Equity and Practice Transformation (EPT) Program: **Technical Assistance Kick Off**

August 2024

Welcome EPT Practices

Agenda

1. Welcome
2. Creating Impact Together
3. The Work Ahead
4. Implementing EPT at Your Practice
5. Milestones and Deliverables
6. Next Steps

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Time for a poll!

Creating Impact Together

Our role as the EPT Program Office

The Learning Center is contracted with DHCS to serve as the Program Office for the EPT Program and fulfills the following functions:

1. Program oversight, design and coordination across practices, managed care plans/delegated entities, and other key stakeholders.

2. Design and coordinate the technical assistance (TA) strategy for EPT practices, including peer learning and expert consultation.

3. Facilitate continuous learning and best practice sharing across all stakeholders in EPT. Develop insights and share what works and what doesn't.

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Building Capabilities to Transform Care

Primary care is uniquely situated to improve care for patients **and** advance California's goal of reducing inequities and improving outcomes.

- You are the first point of contact for your patients.
- Whether it's diabetes care, well-child visits, or the flu, you do it all across the lifespan.
- You have built meaningful and trusted relationships with your patients and their families.

By building population health management capabilities in primary care, we can transform care for Medi-Cal members.

We're excited to have you on this EPT Journey!

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Baseline PhmCAT Results

Room For Improvement Across All Domains

Legend:
- # of Practices with Limited Capabilities
- # of Practices with Some Capabilities
- # of Practices with Strong Capabilities
- Domain average

Domain	Capability Optimized	Practice-Level Results
Leadership & Culture	Quality work is everyone's responsibility and leaders systematically use data to drive clinical and business decisions.	7.0 1 / 165 / 42
Business Case for Pop Health Management	Solid understanding of financial performance, capacity to manage performance-based and VBP contracts.	5.8 43 / 145 / 20
Technology & Data Infrastructure	Multiple data sources integrated into EMR to address disparities and close care gaps both with engaged and unengaged patients.	5.8 42 / 150 / 16
Empanelment & Access	Provider continuity with assigned PCPs; timely care accessed in person, through telehealth and patient portals.	6.8 7 / 155 / 46
Care Team & Workforce	Multidisciplinary team performing at top of their license with documented workflows, standing orders, and self management support.	6.5 12 / 158 / 38
Patient-centered population-based care	Registry data used for pre-visit planning and to proactively outreach to patients on overdue care or in need of referrals.	6.7 4 / 163 / 41
Behavioral Health	BH services readily available through onsite staff or agreement with outside organization that includes routine screening and referrals.	5.7 43 / 151 / 14
Social Health	Universal screening identifies patients' high impact social needs and referrals to community-based services are tracked and followed up on.	5.7 35 / 154 / 19

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The Work Ahead

Achieving Shared Goals

What do we want to learn?

- How to be successful with PHM implementation.
- Promising practices in each PHM building block.
- The best ways to spread promising practices across California.
- How to achieve equitable outcomes and overcome barriers.

How will we know if we are successful?

- Achievement of EPT milestones and directed payments.
- Improved population health capabilities, as measured through the annual PhmCAT.
- Improved performance on EPT Key Performance Indicators (KPIs).
- Adoption of standardized curriculum and tools that results in equitable outcomes.

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EPT Content Roll Out

2024

Access, Empanelment, Data to Enable PHM, and KPIs

Submit up to 4 deliverables: 2024 PhmCAT (completed), Empanelment, and Data

2025

Continue content from 2024. Begin Models of Care* and Value-Based Payment

Est. Submitting 9 Deliverables

2026

Continue content from 2025. Provide additional support to practices as needed.

Est. Submitting 13 Deliverables

* Models of Care includes the populations of focus, health equity, social health, behavioral health, and more!

Learning Communities

The Learning Communities (LCs) are cohorts of EPT practices grouped by geography and practice type.

- You'll meet with your LC three (3) times a year for a four (4) hour virtual learning session.
- Your core team should attend — at least one (1) team member from small practices, and 2 or more team members from medium to large practices.
- We'll post a list on our website sharing which practices are in each of our three (3) LCs — Sequoia, Palm, and Redwood.

Next steps:
Your EPT core team will receive a calendar invite for the October LC, which will cover Empanelment and Access.

