PHM INITIATIVE

Los Angeles Regional Learning Session

Tuesday, September 30th, 2025

PHM INITIATIVE

Welcome!!

- TABLE 1: Northeast Valley Health Corporation
- TABLE 2: Northeast Valley Health Corporation and Comprehensive Community Health Centers
- TABLE 3: East Valley Community Health Center and Eisner Health Center
- TABLE 4: Asian Pacific Health Care Venture
- TABLE 5: UMMA Community Clinic
- TABLE 6: Saban Community Clinic
- TABLE 7: San Fernando Community Health Center
- TABLE 8: Park Tree Community Health Center
- TABLE 9: APLA Health
- TABLE 10: Universal Community Health Center
- TABLE 11: Via Care Community Health Center & Venice Family Clinic
- TABLE 12: Valley Community Health Care

We will get started promptly at 9:00 AM
Please sit with your teams at your assigned tables.
Coaches, Faculty, RACs, MCP, & guests please sit at **Tables #12-19**

Disclosure

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.

The following individuals have disclosed independent consultancy ownership: Denise Armstorff, Fiona Donald, Kristene Cristobal, Jennifer Powell, Claire Richardson, and Roza Do. These relationships have been mitigated.

Continuing Education Credits

In support of improving patient care, the Institute for Healthcare Improvement is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

This activity is approved to provide 4.5 credits for physicians, nurses, and Certified Professional in Patient Safety (CPPS) recertification.

JOINTLY ACCREDITED PROVIDER™

INTERPROFESSIONAL CONTINUING EDUCATION

Housekeeping

Restroom

WIFI
Password: PHMI2025

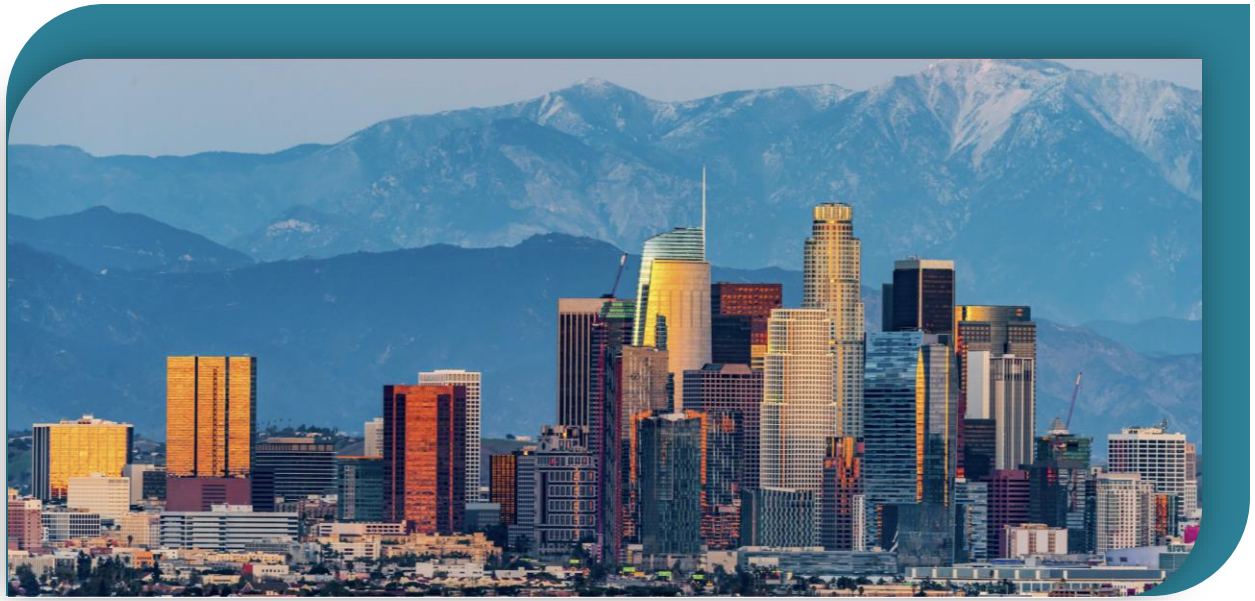
Emergency Preparedness Plan

Take Breaks

Parking Validation

Los Angeles Regional Representation

1. APLA Health
2. Asian Pacific Health Care Venture
3. Comprehensive Community Health Centers
4. East Valley Community Health Center
5. Eisner Health
6. Northeast Valley Health Corporation
7. ParkTree Community Health Center
8. Saban Community Clinic
9. San Fernando Community Health Center
10. UMMA Community Clinic
11. Universal Community Health Center
12. Valley Community Healthcare
13. Venice Family Clinic
14. Via Care Community Health Center



Today's Support Leads

Isabella Chavez
She/Her

Maria Garcia
She/Her

Kristene Cristobal
She/Her

Lindsay Lozada Dietz
She/Her

Jackie Nuila
She/Her

Angela Sherwin
She/Her

Nhi Tran
She/Her

Roseanne Ibarra
She/Her

PHMI Program Team

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She / Her

Director of Technical Assistance and Practice Transformation

Meena Mital
She / Her

Senior Director

Joe Lee
He / Him

Partner Engagement Manager

Aisha Iqbal
She / Her

Director of PHMI Technology

Los Angeles Coaches

Denise Armstorff
She/Her

Lindsay Lozada Dietz
She/Her

Roza Do
She/Her

Paige Nichols
She/Her

Claire Richardson
She/Her

Agenda

01	**Connection Activity**
02	Tools for Tackling the Challenges of Behavioral Health Integration
03	Responding to Health-Related Social Needs
04	**Lunch**
05	Using Storytelling to Sustain and Spread Your PHM Work
06	**Wrap-Up & Next Steps**

Regional Learning Session Rational Objectives

Regional convenings are designed to build a community of peers, and support CHCs as they share identified promising practices and emerging challenges for population health management.

By the end of this convening, participants will:

1. Build a stronger sense of **community amongst peers** working on PHMI regionally
2. **Apply strategies** that further advance CHC capabilities related to Population Health Management (PHM)
3. **Discuss current and emerging PHM challenges & share promising practices** with their peers
4. Describe actions that support a **foundation of equity & trauma informed culture** to address disparities in care
5. **Identify** shared goals and available support from PHM stakeholders to strengthen collaboration

Connection Activity

Activity Overview

Step 1: Find someone nearby to partner with (if possible, choose someone who isn't your usual work buddy).

Step 2: Take turns sharing. Each person gets **5 minutes** to respond to the prompts below:

- One strength I bring to my work is…
- One thing that sustains me in this work is…
- One thing that's getting me through right now is…
- One of my "anti–pet peeves" – something small that brings me outsized delight – is…

15 Minutes

PHM INITIATIVE

Tools for Tackling the Challenges of Behavioral Health Integration

Today's Facilitators

Emma Ansara

She / Her

Behavioral Health SME

Ben Miller

He/Him

Behavioral Health SME

Tools for Behavioral Health Integration

Facilitators: Emma Ansara and Ben Miller

Session Objectives

1. Connect PHMI work to broader ideas of behavioral health integration.
2. Articulate what helps integration succeed at the team level.
3. Plan tools and small changes to test back home.

Using Mentimeter for Participation

Scan me

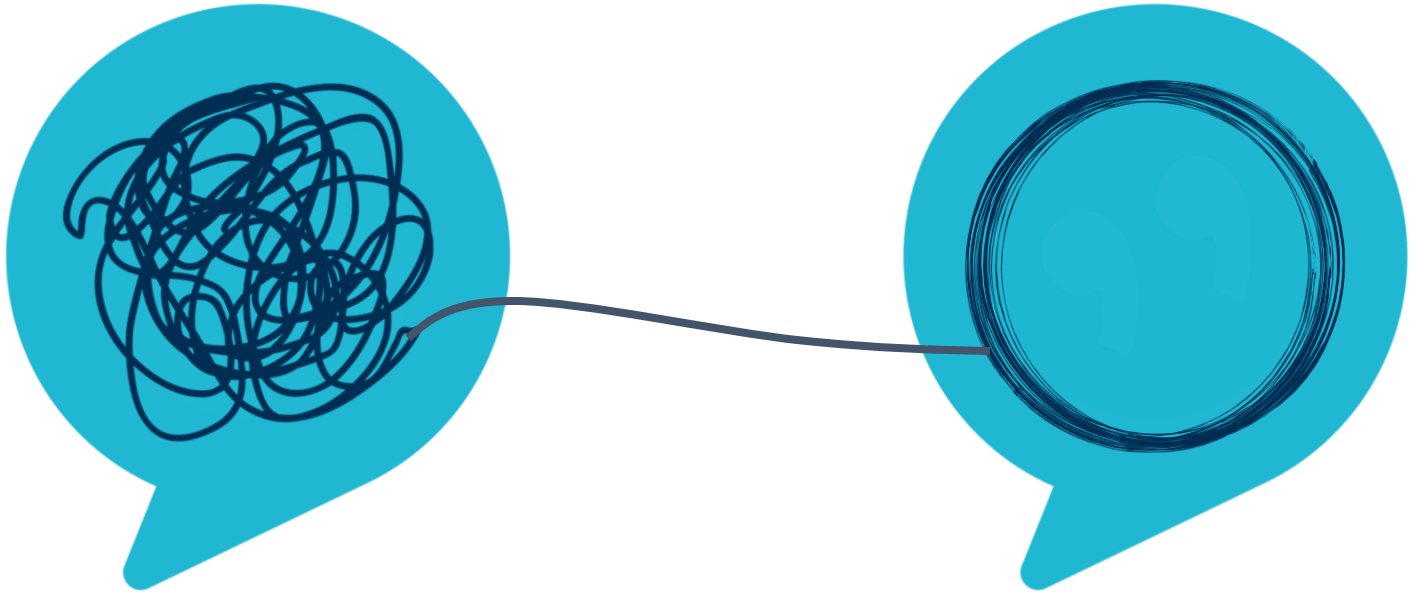
Or go to www.menti.com on your device and use code **6171 8479**


