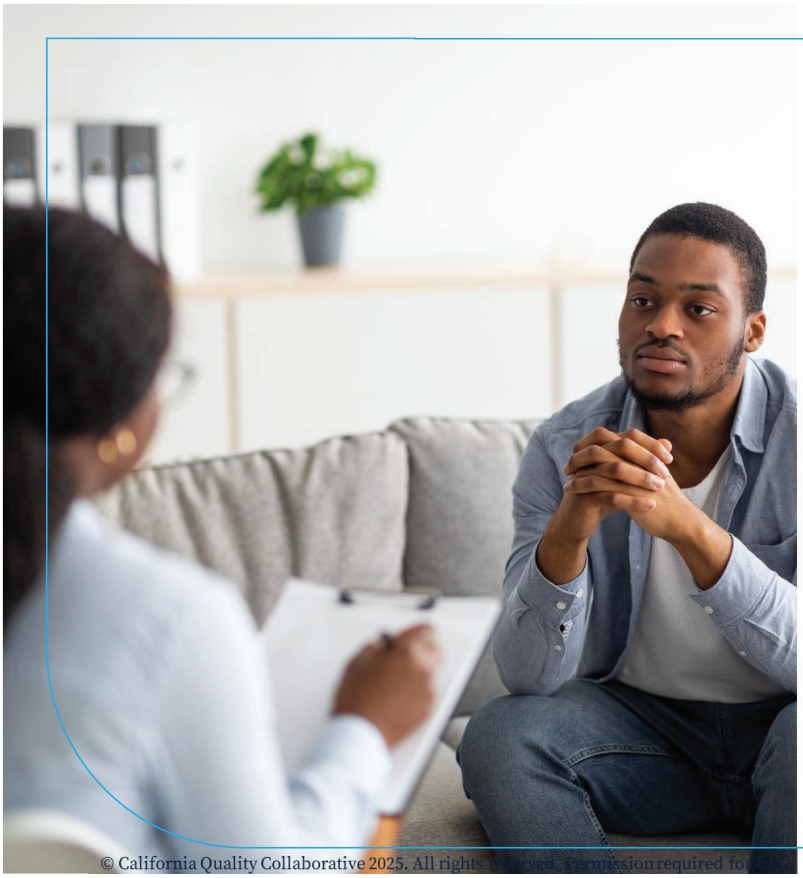
As you get settled, we invite you to reflect on two sticky notes

- **What are you most proud of in CalHIVE BHI to date?**
- **Where do you see your BHI program by 2026?**

California Quality Collaborative



Tuesday, May 13, 2025

2025 CalHIVE BHI Convening

Successes, Systems & Sustainability

California Quality Collaborative

Welcome CalHIVE BHI Teams!
Celebrating Your Vision for BHI

POMONA VALLEY HOSPITAL MEDICAL CENTER

To provide sustainable integrated behavioral health care to meet the needs of every patient.

Community Memorial HEALTHCARE

Every patient is seen, heard, and offered compassionate, culturally sensitive, and holistic guidance for their mental health journey.

Riverside Family Physicians

To foster a culture that embraces continuous improvement and positive changes on improving patient and staff well being.

SHARP

The best place to start and support your journey to happiness.

CHINESE HOSPITAL & CLINICS

Is dedicated to build a culturally and linguistically competent behavioral health center to lower the barriers for our community in accessing behavioral health care.

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

To promote and support the well-being of all SFHN Patients through seamless care team collaboration.

Scripps

Bringing comprehensive, compassionate and supportive behavioral health to southern California today, tomorrow, and forever forward.

perlmanclinic

Every patient deserves access to appropriate resources driven by evidence-based care. To build systems that enable PCP's to confidently care for those with behavioral health needs that impact their overall wellbeing.

Invitations to Connect Today

CalHIVE BHI Values

1. Collaboration around a common goal
2. Trust & transparency
3. Reflect, revise & adjust

Take care of yourself

Ensure space for all voices

Disconnect and **re-connect**

Capture some joy!

Housekeeping & Logistics

Logistics

- Restrooms
- Meals
- Parking
- Photographer
- Awards

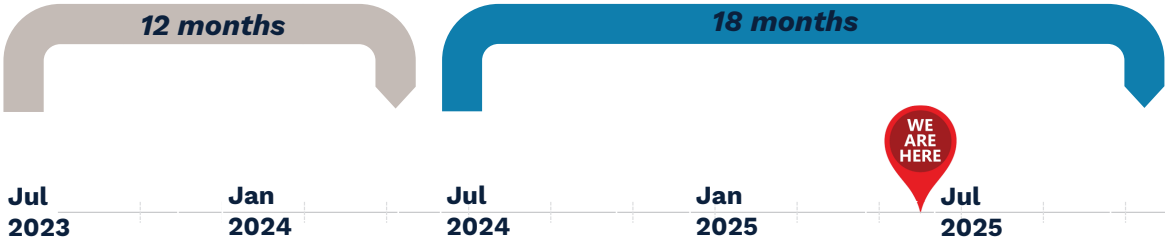
Materials

- Workbook & Handouts
- Event Evaluation
- Materials on CalHIVE BHI website

Today's Agenda

Timing	Session
8:00 a.m. – 8:30 a.m.	**Breakfast**
8:30 a.m. – 9:00 a.m.	Welcome: Where We've Come, Where We're Going
9:00 a.m. – 10:30 a.m.	BHI Pilot Site: Bright Spot Sharing
10:30 a.m. – 10:45 a.m.	Systems Level Implementation
10:45 a.m. – 10:55 a.m.	**Break**
10:55 a.m. – 12:15 p.m.	BHI Implementation – What Now?
12:15 p.m. – 1:15 p.m.	**Lunch & Networking**
1:15 p.m. – 2:15 p.m.	Sustainability
2:15 p.m. – 3:15 p.m.	Behavioral Health Equity Improvement Plan (BHEIP): Small Tests of Change
3:15 p.m. – 3:25 p.m.	Reflections & Commitments: Looking Ahead to 2026
3:25 p.m. – 3:30 p.m.	Closing & Award Ceremony

Sustainability Plan – 2026 CalHIVE BHI Deliverable



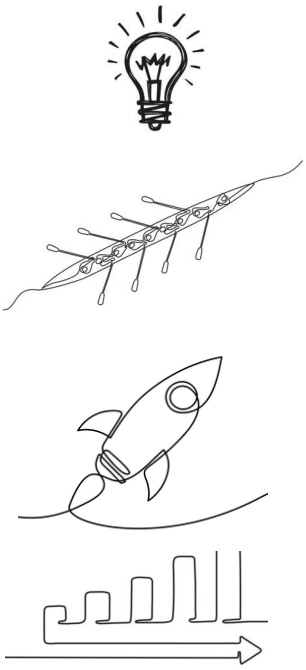
PREPARE

- Build team
- Readiness assessment & recommendations
- Select integration model and pilot site
- Report and analyze BH screening data

IMPLEMENT

- Implement care model at pilot site
- Adopt clinical, data, operational workflows, including training
- ***Make improvements!***
- Analyze and improve patient engagement
- Create Behavorial Health Equity Improvement Plan

Successes, Systems & Sustainability



By the end of today, we hope you will have…

- **Presented** successful BHI practices
- **Analyzed** data trends from pilot site measures (process and financial)
- **Identified** continued improvement opportunities to integrate behavioral health into primary care
- **Co-designed** CalHIVE BHI sustainability plan
- **Evaluated** small tests of change and identified opportunities to enhance Behavioral Health Equity Improvement Plan
- **Celebrated** cohort success

Thank you! From the CalHIVE BHI Team

Peter Robertson
Senior Director, Practice Transformation
Advisor

Kristina Mody
Director, Practice Transformation
CalHIVE BHI Director/ Improvement Advisor

Mary Nickel-Nguy
Senior Manager, Behavioral Health Integration
Improvement Advisor

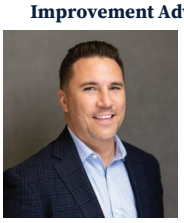
Daniela Vela Hernandez
CFHA Technical Assistance Associate
Improvement Advisor

Jose Ordonez
Manager, Data Analytics
Data Lead

California Quality Collaborative

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Erika Lind
Manager, Care Transformation Events and Learning



Brian Sandoval
Clinical Advisor, BHI Integration

Anna Baer
Program Coordinator, Care Transformation
Event Manager

California Quality Collaborative

BHI Pilot Site: Bright Spot Sharing

Anna Baer

Daniela Vela Hernandez

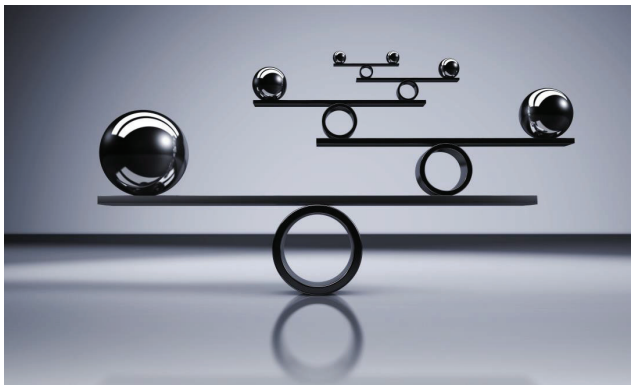
What Makes a Good Training?

Take a few moments to reflect with your team around you.

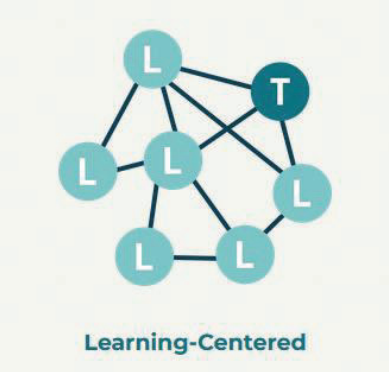
What makes a good training?

Consider:

- What elements it may use to convey teachings
- Techniques and tools



Learner Centered Design



▶ ***Learn more:***

- Global Learning Partners

Bright Spot Sharing

We are ready to learn your **integration successes and bright spots!**

Each team will share for **6 minutes.**

During the presentations, use **Post-it notes** at your table to write down at least **one question** to ask during small discussions.

