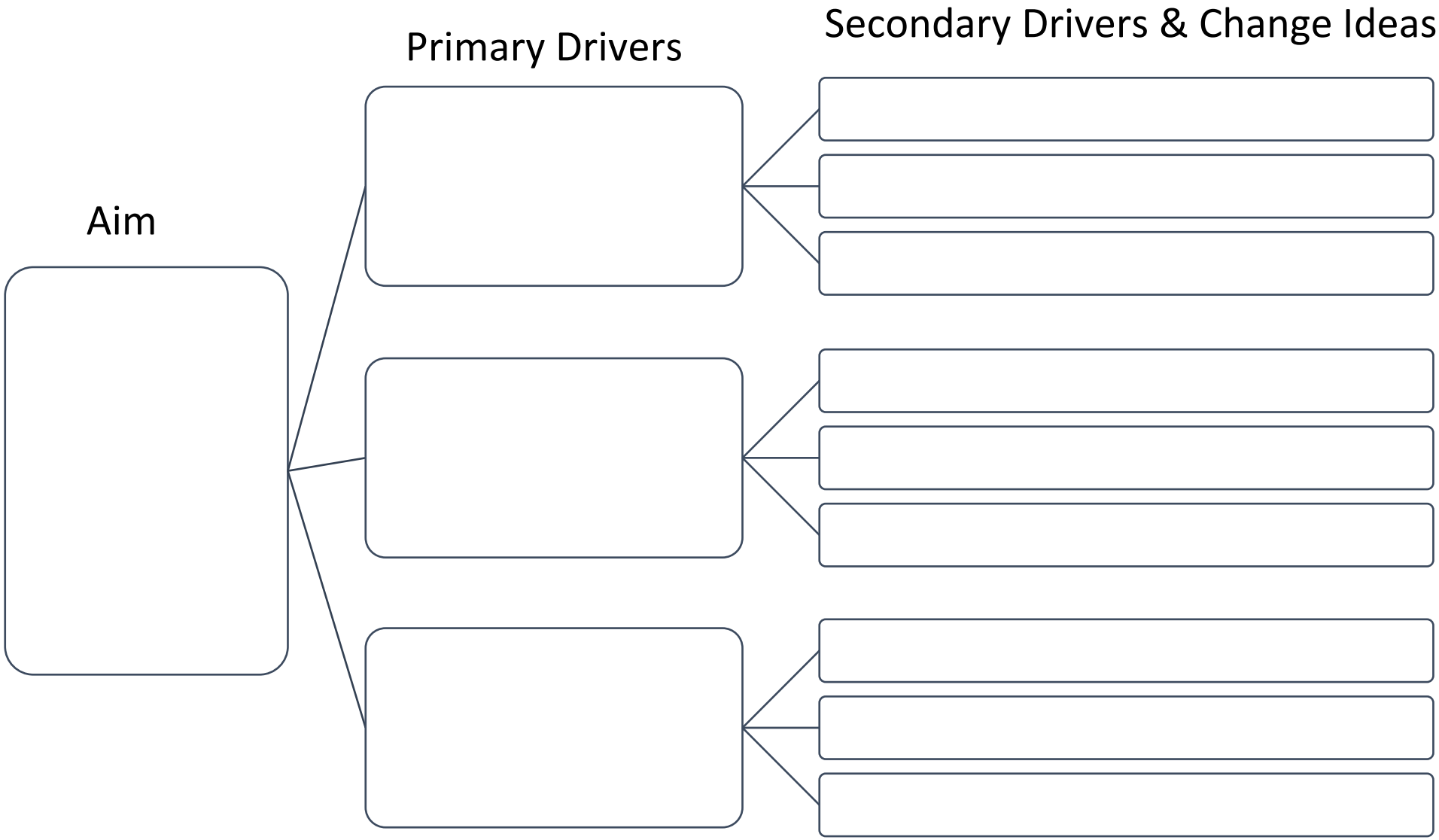
Secondary drivers may continue to be broken down – outlining more detailed project activities.



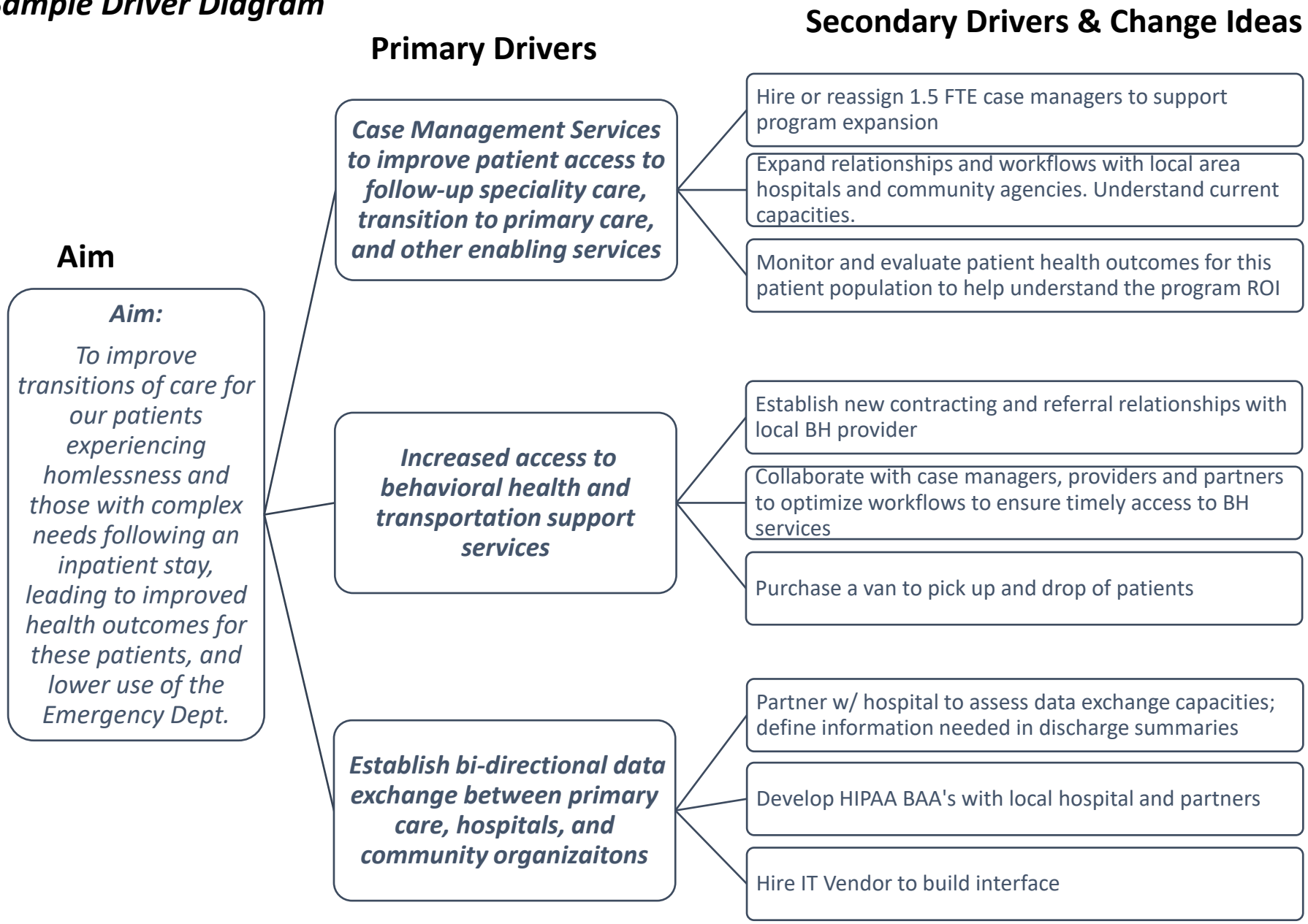
Tips for creating driver diagrams:

- ❑ **Post Its:** Putting ideas and actions on sticky notes gives the team the option to rearrange activities, regroup and categorize activities, and easily organize the elements into a driver diagram.
- ❑ **Ask - "How Might We?"** For each layer ask "how might we…" to dive deeper into project specifics. For example, our aim is to improve diabetes outcomes.
  - **How might we** improve diabetes outcomes?
    - Provide coaching and self-management support – but **how might we** improve health coaching and self-management support?
      - Organize a motivational interviewing training.
      - Improve warm hand-offs to a health coach during a regular visit with their PCP.

Featured Tool: Driver Diagram Template



Sample Driver Diagram



2.3 Creating A Logic Model

If your team has worked through each of sections in the planning toolkit so far, you have defined your target population, explored best practices, identified several changes/activities that can help to advance your work toward your desired outcomes, and sorted/prioritized these changes to see which activities will drive you toward your desired outcomes. With these pieces in place, your team can begin to map out the project overall – to help organize the aim, goals, deliverables and activities.

- Logic Model: a high-level, visual representation of the overall project that links activities and resources to outcomes and overall impact.

- The LICN Implementation Program Grant requires the submission of a Logic Model (template is reviewed here).

About Logic Models

Logic Models are a visual representation of the **theory of change** that underlies a project or program, highlighting relationships and linkages between the various elements that make up a project or an organizational effort. It is a great tool that can be used to communicate about the project with other team members and those responsible for the project activities. The logic model is also a useful communication piece for leadership within the organization as well as those stakeholders outside of the organization to better understand the vision for the effort and the steps being taken to get there.

