PHM INITIATIVE

PHMI Statewide Learning Session, Day 2

March 6, 2025

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Managed Care Plan (MCP) Panel: Advancing PHM in Partnership with Health Centers

Moderator

Bobbie Wunsch

PHMI Consultant

Panelists

Dr. Bob Moore

Partnership HealthPlan of California

Ericka Sockaci

Health Net

Ilia Rolon

Health Plan of San Joaquin

Dr. Matthew Pirritano

LA Care

BREAK

10 minutes

Afternoon Breakout Options

- **Senior Leaders Breakout**
  East Ballroom
- **Supporting Sustainability Through Staff Recruitment & Retention**
  Studio 1
- **Leveraging Your Team to Bolster Access to Behavioral Health Support**
  Studio 2
- **Targeted Outreach for Patients Due for Care**
  Studio 3

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Senior Leaders Breakout

March 6, 2025

Welcome

01
Welcome and Updates
10 mins

02
Reflections from the MCP Panel
15 mins

03
Peer Group Dialogue
45 mins

04
Large Group Dialogue
15 mins

05
Wrap-up
5 mins

Facilitators

Roger Chaufournier

IHI Faculty

Allie Shilin Budenz

VP of Health Center Optimization
California Primary Care Association

Rachel Tobey

Co-Executive Director
JSI

Objectives for Today

1. Engage with peers to reflect on what you heard from the MCP panel and the implications for PHMI work.

2. Identify one change idea that will:
   - improve their organization's readiness for VBC contracting
   - support care team and workflow optimization
   - advance efforts to better manage patient assignments from MCPs

Reflections from the MCP Plenary

- What are your reflections from the MCP panel?
- What are the implications for your PHM work?
- Is there a future dialogue you would like to pursue on the monthly Leadership Call on any topics raised?

Small Peer Group Dialogue

Group A: Alternative models for value-based care—preparing, engaging, contracting approaches (ACO, D-SNPS, PACE, etc.)

Group B: Supporting Care Team & Workflow Optimization

Group C: Patient and Site Assignments

Large Group Dialogue

- What did you learn from peers in the small group dialogue?
- What topics do you want to prioritize in future shared learning opportunities?

Wrap-Up

- Next Leadership Call is April 2nd at 12:00 p.m. PST.
- **What topics matter to you?**

Next Session

PHMI Partner Panel: Priorities and Lessons Learned from California's Practice Transformation Initiatives

Please rejoin us in the main room by 3:40 PM.

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Supporting Sustainability
Staff Recruitment & Retention

March 6, 2025

Disclosures

None of the planners, presenters, or staff for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Facilitators

Patricia Mejia

Associate Director of Training, Center for Excellence in Primary Care

Meghan Elliot

Center for Excellence in Primary Care

Learning Objectives

1. Describe several strategies for supporting PHM sustainability through recruitment and retention.

2. Identify one way your health center can improve its staff recruitment or retention efforts.

Agenda

01
Welcome and Overview

02
Life Course Perspective

03
Bright Spots

04
Tabletop Activities

05
Closing

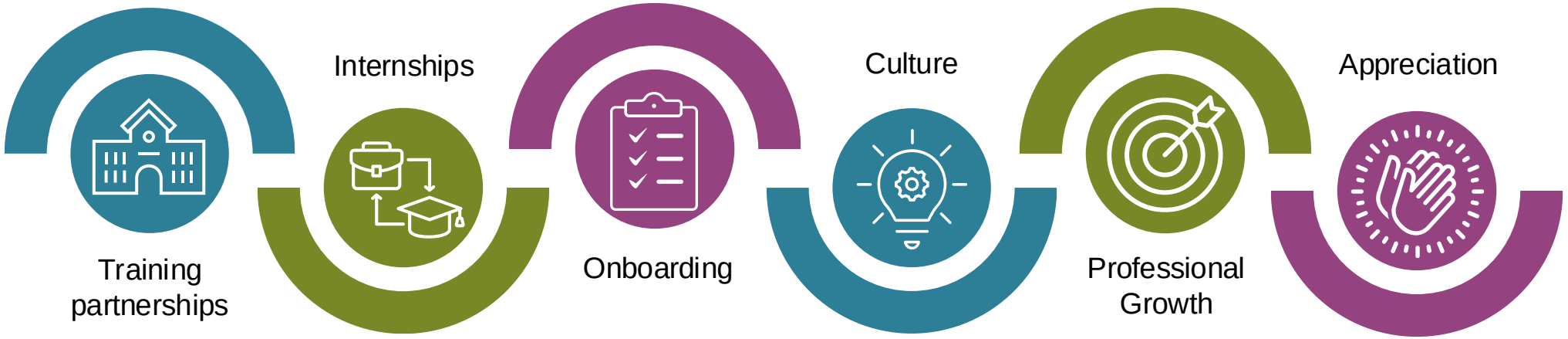
Thought exercise…

Blue Clinic notices that they are losing their MAs at the 18-months to two-year mark.

- What do you think might be going on?
- How does this impact the sustainability of their improvement work?

