PHM INITIATIVE

EXECUTIVE SUMMARY OF EVALUATION FINDINGS

Building Population Health Management Capacity in California Community Health Centers

September 2026

OVERVIEW

California's Community Health Centers (CHCs) operate at the front lines of addressing health disparities and improving clinical outcomes for historically underserved communities across the state. Yet achieving better outcomes requires more than delivering care during office visits. It requires the ability to proactively identify patient needs, engage patients before health conditions worsen, coordinate services across teams, and use data to guide improvement.

The Population Health Management Initiative (PHMI) was created to help CHCs build these capabilities. PHMI is a collaborative effort involving 32 CHCs, Kaiser Permanente, the California Department of Health Care Services, and other partners. The initiative seeks to strengthen population health management infrastructure, improve quality of care, and advance health equity for patients and families served throughout California.

Participating organizations first focused on strengthening foundational capabilities and then implemented targeted improvement strategies for selected populations, including children, pregnant people, adults with preventive care needs, adults living with chronic conditions, and individuals experiencing behavioral health concerns.

PHMI Timeline



This evaluation, led by the University of Chicago, examined whether PHMI improved clinical outcomes and strengthened organizational capabilities. It also identified factors contributing to success and explored challenges that may affect long-term sustainability. Findings draw from:

- **300+** interviews among CHCs and PHMI partners
- **4** rounds of capability assessments using the Population Health Management Capability Assessment Tool (PhmCAT)
- **600+** survey responses among CHC staff and providers
- **7** bi-annual submission of clinical quality measures from participating CHCs

This report focuses on evaluation findings from the first three years of the initiative (2023-2025). PHMI is currently planned to continue for an additional three years, through the end of 2028.

OVERALL KEY FINDING

The evaluation found that PHMI is contributing to measurable improvements in both clinical quality and population health management capabilities. The initiative has created momentum for change while helping organizations develop the foundational capabilities required for long-term transformation.

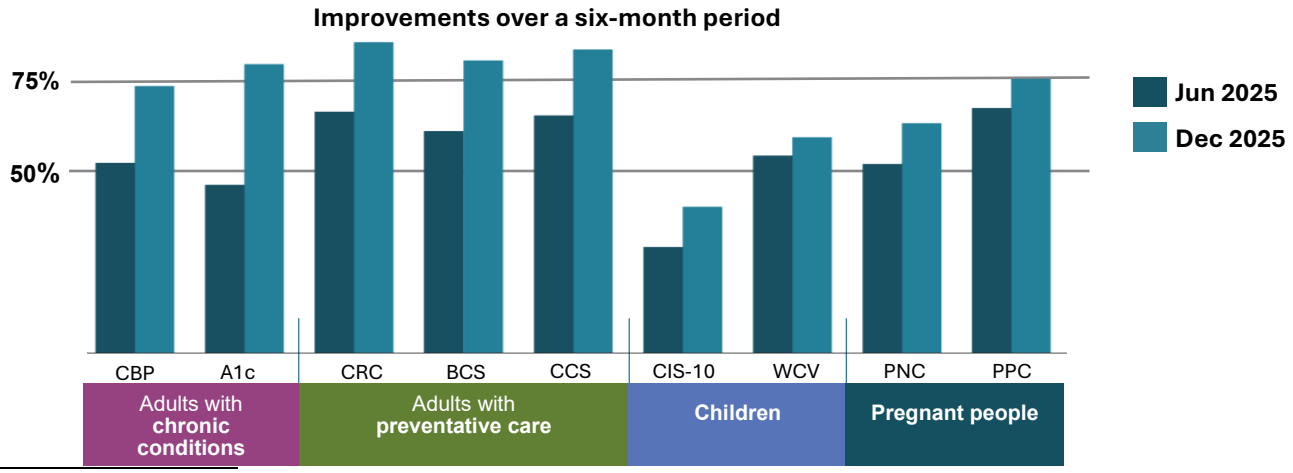
CLINICAL QUALITY IS IMPROVING ACROSS MOST MEASURES

Participating CHCs are seeing meaningful improvements in high-priority clinical quality measures.[1] CHCs began Population of Focus work designed to influence clinical quality measures in late 2024. After a year of focused work on these measures, **eight of nine** core measures improved over time, with nearly all improvements reaching statistical significance (see table below).[2]

Population of Focus	Core Measure	Weighted CHC Average* (CY 2025)	Trend Over Time (2023-2025)
Adults with **chronic conditions**	Controlling high blood pressure (CBP)	66%	▲▲
	HbA1c poor control (A1c)	28%	▲▲
Adults with **preventive care needs**	Colorectal cancer screening (CRC)	40%	▲▲
	Breast cancer screening (BCS)	56%	▲▲
	Cervical cancer screening (CCS)	61%	▲▲
Children	Child immunization status (CIS-10)	26%	▼
	Well child visits (WCV)	58%	▲▲
Pregnant people	Pre-natal care timeliness (PNC)	85%	▲▲
	Postpartum care timeliness (PPC)	82%	▲
People with **behavioral health** conditions	Depression screening and follow-up (DS & DF)	*A data reporting issue impacted the validity of data on depression screening & follow-up; data are being excluded from analysis until the issues are resolved*	

▲▲ Statistically significant improvement (p<0.05) ▲ Improving trend ▼ Declining trend

For most measures, 75% or more of participating CHCs were found to have improved performance. This represented a substantial improvement from mid-2025, where only about half of the CHCs had seen improvements in most measures (see figure below).



