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

Note and Acknowledgment: Thank you Hamsa Ramkumar MD for your willingness to share your Data Implementation Plan with the EPT cohort.

PoF Measures are included below for your reference: Children and Youth

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

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
1152	1547	74.47%	25.53%

Text:

What key information do you feel is still missing related to identifying your assigned but unseen patient population?	1. Obtaining an accurate patient assignment list has been an ongoing challenge. Current ones lack up to date patient roster. 2. Practice does not have a centralized tracking capability for last patient visit dates, making it hard to identify unseen patients. 3. Outreach process is not cognizant of contacted patient list, making follow up inefficient. 4. Demographic disaggregation makes the process of cataloging unseen patients difficult. 5. Identifying the social determinants of health as it is a barrier to care.
What is your plan for gathering the missing information?	1. We will continue our effort to obtain the current, accurate and up-to-date roster from care networks. 2. We will use EHR filters for tracking unseen patients in the last 12 months. 3. We will link our outreach process to the EHR unseen patients list. 4. We will include collecting the updated demographic information in our outreach process. 5. We will capture social determinants as part of the outreach process and in-office visits.

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?

<table>
<tr><td>SMARTIE Goal(s)</td><td>Specific: Within 120 days, our team will identify 90% of the patients assigned to us who have not had a visit in the past 12 months. Our team will successfully conduct at least two outreach attempts to 80% of the unseen patients. This effort will prioritize outreach to patients with limited English proficiency and those from historically underserved racial/ethnic groups, to improve equitable access and engagement in care.

Measurable: We will target these areas for improvement:
1. Improve access for uninsured and marginalized patients. Measures of success for this will include:
a. Increase unseen patient appointments by 5-20% in 12 months.
b. Reduce missed / no-show appointments by 50%
c. Wait time reduction by 40-60% for unseen patients.

2. Staff participation metrics:
a. 100% of staff trained on achieving SMARTIE goals

3. Patient satisfaction metrics:
a. Patient feedback demonstrates a 20% improvement.

The above measures will be tracked over a 12-month period to ensure meeting the specified goals.

Action-Oriented / Achievable milestones:
Our team will conduct biweekly/monthly audits to review progress against the stated measures. Any lack of progress and the root cause will be identified, along with corrective measures. These will focus on:
1. Demographic data on patients and outcomes.
2. Barriers to health care.
3. Cultural sensitivity and inclusivity training.
We will also implement a process to obtain anonymous patient feedback.</td></tr>
</table>

	Relevant/Realistic: Our team will set realistic resource-conscious goals to make meaningful progress towards inclusion and equity, given limited staff, budget and time. We will prioritize DEI to establish equity-related focused trainings. We will also track 1-2 key metrics such as patient visits and satisfaction ratings. By using this method we can utilize existing staff, limit financial investment and integrate this process in routine workflows without overextending any resource. Time-Bound: Our team will strive to achieve this goal by our deadline of 120 days. Inclusive: Our team will configure the execution process to include all requirements and training the staff to reflect on the needs of traditionally marginalized patients. This process will be achieved as follows: 1. Raising the level of DEI awareness in leadership and decision-making personnel. 2. Training staff on cultural humility and the needs of marginalized patients as an ongoing process. 3. Collecting and analyzing disaggregated data on patients to identify and address disparities. 4. Navigating enabling support (transportation through health plans, etc.) and flexible visiting hours. EQUITABLE: Our team will embed fairness and justice into health care by actively identifying and addressing barriers to health care as follows: 1. Screening for social determinants of health. 2. Connecting patients to resources to alleviate identified inequities. 3. Proactively accessing communities facing systemic barriers. 4. Offering flexible clinic hours tailored to this population. 5. Training staff on how systemic inequities impact health. 6. Collecting data on patient outcome disaggregated by race, ethnicity, gender identity, language, ability and income. The above data will be utilized to drive justice-oriented changes in our patient care process.