Cycle of Engagement

Life Course Perspective



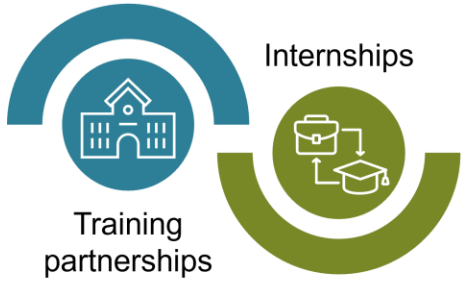
Team Member Recruitment: Hudson Headwaters

Nursing Students

- Partner with State University of New York Plattsburgh
- Offer RN to BSN program & LPN Program
- Nursing students gain experience through onsite rotations
- RN program is a 40-hour clinical rotation ending in a project based on their experiences.
- LPN program pairs students with health center LPNs.

Other Student Opportunities

- Advanced practice students can apply for precepted clinical time at Hudson Headwaters
- Shadow or observation opportunities are available for people 16 or older



Team Member Retention: Altura Centers for Health

Leadership models clinic values

- "I'm not going to ask an employee to do something I'm not willing to do"

Professional growth

- "What are your goals in life?"

Work/life balance

- The multiple roles I have are recognized (mother, employee, etc.)

Shared responsibility & decision-making

- "I am listened to and respected"

Steeped in the community

- "My grandbabies receive care here now."

- FQHC with 10 sites
- Located in Tulare County
- Accept all patients regardless of ability to pay
- Services: Family medicine, pediatrics, obstetrics, dental, chiropractic care, behavioral health, specialty services, school-based medical/dental mobile services

Team Retention: The Institute for Family Health

Stay Interview

The Institute for Family Health | Cindy-Lou Killikelly, MSN, RN, NEA-BC, AMB-BC

- What do you look forward to when you come to work each day?
- What do you like most or least about working here?
- What keeps you working here?
- If you could change something about your job, what would that be?
- What would make your job more satisfying?
- How do you like to be recognized?
- What talents are not being used in your current role?
- What would you like to learn here?
- What can I do to best support you?
- What can I do more of or less of as your manager?
- What might tempt you to leave?

- FQHC with 27 practices
- Serve over 100,000 patients
- Accept all patients regardless of ability to pay
- Services: Primary care, mental health, dental care, social work
- Conduct an annual “Stay Interview”

Team Effectiveness

In conversation with **West County Health Centers**

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Tabletop Activity

What Are You Doing Now?

- Identify a scribe to take notes for the group, as well as someone who will share out to the larger group.
- Discuss what your practice is currently doing in the areas of:
  - Team recruitment (10 mins)
  - Team retention (10 mins)
  - Team effectiveness (10 mins)

Gallery Walk:
What are you doing now?

- Take 10 minutes to walk around the room and see what other practices are doing.
- Use the handout to note your takeaways.

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Tabletop Activity 2

Hot Topic

One clinic at each table volunteers to present a challenge they have in one of the three areas. The volunteer clinic will:

- Share their challenge
- Share what they have already tried
- Answer clarifying questions from the group
- Listen to suggestions from the group
- Identify one suggestion they would like to try out

Hot Topic Debrief

Resources

- Getting to the Heart Curriculum: https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Getting%20to%20the%20Heart%20Workbook.pdf

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PHM INITIATIVE

Leveraging Your Team to Bolster Access to Behavioral Health Support
for All Populations of Focus (PoF)

March 6, 2025

Facilitators

Emma Ansara

Behavioral Health PoF
SME

Dr. Lyn Yasumura

Pregnant People PoF
SME

Catherine Craig

IHI Faculty

Learning Objectives

1. Discuss how to leverage the workforce you have to provide as much BH support as possible.
2. Identify at least one idea to test in your CHC to expand access to BH support.

Agenda

01	Welcome	*5 mins*
02	Sharing the local need for integrated BH care	*10 mins*
03	Best practices in expanding access to BH care	*20 mins*
04	Capsule exercise on local challenges to BH access	*45 mins*
05	Takeaways	*10 mins*

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Why We Prioritize Integrated BH Across PHMI

