PHM INITIATIVE

Action Community Homeroom: Chronic Conditions

March 3-4, 2026

PHM INITIATIVE

Get to Outcomes in 2026

March 3, 2026

Welcome to the Chronic Conditions Action Community!

Seating Assignment

- Table 1: Anderson Valley & Sonoma Valley
- Table 2: Comprehensive Community Health Center & Valley Community Health
- Table 3: Omni & Park Tree Community Health
- Table 4: San Fernando & SCHIP
- Table 5: Universal & Via Care & Eisner
- Table 6: PT Partners

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

Dr. Fiona Donald

Action Community Director, PoF SME

Hithu Kodicherla

Program Manager
JSI

Our PT Coaches

Lindsay Lozada-Dietz
PT Coach

Roza Do
PT Coach

Claire Richardson
PT Coach

Denise Armstorff
PT Coach

Our HIT Coaches & Subject Matter Experts

Marianna Kong
PoF SME

Amena Hashim
HIT Coach

Christina Kim
HIT Coach

Andrew Hamilton
DQ&R SME

Julita Mir
Empanelment SME

Teams You'll Teach and Learn From

Anderson Valley Health Center

CCHC Comprehensive Community Health Centers
Your Health, Our Mission.

Omni Family Health
Our Family Serving Yours
Since 1978

parktree Community Health Center

SFCHC
SAN FERNANDO COMMUNITY HEALTH CENTER

SONOMA COUNTY INDIAN HEALTH PROJECT

SONOMA·VALLEY COMMUNITY HEALTH CENTER

UNIVERSAL community health center

Valley Community Healthcare

ViaCare
your health, your way

EISNER HEALTH

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.

• PHMI •

March 2026

What's on the Menu

To be served up by March 31, 2026

I. Identify PH Leadership Team

Served

Executive sponsor, clinical lead, and quality improvement lead – your essential trio for driving population health forward.

II. Assess Current State

Served

Review PhmCAT scores, sustainability plan, clinical outcome measures (by race/ethnicity), equity SMARTIE goals, PHMI business case, and your CHC's strategic plan.

III. Create/Refine a Vision Statement

Today

Leverage current state assessment results to craft a population health vision that unites your organization around shared priorities.

IV. Set 3 SMARTIE Goals for 2026

Tomorrow

One goal each for: (a) improving clinical outcomes for your PoF, (b) implementing evidence-based best practice interventions, and (c) spreading interventions to identified clinic sites.

Compliments of the Population Health Management Initiative

In Our Action Community…

- We are all focused on Chronic Conditions: Improving Clinical Outcomes in Hypertension and Diabetes.
- We all will understand "where we are starting from" and make plans "to get to where we want to go."
- We can make important, measurable progress at our clinics this year, even amidst larger uncertainties.
- We will leverage our Action Community to support each other.

Goals for Action Community Sessions Today and Tomorrow

Today:

- Meet your Action Community peers.
- Finalize your PHMI Vision today.

Tomorrow:

- Create and finalize one or more of your SMARTIE Goals.
- Focus on Improving Clinical Outcomes for your PoF.
  - Review the PHMI resources that can support your goals e.g., Change Packages and Measurement Strategies.
- Hear and learn from peers.
- Have fun! Ask questions!
- Take care of yourself to support feeling energized!

How Our Action Community (AC) Will Work in 2026

Action Community Monthly Touchpoint:

- Here are some options for you to consider:
  - **3rd Wednesday of every month (starting April 15th 12-1 pm PT) OR**
  - **4th Friday of every month (starting April 24th 12-1 pm PT)**
- Celebration of successes in your PHMI processes and goals
- Facilitation of peer problem-solving

Let's meet each other and get cooking!





While we are in our Chronic Conditions AC today and tomorrow, we are going to get creative and roll up our sleeves!