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Practice Tracks

Practice Tracks (PTs) are smaller groups of EPT practices that dive deeper into the content through more frequent and shorter meetings.

- You'll meet with your PT every other month (6x a year) for a 90-minute session to troubleshoot challenges and connect with ~15-30 peers.
- Your core team should attend — at least one (1) team member from small practices, and 2 or more team members from medium to large practices.

Thank you to our PT Facilitators: California Medical Association, California Primary Care Association, Indigenous PACT, Institute for High-Quality Care, Thacher Consulting, and UCSF Center for Primary Care.

Next steps:
Your Practice Track facilitator will reach out to your practice's Team Lead to schedule the September Practice Track meeting.

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Expert Consultation & Coaching

Expert Consultation

- National PHM experts will support you in your EPT journey. Experts will host office hours to:
  - Answer questions PHM content
  - Troubleshoot barriers or challenges
  - Prepare practices for deliverable submission
- Office hours will be designed around challenges EPT practices are facing.
- Expert consultations start in October to help prepare you to submit the November deliverables. Stay tuned for dates!

Practice Coaching (Optional)

- Coaching provides 1:1 support to:
  - Translate curriculum and tools into practical changes.
  - Test, implement, and measure impact of changes on meeting milestones.
  - Submit EPT deliverables
- Practices select a coach from a vetted pool.
- DHCS EPT funding **does not cover** coaching. If you want coaching support:
  - Reach out to your sponsoring MCP to see if they will fund coaching for your practice.
  - You may also purchase a coaching package using your practice's funds.

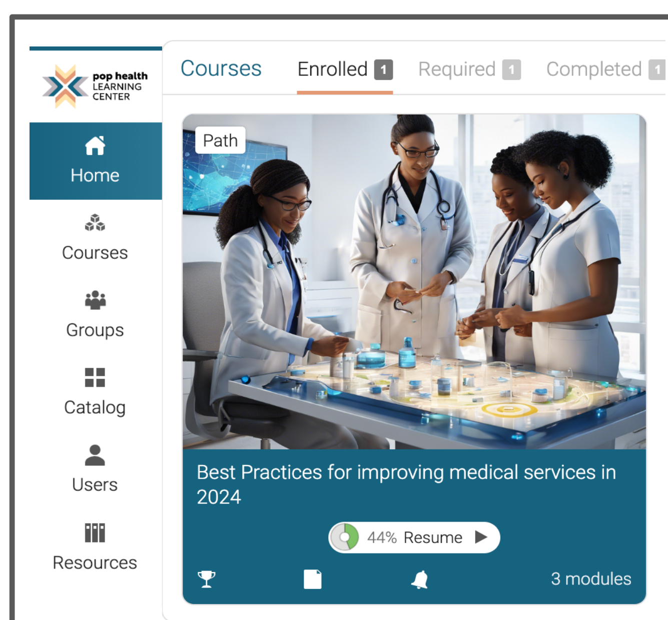
PopHealth+

PopHealth+ is an eLearning system that serves as your online EPT home. It will:

- Prepare you for Learning Community events (e.g., you may be asked to complete pre-work)
- Help you implement concepts or tools you learned in your Learning Community
- Enable you to upload deliverables and download tools

Most importantly, PopHealth+ is where you'll access content on each PHM building block. For example:

- Your practice could view a 15-minute video that describes steps to reduce no-shows and why that contributes to disparities reduction.



You'll receive PopHealth+ training and login in September!

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TA Partner: Coleman Associates

About Us: We are former frontline staff, MAs, providers, nurses, administrators. We speak multiple languages and have walked in your shoes by serving patients directly. Some of us still do.

- We have worked with health centers and practices since 1993, in all 50 states including Puerto Rico, Guam, & Alaska.