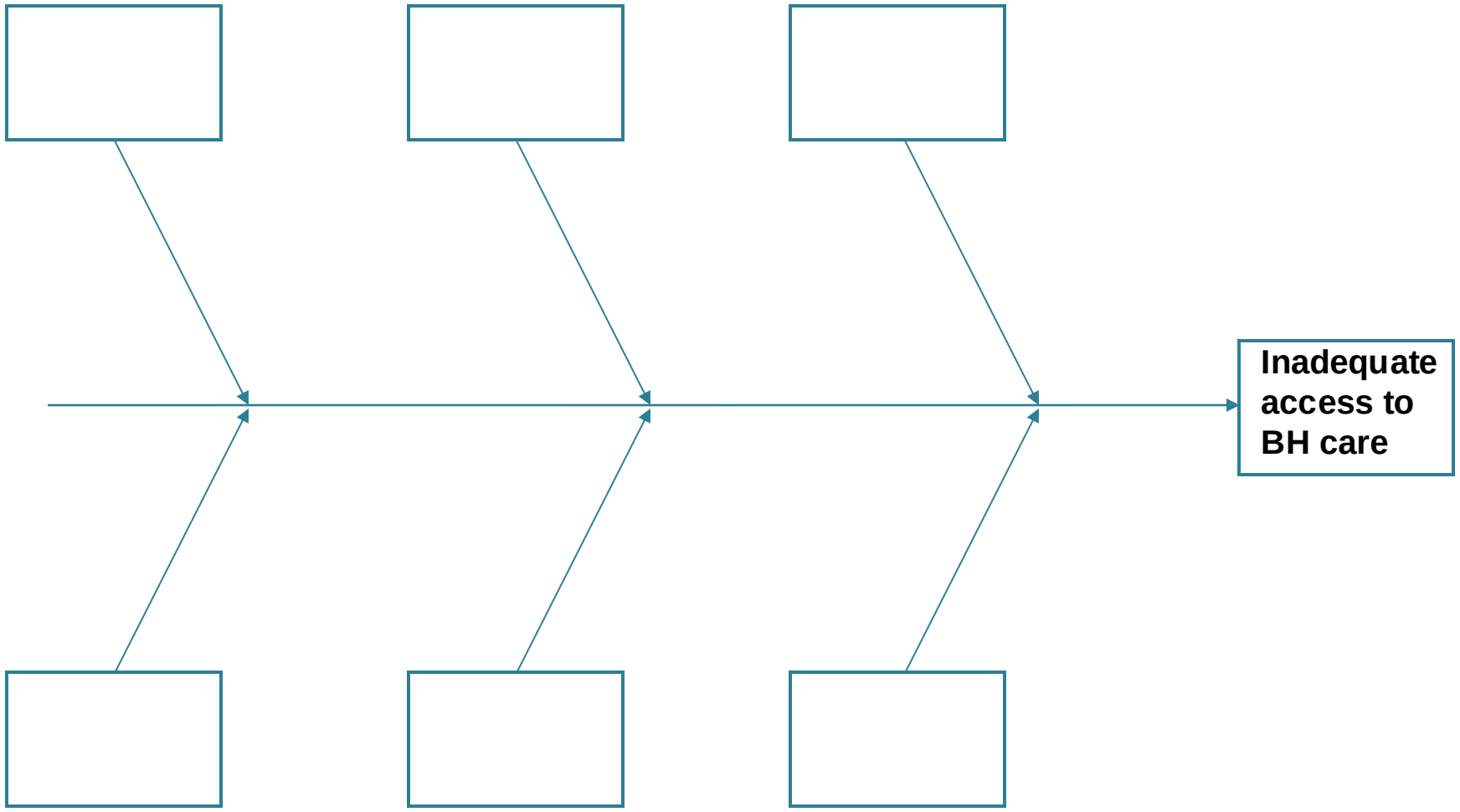
Why Integrated BH Care Matters

How is the demand for BH services different in your clinic...
since last year? In the past few months?

What community-level traumas are you and your clinic facing?

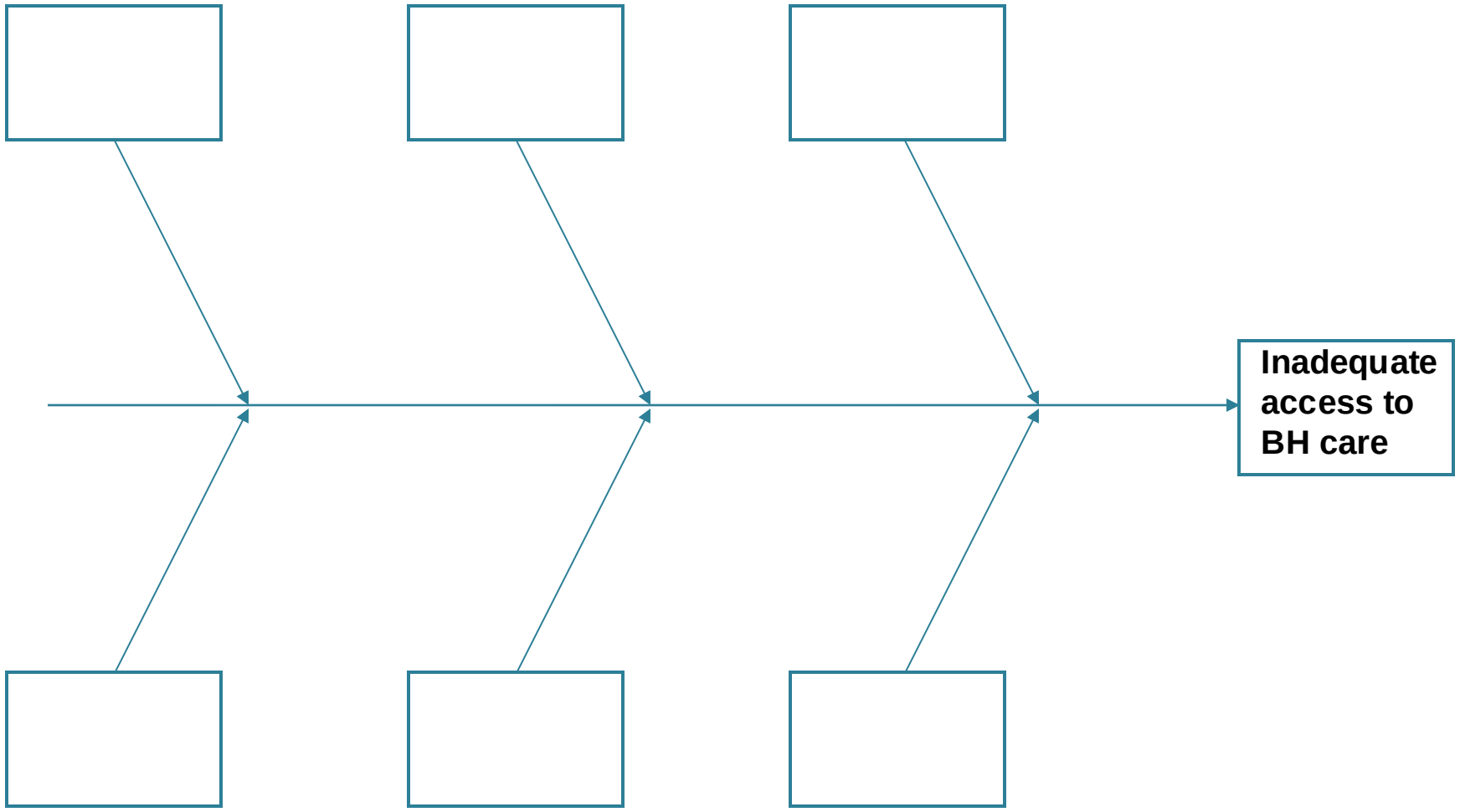
How are patients and staff impacted differently now
than they were a year ago?