60


Ritter
by MIDMARK

Fragmentation

Integration



Grounding

- Reconnecting practice with purpose after significant staff turnover (and among competing demands)
- Supporting real-world implementation through workflows, peer learning and applied tools
- Emphasis on small, actionable steps
- Centering integration as a team-based, not siloed, effort

Lightning Case Share

Courtney Greaux, MHA
Director of Operations

Ani Keshishian, LVN
Director of Quality Improvement & Credentialing

Raymond Retirado, RN
VP of Quality & Clinical Programs (PHMI Site Lead)

Comprehensive Community Health Centers

- Los Angeles County
- >120,000 Patients
- 6 Locations (soon to be 7!) & Mobile Services

Comprehensive Community Health Centers
Your Health, Our Mission

Celebrating 20 years of ensuring the health and wellness of those we serve

Behavioral Health & Psychiatry: Referral Process

Courtney Greaux, MHA
Director of Operations
September 30, 2025

CCHC Behavioral Health & Psychiatry

Team Structure

5 LCSWs, 2 ACSWs, Psychiatry: 1 MD, 1 NP
Leadership: BH Director (Provider); Clinic Administrator & BH Supervisor (Operations)
Support Staff: 3 (Front Office (PCC), Community Health Worker, BH Coordinator)

Services

Behavioral Health (Adult & Pediatric)
Psychiatry (Adult)
Pacific Clinics partnership (Pediatric)
Substance Use Disorder (SUD)
Enhanced Care Management (ECM)

Scope & Access

More than 175,000k visits annually (all sites/services); 5% BH/Psych
Co-located with Primary Care
Short-term care model

Adult
REFERRAL WORKFLOW

Using clinical judgment and PHQ results, PCP determines referral type: Routine vs. Urgent.

Routine Referral Process

1. PCP creates “Routine” BH/Psych referral in EMR. (SUD → Addiction Specialist directly)
2. BH Patient Care Coordinator (PCC) reviews Referral Widget daily and schedules with internal provider.
3. If insurance is non-contracted, BH Community Health Worker (CHW) contacts patient and assists with external linkage.

Urgent Referral Process

Step 1 – PCP Determines Risk

- If PHQ-9 high and/or patient expressing thoughts of harm/suicidal ideation → PCP conducts risk assessment and completes safety plan.
    - If immediate/emergent risk is determined: Call 911 and engage internal BH/Psych provider to support de-escalation.

Step 2 – Refer to Psychiatry

- Psychiatry provider completes initial urgent visit → determines next steps (i.e. treatment plan, additional BH referral, or external referral).
    - If insurance is not contracted: Psychiatry provider still completes initial urgent visit.
    -Psych MA + BH Community Health Worker (CHW) coordinate external linkage/next steps.

Pediatric
REFERRAL WORKFLOW

Using clinical judgment and PHQ results, PCP determines referral type: Routine vs. Urgent.

Routine Referral Process

Follows the same process as adults → PCP selects routine referral → BH support staff schedule and/or link patient to external resources.

Urgent Referral Process

Step 1 – PCP Determines Risk

- Thoughts of harm/suicidal ideation → PCP conducts risk assessment and safety plan.
- If immediate/emergent risk is determined: Call 911 and/or engage internal BH/Psych provider to support de-escalation.

Step 2 – Refer for Services

- PCP creates urgent **Behavioral Health** Referral ***or,***
- PCP selects **Collaborative Care** Referral for psychiatry support (Pacific Clinics Collaboration)

Collaborative Care

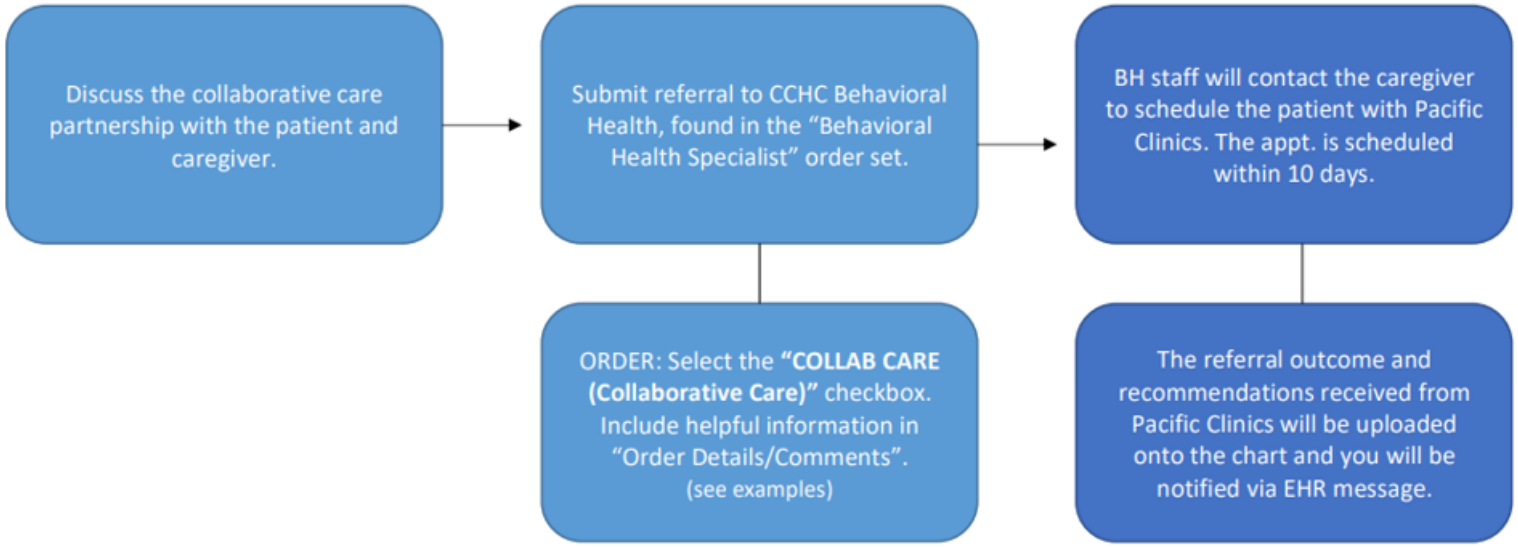
REFERRAL WORKFLOW

Pediatric Provider Referring to Collaborative Care (Pacific Clinics)

Which patients can be referred for Collaborative Care?

- mild to severe non-suicidal depression or anxiety (i.e. PHQ-9>5 and/or GAD>5)
- ADHD evaluation
- medication needs related to depression and anxiety
- caregiver/family support to help patient's depression and/or anxiety
- patients on the waitlist for individual psychotherapy for depression and anxiety

If a pediatric patient is identified for collaborative care services, follow this process:



For brief "curbside" psychiatric consultation, a referral isn't required. Contact the Child Adolescent Psychiatrist directly, in accordance with the monthly schedule.

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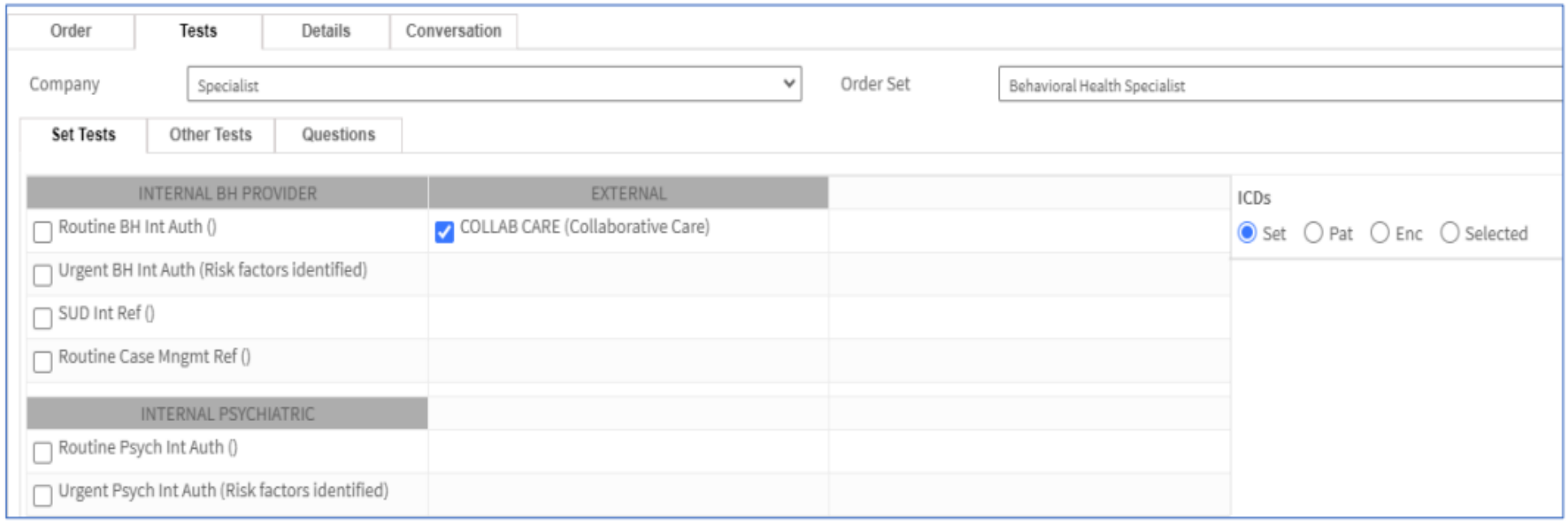
EHR Example



KEY ELEMENTS

Referral Workflow

- Dedicated referral team within the department.
  - Use of EMR widget with real-time review, ensuring active management of both internal and external referrals.
- Referral advisement by LCSW Leadership.
- Internal bridge for urgent needs: If insurance is not contracted, urgent referrals see a Psychiatry provider (adults)

Scheduling Practices

- Use of a scheduling template alongside caseload tracking to help close gaps and balance workload.

Patient Relationship Building

- Direct communication with familiar faces in the BH/Psych Department (not through call center) to foster engagement and trust.

Leadership Alignment

- Ops and Clinical Leaders jointly track metrics, address bottlenecks collaboratively, and drive improvements.