CHC Aprons

- Each CHC has an apron.
- Take it back to your clinic as a PHMI souvenir.
- Make the apron your own with your CHC name.
- Decorate! Any way you want over the next 2 days – inspiration, notes from other CHCs, etc.

Collaboration Activity





- Count off 1, 2, 3, 4, 5, 6.
- Sit at a table with other who have your number.
- Build and create a free-standing structure with spaghetti, marshmallow, tape, string, and scissors.
- Goal is to create the longest structure you can and put the marshmallow on the top.
- Runner up – most aesthetically pleasing structure.
- Winners will earn a ✨ prize ✨ in our Action Community.

PHM INITIATIVE

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.

What does the future look like if we succeed beyond our wildest dreams?

Considerations to **strengthen** your CHC's PHMI Vision:

- Identify local needs
- Align with your CHC mission
- Outcome Focus
- Impact & Equity
- Satisfaction both for your patients, providers, staff and community

One Clinic's Vision

MCC is committed to reducing the impact of breast cancer on our community, one screening at a time, by removing barriers, providing whole-person care, and expanding access to early detection so cost never stands in the way of saving lives.

If you have a vision statement, access it now to refine.
If you do not have a vision statement, use this time to create one.

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.
5. Share your vision statements (with the whole group at the end).

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.

- **If you picture running a relay race and you need to jump over hurdles, what are the 2 biggest hurdles you need to pass over?**
- **Why were they the most important?**

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

- Share as a team what you wrote down as the 2 biggest hurdles.
- Make a list of each team member's ideas; we'll use it tomorrow.

Our Action Community Identity

How Our Action Community (AC) Will Work in 2026

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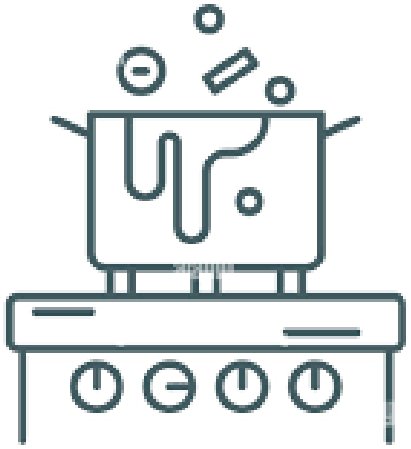
What's Our AC Name?

- Option 1: In the Kitchen with Chronic Conditions
- Option 2: Cookin' with Chronic Conditions
- Option 3: Chronic Conditions Chefs

Other AC Name suggestions?

What's Our AC Logo?

Option #1



Option #2

Option #3

Tomorrow Takes a Turn for the Tactical: We will map our next steps to achieving our vision

1. Finetune SMARTIE goals.
2. Develop a plan to measure progress.
3. Prioritize which measures to track progress.
4. Decide which changes give the most bang for your buck.
5. Coach each other and hear from our peers.

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 SMARTIE Goals

25 mins

02

Peer Coaching

25 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.

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.

CHCs will develop 3 SMARTIE Goals

A. Improving clinical outcomes across the organization for the selected PoF* (HEDIS/PHMI Metrics)

#1 Priority

B. Sustainability Goal (April-Sept)

C. Spreading Goal (By September)

If you have time

These are just milestone supporting Goals

**Ultimate goal is improved clinical outcomes (HEDIS/PHMI metrics), so SMARTIE goals B and C are in support of A*

Each SMARTIE goal will have an implementation plan with an associated data strategy which could include outcome metrics, process metrics, balancing metrics, stratified data, site level data, and care team/provider level data for review at each monthly and quarterly meeting.

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.

Example SMARTIE Goals

- By December 31, 2026, our Clinic will increase the percentage of assigned patients with diabetes control (HgbA1C) < 8 % from 33% to 38% . We will increase the percentage of Spanish-speaking patients with diabetes who have a HbA1c below 8% from 33% to 43%
- We will achieve this goal by :
  - Implementing a culturally and linguistically appropriate diabetes self-management education program, co-designed with Spanish-speaking community health workers and patients with lived experience
  - Referring all patients with diabetes who screen positive for food insecurity for care management intervention
  - Outcomes will be tracked monthly and disaggregated by language, food security status, and HbA1c level.

