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UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

June Learning Communities Part 1

Population Health Learning Center
University of California Center for Excellence in Primary Care
Subject Matter Experts

Welcome

While we're waiting, please:

Rename yourself

1

Click the Participants icon

2

Hover over your name & click Rename

3

Add your name, pronouns and organization's name

Please no acronyms

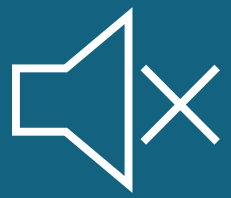
4

Click OK

If you connected to the audio using your phone

- Find your participant ID; it should be in the top left of your Zoom window
- Once you find your participant ID, press: #number# (e.g., #24321#) to connect your audio and video
- The following message should briefly appear: "You are now using your audio for your meeting"

Housekeeping Reminders



Mute

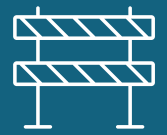
We will mute lines during the presentation to prevent background noise

Questions

Submit questions using the chat feature

Slides + Recording

Slides and recording will be posted PopHealth+



Tech Issues

Private chat Rachel Kochhar for assistance

Please chat in!

- Your name
- Role
- Organization
- One thing you are hoping to learn more about today

PHLC Presenters

Tammy Fisher, MPH
Chief Program Officer

Mary Deane, MPH
Director of Programs

Rachel Kochhar, MPH
Programs Associate

Jennifer Sayles, MD, MPH
Chief Executive

CEPC Presenters

Patricia Mejía
Associate Director of Training

Meghan Elliott
Trainer

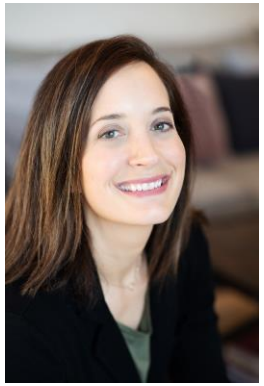
Rachel Willard-Grace
Director

Subject Matter Expert Presenters

Roberto Rodriguez, MD, MPH
Children and Youth

Marianna Kong, MD
Adults with Chronic Conditions and Preventative Needs

Neha Gupta, MD
Adults with Chronic Conditions and Preventative Needs



Elizabeth Horevitz, PhD, LCSW
Behavorial Health

Nathana Lurvey, MD
Pregnant People

Learning Objectives

- Reflect on program progress and plan for upcoming work
- Assess and strengthen care team models
- Adopt and operationalize clinical guidelines
- Design and implement pre-visit planning workflows
- Collaborate and share implementation strategies with peer practices

Agenda

Day 1	
Time	Topic
25 min	Welcome + Program Check-In
45 min	The road ahead: Disparity Reduction Plan and Models of Care
10 min	Break
35 min	Care Team Assessment & Implementation Deep Dive
5 min	Closeout + Day 2 Preview

Day 2	
Time	Topic
15 min	Welcome Back + Key Themes from Day 1
40 min	Adopting Clinical Guidelines to Standardize Practice
10 min	Break
40 min	Pre-Visit Planning to Close Gaps
15 min	Reflection + Commitments

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Progress on Performance

Third next available appointment	Disparity Reduction	Access	Data Implementation Plan
• **73% of practices** (144 /198) TNAA is less than 10 days up from **61% of practices** (120/198) in Fall 2024	• **75% of practices** (148/198) were able to stratify their Population of Focus by race/ethnicity and at least one additional demographic	• **78% of practices** (154/198) have met the empanelment policy and procedure milestone	• **63% of practices** (125/198) have met the data implementation plan milestone

June 26, 2025

PhmCAT Domains	May 2024 Avg	May 2025 Avg	Change (May 2024 to May 2025)*	# of practices that have improved	% of practices that have improved	Average Improvement among practices that improved
Technology & Data Infrastructure	5.6	6.2	0.6	125	65%	1.44
Social Health	5.5	6.1	0.6	124	65%	1.44
Empanelment & Access	6.8	7.3	0.5	121	63%	1.17
Care Team & Workforce	6.5	7.0	0.5	123	64%	1.29
Business Case for PHM	5.6	6.0	0.4	118	62%	1.37
Pt-centered, Population-based Care	6.7	7.1	0.4	117	61%	1.08
Behavioral Health	5.5	5.9	0.4	108	57%	1.45
Leadership & Culture	7.0	7.3	0.3	117	61%	0.96
Composite	6.2	6.6	0.4	129	65%	1.01

*all changes were statistically significant at the 0.05 level

Learnings from EPT Practices

"We now have a plan to address the assigned but unseen population, including to do outreach and get reports. We are now more organized and focused. We are not just taking it as it comes. In a small practice, it's hard to prioritize. We had to create a plan and give people ownership. Everyone has an assignment and we have committed to our goals. We can hold ourselves accountable."

"EPT has forced us to slow down and assess what we are doing. We are more streamlined and organized. This has had a direct impact on patient care…We have implemented initiatives in EPT that has cut back on our administrative workload and allowed our providers to spend more time caring for their patients. Our staff has been exposed to information that has helped them with their development, they feel more empowered and motivated"

Practice Spotlight: Capitol Family Medical

- Where did your practice start on its population health journey?
- What has surprised you most along the way?
- What's one change you're proud of that your team has made related to empanelment?
- What's one thing you're planning to improve next?

Your Turn! Chat in

- What’s one change you've made that you’re most proud of related to EPT?

What's Ahead?

