PHM INITIATIVE

Action Community Homeroom: Behavioral Health

March 3-4, 2025

PHM INITIATIVE

Get to Outcomes in 2026

March 3, 2026

Welcome to the Behavioral Health Action Community!

Session Agenda

01

Meet Your Action Community

30 mins

02

Refine Your PHMI Vision

25 mins

03

Identify What's Getting in the Way

20 mins

04

Form Our Action Community Identity

15 mins

Your Action Community Leaders

Catherine Craig

Action Community Director

Alexis Sasso

Action Community Project Manager

Our Coaches and SMEs

Emma Ansara
Action Community SME

Ben Miller
Action Community SME

Lindsay Swain Hunt
PT Coach

Learning Objectives

1. Build relationships with peers working on similar improvements.
2. Refine your PHM vision for this year.
3. Determine key problems that must be solved to achieve the vision.

In Our Action Community…

- We are all focused on Behavioral Health Integration.
- We all have something to teach and something to learn.
- We can make important, measurable progress at our clinics this year, even amidst larger uncertainties.
- We will get farther if we support each other.

How Our Action Community (AC) Will Work

At the Statewide Learning Session:

- Time with your team to design and decide
- Time with AC peers to coach each other and strengthen plans

Action Community Monthly Touchpoint:

- Monthly virtual call starting in April
- Celebration of successes
- Facilitation of peer problem-solving
- Spread of expertise in response to your progress and roadblocks

Teams You'll Teach and Learn From

Alexander Valley Healthcare
Caring for our community since 1994

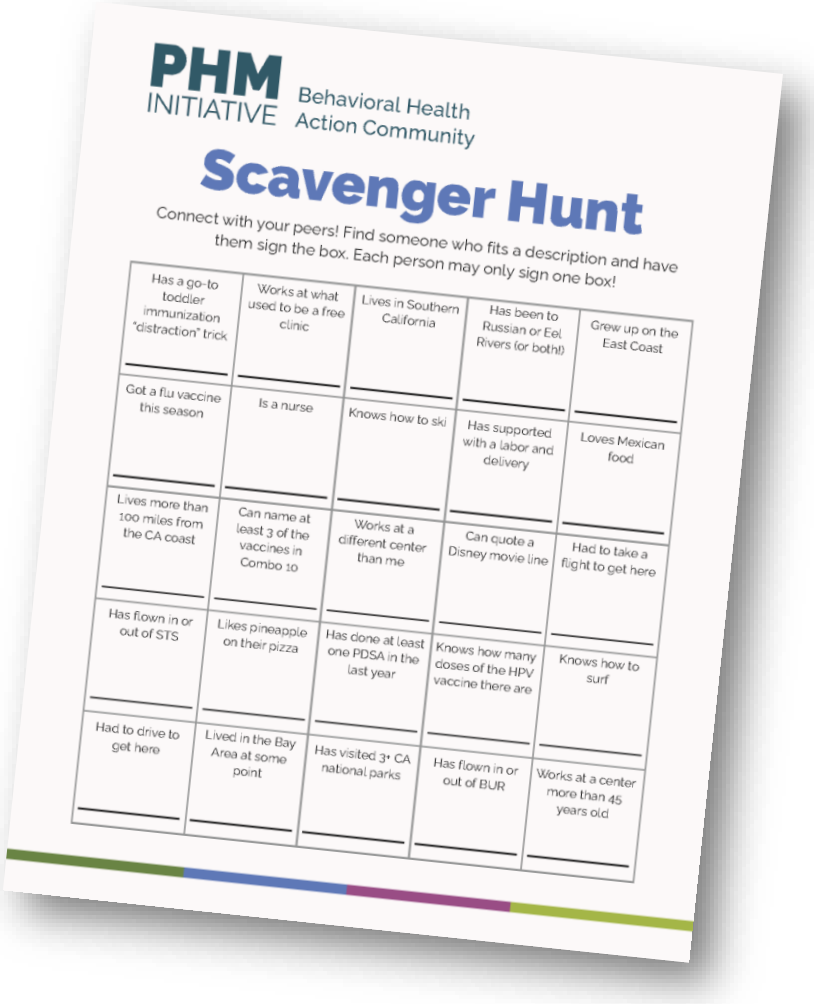
West County Health Centers
Caring for our Communities

APHCV

Asian Pacific Health Care Venture

Collaboration Scavenger Hunt

- Find people to initial a square.
- Each person may initial only *one* square.
- If you have the most squares completed when we call time, you will earn a ✨ *place of honor* ✨ in our Action Community.



