PHM INITIATIVE

Welcome to the March 2026 PHMI Statewide Learning Session!

March 3, 2026

Presenters

Meena Mital, MD
PHMI Director

Elena Thomas Faulkner
Project Director,
PT Partners

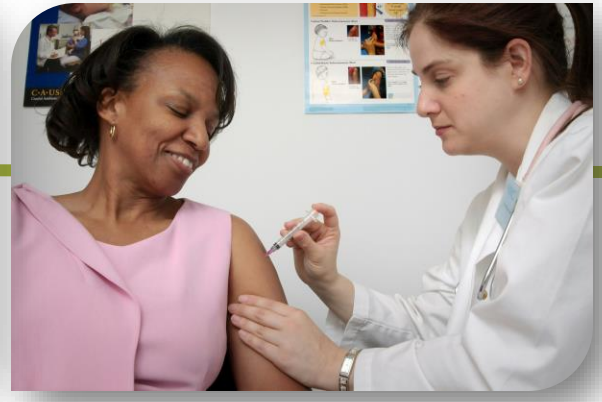
Tim Ho, MD
Regional Assistant Medical Director, Southern California Permanente Medical Group

Welcome from Dr. Mital and Dr. Ho

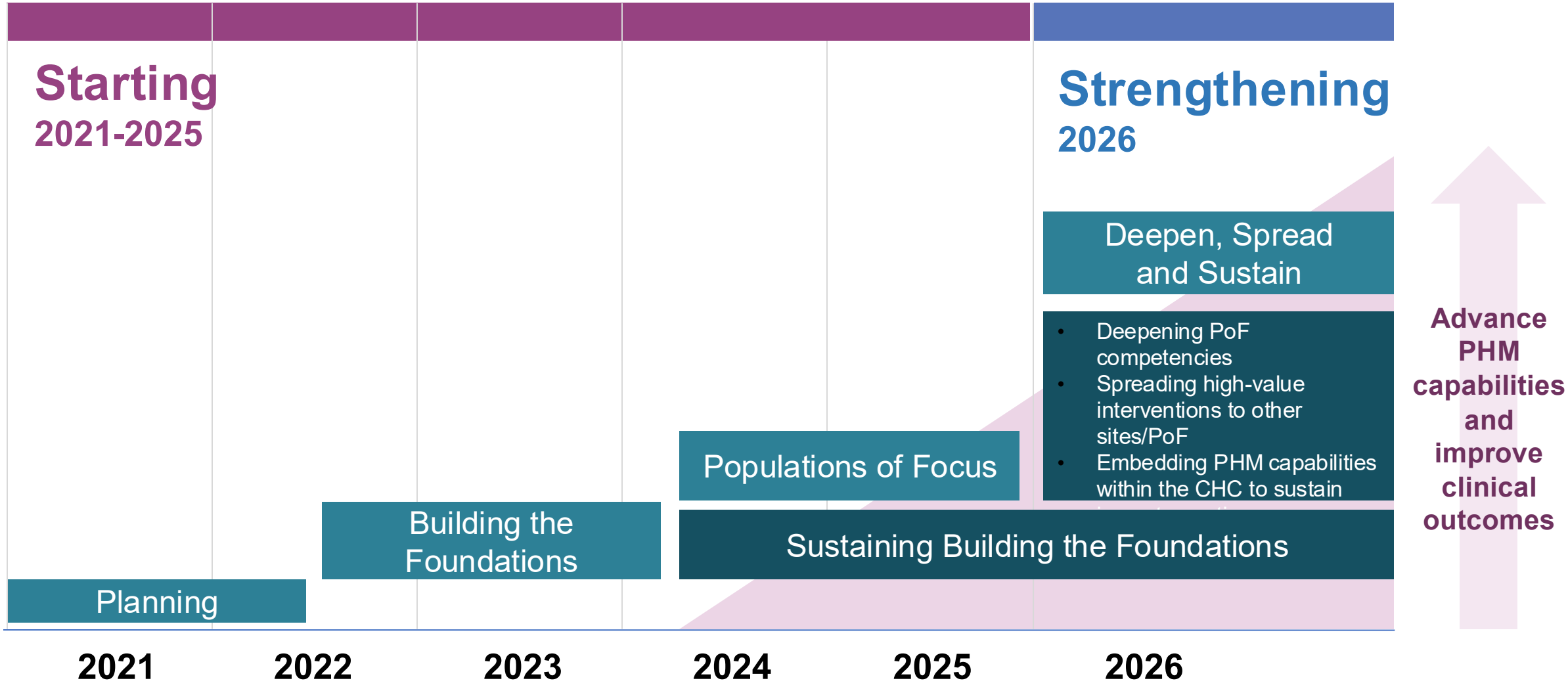
Our North Star

Improve the quality of care and address disparities for all patients and families served by California Community Health Centers



Continuing Our PHMI Journey



Health Centers

Alexander Valley Healthcare
Feel Good... We Have You Covered

Alliance Medical Center
Clínica Alianza

Anderson Valley Health Center

EISNER HEALTH

opendoor
Community Health Centers

Comprehensive Community Health Centers
CCHC
Your Health, Our Mission.

APHCV

COMMUNITY
Medical Centers

Mendocino Coast Clinics

Omni Family Health
Our Family Serving Yours
Since 1978

parktree
Community Health Center

Petaluma HealthCenter

RCMS
COMMUNITY HEALTHCARE

Redwoods Rural
HEALTH CENTER

SONOMA VALLEY
COMMUNITY
HEALTH CENTER

Santa Rosa
COMMUNITY
HEALTH
All of us. For all of you.

25 UMMA
COMMUNITY CLINIC
YEARS OF SERVICE

UNIVERSAL
community health center

Valley
Community
Healthcare

Venice Family Clinic

SABAN
COMMUNITY
CLINIC

SFCHC
SAN FERNANDO COMMUNITY
HEALTH CENTER

SONOMA COUNTY
INDIAN HEALTH PROJECT

ViaCare
your health, your way

West County
Health Centers
Caring for our Communities

PHMI Stakeholders and Collaborators

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

California Primary Care ASSOCIATION

Regional Associations of California

Aliados Health
Access | Equity | Advocacy | Innovation

CCALAC
Community Clinic Association of Los Angeles County

NORTH COAST CLINICS NETWORK

CVHN
Central Valley Health Network

Practice Transformation (PT) Partners

JSI

Primary Contractor

Institute for Healthcare Improvement

CCI
CENTER FOR CARE INNOVATIONS

AllianceChicago
Innovating for better health

UCSF
Department of Family & Community Medicine
Center for Excellence in Primary Care

Technical Assistance Partners

HMA
Health Management Associates

siren
Social Interventions Research & Evaluation Network

forv/s mazars

HEALTH BEGINS

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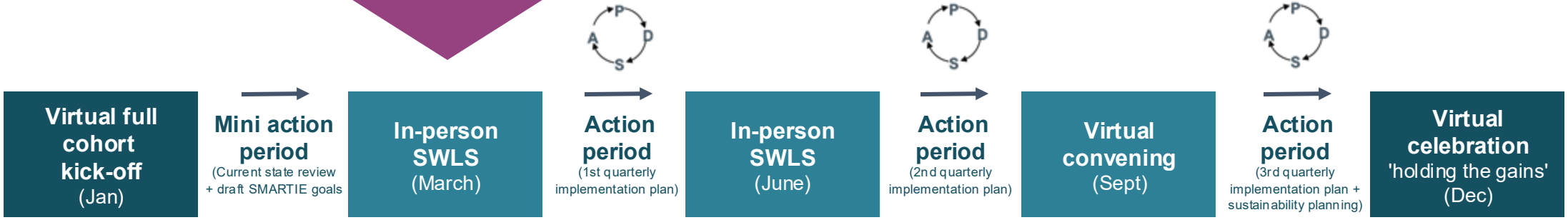
Our Time Together

We Are Here!



Launching Today!

Action Communities and Leadership Groups

Our Agenda Is Designed To...

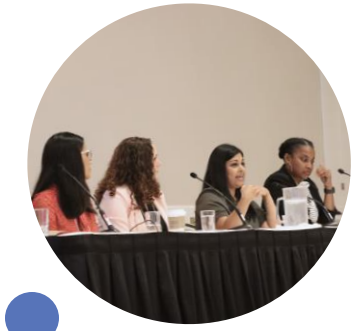
Connect

Inspire

Dig Deep

Advance

Ground



Getting Started with Connection

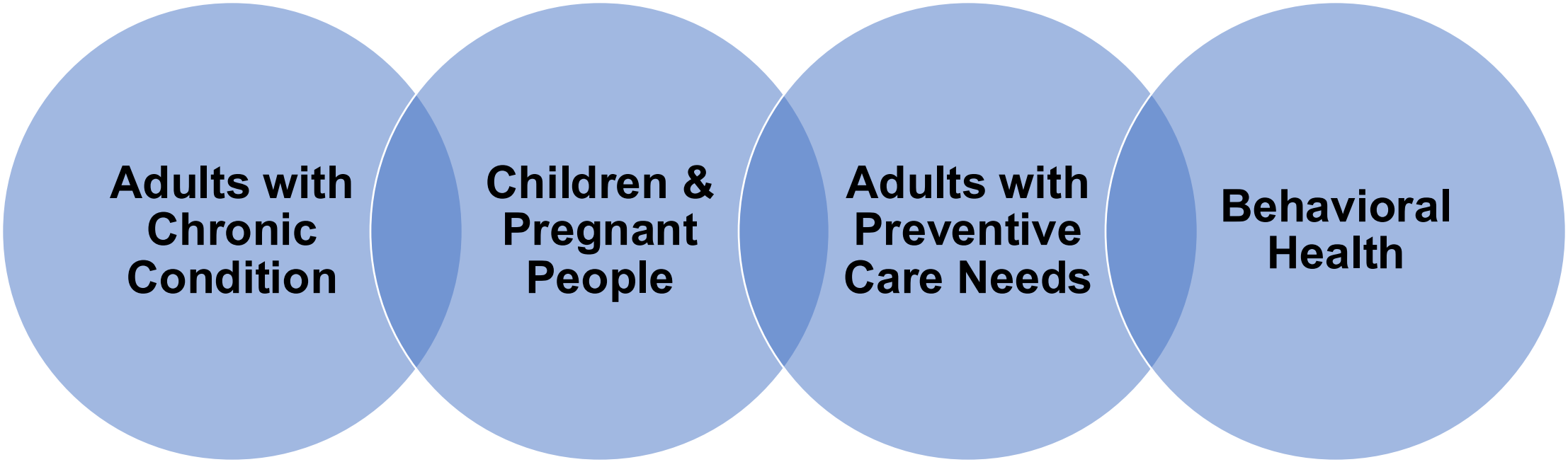
Today's Agenda: Strategic Launch

1	Getting to Outcomes – in your Action Communities
2	Championing Improvement
3	Panel: Building Equitable Care
4	Keynote
5	Wrap-up
6	Reception

Tomorrow's Theme: Getting into the Details

- Breakfast Blends
- Plenary Sessions:
  - Moving from Implementation to Spread
  - Optimizing Data for Improvement
- Leadership Focus:
  - Key Financial Levers to Sustain PHM
  - The AI Imperative: Leading Through Disruption and the Survival of the Safety Net
  - Policy Forces and CHC Actions: Advancing PHM Amidst Headwinds
- In Action Communities:
  - Fine-tune Your Team Goals
  - Develop a Measurement Strategy
  - Select High-Leverage Change Strategies
  - Speed Coaching

Launching: Action Communities



Adults with Chronic Condition	Children & Pregnant People	Adults with Preventive Care Needs	Behavioral Health
Fiona Donald Mariana Kong (SME) Hithu Kodicherla	Jen Powell Anda Kuo & Lyn Yasumura Emma Gier	Paige Nichols Lyn Yasumura Shaivi Herur	Catherine Craig Emma Ansara & Ben Miller Alexis Sasso

Health Center Leadership Roundtables

Focused on **connection** among organizational leaders, charged with **championing, sustaining** and **monitoring** PHM at their health center.

Statewide Learning Session Breakouts	Virtual Meetings throughout the year

Health Center Leaders
CEO, COO, CFO, CMO

Clinical Leaders
CMO/CBHO

Ask

Ideas
Guidance
Experience
Support

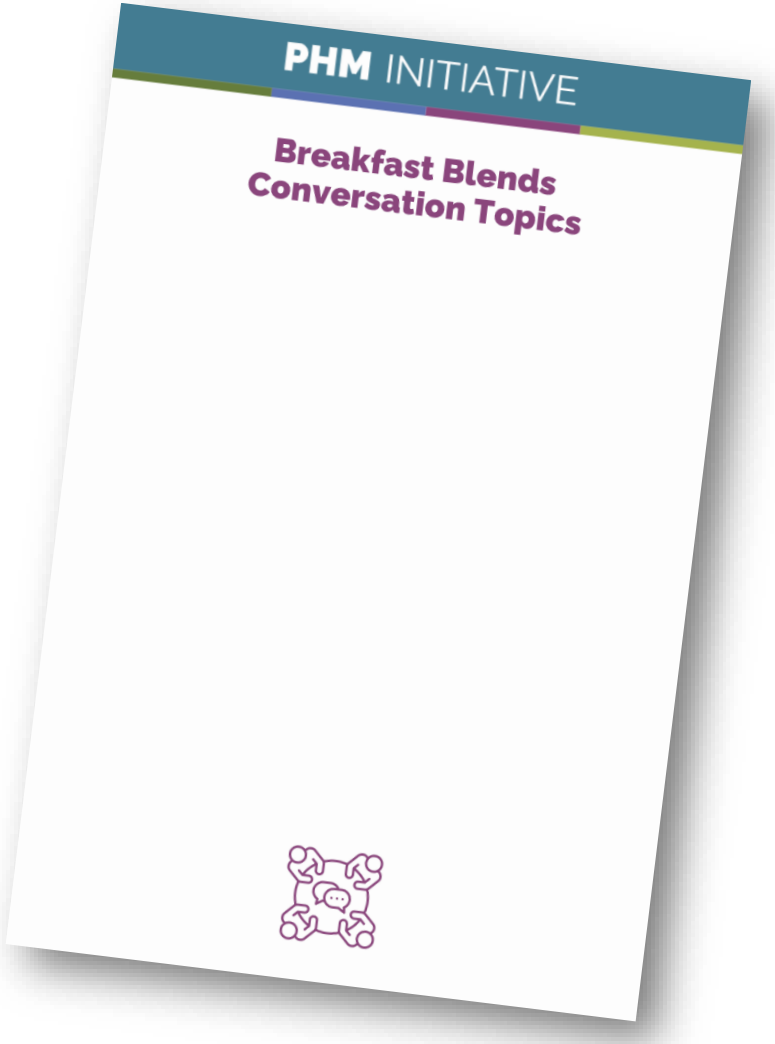
Offer

Please include your name and organization on asks and offers!

Breakfast Blend Opportunity

Is there a topic you are itching to discuss with colleagues?

- Add TOPIC to the flipchart with YOUR NAME and CHC NAME.
- Find the breakfast table with the sign for the topic tomorrow at 8.
- PT Partner staff will help facilitate breakfast blends.



Housekeeping

- We're here to help!
- Wayfinding (homerooms, restrooms, etc.)

Please transition to your Action Community Homeroom.

Next session starts at 12:35 PM:
Get to Outcomes in 2026

Quarter Deck (1st Floor)	**Adult with Preventive Care Needs** - *red nametag dot*
Mariposa (2nd Floor)	**Adults with Chronic Conditions** - *dark blue nametag dot*
California (4th Floor, Executive Meeting Center)	**Children and Pregnant People -** *yellow nametag dot*
El Dorado (2nd Floor)	**People with Behavioral Health Conditions** - *green nametag dot*

Championing Improvement

March 3, 2026

Session Agenda

1	Opening	*5 mins*
2	Culture of Improvement	*10 mins*
3	Santa Rose Community Health Spotlight	*5 mins*
4	Contributing from Your Role	*15 mins*
5	Flex Your Skills	*15 mins*

Presenters

Eddie Turner
Action Communities Director

Denise Armstorff
PT Partner Coach

Learning Objectives

1. Consider each team member's role in continuing to build a culture of improvement
2. Apply methods for learning from data, tests, and failures
3. Describe ways to maintain an effective implementation team

Why talk about improvement now?

Photo credit: Genaro Molina, Los Angeles Times, Sept. 22, 2020

Habits for improvement will prepare you to meet the moment.

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Creating a Culture for Improvement

Quality Improvement Relies on Organizational Culture

"Organizational culture is the collection of values, expectations, and practices that guide and inform the actions of all team members."

Culture is created through consistent, authentic behaviors and actions.

Organizational culture influences and shapes all aspects of your business.

Wong, K. (n.d.). Organizational culture: Definition, importance, and development. Retrieved February 02, 2021, from https://www.achievers.com/blog/organizational-culture-definition/

What matters most to you in an organization's culture? Which values, expectations, behaviors, and practices?

Join by Web

PollEv.com/katierobert773

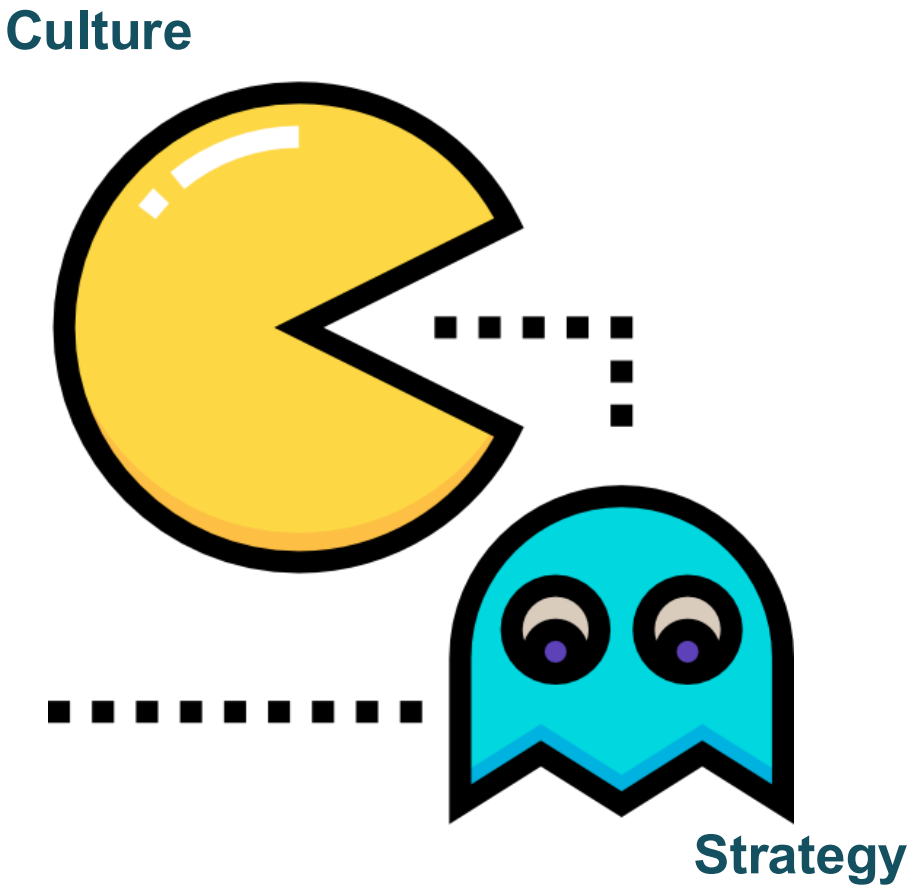
Join by QR code

Scan with your camera app

In a Battle Between Culture and Strategy . . .