Additional Information:

What information, in addition to your baseline data, did you use to develop your SMARTIE Goal(s)?	In addition to the baseline data on our patient population, we used our past office experience, patient feedback and care network feedback to formulate areas for improvement. These included: 1. Bolstering our SMARTIE goals to accommodate patient and staff experiences. 2. Analyzing patient and staff feedback from surveys. Patient feedback gives us insight into their level of trust, cultural safety and barriers to health care. Staff input is weighed in to understand their challenges in delivering inclusive care and their ideas for improvement.

	3. Analyzing community needs and demographics. This is achieved by understanding the racial, ethnic, socioeconomic and linguistic makeup of the community served to recognize their access barriers.

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
Data-Driven Identification of Patients with Care Gaps	We used: 1. EMR data for this intervention. 2. Patient registration forms for any missing data. 3. Health plan roster provided by the MCPs.	Patients' needs were addressed by: 1. Clearly defining care gap closure mechanisms. 2. Capturing patient willingness to make future appointments, reducing no-shows.	1. PCP 2. Patients 3. Staff 4. MCPs
Standardize Preventative Care Protocols	We used data from: 1. Clinical guidelines (HEDIS) 2. AAP 3. EMR (data from patient charts)	Patients' needs were addressed by: 1. Implementing the recommended clinical guidelines 2. Monitoring improvements in healthcare outcomes	1. PCP 2. AAP 3. Patients 4. MCPs
Outreach & Engagement	We used the following: 1. EMR data 2. MCP roster 3. Internal outreach process	Patient needs were addressed by: 1. Tailoring messages in their preferred language 2. Adhering to patient cultural norms	1. PCP 2. Patients 3. Staff
Pre-Visit Planning	We used the following: 1. EMR data 2. CAIR registry 3. MCP roster	Patients’ needs were addressed by: 1. Confirming care gaps to be addressed (vaccines, etc.) 2. Identifying special patient needs (interpreter, etc.)	1. PCP 2. Patients 3. Staff
Collect & Act on Patient Feedback	We use the following: 1. Verbal patient feedback 2. Patient feedback surveys	Patients’ needs were addressed by: 1. Accommodating patients' unique requirements into their care plan	1. PCP 2. Patients 3. Staff

		2. Revising office procedures to accommodate acceptable changes.	

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?	Limitations of our previous approach were: 1. Incomplete and/or inaccurate EMR data that resulted in: a. Outdated contact information. b. Lack of real-time reporting. c. Incomplete stratification of EMR data (MCPs). 2. Outreach barriers that included: a. Low patient response to staff calls and messages. c. Low staff capacity. 3. Workflow and operational limitations that led to: a. Lack of clear outreach ownership in the team. b. Disconnected outreach and visit workflows. c. Lack of feedback loop. 4. Technological limitations including: a. Limited EMR capabilities. b. Lack of integration between texting and email platforms. 5. Patient limitations including: a. Low health-related literacy. b. Distrust in the system. c. Cultural barriers

How does the new approach address gaps or barriers?	The new approach addresses most of the above limitations by: 1. Engaging the EMR vendor and MCPs to resolve limitations 1 and 4. 2. PCP and staff revising the current outreach process to resolve most of the identified limitations 2 and 3. 3. PCP and staff educate the patients to resolve limitation 5 as much as possible.
What new strategies, technologies, or partnerships are being introduced?	The new strategies we are starting to implement include: 1. Increasing patient outreach efforts on a frequent basis. 2. Incorporation of QHIO data into daily workflows for pre-visit planning. 3. EMR upgrades to make it user-friendly. 4. EMR integration with various QHIOs to obtain real time accurate patient data.

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.

Workplan Uploaded

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.