PHM INITIATIVE Behavioral Health Action Community

Scavenger Hunt

Connect with your peers! Find someone who fits a description and have them sign the box. Each person may only sign one box!

Has a go-to toddler immunization "distraction" trick	Works at what used to be a free clinic	Lives in Southern California	Has been to Russian or Eel Rivers (or both!)	Grew up on the East Coast
Got a flu vaccine this season	Is a nurse	Knows how to ski	Has supported with a labor and delivery	Loves Mexican food
Lives more than 100 miles from the CA coast	Can name at least 3 of the vaccines in Combo 10	Works at a different center than me	Can quote a Disney movie line	Had to take a flight to get here
Has flown in or out of STS	Likes pineapple on their pizza	Has done at least one PDSA in the last year	Knows how many doses of the HPV vaccine there are	Knows how to surf
Had to drive to get here	Lived in the Bay Area at some point	Has visited 3+ CA national parks	Has flown in or out of BUR	Works at a center more than 45 years old

Winner of Collaboration Scavenger Hunt

Your ✨ *place of honor* ✨ will be revealed on our first Action Community Monthly Touchpoint call.

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Refine Your PHM Vision for 2026

Craft a Vision That Inspires Action

- **Ambitious**: It will make people healthier.
- **Achievable**: In the time we have, with the resources we have.
- **Inspiring**: Your team will be proud when you achieve it.
- **Succinct**: It captures the spirit, not the details.

One Clinic’s Vision

PHC's mission is to promote optimal health and wellbeing for all through comprehensive, patient-focused, accessible and equitable medical, mental health, and dental care.

Team Time: Refine Your PHM Vision (20 min)

1. Going around the table, share what is important to **you** to accomplish in population health management in 2026.
2. Read your team's draft vision aloud.
3. Compare the draft vision to what everyone shared. Make clarifications, additions, or subtractions so that the vision is as ambitious and meaningful as you believe it should be.
4. Lock in your CHC's vision.

What's standing in the way of realizing your vision?

Silent Reflection: What's Standing in the Way?

Take 2 minutes to silently jot down your answers:

Imagine it's December 31, 2026 and you achieved your PHM vision.

- **What were the two most important changes you made or problems you solved along the way?**
- **Why were they the most important?**

Team Time: What's Standing in the Way? (10 min)

- Going around the table, share your two most important changes or problems to solve.
- Make a list of each team member's ideas; we'll use it tomorrow.

Our Action Community Identity

What's Our AC Name?

What's Our AC Logo?

Tomorrow Takes a Turn for the Tactical

1. Finetune SMARTIE goals.
2. Coach each other.
3. Pick “the vital few” measures to track progress.
4. Decide which changes give the most bang for your buck.
5. Find out what peer teams are planning.

Please transition to General Session Space

Next session starts at 2:30 PM:
Championing Improvement

Islands Ballroom	General Session Space

PHM INITIATIVE

Finetuning Our Team Goals

March 4, 2026

Session Agenda

01

Refine Goals

20 mins

02

Peer Coaching

30 mins

03

Tweak Change Ideas

10 mins

Learning Objectives

1. Refine SMARTIE goals, with a focus on clinical outcomes.
2. Compare goals across CHCs, growing familiarity with each other's focus areas and ambitions.
3. Select new ideas from the Change Package in light of your refined goals.

A Preview of Our AC Logo

Yesterday When We Met, You…

- began connecting across health centers
- settled your PHM vision for 2026
- named what's getting in the way of achieving the vision

Now, let's take a step toward specific, measurable progress.

"Soon" is not a time

"Some" is not a number

"Hope" is not a plan

Tips for an Effective SMARTIE Goal

- Name what you will accomplish.
- Specify how much better you will get.
- Place boundaries around area of focus, e.g., a population, a site.
- Name for and with whom you will work.
- Consider data collection. What do you already collect? What would be light-lift?
- Get clear enough that anyone could read it and understand.

Team Time: Stress-Test Your Goals (15 min)

1. Read your draft clinical outcomes goal aloud.
2. Have a candid conversation inside your team:
   - What would make the goal clearer or more motivational?
   - What happens if we do or don't accomplish it? What would make it more important?
   - What would make it more feasible on this timeline, with our resources?
3. Edit the goal as you go.
4. Discuss your sustainability goal, as time allows.