Comprehensive Community Health Centers
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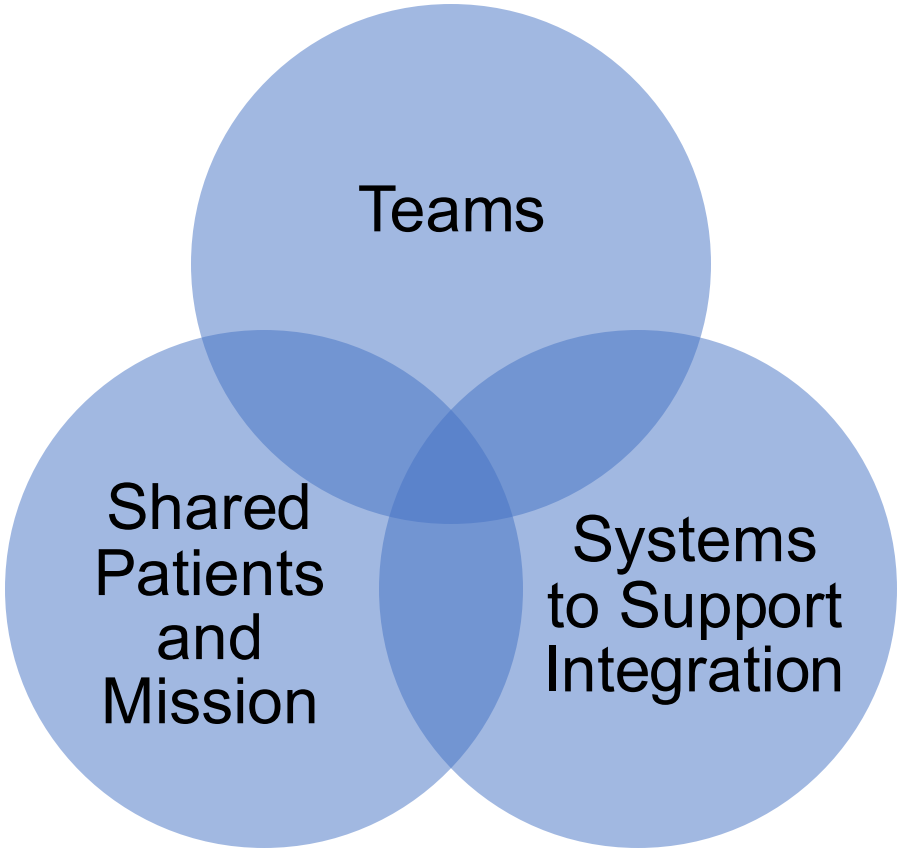
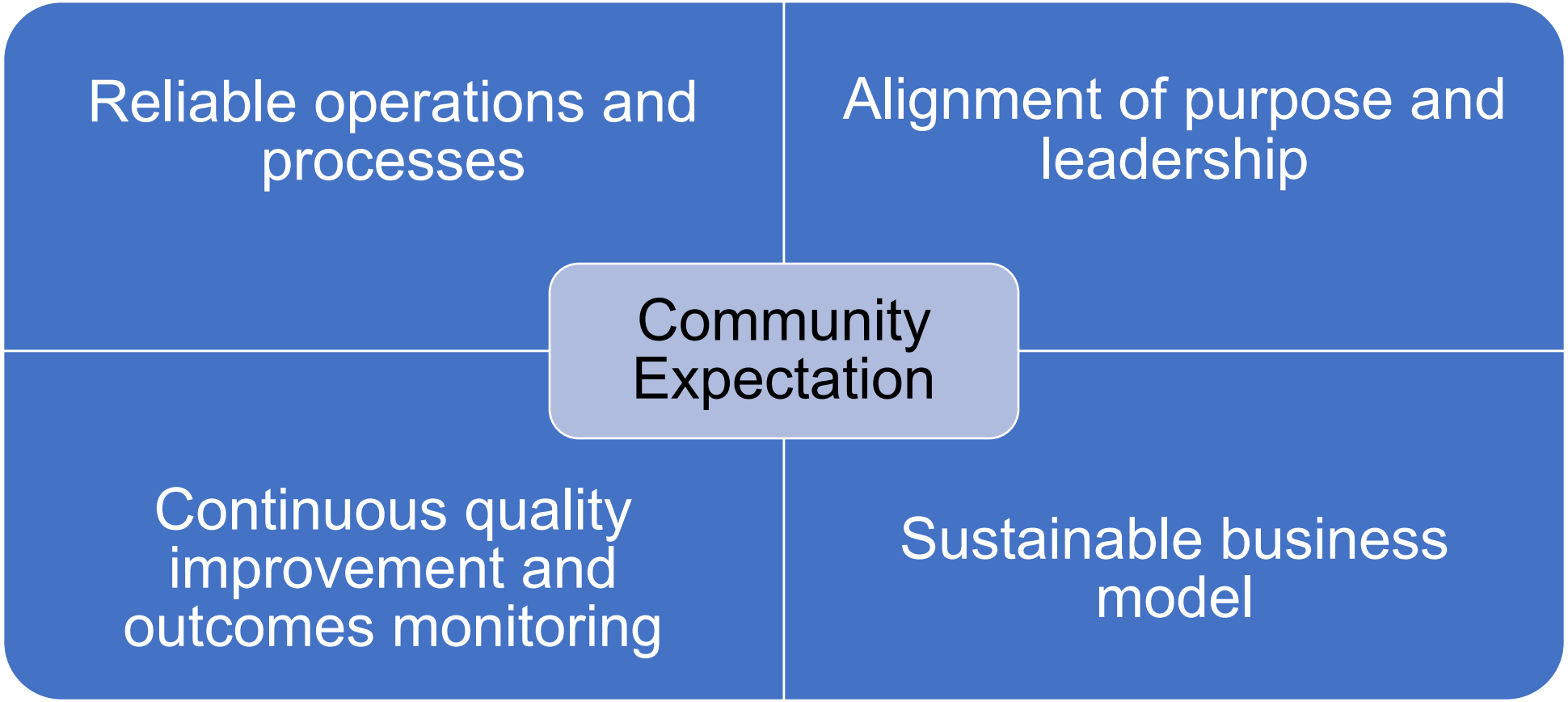
Celebrating 20 years of ensuring the health and wellness of those we serve

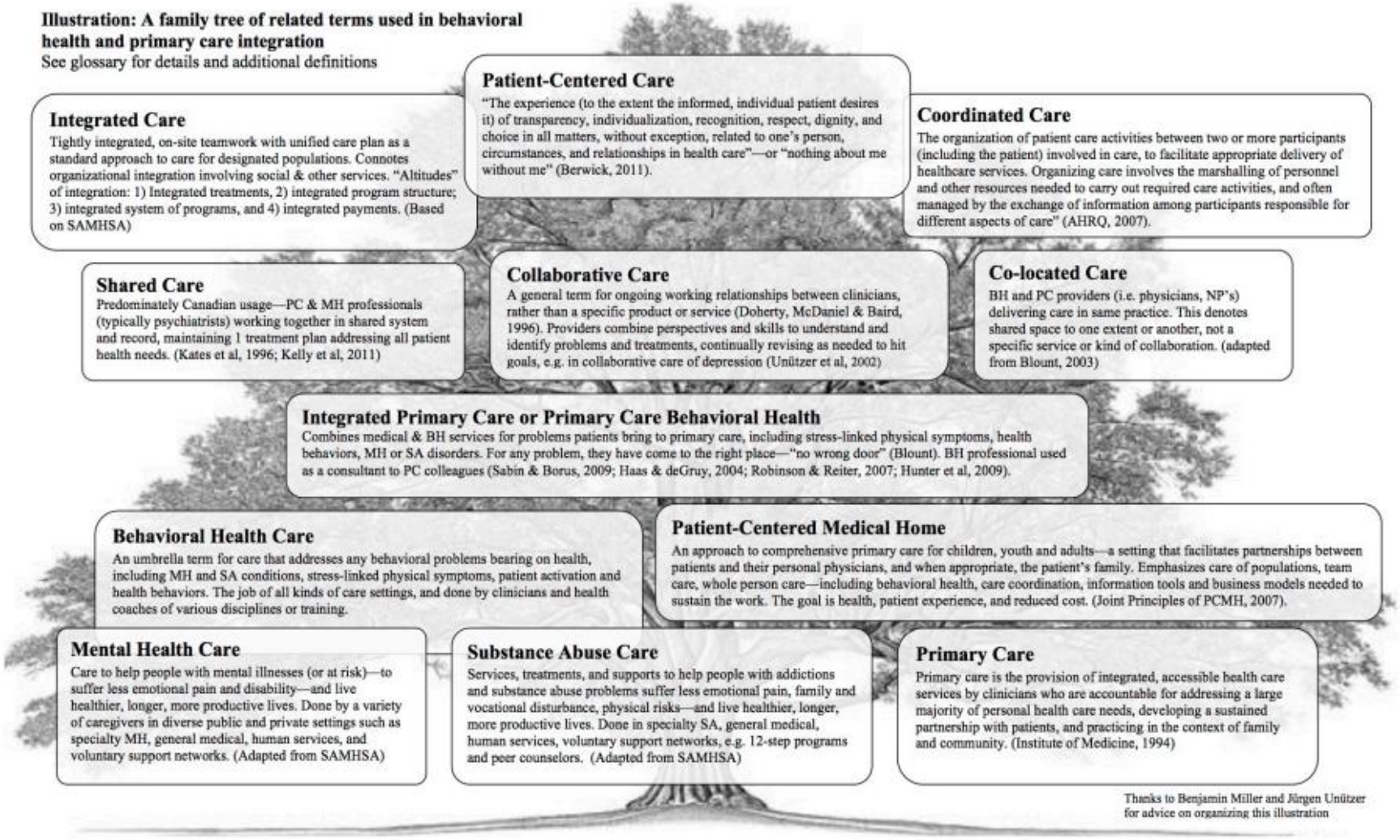
Thank You.