Root Causes of Inadequate Access to BH Care

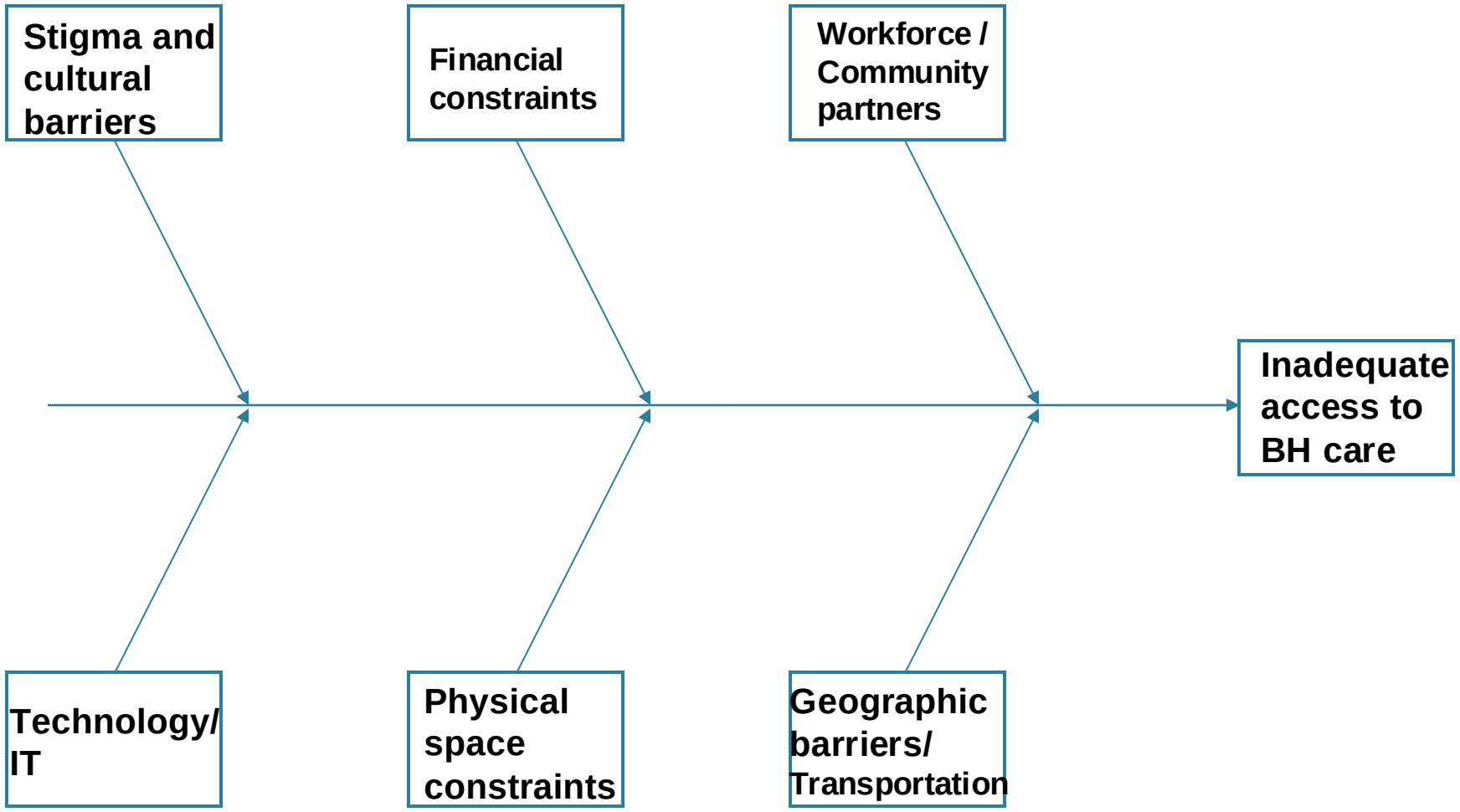


What's My Role in Supporting BH?