Peer Coaching

Peer Coaching: Strengthen Your Goals (20 min)

- One person from your CHC will remain at your table to share your SMARTIE goal(s), starting with the clinical outcome. Become a sponge! Listen, take notes, resist the urge to defend or explain.
- Everyone else will rotate tables to hear other CHCs' goals and brainstorm ideas:
  - What could make the goal clearer or more motivational?
  - What could make it more ambitious?
  - What could make it more feasible on this timeline?
- Visit each of the other CHCs; rotate whenever you are ready.

Team Time: Process Feedback (10 min)

- **Notetakers:** Share the ideas and questions you received.
- **Team:** Listen generously. Discuss and continue strengthening your SMARTIE goal(s). Signal us if you want thought partnership.
- *Finished early?* Revisit the change strategies ~~ideas~~ your team selected in February. Consider if your refined goal calls for different ideas from the Change Package.

Your SMARTIE goal should be in great shape by the end of this session.

Please transition to General Session Space

Next session starts at 11:15 AM:
Optimizing Data for Improvement

Islands Ballroom	General Session Space

Lunch

1 Hour – Back Here at 1:00 pm

PHM INITIATIVE

Developing a Measurement Strategy

March 4, 2026

Session Agenda

01

Opening

5 mins

02

Team Time

40 mins

03

Closing

5 mins

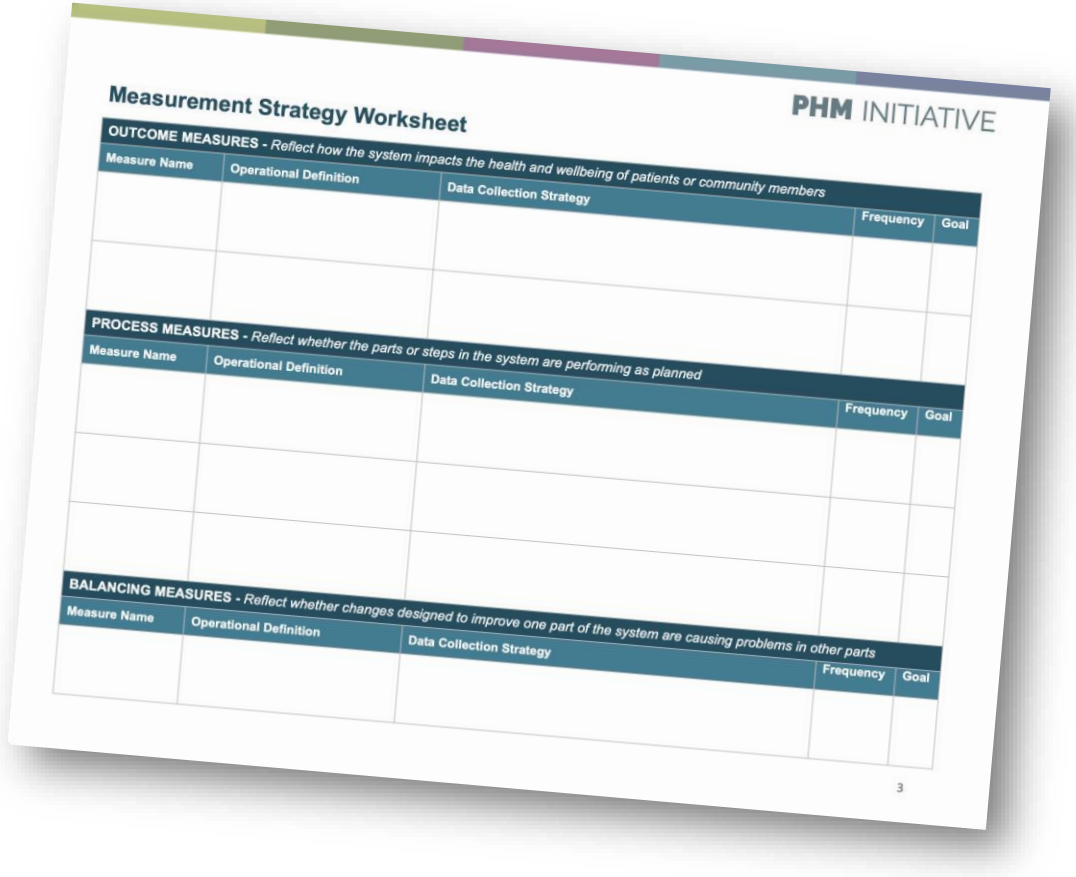
Learning Objectives

1. Select a small family of measures aligned with your team's clinical outcome SMARTIE goal (and other SMARTIE goals, if time allows).