After the presentations, we will create **discussion groups** to ask questions from other teams

Sharp
PHQ-9 Pre-Screening QI project

Community Memorial
Community Health Workers

Scripps
Provider Engagement

Riverside
Community Engagement

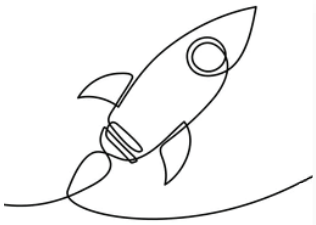
Chinese Hospital
Launching CoCM program internally

Pomona Valley
Billing lessons learned

Perlman Clinic
Virtual patient visits & leveraging patient portal

SFHN
BHI Workflows (with multiple disciplines)

Voting | Most Improved and Most Impact



Most Impact

Pink Card

Most Improved

Blue Card

Reminders:

Consider creativity!

Don't vote for your own team

California Quality Collaborative

DEPRESSION SCREENING OPTIMIZATION

Sharp Rees-Stealy

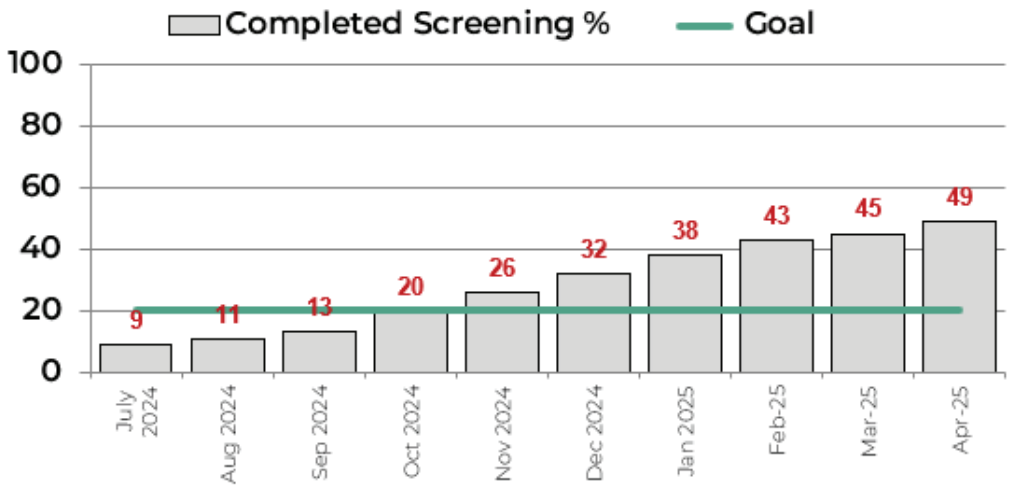
SHARP

1 Sharp Rees Stealy: Where We Started

- At the start of out project in July 2024, our pilot site Depression Screening (PHQ9) rate was at **9%**
- We implemented a Green Belt project with a goal to increase the rate to **20%**
- The patient rooming process was identified as a key factor in screening inconsistencies
- Standard rooming process created with education and accountability
- We enhanced processes utilizing Epic pre-screening capabilities
- Current screening rate is at **49%**

Progression of Manual Screening
Sharp Rees Stealy

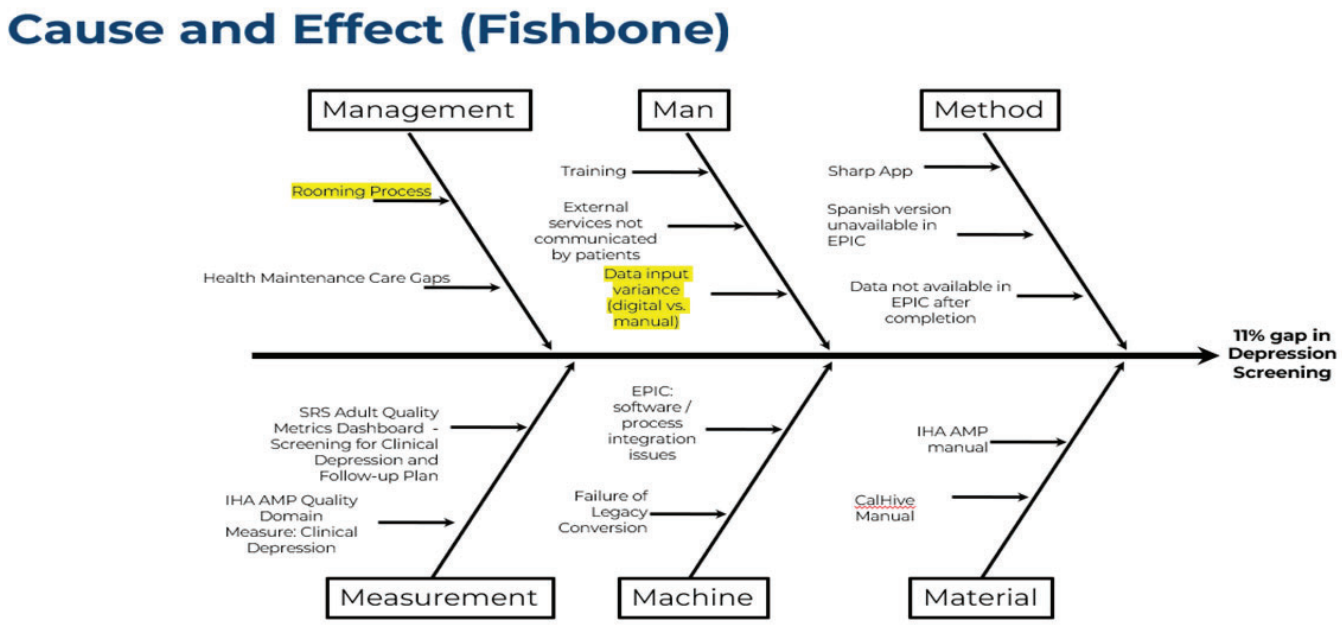
Screening for Clinical Depression and Follow-up Plan:
Pilot Site HMO patients



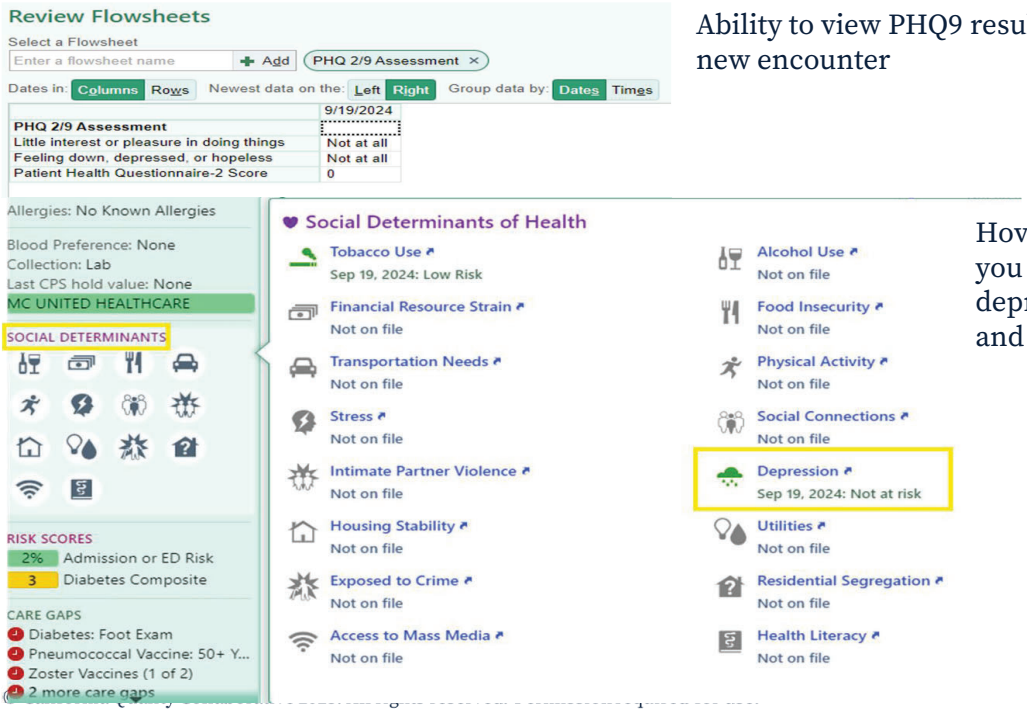
2 Sharp Rees Stealy: Challenges We Faced

- Medical Assistants (MAs) did not have a standardized process – varied by MA, LVN, RN, PCP
- Variance in data collection and entry – some MAs were directly inputting data into Epic. While others were using pen and paper and faxing info
- The end goal is to screen 100% of patients coming in to see PCPs

Waste Walk Results
Sharp Rees Stealy



Epic Optimization Highlights
Sharp Rees Stealy



Ability to view PHQ9 results without having to create a new encounter

Hovering over the Storyboard allows you to quickly view date that depression screening was completed and whether patient is at risk

3 Sharp Rees Stealy: How You Can Do It Too!

- Identify why the main issue is occurring (5 Whys)
- Once issue is identified, process of standardization can be implemented using personal or technology
- Waste walk is a simple yet effective tool to identify gaps and why specific issues are occurring
- Optimize your EMR (Epic) reporting tools, auto-send to My Sharp App (Dr. Clark)

California Quality Collaborative

Community Health Workers

Riverside Family Physicians

Riverside Family Physicians

1 Riverside Family Physicians: Where We Started

- Riverside Family Physicians Established in 1999
- Multi-site primary care practice in Riverside County
- 2019 – Partnered with IEHP to implement the Health Homes Program
- 2021 – Partnered with IEHP to implement Enhanced Care Management (ECM); a broader population health strategy design within CalAIM

1 Community Health Workers Riverside Family Physicians

- Community Health Worker (CHW): a frontline public health worker who is a trusted member of the community they serve. This trust allows them to act as a bridge between health or social services and the community, helping to improve access to services and the quality of care.
- We currently have 8 CHWs and serve 900+ patients.
- CHW function:
  - Care Coordination
  - Outreach
  - Coaching
  - Resources

Dr. Paik and the ECM team provide total patient care to homeless individuals at a local church

2 Riverside Family Physicians: Challenges We Faced

- Lack of clarity surrounding the role of Community Health Workers (CHWs), which created confusion among staff and affected program implementation.
- We initiated monthly meetings with IEHP to provide ongoing education and support, helping staff gain a clearer understanding of the CHW role and the goals of the program.
- We are actively exploring opportunities to strengthen partnerships with community organizations to expand our reach and better support the needs of our patients.