Action: Get ready for Team time -SMARTIE Goals

- If you have a draft SMARTIE goal(s), access them now and prepare to review.
- If you do not have SMARTIE goal (s), let's create one focused on clinical outcomes.
- Ask for help from those in the room!

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

1. Have one person from your team, read your draft clinical outcomes SMARTIE 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.

Peer Coaching

Peer Coaching: Strengthen Your Goals (25 min)

- Write your SMARTIE goal on the flipchart paper (5 mins).
- Half of your team will stay with your SMARTIE goal, the other half will move to other CHC goals to provide feedback on their SMARTIE goal.
- Consider:
  - What could make the goal clearer or more motivational?
  - What could make it more ambitious?
  - What could make it more feasible on this timeline?

Team Time: Process Feedback from your Peers (10 min)

- **Notetakers:** Share the ideas and questions you received.
- **Team:** Listen generously. Discuss and continue strengthening your SMARTIE goal(s). Raise your hand if you want thought partnership from the coaches and SMEs in the room

Your Clinical Outcomes 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

15 mins

02

Team Time

30 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.

Selecting Measures Tip #1:

Start with the Goal, Work Backwards

An **outcome measure** should directly reflect the SMARTIE goal

If it doesn't, you may be measuring activity, not impact

Selecting Measures Tip #2:

Pick One Primary Outcome

Usually you can find one main signal to define success
(Complex situations may need two outcome measures—rare!)

It should be simple enough to explain in one sentence

Examples:

- Diabetes goal → % patients with A1c < 8
- Referral goal → % referrals completed within 30 days

Selecting Measures Tip #3:

Process Measures Move in 1-2 Weeks

Pick **process measures** that…

- Can be “seen” quickly
- Are under your control
- Relate to your change strategies and workflows

Good process measures 😇

% visits w/pre-visit planning completed
% patients outreached w/in 48 hours

Bad process measure 😈

Annual UDS metric

Selecting Measures Tip #4:

Tasks ≠ Process Measures

Training staff is an activity—not a success measure

Process measures happen with patients

So instead of “# staff trained,”

think “% of visits using new intake workflow”

Selecting Measures Tip #5:

Include Balancing Measures

If you improve clinical outcomes but burn out staff or incur unplanned costs, that's not sustainable progress!

Try balancing measures that track unintended consequences, e.g.:

- Staff overtime hours
- Patient complaints
- Clinician satisfaction
- 7-day return visits
- Cost per visit

Selecting Measures Tip #6:

Limit It to the "Vital Few"