2. Draft an operational definition for each measure, including how they will be calculated and how data will be collected.

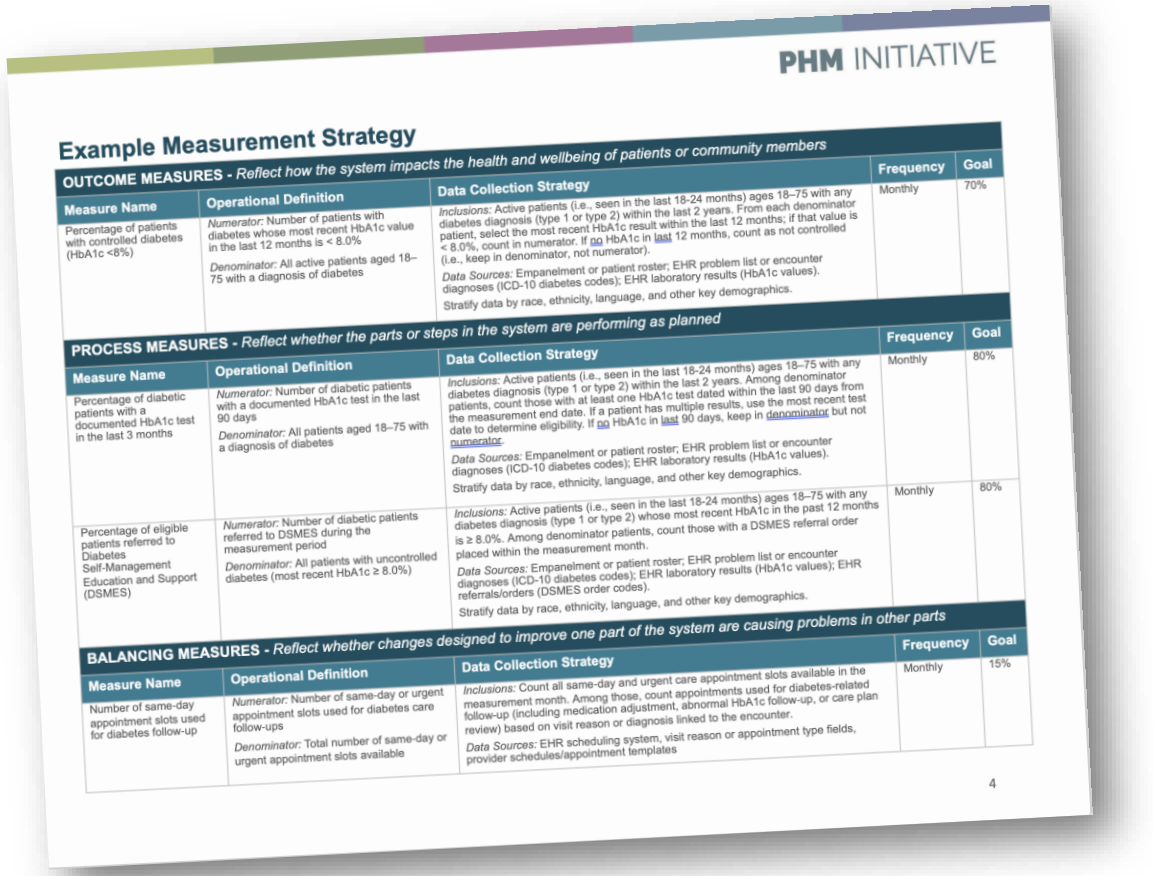
Measurement Strategy Worksheet

- ✓ Start by selecting a family of measures to support your clinical outcome SMARTIE goal (first column).
- ✓ Then, develop operational definitions for each measure (other columns).



Measurement Strategy Worksheet

Refer to the examples on the back of the worksheet, if helpful.