Culture determines:

- How decisions actually get made
- How people behave when no one is watching
- Whether people speak up
- Whether risk-taking is safe
- Whether accountability is real
- Whether change sticks



How Culture Eats Strategy . . .

If the Strategy Says…	And Culture Does This…	In Healthcare, It Can Look Like…
"Use data to drive improvement."	Shapes whether data is used for rapid reporting or for reflection and learning	Dashboards are reviewed quickly, without time to reflect on trends or disparities
"Prioritize quality and population health."	Influences whether improvement is experienced as core work or competing work	Improvement feels secondary to daily operational demands
"Empower teams and innovate."	Determines whether stability is protected through caution or strengthened through small tests	Small tests of change are delayed, even when they could reduce burden long-term
"Collaborate across teams."	Reinforces silos or encourages shared accountability	Care teams operate in parallel rather than coordinating around shared patients
"Encourage continuous learning."	Affects whether we move task-to-task or pause to study and adapt	Limited time to reflect, refine workflows, or build long-term capability

The Connection Between Culture and Results

Generate or reinforce desired culture

Create new experiences

Smith, R. C. (n.d.). Change the Culture, Change the Game. Retrieved August 06, 2017, from https://www.goodreads.com/book/show/8886396-change-the-culture-change-the-game

Foundational Elements of QI Culture

Element	What It Requires
Leadership Commitment	Align vision with strategy • Set expectations • Model support • Commit resources
QI Infrastructure	Align with mission • Ensure oversight • Integrate into performance systems
Empowered Workforce	Build capability • Foster collaboration • Embed QI into daily work
Patient & Family Engagement	Create structured partnership • Incorporate patient voice
Continuous Improvement	Make improvement ongoing • Use data to test, learn, adapt

CHC Spotlight:
Building a Culture of Improvement

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Contribute from Your Role

We'll Consider Two Roles

- Implementers
- Sponsors

Another important role is people with lived experience

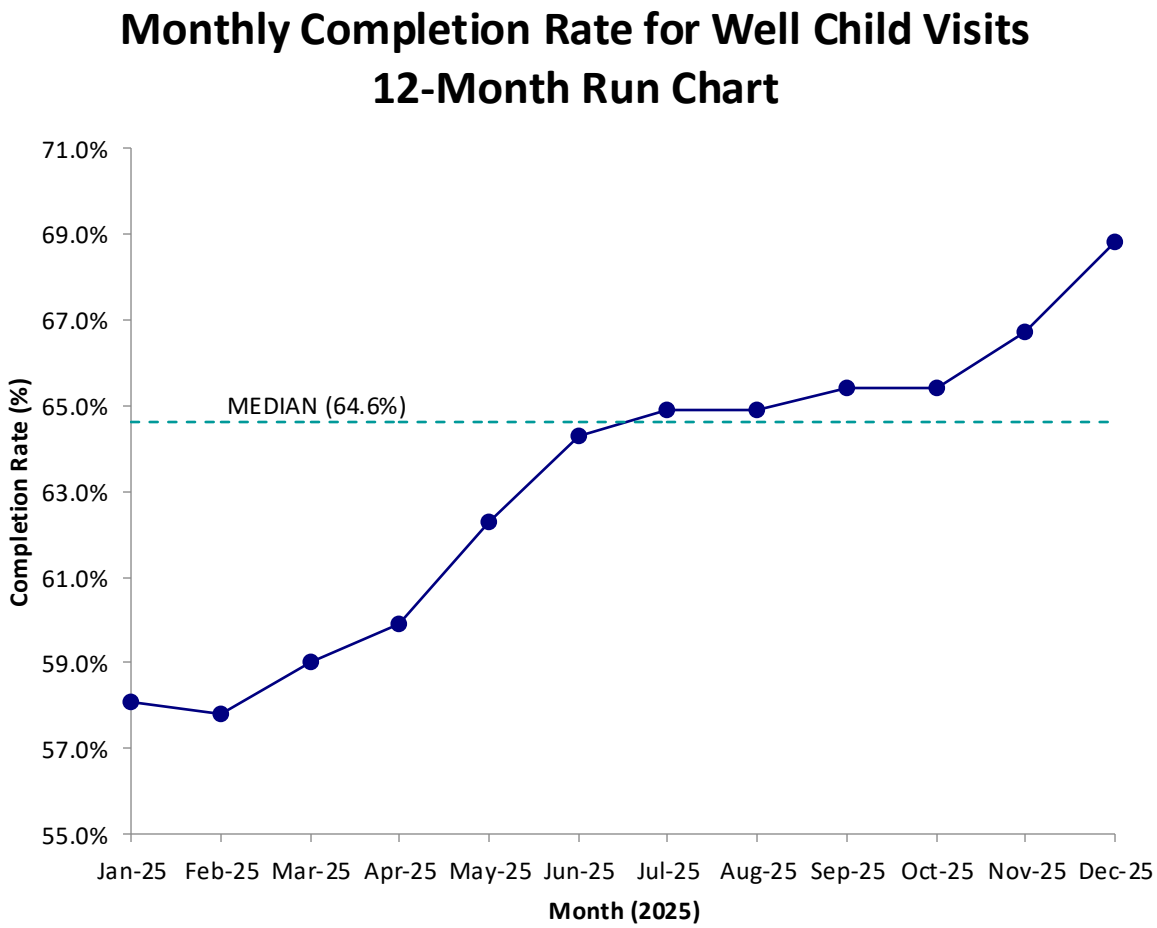
You need them for effective, sustainable, and just improvements

Habits for Effective Sponsors

- **Make improvement a strategic priority**—tied to financial goals, workforce goals, access targets, etc.
- **Remove obstacles only they can fix**; think IT, staffing, policy
- **Protect time for good habits**: ensure the team has time for data review, recording PDSAs, team meetings
- **Model psychological safety** by emphasizing learning, celebrating failed tests, speaking with ‘gracious candor’

Habits for Effective Implementers

1. **Keep the SMARTIE goal front and center**; paste it across the top of meeting agendas, hang it in common spaces
2. **Review data frequently**, weekly if possible, on run charts



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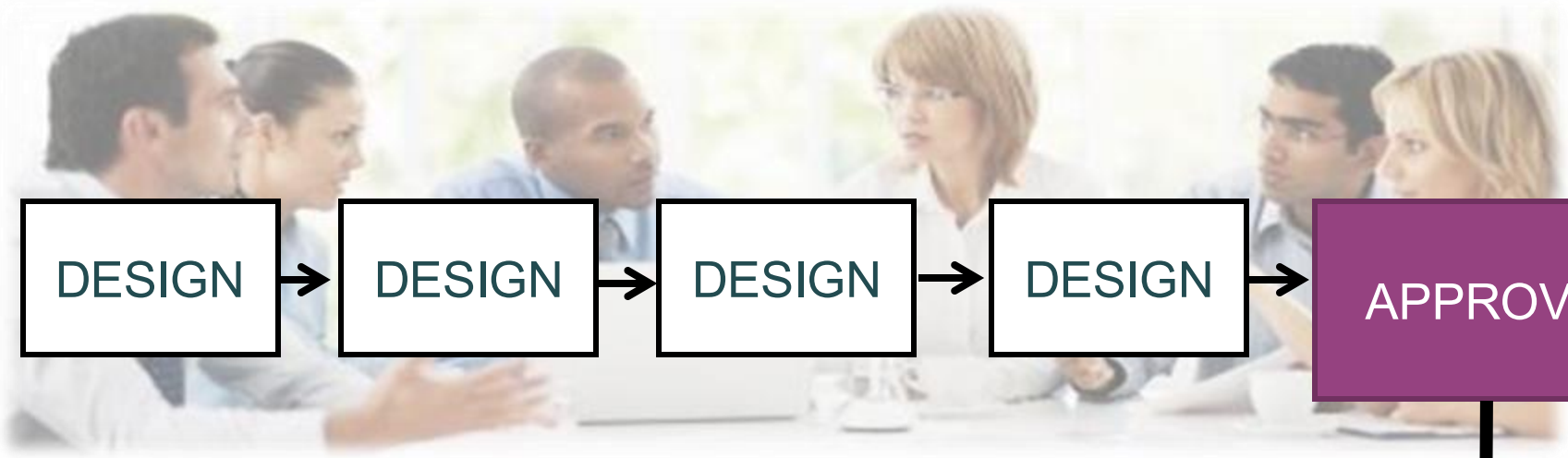
3. **Run small tests**, not grand rollouts

A Typical Approach

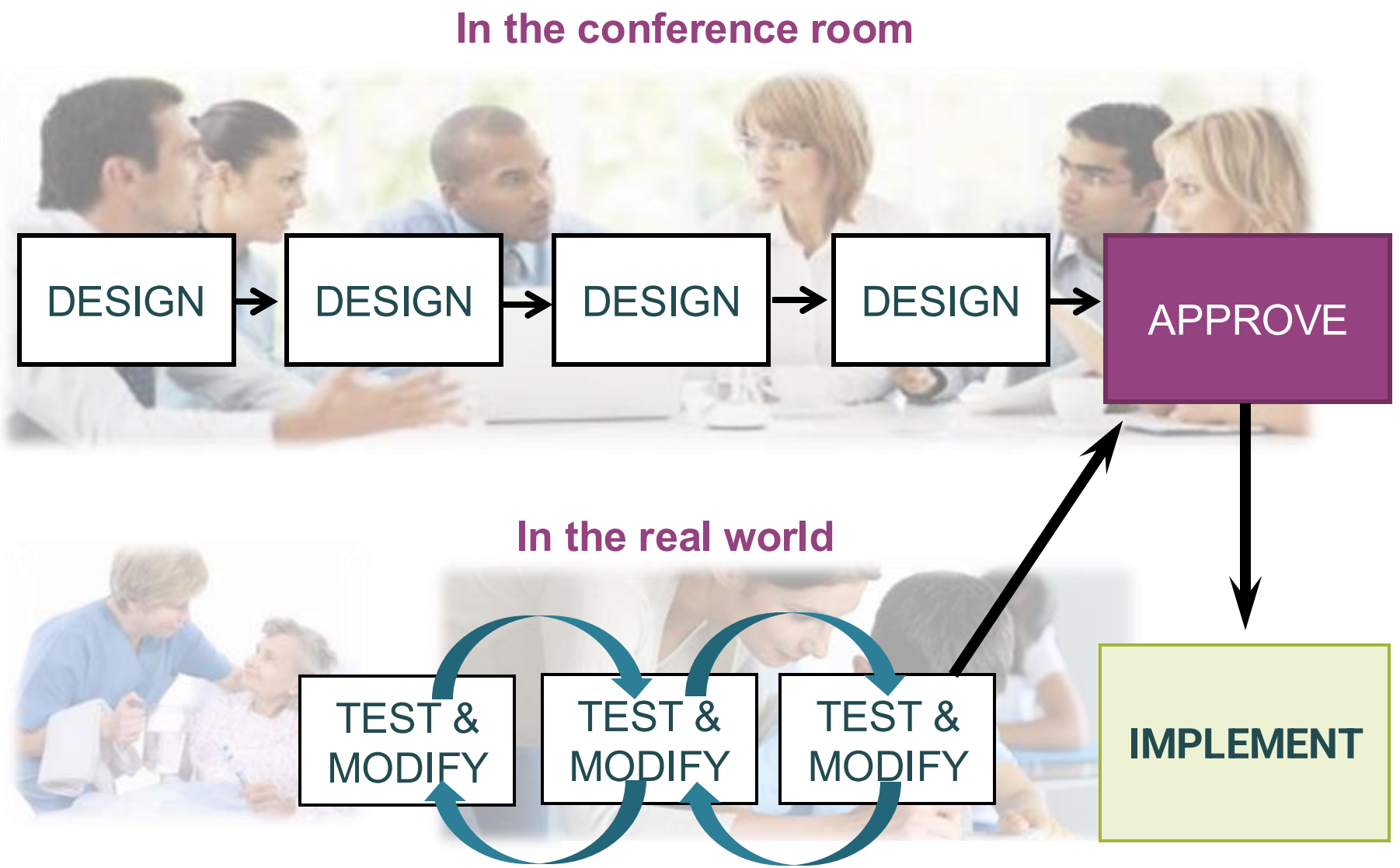
In the conference room



In the real world

IMPLEMENT

A Quality Improvement Approach



Habits for Effective Implementers

1. **Keep the SMARTIE goal front and center**; paste it across the top of meeting agendas, hang it in common spaces
2. **Review data frequently**, weekly if possible, on run charts
3. **Run small tests**, not grand rollouts
4. **Document what happened** as soon as possible; documentation enables learning
5. **Change the plan as you learn**; move on from change strategies that aren't creating measurable progress toward the goal

Improvement habits make you agile so that you can spot opportunities and take action

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Flex Your Improvement Skills

Signs Your PDSA Needs Another Go

A task,
not a test

Tested
too big

Adopt the 1:1:1 rule

Start with one patient,
one provider,
one clinic session

Skipped
predictions

Good idea but
no outcomes

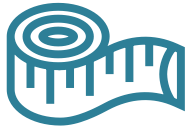
Spread
too fast

Increased scale
AND scope

Data not
collected

Implementers and Sponsors: How will you strengthen your PDSA practices this month?

A task,
not a test



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Start with one patient,
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Good idea but
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Spread
too fast

Increased scale
AND scope

Data not
collected

Break

20 Minutes – Return Here at 3:30 pm

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Building Equitable Care

Moderator and Panelists

Roseanne Ibarra
Equity SME

Chloe Guazzone-Rugebregt
CEO, Anderson Valley Health Center

Marcelle Scramaglia
QI Coordinator, Anderson Valley Health Center

Nicole Levine Arce
Director of Clinical Programs, Comprehensive Community Health Center

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Keynote: Rafael Gomez

March 3, 2026

Presenters

Rafael Gomez

Owner,
El Cambio Consulting

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Miss Castaldi To Spend Year With VISTA

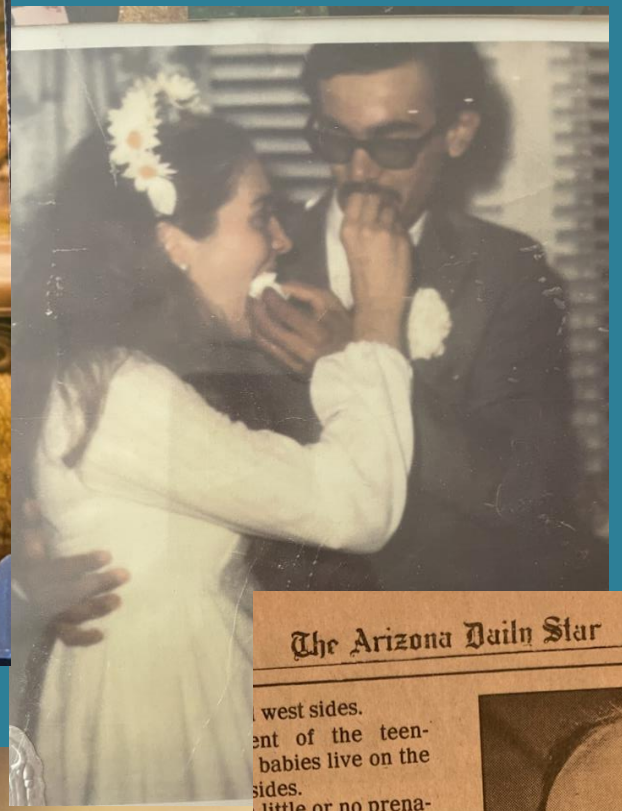
Diana Castaldi, 20 year old daughter of Mr. and Mrs. S.J. Castaldi, 1300 Yukon Way, left last Wednesday for a six-week training session for VISTA (Volunteers in Service to America).

She will get her training at St. Edwards University in Austin, Tex., after which she will receive her assignment.

Diana was valedictorian of her class at Novato High School (1967) and made the top grade point average (3.83 out of 4.0) in her graduating class at the College of Marin this year.

She will serve for a year in the VISTA project, which is designed to help the poor help themselves.

DIANA CASTALDI
VISTA Worker
(Russ Booth Photo)



The Arizona Daily Star

west sides.
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babies live on the
sides.
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s," said Gomez.
spent on prenatal
saved in the long

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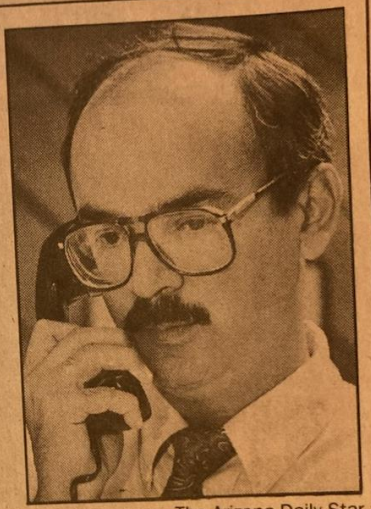
Care Cost Contain-
expanded its ser-
gnant women who
overty guidelines.
ide program is ex-
$31 million for fiscal
the federal govern-
ng 60 percent of the

340 women are ex-
roll in the program
ar.

center's staff deliv-
ies last year at Kino



The Arizona Daily Star

Robert Gomez

the median household in our ser-
vice area that is about one-fourth
to one-third of their annual in-

Growth and Presence of California Federally Qualified Health Centers

Today…

6.2 million patients

31.5 million total visits

$10+ billion in revenue

Since 2013…

- 55% patients served
- 2.48 million Medi-Cal patients with a visit
- 98% total visits
- 320% non-medical visits (e.g., dental, mental health, vision)

Principles for Moving Forward…

1. Recognize that we serve multiple, distinct populations
2. Connect population health management to aligned financial strategies
3. Take advantage of payer and program doors that are opening
4. OK to make choices and start in small and focused ways
5. Make data and accountability a hallmark of the health center commitment
6. Don’t be afraid to band together
7. We can see new challenges as an invitation to creativity
8. Recognize your power and act with purpose

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Looking Ahead

March 3, 2026

Grateful for our time together!