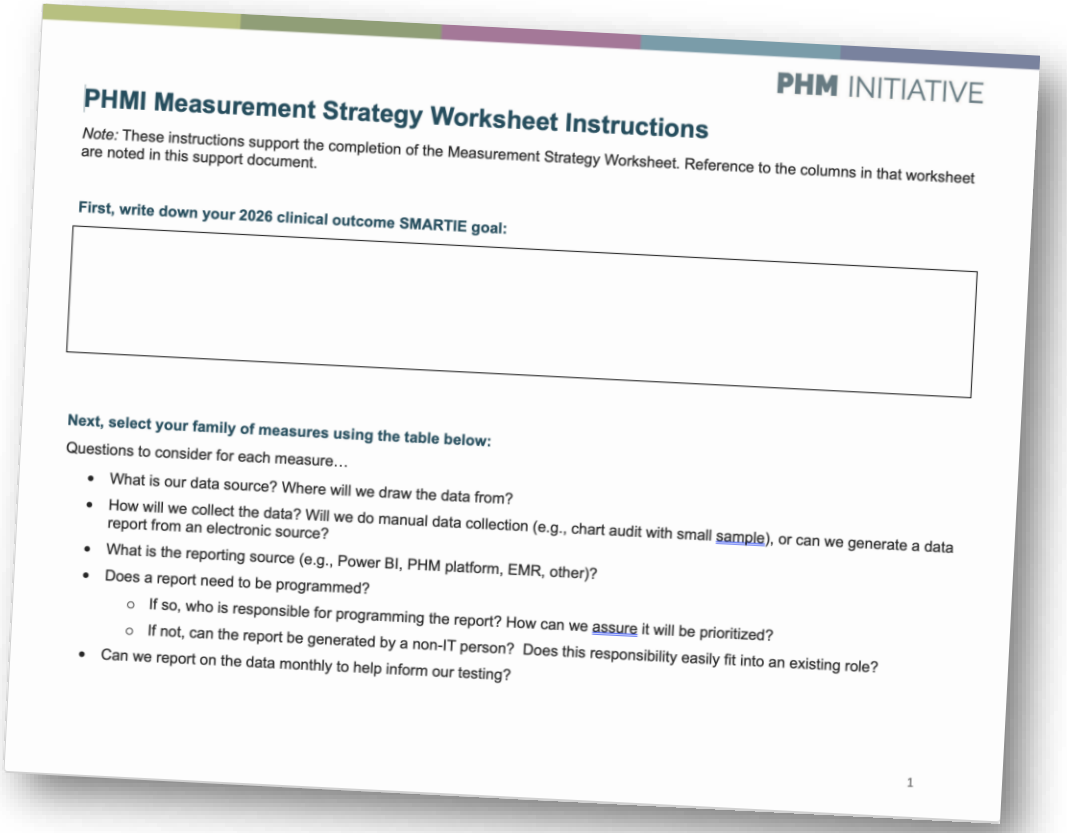
How close can you get to this lineup?

- 1 outcome measure
- 2 process measures
- 1 balancing measure

Too many measures becomes a laundry list

Measurement Strategy Worksheet Instructions

- ✓ 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).



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PHMI Measurement Strategy Worksheet Instructions

Note: These instructions support the completion of the Measurement Strategy Worksheet. Reference to the columns in that worksheet are noted in this support document.

First, write down your 2026 clinical outcome SMARTIE goal:

Next, select your family of measures using the table below:

Questions to consider for each measure…

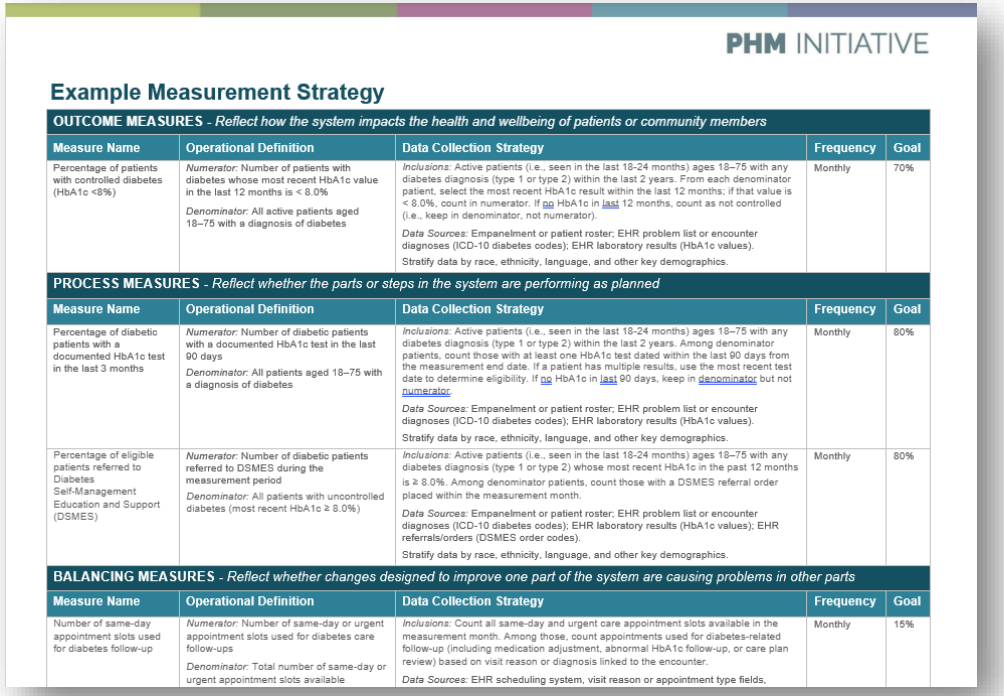
- What is our data source? Where will we draw the data from?
- How will we collect the data? Will we do manual data collection (e.g., chart audit with small sample), or can we generate a data report from an electronic source?
- What is the reporting source (e.g., Power BI, PHM platform, EMR, other)?
- Does a report need to be programmed?
  - If so, who is responsible for programming the report? How can we assure it will be prioritized?
  - If not, can the report be generated by a non-IT person? Does this responsibility easily fit into an existing role?
- Can we report on the data monthly to help inform our testing?