3 Riverside Family Physicians: How You Can Do It Too!

- **Collaborate with MCPs (Managed Care Plans)** to align goals, share resources, and improve patient care.
- **Continue to engage senior leadership** to understand and value CHW efforts and guide organizational change.
- **Foster teamwork** by valuing input from all levels.
- **Provide ongoing training** to keep CHWs skilled and confident.
- **Use analytic platforms** to identify target populations and measure outcomes.

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Provider champions and provider engagement

Scripps Health

Scripps

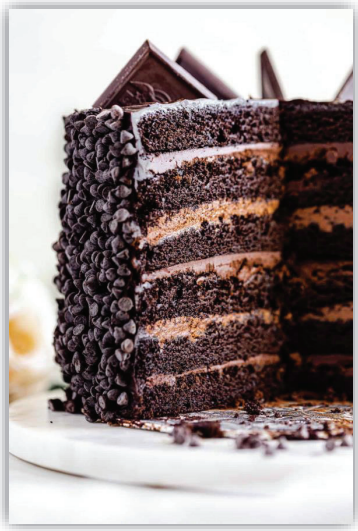
1 Scripps Health: Where We Started

- Started from nothing
  - No Behavioral Health team support
    - No social workers, therapists, case workers
  - Peds had 1 PA with psych training
- Limited resources for patients
  - Included handing out phone numbers for therapists, difficulty maintaining up-to date resources, unknown insurance coverage
- Internal vs External program?

Bright Spots
Scripps Health

Leadership Buy-In

- Support from clinical leaders helped prioritize integration
- Provider 'champions' boosted leader & staff engagement



Bright Spots
Scripps Health

Role Clarity & Accountability

- External vendor selection
- Cross-departmental collaboration
- Defined team roles for behavioral health workflows

Consistent Screening Practices

- Leveraging existing EHR systems: Routine PHQ-9, available GAD-7
- EHR prompts + clinician scripts = higher completion rates

Bright Spots
Scripps Health

Program Launch

- Created BHI training modules
- Departmental CoCM Launch
- Patient-facing communications, SMS

Ongoing Communication

- Process improvement meetings with all team members
- Keeping all "layers" up to date

Data to Drive Change

- Dashboards tracked screening/follow-up rates
- Used for feedback, planning, and celebrating wins
- Goal is to be financially sustainable

3 Scripps Health: How You Can Do It Too!

- Scripps Health has a dyad team structure
  - Culture encourages working as a team
- Looking for physician champions that recognize the value of BHI
  - Reduce stigma attached to behavioral health care
- Created a team to support the behavioral health needs of our patients
- Working from a true Preventative Care perspective instead of Reactive Care
- Transparent communication of what BHI entails

California Quality Collaborative

Community Health Worker Development

Community Memorial Healthcare

Community Memorial HEALTHCARE

1 Community Memorial: Where We Started

- CMH never had Community Health Workers (CHW)
- CMH received the Gold Coast Enhanced Care Management (ECM) Contract which launched the development of CHW's.
- Created Job Descriptions; Posted internally and externally
- Hired 3 CHW's starting in December 2024
- Candidates are a combo of MA's, Schedulers, and those with lived experience
- Bright Spot – 3 of the CHW's have been internal candidates and internal experiences help.
- Easy to engage leadership for positions as the cost is less and we are training them thanks to the grant we got.

2 Community Memorial: Challenges We Faced

- Challenges – Early On in the development
  - Lack of mental health training with extremely vulnerable patients – our highest risk patients in the health system.
  - Security, safety, and lack of being in the "field". We had to mitigate security and safety trainings
  - Lived experience doesn't mean that they know how "to do" behavioral health with highly complex patients.
- How did you overcome the challenges of working with our highest risk patients? – Hired an outstanding LCSW and 2 more seasoned MSW's.
  - Received the mental health training through CQC to help our CHW's. This has been GREAT for them and they are growing in their skill set.
- What are some aspects of the topic you are still looking to improve?
  - We need to provide CHW's ongoing trainings.
  - We want to empower them in their current roles and give them opportunities for growth.

3 Community Memorial: How You Can Do It Too!

- What are the key steps other organizations need to take to find the same success?
  - Consider MSW staff who can supervise the CHW's
  - Find a grant that can help create a base and foundation for CHW development and include training.
  - Get a grant for Training – the training of our CHW's has been invaluable and they all have grown a lot because of it (training through CQC).
- What are the most important takeaways organizations should be thinking about?
  - We created teams to work in Triads – RN/MSW/CHW so they can feel more confident in working with these challenging patients. They go to team leader LCSW with medical social work in ED and knowledge of staff is incredible.
  - HIRE the right people! Take the time to do thorough background checks and reference checks. Give them hard scenarios to have to think about and what they would do.
  - Created "swim" lanes so each discipline is knowledgeable about who should do what. Train however on all things – suicide calls, substance use, trauma informed treatment etc.

Community Memorial: Entire team including CHW's, Social Workers, LMFT, LVN's, RN's!

California Quality Collaborative

Building & Scaling CoCM – A Ground-Up Approach

Chinese Hospital & Clinics

CHINESE HOSPITAL & CLINICS

1 Where We Started

2023 – 2024

Planning & Design

- Choosing a model
- Recruiting the right team
- Data measures
- Developing workflow
- Setting up billing codes

June 2024

Program Launch

- Jun – Sep 2024: 9 total enrollees
- Low referral rates
- Provider and staff engagement
- Claims denials: active tracking and communication with individual payer

December 2024

Midpoint Report

- Dec 2024: 29 total enrollees (18 active)
- Patient graduating from CoCM or got connected to specialty care
- Tightening workflow: referral management

April 2025

Current State

- Apr 2025: 45 total enrollees (24 active)
- Scaling & expand
- Recruiting new BHCs - lay counselor trainings
- Exploring: psychiatrist direct counseling

2 Challenges We Faced

Reimbursement and Claims Management
- Rapidly evolving reimbursement policies
- Intensive follow-up required to secure patient

Registry Tracking
- Difficulty maintaining updated registry as panel size grows
- Tracking of patient outcomes and billing data

Provider & Staff Engagement
- Sustained engagement needed across care teams
- Ongoing communication and visibility into program outcomes

Workflow
- Documentation of referrals workflows
- Behavioral health care manager staffing

Resources Constraints
- Limited availability of in-network behavioral health clinicians

3 How You Can Do It Too!

Secure Stakeholder Buy-In

- Senior/clinical leadership to champion the program

Clear Operational Workflow

- It should be easy and straightforward
- Create communication loops for treatment adjustments

Understand the Billing Structure

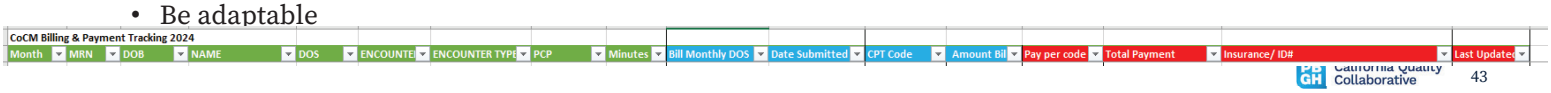
- Billable CPT codes and their documentation and time requiremen
- Know your contacts for major insurance payers

Structured Meetings

- Huddles to align on barriers, metrics, and patient progress. Show your impact.

Key Takeaways

- Start small with a pilot panel to test workflow and refine
- Track metrics that matter: patient outcome, revenue captured, patient satisfaction, care team experience
- Be adaptable



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BHI FINANCIAL SUSTAINABLITY

Pomona Valley Health Center

POMONA VALLEY HOSPITAL MEDICAL CENTER

1 Where We Started

- In October 2023, Debra the Director of Billing joined the CalHIVE team
- In July 2024, BHI program launched the planning phase
- In January 2024, Dr. Blocker got credential with Medicare first time to have a BHI provider credentialed in their system
- In Spring 2024, a consultant was brought in to refine BHI workflows and documentation
- In June 2024, Dr. Blocker was credentialed with Medi-Cal and BHI workflows and guidelines were drafted
- In August 2024, BHI CPT codes were upload to EHR
- In September 2024, first BHI billing was dropped
- In October 2024, refined BHI templates for BH provider

Key stakeholders involved in the initiative include the Credentialing department, Billing department, ambulatory staff, leadership team, and documentation consultant.

2 Challenges We Faced

- The biggest challenges we faced were credentialing, educating Billing department staff, and navigating the complexities of an IPA structure.
- We had a knowledgeable team member in the Billing department with prior experience in behavioral health billing, which allowed for effective staff training and education. Additionally, leadership brought in a consultant to refine workflows and establish clear guidelines, ensuring a smoother implementation. Dr. Blocker played a key role in this process, providing essential clinical guidance to support integration efforts.
- We continue working on expanding credentialing with commercial and managed care plans to strengthen access and sustainability.

3 How You Can Do It Too!

- Dedicate resources and manpower to developing and process improving your BH revenue cycle. Cross department collaboration. Leadership buy-in. Identifying existing knowledge from current team members and bridging the gap by reaching out to appropriate people.
- Gradual process that still require ongoing improvements. Stakeholders, processes, and meeting structures are also important. Keeping team members invested as other priorities come up.
- Find key stakeholder who know and are dedicated to the work.

perlmanclinic ++

telemedicine BHI

Background

perlmanclinic ++

Primary Care - multiple locations in San Diego, Ca.

perlmanwellness ++

Mental health therapy - virtual only.

What we had:

1

Primary Care

PCP team:

- not all comfortable with mental health needs.
- difficulty referring patients for mental health.