Tomorrow's Theme: Getting Into the Details!

Plenary sessions:

- Moving from implementation to spread
- Using data for improvement
- Speed coaching

Leadership Focus:

- PHM and financial levers
- Artificial intelligence over lunch
- Advancing PHM against policy headwinds

Action Communities:

- Refine your SMARTIE goals
- Select high-leverage changes
- Develop a measurement strategy

Tomorrow at 8AM: Breakfast Blends

Grab breakfast at 8, then join a small group table by 8:15 to connect with peer CHCs around topics of shared interest!

Bayview Ballroom:

1. Sonoma County Regional Breakfast Blend, hosted by Aliados
2. North Coast Regional Breakfast Blend, hosted by NCCN

3-4. Los Angeles Regional Breakfast Blend, hosted by CCALAC

5. Central Valley Regional Breakfast Blend, hosted by CVHN

Quarter Deck:

6. <BUILD IN TOPIC FROM DAY 1 POSTER>, hosted by [PT partner]
7. <BUILD IN TOPIC FROM DAY 1 POSTER>, hosted by [PT partner]
8. <BUILD IN TOPIC FROM DAY 1 POSTER>, hosted by [PT partner]

Pair and Share

What are you bringing home from today's session?

What are you curious about for tomorrow's session?

Join us at the reception!

- Please help yourself to some hors d'oeuvres in the foyer and *return to this room* to mingle.
- To find others in your Action Community, look for the colorful dots on name tags!
- Feel free to use the conversation prompts on the tables.

But first...

Please join us for a photo!

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Breakfast Blends

March 4, 2026

Starting at 8:15: Breakfast Blends

Grab breakfast, then join a small group table to connect with peer CHCs around topics of shared interest!

Bayview Ballroom:

1. Sonoma County Regional Breakfast Blend, hosted by Aliados
2. North Coast Regional Breakfast Blend, hosted by NCCN
3-4. Los Angeles Regional Breakfast Blend, hosted by CCALAC
5. Central Valley Regional Breakfast Blend, hosted by CVHN

Quarter Deck:

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7. <BUILD IN TOPIC FROM DAY 1 POSTER>, hosted by [PT partner]
8. <BUILD IN TOPIC FROM DAY 1 POSTER>, hosted by [PT partner]

Wrapping Up Now:
Breakfast Blends

Upcoming at 9AM:
Day 2 Welcome (in this general session space)

Please grab any additional food or beverages and take a seat!

PHM INITIATIVE

Welcome!
PHMI Statewide Learning Session, Day 2

March 4, 2026

Share with the person next to you:

What questions or reflections are still circling around in your mind?

What learnings are you squared away about from yesterday?

Today's Theme: Getting Into the Details!

Breakfast Connection

Plenary Sessions:

- Moving from implementation to spread
- Using data for improvement
- Speed coaching

Leadership Focus:

- Key Financial Levers to Sustain PHM
- The AI Imperative: Leading Through Disruption and the Survival of the Safety Net
- Policy Forces and CHC Actions: Advancing PHM Amidst Headwinds

Action Communities:

- Fine-tune your team goals
- Select high-leverage changes
- Develop a measurement strategy

Presenters

Catherine Craig

IHI Faculty

Maggie Jones

Director, CCHE

PHM INITIATIVE

PHMI Evaluation Findings

March 2026

Evaluation Overview

- **Over 150** interviews and **almost 400** surveys completed among the staff and providers across the CHCs between Jan. 2024 and March 2025 (and more counting!)
- **4** completions of PhmCAT, with participation from all 32 teams and **over 500** individuals
- **7** bi-annual data submissions from all 32 CHCs

Thank you for making this evaluation possible!

Seeing Our Impact Grow

Implementation Support	Intermediate Outcomes	Long-Term Outcomes
Technical Assistance (Coaching, SME Support, Virtual and In-person Learning Sessions)	**Process Measures** (PHM Capabilities, Empanelment, Social Needs Screening)	**Clinical Measures** (HEDIS & UDS Clinical Quality Measures)

Where We Started

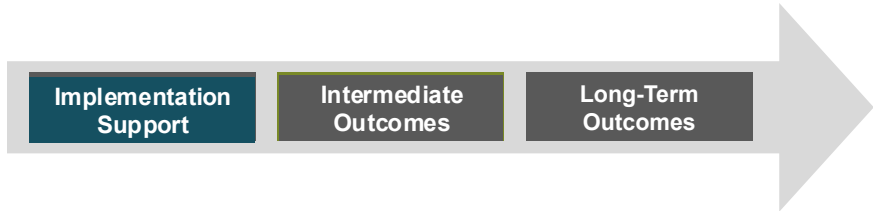
Implementation Support	Intermediate Outcomes	Long-Term Outcomes
Technical Assistance (Coaching, SME Support, Virtual and In-person Learning Sessions)	**Process Measures** (PHM Capabilities, Empanelment, Social Needs Screening)	**Clinical Measures** (HEDIS & UDS Clinical Quality Measures)

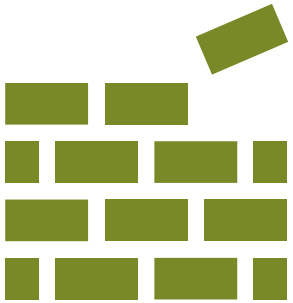
High Levels of CHC Engagement

Implementation Support → Intermediate Outcomes → Long-Term Outcomes

TA Modality	2024	2025
Individual Coaching & SME Support	119 total hours/month	93 total hours/month
Statewide In-person Learning Sessions	131 attendees	120 attendees
Regional In-person Learning Sessions	23-76 attendees per session	21-55 attendees per session
Webinars	35 attendees / 16 CHCs (avg per webinar)	27 attendees / 13 CHCs (avg per webinar)
Total Direct TA Support	207 total hours/month	200 total hours/month

CHCs Met PHM Competencies





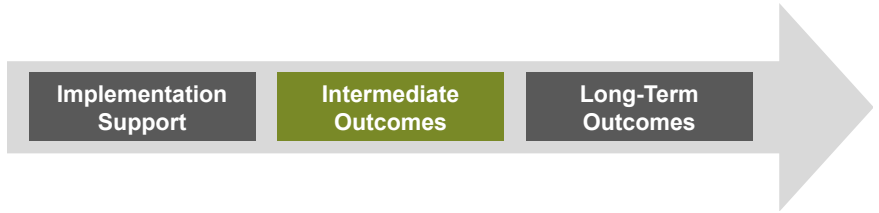
As of July 2025, **31 CHCs completed the 14 Building the Foundation competencies** with 99.5% of total competencies met

As of Dec 2025, **28 CHCs completed all of the 6-8 competencies for their selected Population of Focus**

Where We Are Now

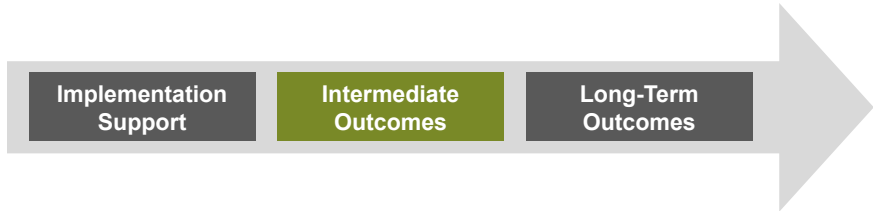
Implementation Support	Intermediate Outcomes	Long-Term Outcomes
Technical Assistance	**Process Measures**	**Clinical Measures**
(Coaching, SME Support, Virtual and In-person Learning Sessions)	(PHM Capabilities, Empanelment, Social Needs Screening)	(HEDIS & UDS Clinical Quality Measures)

PhmCAT Update: Improvement In All Domains



- Significant improvements in **all eight** PhmCAT domains during PHMI
- Significant improvement in **Behavioral Health** for the first time
- **88% of CHCs** improved their overall capability score
- Continued improvement in all domains over the past year

PhmCAT Domains	April 2023 (Baseline)	Nov. 2025 (Most Recent)	Change	CHCs Improving
Leadership & Culture	7.0	7.6	+0.7*	78%
Business Case for PHM	6.4	7.0	+0.5*	66%
Technology & Data Infrastructure	6.3	7.2	+0.8*	84%
Empanelment & Access	6.5	7.4	+0.8*	84%
Care Team & Workforce	6.2	7.5	+1.4*	94%
Patient-centered, Population-based Care	7.0	7.5	+0.7*	75%
Behavioral Health	6.7	6.9	+0.6*	56%
Social Health	6.4	7.1	+0.8*	75%
Overall Capability Score	***6.5***	***7.3***	***+0.8****	***88%***

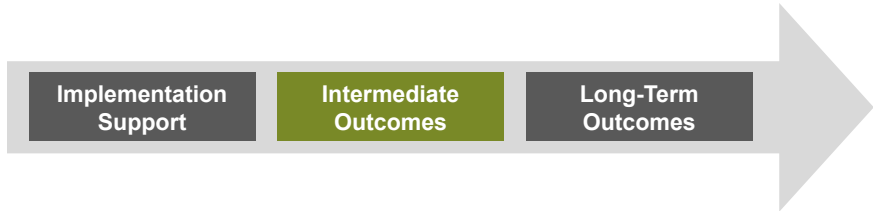


CHC Impact: Care Teams

Focus on **care teams** has:

- Strengthened care teams through standardized workflows
- Improved care coordination
- Improved inner-CHC communication by improving workflows and instituting regular huddles
- Deepened relationships with patients

> *It helps us to be able to target the patients and to really provide them the well-rounded care that they need.* ***No longer is it all on the provider's shoulders, but there's a team that's working with the provider.*** *And within that team, we all have our various roles…*
>
> *— CHC staff*



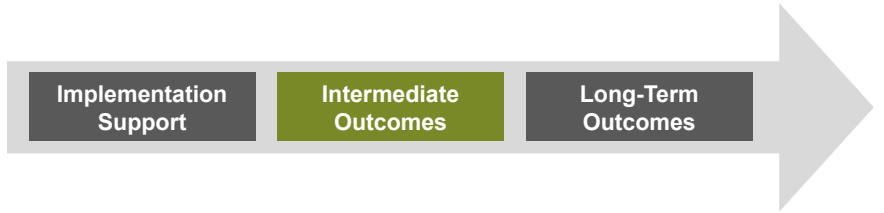
CHC Impact: Empanelment

Focus on **empanelment** has:

- Helped to dedicate staff for efforts which has improved leadership buy-in
- Improved quality and continuity of care
- Increased CHC awareness of how patients are assigned by MCPs and what they are held accountable for

> *Having a dedicated empanelment manager and clear policies has **made a huge difference in continuity and access**.*
>
> *— CHC staff*

CHC Impact: Data Quality

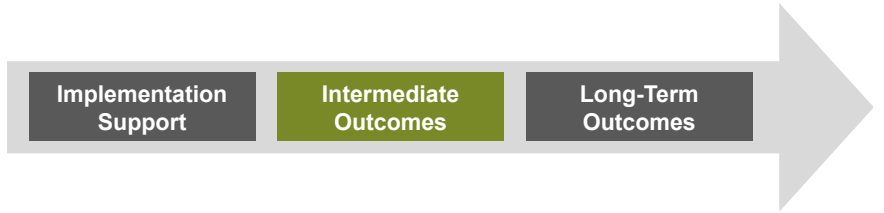


Focus on **data quality** has:

- Improved data quality/accuracy and monitoring of measures
- Enabled stratification of data by key demographics
- Strengthened understanding of care gaps
- Led to development of new reports/dashboards and data integration

> *We've never **looked at the patient data in that way before**. So, it was a really great exercise. It made me really excited about my job.*
>
> *— CHC staff*

CHC Impact: Social Health



Focus on **social health** has:

- Increased the number of CHCs screening for social needs within their Population of Focus
- Shed light on community needs and how best to tailor care for patients
- Helped implement, refine, or expand screening and referral systems across most CHCs

> *[Social determinants screening] has been on our radar for a long time… And so I feel like with…so many other small things,* ***PHMI has just like driven us, like do it now…***
>
> *— CHC Staff*

PHMI Has Contributed to Progress

The majority of CHC staff survey respondents agreed that PHMI has improved:

Empanelment	**71%**
Care teams	**70%**
Patient care	**68%**
Data capabilities	**67%**
Addressing social needs	**64%**

On the Road to Long-Term Outcomes

Implementation Support	Intermediate Outcomes	Long-Term Outcomes
Technical Assistance (Coaching, SME Support, Virtual and In-person Learning Sessions)	**Process Measures** (PHM Capabilities, Empanelment, Social Needs Screening)	**Clinical Measures** (HEDIS & UDS Clinical Quality Measures)

PHM INITIATIVE

Moving from Implementation to Spread

March 4, 2026

Presenter

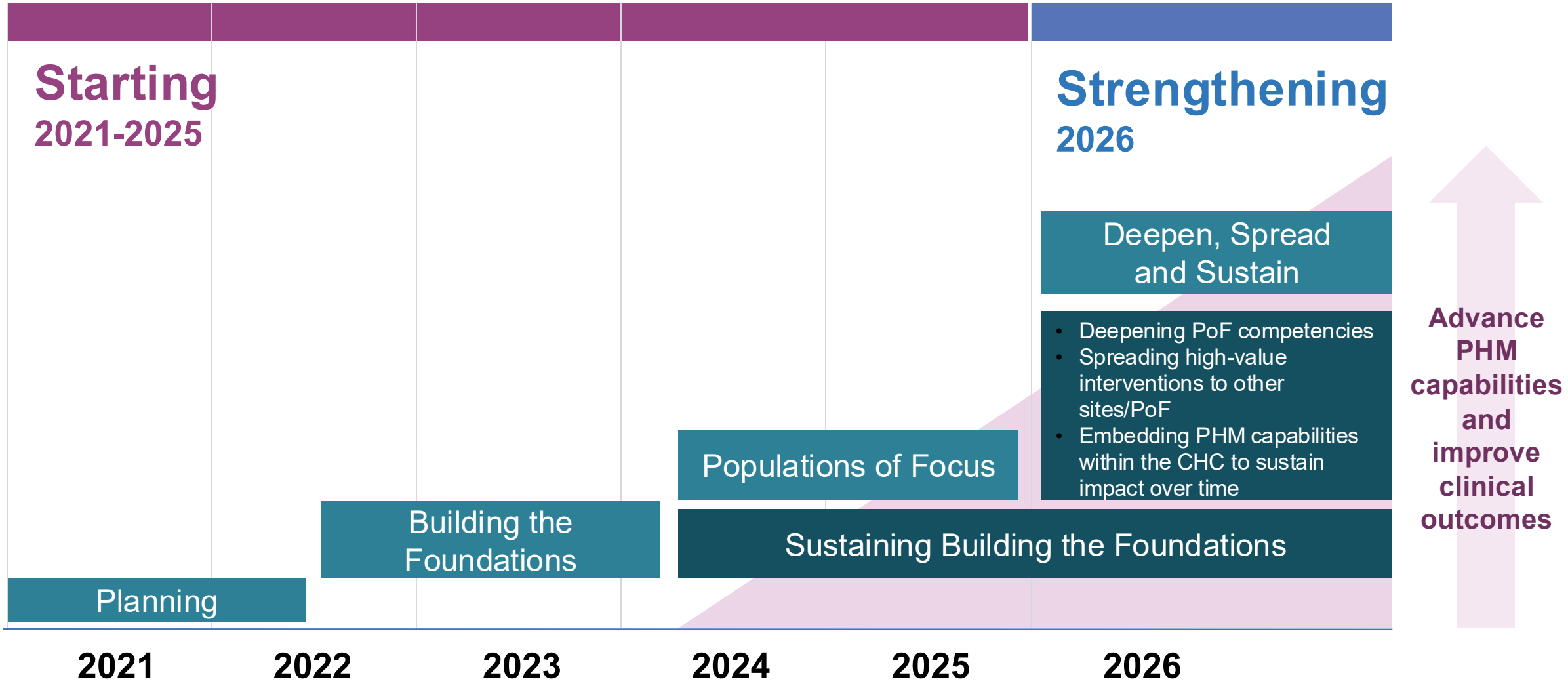
Jen Powell

Sustainability
& Spread SME

Session Learning Objectives

1. Describe relationship between implementation, sustainability and spread.
2. Define spread for different sized CHCs and context.
3. Describe conditions for spread.
4. Articulate next steps in developing SMARTIE goal.

Continuing Our PHMI Journey



Moving from Implementation to Sustainability to Spread

	Year 1 (2024)	**Year 2** (2025)	**Year 2** (Quarter 4 2025)
PHMI Areas of Focus	**Build PHM Foundations**: • Empanelment • Care Teams • Data Quality & Reporting • PHM Business Case	**Test & Implement PHM strategies** to meet Population of Focus Foundational Competencies	**Sustainability Plan**: IdentifiedPHM strategies to hardwire over time
Center Level Teams	***PHMI Foundational Teams*** *establishing systems for the four standards*	***PHMI Implementation Team (Original Site)***	***PHMI Lead with Implementers and Leaders***

Moving from Implementation to Sustainability and Spread

Year 3 (Quarter 1 2026) → **Year 3** (Quarter 2-4 2026)

PHMI Areas of Focus

Establish a SMARTIE goal to improve PoF clinical outcome

↓

Establish supportive SMARTIE goals:

1. Hardwire/Sustain a strategy that supports the clinical goal
2. Determine one PHM **Strategy to spread to reach clinical goal**

Implement new and 'hardwired' change strategies that will lead to improved clinical outcomes

Spread selected PHM strategy with a clearly articulated plan

Center Level Implementation

CHC Action Teams *with Pop Health Leadership Team*

CHC Action Teams: *Test, implement, and hard wire strategies.*

New Action Teams *established in areas being spread.*

Support from Pop Health Leadership Team

What Is Spread?