Key Functional Areas of Integration



Enabling Functions that Support Integration





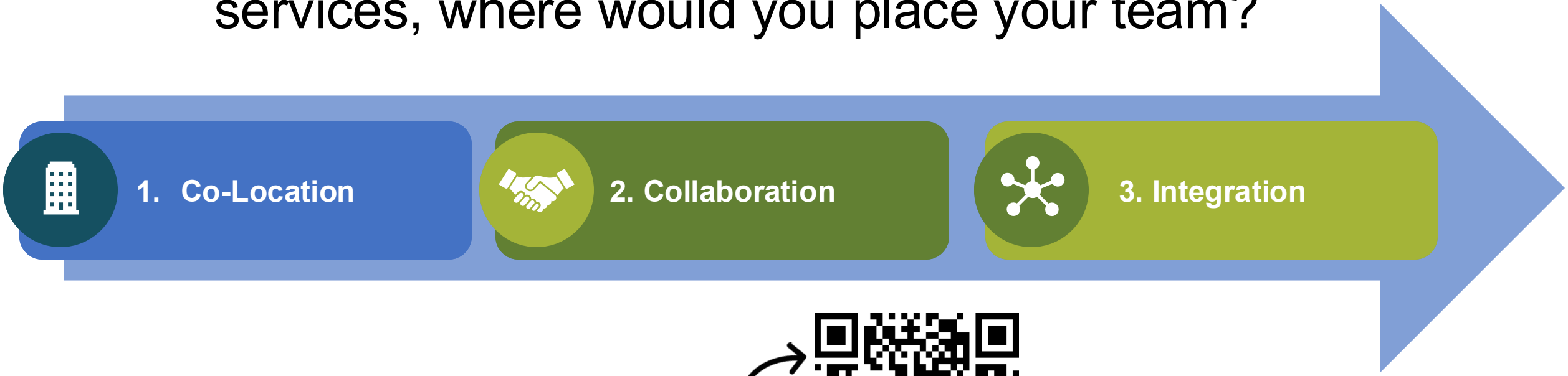
From: Peek CJ and the National Integration Academy Council. *Lexicon for Behavioral Health and Primary Care Integration:* AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013.Available at http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf.

Operationalizing Your Vision

- Approaches to integration vary widely:
  - **Co-location:** BH placed in PC – be careful not to become the "house shrink"
  - **Bidirectional co-location:** PC placed in BH
  - **Collaboration:** Quality of the relationship between providers
    - Frequency of sharing info, joint treatment planning, true biopsychosocial approach
  - **Integration:** BH is a regular part of the care team, and no special paperwork or processes are needed to see BH.

Mentimeter – 1, 2, or 3

On the continuum of co-location of behavioral health services, where would you place your team?



Where are you?

Or go to www.menti.com on your device and use code **6171 8479**

Building Practice Capacity

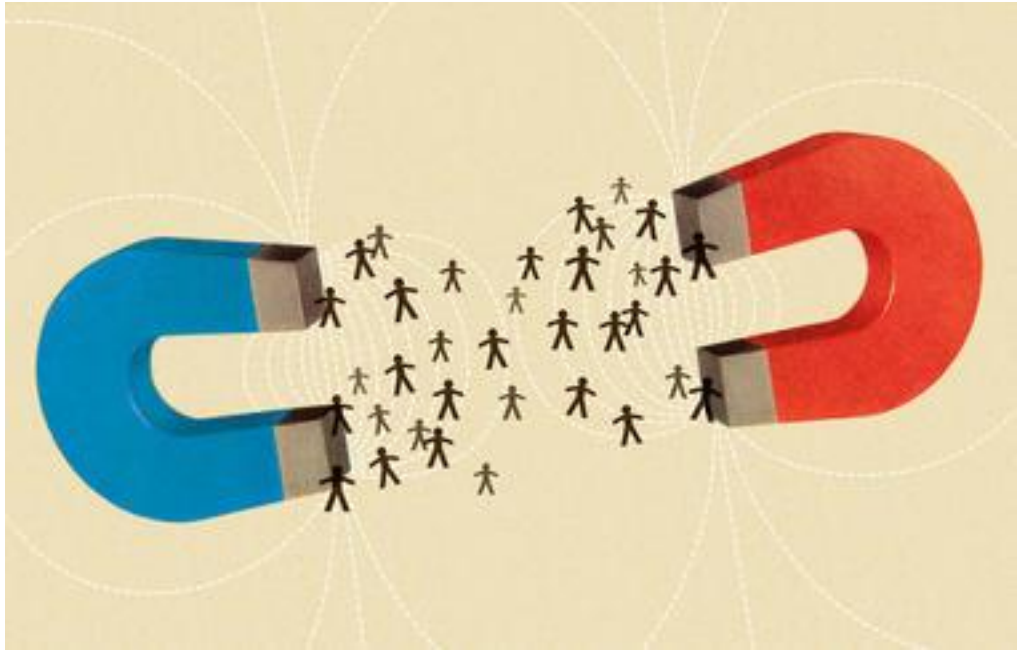
Creating a team-oriented practice

- Offer internal practice to the team through tailored trainings
- Consultation/co-management relationships with behavioral health
- Coordinate relationships within medical neighborhood
- Share workflow to foster multidisciplinary teams

Operationalizing your Vision: Tradeoffs

Accessibility and Integration can be at odds with one another.

A shared vision of BH integration can help guide around necessary tradeoffs.



Operationalizing Your Vision: Scheduling

Visits

- Align visit length (e.g., 15–30 min) with brief intervention goals and access needs
- Define expected number of follow-ups per patient episode
- Clarify expectations (1:1 care vs. team-based consults with PCPs)
- Reserve flexible BH time for warm handoffs and real-time consults
- Embed these decisions within supervision, training and role expectations

Operationalizing your Vision: Telehealth

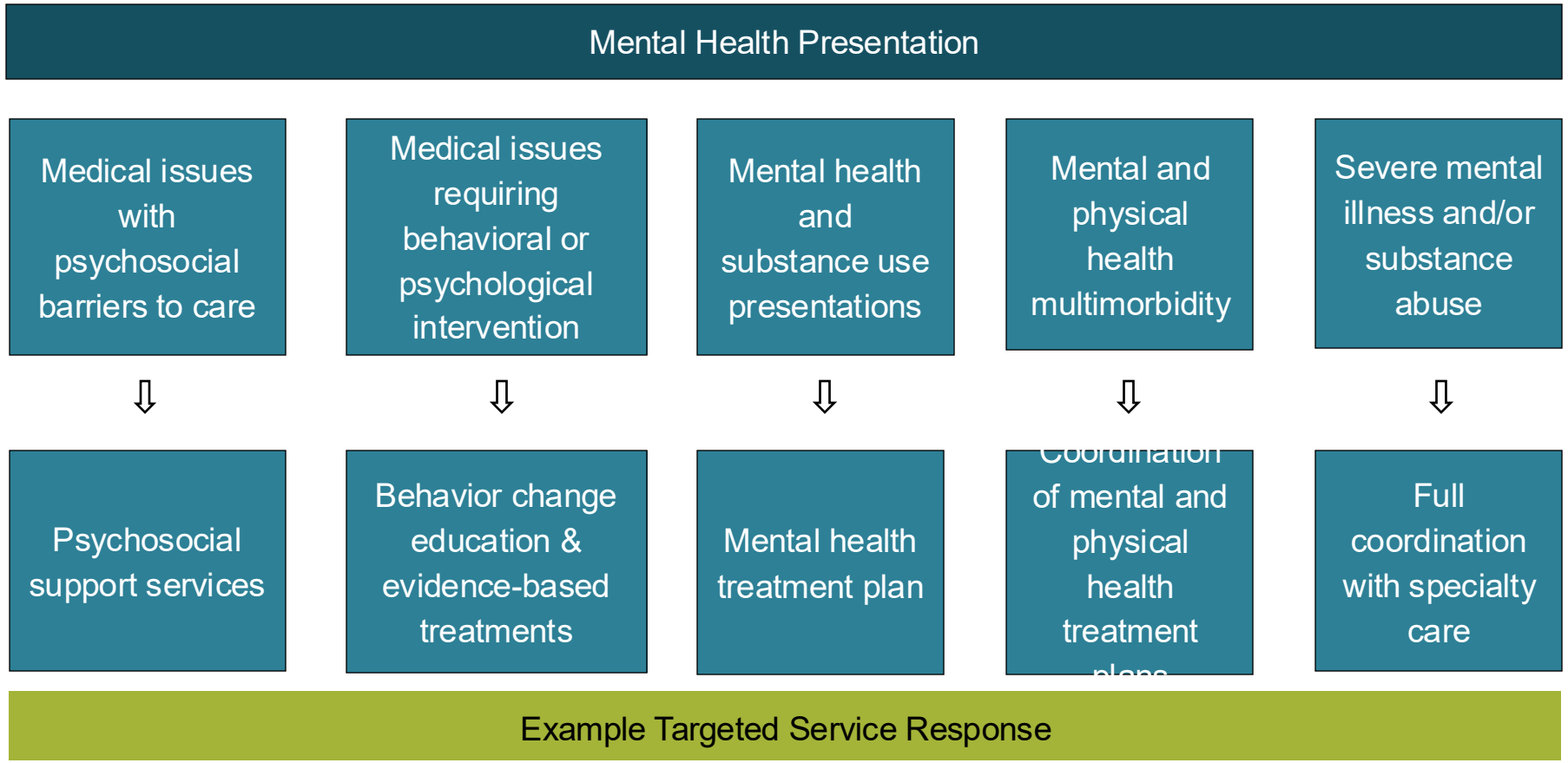
Telehealth Advantages	Integration Challenges
Expands reach without adding new staff	Risk of fragmented workflows (handoffs, huddles harder)
Increases timely access, especially for rural/underserved	Reduced real-time collaboration and co-location benefits
Flexible for patients and staff scheduling	Digital divide creates equity gaps
Helps stretch limited workforce capacity	Telehealth platforms may not align with EHR/registries
Supports continuity when in-person visits aren't possible	Can dilute relational, team-based foundation of care

Operationalizing Your Vision

- Maintain easy access to behavioral health care with population health focus.
- Shift from "who asks for therapy?" to "who needs support?" and "how can we reach them in early stages of need?"
- Generalist approach → Be ready to provide brief interventions.