2

Mental Health

Therapy team:

- not an option for all patients.
  - insurance
  - access
  - patient ideals

3

UCSD

UCSD psych team:

- UCSD patients and PPO
- Access issues
- not an option for all patients
- UCSD ⟶ MPC

Determine Coaching Staff

Using therapist team members that are already on board with Perlman Clinic.

This meant Telemedicine only.

Training Coaches

We determined what training would be most appropriate based on their own experience.

Adjust EMR Workflow

Key Principals

Billing Training

Create Training Material

Challenges

Encouraging Referrals and Scheduling

1. One on one training in offices
   a. Difficult to manage
   b. Slow progress
2. Education on “Coaching” - Quick
   a. MA training
   b. Provider training
3. MA Scheduling
   a. Difficult to ensure was done

Challenges

- Great Feedback from PCP - liked the idea
- Not easy to recall when needed
- MA team didn’t schedule the appointments often
- Pilot site was unsuccessful
- Coaching team transitioned to Mental Health Therapy
- Therapists not knowledgeable with health Dx

Solving Problems:

1. Additional training and materials for the coaches
    a. Still therapists
    b. Don’t need to transition patients to mental health therapy
2. Expand to all clinics
    a. Medical Assistant Training
    b. Easy and familiar order for provider staff

Old Workflow

1. **Provider sees patient & determines coaching would be beneficial**
2. **Provider informs MA that visit is needed (attempted warm-hand off)**
3. **MA schedules the patient with Coaching staff**
4. **Coaches see patient**

New Workflow

1. **Provider sees patient & determines coaching would be beneficial**
2. **Provider places referral for internal Coaching**
3. **Wellness support team reaches out to patient to schedule**
4. **Coaches see patient**

Still working on:

- focus on feedback
- tools for PCP care team and coaching team
- education for patients
- whole team understanding

Recap:

We are able to offer “coaching” to patients right now

It is difficult to ensure staff utilize new orders, tools and referrals – break their workflow and rebuilding it

Coaching staff are still therapists

California Quality Collaborative

TOPIC:

Weaving several disciplines into BHI workflows, tailoring for clinic needs.

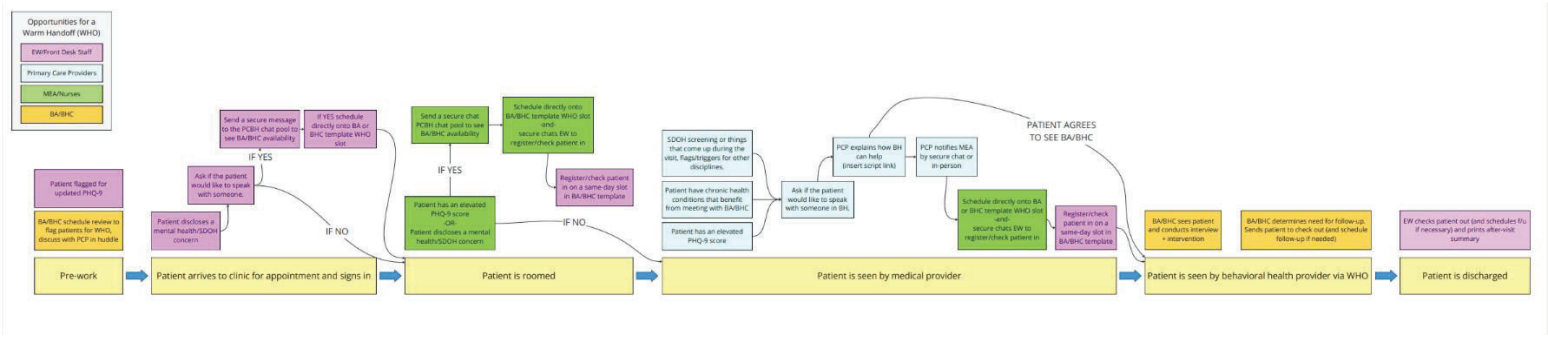
San Francisco Health Network

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

1 Where We Started

- Background/where the team started: **BH was operating as a separate department within PC clinics.**
- How we rolled out the changes:



2 Challenges We Faced

- Challenges we faced: **Medical and Behavioral Health Provider buy-in at pilot clinic, especially around co-location.**
- How we overcame challenges and solved issues:
  - **Incorporated feedback into Standard Work**
  - **Readiness rubric to determine next wave of clinics**
  - **Front line champions**
  - **Support of advisor**
- What we are still looking to improve:
  - **Gatekeeping from some medical providers.**
  - **Creating a process to audit SW on a regular basis and incorporating changes**

3 How You Can Do It Too!

- **Ensure alignment on the vision across key stakeholders.**
- **Obtain support from teams that can provide infrastructure support like IT, epic, health information management, and centralized call center.**
- **Engage front-line staff**
- **Written Standard Work for all disciplines is key**

Bright Spot | Discussion Groups

Table 1	Table 2	Table 3	Table 4
Sharp PHQ-9 Pre-Screening QI project	**Pomona Valley** Billing lessons learned	**Scripps** Provider Engagement	**Community Memorial** Community Health Workers
Perlman Clinic Virtual patient visits & leveraging patient portal	**Chinese Hospital** Launching CoCM program internally	**SFHN** BHI Workflows (with multiple disciplines)	**Riverside** Community Engagement

Pick a table to join and ask questions.

- Spread team members throughout the topics
- Feel free to move to different tables throughout the discussion.

California Quality Collaborative

Systems Level Implementation

Kristina Mody

Doing Something Bigger Together

One organization cannot move the market.

- Set the California quality agenda
- Shape alignment across partners

California Quality Collaborative (CQC)

Advancing the quality and efficiency of the outpatient health care delivery system by creating scalable, measurable improvement.

Launched in 2007, CQC is a **multi-stakeholder quality improvement program** of the Purchaser Business Group on Health.

Aligns priorities and coordinates activities across partners for greater collective impact.

Identifies and spreads best practices across the outpatient delivery system in California.

The program trains 2,000 individuals from 250+ organizations each year

CQC's track record includes **20% relative improvement** in clinical outcomes and **10:1 ROI**

Sponsors

California Quality Collaborative (CQC)

Trains **2,000 individuals from 250+ organizations** each year

Program track record demonstrates **20% relative improvement in clinical outcomes** and 10:1 ROI

Delivery System Transformation
Identifies and spreads best practices across the delivery system in California through training and coaching

Multistakeholder Alignment
Drives adoption as neutral convener consensus across partners for greater collective impact

Statewide System Transformation

Advancing the quality and efficiency of California's health care delivery system by creating scalable, measurable improvement

CQC Sponsors

Provider organizations

Purchasers

Patients

Delivery System Partners

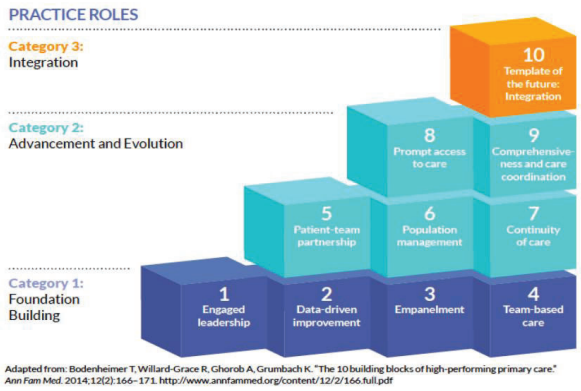
CQC Steering Committee

Key Principles of Behavioral Health Integration

1. Behavioral Health Integration is **Advanced Primary Care**

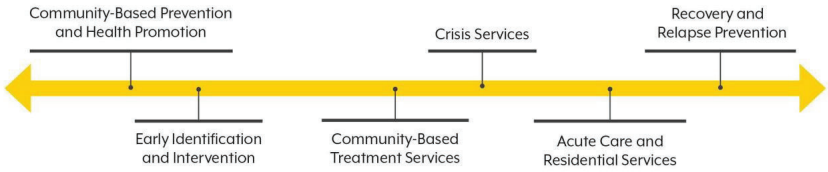
2. Behavioral Health Integration makes **behavioral health preventative**

3. Behavioral Health Integration should be your **population health strategy**



Adapted from: Bodenheimer T, Willard-Grace R, Ghorob A, Grumbach K. "The 10 building blocks of high-performing primary care." *Ann Fam Med*. 2014;12(2):166–171. http://www.annfammed.org/content/12/2/166.full.pdf

Behavioral Health Continuum of Care



▶ ***Sources:*** *Colorado State Innovation Model, Colorado Behavioral Health Administration*

California | Industry Levers for BHI

Regulatory Oversight

- California: recently implemented law (SB 1320 of 2024) requires commercial plans to "have a process to pay" for BHI, effective July 1, 2025 – **implementation guidance given in All Plan Letter (page 36)**
- California purchasers (CalPERS, Covered California) **requiring plans to demonstrate BHI support**
- California: **health plan investigations** around behavioral health (Department of Managed Health Care)

Cost & Affordability

California: Office of Health Care Affordability ongoing work

- Set statewide spending target for 2025 (not for enforcement); 2025: will set 2026 target (for enforcement in 2028) - **integrated care counts for both primary care and behavioral health investments**
- BH Investment – defining, measuring and reporting BH spending (including **defining BHI**)

Quality Measurement

California: **statewide use of Depression Screening and Follow-up for Adolescents and Adults** (DSF-E)

- IHA AMP MY 2025 - recommended Benchmarking, Payment, Public Reporting
- Medi-Cal Managed Care Accountability Set (MCAS) - MY 2025 – Reporting
- Included in OHCA Quality and Equity Measure Set

2025 CQC Behavioral Health Integration (BHI) Payer Workgroup

In 2025, CQC is convening a workgroup supporting commercial health plans to:

Collaborate with peers and BHI SMEs to facilitate BHI implementation for plans and providers

Create a network of health plan leaders ready to support BHI

Co-design documents to help ready plans and providers for BHI implementation:
- BHI FAQ for plans
- BHI Implementation Guide for providers
- BHI data request process

Participants

aetna, CVS Health, Western Health Advantage, United Healthcare, blue california, Optum, blue california Promise Health Plan, Optum, health net

▶ Sustainable Behavioral Health Integration Financing: Successful Practices & Opportunities (CQC Issue Brief, October 2024)

System-wide Integration (Gold Standard)

Coordinated		Co-Located		Integrated	
Level 1 Minimal Collaboration	**Level 2** Basic Collaboration at a Distance	**Level 3** Basic Collaboration Onsite	**Level 4** Close Collaboration Onsite with Some System Integration	**Level 5** Close Collaboration Approaching an Integrated Practice	**Level 6** Full Collaboration in a Transformed/ Merged Integration Practice

Coordinated

- BH works ***with*** primary care
- Patients perceive they are receiving care from a specialist who collaborates closely with PCP

Integration

- BH works ***within*** primary care
- Patients perceive BH services as part of their health care with PCP

▶ ***Source:*** SAMSHA

Implementation – In Reality

▶ ***Source:*** *CalHIVE BHI Commons, November 2024*

California Quality Collaborative

BREAK

California Quality Collaborative

BHI Implementation – What Now?