The process through which **new working methods** developed in one setting are **adapted in another context.**

PHMI Definition of Spread for Centers with two or more sites

- Spread is defined as taking an existing, tested, and documented PHM strategy from the original site (clinical site where the strategy was tested) to one or more additional sites.
- Spread strategies should be selected that will enable your center to meet your clinical outcome goals either in 2026 or beyond, including that it will be spread across enough patients/members to meet the clinical goal.
- Location is defined as a new geographic location where there is one or more primary care provider/care team. Center will define the scale of the spread (will the strategy be spread across one location or more than one location, with specificity to the number of care teams?).

PHMI Definition of Spread
One site

Centers with one site or two sites

(where 2nd location is not conducive to spread):

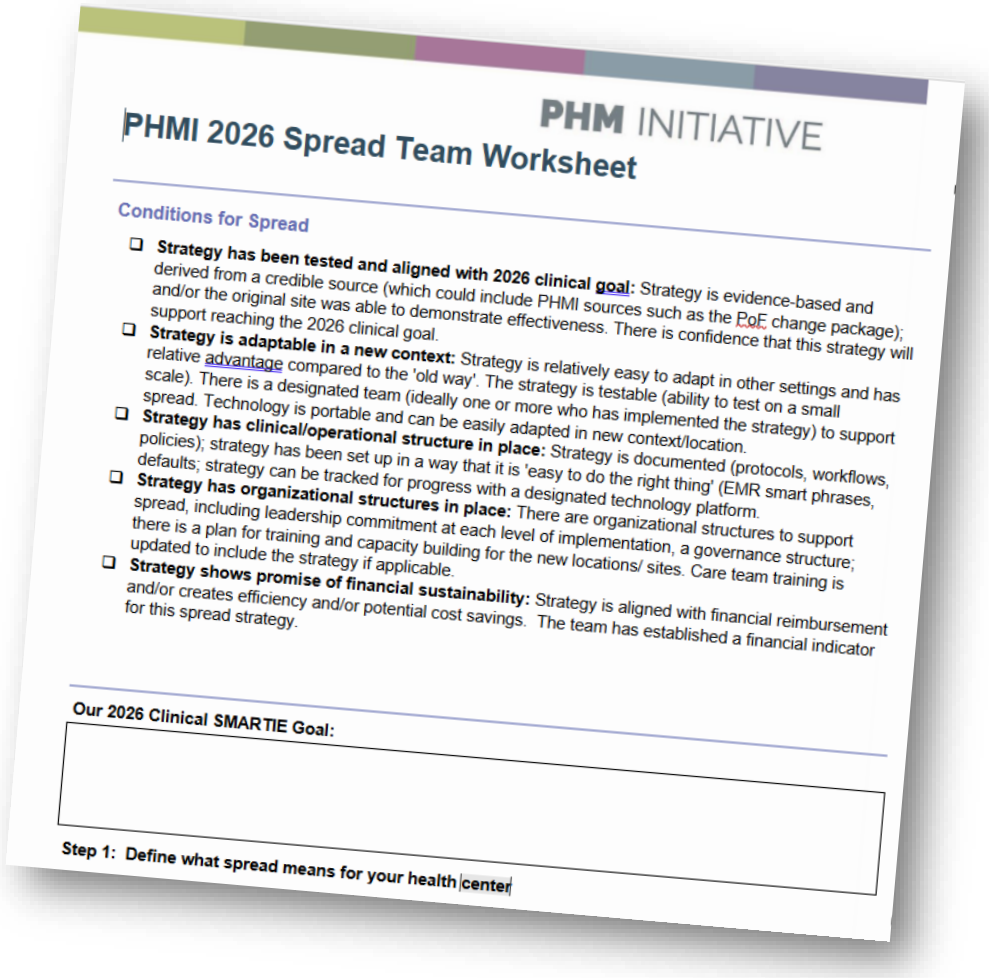
1. Adapt an existing, tested, and documented PHM strategy applied to one PoF HEDIS/UDS measure to another HEDIS/UDS measure *in that PoF.*
2. If all PoF measures are at or close to goal and trending upward, CHC will select a strategy to spread that can target a HEDIS/UDS measure *in another PoF.*
3. Spread PHM strategy across another service line.

Example 1:
PHM strategy that was applied to HTN high risk patients is spread to high-risk patients with diabetes.

Example 2:
PHM strategy for outreach to high-risk patients with chronic conditions is spread to patient outreach for an adult prevention measure.

Example 3:
PHM strategy for outreach is adapted for patients enrolled in ECM.

Spread Worksheet



PHM INITIATIVE

PHMI 2026 Spread Team Worksheet

Conditions for Spread

- ❑ **Strategy has been tested and aligned with 2026 clinical goal:** Strategy is evidence-based and derived from a credible source (which could include PHMI sources such as the PoE change package); and/or the original site was able to demonstrate effectiveness. There is confidence that this strategy will support reaching the 2026 clinical goal.
- ❑ **Strategy is adaptable in a new context:** Strategy is relatively easy to adapt in other settings and has relative advantage compared to the 'old way'. The strategy is testable (ability to test on a small scale). There is a designated team (ideally one or more who has implemented the strategy) to support spread. Technology is portable and can be easily adapted in new context/location.
- ❑ **Strategy has clinical/operational structure in place:** Strategy is documented (protocols, workflows, policies); strategy has been set up in a way that it is 'easy to do the right thing' (EMR smart phrases, defaults; strategy can be tracked for progress with a designated technology platform.
- ❑ **Strategy has organizational structures in place:** There are organizational structures to support spread, including leadership commitment at each level of implementation, a governance structure; there is a plan for training and capacity building for the new locations/ sites. Care team training is updated to include the strategy if applicable.
- ❑ **Strategy shows promise of financial sustainability:** Strategy is aligned with financial reimbursement and/or creates efficiency and/or potential cost savings. The team has established a financial indicator for this spread strategy.

Our 2026 Clinical SMARTIE Goal:

Step 1: Define what spread means for your health center

Conditions to Consider: Selecting a Strategy & Selecting Where to Spread

- Strategy has been tested and is aligned with the 2026 clinical goal
- Strategy is adaptable to new context
- Strategy has clinical/operational structures in place
- Strategy has organizational structures in place
- Strategy shows promise of financial sustainability

Optimal Health Center has 6 primary care locations; 4 locations have multiple primary care teams. They established systems for **empanelment** in 2024; they have successfully 'paneled' patients for 3 of the 6 primary care locations. They are using their PHM platform to enhance communication and tracking with provider/care team.

Their designated Population of Focus is **Chronic Conditions. Their clinical goal is to improve the number of patients with controlled A1C (to under 9) from 50% to 70% by the end of the year.** *They have identified outreach for care gaps as a key strategy to meet their clinical goal.*

They have expanded their care team model to include defined roles and protocols for pre-visit planning and care gap outreach across 3 locations. With the recent departure of the PHMI clinical lead, there is a lack of training and commitment. Their PHM platform enables access to data to inform outreach and care protocols, but there is not consistency in accessing it.

Their sustainability plan includes more hardwiring (protocols, training, workflow) in empanelment and care team model to better position themselves to roll out across all locations.

They are considering a spread strategy to move their outreach for care gaps protocol across all locations (9 primary care providers).

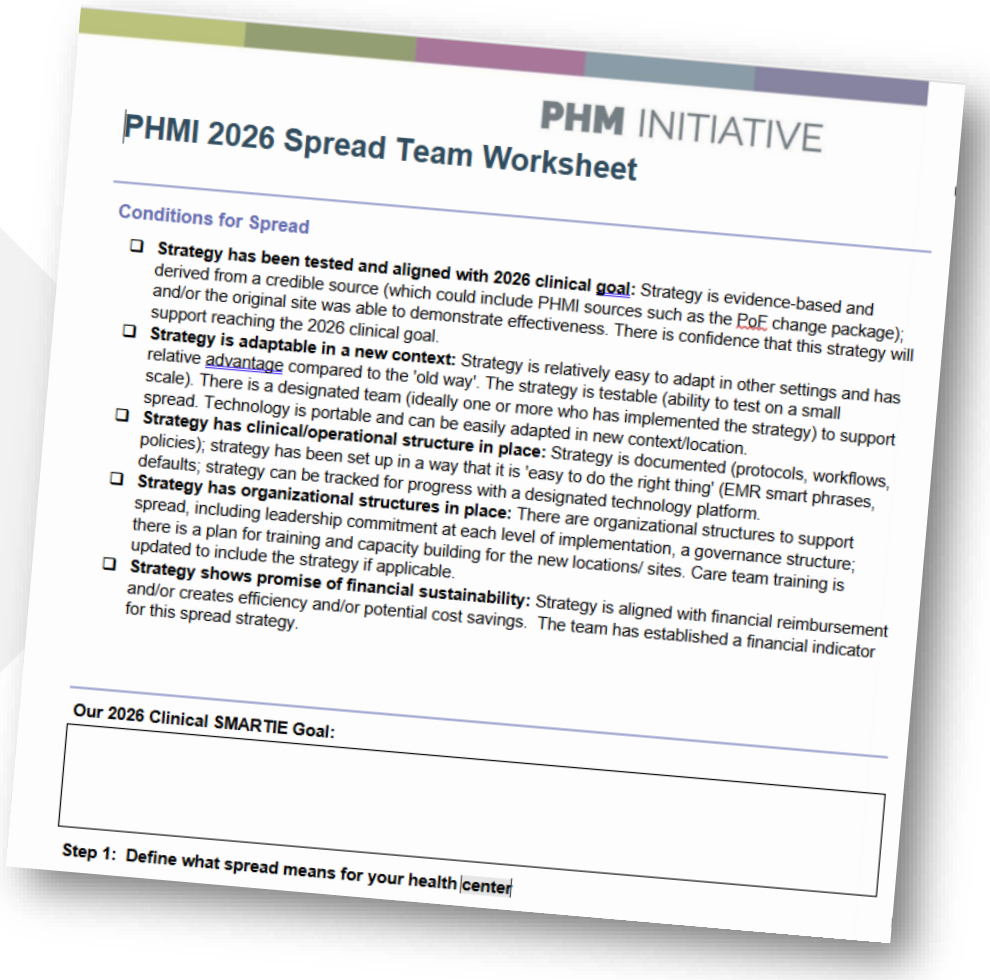
Case Study Prompts

Optimal Health Center is considering spreading their outreach protocol for HTN high-risk patients with care gaps across all locations.

1. Is this strategy aligned with their clinical goal?
2. Are their workflows and procedures that are followed consistently?
3. Is the PHM platform being optimized?
4. Are structures in place in place (leadership, champions?)
5. What recommendations can you make this to the team?

Next Steps

1. Jot down a few ideas that surfaced from this session on the Spread Worksheet.
2. Consider how to move through the steps outlined in the worksheet today (time permitting) and over this next month.
3. Draft Spread SMARTIE goal by 3/31.



PHM INITIATIVE

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Our 2026 Clinical SMARTIE Goal:

Step 1: Define what spread means for your health center

Next sessions starts at 10:10 AM:

Leadership Session: Key Financial Levers to Sustain PHM

Bayview Ballroom (1st Floor)	**Leadership session** - *purple nametag dot*

Finetuning Our Team Goals – by Action Community

Quarter Deck (1st Floor)	**Adult with Preventive Care Needs** - *red nametag dot*
Mariposa (2nd Floor)	**Adults with Chronic Conditions** - *dark blue nametag dot*
California (4th Floor, Executive Meeting Center)	**Children and Pregnant People -** *yellow nametag dot*
El Dorado (2nd Floor)	**People with Behavioral Health Conditions** - *green nametag dot*

PHM INITIATIVE

Key Financial Levers to Sustain PHM

Strategies to Maintain Financial Health for PHM Programs

Your Team

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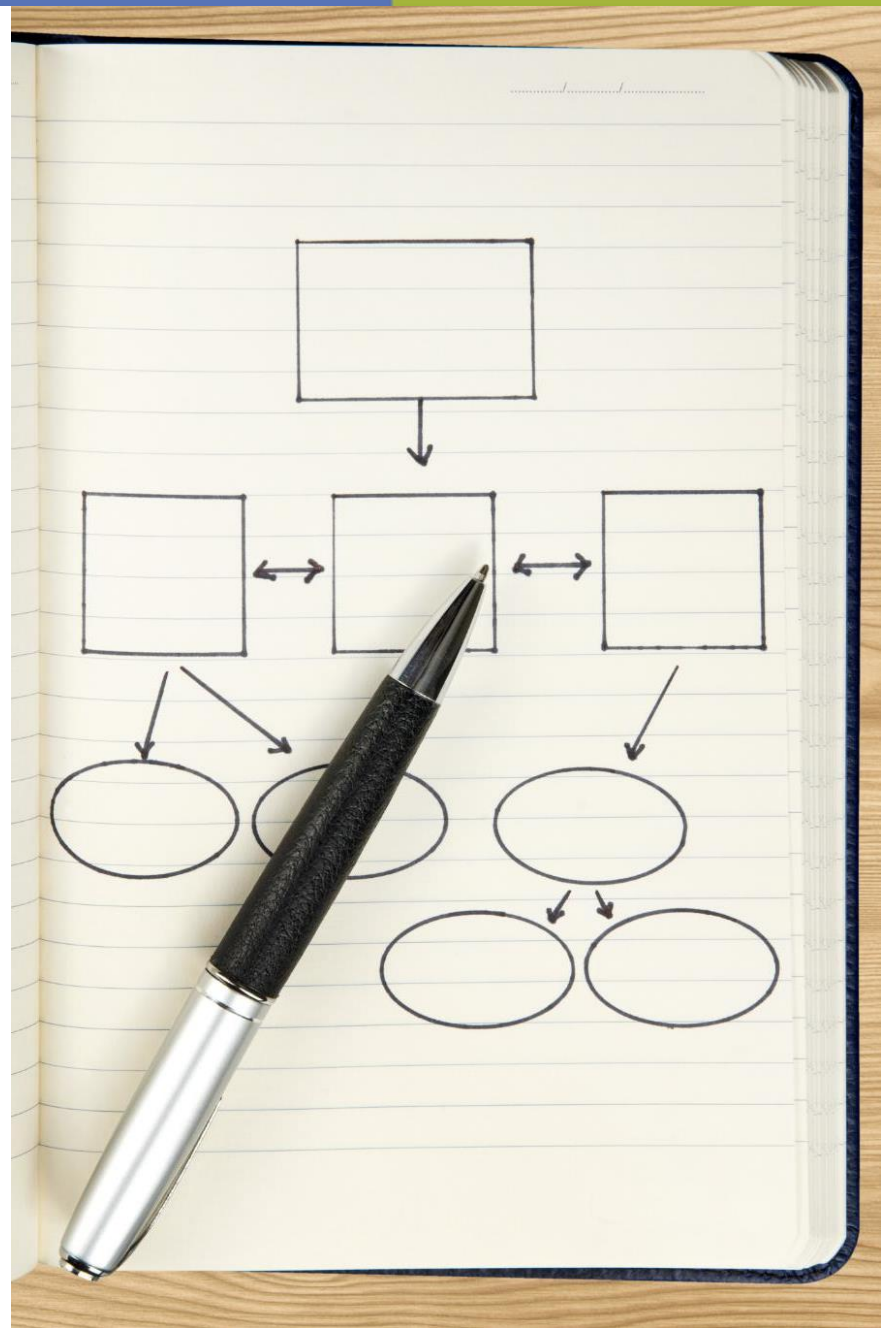
PHM INITIATIVE

Session Introduction and Learning Objectives

Session Agenda Overview

- Costing of Population Health Management
- Estimating Financial Impact on Medi-Cal Cuts
- Evaluating the Revenue/Benefit of Population Health Management
- Large Group Discussion
- Technical Assistance Opportunities



Session Objectives for CHC Leaders

1. Understand the importance of:
   - Costing population health management
   - Analyzing revenue impact from Medi-Cal and policy changes
   - Linking PHM to pay-for-performance
2. Learn about financial technical assistance (TA) offerings in PHMI in 2026.

PHM INITIATIVE

Costing of Population Health Management

Granularity and Business Case Tools

Granular Financial Data

A detailed approach to financial data is essential for accurate costing in population health management.

High-Level Financial Setup

Setting up cost centers, activity-based views, and attribution models ensures accurate cost tracking.

PHMI Business Case Tool

This flexible tool helps compare cost scenarios and supports informed decision-making for health centers.

Prioritizing Resource Allocation

Focusing on minimum cost tracking and using business tools helps prioritize spending effectively.

