Equity and Practice Transformation (EPT) Payment Program
Data to Enable Population Health Management
Data Implementation Plan

Note: This template is provided for informational purposes only and is intended to outline the required components of your submission. It should not be used to submit your final deliverable. All submissions must be made through the designated Deliverable Portal.

Instructions

The purpose of the *Data to Enable Population Health Management* milestones is to support your practice in building the data infrastructure needed to collect and utilize data effectively. This includes improving access to care for both assigned and unseen patients, supporting clinical decision-making at the point of care, addressing care gaps through patient outreach, and enhancing your practice's ability to report and stratify Key Performance Indicators (KPIs) for your Population of Focus (PoF). By doing so, your practice can identify areas for improvement and track progress in closing care gaps.

The data implementation plan will guide your practice in addressing previously identified data, technology, and operational gaps. It will help you set improvement goals and determine how to measure the impact of the changes implemented for your Medi-Cal population.

Your data implementation plan must address data and technology gaps and how you will transform practice operations related to the following strategies:

- Identifying and outreaching to the assigned but unseen population
- Using gaps in care reports that include practice and Managed Care Plan (MCP) data
- Data exchange with two external partners, at least one of which is a Qualified Health Information Organization (QHIO)

Using the questions as a prompt, please describe your goals, gaps that will be addressed, how they will be addressed, and how you will measure the impact of the changes that are implemented for each of the strategies.
Your practice's Population of Focus is: Your Population of Focus will be displayed here

PoF Measures are included below for your reference:

Abbr	Measure	Pregnant	Adult Chronic	Adult Preventive	Children /Youth	Behavioral
DSF-E	Depression screening - 12-17yo				x	

DSF-E	Depression screening - Total		x	x		x
DSF-E	Follow-Up on Positive Depression Screen - 12-17yo				x	
DSF-E	Follow-Up on Positive Depression Screen - Total		x	x		x
PPC	Postpartum Care	x				
PPC	Timeliness of Prenatal Care	x				
PDS-E	Postpartum Depression Screening	x				
PDS-E	Follow-Up on Positive Postpartum Depression Screen	x				
COL-E	Colorectal Cancer Screening			x		
BCS-E	Breast Cancer Screening			x		
CCS	Cervical Cancer Screening			x		
CBP	Controlling High Blood Pressure		x			
HBD	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)		x			
DRR-E	Depression Follow-Up					x
DRR-E	Depression Remission					x
DRR-E	Depression Response					x
POD	Pharmacotherapy for Opioid Use Disorder					x
CIS	Child Immunization Status – Combo 10				x	
W30	6 well child visits in first 15 months of life				x	
W30	2 well child visits between 15 and 30 months of life				x	
WCV	Well child visit between 3 and 21 years of age				x	

STRATEGY 1: IDENTIFFYING AND OUTREACHING TO THE ASSIGNED BUT UNSEEN POPULATION

Patients who are assigned to a practice but are not seen can significantly hinder a practice's quality and access goals and bring down HEDIS performance metrics. Having a mechanism to identify, prioritize, manage, and report outreach efforts to the assigned but unseen patient population is essential to improving quality performance and optimizing payments in Health Plan P4P programs and value-based payment programs.

Using your responses to the Empanelment and Access Gap Assessment as a reference, outline your organization's plans to improve how you manage patients that have been assigned to your practice but not yet seen.

1. **Please share baseline data/information for your assigned but unseen patients in your Medi-Cal Population. Please report on your whole Medi-Cal population, not just your selected PoF. This is a point-in-time measure: you take the assigned Medi-Cal members as of that specific moment and look back 12 months to see who has had a visit. This includes all visit types, not just well visits.**

Numeric:

Numerator: Number of assigned Medi-Cal patients who have had a visit in the past 12 months	**Denominator: Total number of assigned Medi-Cal patients**	**Assigned and Seen Rate (%) (Auto Calculated)**	**Assigned and Unseen Rate (%) (Auto Calculated) Assigned and Unseen Rate = 100% minus Assigned and Seen Rate**

Text:

What key information do you feel is still missing related to identifying your assigned but unseen patient population?	
What is your plan for gathering the missing information?	