Daniela Vela Hernandez

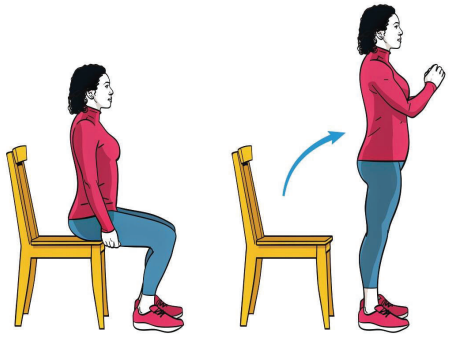
Jose Ordonez

Brian Sandoval

Poll: What Data Challenges Are You Experiencing?

Please stand up if any of the following statements resonate with your experience or reflect a challenge in your organization:

- "Stand up if ensuring the accuracy and completeness of BHI data has been a persistent challenge in your setting."
- "Stand up if timeliness of data — receiving or reviewing it when you actually need it — is an issue you face."
- "Stand up if turning BHI data into actionable insights or decisions is something your team struggles with."
- "Stand up if engaging your broader team in using BHI data is difficult or inconsistent."



Let's Discuss!

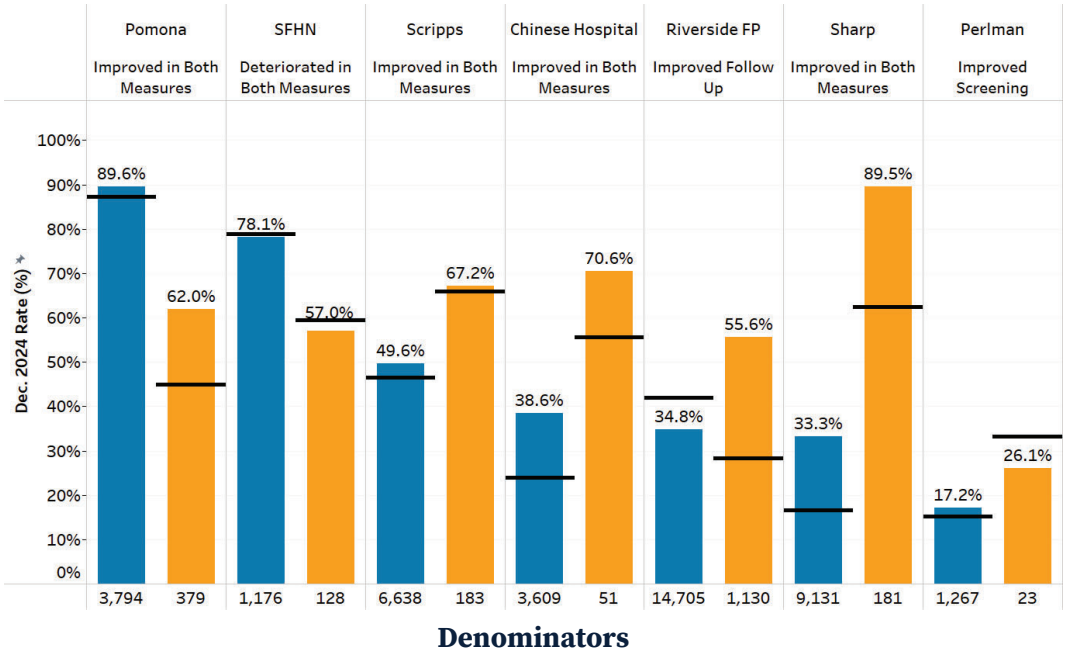
Take a moment to reflect on the results from the previous activity…

- What stood out to you the most?
- Which challenge do you feel most ready to address — and why?

What Does Data Tell You & What Does It Mean?

- **Why Data Matters:**
  - Tracks implementation success and impact.
  - Demonstrates program value to stakeholders.
  - Identifies areas for process improvements.
- **Process Measure Trends** and **Financial Metrics** help support **Strategic Decision-Making**
  - Using data insights to optimize workforce allocation and training.
  - Aligning trends with leadership strategies for sustainability.

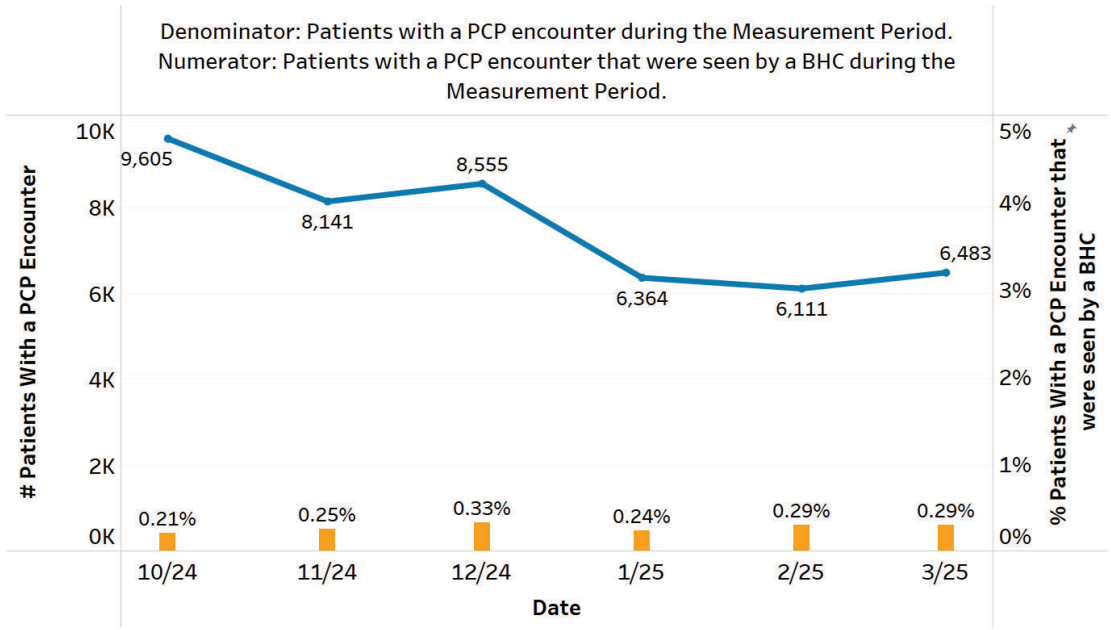
Comparison: Depression Screening and Follow-Up by Pilot site (2023 vs. 2024)



Baseline (Dec. 2023)

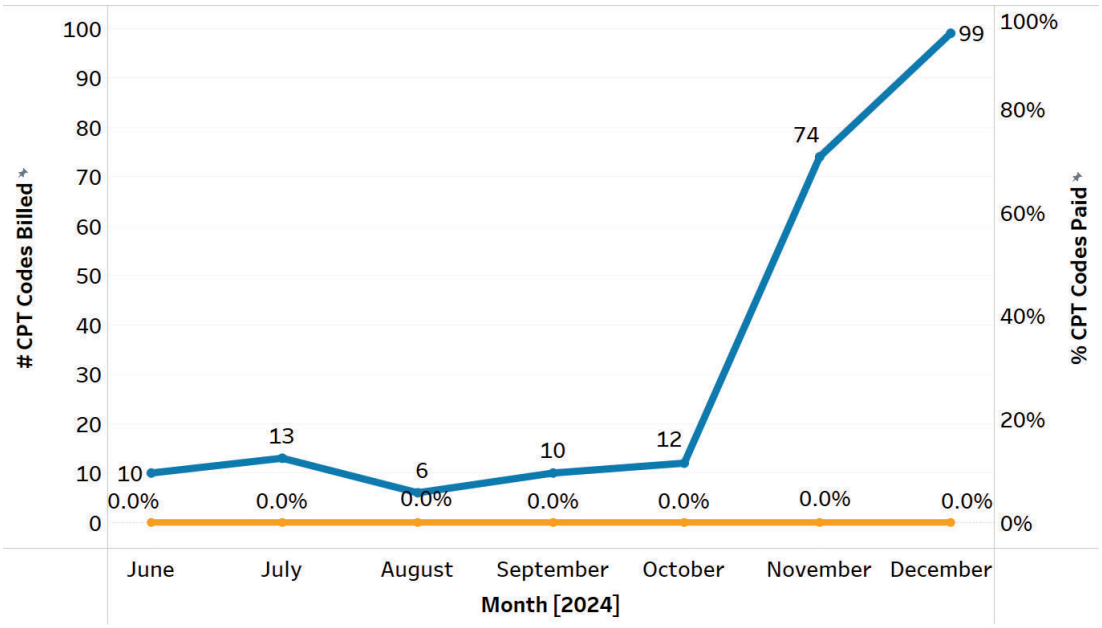
- Organizations with higher depression screening rates tend to have lower follow-up rates, and vice versa.
- From 2023 to 2024:
  - 4 organizations improved in both screening and follow-up.
  - 1 organization improved in follow-up but declined in screening.
  - 1 organization improved in screening but declined in follow-up.