- Depression
- Anxiety
- Obesity
- Pain
- Diabetes
- Headaches
- Hypertension
- Grief
- Sleep
- Stress
- Adjustment to illness

What are the range of behavioral health services offered?



Morning Huddles

Purpose:
- Review the day's schedule
- Strategize on patients needing behavioral health (BH)
- Strengthen team communication and clarify roles

Key Components:
- Schedule a **brief daily huddle** with PCPs, BHCs, RNs, MAs
- Review positive BH screens (PHQ-2/9, GAD-7) flagged in EHR
- Jointly identify patients requiring warm handoffs or follow-up

Benefits:
- Proactively targets integrated care opportunities
- Ensures all team roles are activated and coordinated
- Boosts efficiency and patient-centered teamwork

Mini-Huddles & Warm Handoff Workflows

Mini-Huddles (During the Day)

- Quick (<1 min) updates between PCPs and BHCs
- Happens before or immediately after patient visits
- Facilitates rapid coordination and clarifies next steps
- Especially useful for part-time or mobile BHCs

Warm Handoff Script Highlights:

- PCP introduces: “I’d like to bring in [BHC name], who’s great at…”
- BHC enters seamlessly and briefly reviews patient context
- Conversation transitions to BH care while maintaining continuity

Workflow Considerations:

1. **EHR flags/screens** trigger BH involvement
2. **Brief physical/quick verbal briefing** within the exam room
3. **Clear role handoff**, with the PCP facilitating introduction

Result:

- Smooth, respectful, real-time transition to BH services
- Increased patient trust and engagement in integrated care

Mentimeter

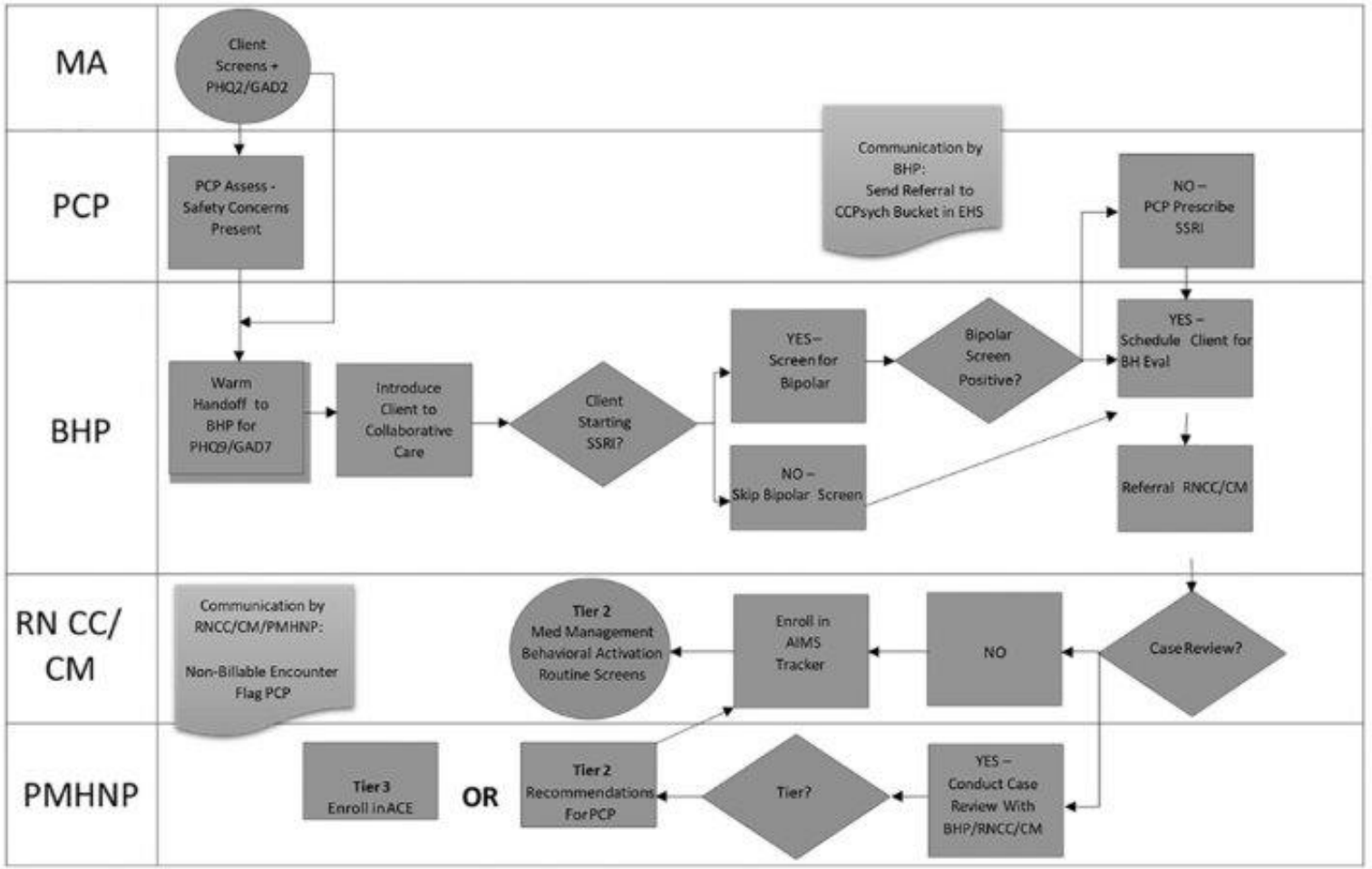
Do you huddle regularly in teams that include PC and BH staff?

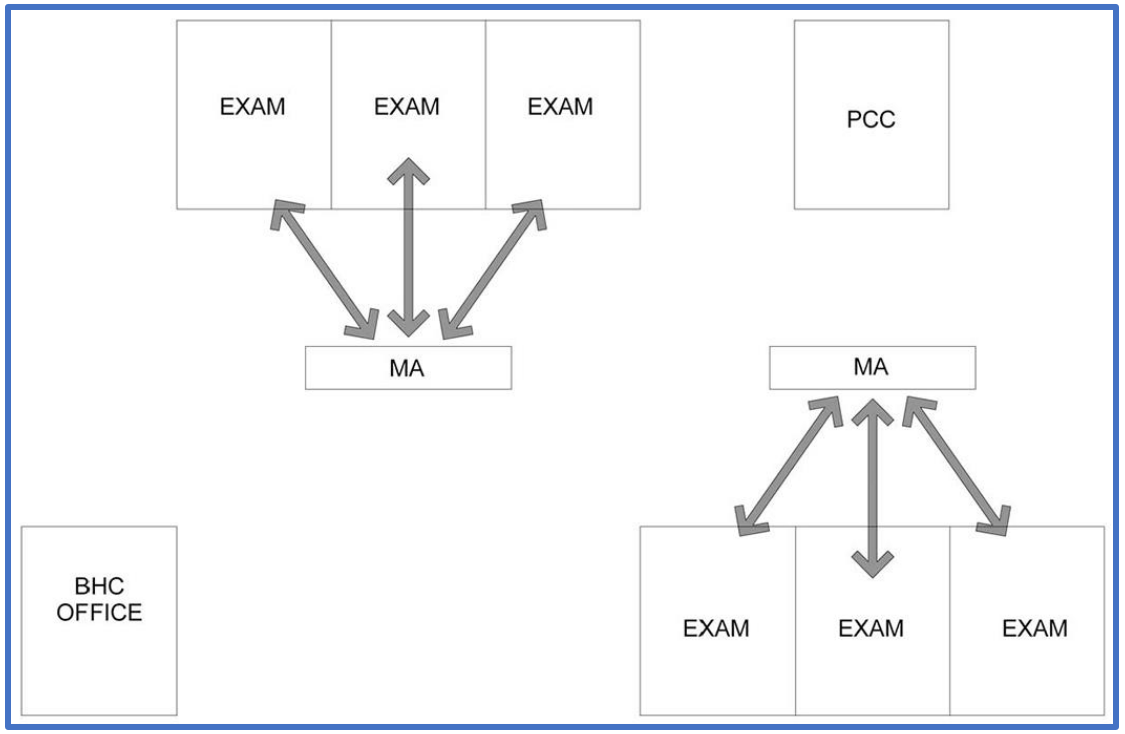
Do you utilize an approach like a "mini-huddle" to communicate among BH/PC teams members throughout the day?

How do you huddle?

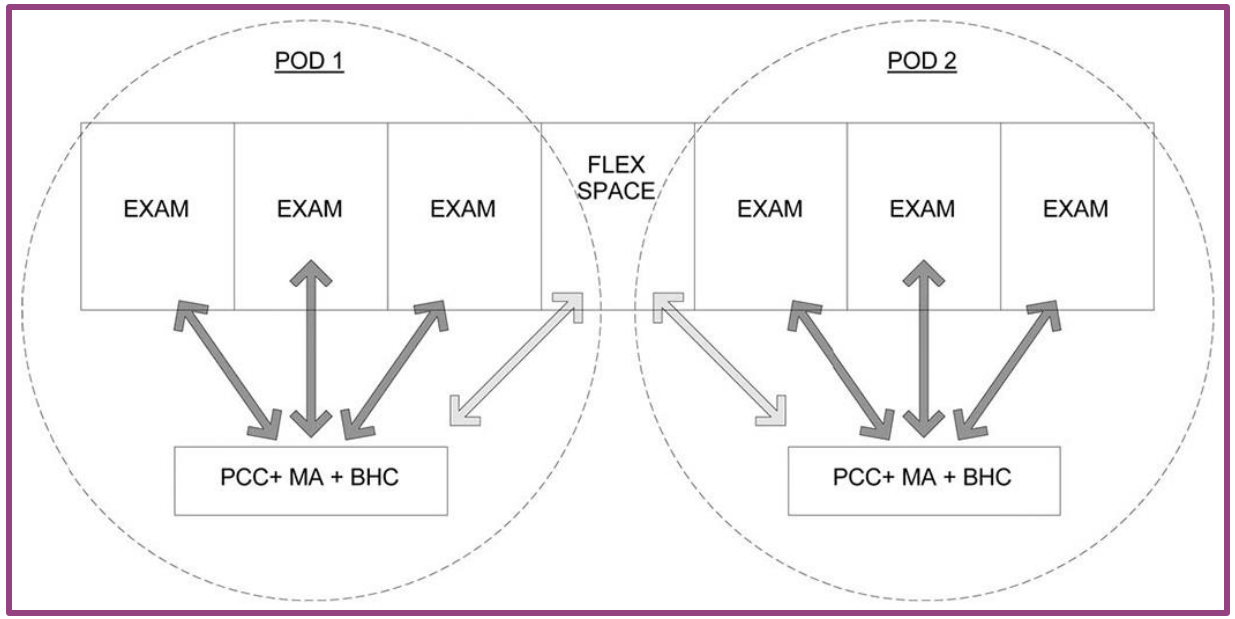
What Integration Looks Like

- Screening → Warm Handoff → Documentation → Follow-up
- Highlight common breakdown points
- PCP, BHP, RN, Front Desk – how do they intersect?