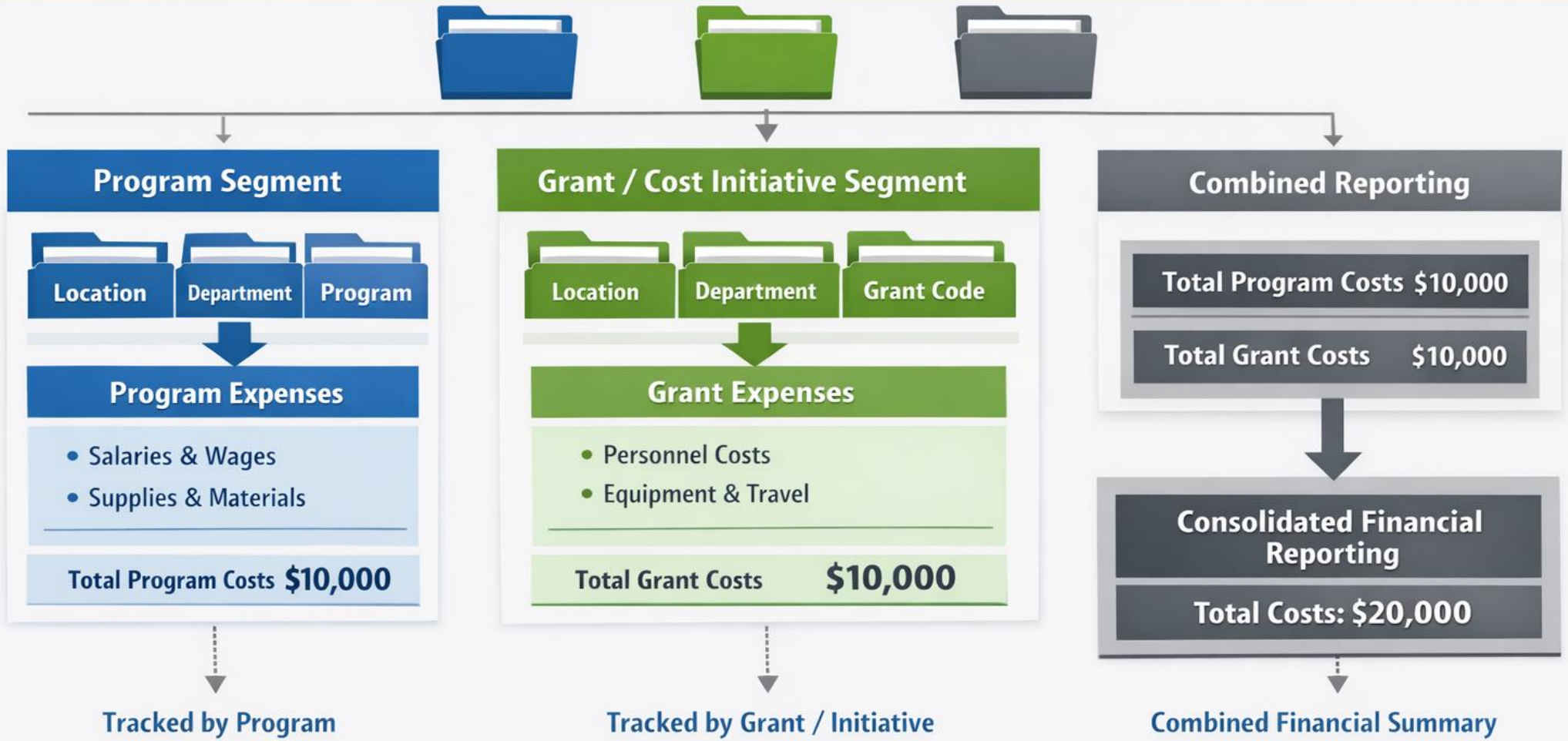
Decision Making During Financial Adversity

- Cash is king – cash flow management
- Staffing re-alignment due to reductions in funding while facing workforce challenge
- Leverage of new technology for process efficiency and production
- Revenue cycle management opportunities
- Balancing compliance and risk
- Communication across executive leadership

Tracking of PHMI Costs

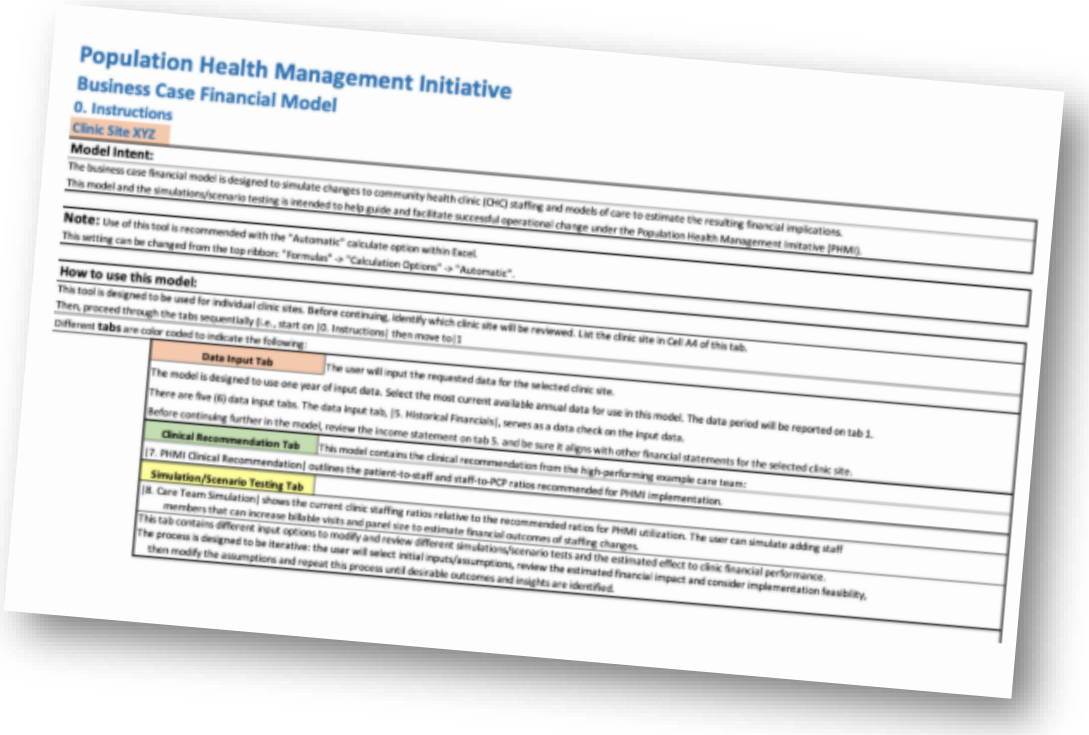
- Identify the FTEs that are participating in the activity
- One time investments vs ongoing maintenance
  - Technology investment
- Recommended General Ledger coding for activity – next slide

Segmented General Ledger Tracking



Business Case Tool

- A resource/template to support budgeting and projections
- Can be helpful to map identified activity for program to cost
- Don't have to utilize all components of tool to be effective



Population Health Management Initiative

Business Case Financial Model

0. Instructions

Clinic Site XYZ

Model Intent:

The business case financial model is designed to simulate changes to community health clinic (CHC) staffing and models of care to estimate the resulting financial implications. This model and the simulations/scenario testing is intended to help guide and facilitate successful operational change under the Population Health Management Initiative (PHMI).

Note: Use of this tool is recommended with the "Automatic" calculate option within Excel. This setting can be changed from the top ribbon: "Formulas" -> "Calculation Options" -> "Automatic".

How to use this model:

This tool is designed to be used for individual clinic sites. Before continuing, identify which clinic site will be reviewed. List the clinic site in Cell A4 of this tab.

Then, proceed through the tabs sequentially (i.e., start on |0. Instructions| then move to|1

Different **tabs** are color coded to indicate the following:

Data Input Tab The user will input the requested data for the selected clinic site.

The model is designed to use one year of input data. Select the most current available annual data for use in this model. The data period will be reported on tab 1.

There are five (6) data input tabs. The data input tab, |5. Historical Financials|, serves as a data check on the input data.

Before continuing further in the model, review the income statement on tab 5. and be sure it aligns with other financial statements for the selected clinic site.

Clinical Recommendation Tab This model contains the clinical recommendation from the high-performing example care team:

|7. PHMI Clinical Recommendation| outlines the patient-to-staff and staff-to-PCP ratios recommended for PHMI implementation.

Simulation/Scenario Testing Tab

|8. Care Team Simulation| shows the current clinic staffing ratios relative to the recommended ratios for PHMI utilization. The user can simulate adding staff members that can increase billable visits and panel size to estimate financial outcomes of staffing changes.

This tab contains different input options to modify and review different simulations/scenario tests and the estimated effect to clinic financial performance.

The process is designed to be iterative: the user will select initial inputs/assumptions, review the estimated financial impact and consider implementation feasibility, then modify the assumptions and repeat this process until desirable outcomes and insights are identified.

Business Case Tool eLearning module:
https://phmiportal.com/elearning/business-case-tool

Business Case Tool Additions

1. Estimate PPS revenue lost when UIS members no longer receive PPS wrap or dental services (effective 7/1/2026).
2. Inclusion of Oral Health and Behavioral Health lines of business.
3. Organizational (all site) forecasts and simulations as well as calculate the blended PPS rate across sites.
4. Calculate capital expense (for PHMI HIT solutions and other capital investments).
5. Enhanced payor mix forecasting for HR 1 and state policy changes (e.g., work requirements, enrollment freeze for UIS).
6. Inclusion of tabs to simulate changes to VBC contracts - MCO based and MSSP arrangements.

PHM INITIATIVE

Estimating Financial Impact of Medi-Cal Cuts

Revenue Impact Calculations and Scenario Modeling

Data Sources for UIS Numbers

Reliable data sources are essential for estimating Uninsured Individuals Served to calculate revenue impacts accurately.

Scenario Modeling Factors

Volume, rate, mix, and timing are key elements to consider in financial scenario modeling for Medi-Cal changes.

Federal Policy Impact Preparation

Prepare for federal policy changes in 2026 and 2027, including dental coverage and work requirements adjustments.

Revenue Fluctuation Anticipation

Understanding policy nuances helps CHCs anticipate revenue changes and make informed sustainability decisions.

Data Sources of UIS Numbers

Assembly District	ACA Expansion Adults Ages 19 to 64	Adoption/ Foster Care	Children's Health Insurance Program (CHIP)	Long-Term Care	Other[1]	Parent/ Caretaker Relatives & Children	Seniors & Persons with Disabilities	Total
78	46,643	1,057	7,869	464	11,427	36,087	19,301	**122,848**
79	78,511	1,794	18,161	587	28,500	97,382	37,020	**261,955**
80	72,414	1,643	19,825	234	16,247	84,509	35,696	**230,568**
N/A	3,974	3,633	1,371	14	3,540	9,412	3,093	**25,037**
Grand Total	**4,191,548**	**161,571**	**1,200,470**	**41,981**	**2,118,287**	**4,974,059**	**2,202,494**	**14,890,410**

- 2,118,287 Medi-Cal UIS / 14,890,410 Medi-Cal enrollees = 14.2% statewide
- Assembly District 79 28,500 UIS / 261,955 Medi-Cal enrollees = 10.9%
- Assembly District 54 79,719 UIS / 312,387 Medi-Cal enrollees = 25.5%
- Assembly District 21 40,571 UIS / 120,230 Medi-Cal enrollees = 33.7%

https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Preliminary-Medi-Cal-Legislative-Districts-July2024.pdf

UIS Impact Calculation

	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Total
Total Medi-Cal MediCal & BH Visits	10,000	9,990	9,980	9,970	9,960	9,950	9,940	9,930	9,920	9,910	9,900	9,890	
% Medi-Cal Medi-Cal & BH Visits UIS	25.0%	24.9%	24.8%	24.7%	24.6%	24.5%	24.4%	24.3%	24.2%	24.1%	24.0%	23.9%	
Medi-Cal Medical & BH Visits to UIS	2,500	2,488	2,475	2,463	2,450	2,438	2,425	2,413	2,401	2,388	2,376	2,364	
Medi-Cal PPS Revenue Change - No PPS Payment @ $250/visit							(606,340)	(603,248)	(600,160)	(597,078)	(594,000)	(590,928)	(3,591,753)
Medi-Cal FF Revenue Offset ($105/visit rate)							254,663	253,364	252,067	250,773	249,480	248,190	1,508,536
Total Revenue Impact Medical & BH							(351,677)	(349,884)	(348,093)	(346,305)	(344,520)	(342,738)	(2,083,216)
Medi-Cal Dental Visits - Baseline	3,300	3,297	3,293	3,290	3,287	3,284	3,280	3,277	3,274	3,270	3,267	3,264	
Medi-Cal Dental Revenue w/Current Rules	825,000	824,250	823,250	822,500	821,750	821,000	820,000	819,250	818,500	817,500	816,750	816,000	
% Medi-Cal Dental Visits UIS	25.0%	24.9%	24.8%	24.7%	24.6%	24.5%	24.4%	24.3%	24.2%	24.1%	24.0%	23.9%	
Medi-Cal Dental Visits to UIS	825	821	817	813	809	805	800	796	792	788	784	780	
Medi-Cal Dental Revenue from UIS Under Current Rules	206,250	205,250	204,250	203,250	202,250	201,250	200,000	199,000	198,000	197,000	196,000	195,000	
% of Dental Visits to Patients 19+ Years	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	
Self-Pay Visits to UIS After 19+ Inelgibile for Dental							600	597	594	591	588	585	
Denti-Cal Visits to UIS 0 - 18							200	199	198	197	196	195	
Self-Pay UIS Dental Revenue ($40/visit)							24,000	23,880	23,760	23,640	23,520	23,400	
Denti-Cal UIS Revenue($150/visit)	-	-	-	-	-	-	30,000	29,850	29,700	29,550	29,400	29,250	
Dental Revenue from UIS After Cuts							54,000	53,730	53,460	53,190	52,920	52,650	
Total Revenue Impact Dental							(146,000)	(145,270)	(144,540)	(143,810)	(143,080)	(142,350)	(865,050)
Total Revenue Impact from UIS Cuts							(497,677)	(495,154)	(492,633)	(490,115)	(487,600)	(485,088)	(2,948,266)

PHM INITIATIVE

Evaluating Revenue and Benefit of PHM

Future Value-Based Payment Opportunities

VALUE-BASED REVENUE TYPE	DESCRIPTION	TYPICAL BENEFIT
P4P Incentives (IPA/MCP)	Payments tied to quality or utilization metrics	Partial cost offset, helps justify PHM activities
Shared Savings	Rewards for reducing total cost of care	Supports long-term PHM sustainability
Bundled Payments	Single payment for a full episode of care	Encourages care coordination and efficiency

Non-Financial Benefits Supporting PHM Sustainability

NON-FINANCIAL BENEFIT	IMPACT AREA	ORGANIZATIONAL ADVANTAGE
Improved Quality Outcomes	Clinical Performance	Better patient health and alignment with quality programs
Operational Efficiency	Workflow and Resource Utilization	Reduced waste and more effective team-based care
Empanelment & Continuity	Care Coordination	Stronger patient-provider relationships and reliability
Reduced Restart Costs	Operational Stability	Prevents costly disruptions and preserves investments

Measurement Considerations

BENEFIT TYPE	EXAMPLES
Financial	Net revenue, avoidable costs, shared savings, incentive payments, value-based payments
Operational	Capacity gained, cycle time reduction, staffing stabilization
Clinical/Quality	Measurable outcome improvement, reliability
Strategic	Contract positioning with Plans/IPAs, long-term sustainability

PHM INITIATIVE

Large Group Discussion

Discussion Prompts for Financial Scenario Planning

- What changes is your CHC making as a result of financial scenario planning?
- What data sources have been helpful in your financial scenario planning?
- If you haven't started doing financial scenario planning, what is holding you back from doing so?

PHM INITIATIVE

Technical Assistance (TA) Opportunities

Individualized TA Opportunities

Financial Measurement Tracking

Support CHCs in selecting and tracking financial balancing measures aligned with SMARTIE goals for sustained performance.

Financial Viability Analysis

Help CHCs analyze budget impacts from policy changes like reimbursement models to anticipate revenue shifts with a focus on Medi-Cal payment changes that will affect PHM sustainability.

TA Opportunities (cont.)

Business Case Development

Enable evaluation of long-term sustainability and ROI for PHM programs and service expansions. Utilizing the existing PHMI Business Case tool, or a tool that your CHC is already utilizing for financial planning, evaluate the financial sustainability and spread of PHM across new sites or service lines.

Operational Integration and VBP Support

- Assist with opportunity identification (e.g., revenue , contractual, scope change, service line) with a focus on data interpretation for revenue enhancement.
- Guide CHCs through value-based payment arrangements and assist with contract performance optimization, coding requirements and financial projections related to participation.

Feedback on TA Opportunities

- Which of these TA offerings do you see as being **most impactful** for your CHC right now?
- What is one **unmet need** or challenge you're facing that we haven't touched on today?
- Which financial sustainability or spread topics would benefit most from a peer-to-peer leadership deep dive?

Write your answers on a notecard and leave them in the center of the table.

Thank You

PHM INITIATIVE

Using Data for Improvement

March 4, 2026

Session Agenda

1	What's Different in 2026
2	Learning from Petaluma
3	7 Tips for Selecting Measures
4	Processing Time

Presenters

Eddie Turner
Action Communities Director

Denise Armstorff
PT Partner Coach

Learning Objectives

1. Understand how to use data for improvement and learning in new ways for PHMI in 2026
2. Learn from a CHC's approach to measurement
3. Apply methods for tracking data over time to your SMARTIE goals


2883 Rumcakes
Pastries 2883
PASTRY
La Taqueria
2889
MISSION ST
RESTAURANT

New in PHMI This Year: Deep Focus

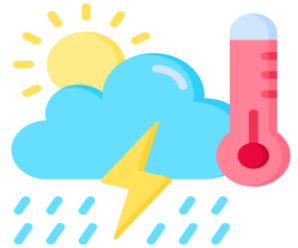
- Focus on **improving in a single clinical outcome measure** for your population of focus
- Build a “vital few” measurement strategy around it
- Use structured improvement methods to make progress bold and sustainable

This session will prepare you to strategically select measures that drive progress and learning.

PHM INITIATIVE

Using Data to Drive Action in Petaluma

What Do All of These Things Have in Common?



Focus for 2026: Improve Clinical Outcomes

Data will be needed to . . .

Understand	How does the current system perform?
Predict	What interventions might improve the performance of the current system?
Evaluate	Did our interventions result in improvement?
Monitor	Are our improvements sustained over time?
Engage	Are we considering what is important for other to know?

All Improvement Begins with Data

PHM INITIATIVE

Analyzing Performance Data

What story is the data telling?

- Run charts – Data Over Time

Informs

Developing SMARTIE Aim

What are we trying to accomplish?

- How good do we want to be and by when?
- What is our baseline?
- What is an achievable, yet ambitious target within the timeframe that we have identified?

Informs

Establishing a Measures Set

How will we know the change is an improvement?