Root Causes of Inadequate Access to BH Care



Root Causes of Inadequate Access to BH Care



BH Integration Can Look Like:

Co-location	Moving towards Integration	Integration
• Responding to PHQ-9 screenings • Locating BH professionals in the primary care setting *without shared record, case discussions or shared approach to care*	• Responding to PHQ-9 screenings • Routinely screening for substance use, anxiety and adverse childhood events • Training front office staff on trauma-informed principles • Training rooming staff on suicide assessment	• Responding to PHQ-9 screenings • Women's health NP providing visits in a community mental health setting • Cross-training SUD professionals to aid with depression screening f/up (Alexander Valley) • Development of a shared ROR to facilitate exchange of SUD/MH information with a community partner

What It Takes to Strengthen Integration

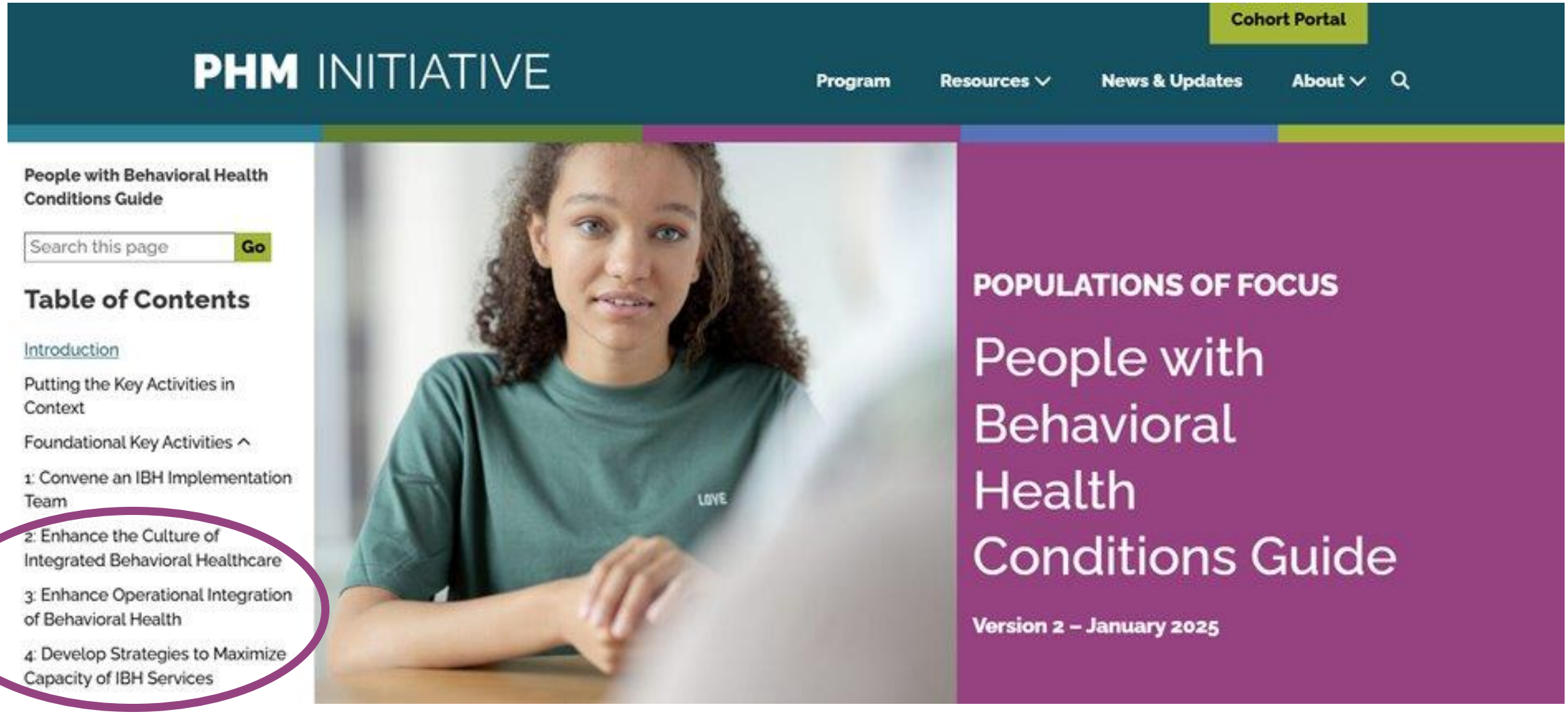
Enhancing a culture of integration requires:

- Developing and updating a shared vision for IBH
- Developing shared language
- Cultivating a flexible approach to BH to meet patient needs, leveraging organizational resources and capitalizing on the funding landscape
- Ongoing collaboration across departments and teams, professions and roles
- Leadership support including resource allotment
- Senior leader champion

Strategies to increase BH provider capacity:

- Re-imagine care team roles and responsibilities
  - Expanding scope of work to include behavioral health skills
- Focus on associate social worker (ASW) recruitment and career pipelines

Where to Turn: Key Activities 2, 3 and 4



Alliance: Cultivating a Culture of Integration

Strategic workgroups:

1. BHI workgroup with representation of clinic-wide care teams, CFO, BH and medical leadership
2. SDoH Integration team: Director of Ops, nursing, ECM MAs

Align Senior sponsor: CEO

Key Challenges:

- Hybrid workforce (many therapists working virtually and part-time)
- High rates of staff turnover
- BH workflows not implemented, seen as too complicated in a busy day
- Different support systems for medical and BH staff
- Inadequate numbers of bilingual therapists

Alliance: Taking Steps to Integrate Behavioral Health

Build a culture of integration:

- Establish a shared language/vision.
- Emphasize the organizational mission in conversations with staff.
  - Articulating how and why empowers mid-managers to resolve challenges.
- Approach cross-department conversations with curiosity.
- Develop metrics to comprehensively assess integration.