Role in EPT: Subject Matter Expert on Access

Pain Points We Can Help Address

- High no-show rates and high third-next available appointr
- Highly unpredictable schedules

Types of Tools/Support We Offer:

- Coleman's Jockey-ing the Schedule Tools
- Coleman's Simplified Patient Schedule Tools

EPT Key Contacts: Amanda Laramie, Brizzia Burgos

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TA Partner: Coleman Associates

Access Change Concepts

How to Actively Manage Your Schedule	Jockeying & Tele-Jockeying the schedule
	Tactics to reduce Third Next Available Appointment
Framework for Online Scheduling	Simplified Patient Schedule template optimization
	Telehealth Scheduling practices
	Cluster Tactics
Anticipatory Practices for Clinician Turnover	Same-day access best practices

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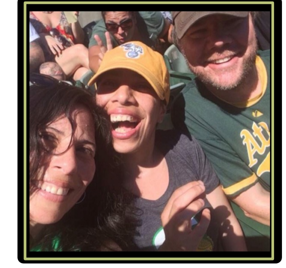
TA Partner:
UCSF Center for Excellence in Primary Care

About Us: We champion promising innovations in primary care to improve the patient experience, enhance population health and health equity, reduce the cost of care, and restore joy and satisfaction in the practice of primary care.

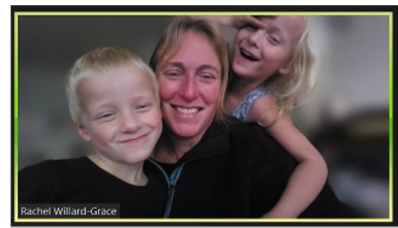
- Our team has experience in clinical care, case management, and administration, including in rural settings and small private practices.



Role in EPT: Subject matter expertise on empanelment and population health. Support for training and peer learning experiences.

Pain Points We Can Help Address:

- Challenges such as turnover and part time schedules
- Getting buy-in for shift from provider-centric to team-based culture



Types of Tools/Support We Offer:

- CEPC's HEAR Technique to address patient hesitancy
- CEPC's training to redesign and coach staff for enhanced team-based roles

EPT Key Contacts: Rachel Willard-Grace, Patricia Mejía

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TA Partner: UCSF Center for Excellence in Primary Care

Empanelment Change Concepts

Empaneling patients	Developing an empanelment policy
	Aligning PCP assignment with visit history
	Engaging patients and staff in empanelment and continuity
Balancing Panels	Calculating ideal panel size
	Opening and closing panels to manage panel size
	Active reassignment of patients
Monitoring empanelment	Identifying and calculating Key Performance Indicators (KPIs)
	Interpreting KPIs to support empanelment and continuity

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2024 Practice Journey: Access & Empanelment

PopHealth+ Modules (Foundational knowledge)	**Learning Community** (dive deeper + Q&A)	**Hands-On Support**	**Deliverables for Access & Emp. ***
Access • Jockeying the schedule • Robust Confirmation Calls/ Texts **Empanelment** • Empanelment foundations • Assess your current state of empanelment	**Access** • Real-time schedule management • Identify the causes of no-shows and pilot solutions **Empanelment** • Address challenges • Analyze data • Communicate assignments • Determine panel sizes	**Practice Tracks** Bimonthly webinars for peer exchange and diving deeper **Expert Consultation** Ad hoc office hours with national experts **Coaching (optional)** Support for workflow redesign, sample templates, etc.	1. Assess empanelment environment 2. Empanelment policy & procedure 3. KPI Submission

* Can be submitted as early as November 2024 and may be submitted in 2025.

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Implementing EPT At Your Practice

The Next Three Months

Empanelment & Access

- Watch the **PopHealth+ modules** to learn the content to prepare you to submit the upcoming empanelment and access deliverables and meet November milestones.
- At the **October Learning Community**, go deeper in empanelment and access change concepts, attend breakout sessions with peers, and share about your progress with the empanelment/access deliverables.
- Refine your deliverables prior to submission at the **expert consultation** webinar.

Data To Enable PHM

- Access **PopHealth+ modules** to learn more about data governance.
- Attend **expert consultation** to receive customized support on the deliverable.

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Steps for Success

Establish your core team

- Define a core team of 2 – 8 staff, based on practice size.
- Include at least one clinical and one administrative staff.

Complete trainings

- Access PopHealth+ for virtual modules, templates, and more.
- Attend the October Learning Community.

Test changes

- Implement the EPT curriculum.
- See what works and what needs to be adapted.
- Share your experiences in Practice Tracks meetings.
- Participate in optional coaching for extra support.

Submit deliverables

- Demonstrate evidence of milestone completion to attain directed payment.