More integration happens in this configuration



Less integration happens in this configuration

Handoffs in Action

- Warm handoff script example
- Tips: timely, respectful, efficient

Warm Handoff Script Example

- PCP to PT: “Ms. Lopez, one of the ways our team works together is by connecting patients with someone who’s trained to help with stress, mood, sleep — all the things that affect health, but aren’t always easy to talk about. I’d like you to meet Jordan, our behavioral health clinician.”
- PCP to BH: “Jordan, this is Ms. Lopez. We were talking about how hard it’s been for her to fall asleep and stay asleep since her surgery, and she’s feeling pretty worn down. I thought it would be helpful for you two to connect.”
- BHC to PT: “Thanks, Dr. Chen. Ms. Lopez, it’s really common for pain and life stress to affect sleep and mood. I work with people on quick, practical ways to feel more in control of things like this. If you have a few minutes now, I’d love to hear more about what’s going on.”

Show of Hands

Does your team have scripts to support warm handoffs?

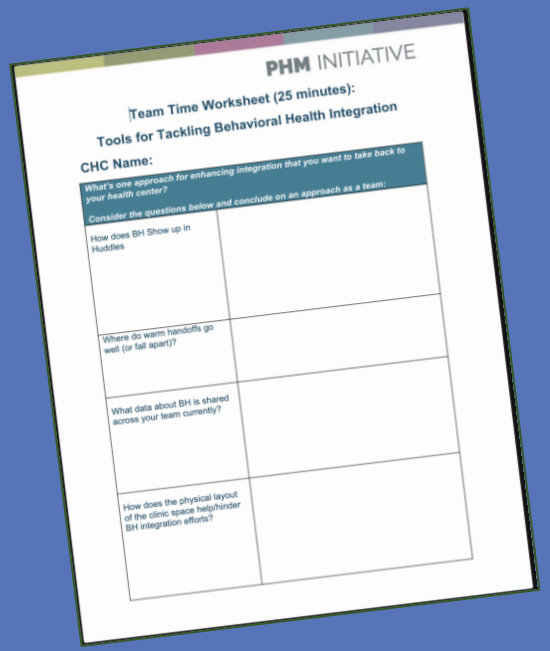
Do you have a process for warm handoffs for a hybrid team?

What's your process?

Tools for Operationalizing Your Vision of BH Integration

Huddles (AM & Mini)	Integration Approaches	Scheduling
Physical Layout	Expansion of BH Service Range	Depression Screening Workflow

Team Activity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Team Time Worksheet (25 minutes):

Tools for Tackling Behavioral Health Integration

CHC Name:

What's one approach for enhancing integration that you want to take back to your health center?

Consider the questions below and conclude on an approach as a team:

How does BH Show up in Huddles	
Where do warm handoffs go well (or fall apart)?	
What data about BH is shared across your team currently?	
How does the physical layout of the clinic space help/hinder BH integration efforts?	

25 Minutes

Team Activity

Step 1: Assemble with your team.

Step 2: Discuss what integration could look like at your CHC using the discussion questions provided in the worksheet.

- **Main question:** What's one approach for enhancing integration that you want to take back to your health center?
    - Example: "We want to develop a protocol for follow-up to PHQ9 results that is standardized."

Pair & Share

Peer Sharing & Feedback

25 Minutes

Activity:
Pair & Share

Purpose: Share your team's ideas, get fresh perspectives and spark new thinking.

Instructions:

- Pair up with your assigned team.
- Take turns sharing what your team discussed during "team time."
- Use the prompts on the worksheet to guide your conversation.
- When the exercise is concluded, we will meet back in the main room

Tools for Tackling Behavioral Health Team Time Room Assignments and Pair Share

Assigned Room	CHCs	Pair and Share Facilitators
Main Room	Park Tree Community Health Center	Lindsay Lozada Dietz
	San Fernando Community Health Center	
	Comprehensive Community Health Centers	Roseanne Ibarra
	APLA Health	
	East Valley Community Health Center	Denise Armstorff
	Valley Community Health Care	
East Ballroom	UMMA Community Clinic	Claire Richardson
	Saban Community clinic	
	Northeast Valley Health Corporation	Emma Ansara
	Asian Pacific Health Care Venture	
Director Room	Eisner Health	Roza Do
	Universal Community Health Center	
	Via Care Community Health Center	Paige Nichols
	Venice Family Clinic	

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Wellness Moment

Break

15 Minutes

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Responding to Health-Related Social Needs

Robin Haller

PHMI Social Health SME

She/Her

Objectives:

Responding to Health-Related Social Needs

By the end of this session, you will be able to:

1. Identify next steps for advancing along the PHM social health framework
2. Discuss ways that peer organizations are developing partnerships to respond to health-related social needs
3. Identify the resources available for connecting patients to housing-related supports in the LA region

Panel Participants

Jackie Provost

Saban Community Clinic

Arnali Ray

Hollywood Food Coalition

Alex Sato

The Center in Hollywood

Carly Goldblatt

Health Net

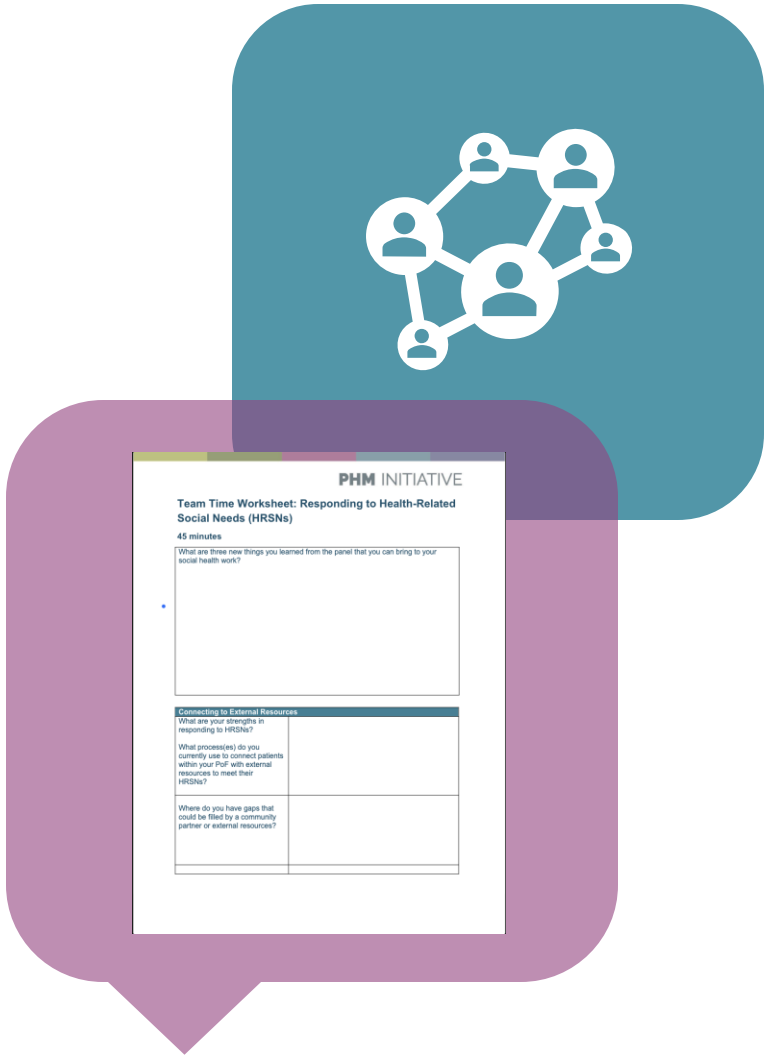
Matilde Gonzalez-Flores

L.A. Care

Moderator: Fiona Donald - PHMI SME

Team Time

- Join your team in your assigned breakout room and use the "Responding to Health-Related Social Needs" worksheet to guide your conversation.
- Panel speakers will circulate between groups to answer questions.
- Coaches will join you (and may circulate if they have multiple teams).
- Completing this worksheet will advance your work on the social health foundational competency by documenting your current approach and identify next steps for progress.
- At the end of the session, you will share an "ah-ha" or a next step that you identified with the other teams in your breakout room.