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Example Measurement Strategy

OUTCOME MEASURES - *Reflect how the system impacts the health and wellbeing of patients or community members*				
Measure Name	**Operational Definition**	**Data Collection Strategy**	**Frequency**	**Goal**
Percentage of patients with controlled diabetes (HbA1c <8%)	*Numerator:* Number of patients with diabetes whose most recent HbA1c value in the last 12 months is < 8.0% *Denominator:* All active patients aged 18–75 with a diagnosis of diabetes	*Inclusions:* Active patients (i.e., seen in the last 18-24 months) ages 18–75 with any diabetes diagnosis (type 1 or type 2) within the last 2 years. From each denominator patient, select the most recent HbA1c result within the last 12 months; if that value is < 8.0%, count in numerator. If no HbA1c in last 12 months, count as not controlled (i.e., keep in denominator, not numerator). *Data Sources:* Empanelment or patient roster; EHR problem list or encounter diagnoses (ICD-10 diabetes codes); EHR laboratory results (HbA1c values). Stratify data by race, ethnicity, language, and other key demographics.	Monthly	70%

PROCESS MEASURES - *Reflect whether the parts or steps in the system are performing as planned*				
Measure Name	**Operational Definition**	**Data Collection Strategy**	**Frequency**	**Goal**
Percentage of diabetic patients with a documented HbA1c test in the last 3 months	*Numerator:* Number of diabetic patients with a documented HbA1c test in the last 90 days *Denominator:* All patients aged 18–75 with a diagnosis of diabetes	*Inclusions:* Active patients (i.e., seen in the last 18-24 months) ages 18–75 with any diabetes diagnosis (type 1 or type 2) within the last 2 years. Among denominator patients, count those with at least one HbA1c test dated within the last 90 days from the measurement end date. If a patient has multiple results, use the most recent test date to determine eligibility. If no HbA1c in last 90 days, keep in denominator but not numerator. *Data Sources:* Empanelment or patient roster; EHR problem list or encounter diagnoses (ICD-10 diabetes codes); EHR laboratory results (HbA1c values). Stratify data by race, ethnicity, language, and other key demographics.	Monthly	80%
Percentage of eligible patients referred to Diabetes Self-Management Education and Support (DSMES)	*Numerator:* Number of diabetic patients referred to DSMES during the measurement period *Denominator:* All patients with uncontrolled diabetes (most recent HbA1c ≥ 8.0%)	*Inclusions:* Active patients (i.e., seen in the last 18-24 months) ages 18–75 with any diabetes diagnosis (type 1 or type 2) whose most recent HbA1c in the past 12 months is ≥ 8.0%. Among denominator patients, count those with a DSMES referral order placed within the measurement month. *Data Sources:* Empanelment or patient roster; EHR problem list or encounter diagnoses (ICD-10 diabetes codes); EHR laboratory results (HbA1c values); EHR referrals/orders (DSMES order codes). Stratify data by race, ethnicity, language, and other key demographics.	Monthly	80%

BALANCING MEASURES - *Reflect whether changes designed to improve one part of the system are causing problems in other parts*				
Measure Name	**Operational Definition**	**Data Collection Strategy**	**Frequency**	**Goal**
Number of same-day appointment slots used for diabetes follow-up	*Numerator:* Number of same-day or urgent appointment slots used for diabetes care follow-ups *Denominator:* Total number of same-day or urgent appointment slots available	*Inclusions:* Count all same-day and urgent care appointment slots available in the measurement month. Among those, count appointments used for diabetes-related follow-up (including medication adjustment, abnormal HbA1c follow-up, or care plan review) based on visit reason or diagnosis linked to the encounter. *Data Sources:* EHR scheduling system, visit reason or appointment type fields, provider schedules/appointment templates	Monthly	15%

4

Quick Debrief! How did it go?

What felt easy about selecting and defining measures? What felt hard? Where did your team get stuck?

Next steps

In March, with your coach, you will:

1. Finalize all 3 SMARTIE goals.
2. Draft your implementation plan.

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Selecting High-Leverage Change Strategies

March 4, 2026

Session Agenda

01

Refine Change Ideas

20 mins

02

Prioritize with an Impact-Effort Matrix

25 mins

03

Plan Your PDSA

25 mins

Learning Objectives

1. Prioritize change ideas.
2. Design next test of change (“PDSA”).

So Far You Have…

- ✓ Settled your PHM vision
- ✓ Named what's getting in the way of achieving the vision
- ✓ Crafted your SMARTIE goal(s)
- ✓ Selected measures

Now, we will prioritize changes to decide which ones will have the greatest impact toward your goal.