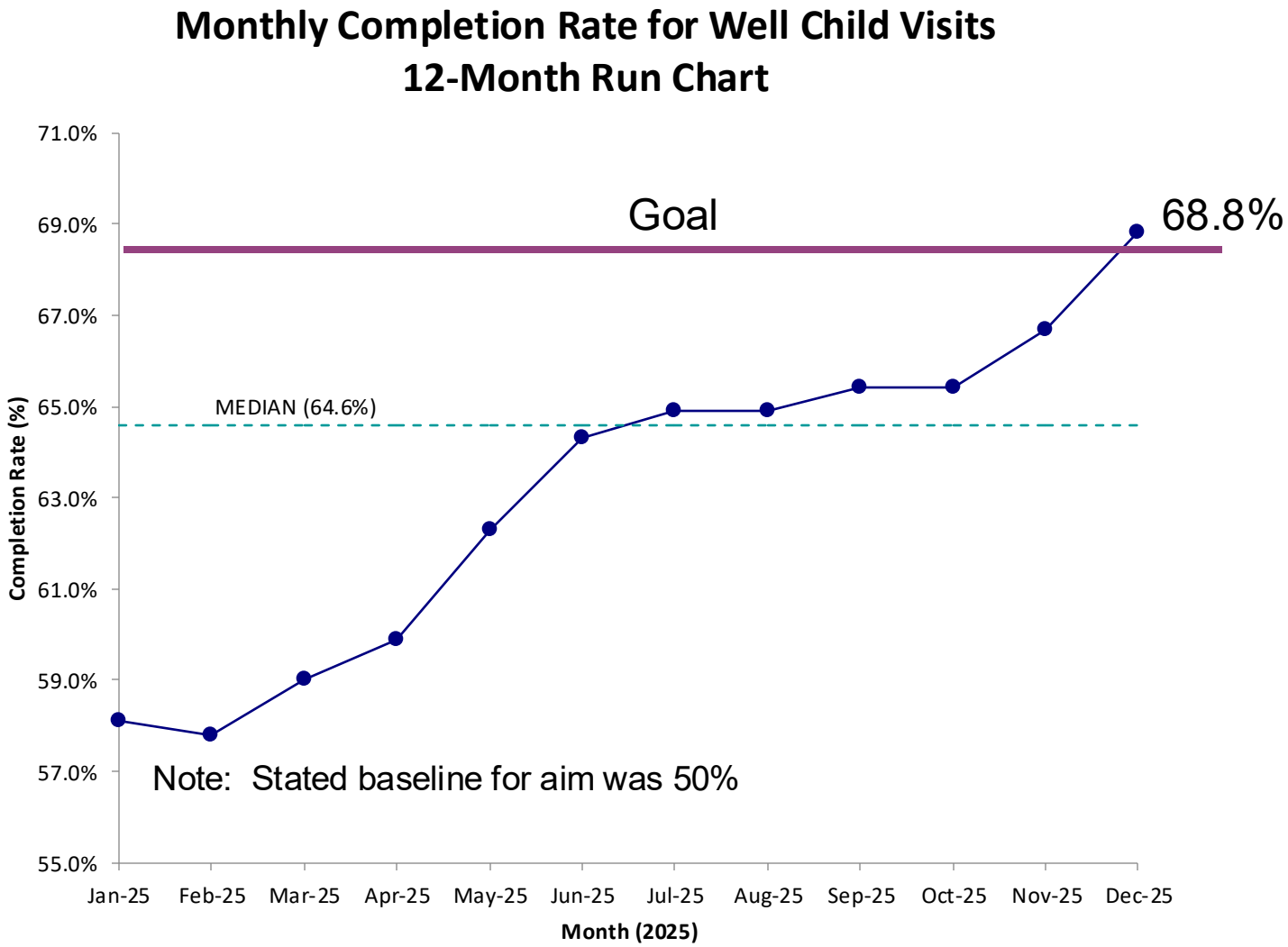
- **Outcome Measures -** Mirror the aim statement
- **Process Measures** – Steps in the process that are good indicators that I will achieve the outcome
- **Balancing Measures** – Unintended consequences or impacts resulting from the changes

Let's look at an example together

Petaluma Health Center

Well-Child Visit Completion Rate Over Time

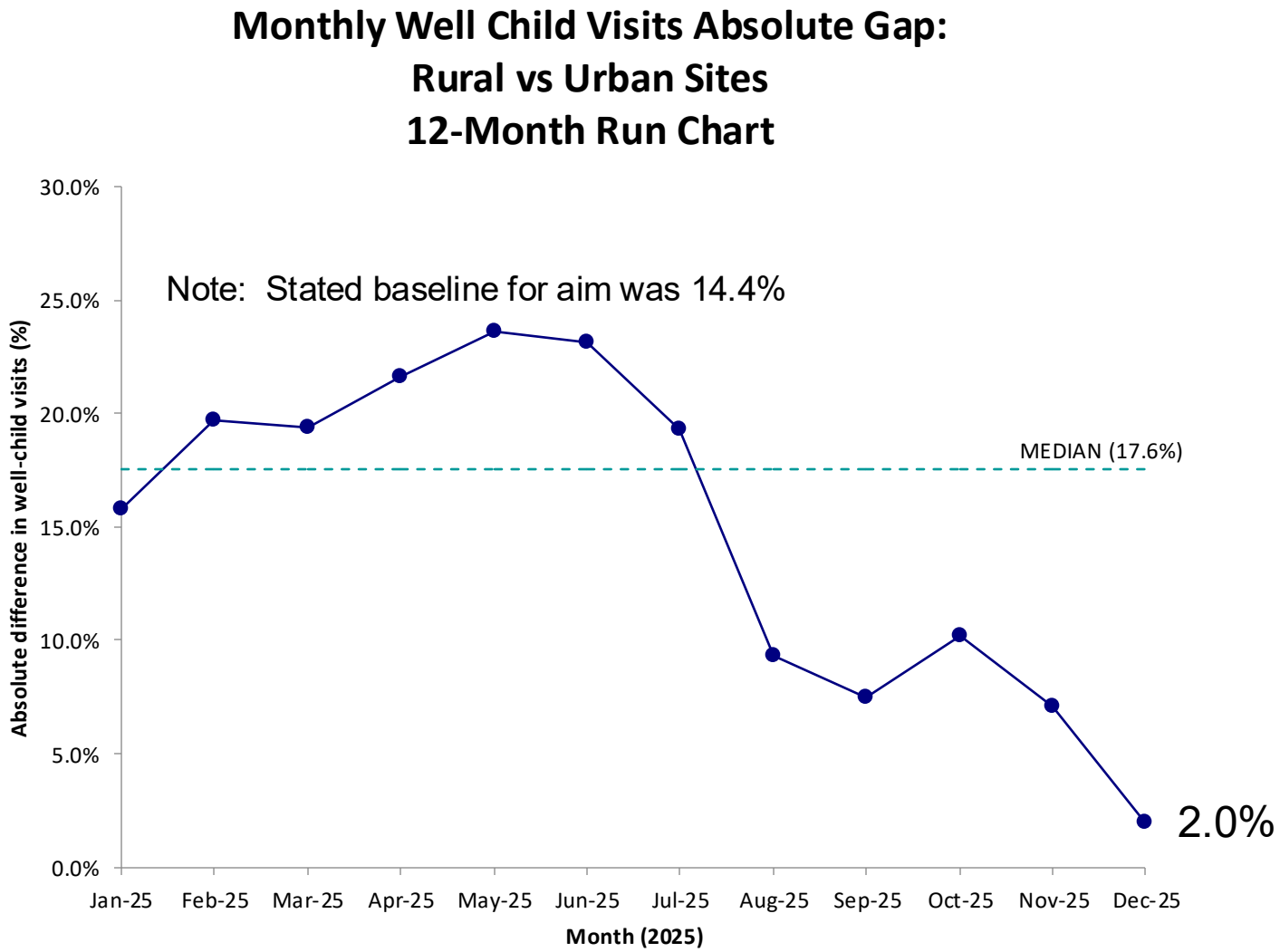
- Monthly well-child visit completion rates tracked over a 12-month period.
- Performance displayed using a run chart with a fixed median.
- Completion rates showed a steady upward trend across the year.
- Sustained performance above the median observed in the second half of the measurement period.



TARGET = 68%

Well-Child Visit Equity: Rural vs Urban Sites

- Monthly well-child visit completion rates stratified by rural and urban sites.
- Equity assessed using the absolute percentage-point gap between groups.
- Large baseline equity gap observed in the first half of the year.
- Marked and sustained reduction in the rural–urban gap beginning mid-year.
- By year-end, the equity gap narrowed substantially toward zero.



TARGET = 0%

Clinical Outcome Measure Aim Statements 2026 – Children

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Clinical Measure Aim

- **By December 31, 2026, Petaluma Health Center will improve the health of the children in our community as evidenced by:**
  - Increasing the percentage of children who have completed 6 or more well-child visits in in their 15 months of life from 68.8% [# of children] to XX% [# of children].*
  - Increasing the % of children who are fully immunized by age 2 from 40.5% [# of children] to XX% [# of children].

Target percentages will be set at the 90th percentile of Partnership Health Plan's QIP measures

Equity Aim

- **By December 31, 2026, Petaluma Heath Center will improve the heath of the children in our community as evidenced by decreasing deviation rates of:**
  - **Well-child Visits**
    - Between populations assigned to the most rural vs. most urban practice sites from 2% to 0% (2025 baseline – 14.4%)
    - Between Spanish-speaking vs. English-speaking populations from 13.8% to 0% (2025 baseline – 3%)
  - **Immunizations**
    - Between populations assigned to the most rural vs. most urban practice sites from 2.7% to 0% (2025 baseline – 39%)
    - Between Spanish-speaking vs. English-speaking populations from 9.9% to 0% (2025 baseline – 2%)

Measures Set

Outcome Measure

% of children with 6 WCV in the first 15 months of life
% of children who complete the CIS 10 immunization series by 24 months

Process Measures

% of children identified with care gaps who received outreach/reminder
% of children who receive 2/2 flu vaccines by their 18-month birthday
% of children who have a future well-child check appointment scheduled on the day of most recent visit

Balancing Measures

% of patient-facing continuity for children in the denominator during the measurement year
% of patients, stratified by primary language, who completed developmental screening (ASQ) in the 12-month measurement period

Use of Data Doesn't End There . . .

Understand	How does the current system perform?
Predict	What interventions might improve the performance of the current system?
Evaluate	Did our interventions result in improvement?
Monitor	Are our improvements sustained over time?
Engage	Are we considering what is important for other to know?

PHM Change Strategies Alignment with Sustainability Plan

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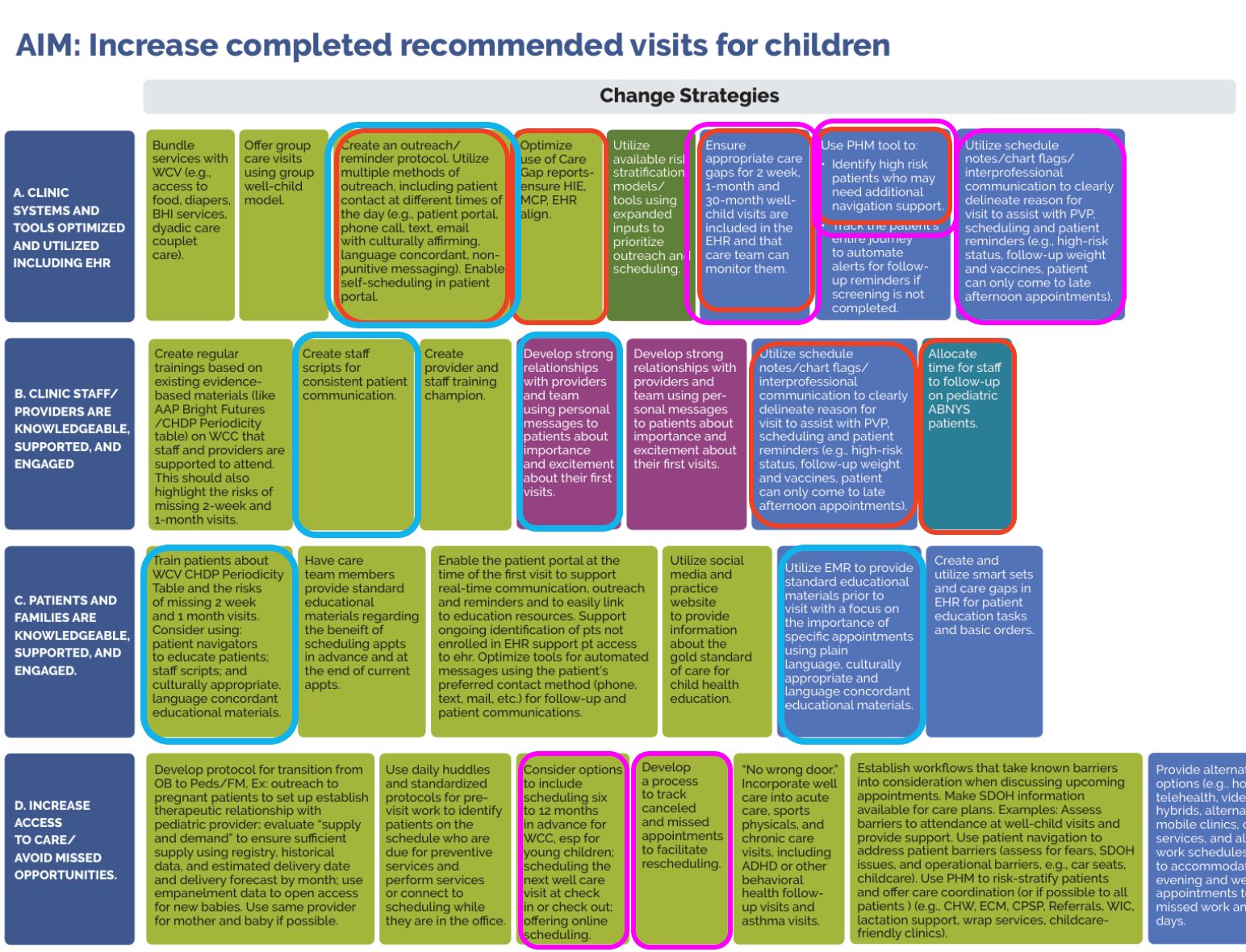
AIM: Increase completed recommended visits for children



- Key Drivers
- Clinical Strategies
- Data Strategies
- HIT Strategies
- Empanelment Strategies
- Access Strategies
- Equity Strategies

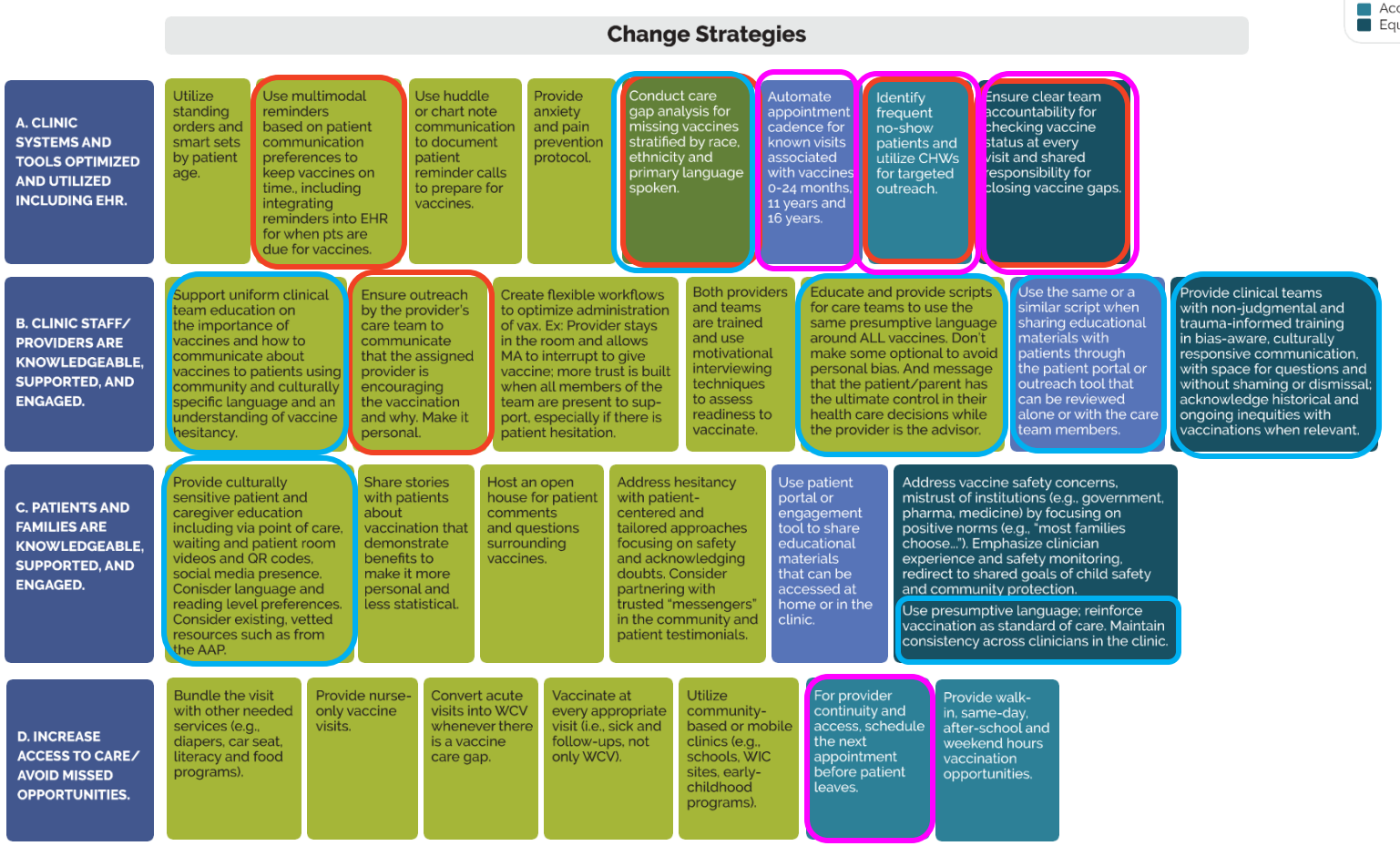
PHC's Identification of What to Strengthen / Standardize Related to CPSP/MA 3 Roles

Proactive Identification & Outreach
- Reliable care-gap reports
- Clear outreach ownership
- Repeated outreach until well-child visits and immunizations

Closing the Loop on Scheduling & Visit Completion
- Confirm next WCV is scheduled
- Re-engage no-shows
- Track completion (not just attempts)

Standardized, Culturally & Linguistically Appropriate Preventive Education
- Consistent education scripts
- Reinforced messaging
- Tailored communication by language/literacy

AIM: Increase percentage of received vaccines recommended for children



- Key Drivers
- Clinical Strategies
- Data Strategies
- HIT Strategies
- Access Strategies
- Equity Strategies

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Standardized, Culturally & Linguistically Appropriate Preventive Education
- Consistent education scripts
- Reinforced messaging
- Tailored communication by language/literacy

And the Use of Data Continues . . .

Understand	How does the current system perform?
Predict	What interventions might improve the performance of the current system?
Evaluate	Did our interventions result in improvement?
Monitor	Are our improvements sustained over time?
Engage	Are we considering what is important for other to know?

