Primary Care Assessments, Coaching, and Technical Assistance (ACT)

Provider Launch Webinar

HPSM Primary Care Investment Strategy

September 15, 2025

HealthPlan OF SAN MATEO
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UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

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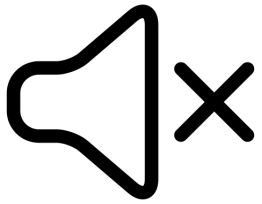
Housekeeping

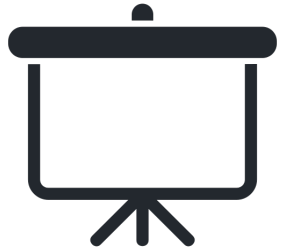
Please help us make this virtual meeting successful:



Remain muted while not speaking

Enabling video appreciated but not required

Type questions in the chat, or wait until Q&A at 12:45



Slides and other resources will be available on website

Agenda & Objectives

• **Welcome**	12:00 – 12:05
• **ACT Initiative Arc: Connecting to HPSM's Primary Care Investment Strategy**	12:05 – 12:15
• **Introduction to HPSM Partner Organizations and ACT Initiative**	12:15 – 12:45
• **Q&A**	12:45 - 12:55
• **Closing**	12:55 – 01:00

By the end of this session, I will have:

1. Become oriented to the Initiative and the value it may bring to my organization;
2. Asked questions to aid in my understanding of the Initiative;
3. Considered who I might involve from my organization as impacted stakeholders

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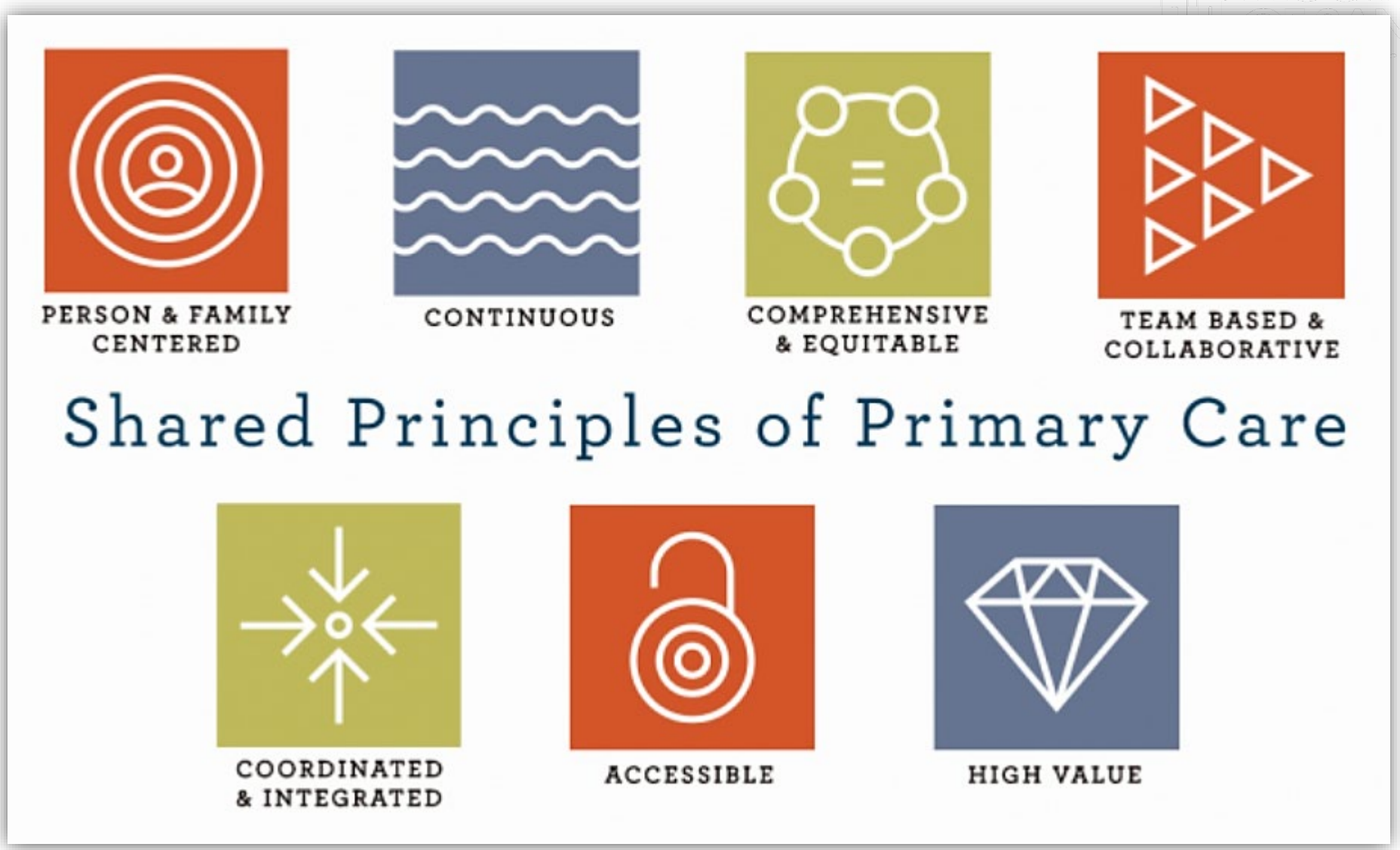
Primary care *is the only health care component where an increased supply is associated with better population health and more equitable outcomes.*