While there are many logic model templates, most provide an overview of a project by showing links between:

- **inputs/resources to be used**
- **activities or processes to be implemented**
- **what are the outcomes both in the shorter term and for longer term impact**

LICN Program Logic Model

Box 1 – Target Population

The logic model is read from left to right with the first area of the model noting where you are beginning – in this format the **Target Population**. The logic model should note the specific focus (i.e., an overview of the target population) for the proposed LICN project. The model can include any subset populations being considered from the assessments in *Chapter 1*. The **Target Population** listing is separate from the logic model elements and their articulated links.

Box 2 – Program Theory of Change

The next section is the **Program Theory of Change** – what services will be designed, refined, implemented or spread. These are the changes at a high level gathered from previous research in best practices and brainstorming efforts from *Section 2.1*. For those who drafted a driver diagram for their project, the primary drivers often outline the project theory of change that will get the team to their LICN goals of increased access to medical, behavioral health, and/or enabling services.

Box 3 – Activities

Activities are the to-dos; the action items that you will take to get you to your outcomes. These are the "secondary drivers" from the driver diagram in *Section 2.2* – what is needed to do to implement your changes.

Box 4 – Outcomes

Outcomes are the results of the action items. These are short or mid-term outcomes during the grant period. Be sure to keep these realistic for the times you have, the resources you have and the bandwidth and capacity of all of your partners. The environmental scan from *Chapter 1* will provide you a sense of this scope and scale that is possible during the grant period.

Box 5 – Impact
Impact is the longer term, 3+ year vision for this work – what will be the ultimate impact of your outcomes on access, the community, the target population, etc.

Box 6 – Assumptions/Conditions for Success
Assumptions/Conditions for Success are those elements or conditions that must be in place for the overall logic of the project to hold true. For example, a team may assume that the team will have adequate staff or patient engagement, and dedicated time to meet and manage the effort and complete their work. These assumptions are important to define at the onset of project and to revisit and be mindful of throughout the project implementation. While teams may be able to make contingency plans for some of these conditions, some may need to be raised with leadership for further support.

Logic Model Template with Prompts

Target Population	Program Theory of Change	Activities	Outcomes	Impact
The target population consists of: Refer to the LICN program requirement to be sure your target population meets the LICN program Implementation Grantee requirements.	*If we provide these services and/or make these changes…* What are the new or expanded services that your organization (and partners) will provide, and how will this help achieve the LICN goals of providing timely access to medical, behavioral health, and/or enabling services and improving overall health for this target population?	*And if the program provides…* Things you will do – **actions you will take** – to achieve the outcomes and impact you seek. **Activities** may include: *Data collection, tracking & analysis, Process mapping*, *small tests of change* etc.	*Then we will see the following outcomes…* Short and medium-term results of your project; what you hope will be the results of your activities. Focus on realistic, tangible – ***scope and scale*** – outcomes ○ *What can be accomplished in the time allotted?* ○ *What can be accomplished given competing priorities?* ○ *"Motivating" target without being overwhelming* ○ *Include data projections for impact*	*Ultimately, 3-5 years into the future, we hope to see…* Short/Long-term, lasting changes you expect (and hope) to see in the ***patients you serve***, in ***your organization***, and/or in **your community** as a result of your project

Assumptions/Conditions for Success

Conditions that must exist and expectations that must be met in order for your project to be successful – i.e., your logic to hold true. This could include themes like **resources and support** (e.g., expectations, commitment, and engagement of leadership), **staff or patient engagement** (e.g., expectations of patient, provider or other staff behavior), results of a certain intervention, and **timelines** for system implementations or hiring staff.

Example Logic Model: Improving Transitions of Care

Target Population	Program Theory of Change	Activities	Outcomes	Impact
Patients who recently had a inpatient stay who are: 1. Experiencing homlessness, and/or 2. Have complex needs and limited home or community supports	By developing the following components, we will be able to improve health outcomes and reduce inpatient readmission rates for the target pop.: • Improving referral coordination and case management by expanding staff to include 1.5 additional case • Expand behavioral health services • Improve transportation to services by purchasing a van. • Establish bi-directional data exchange between primary care, hospitals, and community organizations so that patient information is sent to medical home within 24 hours of service	• Hire or reassign 1.5 FTE case managers • Expand relationships and workflows with local area hospitals and community agencies • Monitor and evaluate patient health outcomes • Establish new contracting and referral relationships with local BH provider • Purchase a van • Partner w/ hospital to assess data exchange capacities; define information needed in discharge summaries • Hire IT Vendor to build or improve interface between our two systems	**Patient Outcomes** • Reduced inpatient readmission rates • Improved health outcomes (tracked using measures like HbA1c's, PHQ-9, …) • Improved adherence to care plans, medications, and follow-up appts. **Access:** • Improved access to behavioral health • 85% of patient discharge notes received by PCP within 24 hours of discharge • Reduced no show rates **System** • Cost savings via reduced readmissions	• Community leading healthier, happier lives. • A system of healthcare providers and community agencies that effectively coordinate and collaborate on services to improve the health of their patients. • Improved IT systems near real-time data exchange between organizations. • Built efficient and effective complex care management services that are sustained via value-based reimbursement models. • Patients can access healthcare services in a timely manner, even if they have transportation challenges

Assumptions/Conditions for Success

- We will be able to hire or reassign case managers in the first 3 months of program (navigating COVID19 response and hiring freezes)
- We'll be able to sustain this program by demonstrating cost savings to the system (hospitals, insurers, etc.) via improved health outcome and reduced ED readmission rates
- We'll be able to navigate complicated BAA's with county and private hospitals to promote data exchange
- By providing patients access to transportation services, patients will be more inclined to keep follow-up appointments.

Featured Tool: Logic Model Template

Target Population	Program Theory of Change	Activities	Outcomes	Impact

Assumptions/Conditions for Success

-
-
-

2.4 Identifying Your Project Measures

A project's measurement and evaluation strategy must be established while you develop the Theory of Change. The changes you select may have the potential to help the project achieve its long-term goal, but if the team cannot measure and track the progress of the effort, they won't be able to demonstrate that impact. Consider the following questions about measuring impact for your project:

- ❑ What can we measure for the activities and/or changes we are planning?
- ❑ Do we have access to data that would let us track the progress of our efforts?
- ❑ Is it feasible to get the data – i.e., do we have to create a new report, reprogram a system, or implement new software?
- ❑ Can we review the measures/data regularly – e.g., daily, weekly, monthly?
- ❑ Is the data reliable?
- ❑ Will the resulting information be of interest to leaders, staff, funders, stakeholders, etc.?

Data plays a critical role for any change initiative because it helps the team understand 1) **at the end of the project**, did you achieve your project goals, and did your project have any impact, and 2) **during the project,** how well are the change ideas working, which gives the team a chance to make adjustments and continue to improve.

Further guidance on measures – creating a data collection plan and an evaluation strategy – is available in *Chapter 3.*

Logic Model as a Resource for Identifying Your Project Measures

The logic model's Activities, Outcome and Impact boxes serve as an excellent resource for identifying your project measures.

Example Logic Model: Improving Transitions of Care

Target Population	Program Theory of Change	Activities	Outcomes	Impact
Patients who recently had a inpatient stay who are: 1. Experiencing homlessness, and/or 2. Have complex needs and limited home or community supports	By developing the following components, we will be able to improve health outcomes and reduce inpatient readmission rates for the target pop.: • Improving referral coordination and case management by expanding staff to include 1.5 additional case • Expand behavioral health services • Improve transportation to services by purchasing a van. • Establish bi-directional data exchange between primary care, hospitals, and community organizations so that patient information is sent to medical home within 24 hours of service	• Hire or reassign 1.5 FTE case managers • Expand relationships and workflows with local area hospitals and community agencies • Monitor and evaluate patient health outcomes • Establish new contracting and referral relationships with local BH provider • Purchase a van • Partner w/ hospital to assess data exchange capacities; define information needed in discharge summaries • Hire IT Vendor to build or improve interface between our two systems	**Patient Outcomes** • Reduced inpatient readmission rates • Improved health outcomes (tracked using measures like HbA1c's, PHQ-9, …) • Improved adherence to care plans, medications, and follow-up appts. **Access:** • Improved access to behavioral health • 85% of patient discharge notes received by PCP within 24 hours of discharge • Reduced no show rates **System** • Cost savings via reduced readmissions	• Community leading healthier, happier lives. • A system of healthcare providers and community agencies that effectively coordinate and collaborate on services to improve the health of their patients. • Improved IT systems near real-time data exchange between organizations. • Built efficient and effective complex care management services that are sustained via value-based reimbursement models. • Patients can access healthcare services in a timely manner, even if they have transportation challenges

Assumptions/Conditions for Success

- We will be able to hire or reassign case managers in the first 3 months of program (navigating COVID19 response and hiring freezes)
- We'll be able to sustain this program by demonstrating cost savings to the system (hospitals, insurers, etc.) via improved health outcome and reduced ED readmission rates
- We'll be able to navigate complicated BAA's with county and private hospitals to promote data exchange
- By providing patients access to transportation services, patients will be more inclined to keep follow-up appointments.