45 minutes

Responding to Health-Related Social Needs
Team Time Breakout Rooms & Pair Share Assignments

Assigned Room	CHCs	Group Share Facilitators
Main Room	Park Tree Community Health Center	**Lindsay Lozada Dietz**
	Universal Community Health Center	
	East Valley Community Health Center	
	APLA Health	
	Comprehensive Community Health Centers	
	Valley Community Health Care	
East Ballroom	UMMA Community Clinic	**Robin Haller**
	Northeast Valley Health Corporation	
	Saban Community clinic	
	Asian Pacific Health Care Venture	
Director Room	Eisner Health	**Roza Do**
	San Fernando Community Health Center	
	Via Care Community Health Center	
	Venice Family Clinic	

45 minutes

Wellness Moment

Lunch

- Served in the foyer
- Please connect with **Amy Bourmatnov** if you have any dietary restrictions.
- Please return to the Main Room by **1:45pm** for a group photo! 😊

60 Minutes

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Using Storytelling to Sustain and Spread Your PHM Work

Today's Facilitators

Stacey Moody

She / Her

PHMI SME

Fiona Donald

She / Her

PHMI SME

Objectives:

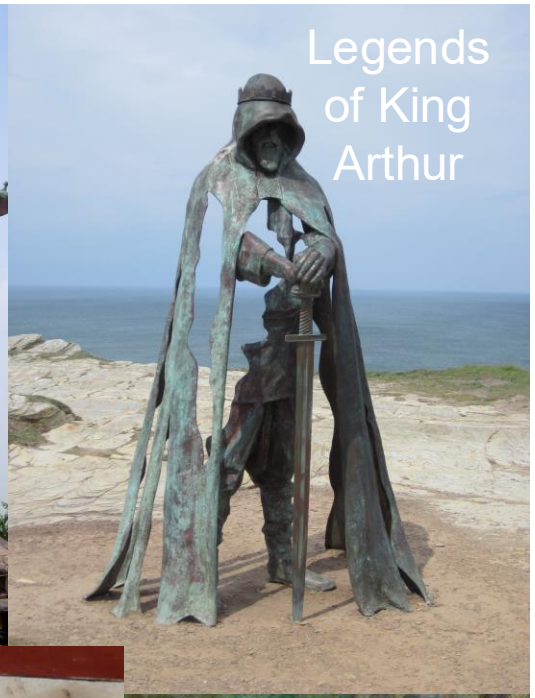
Using Storytelling to Sustain and Spread Your PHM Work

By the end of this session, you will be able to:

1. Describe how storytelling can reinforce and normalize organizational change
2. Apply a simple method to craft a compelling story about the impact of your population health management efforts
3. Begin developing an impact story to share with leadership, care teams, patients, and managed care plans
4. Identify how this story fits into the broader sustainability planning and next steps


Lascaux
Cave


Hanuman

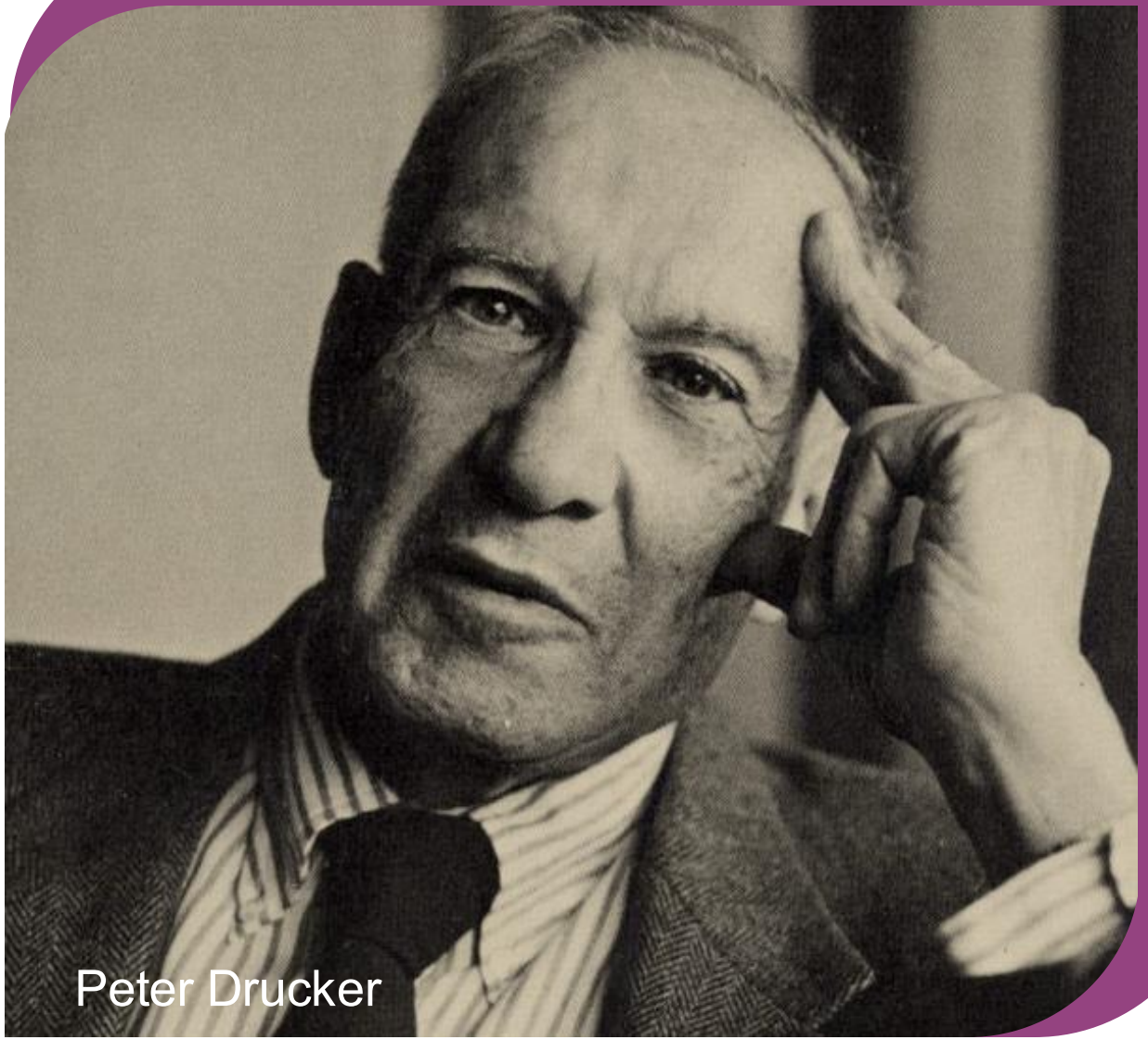

Legends
of King
Arthur

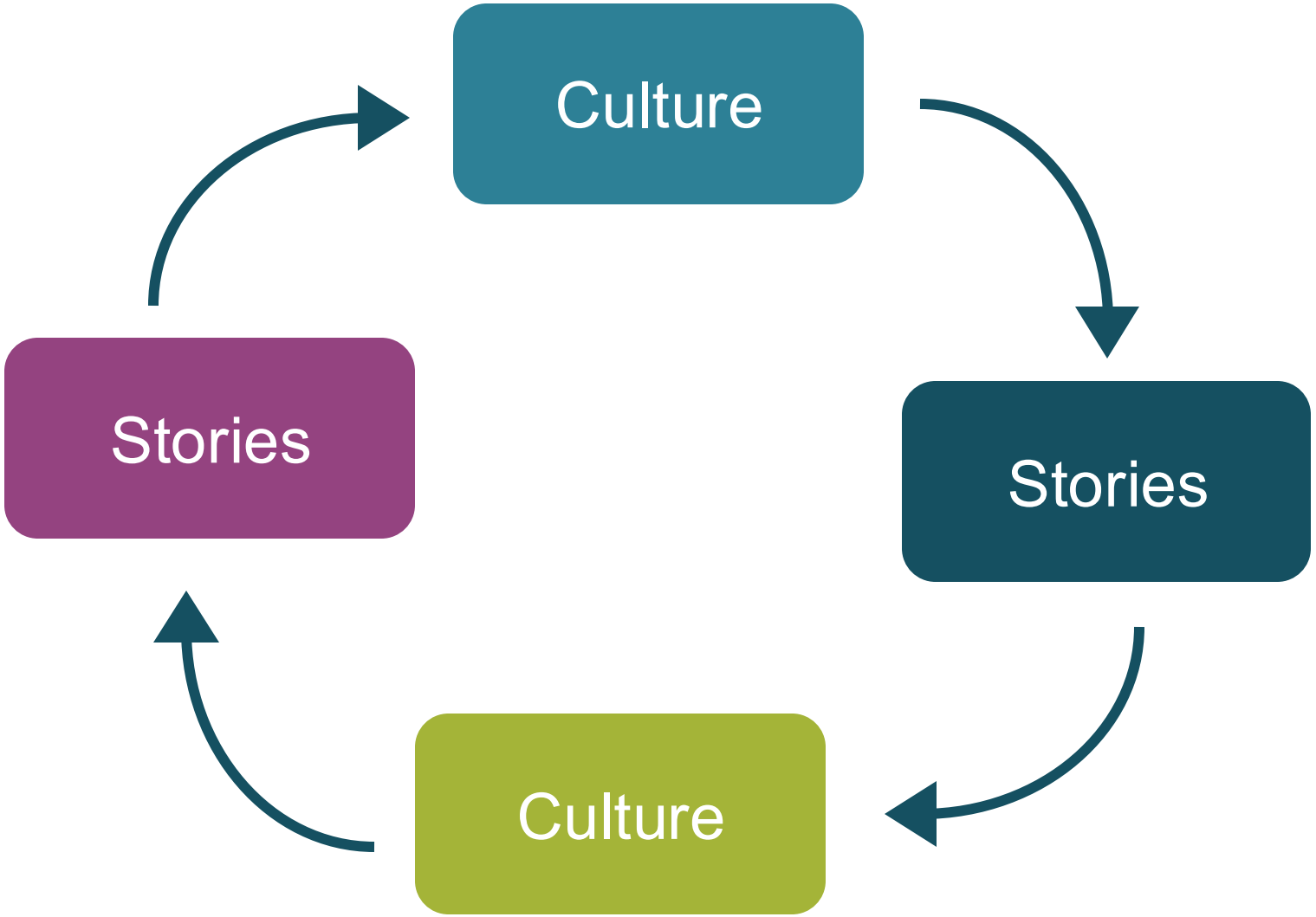

Vine
LinkedIn
Facebook
YouTube
Tumblr
Twitter
Instagram
Google+


Maya Hero Twins


Anansi

“Culture eats strategy for breakfast.”



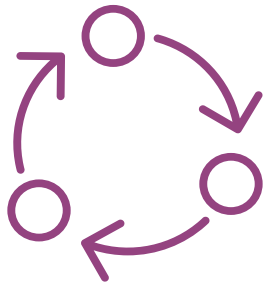

Culture
Stories
Culture
Stories

Why are stories essential for population health?