Integration Activities:

- Identify barriers to access to BH care
- Deploy staff flexibly
- Staff training, including cross-training (CHWS/MAs/CM for ECM)
- Strategically use available funding opportunities
- SDoH as a continuation of BH work that evolved to ECM

Alliance: Building a Bench of BH Staff

- Hire remote/part-time behavioral health therapists.
- Cross-train CHWs in MA and ECM competencies.
- Mental Health Talent Pipeline: Launching July 2025 (goal of hiring bilingual therapists from the community)
  - Partnership with USF using $500K in local grant funds
  - Leveraging CA's ability to bill for non-licensed care providers
  - Traineeships and associateships to master's students and new graduates

Alliance:	**Current BH staffing model:**
>12,000 patients 3 sites	10 therapists (part-time and virtual), 2 MAs, 2 psychiatrists (part-time), 2 clinical support, 1 SUD counselor...hoping to grow.

Table Exercise: Expanding Access to BH Supports

Capsule Exercise Instructions

At your table:

- Select **1** root cause of inadequate access to care.
- Develop as many problem-solving ideas as possible to help address that root cause.
- Write each potential approach or change idea on a Post-it and place it on the poster-sized fishbone diagram.
- When you've exhausted all ideas, pick a second root cause and repeat the exercise.

Wrap Up

Key Takeaways

- Everyone has a role in supporting BH care.
- There are many ways to expand access to BH care.
- BH IG key activities 2, 3 and 4 help to build a solid foundation, specifically:
  - Enhancing a culture of integration takes sustained effort and senior leadership support.
  - Developing flexible and expansive staffing models can boost access to BH care and bolster staff satisfaction.

Reflection & Action Items

What's one approach from this session you will try in your CHC?

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Next Session

PHMI Partner Panel: Priorities and Lessons Learned from California's Practice Transformation Initiatives

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Targeted Outreach for Patients Due for Care

Please sit based on your PoF:
Chronic Conditions, Preventive Care Needs, and Children

March 6, 2025

Agenda

01	Welcome & Overview	*5 mins*
02	Case Example	*10 mins*
03	Components of a Targeted Outreach Strategy	*15 mins*
04	Small Group Discussions by PoF	*35 mins*
05	Report Out	*15 mins*
06	Reflection & Key Takeaways	*10 mins*

Scoping Today's Discussion

PHMI emphasizes that it is foundational to have an outreach protocol to reach and engage all attributed patients, including these (overlapping) groups:

1. Patients who are assigned but not seen
   Stay tuned - 11 clinics will be diving into this challenge during the upcoming PHMI Affinity Group (March - May 2025)!
2. Patients who are due for follow-up/have a care gap
   Focus for today: diabetes and hypertension, cancer screening, and well-child visits and immunizations
3. Patient-centered outreach and scheduling access

Going deeper: populations with special needs and patients who have been lost to engagement; deep engagement with community partners

Facilitators

Dr. Fiona Donald

Chronic Conditions PoF SME

Dr. Gena Lewis

Children PoF SME

Margaret Franckhauser

Adult Prevention PoF SME

Learning Objectives

Our goal: Walk away with actionable ideas for enhancing your clinic's outreach strategy for your PoF.

1. Describe components of a successful targeted outreach strategy.
2. Recognize how to segment and prioritize outreach within your population of focus.
3. Discuss strategies to prioritize staff's time to outreach more effectively to improve outcomes and patient experience.

Overview: Components of a Successful Targeted Outreach Strategy

1. Segment your population.
Who do you want to reach and why?

2. Balance access & scheduling.
How soon can you schedule these patients?

3. Assess resources for outreach.
What resources do you have available for outreach?
How do you know when to give up?

4. Enhance equitable, person-centered care.
How can you further increase access and improve the patient experience?

5. Communication and Buy-in
How can you encourage buy-in and ownership from others on the team?

6. Documentation and Sustainability
Where will you document your outreach efforts?
How will you track if outreach was successful?

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Case Example: Clinica Sierra Vista's Outreach PDSAs for Adults with Diabetes

In Conversation with Clinica Sierra Vista

Population of Focus: Adults Living with Chronic Conditions - Diabetes

Subpopulation: Patients with Diabetes and Hgb A1C >9

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Components of a Successful Targeted Outreach Strategy

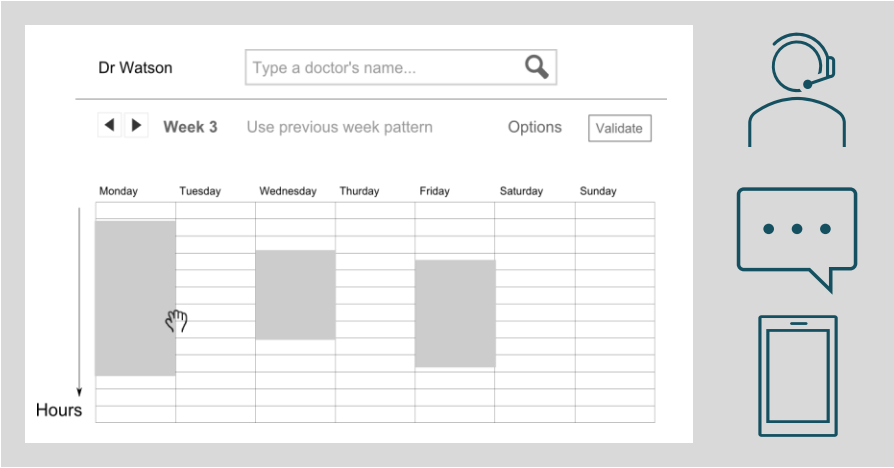
1. Segment Your Population

Who do you want to reach and why?

