PHM INITIATIVE

# Roadmap for Creating Your Population Health Management (PHM) Vision

PHM enables practices to deliver more equitable, efficient, high-quality care to improve patient outcomes and reduce disparities. A strong PHM vision provides clarity of purpose, greater alignment, improved communication, increased engagement, and focused goal setting.

## STEP 1: Form Your Population Health Leadership Team

- Establish a Population Health Leadership Team that is responsible for ensuring alignment of PHM work with organizational priorities and proactively setting and monitoring annual goals for improving clinical outcomes and reducing disparities for your selected Population of Focus.
- Must include but is not limited to, an executive sponsor, a clinical lead (medical and/or behavioral health), and quality improvement lead.

## STEP 2: Review Your Data

- Review the following documents/data: scores on the Population Health Management Capabilities Assessment Tool (PhmCAT), the PHMI sustainability plan, clinical outcome measures for selected PoF (overall and segmented by race/ethnicity), equity SMARTIE goal, PHMI business case, your center's strategic plan, and any other related data.
- Assess current state of population health capabilities, clinical outcomes, and disparities to identify aligned and prioritized opportunities for improvement.

## STEP 3: Define Your WHY – State Your VISION

- **Identify Local Needs:** What are the most pressing health disparities in your specific zip codes?
- **Align with Mission:** How does PHM fulfill your health center's founding mission to serve the underserved?
- **Outcome Focus:** What are you aiming to improve within your PoF? Increase preventive visits, manage chronic hypertension, improve behavioral health, etc.?

## Example Vision Statements by Population of Focus

- **Children**: To achieve health equity through a standard of pediatric excellence where every child and adolescent at our health center meets their developmental milestones.

- **Pregnant People:** To establish a continuum of care that ensures every parent and infant—regardless of zip code or language—achieves optimal health outcomes through data-driven intervention, culturally rooted support, and a seamless transition from pregnancy to parenthood.

- **Adults Living with Chronic Conditions:** To empower every patient across our network to live a life uninterrupted by the complications of diabetes.

- **Adults with Preventive Care Needs**: Improve patient health outcomes by scaling breast cancer screening and population health management to multiple sites within our network.

- **People with Behavioral Health Conditions:** To transform our healthcare delivery into an integrated system where behavioral health is a standard of care for every patient—eliminating stigma, identifying risk proactively through data, and ensuring that mental wellness is seamlessly woven into the fabric of primary care.