How Petaluma Practices Continuous Use of Data

- Sharing outcome measure performance data at every team meeting
  - Can be informal – access and manipulate Relevant platform in the moment
- Sharing documented PDSAs
  - Compare predictions to results
  - Share data collection sheet
- Developing team-level performance dashboards
  - Establish accountability at the team level

Monthly Data Shows the Way Forward

- Design a family of measures for each SMARTIE goal
- Pick measures for which you can **collect monthly data**
- Good measures act as a “canary in the coal mine” to indicate if you are headed in the right direction or need to adjust

TUESDAY, SEPTEMBER 27, 2016 · THE WASHINGTON POST

A3

POLITICS & THE NATION

Violent crime rate rose sharply in 2015, FBI reports; homicides jumped 10%

Cause of spike uncertain; number of homicides far below peak in early '90s

BY MARK BERMAN

Homicides in the United States ent up by more than 10 percent 2015 over the year before, while olent crime increased by nearly ercent in the same period, ac- ding to statistics released by the FBI. ...ntry reported ...lent

Lynch said Monday in Little Rock. A nationwide debate over crime has been raging based on the number of cities where homicides have gone up and, in some cases, surged dramatically. Police departments in many of the places that saw homicides go up in 2015 say they have also seen increases so far this year, though officials and experts have disagreed on precise causes.

Experts say the rise in homicides in the country's urban centers is driving the overall increase.

The FBI statistics were released just hours before Trump and Hillary Clinton, his Democratic opponent, meet for their first presidential debate. Crime and law enforcement have become major ...paign, with ...

CHRISTIAN K. LEE/ASSOCIATED PRESS

Antonio Brown, father of Amari Brown, 7, talks about the shooting that took his son's life in Chicago in July 2015.

half of all murders — occurred in that region alone.

Once again, white people were far more likely to be killed by white people and black people far more likely to be killed by black people. One in 5 people were killed by an acquaintance, the FBI found, and almost half of all killings involved a single victim and offender; the FBI found. Nearly 1 in 10 homicide victims were younger than 18, more than 400 were younger than 5.

Among all of the violent crimes reported last year, guns were part of a sizable percentage, the FBI found. Guns were used in more than 7 in 10 murders, more than 4 in 10 robberies and a quarter of all aggravated assaults.

The FBI figures are released through its Uniform Crime Reporting Program, which collects numbers from more than ... law enforcement agencies ... pating voluntarily.

In addition to the ... the FBI also collects ... how often police ...

... ...tored." ... in an ... no- ... since 2012, but it trails the 1,798 million seen in 1995, when the United States had more than ... fewer residents. ... rate was ...

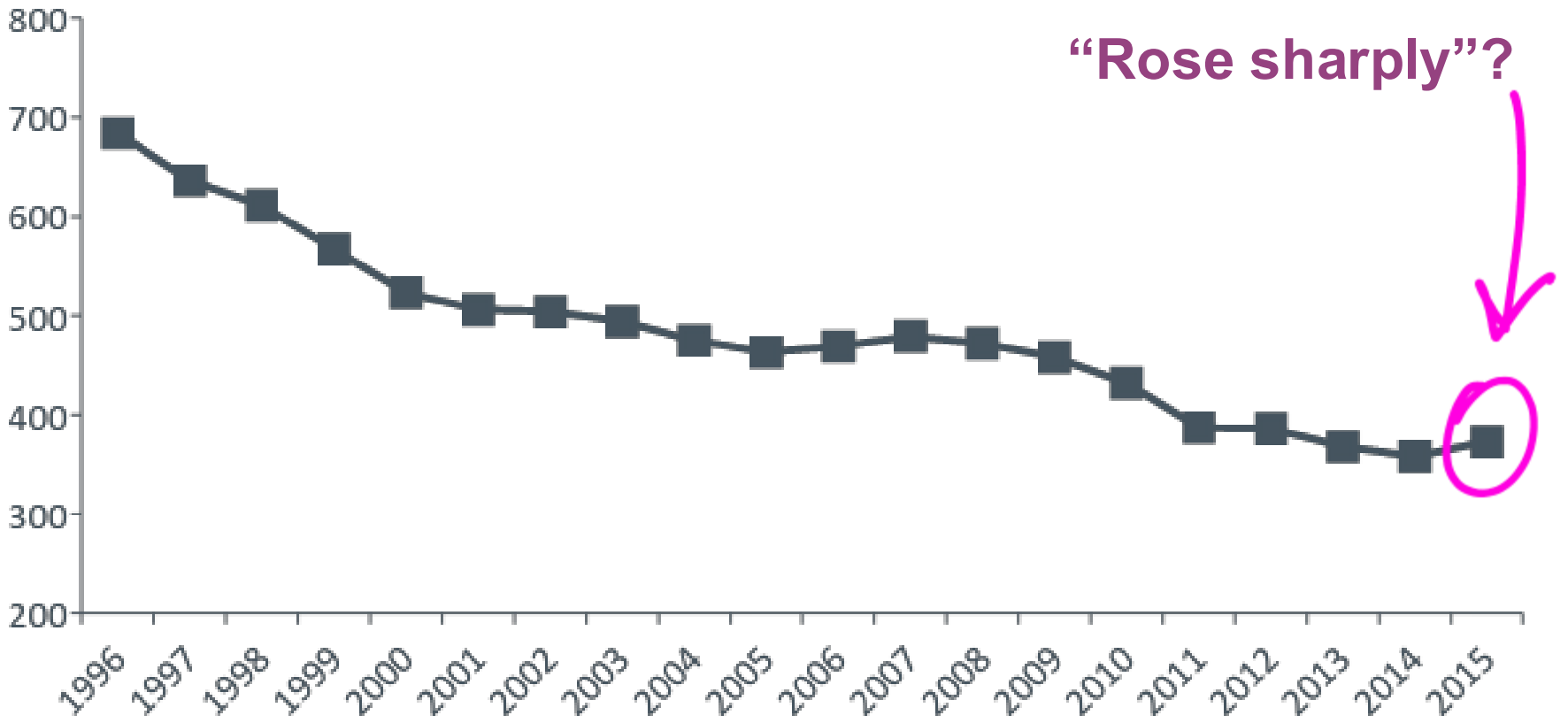
data) found that 990 people w... shot and killed by officers. ... Americans are generally ... fied that crime is going up ... wide, though Gallup po... ing, back nearly thir... shows that America... ways think crime is ... when it is declinin...

Law enforcement ... criminologists ... what may be ... in homici... could stu... drug sa... has ...

Washington Post:

"Violent crime rate rose sharply in 2015, FBI reports; homicides jumped 10%"

U.S Violent Crime Rate per 100,000 Residents



PHM INITIATIVE

7 Tips for Selecting Measures

Snap the tips your team can use

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

Selecting Measures Tip #7:

Simple/Fast Is Better Than Perfect/Slow

Pick measures that set you up to collect data by April

It is better to manually sample 20 charts every week than wait three months for a polished dashboard

Sticky notes and hashmarks are a time-tested measurement tool

Swap Notes at Your Table

- What did you learn from Petaluma's example?
- What tip for selecting measures does your CHC most need to try?
- Consider your SMARTIE goal(s). What will be tricky about selecting measures? Jot down a question for coaches/SMEs.

Optional Leadership Roundtable Lunch is starting now in the Bayview Ballroom:
The AI Imperative: Leading Through Disruption and the Survival of the Safety Net

All others, please enjoy your lunch at the Berkeley Boathouse Restaurant.

Next session starts in Action Community Homerooms at 1:00 PM: *Developing a Measurement Strategy*

Lunch

1 Hour – Back at 1:00 pm

PHM INITIATIVE

The AI Imperative: Leading Through Disruption and the Survival of the Safety Net

March 4, 2026

Please transition to your Action Community Homeroom.

Next session starts at 1:00 PM:
Developing a Measurement Strategy

Quarter Deck (1st Floor)	**Adult with Preventive Care Needs** - *red nametag dot*
Mariposa (2nd Floor)	**Adults with Chronic Conditions** - *dark blue nametag dot*
California (4th Floor, Executive Meeting Center)	**Children and Pregnant People -** *yellow nametag dot*
El Dorado (2nd Floor)	**People with Behavioral Health Conditions** - *green nametag dot*

PHM INITIATIVE

Policy Forces and CHC Actions: Advancing PHM Amidst Headwinds

March 4, 2026

Learning Objectives

By the end of the session, participants will be able to:

1. **Characterize the major policy forces** and their **high-level impacts** on CHCs in 2026.
2. **Identify** CHCs' **operational, clinical, and strategic responses** to these policy forces.
3. **Articulate specific ideas** about how to make continuous forward **progress on PHMI core competencies** in the challenging policy environment.

Experiential Goal: PHMI CHC participants will **connect** with other CHC leaders in similar roles to **share** experience and discuss how policy-driven impacts are affecting PHM efforts.

Presenters

Rachel Tobey
Health Policy Insights

Allie Budenz
CPCA

Rafael Gomez
El Cambio Consulting

PHM INITIATIVE

Federal & State Policy Landscape

Policy Forces

Federal Policy and Actions

State Commitment to Primary Care

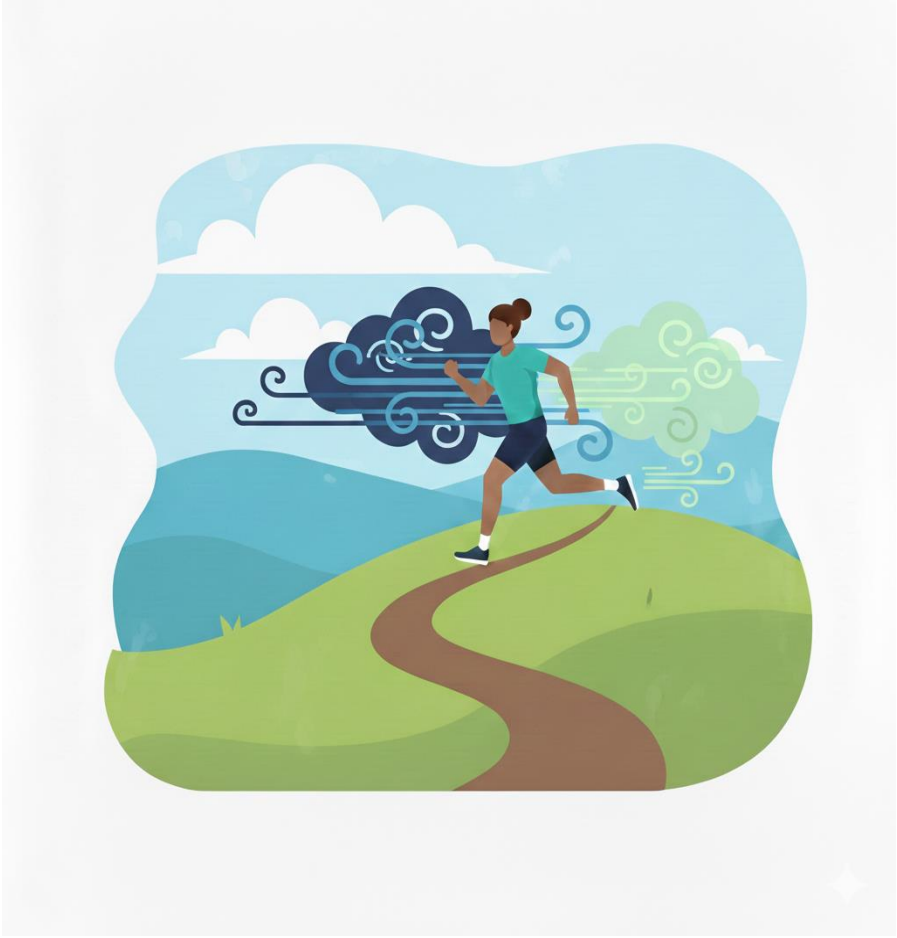
CalAIM Implementation

State Policy & Budget

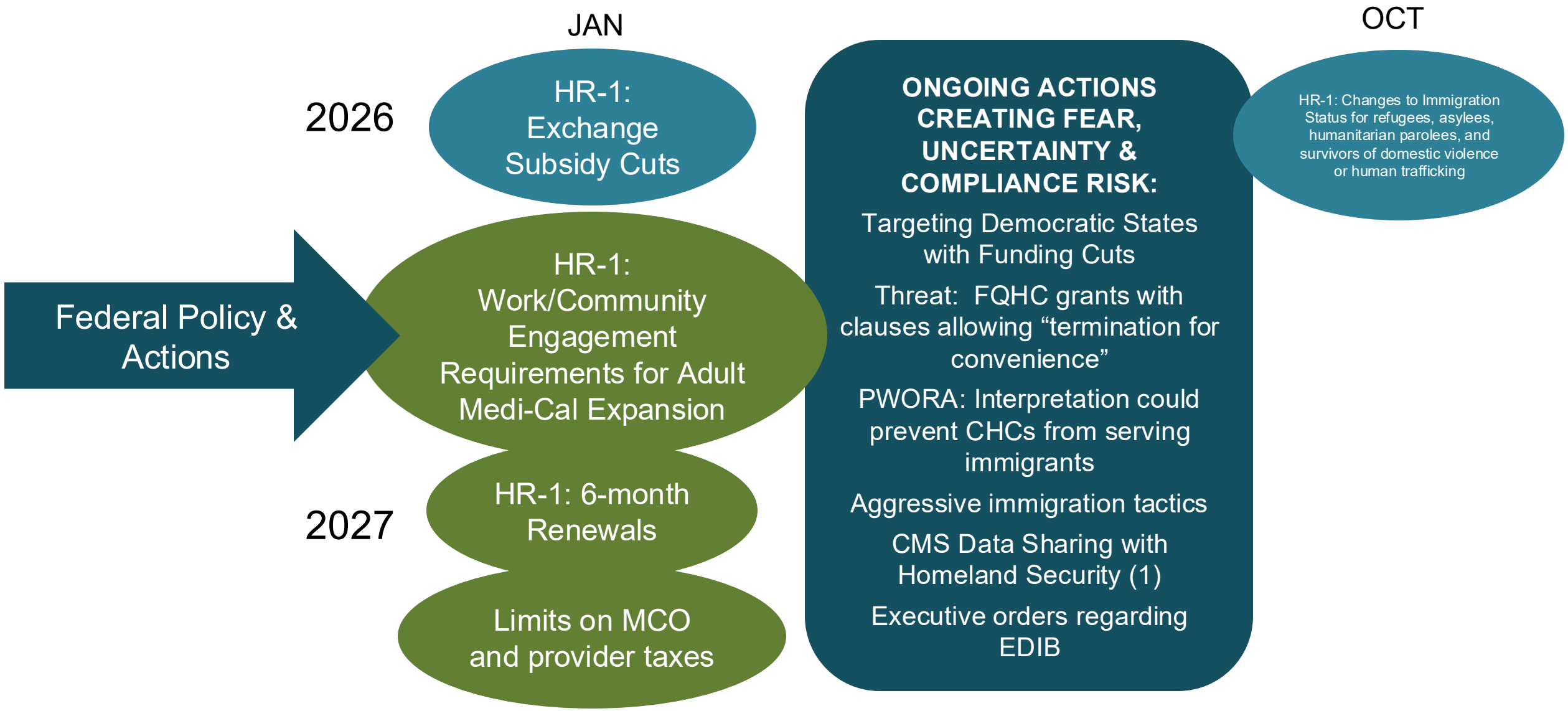
Strong History of CHC Resilience

Federal Unknowns

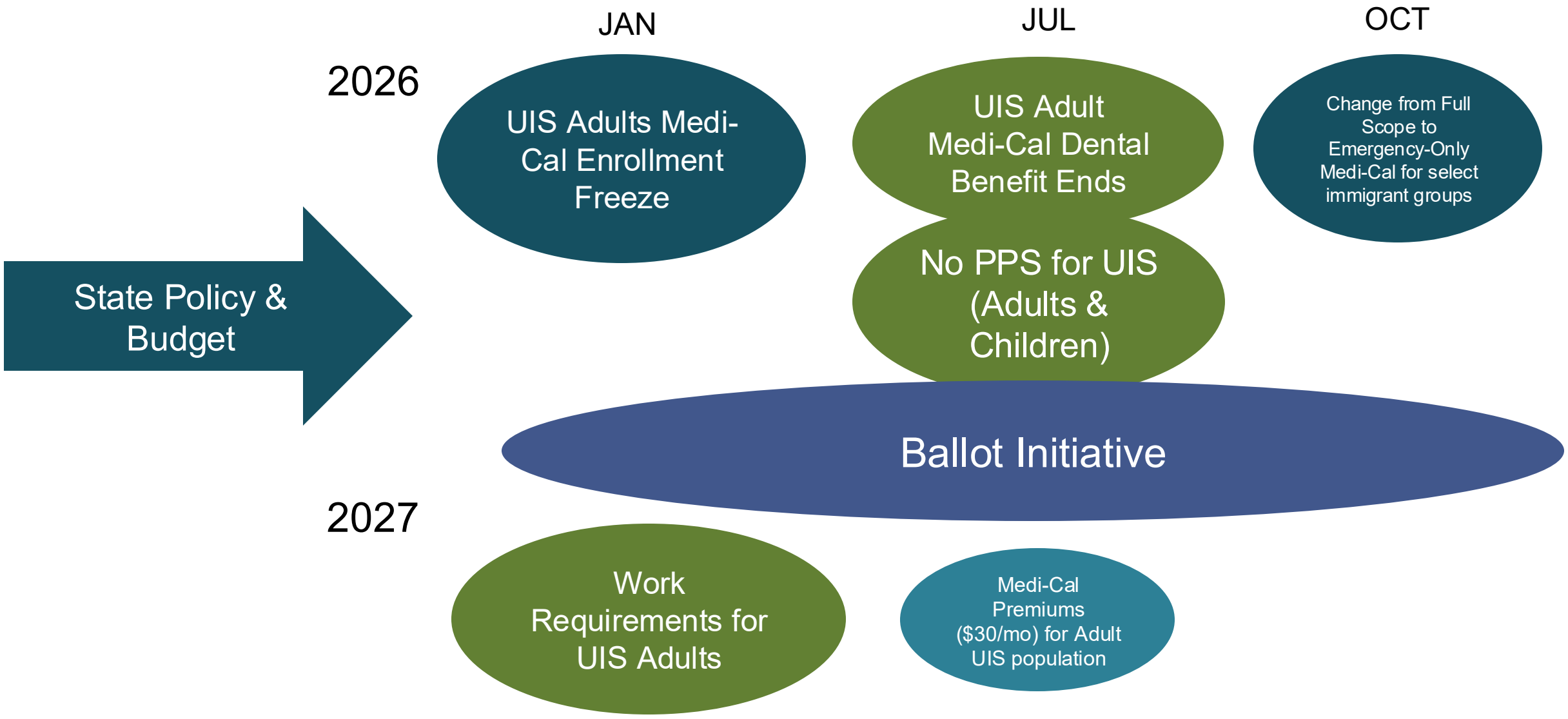
State Unknowns



Headwinds: Federal Policy & Actions



Headwinds: State Budget & Policy



Tailwind: State Policy

2024 - State set goals for increased primary care spend, total medical expense (TME) growth caps and value-based payment (VBP) adoption (1):