Process Measure: BHI Service Utilization



- From October 2024 to March 2025, organizations reported low utilization rates of BHI services
- What benchmarks can we use to assess our level of integration by tracking BHI services?

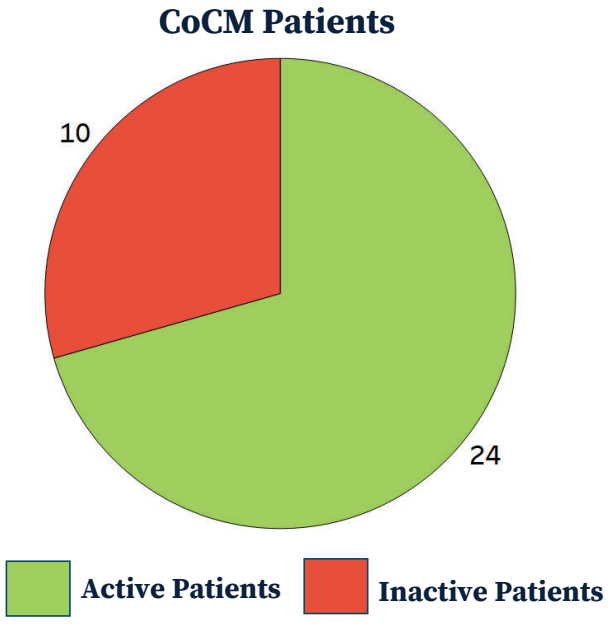
Financial Measure – No Reimbursement and/or Tracking



- Some organizations are facing challenges with:
  - Billing and reimbursement for BHI services
  - Tracking BHI services by CPT codes and linking them to reimbursement amounts

CoCM Program Profile – Site Visit Overview

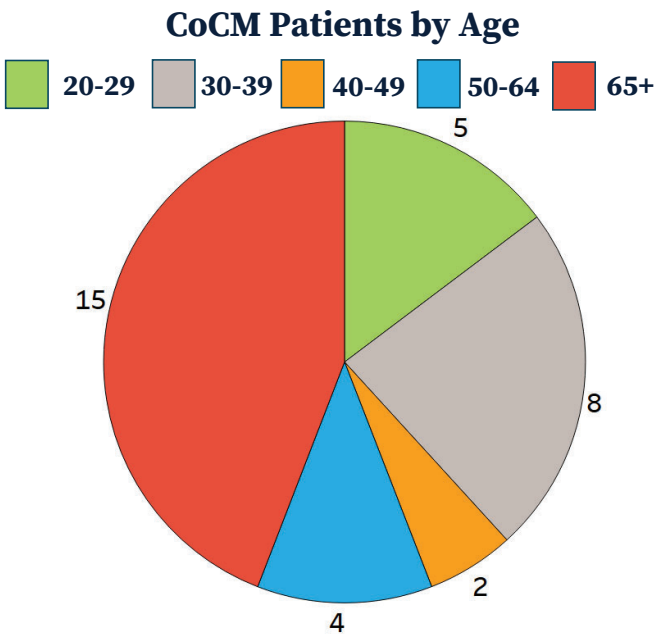
- Total: 34 patients
  - Active: 24 patients
  - Inactive 10 patients
- PHQ9 scores: 0 – 27
- Diagnoses:
  - Mild/moderate depression
    - Few severe cases
  - Anxiety
  - Few schizophrenia and bipolar cases
- 1/3 of patients currently seeing a behavioral health provider



CoCM Program – Patient Demographics

- Age of Total Patients (21 – 93):
  - 20 – 29: 5
  - 30 – 39: 8
  - 40 – 49: 2
  - 50 – 64: 4
  - 65 + : 15

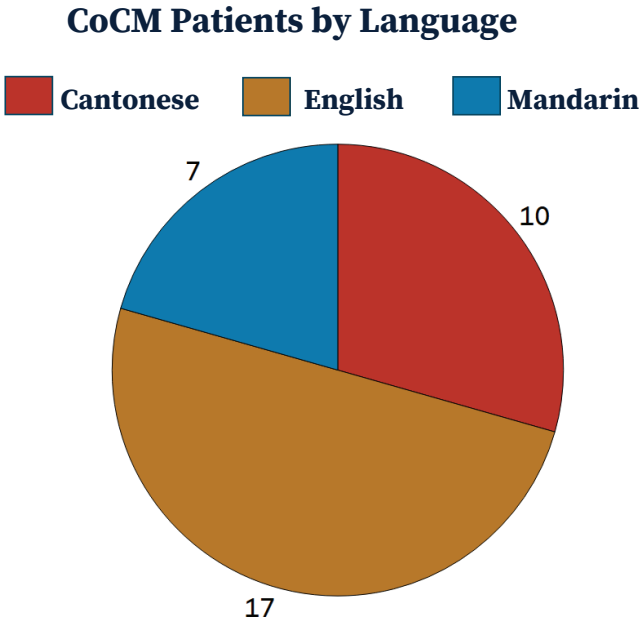
- 40% of participants are 65+



CoCM Program – Patient Language Needs

- Language of Total Patients:
  - Mandarin: 7
  - Cantonese: 10
  - English: 17

- Expansion of program is purposeful
- Data reflects opportunities for growth



Using Data to Drive Your Next Test of Change

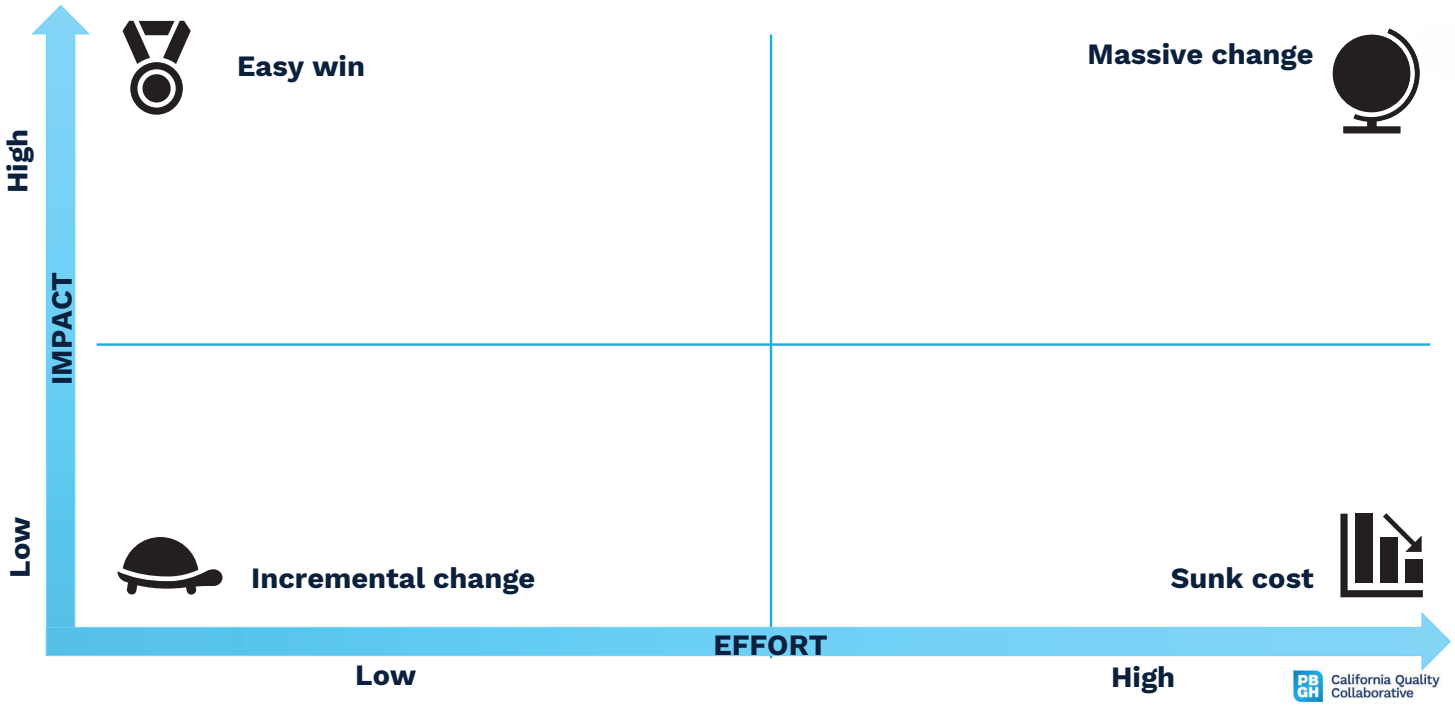
- **Obtaining Data:**
  - How and when is data captured?
  - What is done in response to data?
- **Finding Opportunities with Data:**
  - How data can drive BHI expansion.
  - *Case examples.*
- **Engaging Key Leadership:**
  - Presenting data to leadership to gain buy-in.
  - Making the business case for sustained investment.
- **Training & Hiring Implications:**
  - Identifying staff coverage gaps through data.
  - Strategic hiring—when and where to expand the workforce.
  - Intra-site vs. inter-site growth.

Team Time:
Use Your Data to Identify Actionable Opportunities

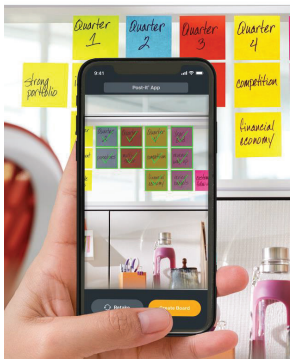
1. Review data	Examine team data packet Identify priority data points (1-2)
2. Brainstorm	Gather as many ideas as possible to improve data (use post-its!)
3. Cluster	Group similar ideas to find themes
4. Assess Feasibility	Map priority solutions on prioritization matrix
5. Prioritize	Get team consensus on 1-2 feasible solutions

25 MINUTES

Prioritization Matrix



Team Time



Try it – Post It App

Free

Will scan notes

Upload to collaborative whiteboard

Allows you to move around and edit

Share-Out

- Let's hear an easy win and a sunk cost that you identified
- What surprised you about this process?

Voting | Most Improved and Most Impact

Most Impact

Pink Card

Most Improved

Blue Card

Reminders:

Consider creativity!