But First…

Open Your Calendar App

Let's determine a time for our Action Community Monthly Touchpoints:

Starting in April...

- Option A: ***Third Thursday of the month, 9-10am PT.***
- Option B: ***Fourth Thursday of the month, 9-10am PT.***

We will come back together to…

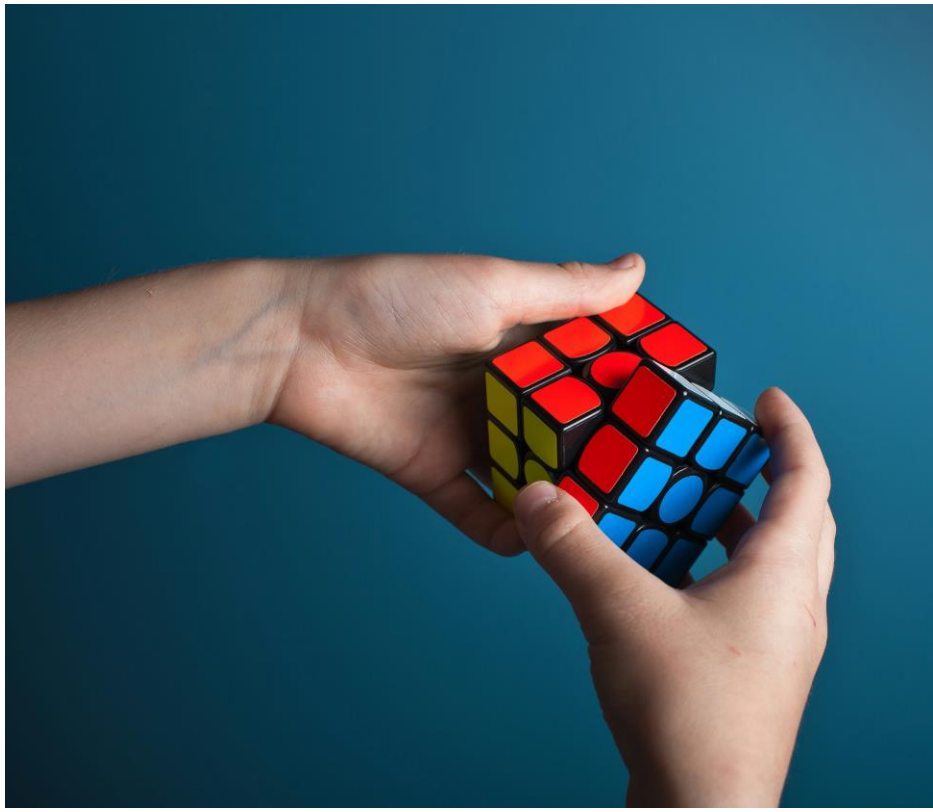
- Celebrate successes and learning
- Facilitate peer problem-solving
- Spread expertise in response to your progress and roadblocks

Consider who else from your clinic will need the call invite.

Let’s Prioritize the Changes You’ll Make

To Speed Up Your Progress, Speed Up Your Learning

- You have ideas for how to achieve your goal.
- Your plan should change as you learn and as conditions change.
- **If your plan is the same in 6 months** as it is today, you are missing important learning.
- Do your best to pick changes, implement with curiosity, and be prepared to adapt as you go.