1

Example Measurement Strategy: Outcome Measure

Reflect how the system impacts the health and wellbeing of patients or community members

- Measure: Percentage of patients with controlled diabetes (HbA1c <8%)
- Operational Definition:
  - 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



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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,	Monthly	15%

Example Measurement Strategy: Process Measure

Reflect whether the parts or steps in the system are performing as planned

- Measure: Percentage of diabetic patients with a documented HbA1c test in the last 3 months
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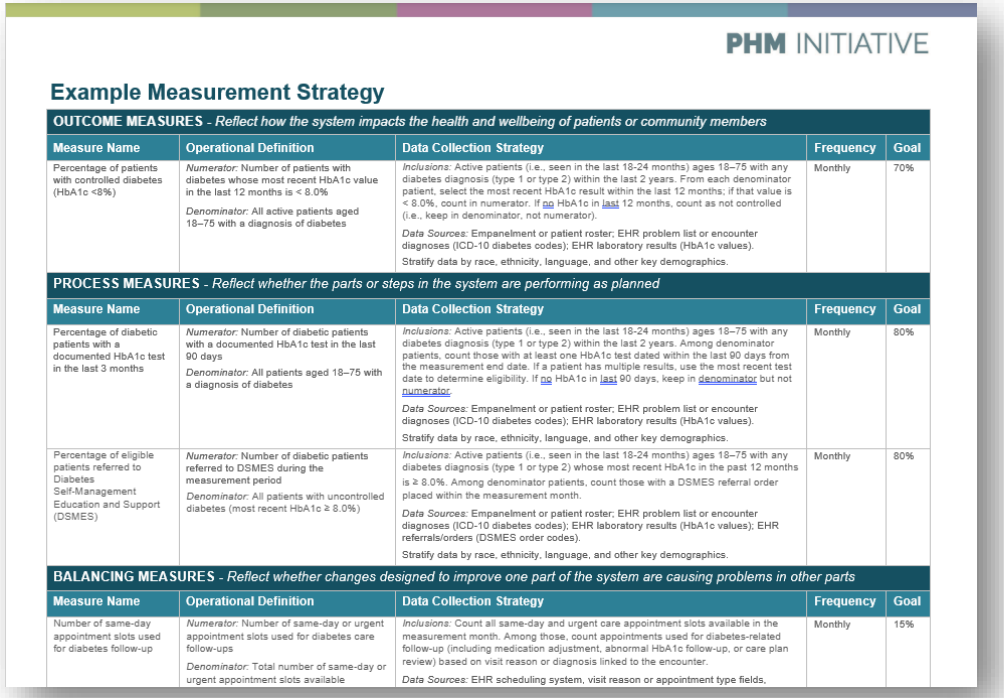

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Example Measurement Strategy