Measures ideas can be found in Activities, Outcome, and Impact sections of your program logic model.

Consider the sample logic model for improving transitions of care. In the Outcomes section, case management was to be increased by hiring additional 1.5 case managers. A few measures may stem from this effort, including the number of patients enrolled in case management and the % of patients who enrolled and completed a set number of case management encounters.

Measurement Frameworks

Results-Based Accountability (RBA)

A measurement framework can assist in outlining the different types of measures for a project. While there are multiple measurement frameworks that may be applicable, the Results-Based Accountability (RBA) Framework (http://ceelo.org/wp-content/uploads/2019/04/Clear-Impact-RBA-Guide.pdf) has been considered highly approachable and flexible, especially for community collaborations, social services, and/or public health programs that may be challenging to quantify. RBA provides the following prompts:

1) ***How Much Did We Do?*** For example, the number of telehealth visits provided, the number of patients that attended group education classes, etc. ***(Consider your Activities and some Outcomes from your logic model)***

2) ***How Well Did We Do It?*** For example, the percentage of patients accessing telehealth, patient and provider satisfaction with telehealth visits, attendance rate at the group education classes ***(Consider the Outcomes section from your logic model)***

3) ***Is Anyone Better off Now than Before the Program?*** For example, average blood pressure and hemoglobin scores for this group of patients, adherence to care plans, prescription refill rates, program expenses and revenues. ***(Consider the Outcomes and Impact sections of your logic model)***

Each of these questions becomes a category of measures that the team could track during their project.

Model for Improvement

If you've participated in quality improvement learning collaboratives in the past, or are familiar with the Model for Improvement, you've likely had to define three types of improvement project measures: *outcomes, process, and balancing* measures. However, this classic improvement science framework has proven challenging to understand and apply; thus, needing a more intuitive naming:

1) ***Outcomes Measures***: the results or impact of the services provided to patients/clients. Ultimately, at the end of the project, these are the measures that your team hopes to improve. These are usually linked to your patient or client health outcomes (e.g., improvement in diabetes indicators like HbA1c; emergency department utilization for non-urgent needs; recidivism, etc.)

2) ***Intervention Measures*****:** (a.k.a. "process measures") these measure how effective the changes you plan on making to the system, or the new services you will provide are. How well did your efforts improve your *Outcomes Measures?* How effectively were changes adopted? (e.g., if you're working on referral coordination, you may track the number of patients working with the patient navigator and the percentage of patients contacted by the referral coordinator who kept their referral/follow-up appointment)

3) ***System Measures***: (a.k.a. "balancing measures") these measure the changes from a broader healthcare systems/community perspective. Consider this from an operational, financial, and/or patient experience perspective (e.g., costs vs revenues for the program). These may also be helpful measures to monitor that your project is not having any unintended or inadvertent impacts (e.g., to make sure a project isn't negatively impacting access to appointments, the project team may track third next available).

The table below compares how both frameworks would define project measures for a care transitions project trying to provide case management and transportation services for patients with a recent inpatient or emergency room stay. Review the example, then brainstorm your ideas for measures using the ***Team Measures Brainstorm*** worksheets.

Results-Based Accountability Approach	Outcomes, Intervention, System Approach
How Much We Did: - How many patients were enrolled in case management - How many patients received transportation services - How many patients accessed behavioral health services ***How Well We Did It:*** - % of patients enrolled in case management with at least 3 sessions - % of patients who received necessarily follow up care with 30 days of an inpatient discharge - Show rate for follow-up appointments - % of discharge notes received by PCP within 24 hours of inpatient discharge ***Is Anyone Better Off?*** - Reduction in ED Use and readmission rates - Improved health outcomes for patient (HbA1c's, PHQ9) - The financial impact of this work for our organization, partners, or broader health system - Return on Investment (ROI). Hopefully this program can demonstrate improved revenues and/or cost savings	***Outcomes***: - Reduction in ED Use and readmission rates - Improved health outcomes for patient (average scores for HbA1c, PHQ-9) ***Intervention***: - How many patients were enrolled in case management - How many patients received transportation services - How many patients accessed behavioral health services - % of patients enrolled in case management with at least 3 sessions - % of patients who received necessarily follow up care with 30 days of an inpatient discharge - Show rate for follow-up appointments - % of notes received by PCP within 24 hours of inpatient discharge ***System:*** - Access measures – third next available appointments, capacity measures, etc. - The financial impact of this work for our organization, partners, or broader health system - Return on Investment (ROI). Hopefully this program can demonstrate improved revenues and/or cost savings

Featured Worksheet: Team Measures Brainstorm

Results-Based Accountability Approach

*In this initial brainstorm, identify as many meaningful measures as you can. In the next section, Data Collection, teams will explore how realistic it would be to collect this data – which can help streamline your measures.

What We Did	How Well We Did It	Is Anyone Better Off?
What new services did we offer?	*How well were these services adopted by organization and used by our clients/patients?*	*What impact did this program have on our clients'/patients' lives? With our organization? With our community partners?*

Featured Worksheet: Team Measures Brainstorm

Outcomes, Intervention, and Systems Measures Approach

*In this initial brainstorm, identify as many meaningful measures as you can. In the next section, Data Collection, teams will explore how realistic it would be to collect this data – which can help streamline your measures.

Outcomes	Intervention	System Measures
What are we ultimately trying to improve? From a patient outcome perspective? From a health system outcomes perspective?	*What changes are we planning to test and implement? What measures will help us understand how well these changes are being adopted?*	*What are some of the "downstream," systems-related results of this project? How will we know if this work had any unintended impacts on the broader health system?*

Chapter 3 – Drafting a Project Work Plan

CHAPTER FOCUS

Developing a comprehensive project work plan.

SECTIONS

3.1 Project Overview
3.2 Measures and Evaluation Strategy
3.3 Team Roles and Responsibilities
3.4 Key Success Factors/Risks
3.5 Activities
3.6 Budget
3.7 Sustainability Plan
3.8 LICN Project Planning Checklist

FEATURED TOOLS

- LICN Project Work Plan Template and Sample Project Work Plan
- RACI Chart
- Data Collection Plan Template

CONSIDERATIONS

*Specific considerations are detailed further in each Section.

This chapter provides a series of prompts and templates to guide teams in drafting a comprehensive project work plan. As you review the content in this section, you'll note that many of these work plan elements have already been drafted or outlined from your previous work in Chapters 1 and 2. These connections are noted throughout this section, and can be found in the attached LICN Project Work Plan.

While a majority of the content that your team will develop in your LICN project work plan can be directly applied into a future grant proposal (e.g., the LICN Implementation Grant Proposal), there are additional elements and considerations included in this guide to help your team actively manage the program and avoid common missteps and challenges teams face in the early phases of their project.

Each Section ends with a checklist of final reminders to consider and common missteps to avoid. Take the following considerations with you as your team develops the project work plan:

Reminders and Recommendations	Common Missteps
❑ Address the vision, skills, incentives, resources, and action plan needed to drive change ❑ Summarize the key elements of your project, tied to your drivers ❑ Adapt the format to the appropriate scope and scale of your project	❑ **"One and Done"** – the project plan is a living document that should be consistently reviewed & updated ❑ **Not enough voices** – try to get input from multiple stakeholders ❑ **Kept under wraps** – share as part of your communication plan to get buy-in and raise awareness

3.1 Project Overview

A project overview, or executive summary, is a two-page summary highlighting the core elements of a project. The elements that should be addressed in a project summary vary based on the complexity of the project, but at a minimum should include:

- ❑ Problem/Needs Statement
- ❑ Theory of Change
- ❑ Aim Statement
- ❑ Outcomes, and Deliverables
- ❑ Assumptions and Key Success Factors
- ❑ Longer-term Vision and Impact
- ❑ Key Partners
- ❑ Sustainability

Problem/Needs Statement

Describe the background and context of the project. Why are you pursuing this area of focus at this time? What data do we have about how the county system(s) is currently functioning?

[Refer to the LICN Planning Toolkit Chapter 1: Project Focus – Current Environment and Target Population]

Theory of Change

Discuss the changes the project proposes and how/why you believe these changes will bring improved outcomes for your patients/clients, organization, and/or health system. Be sure to define your project's target population in this section.

[Refer to the LICN Planning Toolkit Chapter 2: Theory of Change – Logic Model]

Project Aim Statement

Draft a 2-3 sentence description of the project. This essentially becomes the "elevator pitch" for a project. Be sure that the aim statement remains concise and addresses the following:

- Define the purpose of the project – what are you trying to accomplish
- Identify the system(s) that will be improved and the target population it will affect
- Set a time frame for the project that aligns with the LICN grant requirements.
- Describe projected improvements in a headline measure (i.e., the one project measure that would be well-understood by most of your key stakeholders and would be the strongest indicator of this project's impact)

[Refer to the LICN Planning Toolkit Chapter 2: Theory of Change – Logic Model and Aim]

Project Outcomes and Deliverables

Describe 3-5 short and medium-term changes, improvements, or outcomes the team expects to see in their target population and/or their organization as a result of the project. These outcomes should include each of the key elements that make up "SMART goals" – specific, measurable, achievable, relevant/realistic, and time-bound.
[Refer to the LICN Planning Toolkit Chapter 2: Theory of Change – Logic Model and Project Measures]

Project Assumptions or Key Success Factors

Describe 3-5 assumptions that the project team is making about the project. These are often the conditions that must exist or key success factors that must be met in order for the project to be successful. Assumptions could address

leadership engagement, expectations of patients/clients/providers/staff, verified links between behavior and health outcomes, and dependence on a system or technology.
[Refer to the LICN Planning Toolkit Chapter 2: Theory of Change – Logic Model]

The LICN projects should include a few more themes in their executive summary and project plan as this work likely involves a number of complex workflows and navigating across multiple health care and social service agencies. Additional themes to include in this section are:

Longer-Term Vision/Impact

Describe 2-4 longer-term (i.e., 3 to 5 years) changes, improvements, or outcomes the team expects to see in their target population, organization, and/or the community as a result of this project.