2. **Based on your baseline data, what is your SMARTIE Goal (s) for identifying and outreaching to patients assigned to your practice that have not yet been seen?**

- **Specific:** What is it you want to achieve? Consider including the 5Ws: what, why, who, where, and when.

- **Measurable**: How will you know a change is an improvement and when you have achieved your goal? To be able to track progress and to measure the result of your goal, consider: how much or how many?
- **Action-oriented/Achievable**: To keep you motivated toward attaining your goal, are there identifiable intermediate actions/milestones?
- **Relevant/Realistic:** What results can realistically be achieved given your available resources, including people, knowledge, money, and time?
- **Time-bound:** What is an appropriate deadline for achieving your goal?
- **Inclusive**: How will you include traditionally marginalized people into processes, activities, and decision making in a way that shares power?
- **Equitable**: How will you include an element of fairness or justice that seeks to address systemic injustice, inequity, or oppression?

SMARTIE Goal(s)	

Additional Information:

What information, in addition to your baseline data, did you use to develop your SMARTIE Goal(s)?	

3. **What are the main interventions or steps you plan to test or implement to reach your SMARTIE Goal (s)? How did you identify the selected interventions or steps?** ***Please specify at least 5 and no more than 10.***

Intervention/Step	Data or Information Used for Selection	Patient Needs Addressed	Stakeholders Involved in Decision

a. How are these interventions or steps different from what you are currently doing to identify and outreach to assigned and unseen patients?

Describe what makes these interventions new or improved compared to current outreach methods.

What were the limitations of your previous approach?	
How does the new approach address gaps or barriers?	
What new strategies, technologies, or partnerships are being introduced?	

4. What is your high level workplan for reaching your SMARTIE goal (s)? List the specific interventions or steps of who will do what, how, and by when? Ensure the plan aligns with your SMARTIE Goal(s). Use realistic timelines and responsible parties to track accountability.

Complete the provided table or attach your high level workplan.

Intervention/Step	Who Is Responsible?	How Will It Be Implemented?	Implementation Timeline (By When?)

5. **How will you track your progress in achieving your SMARTIE goal(s)? Identify key metrics that will help assess the effectiveness of your efforts. Additionally, provide an example—such as a screenshot, report, or report template—showing the data elements you plan to track (e.g., the number of assigned and unseen patients monitored weekly over time). Do not include any PHI.**

Key Data Elements to Track Progress

(Improvement efforts require a balanced set of progress indicators, provide a minimum of three and no more than five. Complete the table below to describe what data will be tracked.)

Progress Indicator	**Indicator Description (Numerator/Denominator)**	**Reporting Frequency**

STRATEGY 2: USING GAPS IN CARE REPORTS THAT INCLUDE PRACTICE AND MCP DATA

MCPs typically provide practices with a Gaps in Care report that includes a list of members that are assigned to them and what gaps in care exist for specific measures. This report is typically provided monthly through a secure portal and can be reconciled with information in a practice's EHR or Population Health Management (PHM) system to determine what action needs to be taken to

address the gap (i.e., perform service, follow-up on labs, schedule an appointment, resubmit a claim). Having a process to review gaps in care on a regular basis is key to improving HEDIS performance. Practices may choose to fully automate this reconciliation process by building a report or implementing a process to review information manually.
Using your responses to the HEDIS Gap Assessment as a reference, outline your organization's plans to improve your gaps in care reporting processes.

1. **If you have baseline data, share your most recent care gap closure rate for one measure for your PoF.**
   - A care gap is the difference between the healthcare a patient should receive and what they actually get.
   - Provide the most recent full year of data for the number and percentage of care gaps.
   - You may use your own internal data if you calculate rates for these measures, or you may reference Health Plan care gap reports or Pay-for-Performance (P4P) reports.
   - Please complete for one PoF measure.