Key Data Elements to Track Progress

Progress Indicator	**Indicator Description (Numerator/Denominator)**	**Reporting Frequency**
Patient Outreach & Engagement	Number of patient appointments made (numerator) Number of patients contacted for appointment (Denominator)	Monthly
Clinical Outcomes & Care Gap Closure Rates	Number of patients who followed up for depression (numerator) Number of patients with positive depression screen (Denominator)	Monthly
Equity-Focused Metrics stratified by language	Patients with language barrier seen for a visit (numerator) Patients with language barrier (Denominator)	Monthly

Patient Experience / Feedback	Number of patients providing feedback (numerator) Number of patients requested for feedback (Denominator)	Monthly

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

1. If you have baseline data, share your most recent care gap closure rate for one measure for your PoF.

Baseline Care Gap Closure Rates for PoF Measures

Measure	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
Well child visit between 3 and 1 years of age	Child/Youth	1547	1152	74.5%	25.5%

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)	We will rely on the following SMARTIE goals to improve care gap closure for the population of focus (PoF), well child visit for 3-21 year old patients: 1. Improve access for uninsured and marginalized patients including: a. Increase unseen patient appointments by 5-20% in 12 months using our multi-modal patient outreach approach. b. Reduce missed / no-show appointments by 50% c. Wait time reduction by 40-60% for unseen patients. d. We will offer same day slots and walk-in appointments. e. We will build a script and workflow chart for contacting patients, answering questions and scheduling appointments. f. We will assign a dedicated staff member to lead the initiative of care coordination. 2. 100% of staff trained on achieving SMARTIE goals

	3. Patient feedback demonstrates a 20% improvement. 4. Our biweekly/monthly audits will review progress against the stated measures: a. Demographic data on patients and outcomes. b. Barriers to health care. c. Cultural sensitivity and inclusivity training. 5. We will achieve inclusivity and equity goals as follows: a. Screening for social determinants of health. b. Connecting patients to resources to alleviate identified inequities. c. Proactively accessing communities facing systemic barriers. d. Offering flexible clinic hours tailored to this population. e. Training staff on how systemic inequities impact health. f. Collecting data on patient outcome disaggregated by race, ethnicity, gender identity, demographics, language, ability and income.

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**
Patients with language barriers are a specific subpopulation within our PoF.	Patients with language barriers are hesitant to seek healthcare. This is partially due to their insecurity, fear of comprehension and perceived discrimination. They feel intimidated by not having a say in their health care due to their inability to express themselves. They are also afraid of being misunderstood. Some of them are hesitant to get interpreter services.
Patients with transportation barriers are the second specific subpopulation within our PoF.	Patients with transportation barriers often miss appointments or are no-shows despite multiple outreach efforts.

Patients with economic hardships are the third specific subpopulation within our PoF.	Patients with economic hardships are reluctant to get healthcare for multiple reasons. They have difficulty taking time off work and may not have valid health coverage.
Patients with cultural sensitivity are the fourth specific subpopulation within our PoF.	Patients with cultural sensitivity are very hesitant to seek healthcare appointments for multiple reasons (cultural bias, insensivity to their religious beliefs, dietary preferences, etc.).

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?**

Intervention Description	Intervention Type	Who Is Responsible?	Implementation Timeline (By When?)
Obtain the EMR report monthly. Obtain all MCP patient rosters and create a workflow chart.	Leveraging technology to provide alerts and clinical decision support	Office administrator	30 days
Create a monthly list of all patients requiring: 1. age-appropriate vaccines; 2. Developmental screenings; 3. Annual physicals; 4. Depression screening; 5. Follow up of positive depression screens; 6. All other patients requiring follow ups.	Clinical Guidelines	Physician	30 days
Start patient outreach on a daily basis.	Patient outreach and engagement strategies	Designated medical assistant	30 days
Place the improved workflow chart in the staff shared folder to address reasons for missed appointments, no shows and patient queries.	Optimized team-based care workflows	Office administrator	30 days
Use CAIR registry, EMR and MCP rosters to address patient needs: 1. Confirming care gaps to be addressed (vaccines, etc.) 2. Identifying special patient needs (interpreter, etc.)	Pre-Visit Planning	Front office medical assistant	30 days