[Refer to the LICN Planning Toolkit Chapter 2: Theory of Change – Logic Model]

Key Partners

Describe the other agencies with which the lead agency will be partnering and collaborating to implement this project. Briefly describe each agency's role in this project (i.e., what deliverables or milestones will these partners be leading or providing expertise).

[Refer to LICN Planning Toolkit Chapter 1: Project Focus – Collaboration Partners]

Sustainability

Describe ideas about how the lead agency and key partners will approach sustaining this project beyond any current or planned grant support. ***[Refer to the Sustainability section of this Project Work Plan for additional prompts and considerations]***

Reminders and Recommendations	**Common Missteps**
❑ The problem/needs statement should focus on the problem, not the solution or theory of change. The solution is described in the theory of change section. Use data when you can to describe the "current state" in your problem statement. ❑ Include SMART Elements in your project aim statement and outcomes. ❑ Define outcomes tied to your ***significant*** process changes, deliverables, and/or project goals.	❑ Skipping the problem statement and needs assessment considerations altogether. ❑ Creating an Aim Paragraph, not an Aim Statement - you should be able to say your aim statement in under 30 seconds ❑ Too many project outcomes. Try to narrow down your project outcomes to the 3-6 "headline" outcomes that would be of most interest to your project partners and key stakeholders.

Sample Project Overview

Problem/Needs Statement:

Example County Health System recently collaborated with our local community health center to develop a streamlined care transitions and case management program for Medi-Cal patients with a recent inpatient or emergency room stay. We've seen notable improvements in patient health outcomes in the first two years of the program, with readmission rates dropping by 25% at the Example County Medical Center. Unfortunately, we've been unable to spread this program beyond the Medi-Cal population due to limited funding and grant restrictions. Our inpatient and emergency room readmission rates for our patients experiencing homelessness remains high (50%).

Based on our most recent Point in Time survey, there are approximately 2500 members of our community experiencing homelessness. Our recent social determinants of health assessments indicate that 35% of patients seen in our Medical Center have limited home and community supports to help them heal.

Project Theory of Change

We propose to build off of the successes of our care transitions and case management program and expand the program to support a larger percentage of our patients, particularly patients experiencing homelessness and/or with limited housing and community supports. By hiring additional case managers to provide referral coordination, navigation, and case management services for this population; expanding our referral network to include more behavioral health providers able to provide services to these patients, and establishing improved bi-directional data exchange between our county medical center and community health centers, we will give our patients the supports they need to manage and improve their health conditions.

Project Aim Statement:

By December 2022, Example County Health System will reduce inpatient and emergency room readmission rates for our homeless and complex needs patients from 50% to 30%. We will accomplish this by expanding our case management services, building new referral networks with behavioral health and enabling service providers, and improving data exchange between our County medical center and our local community health center.

Project Outcomes and Deliverables

1. *By December 31, 2020, assign and enroll 50 patients from this target population into the case management program. Add an additional 100 patients in 2021 and 150 patients in 2022.*
2. *By June 30, 2021, 85% of inpatient/ED discharge notes will be received by PCP within 24 hours of discharge*
3. *By June 30, 2021, no show rates for follow-up appointments for this population will decrease from 65% to 30% due to the expansion of transportation support services for this target population.*
4. *By December 31, 2021, inpatient and emergency department readmission rates will decrease from 50% to 30% for this target population*

Sample Project Overview (continued)

Project Assumptions

1. *We will be able to hire or reassign case managers in the first 3 months of program (navigating COVID19 response and hiring freezes)*
2. *We'll be able to sustain this program by demonstrating cost savings to the system (hospitals, insurers, etc.) via improved health outcome and reduced ED readmission rates*
3. *We'll be able to navigate complicated BAA's with county and private hospitals to promote data exchange*
4. *By providing patients access to transportation services, patients will be more inclined to keep follow-up appointments.*

Longer-Term Vision/Impact

System improvements, enhanced partnerships, and expanded services will be streamlined and implemented across the county to allow all community agencies to effectively coordinate and collaborate on services to improve the health of their patients. This will lead to a health system that not only address their community member's acute needs, but also provides supports to improve on the upstream, underlying causes of health issues. This will help our community live healthier, happier, and more active lives. We will be able to sustain these efforts through new value-based reimbursement arrangements with the state and local health plans.

Key Partners

We plan to partner with a number of community agencies including the Main Street Community Health Center, County Department of Mental Health, and the Example County Mission's Respite Medical Care team.

Sustainability

Example County Medical Center team will closely monitor the readmission rates and case management program costs for this program. If we are able to achieve similar reductions in admission rates to our pilot program, the cost savings from lower readmission rates should offset the costs of the case management services. NCMC leadership share these program results with local health plans and the state to explore and negotiation new value-based reimbursement options. We will also closely monitor developments in the California Advancing and Innovating Medi-Cal (Cal-AIM) for new funding streams that could sustain this program.

3.2 The Project Team

This section of the project plan describes the team that will be formed to lead the roll-out of the LICN project. Beyond listing the job titles, biographies, and contact information, this section of the project work plan should provide enough information to give each team member a clear understanding of their specific roles and responsibilities on the project team. This section will review strategies for building an effective project team, including:

- Identifying a multidisciplinary team
- Delineating clear roles and responsibilities
- Identifying key partners and their specific responsibilities
- Committing to a regular meeting plan

Identifying a Multidisciplinary Team

Teams made up of staff from multiple roles, skills, and expertise levels tend to be more successful with these types of complex projects. Consider the following recommended roles:

- **Project Manager** – empowered to manage the project plan and day-to-day activities of the project. This person will likely be the main point of contact for the team, key partners, and any other collaborators involved in the project.

- **Senior Executive Champion** – leader who will oversee the project, help the team navigate complex challenges, approve and/or allocate additional supports, and share project updates with other Senior Leaders, board of directors, etc.

- **Clinical/Service Provider Lead** – makes decisions regarding standards of care/service, provides knowledge and experience of how services are provided to patients, and can share important project updates with other clinicians or service providers.

- **Operational Lead** – guides efficient implementation and helps navigate some of the workflow and protocol issues that may come up over the course of the project.

- **Subject Matter Experts** – any staff role that will be asked to make notable changes to their workflows and/or day-to-day responsibilities should have a representative on the project team. This may include case managers, call center staff, clinic mangers, social workers, etc.

A Note on Team Size – It can be challenging to find the right balance for the size of a project team – large enough to effectively distribute the roles and responsibilities across the team and small enough to have meaningful team meetings and conversations. For the scope and scale of these LICN project efforts, consider building a team of 5 to 8 members.

Defining Team Member Responsibilities

A team filled with the right people can only effectively work together if they have a clear understanding of each other's project roles and responsibilities. Team members should know what is expected of them when it comes to specific project deliverables, to which project goals they are contributing, and their broader project management/team responsibilities (e.g., evaluation and data collection, meeting management, communications, key points of contact for certain challenges or issues, etc.). This also provides insights for team members about who to contact for questions related to a particular project deliverable. The following table lists examples of roles and responsibilities for a project manager and senior leader.

Project Manager *Abby A, Health Services Manager, 213-555-5551; abby@IHQC.org*	• Managing the project design and ideation process • Managing the day-to-day project activities • Coordinates, facilitates and manages team meetings • Keeps issues list and escalates issues to Executive Sponsor • Collects input and completes project grant reports
Senior Executive Leader *Betty B, Chief Operating Officer, 213-555-5552, betty@IHQC.org*	• Participate and provide oversite in the planning process. • Inform and Approve new care transition workflows • Lead efforts to procure new mobile van • Share project updates with senior executive team and board of directors.