Baseline Care Gap Closure Rates for PoF Measures

Measure [Select from drop down, only measures for your practice's PoF will be available for selection]	**Population of Focus**	**Denominator (Eligible Population)**	**Numerator (Received Care)**	**Performance Rate (%) (Auto-Calculated)**	**Care Gap Rate (%) (Auto-Calculated) Care Gap Rate = 100% minus Performance Rate**
Example: Child Immunization Status (CIS)	Child/Youth				

2. **Based on your calculated care gap rate, what is your SMARTIE (Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable) goal to improve care gap closure?**

SMARTIE Goal(s)	

3. **Identify if you will prioritize specific subpopulations within your PoF. If so, what is your rationale for each priority subgroup?**

Priority Subpopulation(s)	**Rationale for Prioritization**

4. **What are the interventions you plan to test or implement to achieve your SMARTIE (s) goal to close care gaps? Interventions should include clinical guidelines, patient outreach and engagement strategies, leveraging technology to provide alerts and clinical decision support, pre-visit planning and optimizing team-based care workflows. List the specific interventions or steps of who will do what, how, and by when?**

Complete the provided table or attach your high level workplan.

Intervention Description	**Intervention Type [Dropdown: clinical guidelines, patient**	**Who Is Responsible?**	**How Will It Be Implemented?**	**Implementation Timeline (By When?)**

	outreach and engagement strategies, leveraging technology to provide alerts and clinical decision support, pre-visit planning and optimizing team-based care workflows]			

5. **What progress indicators will you track to understand your progress toward your SMARTIE goal(s) in closing care gaps? You may also attach an example of a report or screenshot of the data elements you will track to understand progress towards closing care gaps.**

Key Data Elements to Track Progress

(Improvement efforts require a balanced set of progress indicators, provide a minimum of three and no more than five. Complete the table below to describe what data will be tracked.)

Progress Indicator	Data Source	Tracking Frequency

STRATEGY 3: DATA EXCHANGE WITH TWO EXTERNAL PARTNERS, AT LEAST ONE OF WHICH IS A QHIO

Incorporating data points or insights from external partners that can help you improve performance for a particular measure (e.g., hospital/ED discharge data, pharmacy data, specialty consult data). Qualified Health Information Organizations (QHIO) aggregate data from multiple organizations and connecting to a QHIO is an excellent way to quickly gain access to a lot of data through a single connection. However, there may be certain instances where your practice will need to gain access to additional information that is not readily available through a QHIO or from an organization that is not currently exchanging data with a QHIO. In those instances, you may need to establish a plan to acquire that data using an alternative method. Another way to improve performance is to send the necessary data required to meet HEDIS measures to your MCP using supplemental data files. *Note: To be eligible for directed payment, practices must demonstrate they are implementing a new application of their engagement with the QHIO/Partner as of the start of the EPT program.*

Using your responses to the HEDIS Gap Assessment as a reference, outline your organization's plans to initiate or expand the scope of data received by external partners to improve performance.

Part 1: Data Exchange with a QHIO

Question	Response Options
1. Are you already connected with a QHIO? If not, what is your timeline for contracting?	
1a. Which QHIO are you connected to?	**[ ] None** **[ ] Cozeva - Applied Research Works, Inc. QHIO (Note: The Cozeva QHIO is not the same as the Cozeva Population Health Management Platform that some practices have access to via their MCP. The Cozeva PHM will not count toward the QHIO requirement. Cozeva QHIO participants will have completed the Data Exchange Framework (DxF) Data Signing Agreement (DSA))** **[ ] Health Gorilla** **[ ] Long Health** **[ ] Los Angeles Network for Enhanced Services (LANES)**