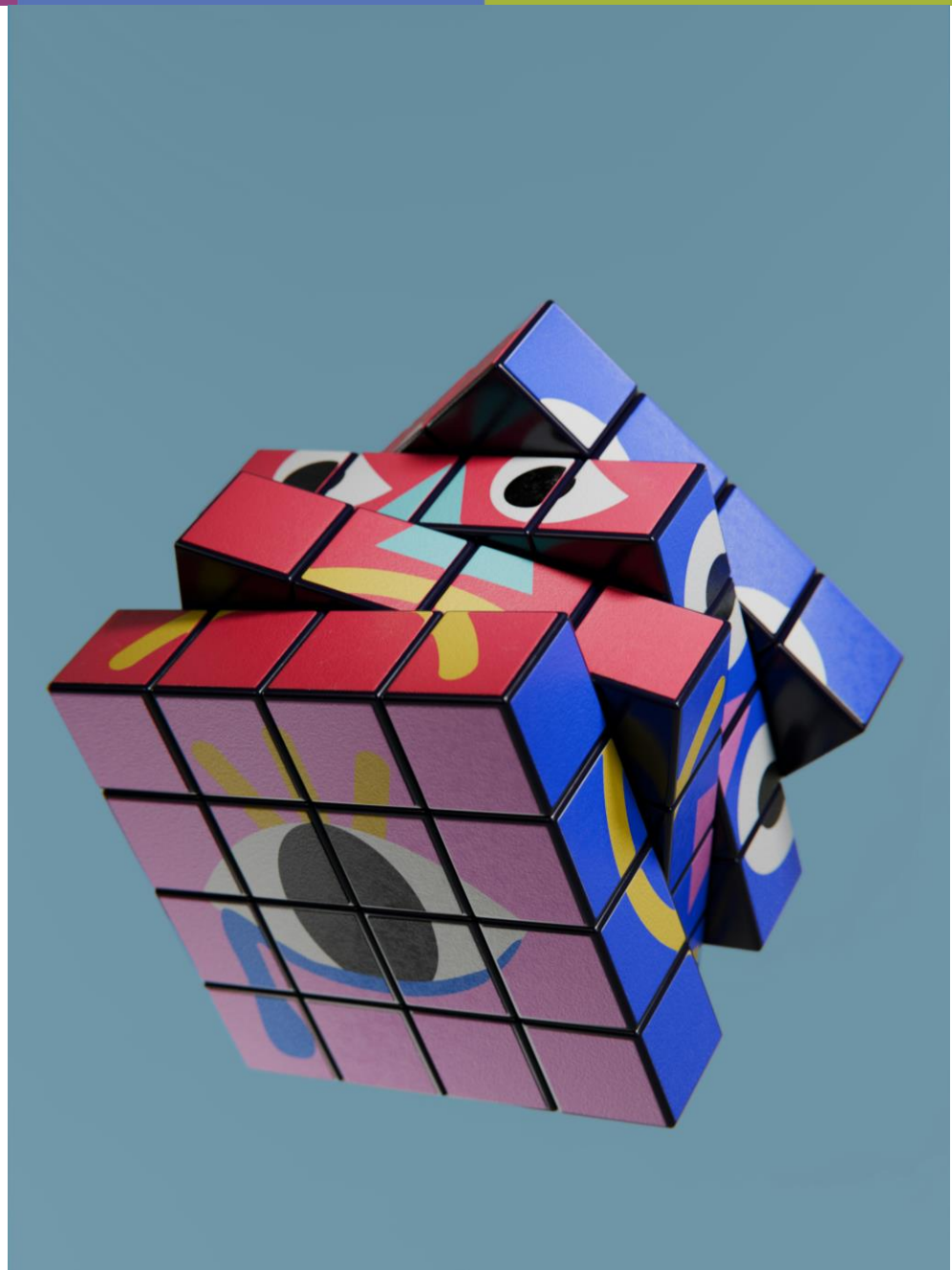


Team Time: Refine Your Changes (15 min)

1. Identify or revisit changes your team...
   - a) selected from the Change Package(s)
   - b) borrowed from peers or
   - c) identified from your daily work.
2. Consider adding changes based on new thinking about the goal, measures, your CHC's needs, or inspiration you're experiencing at the Learning Session.
3. As a team, **pick your "top 6" high-priority changes**, and write one per sticky note.

Change is hard work.

Let’s make it efficient.



Impact-Effort Matrix

Use this tool to predict how much effort and how much impact (in relation to your goals) a change will have.

Team Time: Impact-Effort Matrix (25 min)

- Place each of your top 6 changes on the matrix.
- Discuss as a team why you are picking that position.
- Mark up your matrix if you need to reconsider or add changes.
- Decide on a sequence for the changes; run multiple changes in parallel, if you can collect data for both.
- Pull in a peer from another CHC to double-check your thinking.

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Plan Your Next PDSA

Team Time: Plan Your Next PDSA (25 min)

- [TBD, need to sync up with measures section materials]
- Remember that you'll work with Lindsay in March to complete your Implementation Plan


NINJA
HORSES


NINJA
HORSES

Please transition to the General Session Space.

Next session starts at 4:30 PM:

Let's Make a Prediction and Closing in Gratitude.

Islands Ballroom	General Session Space