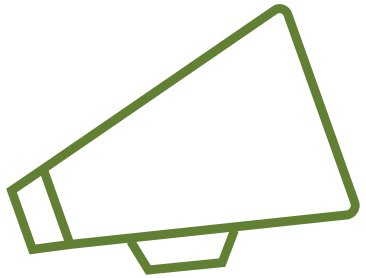
Tell stories to create culture

CLARIFY
what's most worth sustaining

BUILD
buy-in and momentum



AMPLIFY
case for continued support



Learning From the Masters: Pixar

Story Scope

Activity 1: Part I

24 Minutes

Reflect on Key Moments

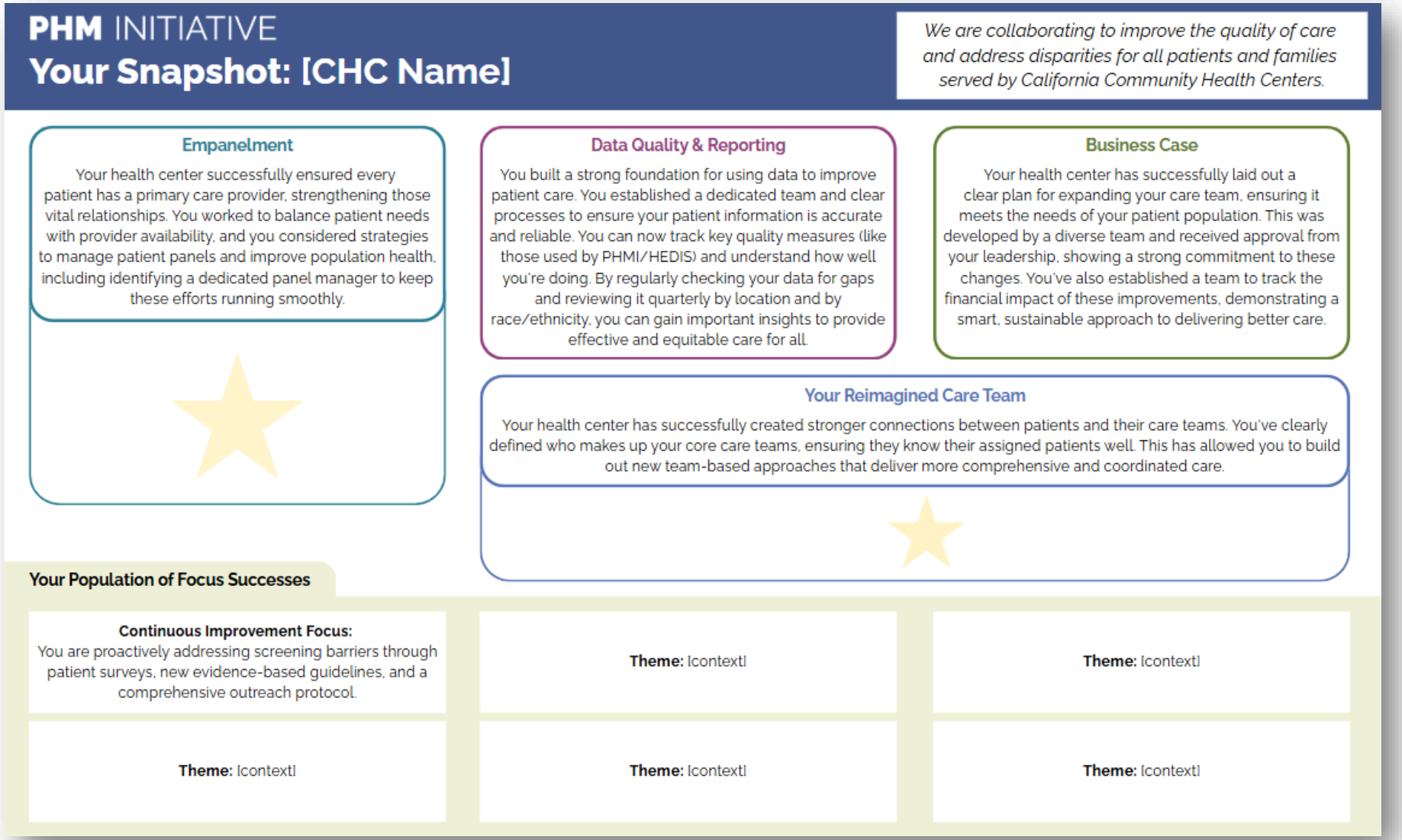
Review your CHC's Snapshot.

- Notice which meaningful **changes in behavior, interactions, collaboration or outcomes** stand out to you.
- Consider both the big milestones and small but powerful shifts.

Select one story idea

- As a team, choose one story idea to develop further.
- It should be authentic, impactful and make you feel something.

CHC Snapshot



PHM INITIATIVE

Your Snapshot: [CHC Name]

We are collaborating to improve the quality of care and address disparities for all patients and families served by California Community Health Centers.

Empanelment

Your health center successfully ensured every patient has a primary care provider, strengthening those vital relationships. You worked to balance patient needs with provider availability, and you considered strategies to manage patient panels and improve population health, including identifying a dedicated panel manager to keep these efforts running smoothly.

Data Quality & Reporting

You built a strong foundation for using data to improve patient care. You established a dedicated team and clear processes to ensure your patient information is accurate and reliable. You can now track key quality measures (like those used by PHMI/HEDIS) and understand how well you're doing. By regularly checking your data for gaps and reviewing it quarterly by location and by race/ethnicity, you can gain important insights to provide effective and equitable care for all.

Business Case

Your health center has successfully laid out a clear plan for expanding your care team, ensuring it meets the needs of your patient population. This was developed by a diverse team and received approval from your leadership, showing a strong commitment to these changes. You've also established a team to track the financial impact of these improvements, demonstrating a smart, sustainable approach to delivering better care.

Your Reimagined Care Team

Your health center has successfully created stronger connections between patients and their care teams. You've clearly defined who makes up your core care teams, ensuring they know their assigned patients well. This has allowed you to build out new team-based approaches that deliver more comprehensive and coordinated care.

Your Population of Focus Successes

Continuous Improvement Focus:
You are proactively addressing screening barriers through patient surveys, new evidence-based guidelines, and a comprehensive outreach protocol.

Theme: [context]

Theme: [context]

Theme: [context]

Theme: [context]

Theme: [context]

Story Scope

Activity 1: Part II

10 Minutes

Identify Potential Story Ideas

Write down potential story ideas on the sticky notes (one idea per sticky). Use these questions to guide your brainstorm:

1. When we joined this initiative, what was the **health problem** we were trying to solve? What was the **human impact** of the problem?
2. What **meaningful changes in behavior, interactions, collaboration, or outcomes** stand out to you as a result of implementing population health management?
3. What felt like a **breakthrough** or **turning point**?

Bring in the Human Perspective

Activity 2

1. **Identify the Main Character**
2. **Identify their Problem**
3. **Bring in the Human Perspective**
4. **Connect to Impact**

20 Minutes

Share & Reflect

Peer Sharing & Feedback

Activity 3

24 Minutes

Pair Up With Another Team

Share your story idea and why you are excited about this story.

Give & Receive Feedback

- What resonated most?
- What felt unclear or missing?
- How could this be tailored for leadership, patients or MCP?

Story Telling Team Time Room Assignments

Assigned Room	CHCs
Main Room	APLA Health
	Comprehensive Community Health Centers
	East Valley Community Health Center
	Park Tree Community Health Center
	Northeast Valley Health Corporation
	Saban community clinic
East Ballroom	Eisner Health
	San Fernando Community Health Center
	Valley Community Health Care
	UMMA Community Clinic
Director Room	Asian Pacific Health Care Venture
	Venice Family Clinic
Writer Room	Universal Community Health Center
	Via Care Community Health Center

Next Steps - Sustainability

You've started a powerful story – now let's plan what comes next.

1 **Develop, Refine, Tailor and Share Your Story**

- Keep using the impact storytelling worksheet to flesh out your story.
- Use the Pixar Story Spine to make it crisp.
- Think about how you can work with your coach to refine your story.
- Discuss how you can use your story to shape resource allocation and organizational commitments.

2 **Identify PHM Approaches To Sustain**

- Work with your coach to identify which PHM strategies and innovations are your priorities.
- Build agreement among your team and leaders about which PHM strategies should be sustained beyond the project.

3 **Develop Your Sustainability Plan**

- Work with your coach to create a sustainability plan using the *Sustainability Planner Tool.*
- Share and discuss the sustainability plan with your health center leaders.

Create a Crisp and Compelling Story

Watch to learn more:
https://www.youtube.com/watch?v=tkWK7QBq6Ik

Next Steps – Story Spine

Use a Story Spine to Tighten Your Narrative

- **"Once upon a time…"**
  (Set the scene – what was the context?)
- **"Every day…"**
  (Describe the usual way things were – the status quo and the problem they were facing.)
- **"But one day…"**
  (What challenge or shift occurred?)
- **"Because of that…"**
  (What action did your team or character take?)
- **"Until finally…"**
  (What changed or was achieved?)
- **"And ever since then…"**
  (What's the lasting impact or insight?)

Closing

Wrap Up & Next Steps

Action Items

1. We've captured all worksheets, shared challenges and promising practices and identified critical areas for support.

2. Coaches and SMEs will follow up with each of you to offer tailored support and guidance on addressing these challenges.

Resources

3 **PHMI Portal**

Log into the portal to access all the handouts from today's event!

4 **CEUs**

If you indicated on your registration that you would like to earn CEUs for this event (nursing, physician or CPPS), instructions on how to claim credits will be emailed to you by the end of the week. Participants seeking CEUs 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.

PHM INITIATIVE

How did we do?

Please take the next couple of minutes to fill out the evaluation form using the QR code or the form

Note that if you requested to receive CEUs for this event, you can complete this form online as part of the CEU process (you will be asked the same questions).

5 minutes

Closing

Thank you!