Don't vote for your own team

California Quality Collaborative

Lunch

Bon Appetit!

PCBH (Brian)

Payer Engagement (Kristina)

Billing (Daniela and Mary)

Vacation Plans (Anna)

Data & Measurement (Jose)

California Quality Collaborative

Sustainability

Kristina Mody

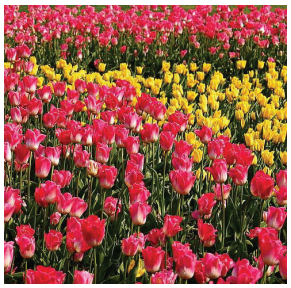
Brian Sandoval

Reflections

Where do you see your BHI program by 2026?

Key Definitions

- **Sustainability**: Ensuring gains are maintained beyond the life of the project



- **Spread**: Actively disseminating best practice and knowledge, and implementing each intervention in every available care setting

Source: UNC

Retained BHI Clinicians

Engaged Providers/Staff

Adopted Workflows

Clinical Outcomes

How do you know your program is integrated and sustainable?

BHI is Routine Care

Financially Sound

Aligned Program Expectations and Outcomes

BHI Measures

Category – Definition	Examples
Clinical Quality – impact of the health care service or intervention on patients' health	• Depression Remission or Response for Adolescents and Adults • HbA1c Poor Control for Patients with Diabetes (> 9%) • Changes in Utilization
Adopted Workflows – if steps in the system are performing as planned	• Depression Screening and Follow-Up for Adolescents and Adults • Population Reach (Unique BHI/Unique PCP) • Huddle Identified vs. Seen
Patient Experience – patient perceptions across continuum of care	• Surveys (add BHI question or independent survey) • Focus groups
Engaged Workforce – experience from providers and care team members, workload, collaboration	• Surveys and Interviews • Collaboration: Provider Huddles, Team Meetings, consultations • 1:1 Discussions
Financial – direct and indirect costs and revenue	• Revenue Generation: Screening Codes and Visits • Quarterly Profit & Loss Reports • Claims processing • Sustainable contracting (VBC)

Source: Types of Health Care Quality Measures, AHRQ

BHI Scaling

Scaling:

Intra-site scaling: Same clinic, more BHI Staff

Inter-site scaling: New site, new/existing BHI staff

***Intra-site** scaling should come **BEFORE inter-site**

When do I scale?

1. Current model/site(s) are independently sustainable
2. A financial strategy for new site(s) is viable
3. BHI Leadership approach is identified and accounted for
4. There is buy-in to do so

Decision Tree

Is your integrated program sustainable?

Yes

Consider Intra-site scaling and developing a plan

No

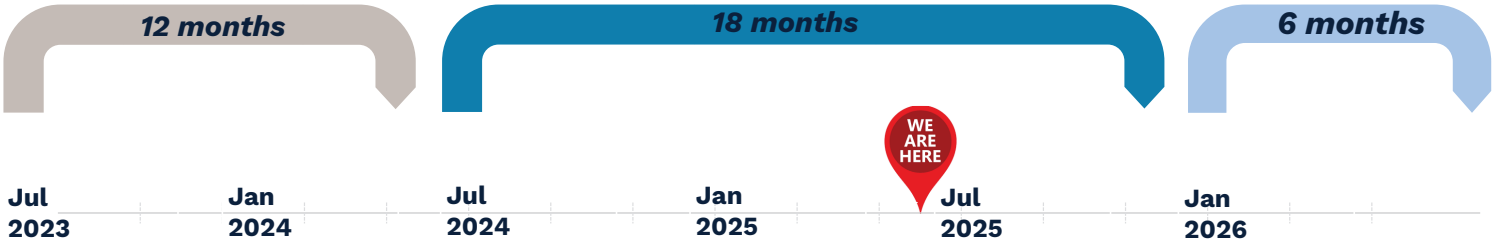
Work on increasing level of integration

Use data packet and measures

Lessons Learned | Sustainability

- Scaling well (vs. wide)
- Grow slow – intentionally
  - Went without BHI in some clinics
- Lost confidence in BHI compromises program
- Measures
  - Follow-up
  - Population Reach
  - Missed opportunities
  - Patient

Sustainability Plan – 2026 CalHIVE BHI Deliverable



PREPARE

- Build team
- Readiness assessment & recommendations
- Select integration model and pilot site
- Report and analyze BH screening data

IMPLEMENT

- Implement care model at pilot site
- Adopt clinical, data, operational workflows, including training
- ***Make improvements!***
- Analyze and improve patient engagement
- Create Behavorial Health Equity Improvement Plan

SCALE

- Analyze pilot progress, identify improvement and spread plan
- **Craft sustainability plan**
- Complete project documentation and communication plan

SWOT Analysis

Sustainability: Ensuring gains are maintained beyond the life of the project

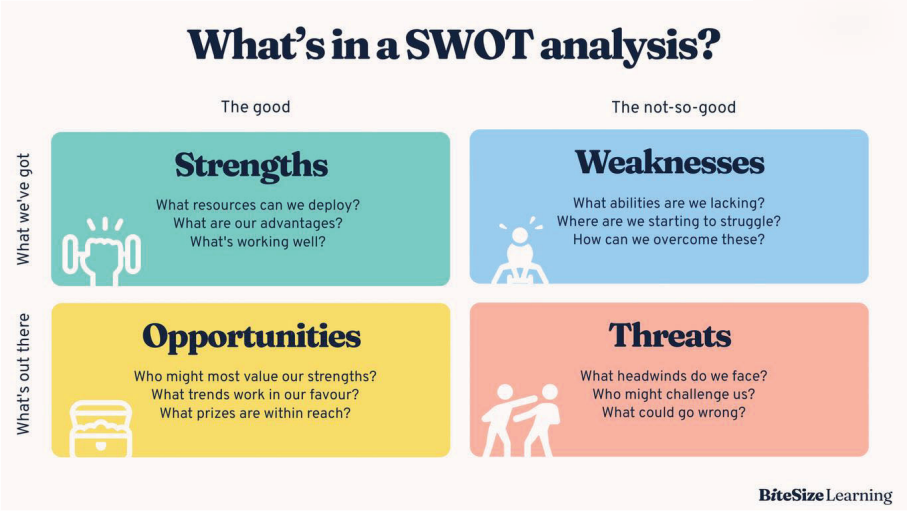
1. As a team

- Complete a SWOT for BHI sustainability

2. In mixed groups:

- Summarize your SWOT around BHI sustainability
- Discuss what you would want to be held accountable for by end of CalHIVE BHI program

3. Share out



35 MINUTES

Source: BiteSize Learning

California Quality Collaborative

Behavioral Health Equity Improvement Plan: Small Tests of Change

Mary Nickel-Nguy

Peter Robertson

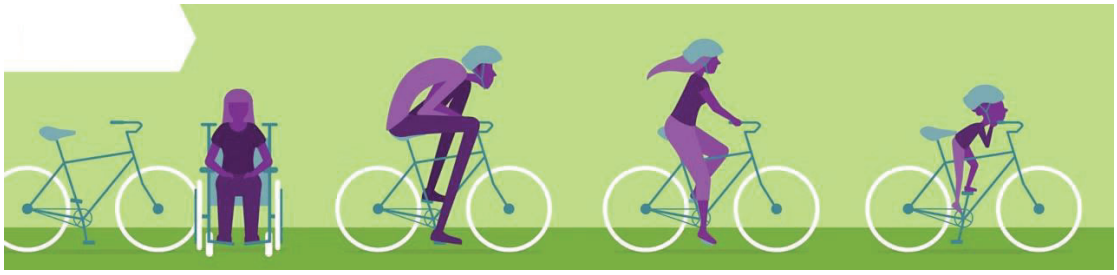
Elevating Equity within our Small Tests of Change

Problem Statement:

- Patients lack reliable sources of transportation

Small Test of Change (PDSA):

- Provide complimentary access to a bike sharing program



Source: Robert Wood Johnson Foundation

Elevating Equity within our Small Tests of Change

Problem Statement:

- Patients lack reliable sources of transportation

Small Test of Change (PDSA):

- Provide complimentary access to a bike sharing program offering a variety of features (accessibility, height, etc.)

Source: Robert Wood Johnson Foundation

Bridge Building Challenge

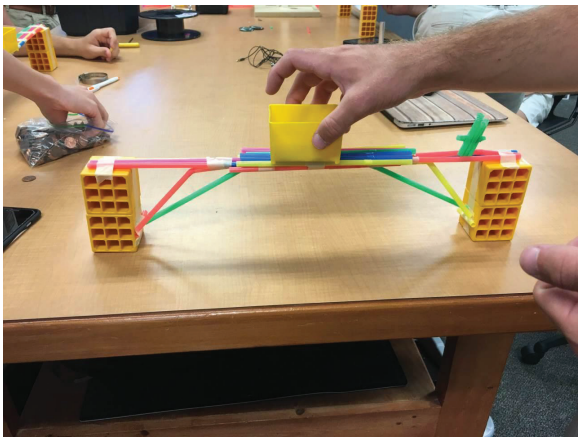
Task: Work with your table group to build a **10-inch bridge** using the provided materials (including chairs).

Conditions: Every group has **the same materials** but a **different weight to support**.