Outlining the Roles and Responsibilities of Your Key Partners

With many of the LICN projects themes requiring new and expanded partnerships with local community agencies, the project work plan should also identify the key partners who will play active roles in the project's success. For each of these key partners, identify main points of contact and describe their specific roles and responsibilities, being sure to include which project deliverables and key activities these organization will be responsible for, consulted with, or informed about. Provided below is an example list of the key partners' roles and responsibilities

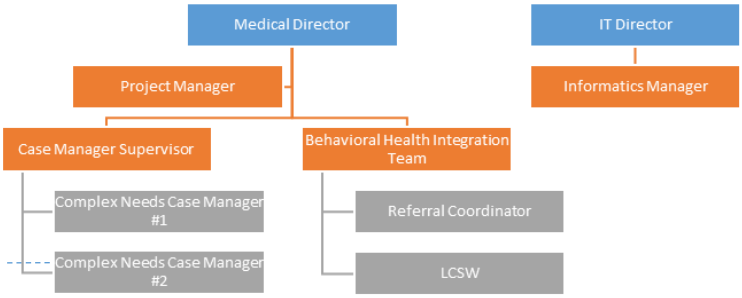
Organization	Main Contact	Project Role/Responsibilities.
County DHHS	Chris C., Chief Informatics Officer, chris@countyhealth.co	• Collaborating on improved data exchange infrastructure • Attend monthly project team meetings • Build relationships with hospital care coordinators and health center case managers
County Mission	Drake D., Respite Care Program Director, drake@countymission.org	• Add 10 new beds/rooms in their Respite Medical Care facility. • Send weekly Respite Care Center capacity reports to Project Case Managers. • Participate in weekly case reviews with county task force.
County Transport, Inc. (subcontracted entity)	Emilia E., Owner emilia@cti.com	• Determines deployment of local drivers to transport clients • Provide monthly invoice for driver hourly rate, mileage, and vehicle maintenance

Optional Tool: RACI Chart

Project success relies on keeping key stakeholders informed and engaged with a clear understanding of their specific roles and responsibilities related to the project. It's challenging to define and coherently map out these responsibilities out across the team. For those that have found this challenging, consider using a ***RACI Chart*** to define broader project responsibilities. See the RACI Worksheet on the following page for an overview of the RACI framework and how it could be used in support of the LICN project.

Project Organizational Chart

LICN Implementation Grant proposals must include an ***Organizational Chart*** and a ***Team Chart***. Consider drafting a program staffing chart and lead agency organization chart and include both in the project work plan.



Featured/Optional Tool: RACI Chart

A **RACI Chart** is a table that project managers use to plan and organize the responsibilities of each team member. The RACI structure can be helpful in:

- Connecting specific roles and responsibilities to project activities and deliverables
- Mapping out all the deliverables and activities associated with an individual, and all the people associated with a particular deliverable or activity.
- Providing clarity about the roles and expectations for stakeholders from other teams, departments, or partner organizations

The term RACI stands for **R**esponsible, **A**pprover, **C**onsulted, and **I**nformed – four categories of responsibility. The definition of each of these roles is described in the table below:

RACI		Description	How Many in This Role per Activity?
R	Responsible	Researches options, makes recommendations, completes work	**Usually one** (sometimes more)
A	Approver	Makes the decision and/or has final approval	**One**
C	Consulted	Makes recommendations, provides guidance	**Varies** (0 to many)
I	Informed	Gets informed of project updates and/or decisions made	**Varies** (0 to many)

A RACI Chart resembles a project timeline with column headers for the project deliverables/activities and occasionally start and end dates for each deliverable/activity. To the right of these columns are a listing of the key team members associated with the project. Each of those individuals will have assigned responsibilities for the project, which will be designated using the RACI framework.

Sample RACI Chart Created During the Project Planning Phase:

Project Deliverables	Start Date	End Date	Abby A	Beto B	Carla C	Dave D	Ellie E	Mission and Food Bank	County DHHS	County DMH
Project Monitoring and Reporting	May 1	Dec 30	R	A				C	C	C
Conduct Key Informant Interviews	May 1	June 15			C	R	I			
Develop and implement new IT interface for inpatient discharge data exchange	July 1	Dec 30		C			C	I	R	I
Develop and Implement Case Management Program	July 1	Oct 30	I	A			R	C	C	C

Using a RACI Chart to Map Out Project Responsibilities:

1. **List the project's deliverables** in the left-most column (note: more detailed RACI Charts may assign responsibilities to specific project activities as well as deliverables, but consider starting with just the main project deliverables).
2. **List your key stakeholders, staff, or partners in the top-most row**. This is not meant to be a comprehensive listing of every single staff member involved with the project, rather, it helps plan who among the "core project team" will be driving the project and who will be the "boots on the ground" conducting the intervention work. Each team member should review and agree to their roles and responsibilities.
3. **Assign RACI responsibilities for each deliverable** - for each deliverable, determine who must be Responsible, the Approver, Consulted, or Informed – the definition of each of these roles are described above.

Once you have drafted the initial RACI assignments, be mindful of:

- Communicating and confirming these designated responsibilities with each team member. Team members should agree to the responsibilities outlined in the RACI Chart.
- Only one or two people with most of the "R's" assigned to them – Can you distribute some of these across more people? Will the project require more human resources?
- Assigning the right amount of C's and I's (not too many, not too few), and clarifying who will take the lead in engaging with these individuals.

RACI Template

Project Deliverables	Start Date	End Date								

Building the Foundations of an Effective Team

There are a few characteristics of effective teams that can be fostered and developed early in a project lifecycle to better-position a team to be successful. In addition to the approaches outlined above, effective teams communicate with greater frequency in the early stages of the project. It can be challenging to find the time for staff from multiple departments – and organizations – to meet. Try to establish at least ***Monthly Meetings*** with the "core" team members. Project leads should also leverage ***less formal meetings and touch points*** to keep in regular communication with the team (e.g., morning huddles, quick phone calls, weekly email status updates, etc.). These informal conversations don't need to include the full team – touching base with one or two people at a time can help build and maintain project momentum.

Establishing and agreeing to ***Team Norms and Ground Rules*** can also help teams establish positive habits and encourage productive communication across the team. Ground rules could include, but are not limited to, arriving on time, one person talking at a time, and de-personalizing issues and not placing blame on individuals. This resource from the UCSF Culture of Leadership Program provides some additional examples of ground rules around team communication and decision making.

Reminders and Recommendations	**Common Missteps**
❑ Establish the right work, roles, size, and culture. ❑ Never underestimate the power of building good relationships ❑ Identify a main point of contact on your team for each of your key partners. ❑ Meet as a team early and often over the first few months of the project. ❑ Distribute project measure responsibilities across the team, giving authority and ownership to those team members closest to the work.	❑ Missing key team members. ❑ Identifying the same "Go-to" people for most project deliverables. Explore other potential champions! ❑ Relying only on informal meetings/ communication. ❑ Assuming people know who to reach out to with questions. Explicitly state this in the roles and responsibilities. For example, make it clear that any questions about project measures should be sent to Abby.

3.3 Measures and Evaluation Plan

In Chapter 2: Theory of Change, we reviewed frameworks and prompts to guide teams in identifying measures and indicators that will help 1) demonstrate impact at the conclusion of the project and 2) monitor progress during the project to help inform efforts to optimize new processes and services. In this section, teams will define the strategies they will use to collect data on those project measures – summarized in a ***Data Collection Plan***. A good data collection plan provides the following information for each project measure:

- ❑ A Clear Measure Definition
- ❑ Data Gathering Plan/Strategy
- ❑ Baseline Data
- ❑ Goal or Target

This can be one of the more challenging aspects of drafting a program plan given the level of detail and effort that it requires. But investing time creating a detailed data collection plan helps teams avoid some common project pitfalls like inconsistent data collection (i.e., team members using different systems, queries, or definitions when pulling data reports on a month-to-month basis).

Data Collection Plan Template

MEASURE NAME	MEASURE DEFINITION	DATA GATHERING PLAN	Baseline (as of June '20)	Goal
		Who Collects: How: How Often:		

Measures Definitions:
Create a clear, detailed definition for this project measure. Consider what populations, exclusions, or inclusions should be articulated to clarify what is being tracked. Where applicable, the numerators and denominators should also be defined for these measures. Clear definitions will help ensure that the team is using a consistent definition, promoting consistent data collection over the course of the project. For Example, Patient Wait time could be defined multiple ways – from check-in to vitals, or appoint time to vitals, or check-in to when provider arrives. A detailed definition for patient wait time could be: "The amount of time (in minutes) from when a patient with an appointment checks-in to when the provider enters the room."

As another example, a definition for a measure on reminder calls for referrals could look like:

> *Numerator: number of patients in target population who were readmitted to ABC County Hospital within the 3 months following an inpatient or emergency department visit.*
>
> *Denominator: Total number of patients in target population with an inpatient or emergency department visit.*

Data Gathering Plan:
Identify a consistent and reliable approach the team will take to collect data for each project measure**.** A good data gathering plan describes the following for each measure:

- ❑ **Who** is going to collect/generate this data;
- ❑ **How** will this individual(s) collect this data (which systems or data collection tools will be used); and
- ❑ **How often/frequently** will data be collected and reviewed?

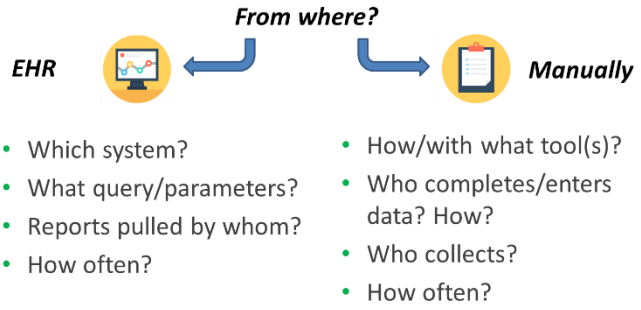
To minimize the burden of collecting and aggregating data, teams understandably look for ways to generate this data from existing IT systems. While this works for many measures, some important indicators aren't easily documented and monitored in existing EHR and disease management platforms. Because of this, we encourage teams to explore both ***Electronic and Manual Data Collection*** strategies for their project measures.