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Example Measurement Strategy: Balance Measure

Reflect whether changes designed to improve one part of the system are causing problems in other parts

- Measure: Number of same-day appointment slots used for diabetes follow-up
- Operational Definition:
  - Numerator: Number of same-day or urgent appointment slots used for diabetes care follow-ups
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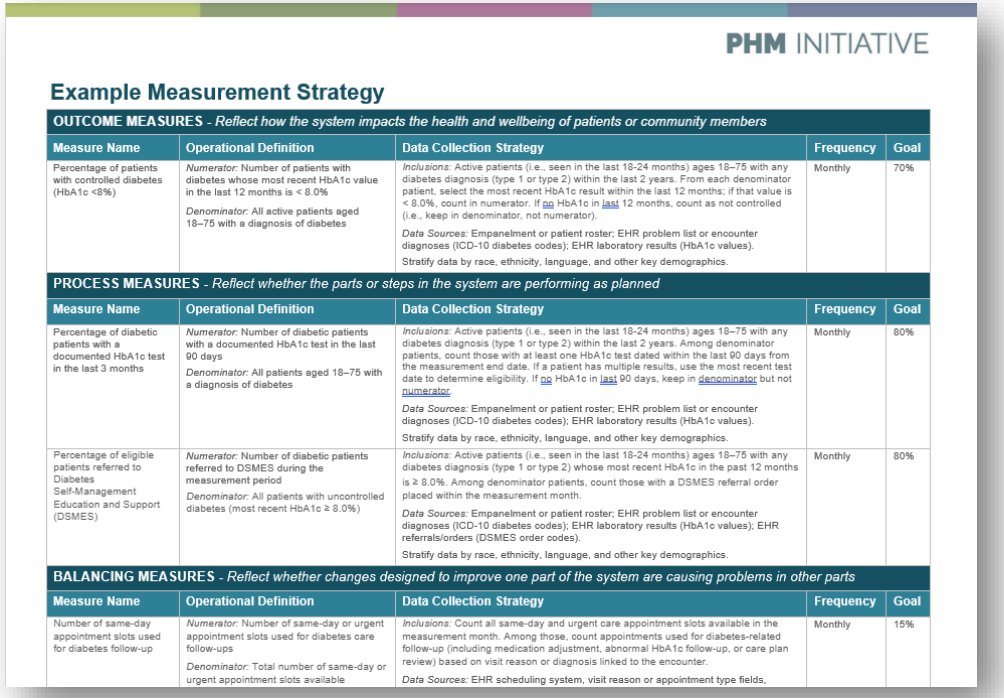

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Clinical Outcome Aim with Measurement Ideas

- Clinical Outcome: Controlling High Blood Pressure
- Outcome Measures:
  - HEDIS/UDS Measure (what point in time- ?)
- Process Measures:
  - % of members enrolled in RPM with controlled HTN within 6 months of program entry
  - % of members with uncontrolled BP with completed visits with care team (interval?)
  - Consider measure around quarterly (or interval) visits with provider for med mgt/reconciliation

Ask your SMEs!

- Put a stickie with your CHC name to request SME support

In the kitchen today….

Data Quality and Reporting and HIT

Improvement Expertise

Financial/Equity/Care Teams/Empanelment

PoF SMEs/Coaches

Quick Debrief! How did it go?

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

PHM INITIATIVE

Selecting High-Leverage Change Strategies

How do you pick the right changes to get to your goals?

March 4, 2026

But First…

Let's schedule our monthly touchpoints

Hold time for our Action Community Monthly Touchpoints: By show of hands,

- **3rd Wednesday of every month (starting April 15th 12-1 pm PT) OR**
- **4th Friday of every month (starting April 24th 12-1 pm PT)**

4th Friday is the winner!

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

Session Agenda

01

Refine Change Ideas

20 mins

02

Prioritize with an Impact-Effort Matrix

25 mins

03

Plan Your PDSA*

25 mins

*Leaders with purple dot will be leaving around 2:35 pm

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*

What's next??