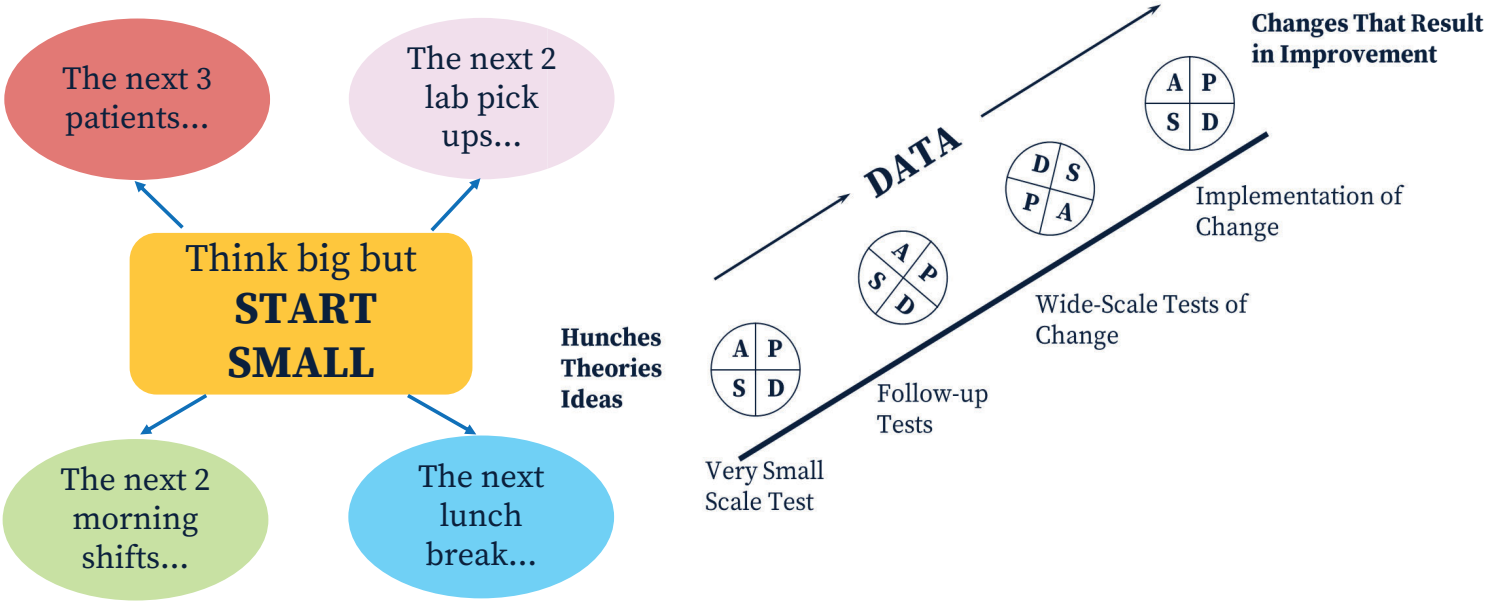
Steps over the next 10 minutes:

1. ***Plan*: Design Your Bridge**: Collaborate with your team to discuss and outline your bridge design before beginning construction.
2. ***Do*: Construct Your Bridge:** Using the materials provided, follow your initial plan to construct your bridge.
3. ***Study & Adjust*:** Assess whether your bridge can effectively support the weight. Strengthen weak points as needed to improve stability and durability.

10 MINUTES



PDSA Cycle: The Step Towards Goals



Montes Medical Group | PDSA Cycle

SMARTIE Aim Statement

By **December 2024**, increase **colorectal cancer screening rates** among **Hispanic or Latino patients** at Montes Medical Group by **25%**, ensuring screenings are **equitable, accessible, and culturally responsive** through **enhanced outreach, education, and provider engagement.**

Objective for PDSA cycle

Enhance outreach and education efforts to raise awareness about the importance of colorectal cancer screening while improving accessibility and equity through multilingual support and expanded access to at-home screening kits.

We plan to....

Patient outreach:

- text message inviting individuals to request an at-home screening kit
- Follow-up phone calls, during which, the care team provided education and support about screening

Data collection tool

The team initiated the collection of patient demographic variables, including language preferences, during new patient registration and established processes for creating an initial outreach list. Outreach efforts were tracked through text messages, follow-up phone calls, and the completion of screening kits

We hope this will..

Among Latino & Hispanic patients, we hope to:

- Increase awareness & engagement
- Improve accessibility
- Enhance equity & inclusion
- Strengthen outreach & follow-up
- Obtain data driven insights

Listen, Learn and Grow

I Like... *Highlight specific strengths or achievements you appreciated during their planning stage.*

Example: "I like how the team has clearly outlined the problem statement and engaged stakeholders early in the process."

I Wish... *Provide constructive suggestions for areas of improvement.*

Example: "I wish there was more focus on defining measurable outcomes for the PDSA cycle."

I Wonder... *Pose thoughtful questions or suggestions to encourage forward-thinking and innovative ideas.*

Example: "I wonder if incorporating patient feedback at this stage could further strengthen the intervention design."

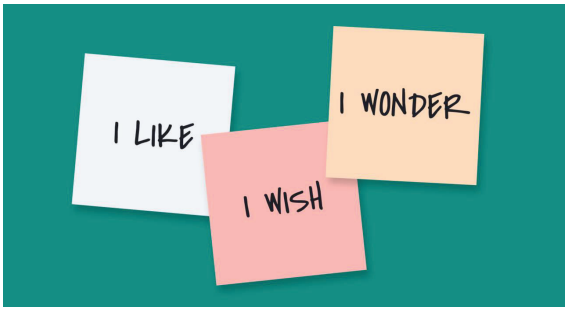
Sharing & Reflecting on our PDSAs

Each team will join a preassigned group and share their PDSA.

- Presenters will have 2-3 minutes to share
- Using the 'Like, Wish, Wonder' approach your peers will share feedback on your design (2-3 minutes)
- Teams will present in the order listed in the groupings below

Group 1

- Perlman
- Pomona
- Scripps
- SRS



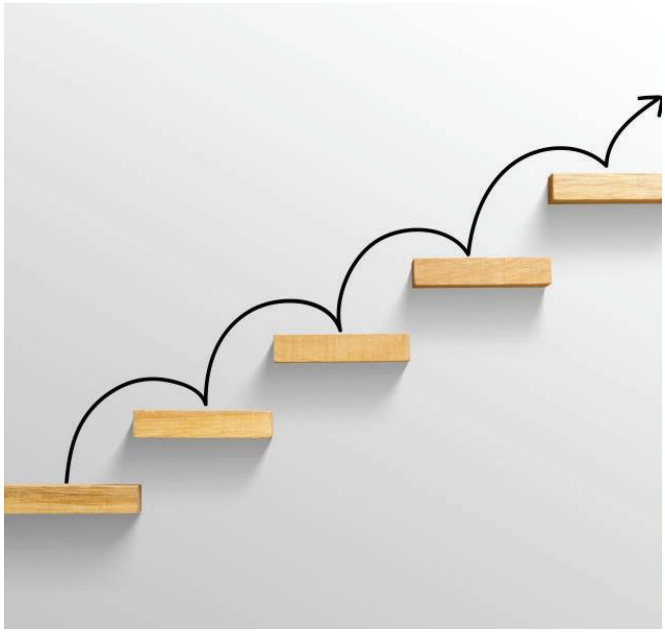
Group 2

- Chinese
- CMH
- Riverside
- SFHN

Sharing & Reflecting on our PDSAs

How will you use the feedback you received to inform your small test of change?

Closing Reflections



Each PDSA highlighted valuable insights, reinforcing that change isn't just about ideas—it's about testing, learning, and refining.

- Every adjustment brings us closer to better outcomes—**no step is too small**.
- **Collaboration strengthens improvement**—sharing experiences helps us refine best practices.
- **Sustainable progress** is built on iteration—PDSAs are not one-time efforts but an ongoing commitment to learning.

California Quality Collaborative

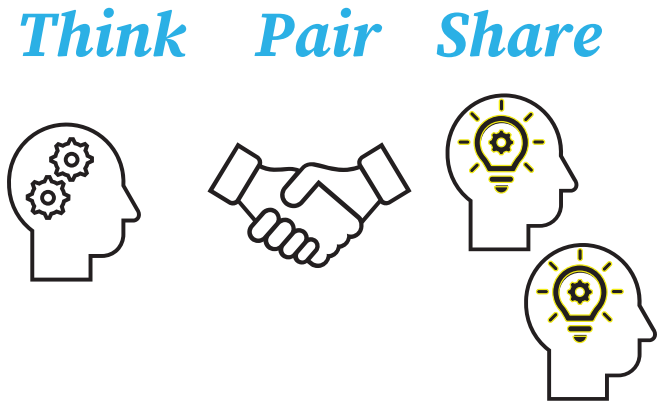
Reflections & Commitments: Looking Ahead to 2026

Daniela Vela Hernandez

I Used to Think… and Now I Think…

Pair and Share Activity

- Use the notecards at your table for this activity
- Reflect and write on the notecard
  - "**I used to think**…." On the front of the notecard
  - "**and now I think**…" on the back of the notecard
- Partner up with someone and share your thoughts



California Quality Collaborative

Closing

Peter Robertson

What's Next

Reminders

Gift of Feedback

- Please complete and return your evaluation forms

Upcoming Events & Deadlines

CalHIVE BHI Commons: Adaptive Leadership for BHI

- Tuesday, June 10, 11 a.m. – 12 p.m.

Cycle 5 Data Webinar

- Thursday, June 12, 12 p.m. – 1 p.m.

Cal-IN Peer Group

- Wednesday, June 18, 12 p.m. – 1 p.m.

Cycle 5 Data BeeHIVE

- Thursday, June 26, 12 p.m. – 12:45 p.m.

Program Website

Find materials from today's Convening on the program website
www.calquality.org/calhive-bhi/

And The Winners Are…

Thank you!

POMONA VALLEY HOSPITAL MEDICAL CENTER

To provide sustainable integrated behavioral health care to meet the needs of every patient.

Community Memorial HEALTHCARE

Every patient is seen, heard, and offered compassionate, culturally sensitive, and holistic guidance for their mental health journey.

Riverside Family Physicians

To foster a culture that embraces continuous improvement and positive changes on improving patient and staff well being.

SHARP

The best place to start and support your journey to happiness.

CHINESE HOSPITAL & CLINICS

Is dedicated to build a culturally and linguistically competent behavioral health center to lower the barriers for our community in accessing behavioral health care.

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

To promote and support the well-being of all SFHN Patients through seamless care team collaboration.

Scripps

Bringing comprehensive, compassionate and supportive behavioral health to southern California today, tomorrow, and forever forward.

perlmanclinic

Every patient deserves access to appropriate resources driven by evidence-based care. To build systems that enable PCP's to confidently care for those with behavioral health needs that impact their overall wellbeing.