	[ ] Manifest MedEx **[ ] Orange County Partners in Health - HIE** **[ ] SacValley MedShare** **[ ] San Diego Health Connect** **[ ] Serving Communities Health Information Organization (SCHIO)**
1b. If not already connected, which QHIO(s) do you plan to connect with as a source for additional data?	**[ ] Cozeva - Applied Research Works, Inc. QHIO** **[ ] Health Gorilla** **[ ] Long Health** **[ ] Los Angeles Network for Enhanced Services (LANES)** **[ ] Manifest MedEx** **[ ] Orange County Partners in Health - HIE** **[ ] SacValley MedShare** **[ ] San Diego Health Connect** **[ ] Serving Communities Health Information Organization (SCHIO)**
2. What specific types of data do you plan to receive from a QHIO? Select all that apply.	**[ ] Hospital Discharge Summaries (ADTs)** **[ ] Emergency Medical Services Data** **[ ] Behavioral Health Data** **[ ] Public Health Reporting Data** **[ ] Social Service Data** **[ ] Substance Use Disorder Data** **[ ] Pharmacy Data** **[ ] Specialty Consult Data** **[ ] Claims Data** **[ ] Other**
3. Which processes will be improved or automated by receiving additional data from a QHIO? Select all that apply.	**<u>Population of Focus: Pregnant People</u>** **[ ] Being alerted when a newly assigned patient is pregnant** **[ ] Identifying patients who need or are receiving doula services** **[ ] Being alerted when a patient assigned to your practice delivers**

	[ ] Tracking the number of days after delivery to ensure a postpartum visit occurs 7-84 days after delivery **[ ] Tracking outreach to patients who need prenatal or postpartum care** **[ ] Administering postpartum depression screenings** **[ ] Sending depression screening results to MCPs** **[ ] Other: _____** **<u>Population of Focus: Children and Youth</u>** **[ ] Identifying and reconciling duplicate patient charts when using registries such as CAIR2 or RIDE** **[ ] Tracking which vaccines a patient is due for** **[ ] Tracking when a patient is due for a well-child visit** **[ ] Administering depression screenings** **[ ] Sending depression screening results to MCPs** **[ ] Other: _____** **<u>Population of Focus: Adult Preventative</u>** **[ ] Determining if a patient is due for a breast cancer screening** **[ ] Tracking outstanding orders/following up on results from breast cancer screenings** **[ ] Identifying patients who qualify for an exclusion from breast cancer screenings** **[ ] Determining if a patient is due for a cervical cancer screening** **[ ] Tracking outstanding orders/following up on results from cervical cancer screenings** **[ ] Identifying patients who qualify for an exclusion from cervical cancer screenings** **[ ] Determining if a patient is due for a colorectal cancer screening** **[ ] Tracking outstanding orders/following up on results from colorectal cancer screenings**

	[ ] Identifying patients who qualify for an exclusion from colorectal cancer screenings **[ ] Administering depression screenings** **[ ] Sending depression screening results to MCPs** **[ ] Other: _____** **<u>Population of Focus: Adult Chronic Care</u>** **[ ] Ensuring that a patient with hypertension has a blood pressure captured at the visit** **[ ] Sending blood pressure results to MCPs** **[ ] Determining if a patient needs a new HbA1c order/should report GMI** **[ ] Sending HbA1c results to MCPs** **[ ] Administering depression screenings** **[ ] Sending depression screening results to MCPs** **[ ] Other: _____** **<u>Population of Focus: Behavioral Health</u>** **[ ] Administering depression screenings** **[ ] Sending depression screening results to MCPs** **[ ] Tracking depression screening follow-ups** **[ ] Monitoring the efficacy of depression treatments** **[ ] Identifying patients with opioid use disorder** **[ ] Reconciling pharmacotherapy medications for opioid use disorder** **[ ] Monitoring dispensing events for patients with opioid use disorder** **[ ] Other: _____**
4. If not already established, what date do you plan to complete your QHIO agreement?	