[1]Understanding Clinical Quality Measures for 2021. https://www.dhcs.ca.gov/wp-content/uploads/2025/10/Understanding-CQMs-for-2021.pdf

[2] *There are 11 core measures; a data reporting issue impacted the validity of data on depression screening & follow-up; data are being excluded from analysis until the issues are resolved*

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

PREVENTIVE CARE

Preventive care measures demonstrated some of the strongest improvements observed during the evaluation period. Significant gains occurred in breast cancer screening, cervical cancer screening, and colorectal cancer screening. CHCs that selected preventive care as their Population of Focus experienced greater improvements than the cohort overall, suggesting that PHMI-supported interventions contributed to these gains. CHCs reported that through PHMI they expanded outreach strategies, more systematically identified care gaps, and redesigned workflows to ensure preventive services became a routine part of care delivery.

> “We constantly struggled with moving the needle around colorectal cancer screening. We tried everything we could think of. I'm really excited to see almost double the number of patients getting screened and exceeding the national average.” — CHC staff

CHRONIC CONDITIONS

Chronic disease measures also significantly improved. Participating organizations reported implementing interventions such as remote patient monitoring, expanded use of clinical pharmacists, case management support, patient education programs, and medically tailored meals. CHCs associated these efforts with improved blood pressure control and diabetes management outcomes across the cohort.

While improvements were evident across the cohort, those CHCs who selected chronic conditions as a focus did not show greater improvements than the cohort overall. This may be because many of the CHCs that chose chronic conditions as their population of focus prioritized either diabetes or hypertension, but not both. Additionally, outcome measures related to chronic disease often require sustained effort and extended time horizons before the full impact becomes visible.

> “There was resistance early on from a few of our providers just not really being on board with wanting to refer anyone with an A1c over 9 to case management... we developed clinical protocols for managing patients with diabetes to get everyone on board.” — CHC staff

MATERNAL AND CHILD HEALTH

Maternal and child health measures have improved. Timeliness of prenatal care improved significantly, and timeliness of postpartum care trended towards improvement. Many organizations reported success in standardizing care delivery, improving care coordination, and strengthening outreach to pregnant and postpartum patients.

Among pediatric measures, well-child visits improved significantly. Childhood immunization rates, however, declined during the evaluation period. Participating organizations identified ongoing challenges with the measure itself. Interviews specifically noted the difficulty with the annual influenza vaccination requirement of the measure. External influences, such as increasing vaccine hesitancy, also impacted progress.

PHMI IS HELPING REACH MORE PATIENTS

An important aspect of population health management is reaching patients who are not actively engaged in care.

PHMI supported CHCs to report HEDIS-like measures,[3] which include all assigned patients, regardless of whether they have ever visited the CHC. Additionally, the evaluation asked CHCs to report on comparable UDS measures,[4] which focus only on patients who had at least one visit during the calendar year. Comparing UDS data over time allowed the evaluation to know whether the CHCs were seeing more patients.

Between 2023 and 2025, for most measures, CHCs generally increased the number of patients included in UDS denominators, suggesting greater success in identifying, engaging, and serving patients who might otherwise have remained disconnected from care.

POPULATION HEALTH MANAGEMENT CAPABILITIES ARE GROWING

PhmCAT Domains

- Leadership & Culture
- Business Case for PHM
- Technology & Data Infrastructure
- Empanelment & Access
- Care Team & Workforce
- Patient-centered, Population-based Care
- Behavioral Health
- Social Health

Clinical outcomes represent only part of the PHMI story. A central aim of the initiative was to strengthen the organizational capabilities that support population health management. These capabilities were organized into eight domains (see domains listed on the left).

Across the cohort, the evaluation found significant improvement across all eight domains measured by the Population Health Management Capabilities Assessment Tool (PhmCAT) from baseline. Additionally, all domains showed continued improvement each year, suggesting CHCs are continuing to build on their progress. The cohort improvements were distributed across participating CHCs with **88% of CHCs improving their overall capability scores**, which is an average across all domains.