For measures that can be tracked ***electronically***, confirm:

- ❑ Staff can generate this data accurately and under the conditions/variables articulated in your measures definitions.
- ❑ Data queries are accurate – are the right filters set up in the system to get the level of data necessary to monitor your project impact?

When exploring ***manual data collection*** strategies, confirm:

- ❑ The collection tool is reliable and efficient to use.
- ❑ Who will collect the data?
- ❑ How frequently will the data be manually collected?



For example, the project team needs to know how often inpatient discharge summaries get transmitted back to the primary care provider within 24 hours of discharge. If the current IT systems aren't able to generate this report, the team needs to create a ***manual data collection*** approach – perhaps asking the case manager to use their existing tracking log. At the end of every week, the case manager will spend 5 minutes tallying the number of discharges and the number of those discharges where the summary was entered into the PCP's EHR within 24 hours.

Baselines

Another critical aspect of any measures and evaluation strategy is to understand how the system is functioning before any changes are introduced into the system. It's important to collect ***baseline*** data at the onset of the project. Teams that wait to collect ***baseline*** data often can't truly know how much improvement was made by their project efforts or was just how things were working originally.

Set a Goal or Target

After collecting the baseline data, establish a goal or target to aim for by the end of the project. Because the LICN grants are 3-year programs, consider creating year 1, year 2, and year 3 goals. Goals should try to strike a balance between realistic and aspirational, where the goal is both motivational and attainable.

When projecting a goal, consider the timeframe and the numerators/denominators to understand what is realistic. For example, if the denominator for a measure is 2000 clients, a 10% change represents 200 clients. Consider how realistic it would be to make the requisite change for 200 patients in 12 months.

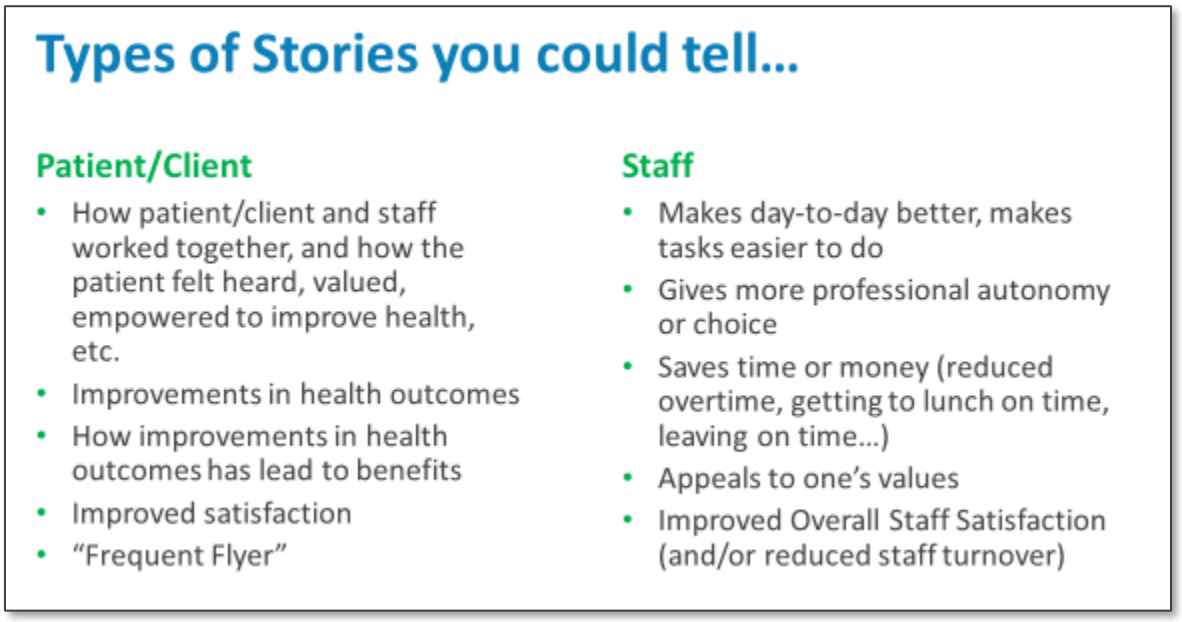
Sample Measurement Plan for Transitions of Care Project

Leveraging the Results-Based Accountability Framework

MEASURE	DEFINITION	DATA GATHERING PROCESS	Baseline (as of May '20)	Goal *June '21*
How Much We Did?				
How Many Patients enrolled in case management	Count – total number of unique patients enrolled in case management services	Who Collects: Case manager How: using patient tracking log How Often?: Monthly	15	120
How many patients received transportation support services	Count – total number of unique patients who accessed transportation support services to get to their follow-up appointments	Count – total number of unique patients enrolled in case management services	5	200
How Well We Did It?				
% of patients enrolled in case management with at least 3 "visits"	Numerator: Total number of patients with at least 3 visits/meetings with case manager Denominator: Total number of patients enrolled in case mgt.	Who Collects: Case manager How: using patient tracking log How Often?: Monthly	0%	65%
% of patients who received necessary follow up care with 30 days of an inpatient discharge	Numerator: Total number of patients discharged in the last 90 days who received necessary follow-up care with 30 days of discharge Denominator: Total number of patients discharged in last 90 days who needed follow-up care	Who Collects: Case manager How: using patient tracking log and our EMR referral tracking system. How Often?: Monthly	25%	75%
Is Anyone Better Off?				
Emergency dept. use	Total number of emergency room visits for the target population in the last 12 months Denominator: Total number of patients in the target population	Who Collects: Case manager How: using patient tracking log and reviewing monthly emergency admission reports from local hospital How Often: Monthly	2.9 Visits per patient	1.8 visits per patient
Readmission Rates	Numerator: number of patients in target population who was readmitted to the hospital in the last 6 months Denominator: Total number of patients in target population	Who: Case Manager How: using patient tracking log and reviewing monthly readmission reports from local hospital How Often: Monthly	38%	15%
Diabetes – Last HbA1c in control (<8.0)	Numerator: number of diabetic patients in target population whose most recent HbA1c was less than or equal to 8.0 Denominator: Total number of diabetic patients in target population	Who Collects: Case manager How: report from EHR How Often?: Monthly	42%	65%
Program ROI	Cost Savings/Revenues - Cost of Case Management and Transportation Services Cost Savings/Revenues will be calculated using average cost of each emergency room visit and inpatient stay.	Who: CFO How: review hospital and ED admissions for target population, review internal accounts for program operating costs. How Often: Annually (July)	TBD	Positive ROI

Outlining a Qualitative Data Strategy

In addition to the quantitative measures that you've outlined above, teams should also consider qualitative elements for their overall program evaluation approach. This may include ***Patient and Staff Interviews*** to understand their experiences navigating through this program/services. It's also important to have a plan in place to collect patient/client and staff ***Stories of Impact***. Stories can be a powerful communication tool because they evoke emotion and are more easily remembered by your target audiences.



At this point in your project design efforts, it's too early to anticipate what stories you'll want to share at the end of your program. But give yourself a reminder in your project work plan to circle back with staff every 3-6 months to collect these stories. This can be described briefly the project's program evaluation plan and included in the project timeline and deliverables.

Reminders and Recommendations	**Common Missteps**
❑ Pick the right measures that will influence your staff – based on RBA or Outcomes, Intervention, System framework ❑ Monitor your measures weekly/monthly ❑ Collect Baseline Data ***Immediately*** ❑ Change Agents = Intervention Measure Champions & Stewards	❑ **Vague Definitions** (e.g., is "Cycle Time" from *check-in* to *check-out*, or *appt time* to *check-out*? ❑ **Relying on IT** to generate data and finding out they can't generate reports for your process measures ❑ **Not collecting data at start of your project** – don't figure out data collection strategies for 2 months when you've already started testing changes

3.4 Key Success Factors and Project Risks.

Going beyond the traditional elements of a project plan, successful teams also proactively find ways leverage their strengths and address any inherent weaknesses or potential project risks. This is explored in a variety of different ways – as risks and risk planning, as key success factors, or SWOT analyses. Regardless of the framing, teams should assess the project structures, activities, assumptions, or other program elements that are critical for the project team to be successful – and dedicate additional planning and resources to ensure success.

Identifying Key Success Factors

Common project key success factors include:

- **Time** to meet and test change ideas
- **Staff engagement** and buy in (e.g., getting providers, coordinators, leaders, to participate in the project and/or adopt the proposed changes)
- **Hiring** staff in a timely manner and retaining staff
- **Patient/client engagement**
- Components of a project's **theory of change holding true** (e.g., lack of transportation is one of the critical challenge to seeking follow-up care. If we purchase a van and provide transportation assistance, our clients will attend their follow-up appointments and improve their overall health).
- **Adoption of new technology** (e.g., EHR vendor will be able to create an interface that gives us up-to-date patient/client information for our case managers and our local hospital)
- **Financial viability** of the project by attaining certain clinical and operational targets

Example: If a critical project activity includes hiring a new case manager to work with the target population, a key success factor might be hiring a case manager within the first three months of the project. Knowing that so much of the initial activities are tied to onboarding this new case manager, the team could then be more intentional around expediting candidate recruitment and interviews.