||| National Academies of Sciences, Engineering, and Medicine


PERSON & FAMILY CENTERED
CONTINUOUS
COMPREHENSIVE & EQUITABLE
TEAM BASED & COLLABORATIVE
Shared Principles of Primary Care
COORDINATED & INTEGRATED
ACCESSIBLE
HIGH VALUE

Challenges Facing Primary Care

- Financial Neglect
- Workforce Shortages, Bandwidth and Burnout
- Underdeveloped Population Health
- Suboptimal Care Experience

Health Plan of San Mateo's Commitment:

To develop and implement a Primary Care Investment Strategy that addresses the primary care crisis— financial neglect and workforce shortages — and promotes Advanced Primary Care to achieve better and more equitable health outcomes for our members.

Primary Care Investment Goals

HPSM will strategically invest in primary care to:

Better allocate resources to address chronic underinvestment, support the implementation of advanced primary care, and shift from a focus on *volume* to *value*.

Promote a robust and thriving workforce: fortify a diverse primary care workforce in San Mateo County that has capacity, bandwidth, and joy.

Improve population health: support our network to be more population focused, in order to achieve better, more equitable health outcomes for our members.

Enhance the care experience for members and families, so that they are satisfied, engaged in their care, and healthy.

8

Quintuple Aim

Better Use of Resources

1. Measure/Report/Increase Primary Care Spend
2. Pay for Advanced Primary Care
3. Test Alternative Payment Models
4. Align with Other Payers
5. **Offer Practice Supports**

Better Population Health

1. **Increase Network Population Health Management Capabilities**
2. Improve Data Transparency
3. Support Data Integration & Interoperability
4. **Improve Performance & Reduce Disparities**

Better Work

1. Bolster the 3Rs: Recruitment, Retention, and Resilience
2. **Promote Team-Based Care that Increases PCP Capacity**
3. Invest in Workforce Development
4. Enhance Staff Diversity, Inclusion, and Belonging

Better Care Experience

1. Uplift member voices
2. Enhance Community Partnerships for more Coordinated, Integrated and Comprehensive Care
3. **Improve Access**
4. **Increase Engagement**

Primary Care Assessments, Coaching and Technical Assistance (ACT)

What is this Initiative?

- Mid-2024 — Request for Proposals initiated to identify a vendor who would work in partnership with HPSM and HPSM's primary care network to assess current state capabilities and help implement tests of change.
  1. Complete **assessments** for the entire primary care network;
  2. Provide targeted **coaching** for select providers within the network; and
  3. Offer other forms of **technical assistance** that lead to better population health management

Primary Care Assessments, Coaching and Technical Assistance

- **Partner Organizations:**
  - Population Health Learning Center (PHLC)
  - UCSF Center for Excellence in Primary Care (CEPC)
- **Partner Strengths:**
  - **Expertise & Experience** in primary care with strong clinical leadership and deep relationships with providers, plans and regulators across California.
  - **Value alignment** emphasizing equity, outcomes, and sustainability.
  - **Quality Practice Coaches** with 10+ years of coaching experience; and include QI and SME coaches.
  - **Customizable options** offering combinations of coaching and peer learning.
  - **Data and evaluation driven** ensuring we can compare our data across our network and California.

PopHealth Learning Center leadership team:

Jennifer N. Sayles, MD, MPH
Chief Executive Officer

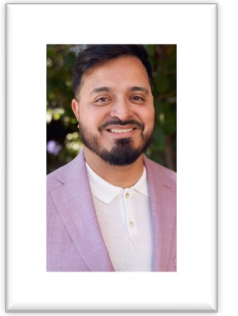
Jennifer led the DHCS & Kaiser Permanente Sponsored Population Health Management Initiative and founded PHLC to scale primary care transformation work. Past roles include chief medical officer and chief population health officer at Inland Empire Health Plan, LA Care, and LA County.