Survey findings of CHC staff and providers indicated that most respondents believed PHMI contributed positively to strengthening their CHC's population health capabilities and patient care. In 2025, CHC staff perceptions of PHMI's contribution increased the most for Population of Focus-related domains *(e.g., patient care, social needs, patient outreach)*, which is where the work was focused during the year. There were also continued increases in perceptions of PHMI contribution to some foundational areas, *particularly care teams and business case*, aligning with the continued support in those areas.

These findings suggest that PHMI is building organizational infrastructure that may continue generating benefits after the formal initiative concludes.

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[3] PHMI Core Measure Specifications Manual. https://phminitiative.com/resource/core-measure-specifications-manual/#understanding-healthcare-effectiveness-data-and-information-set-hedis-measures

[4] Health Center Program Uniform Data System (UDS). https://data.hrsa.gov/topics/health-centers/uds

PHMI'S DESIGN CONTRIBUTED TO IMPROVEMENTS

Several elements of PHMI's design emerged as key contributors to CHC progress.

Strong and Sustained CHC Engagement

While engagement and experience with PHMI varied across the cohort, generally, participating CHCs remained highly engaged throughout the first three years of the initiative, consistently averaging approximately **six hours of participation in direct technical assistance per month**. Across interviews and surveys, CHCs consistently identified individualized coaching, subject matter expertise, and peer learning opportunities as the most valuable supports offered through PHMI.

Structured Implementation Support

PHMI established competencies to inform the program and understand progress. By 2025, **nearly all CHCs had completed foundational competencies, and most had completed competencies associated with their selected Population of Focus.** In the most recent interviews, many participants reported that the structures set up by PHMI helped them identify where to start, generate ideas for intervention, maintain momentum, and focus improvement efforts.

Sequencing Foundational Work before Clinical Improvement Efforts

Most participants reported that **building foundational capabilities before launching disease- or population-specific interventions made subsequent work more effective.** Investments in data systems, care teams, empanelment, and leadership engagement created a foundation upon which more targeted interventions could build.

> *"I think if we hadn't done foundational competency work and really leaned into that work in the first year or two, we would not be seeing the outcomes we're seeing now. And I also don't think it would be sustainable."*
>
> ***—CHC staff***

> *"One of the main changes we have had within the last six months is we've had a change in our CEO. And that had a big impact on buy-in. Our new CEO is really engaged in the patient outcome and has re-engaged some of our staff that were facing burnout to being reenergized in the process."*
>
> ***—CHC staff***

CHC Leadership Engagement

CHC leadership engagement emerged as a critical factor in successful implementation. **CHC leaders played an important role in translating PHMI goals into operational priorities, creating staff engagement strategies, celebrating progress, and securing internal investments** in infrastructure and systems. These actions helped embed PHMI principles throughout participating organizations rather than limiting them to isolated improvement projects. Conversely, a lack of CHC leadership support led to delays in decision-making and lack of a shared vision for PHMI efforts.

Examples of PHMI's contributions to foundational capabilities:

> *"I learned that improving health required moving beyond office visits to more of a proactive, data-driven strategy for the entire community …In order for us to move forward for any kind of intervention, it must be data-driven."*
>
> ***—CHC staff***

> *"Giving our nonclinical staff…the understanding that they're just as critical to the care of this patient as the physician or nurse practitioner is very important because then there's a sense that the team is owning the health of this family or this individual as a group."*
>
> ***—CHC staff***

SUSTAINABILITY REMAINS THE CENTRAL CHALLENGE

Although findings are positive, the evaluation also highlights challenges that could affect long-term sustainability.



First, many CHCs continue to work toward fully institutionalizing PHMI-related changes. While new practices are increasingly embedded in care delivery, organizations often face challenges scaling their interventions and standardizing workflows across sites and providers within their organizations. CHCs also expressed concerns about maintaining momentum after the initiative ends.



Second, many CHCs continue to experience internal capacity constraints, including workforce shortages, staff turnover, competing priorities, and limitations in data infrastructure and analytic capacity. These internal challenges affect organizations' ability to sustain and scale improvement efforts.



Finally, broader external factors create uncertainty. Participants identified concerns related to Medicaid financing, ongoing dependence on grant funding, continued use of visit-based reimbursement models, and limited access to timely managed care plan data. These factors influence the broader environment within which CHCs operate and may affect the long-term viability of population health approaches.

LOOKING AHEAD

The evaluation demonstrates that PHMI is helping CHCs strengthen the systems, capabilities, and practices needed to improve health outcomes and advance health equity.

The initiative's combination of foundational capacity building, targeted population-focused interventions, intensive implementation support, and peer learning has contributed to measurable improvements in clinical quality measures while strengthening the organizational infrastructure that supports long-term population health management.

The next phase of this work will require continued focus on sustainability, including investing in workforce, data systems, and care team models, and navigating financial and policy environments that support proactive, population-based care. If these conditions can be sustained, PHMI offers a promising model for advancing population health management within California's CHCs and improving outcomes for the communities they serve.

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