https://www.hopkinsacg.org/patient-segmentation-how-it-adds-value-to-your-population-health-strategy/

2. Balance Access & Scheduling

How soon can you schedule these patients?



- PCP availability
- Leveraging other members of the care team
- Telehealth
- Limitations of current scheduling practices

3. Assess Resources for Outreach

What resources do you have available for outreach?

Different care team models:

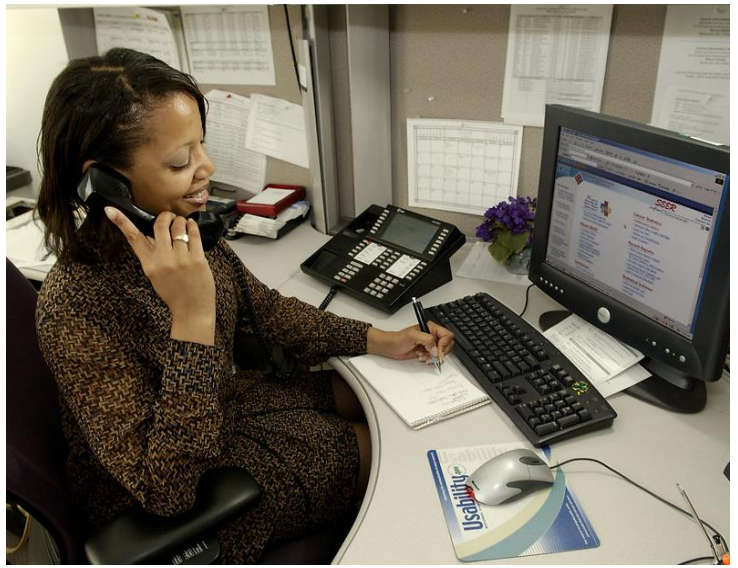
- Put one person in charge of outreach, or
- Share the responsibility amongst MAs/OAs

Assessment of work and allocation of staff time:

- Minutes per call – 20 calls/week x 5 minutes per call =100 minutes

Mode of outreach:

- What is a realistic number of patients that can be outreached to?
- Leveraging the patient portal [for those that use it]



ThePhoto by PhotoAuthor is licensed under CCYYSA.

3. Assess Resources for Outreach (continued)

How do you know when to give up?

A call AND a letter improved follow-through with diabetes monitoring, CRC and mammography by 5-20%.

Personalized outreach in addition to automated outreach improved WCV scheduling, visit completion, and FIT completion rates.

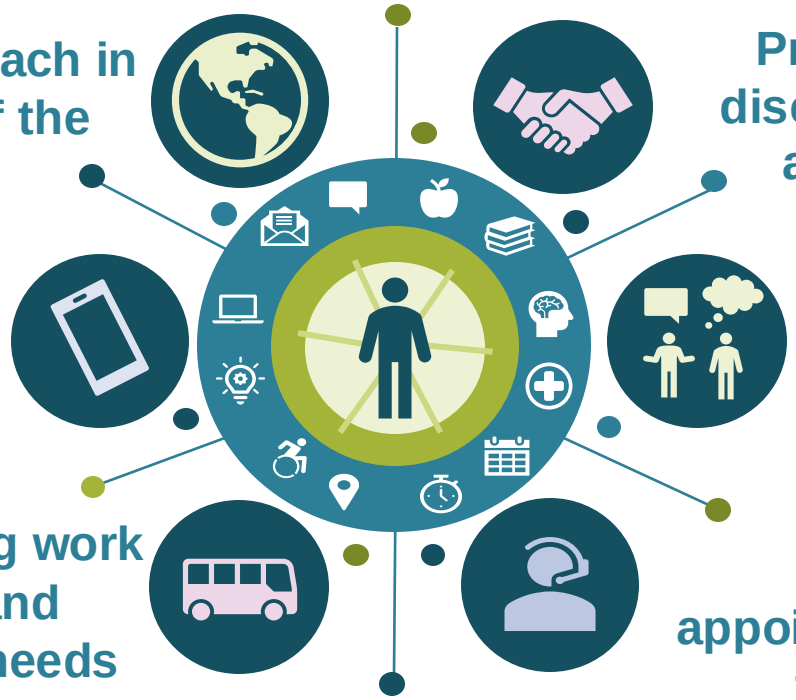
Multiple reminders yielded 5% reduction in no-shows from high-risk patients.

Research supports combining modalities, personalized outreach and multiple reminders.

Derose, Nakahiro, and Ziel, 2009; Phillip et al., 2015; Berset et al., 2023; Coronado et al., 2019; Steiner et al., 2018

4. Enhance Equitable, Person-Centered Care

How can you further increase access and improve the patient experience?