Tammy Fisher, MPH
Chief Program Officer

Tammy implemented multi-payer practice transformation initiatives at scale in primary care. She has held senior leadership roles in quality at Aledade, Center for Care Innovations and Partnership HealthPlan.

Eric Hernandez, MBA, MHSA
Chief Operations Officer

Eric, served as the chief operating officer at Peach Tree Health, an FQHC. He has held leadership roles at Family HealthCare Network and Adventist Health.



Jess Liu, MPH, MS
Director of Analytics & Impact

Jess, served as VP of partner care and account management at Mindoula, working with Medicaid plans to address behavioral health.
Past roles include director of quality improvement at One Medical and Partnership HealthPlan.

Mary Deane, MPH
Director of Programs

Mary, served as director at the Institute for Healthcare Improvement. She led programs in the value, population health and equity portfolios. Past roles include senior quality program manager at Tufts Health Plan.

CEPC team

Patricia Mejia
Associate Director of Training

Megan Elliott
Trainer

Rachel Willard-Grace
Director

Experience of our Team

- Working in clinical settings (e.g., Medical Assistant, Pharmacy Tech, Interpreter, Administrative Director)
- Providing coaching to practices
- Serving as patient navigators and facilitating patient support groups
- Non-clinical case management
- Training practice coaches across California and the U.S.
- Training front line staff in population health, team-based care, and patient communication
- Training and coaching supervisors to implement enhanced team-based care
- Measuring work experience and facilitating conversations on responses to address challenges

Meet Doctor R

Dr. R runs a small adult practice and wants to improve her performance on breast cancer screening.

How is my breast cancer screening rate so low?

What workflows and training do I need to involve my staff in breast cancer screening & follow-up?

What should I include in a care gap report?

How do I partner with my managed care plans to get the data I need?

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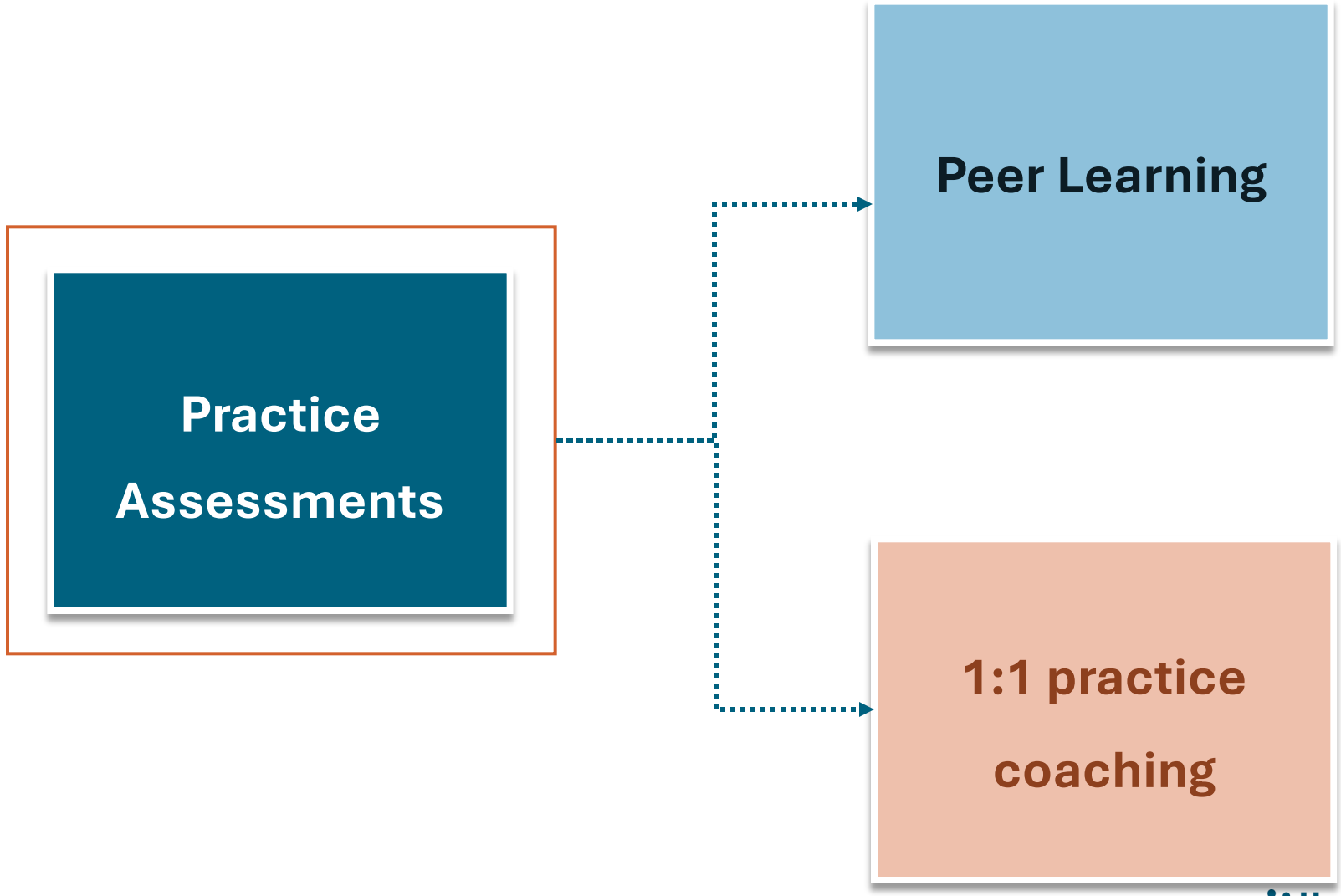
ACT program components