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	September	October	November
Learning Communities & Practice Tracks	Practice Track (1.5 hrs)	Learning Community (4 hrs)	Practice Track (1.5 hrs)
PopHealth+	Review modules and complete assessments (1 - 2 hrs)	Review modules and complete assessments (1 - 2 hrs)	Review modules (1 - 2 hrs)
Optional Opportunities	Coaching (varies)	Coaching (varies) Expert consultation (1 hr)	Coaching (varies) Expert consultation (1 hr)
Independent Work*	Practice Work (1 - 4 hrs)	Practice Work + Learning Community pre-work (1 – 4 hrs)	Practice Work (1-4 hrs)

*This is work you lead in your practice to implement the EPT curriculum. It is not structured or led by the Learning Center.

Expectations for EPT Practices

In addition to the monthly time commitment, there are participation requirements. To remain in EPT, each practice must:

- ✓ Events: demonstrate 80% attendance at Learning Community and Practice Tracks events for at least two members of the team (1 person for small independent practices and small clinics)
- ✓ Milestone attainment in year 1: Achieve year 1 deliverables by end of 2025.
- ✓ Milestone attainment in future years: Deliverable attainment is TBD after year 1.

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Milestones and Deliverables

Final EPT Milestones

PhmCAT — 3 Milestones
- Y1 – 2024
- Y2 – 2025
- Y3 – 2026

Empanelment & Access — 2 Milestones
- Assessment
- Policy & procedure

Data to Enable PHM — 3 Milestones
- Assessment
- Plan
- Progress report

Care Delivery Model — 7 Milestones
- Disparity reduction plan
- Clinical guidelines
- Care team
- Outreach & engagement
- Pre-visit planning
- BH screening & linkage
- SH screening & linkage

Value-Based Payment — 1 Milestone
- Assessment

Key Performance Indicators (KPI) — 9 Milestones
- HEDIS-like and process measures required at each deliverable submission

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KPI Milestones

5 Milestones Tied to HEDIS-like Measures*

- Stratify HEDIS-like measures by race/ethnic and one additional criteria (1 milestone)
- Demonstrate improvement or reach target in 3 HEDIS-like measures (3 milestones total, each measure = 1 milestone)
- Demonstrate improvement in one disparity in one reported HEDIS-like measure (1 milestone)

**Practices are only required to report HEDIS-like measures for their selected population of focus.*

Population	HEDIS-like Measures
Pregnant People	Postpartum care (PPC) Timeliness of prenatal care (PPC) Postpartum depression screening (PDS-E)
Children/Youth	Child immunization status (CIS) Well child visits first 30 months (W30) Child and Adolescent Well-Care Visits (WCV) Depression screening (DSF)
Adult Preventive	Breast cancer screening (BCS) Cervical cancer screening (CCS) Colorectal cancer screening (COL) Depression screening (DSF)
Adult Chronic Care	Controlling high blood pressure (CBP) Glycemic status assessment (GSB) Depression screening (DSF)
Behavioral Health	Depression screening (DSF) Depression remission or response (DRR) Pharmacotherapy for Opioid Use Disorder (POD)

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KPI Milestones (continued)

4 Milestones Tied to Administrative Measures

Empanelment Achievement	Continuity Achievement	TNAA Achievement	Assigned & Seen Improvement
Achieve target for the percent of patients who are assigned to a care team at the practice	Achieve target for patient-side continuity	Achieve target for average number of days to third next available routine appointment (TNAA)	Achieve improvement in assigned patients who had at least one primary care visit within a 12-month period

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November Deliverables

For the November 1st submission, we will accept deliverables for 3 milestones:

- Emp. Milestone 1: Empanelment assessment and baseline data* *– deliverable template available soon!*
- Emp. Milestone 2: Empanelment policy & procedure* *– deliverable template available soon!*
- Data Milestone 1: Data gap assessment – AND - Data governance policy & procedure *– deliverable template available end of August!*

Use these templates to draft responses. You will submit responses by November 1.

The Learning Center will provide practices with templates for all milestone deliverables.

Practices will be notified via email when deliverable templates are ready to download from the Learning Center website.