Next steps

1. Prioritize the changes from the have considered to support your clinical outcomes.

OR

2. Review potential changes in the change package and choose.

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Let’s Prioritize the Changes You’ll Make

Recognizing that you may have committed to certain strategies –like empanelment, using the PHMI platform, care teams based on PHMI work in 2025

Team Time: Select or Refine Your Changes (15 min)

1. If you selected change strategies, review them with your team now.
2. If you have not selected change strategies yet, review the Key Driver Diagram in the Change Packages on the table and discussing.
3. Consider adding changes strategies based on new thinking about the goal, measures, your CHC's needs, or what you have heard today.
4. As a team, pick 6 options for high-priority changes, and write one per sticky note.

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)

- For each change, talk about where it should go on the matrix and post it up.
  - You can take notes on the matrix or add new changes as needed.
- What are the 2-3 changes that make the most sense to focus on?
- Talk about a timeline for the highest priority changes.
- Run your thought process by someone from another CHC at your table and get their thoughts.

Plan Your Next Steps

If you have a chosen a change strategy, you can start to plan your PDSA.

If you are still evaluating your change strategy options, what will you need to do in order to move forward?

Team Time: Plan Your Next PDSA (25 min)

PHM INITIATIVE **PDSA Worksheet**

Name of Clinic Team:
Overall Objective: Improve clinical outcomes by
PHMI Population of Focus: Chronic Conditions

Month(s) testing:

Change Strategy to Test:

PLAN:

1. Briefly describe the test:

2. List the tasks necessary to complete this test (What)	Person responsible (Who)	When	Status

3. What do you predict will happen?

4. What data will be collected to indicate whether this change led to improvement?

DO: Carry out the planned test of change. Collect data; describe observations and problems encountered.

STUDY: What did you learn? Analyze data, observations, problems encountered and determine next steps. How do results compare with your prediction?

ACT: Select next step:

- ☐ **Adapt**: Modify the change and continue testing plan. Plans/changes for next test:
- ☐ **Adopt**: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability
- ☐ **Abandon**: Discard this change idea and try a different one

Team Time: Plan Your Next Steps (25 min)

- Who do you need to talk to move forward with your goal?
- What systems are needed?
- When are you going to do them?
- Ask for coach/SME Support

Those attending the leadership session are invited to go on break at 2:35 PM.

Leadership sessions starts at 2:50 PM:

Policy Forces and Actions: Advancing PHM Amidst Headwinds

Bayview Ballroom	Leadership session – purple nametag dot

All others, please stay here.

Break

15 Minutes – Back at 3:25 pm

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Speed Coaching

March 4, 2026

Chronic Conditions Action Community

- Where do we go from here?
  - By March 31,
  - Clinical Outcome SMARTIE GOAL with measures (process, outcome, balancing) AND Strategies
  - Sustainability (FOUNDATIONS OF PHMI) SMARTIE GOAL with measures (process, outcome, balancing) AND Strategies
  - Spread SMARTIE GOAL –draft
- What do you need?

What are our next steps as an AC

- First Action Community Monthly Touchpoint in April
  - **Please a put a hold in your calendar for 4th Friday of every month (starting April 24th 12-1 pm PT). We will send a formal invitation out soon.**
- We will review progress – how are measurement strategies going? What progress have you made in change strategies?
- Identify common areas for discussion to support chronic conditions
  - Examples: Social Health Needs, Remote Monitoring, Group Visits, Self Education Programs, Care Teams etc.

Ideas

- Mix and mingle by Diabetes (list DM clinics) and HTN (list HTN clinics)
- Mix and mingle by use of PHMI platform
- Mix and mingle by remote patient monitoring—Omni/Universal/Valley
- Mix and mingle by rural clinics and reaching remote populations-Anderson Valley/SCHIP
- Mix and mingle by Empanelment

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