5. What barriers do you anticipate to establishing exchange with a QHIO? *(List potential challenges such as technical integration issues, data standardization, contract negotiations, or data privacy concerns. Please also indicate proposed mitigation strategies.)*	

Part 2: Data Exchange with External Partners

Question	Response Options
6. Which external partner(s) do you plan to exchange data directly with? Select all that apply. *Excluded entities like Care Everywhere , Care Quality, eHealth Exchange . These platforms largely represent pre-established integrations rather than new, transformative partnerships and may be redundant with the QHIO connection for this exercise.*	**[ ] Managed Care Plans (MCPs)** **[ ] Hospitals/Emergency Departments** **[ ] Behavioral Health Providers** **[ ] Community-Based Organizations** **[ ] Specialty Consult Providers** **[ ] Immunization Registries (CAIR2 or RIDE) *(Only practices with children and youth PoF)*** **[ ] Pharmacies** **[ ] Other**
7. What specific types of data do you plan to exchange with an external data sharing partner? Select all that apply.	**[ ] Supplemental Data** **[ ] Hospital Discharge Summaries (ADTs)** **[ ] Behavioral Health Data** **[ ] Social Service Data** **[ ] Substance Use Disorder Data** **[ ] Pharmacy Data** **[ ] Specialty Consult Data** **[ ] Other**

8. Which processes will be improved or automated by exchanging data with an external partner? Select all that apply.	**<u>Population of Focus: Pregnant People</u>** **[ ] Being alerted with a newly assigned patient is pregnant** **[ ] Identifying patients who need or are receiving doula services** **[ ] Being alerted when a patient assigned to your practice delivers** **[ ] Tracking the number of days after delivery to ensure a postpartum visit occurs 7-84 days after delivery** **[ ] Tracking outreach to patients who need prenatal or postpartum care** **[ ] Administering postpartum depression screenings** **[ ] Sending depression screening results to MCPs** **[ ] Other:** **<u>Population of Focus: Children and Youth</u>** **[ ] Identifying and reconciling duplicate patient charts when using registries such as CAIR2 or RIDE** **[ ] Tracking which vaccines a patient is due for** **[ ] Tracking when a patient is due for a well-child visit** **[ ] Administering depression screenings** **[ ] Sending depression screening results to MCPs** **[ ] Other: _____** **<u>Population of Focus: Adult Preventative</u>** **[ ] Determining if a patient is due for a breast cancer screening** **[ ] Tracking outstanding orders/following up on results from breast cancer screenings** **[ ] Identifying patients who qualify for an exclusion from breast cancer screenings** **[ ] Determining if a patient is due for a cervical cancer screening** **[ ] Tracking outstanding orders/following up on results from cervical cancer screenings** **[ ] Identifying patients who qualify for an exclusion from cervical cancer screenings** **[ ] Determining if a patient is due for a colorectal cancer screening**

<table>
<tr><td></td><td>[ ] Tracking outstanding orders/following up on results from colorectal cancer screenings
[ ] Identifying patients who qualify for an exclusion from colorectal cancer screenings
[ ] Administering depression screenings
[ ] Sending depression screening results to MCPs
[ ] Other: _____

<u>Population of Focus: Adult Chronic Care</u>
[ ] Ensuring that a patient with hypertension has a blood pressure captured at the visit
[ ] Sending blood pressure results to MCPs
[ ] Determining if a patient needs a new HbA1c order/should report GMI
[ ] Sending HbA1c results to MCPs
[ ] Administering depression screenings
[ ] Sending depression screening results to MCPs
[ ] Other: _____

<u>Population of Focus: Behavioral Health</u>
[ ] Administering depression screenings
[ ] Sending depression screening results to MCPs
[ ] Tracking depression screening follow-ups
[ ] Monitoring the efficacy of depression treatments
[ ] Identifying patients with opioid use disorder
[ ] Reconciling pharmacotherapy medications for opioid use disorder
[ ] Monitoring dispensing events for patients with opioid use disorder
[ ] Other: _____</td></tr>
<tr><td>9. What is your plan for reaching the goal of receiving additional data from an external source? List the</td><td><table><tr><th>Step</th><th>Who is Responsible?</th><th>How Will It Be Implemented?</th><th>Timeline (By When?)</th></tr></table></td></tr>
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specific steps of who will do what, how, and by when?					