Chapter 1 of this Planning Toolkit reviewed a number of tools and frameworks that can be helpful in identifying these key success factors – including ***SWOT Analyses*** (Strengths, Weaknesses, Opportunities, and Threats) and ***Cause and Effect (fishbone) diagrams***. Teams usually identify some key success factors in the "Assumptions" section of project logic model as well. Consider using one of these tools to facilitate a team conversation about a project's key success factors. Additional prompts and guiding questions could include:

- What are we most concerned about regarding our project? What are some of the project's largest risks associated with your project?
- Historically, why have some of our past improvement efforts struggled or were not sustained? (E.g., lack of project management, staff skeptical about validity of data, no time to meet or test changes, staff turnover, limited or reduced budget)
- Are there any competing priorities that might interfere with your project (e.g., new IT system implementations, site renovations, COVID-19 response, etc.)?
- In the LICN Needs and Skills Assessment, did the results highlight any strengths that should be fostered during the project? Did the results highlight any gaps or weaknesses that may slow or limit our progress?

Next, identify the 3 to 5 factors that could have the largest impact on the project's overall success. Then, identify some additional steps and actions the team can take to promote and/or address these key success factors. If a key success factor involves leveraging a project strength, brainstorm and identify strategies and actions to help the team take full-advantage of this strength. If the key success factor is a weakness or risk, brainstorm ways to proactively mitigate the chances of that risk occurring or limiting the negative impact of that risk (i.e., defining a risk mitigation plan).

Sample Key Success Factors Action Plan

Key Success Factors	Action Plan for Promoting KSF's or Mitigating Project Risks
Risk #1: *No time for team meetings*	• Identify existing meetings and add project updates to agenda
	• Work with team to find a time that potentially works (7:30-8:30 every other Tuesday) and get leadership buy-in
Risk #2: *Providers do not engage in project efforts or requests*	• Draft talking points that demonstrate how project will benefit providers, Meet 1-on-1 with providers
	• Identify an influential provider and recruit them to join the project team as the "Provider champion"
Strength #1 *Leadership support and engagement*	• Have leader(s) join the first two months of project meetings.
	• Identify messages and other communication vehicles leaders can use to promote engagement or awareness of this project across the organization

Reminders and Recommendations	Common Missteps
❑ Address risks and challenges that were identified in the LICN Needs and Skills Assessment. ❑ Develop concrete, actionable steps the team can take to promote strengths and mitigate risks. ❑ Include these action items in the project work plan/timeline (Section 5 of the LICN Project Work Plan Template)	❑ **Focusing predominantly on technology factors or interpersonal/change management factors** and not taking a more holistic approach to identifying project key success factors. ❑ **Lack of follow-through on these action items –** activities are not included in the project work plan/timeline and are therefore not tracked and actively managed in the early months of the project.

3.5 Project Timeline

The next section of the project work plan involves creating a timeline that describes the sequencing and pacing of a project's activities and deliverables. Typically, project timelines include:

- ❑ The overall project deliverables,
- ❑ The main activities that the team needs to accomplish to meet each deliverable, and
- ❑ Who will be responsible for these activities.

The next section of the project work plan involves creating a project timeline that describes the sequencing and pacing of a project's activities and deliverables. Typically, project timelines include the overall **project deliverables,** the **main activities** that the team needs to accomplish to meet each deliverable, **who** will be responsible for these activities, and the **timeline** (start and end dates) associated with each of these activities.

Project Timeline Elements

Deliverables/Activities	**Start & End Date** (Month/Year)	**Parties & Person(s) Responsible**	**Notes** (optional)
Deliverable #1			
Activity #1			
Activity #2			
Deliverable #2			
Activity #1			
Activity #2			

Project timelines are one of the most important components of a project plan. Timelines are often used as the step by step directions for a project, giving project staff clear instructions for what to do and when to do it. Investing time in creating a detailed project timeline positions a team to better lead and manage the project efforts by:

- ❑ **Creating a central repository** of information about the project that can be referenced and reviewed throughout the project lifespan.
- ❑ **Building accountability** by assigning responsibilities and completion timelines for each activity and role
- ❑ **Assessing bandwidth requirements**, especially in a project's planning and design phase – helping to highlight potential bottlenecks.
- ❑ **Providing proactive forecasting, giving staff an opportunity to anticipate** what's coming down the pipeline
- ❑ **Highlighting challenges** with visual status displays to help teams focus attention on activities and deliverables that are behind schedule and experiencing challenges.

Throughout the toolkit there are a few documents that will be helpful to reference as you draft your project timeline. In Chapter 2: Theory of Change, Logic Models and Driver Diagrams were introduced to guide teams into creating a visual representation of their project and theory of change. The LICN logic model template includes two sections – Activities and Outcomes – that can help create the outline for your project timeline. Similarly, in a driver diagram, the secondary drivers are often associated with project deliverables, and elements disseminating from the secondary drivers are likely to be the activities needed to complete that deliverable.

Categories of Activities to Consider for a Project Timeline

Recommendations for Drafting Activities

- **Break-up complex deliverables and activities** into smaller pieces. This will help with staff buy-in by reducing fears and anxieties associated with the scale of these project efforts.
- **For significant process and systems changes, articulate the project roll out in three stages:**
  - **Stage 1:** Design/Prototype the change
  - **Stage 2**: Pilot the change at one site or with a subset of the patient population
  - **Stage 3**: Optimize and Scale-up

  For Example, if a team needs to create and roll out new health education materials, their staged activities could resemble the following:
  1. Design health education materials: 30 days
  2. Pilot Activities at Eastside Clinic for 45 days (fine-tuning curriculum, handouts, scripts, etc.)
  3. Spread activities to Downtown Clinic: 30 days

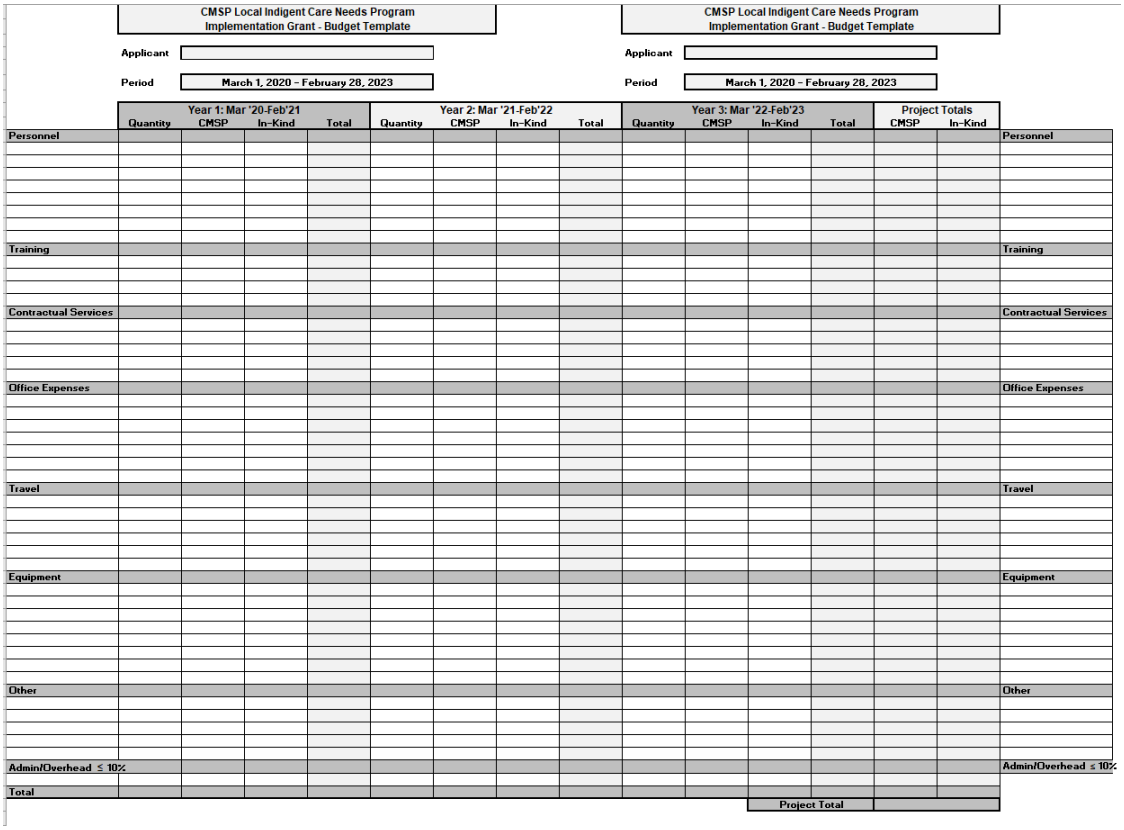
- **Assign activities** to a team member or staff and be mindful of distributing these activities across the care team. Avoid consolidating these activities to just one or two team members.
- **Discuss/Refine estimated timeline** with the team responsible for those activities and deliverables. Consider how competing projects or other large-scale efforts may affect these draft timelines. Make refinements as needed.
- **Refer to the logic model**. Information described in the project timeline should clearly crosswalk back to the logic model and any other overviews of your program theory of change (i.e. driver diagrams).