Why assessments matter

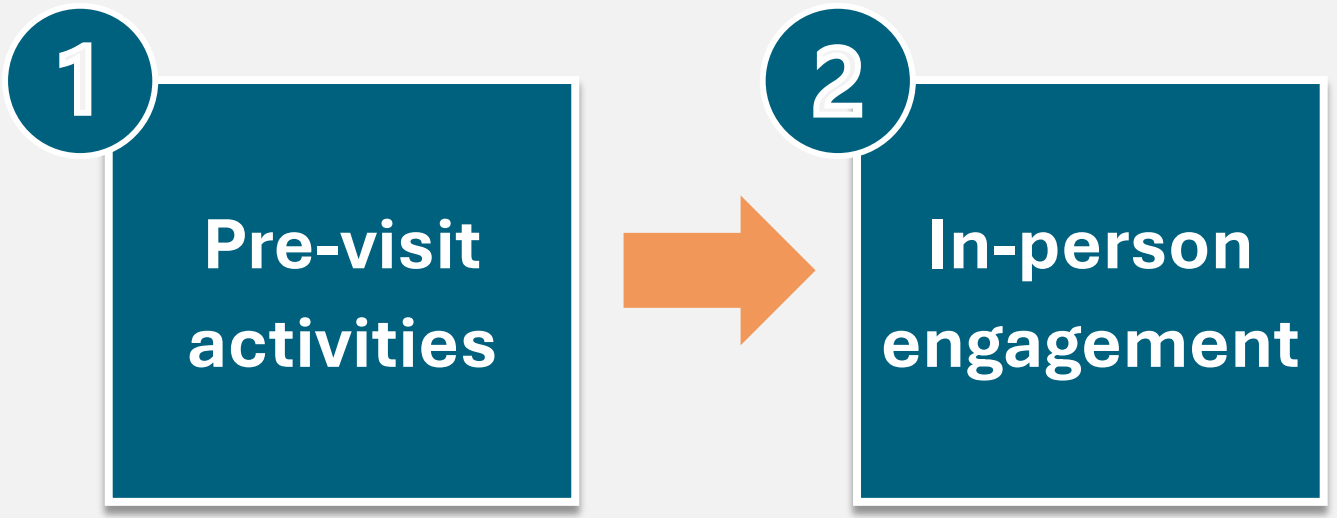
For Practices

- Helps make the invisible work visible
- Builds shared understanding of current PHM capabilities and performance on quality measures across the team
- Engages multiple staff perspectives—not just clinicians
- Creates space for reflection on what's working and what could improve
- Helps focus improvement efforts amid competing priorities
- Offers a starting point for meaningful, practice-driven change
- Provides benchmarking with more than 200 practices across California.

For Health Plan of San Mateo

- Provides a comprehensive picture of practice capabilities and performance on quality measures including access and HEDIS
- Get a sense of where practices most need support & where to start
- Capture progress over time - administered annually throughout the initiative
- Organizes and aligns key changes across multiple HPSM programs & keeps practices focused on shared domains and goals
- Determine which practices could benefit most from 1:1 practice coaching

Two-part approach to conducting practice assessments



Part 1: Pre-visit activities

1

Pre-visit activities

1. **Identify your team!**
2. Team members complete an organizational assessment (the PhmCAT) online
3. Point person reports empanelment, continuity, TNAA (if available), and key demographics.

HPSM provides practice-level data on HEDIS and P4P measures, encounter submission rates, grievance rates, and panel status (open/closed).