1. PC investment benchmark by 2034: **15% of TME allocated to PC**
2. Annual improvement benchmark (2025-2033): 0.5 -1% annual increase in PC spending as a % of TME
3. Total Medical Expense Growth cap (3-3.5% annual)
4. 75% of Medi-Cal members attributed to HCP-LAN Categories 3 and 4 VBP models by 2034

State Commitment to Primary Care

2027 - DHCS will release All-Plan Letter (APL) to align DHCS requirements with State PC investment and VBP goals

Tailwind: State Policy

2026 Medi-Cal MCPs required to implement **D-SNPs for dual-eligible members.**

- PHM capabilities could position CHCs well for contracts under D-SNP where per capita performance $ could be higher

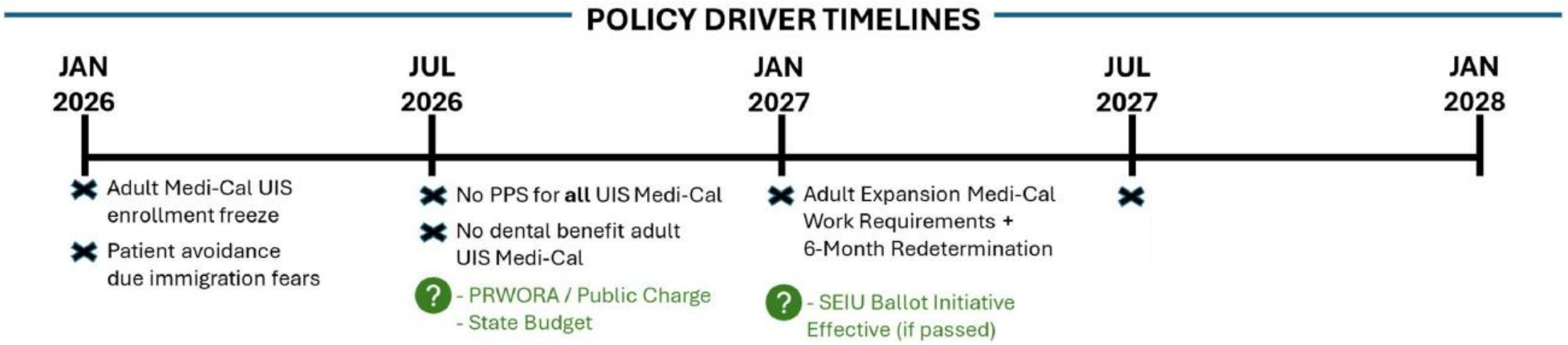
Enhanced Care Management continues.

- State Risk Stratification System should help identify more members for ECM starting 2027.

Tailwind: History

Strong History of CHC Resilience

Putting it Together: Policy Timeline for Health Centers



Doing PHM well is a way to lean into these headwinds and leverage tailwinds.

~20%+ Decline in Medi-Cal Enrollment by 2028

~15%+ Decline in FQHC Patient Revenue by 2028

Source: 2026 Forward Health Policy Drivers and FQHC Planning Tool Prepared by El Cambio Consulting

Projected Impact on Health Centers of Policy Changes

Impact

1. There will be less Medi-Cal patients and less revenue

2. Demand likely to continue outpace FQHC capacity

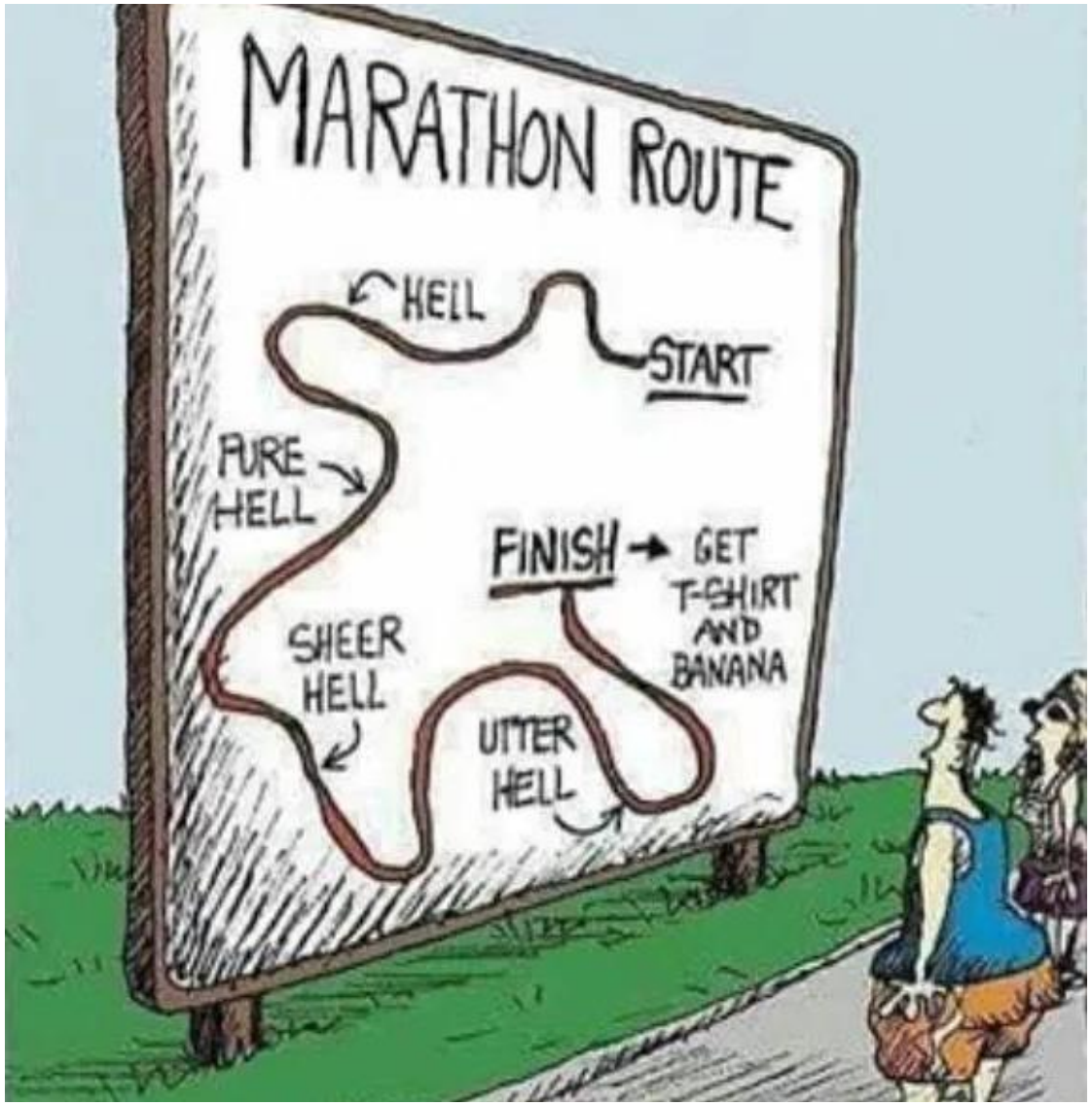
3. Patients will have access to different benefits and services

4. Payor/provider partners under financial stress

5. Increased compliance risk with federal government

6. Patient aging, workforce shortage, and technology trends unchanged

UNCERTAINTY



This is a marathon, not a sprint.

"Steal shamelessly" and implement wisely.

Clinics DO deliver on quadruple aim.

Actions CHCs Are Taking: Short Term

Dynamic Budget Projections/Scenario Planning	Budget multiple budget scenarios and plan for service changes driven by Medi-Cal coverage/benefit changes
Staff/Board Communication	Build staff and Board loyalty, alignment and confidence via value-forward communication, transparency and frequent touches
Financial Stability	Optimize FQHC access and productivity, maximize patient service revenue, improve operational efficiency / cost effectiveness, and scale essential and self-sustaining services
Coverage Retention/Navigation	Maximize and flex enrollment support, navigation and community outreach that results in Medi-Cal retention and enrollment by eligible patients
Immigrant Care/Access	Adapt care modalities (e.g., telehealth, mobile) to maximize essential access at a lower cost threshold...and prioritize communication and outreach

Actions CHCs Are Taking: Long Term

Services/Lines of Business	Adapt to demographic, technology and payer changes – services mix won't necessarily look the same
Diversified Financial Models	Optimize FQHC performance, leverage technology, and diversify revenue sources and payment models
Mission Forward	Explore new and creative strategies to assert your mission
Strategic Partnership	Seek out strategic partnerships that leverage core strengths, position the health center for the future and respond to acute partner needs or gaps

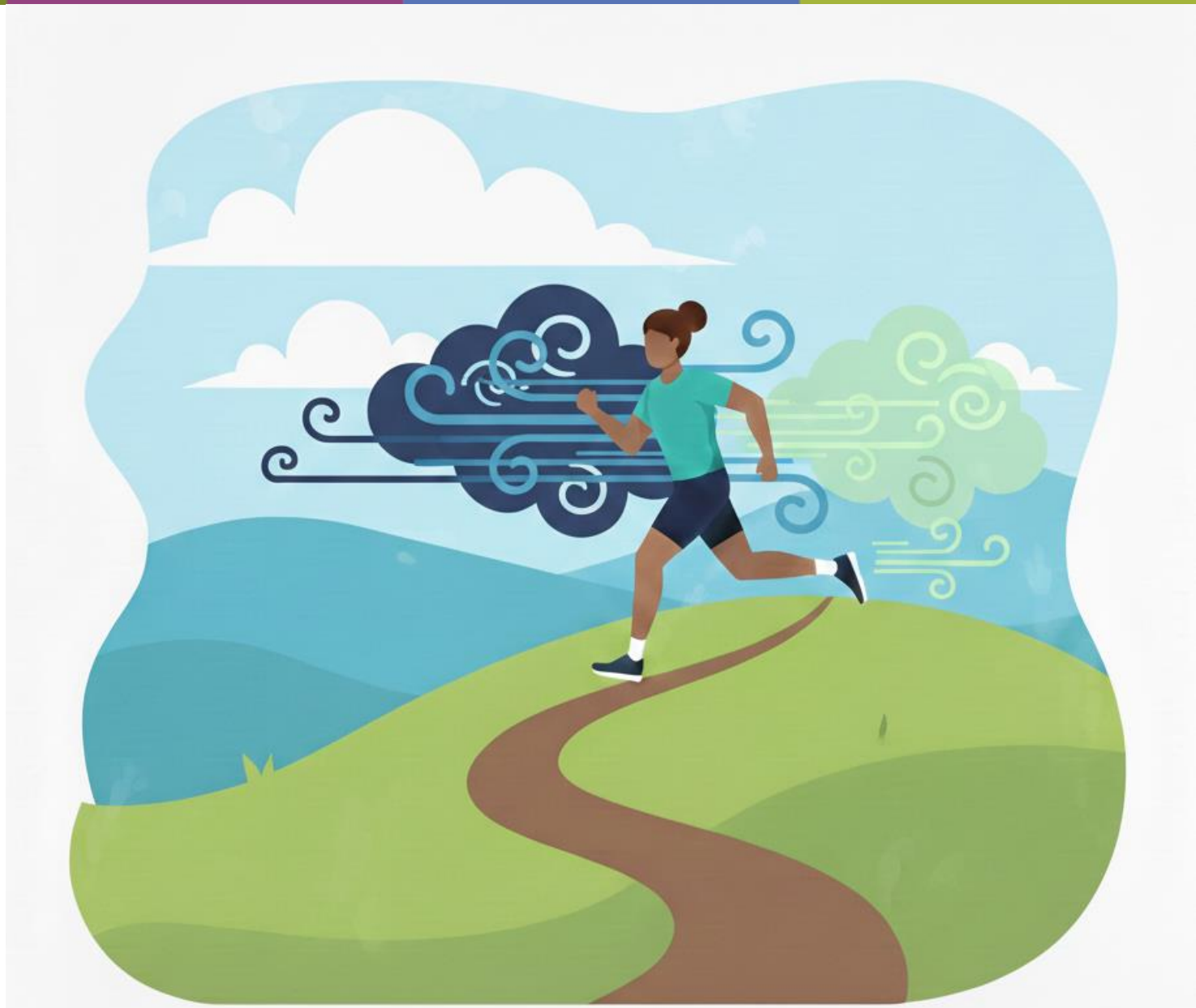
Round Table Discussion

Round Table Discussion (30 min)

Clinical Leaders	Operations Leaders	Business and Strategy Leaders (e.g., CEO, CFO, CSO)
• What changes are you planning for in service delivery (e.g., discontinuing services, leveraging telehealth)? • How are you changing roles on the care team to address needs for outreach/engagement, care gap reduction, care coordination, BHI? • How are community partnerships changing (e.g., to address social needs)?	• What technology strategies are you considering or adopting to be more efficient or effective with PHM? • How are relationships with MCOs changing regarding data sharing and real-time coordination across health system? • How are you optimizing contracts or processes with MCOs?	• What new business strategies are you exploring for sustainability of PHM (e.g., partnerships, outsourcing, service changes, new funding sources)? • How are you planning to stay true to your mission in the context of evolving policy environment? • How do your actions related to financial sustainability relate to your strategies for spread?

Round Table Report Out
(15 min)

Closing: Final Reflections



Health Center Leadership Roundtable

Next Sessions

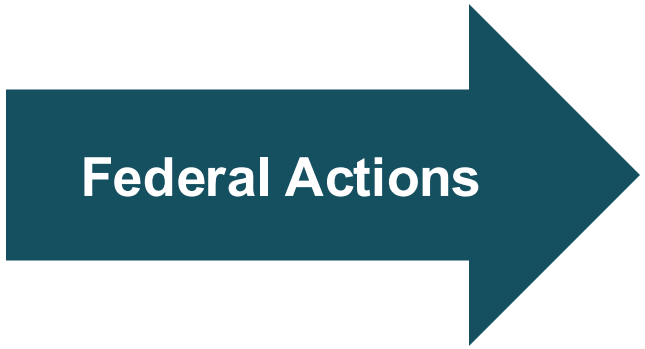
- Virtual Sessions in April
- June SWLS

Appendix: Detail Policy Tables

Federal Policy

Policy Provision	Start Date	Impact to CA Uninsured	Impact $
HR-1: Exchange Subsidy Cuts	Jan. 2026	69,000 (1)	New uninsured patients
HR-1: Changes to Immigration Status for refugees, asylees, humanitarian parolees, and survivors of domestic violence or human trafficking	Oct. 2026	?	Fewer Full-scope Medi-Cal members, some may continue to seek care
HR-1: Work/Community Engagement Requirements for Adult Medi-Cal Expansion	Jan. 2027	1,400,000 (2)	Fewer Medi-Cal members, some may continue to seek care → less revenue & same care
HR-1: 6-month Renewals	Jan. 2027	400,000 (2)	
HR-1: Limits on MCO and provider taxes	Jan. 2027		Likely reductions in state directed payments to FQHCs for backfilling 340(b)
HR-1 Cost sharing	Oct. 2028		Small: FQHCs are exempt

Federal Actions



Action	Timing	Impact
Targeting Democratic States with Funding Cuts	ongoing	State funding decline
Threat: FQHC grants with clauses allowing "termination for convenience"	ongoing	Administrative Compliance Risk
PWORA: Interpretation could prevent CHCs from serving immigrants	unknown	Uncertain Administrative Risk if court allows PWORA reinterpretation to proceed
Aggressive immigration tactics	ongoing	Reductions in seeking care & re-enrolling in Medi-Cal
CMS Data Sharing with Homeland Security (1)	Last confirmed Dec. 2025	Reductions in seeking care & re-enrolling in Medi-Cal
Executive orders regarding EDIB	Jan 2025 and ongoing	Administrative Compliance Risk

State Budget & Policy

State Policy & Budget

Policy Provision	Start Date	Impact to Uninsured	Impact $
State Policy: UIS Adults Medi-Cal Enrollment Freeze	Jan. 2026	~500,000 – 1M based on current UIS population statewide (2)	Reduced UIS enrollment → reduced revenue ~ 25% UIS enrollment reduction in 2026 up to 50% by 2028 (1) Reduced UIS enrollment → reduced revenue
State Policy: Work Requirements for UIS Adults	Jan. 2027		
State Policy: UIS Adult Medi-Cal Dental Benefit Ends	Jul. 2026		Reduced revenue ~ UIS Adult Dental visits X PPS
State Policy: No PPS for UIS (Adults & Children)	Jul. 2026		Reduced revenue ~ UIS visits X (difference of PPS and Medi-Cal FFS)
State Budget: Change from Full Scope to Emergency-Only Medi-Cal for select immigrant groups (3)	Oct. 2026		
Ballot Initiative	Jan. 2027		Existential
State Policy: Medi-Cal Premiums ($30/mo) for Adult UIS population	Jul. 2027		
SB 525 Minimum Wage (4)			Cost increase: $25/hr min by Jul. 2027

PHM INITIATIVE

PHMI Statewide Learning Session

March 4, 2026

PHM INITIATIVE

Closing

March 4, 2026

Presenters

Elena Thomas Faulkner
Project Director, PT Partners

Lindsay Swain Hunt
PT Coach

Dr. Meena Mital
PHMI Director

Reflections

What will you take home?

Speed share at your tables.

- One think you will take back to team members who are not here
- One word that summarizes how you are feeling

http://bit.ly/46rtA9Q

Help us with data to inform our action!

Please take 5 minutes to complete the evaluation

Closing Remarks from Kaiser Permanante

Join us in June!

Continue the momentum in Action Communities and Leadership Roundtables.

Tentatively Scheduled for June 23 & 24, Los Angeles Area

Thank you!

Population Health Management Initiative (PHMI), a California partnership of the Department of Health Care Services, Kaiser Permanente, and Community Health Centers.