5. Communication and Buy-in

How can you encourage buy-in and ownership from others on the team?

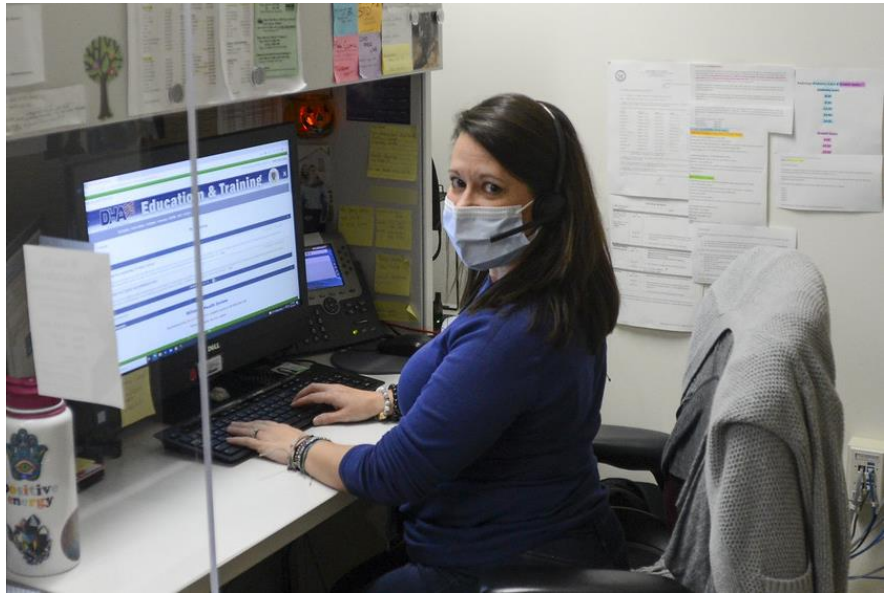


Image: NMCCL: The Call Center, by Navy Medicine. Public domain.

Talking points for staff meeting:

- Our **outreach staff are crucial** to getting patients into the clinic through their communication efforts and relationship with the patient/family
- **Not meeting the metric has a real impact** to our patients and to the financial health of our CHC
- **We can do this!**

6. Documentation and Sustainability

- ✓ Where will you document your outreach efforts?
- ✓ How will you track if outreach was successful?
- ✓ Who is responsible?

Patient Name/ID	Appointment Date/Time	Appointment Type	Provider Assigned	Confirmation Status	Room/Location	Priority/Notes	Scheduled Successfully
John Doe, #12345	02/15/2025, 10:00 AM	Annual Check-up	Dr. Jane Smith	Confirmed	Room 3A	-	✅ (Green)
Mary L., #23456	02/15/2025, 12:00 PM	Follow-up Visit	Dr. Mark Johnson	Pending	Room 2B	Needs interpreter	⏳ (Yellow)
Sam W., #34567	02/15/2025, 3:00 PM	Blood Test Results	Dr. Lily Williams	Confirmed	Room 4C	-	✅ (Green)
Kevin P., #45678	02/16/2025, 9:00 AM	Surgery Consultation	Dr. Sarah Lee	Confirmed	Main Hospital	High-priority	✅ (Green)
Anna G., #56789	02/16/2025, 11:30 AM	Follow-up	Dr. Emma Clark	Canceled	Room 5D	Rescheduled	❌ (Red)

Discussions by PoF (35 minutes)

Children, Chronic Conditions, and Adult Prevention

Segment Your Population

a. Who do you want to reach in your PoF and why?
b. Who do you see as "high risk"?

Balance Access and Scheduling

a. If you're able to reach these individuals, what does the clinic need to do to ensure they have access?

Who from your team needs to be in this conversation to move forward?

CONSIDER EQUITY

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Report Out & Key Takeaways

Report Out

What did you discuss around...

...segmenting your population? Equity?

...balancing access and scheduling?

...other key takeaways?

Reflection

What potential actions will you take back to your team from this session?

Take 3 minutes to reflect silently & jot down your answers.

References

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Break

15 Minutes

Please come back at 3:40

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Moderator

Rachel Tobey

Co-Executive Director
JSI

Panelists

Allie Budenz

VP of Health Center Optimization, California Primary Care Association

Dr. Jeff Norris

Value-Based Payment Branch Chief, DHCS

Dr. Jennifer Sayles

Founder and CEO, Population Health Learning Center

Katie Andrew

Director of Government Affairs, Quality & Behavioral Health, Local Health Plans of California

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Closing & Gratitude

March 6, 2025

Thank you!

What's Next

- Materials on Cohort Portal
- Additional peer learning opportunities to go deeper:
  - Regional learning sessions:
    - Los Angeles - June 17th
    - Central Valley - July 15th
    - North Coast - August 28th
    - Sonoma County - September 16th
- Meet with your coach to identify next steps to advance your action plan and build toward sustainability.

Continuing Education Credits

If you indicated during registration that you would like to earn credits for this event (nursing or Certified Professional in Patient Safety), please look out for instructions on how to claim credits in the next PHMI communications.
You will be asked to complete an additional evaluation online as part of the continuing education process.

Participants seeking continuing education will have 30 days from today to claim credits.

Please note that you must have an account on ihi.org to receive credits.
If you have not yet set one up, please do so before attempting to claim your credits.

Thank you!

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