Part 2: In-person engagement

2

In-person engagement

Identify time for a member of our practice coaching team to come for a 1-hour in-person meeting with your team

We will:

- Share your team's aggregated PhmCAT results
- Highlight variations and share perspectives
- Work with you to identify priority improvement areas
- Discuss practice pain points, successes, hopes and coaching experiences
- Answer your questions

Population Health Management Capabilities Assessment (PhmCAT)

A multi-domain assessment used to understand practice competencies and identify strengths and opportunities for development

Collaborative effort with DHCS, managed care plans, providers, and subject matter experts to develop an assessment that can be utilized across multiple CA programs/ initiatives

Used in two large statewide initiatives to identify learnings and refine/evolve the assessment overtime

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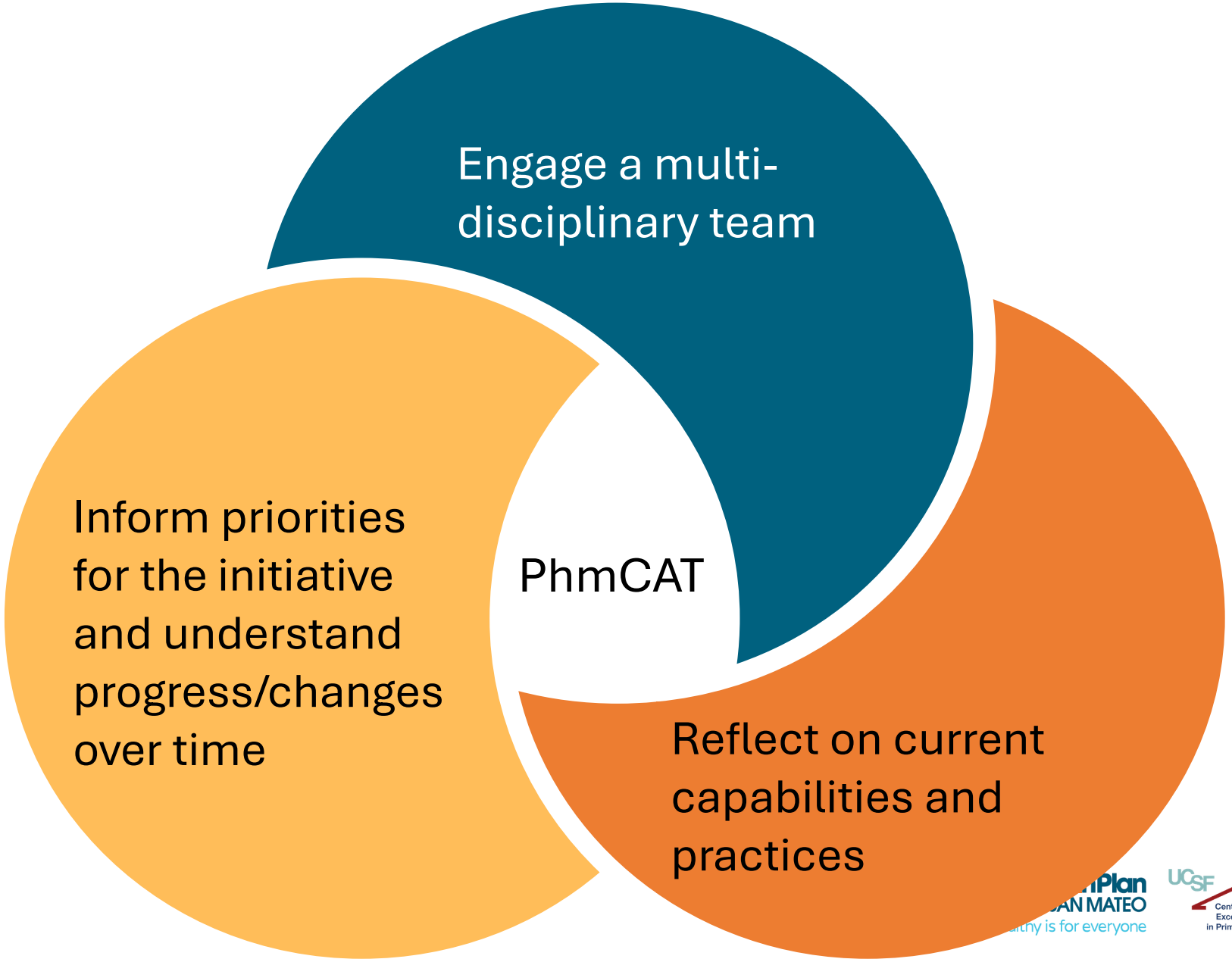
Practices will use the PhmCAT to…



PhmCAT sourced from validated tools

50

Fifty questions covering eight domains

1-10

Self assessed capabilities on a scale of 1-10

9

Questions drawn from nine validated and/or widely used assessment tools

1. Patient-Centered Medical Home Assessment: Center for Accelerating Care Transformation & Comagine Health.

2. Adaptive Reserve: Jaén CR, Crabtree BF, Palmer RF, et al. Methods for evaluating practice change toward a patient-centered medical home. Ann Fam Med. 2010;8(Suppl 1): S9-S20.