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

Progress Indicator	Data Source	Tracking Frequency
1. Identify unseen patients with care gaps	1. EMR report 2. MCP rosters 3. CAIR registry	Monthly
2. Standardize clinical workflows	1. HEDIS guidelines 2. CAIR registry 3. EMR patient data	Daily
3. Launch multi-modal approach to outreach	1. EMR report 2. MCP rosters	Weekly
4. Pre-visit planning (PVP)	1. EMR report 2. MCP rosters 3. CAIR registry 4. Patient input	Daily
5. Patient feedback.	1. Post-visit patient feedback. 2. Post-visit staff feedback. 3. Feedback survey input.	Weekly

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

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?	We are in the process of successfully implementing data exchange with different QHIOs in the next few months. There are glitches in the QHIOs (OCPHI) we are trying to interface with first, and this is preventing the operation of the interface. Once the glitches are resolved, we hope to have this QHIO interface working.
1a. Which QHIO are you connected to?	[x] 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?	[x] Cozeva - Applied Research Works, Inc. QHIO [ ] Health Gorilla [ ] Long Health [ ] Los Angeles Network for Enhanced Services (LANES) [ ] Manifest MedEx [x] 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.	[x] Hospital Discharge Summaries (ADTs) [x] Emergency Medical Services Data [ ] Behavioral Health Data [ ] Public Health Reporting Data [ ] Social Service Data [ ] Substance Use Disorder Data [ ] Pharmacy Data [x] Specialty Consult Data [ ] Claims Data [x] Other Laboratories
3. Which processes will be improved or automated by receiving additional data from a QHIO? Select all that apply.	<u>Population of Focus: Children and Youth</u> [x] Identifying and reconciling duplicate patient charts when using registries such as CAIR2 or RIDE [x] Tracking which vaccines a patient is due for

	[x] Tracking when a patient is due for a well-child visit [x] Administering depression screenings [x] Sending depression screening results to MCPs [ ] Other: _________
4. If not already established, what date do you plan to complete your QHIO agreement?	November 2025
5. What barriers do you anticipate to establishing exchange with a QHIO?	1. QHIOs are reluctant to spend their resources to establish bi-directional data transfer capability with small practices like us. 2. Financial burden placed on us to establish QHIO connectivity.

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.**	[x] Managed Care Plans (MCPs) [x] Hospitals/Emergency Departments [x] Behavioral Health Providers [ ] Community-Based Organizations [x] Specialty Consult Providers [x] Immunization Registries (CAIR2 or RIDE) *(Only practices with children and youth PoF)* [x] 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 [x] Hospital Discharge Summaries (ADTs) [ ] Behavioral Health Data [ ] Social Service Data [ ] Substance Use Disorder Data [ ] Pharmacy Data [x] Specialty Consult Data

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<tr><td></td><td>[ ] Other</td></tr>
<tr><td>8. Which processes will be improved or automated by exchanging data with an external partner? Select all that apply.</td><td><u>Population of Focus: Children and Youth</u>
[x] Identifying and reconciling duplicate patient charts when using registries such as CAIR2 or RIDE
[x] Tracking which vaccines a patient is due for
[x] Tracking when a patient is due for a well-child visit
[x] Administering depression screenings
[x] Sending depression screening results to MCPs
[x] Other: __Laboratories_______</td></tr>
<tr><td>9. What is your plan for reaching the goal of receiving additional data from an external source? List the specific steps of who will do what, how, and by when?</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>
<tr><td>1. Contact MCPs to coordinate QHIO connectivity</td><td>PCP</td><td>Phone calls, email.</td><td>November 2026.</td></tr>
<tr><td>2. Contact contracted IPAs and their lead clinician manager to coordinate required interface efforts.</td><td>PCP</td><td>Phone calls, email.</td><td>November 2026.</td></tr>
<tr><td>3. Contact the QHIO systems lead to assist with interface development.</td><td>PCP and Office Administrator</td><td>Phone calls, email.</td><td>November 2026.</td></tr>
<tr><td>4. Contact contracted hospitals to interface their EMR with ours.</td><td>PCP</td><td>Phone calls, email.</td><td>November 2026.</td></tr>
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