Reminders and Recommendations	Common Missteps
❑ **Break large deliverables into small pieces** – makes it less overwhelming and easier to jump into project activities ❑ **Invest time in creating work plan/timeline** that can be used and referenced throughout project ❑ **Highlight potentially problematic areas** (e.g., too short a timeframe), discuss with team & leadership	❑ Creating a project timeline that is too vague - not enough activities and references to concrete deliverables in the timeline ❑ Creating a timeline that is too detailed - too many activities, too far into the weeds ❑ Omitting activities and deliverables related to project management, communications, and data/evaluation.

3.6 Budget

Project Line Items

Develop a budget for the project that outlines the costs associated with the project – including staffing and personnel, training, consultants, equipment, travel, and other expenses. For those planning on submitting a LICN Implementation Grant Proposal, it's recommended to review the Implementation Grant requirements and leverage the LICN Budget form. The Implementation Grant Budget template can be downloaded as an Excel file here.



CMSP Local Indigent Care Needs Program
Implementation Grant - Budget Template

Applicant

Period: March 1, 2020 – February 28, 2023

	Year 1: Mar '20-Feb'21				Year 2: Mar '21-Feb'22				Year 3: Mar '22-Feb'23				Project Totals		
	Quantity	CMSP	In-Kind	Total	Quantity	CMSP	In-Kind	Total	Quantity	CMSP	In-Kind	Total	CMSP	In-Kind	
Personnel															Personnel
Training															Training
Contractual Services															Contractual Services
Office Expenses															Office Expenses
Travel															Travel
Equipment															Equipment
Other															Other
Admin/Overhead ≤ 10%															Admin/Overhead ≤ 10%
Total															
											Project Total				

Budget Narrative

To provide additional context for each of the budget line items, create a budget narrative that links the budget items to the project deliverables and outcomes. The budget narrative should describe:

- How estimates were determined
- The necessity of each line item – personnel, infrastructure, materials, supplies, etc.
- Any other assumptions taken into account when generating the budget
- If you are subcontracting services or procuring supplies from a partner organization, summarize their contribution to your project, as well as any invoicing or reporting responsibilities to you as the Lead Agency.

Reminders and Recommendations	Common Missteps
❑ The budget narrative is clear and provides detail for the budget line items. ❑ The budget is reasonable and realistic to support the project efforts. ❑ For any budget elements that may not be sustainable beyond the grant period, reference this in the budget narrative and note that in the Sustainability Section of the Work Plan (Section 7)	❑ Some budget elements are not reflected in the work plan (e.g., consultant recruitment plan and assigned responsibilities are not clearly defined in the work plan).

3.7 Sustainability Plan

For the LICN Program, all Implementation Project Grantees will be required to submit a detailed sustainability plan ***in year 2 of the grant period***. However, in the Implementation Project grant proposals, teams will be asked to describe initial ideas and opportunities for sustaining the proposed project beyond the 3-year grant period. It is not expected of teams to have a concrete sustainability plan drafted in these early stages of your program design and roll out. Instead, briefly describe initial ideas about how your organization and your key partners might continue or sustain the project once the funding period has concluded (i.e., how will you ensure new services will continue to be provided, and that outcomes are maintained after the LICN program grant period ends?).

Brainstorming Ideas for Sustainability

The following prompts and considerations are offered to help your team brainstorm these initial sustainability ideas.

- ❑ What will the program look like in at the end of the grant period?
- ❑ What resources would be needed to sustain the program (e.g., funding, staffing, skills and capacities, infrastructure and partnership support, etc.)?
- ❑ When will a financial analysis of the program be completed? Who will conduct this analysis?
- ❑ What are the potential source(s) of funding that could be leveraged to sustain this project?
    - Operational efficiencies
    - State and federal value-based payment and shared savings opportunities
    - Contracting agreements and/or programs supported by the Local Health Plans
    - Other grant or sponsorship opportunities
- ❑ What strategies and approaches have your organization used in the past to sustain larger-scale initiatives? For example, redefining job descriptions, standardizing or embedding changes, ongoing staff training, securing continued funding, etc.?
- ❑ What "outside-the-box" strategies could be explored (e.g., policy, advocacy, development of new networks and partnerships, social marketing and communication strategies, etc.)?

Reminders and Recommendations	**Common Missteps**
❑ Add a few activities or deliverables to your project timeline (section 5 of the project work plan) around assessing the project value/impact and building a comprehensive project sustainability plan	❑ Deferring most sustainability ideas to securing new grants or waiting for policy changes without any reference to internal strategies ❑ Not addressing actions to sustain internal capacities (workflows, skills, continued staff training, etc.)

Sustainability References

DHCS's California Advancing and Innovating Medi-Cal (CalAIM) updates page:
https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

AHRQ's Planning for Sustainability Guide:
https://www.ahrq.gov/funding/training-grants/hsrguide/hsrguide6.html

HRSA's "The Dynamics of Sustainability" Primer for Rural Health Organizations
https://www.ruralhealthinfo.org/assets/1211-4984/dynamics-of-sustainability.pdf

Rural Health Information Hub's Sustainability Planning Tools Library
https://www.ruralhealthinfo.org/sustainability

CDC's Sustainability Guide for Healthy Communities
https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/pdf/sustainability_guide.pdf

3.8 LICN Project Planning Checklist

This checklist summarizes the core components found in this LICN Planning toolkit. Review this checklist before your team begins its design efforts, an refer to the checklist during the planning process to help track and monitor progress.

Chapter 1: Project Focus

Key Activities:

- ❑ Conduct research and data mining to obtain information about the local community, and define a target population for your LICN project.
- ❑ Leverage root cause analysis tools like fishbone diagrams, workflow mapping, Gemba walks, and qualitative research, to understand how the systems are functioning and the factors that are impacting your target population's health outcomes.
- ❑ Explore your organization's current state by assessing key priorities, reviewing the LICN Needs and Skills Survey results, and/or completing a SWOT Analysis. Share observations with your colleagues and partners to confirm accuracy of your findings. Obtain confirmation/approvals when appropriate from leadership, key stakeholders, and champions.
- ❑ Confirm your project focus. Identify some improvement opportunities your team could address through this LICN Grant Opportunity. Share these with your partners and key stakeholders, and prioritize/select a project focus.

Tools and Templates:

- ❑ Health Indicators and Searchable Database Reference Lists
- ❑ Root Cause Analysis Tools like Fishbone Diagrams & 5-Why's
- ❑ Process Flow Mapping and Journey Mapping
- ❑ Gemba Walks
- ❑ Surveys, Interviews, and Focus Groups
- ❑ Project Inventory
- ❑ LICN Needs and Skills Assessment
- ❑ SWOT Analysis
- ❑ The Practical Playbook for forming partnerships

Chapter 2: Theory of Change

Key Activities:

- ❑ Research what has already been tried and tested at your organization and/or in your community
- ❑ Identify and log best practices (internally to your organization *and* externally in similar organizations or systems)
- ❑ Engage in group brainstorming to discuss potential improvement or implementation project ideas
- ❑ Prioritize and organize the ideas, identifying the projects that could have the greatest impact on our target population
- ❑ Outline your LICN project "theory of change" using a logic model to help organize your project's aim, goals, deliverables, and activities.
- ❑ Identify key indicators of success. Collect baseline data for these measures

Tools and Templates:

- ❑ Best Practices Log Group Brainstorming approaches like the Nominal Group Technique and affinity diagrams
- ❑ Priority Matrix
- ❑ Driver Diagrams
- ❑ Logic Models Outlining your Program's Theory of Change
- ❑ Measurement Frameworks like Results-Based Accountability and the Model for Improvement.

Chapter 3: Drafting a Project Work Plan

Key Activities:

- ❑ Develop project aim and goals that include SMART elements
- ❑ Establish a project team
  - ○ Identify team leadership
  - ○ Identify and recruit team members
  - ○ Develop team member roles and responsibilities with team lead.
  - ○ Establish key points of contact and clear roles and responsibilities at each of your partner organizations
- ❑ Define Program Evaluation Strategy and Impact Measures
  - ○ Create measures collection plan outlining outcome, intervention, & system measures.
  - ○ Test measurement strategy, including data reports, manual data collection tools, etc.
  - ○ Outline qualitative data collection strategy (e.g., patient and staff experience, collecting stories of impact, etc.)
  - ○ Finalize measurement strategy
- ❑ Identify the key success factors or risks associated with you project, and define an action plan to promote and/or address these key success factors
- ❑ Develop project timeline with a plan to complete key activities and deliverables
- ❑ Draft a project budget
- ❑ Brainstorm ideas for how the team could sustain this project beyond the 3-year LICN grant period

Tools and Templates:

- ❑ LICN Project Work Plan Template
- ❑ Sample LICN Project Work Plan
- ❑ Team member and key partner roles and responsibilities
- ❑ RACI Chart
- ❑ Project Organizational Chart
- ❑ Data Collection Plan
- ❑ Risk Mitigation Plan
- ❑ Project Timeline
- ❑ Budget Template