3. NACHC Payment Reform Readiness Assessment: National Association of Community Health Centers.

4. Baseline Organizational Assessment for Equity Infrastructure: California Department of Public Health.

5. Cities of Opportunity Action Cohort Capacity Checklist: National League of Cities.

6. Analytics Capability Assessment: Center for Care Innovation

7. Primary Care Team Guide Assessment: Center for Accelerating Care Transformation.

8. Building Blocks of Primary Care Assessment: Center for Excellence in Primary Care.

9. Measuring behavioral health integration in primary care: Pourat N, Tieu L, Martinez A. Pop Health Mgmt. 2022; 25:6.

PhmCAT Domains

- → Leadership & Culture
  [7 questions]
- → Business Case for PHM
  [5 questions]
- → Technology & Data Infrastructure
  [7 questions]
- → Empanelment & Access
  [5 questions]
- → Care Team & Workforce
  [6 questions]
- → Patient-centered Population Based Care
  [10 questions]
- → Behavioral Health
  [5 questions]
- → Social Health
  [5 questions]

Financial incentives for contracted HPSM providers who complete the assessment

Incentives are intended to offset staff time to complete the assessment

- **$2,500** for 1 contracted site
- **$5,000** for 2 - 4 contracted sites
- **$10,000** for 5 or more contracted sites

Who should be involved in the assessments?

Establish a core team: A mix of decision-makers and frontline staff

At minimum, 3 roles should be represented:

- 1 Provider
- 1 Front-line staff (MA or Nurse)
- 1 Administrative/Office Manager

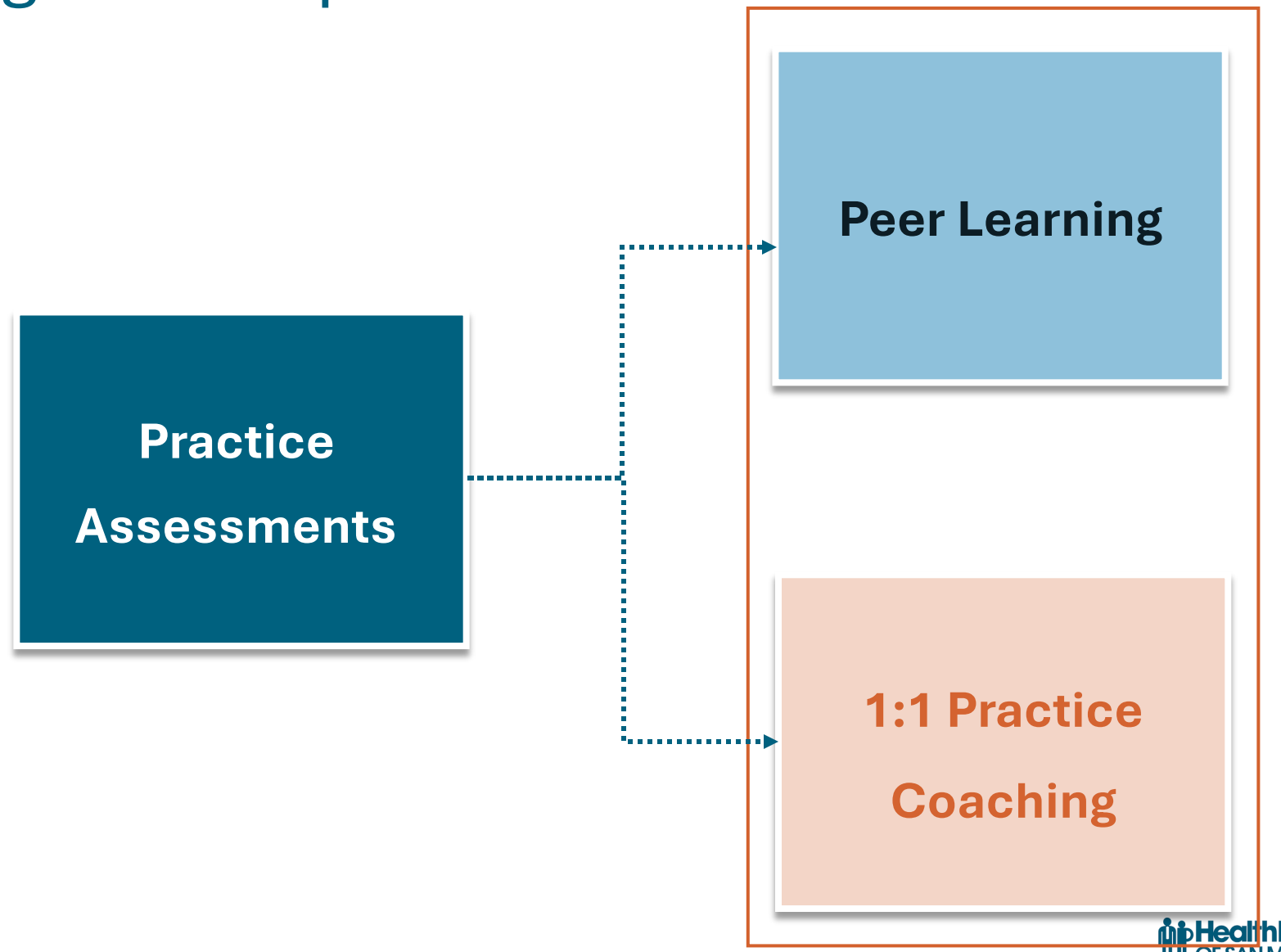
Include additional roles if available:

- Executive Sponsor (CEO, COO)
- Clinical Lead (CMO, Medical Director)
- Finance Lead (CFO, Manager)
- Data & Technology Lead (CIO, IT Director)
- Quality Lead (Quality Manager/Director)

Spread the work across core and additional sites with these resources:

- FAQ with key messages: *what's in it for the practice*
- Short video describing the initiative

ACT program components



Practice Support Options: Coaching and Peer Learning

1:1 Practice Coaching

- Tailored one-on-one support to address practices most pressing challenges and desired goals
- ~5 hours/month, with more available if desired, offered to 15+ practices
- Coaches bring clinic experience + improvement expertise
- Virtual support with 1–2 in-person visits each year
- Different from consultants

Peer Learning

- Learn from peers through facilitated sessions
- Deep dives into content prioritized from the assessment process
- 60–90 minute virtual, synchronous sessions offered every other month
- Access subject matter experts, best practices, tools, and templates
- On-demand learning to build population health management foundations

Coaching Accelerates Practice Improvement

- Two systematic reviews found that practices that participated in coaching, as compared to those that didn't, had:
  - Greater improvements in the quality of care provided.[1]
  - Increased uptake of evidence-based guidelines.[2]

"In simple terms, we would not have been able to accomplish what we have without the guidance of (Evelyn – Coach) and her coaching team. Their involvement has been critical to our success."

~ EPT Clinic

1. Z. Nagykaldi, J. W. Mold, and C. B. Aspy, "Practice Facilitators: a Review of the Literature," Family Medicine, Sept. 2005 37(8):581–88.
2. N. B. Baskerville, C. Liddy, and W. Hogg, "Systematic Review and Meta-Analysis of Practice Facilitation Within Primary Care Practices," Annals of Family Medicine, Jan.–Feb. 2012 10(1):63–74.

Coaching helped Dr. R accelerate and sustain improvements

- We reviewed P4P data with our coach. We learned that we have low breast cancer screening rates for younger people, and we're leaving money on the table.
- We worked with our managed care plan to get data on members in a standard format. We also received patient-friendly brochures to share with patients.
- We don't have standard screening across providers, so we implemented screening guidelines and developed a registry.
- Our coach helped us create a staff-friendly activity to help them get comfortable answering our patients' most common questions about breast cancer screening.
- We added breast cancer screening opportunities to our daily huddles