**14 practices are ineligible for the empanelment & access milestones.*

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November Milestones

Empanelment & Access

1. Empanelment assessment: Assess current empanelment environment including understanding of baseline data on percent of patients who are empaneled to a provider/care team, continuity based on current assignment, and third next available appointment.
2. Empanelment policy and procedure: Develop and implement a standard policy and procedure that addresses the method of assigning patients to care team panels, changing assignments, maintaining panel size and continuity, and monitoring empanelment effectiveness.

Data to Enable PHM

1. Data governance and KPI gap assessment: Develop a data governance policy and procedure and assess how the practice is accessing, using, managing, sharing, reporting, and integrating data from external sources that are required to produce KPIs for the selected population.

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November KPI Submission

Empanelment & Access Administrative Measures for November 1st

- All practices* submit:
  - Empanelment
  - Continuity, and
  - Third Next Available Appointment (TNAA)
- The PHLC will provide metric specifications as soon as approved by DHCS – *available end of August!*

HEDIS-like Measures for November 1st

- Put into practice reporting population of focus HEDIS-like measures - *detail forthcoming!*

**Including the 14 practices who are ineligible for the empanelment & access milestones.*

Practices are expected to submit the KPI report at each deliverable due date (twice a year).

The submission of the KPI report is considered a requirement of participation in the program. Submission of the KPI report in and of itself is not payable; reaching milestones related to KPI performance is payable.

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Next Steps

Meet the TA Team!

Practice Track Facilitators

- California Medical Association
- California Primary Care Association
- Indigenous PACT
- Institute for High-Quality Care
- Thacher Consulting
- UCSF Center for Primary Care

Subject Matter Experts

- Coleman Associates
- Health Begins
- Recast Health
- UCSF Center for Excellence in Primary Care

The Learning Center is currently recruiting SME partners!

Coaches

- California Medical Association
- Denise Armstorff
- Elevation Health
- Inland Empire Foundation for Medical Care

PopHealth+ (eLearning Hub)

- Innovative Global Learning Solutions

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2024 Checklist

Questions? Contact the Learning Center at info@pophealthlc.org

August	September	October	November
Activities ✓ Ask your sponsoring MCP how can they support your EPT practice ✓ By Aug 16, complete EPT questionnaire **Events** ✓ Join Aug 22 EPT TA webinar (repeat of today) ✓ Join *optional* Aug 27 EPT Coaching webinar	**Activities** ✓ Access PopHealth+ after Sept 9 launch; watch modules on Access, Empanelment, & Data ✓ Prepare for November deliverables **Events** ✓ Join first Practice Track meeting.	**Activities** ✓ Continuing viewing modules on Access, Empanelment & Data ✓ Complete pre-work for October Learning Community **Events** ✓ Attend Learning Community (Access & Empanelment content) ✓ Attend expert consultation	**Activities** ✓ Submit deliverables by November 1 (the Learning Center will review by November 30) **Events** ✓ Join second Practice Track meeting.

Appendix

Payment Structure & Cycle

- Due to the state budget reduction, there have been modifications to the potential practice payments.
  - All practices, regardless of size, may earn a potential payment of $250,000.
  - Practices with 2,001+ lives may earn an additional $20 per assigned life.
  - The maximum potential payment is set at $3.19M.
  - All milestones are weighted equally.
- The state budget reduction process also impacted the PhmCAT 1 payment timeline.
  - Practices will receive the PhmCAT 1 payment in March 2025.

Max potential payment: $3.19M

Additional Potential Payment of $20 per Assigned Patient for Practices with 2,001+ Assigned Patients

Base Potential Payment for All Practices: $250K

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PHM Building Blocks

Building Block	Focus
Empanelment & Access	Assign patients to defined clinician/team panels, learn strategies that improve provider continuity, access to care, and appointment availability.
Data to Enable PHM	Assess & improve capabilities to support patient care, close care gaps, and reduce disparities.
Care Delivery Model	Improve care team functioning to perform core PHM activities for the Population of Focus. Includes outreach & engagement, care gap closure, addressing disparities, and screening and linkage to care for Behavioral Health and Social Health.
Value Based Payment (VBP)	Assess readiness to engage in VBP contracting
Key Performance Indicators	Demonstrating improvement or meeting targets on HEDIS or administrative measures.

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