Peer Learning Opportunities

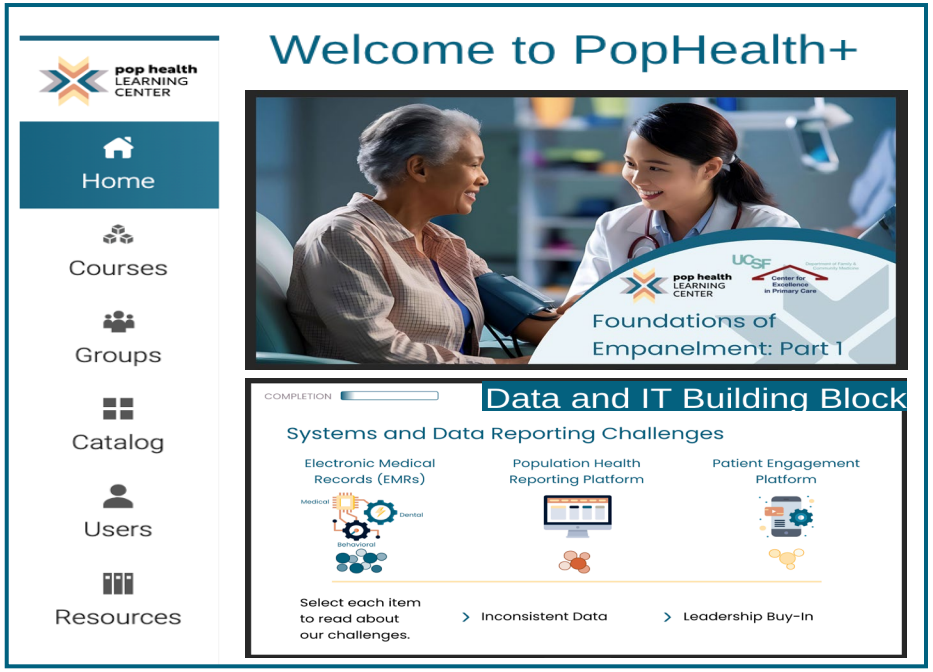
- Virtual learning sessions, small group cohorts organized by practice type and size
- Example focus areas:
  - Outreach to assigned/unseen patients
  - Care-gap workflows (P4P)
  - Reducing no-shows, improving access
  - Strengthening team-based care
- Participation: 1-2 members (small practices) or 2+ members (medium/large)

" We now have a plan to address the assigned but unseen population, including to do outreach and get reports. We are now more organized and focused; we are not just taking it as it comes. In a small practice, it's hard to prioritize. We had to create a plan, give people ownership, everyone has an assignment, and we have committed to our goals. We can hold ourselves accountable."

Asynchronous Learning Modules through PopHealth+

Functionality Includes

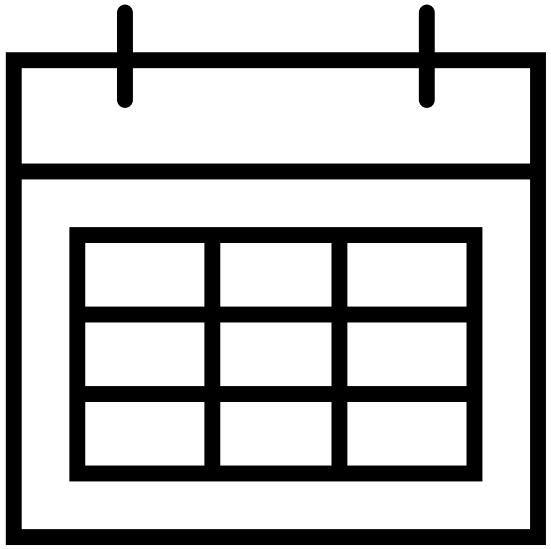
- Brief, interactive courses developed with experts on key population health subjects (e.g., empanelment, access, data governance)
- Self-paced or facilitated learning options with synchronous and asynchronous formats
- Repository of relevant tools and tip sheets



"Every week I go in and look for 3rd next available appointment…PHLC was the first place I ever learned about it…I love using the PopHealth+, it goes through and explains the details. I wasn't going to get that anywhere else."

~ Small independent practice

Timeline



Overview Webinars: Same content, four options to attend

- October 6, 2025: 12-1pm
- October 8, 2025: 5-6pm
- October 23, 2025: 12-1pm
- October 27, 2025: 5-6 pm

Start Completing Online Assessments

- October 6, 2025

Assessment Deadline (portal closes)

- November 7, 2025

Technical Assistance: 1:1 Practice Coaching + Peer Learning

- Q1 2025

Q&A

Please type in chat or unmute to ask questions of HPSM or Partner Organizations.

Your questions will used to inform an FAQ resource that will be available on HPSM website.

Closing

- **Revisit Session Objectives:**
  1. Become oriented to the Initiative and the value it may bring to my organization;
  2. Asked questions to aid in my understanding of the Initiative;
  3. Considered who I might involve from my organization as impacted stakeholders

- **Stay tuned for next steps:**
  - Technical Assistance webinars to follow in October
  - Please whitelist the following domains for inbound email communications: phlc.org, ucsf.edu, hpsm.org
  - HPSM Website updates coming, including FAQ and short orientation video for asynchronous viewing among colleagues
  - Reach out to scott.fogle@hpsm.org with additional questions