EPT Program Timeline: What's Next?

- 🗓️ Nov 1, 2025 – Cycle 3
- 🗓️ May 1, 2026 – Cycle 4
- 🗓️ Nov 1, 2026 – Final Submission Window

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Cycle 3 (Nov 2025): Care Redesign in Action

- 📉 Reduce Disparities: Implement plan with staff & patient input
- 👥 Care Team Redesign: Assess roles & fill gaps
- ⚕ Adopt Clinical Guidelines: Workflow adaptation + EHR integration
- 📞 Enhanced Outreach: Engage assigned but unseen population
- 🚗 Pre-Visit Planning: Chart review & health maintenance reports
- 🔁 Data Implementation: Report on 3 data strategies incl. QHIO exchange
- 📈 KPI Tracking: Continue with Empanelment, Continuity, TNAA, Disparity Reduction

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Cycle 4 (May 2026): Behavioral Health & Social Needs

- 🧠 Behavioral Health: PHQ/SUD screening + closed-loop referral
- 🏠 Social Needs: HRSN screening & Z-code capture
- 💵 VBP Readiness: Gap analysis & MCP-coordinated action plan
- 📊 2026 PhmCAT: Complete updated assessment
- 📈 KPI Submission: Continue core metric tracking

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Cycle 5 (Nov 2026): Demonstrating Improvement

- ✅ KPI Achievement: Sustained/achieved Empanelment, Continuity, TNAA, Disparity
- 🎯 MCP Measures: Improvement in Assigned & Seen and 3 PoF HEDIS®-like metrics

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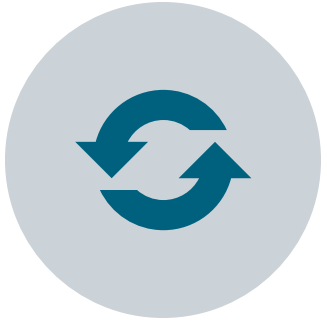
Cross-Cutting Priorities

Integration: Align workflows for screening, outreach, clinical practice

Engagement: Include staff, patient, and community voices

Data: Improve interoperability and reporting



Adaptation: Apply learning and feedback iteratively

Upcoming EPT TA

Population of Focus Practice Tracks

- Clinical subject matter experts and practice track facilitators will be leading peer sharing and content presentation for the EPT models of care content.

EHR User Groups Designed to Support Optimal Use and EPT Reporting

- NextGen: July 14, August 5, August 26
- eClinical Works: July 14, August 4, August 25

Office Hours

- Monthly sessions focused on Access with Coleman Associates
- Bimonthly sessions with the Learning Center for general EPT questions

- Coach Café on Improving Care Gap Closure: Focused on improving care gap closure and sharing real-time stories, challenges, and solutions:
- The Clinicians AI ToolBox - This session reviews current generative AI tools that can help reduce workforce burnout and advance value-based care.

Next Learning Community

- The next Learning Community will be in late September/early October to help practices prepare for the Nov deliverables cycle

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The Road Ahead: Disparity Reduction Planning

University of California Center for Excellence in Primary Care

Goals

- Introduce Disparity Reduction Plan
- Show interconnections of Care Team Plan, Pre-visit planning, and Outreach Plan as parts of a holistic strategy.
- De-mystify steps for next deliverables and clarify how upcoming deliverables work together as part of a coherent strategy to address disparities.

Intro Disparity Reduction Plan

Disparity Reduction Plan

Understanding Root Causes

- Looking at your data
- Staff and patient perspectives
- Mini-Journey Mapping

Intervention

Implementation of Clinical Guidelines

Care Team Assessment & Implementation

Pre-visit Planning
(Closing the gap for people coming in for care)

Outreach
(Closing the gap for people NOT coming in for care)

Plan-Do-Study-Act

Intro Disparity Reduction Plan

Disp

Understanding Root Causes

- Looking at your data
- Staff and patient perspectives
- Mini-Journey Mapping

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Care Tea

Pre-visit

(Closing th
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Equity and Practice Transformation (EPT) Payment Program
Disparity Reduction Plan Deliverable Template

Disparity Reduction Plan Template

Milestone:
Develop and implement a plan to reduce a disparity in at least one HEDIS®-like metric related to your population of focus. Plan should include feedback and participation from staff and patients or community partners.

1. Population of Focus
[automatically displayed]

2. Selected HEDIS®-like Metric * required
(e.g., Well-child visits, postpartum care, diabetes management, etc.)

Metric Name: _____

3. Identified Disparity * required
Briefly describe the disparity you're aiming to reduce (e.g., While our overall colorectal screening rate is 63%, the rate for Spanish-speaking patients is 42%)

Tip: Identifying a disparity might require stratifying your population of focus by a demographic variable (ex. gender, race, language, insurance status, etc.) and comparing the outcome of your selected HEDIS metric to average of your clinic/system and/or across groups within this demographic variable of focus in your selected population of focus.

Description:

4. Understanding the Population of Focus (optional)
Identifying and naming current conditions behind the identified disparity for your population of focus (optional)

What is known about current conditions in your practice/system in the context of your identified disparity facing your population of focus? Below are questions we **recommend** you reflect on to help you develop a broad understanding of the disparity of focus:

How does this population receive care? (ex. telephone vs. video calls, in-person, etc.)	
How often is this population of focus going to the emergency room and/or being hospitalized?	
How consistently are patients in this population following up with your practice/system after a hospitalization?	

Plan-Do-Study-Act

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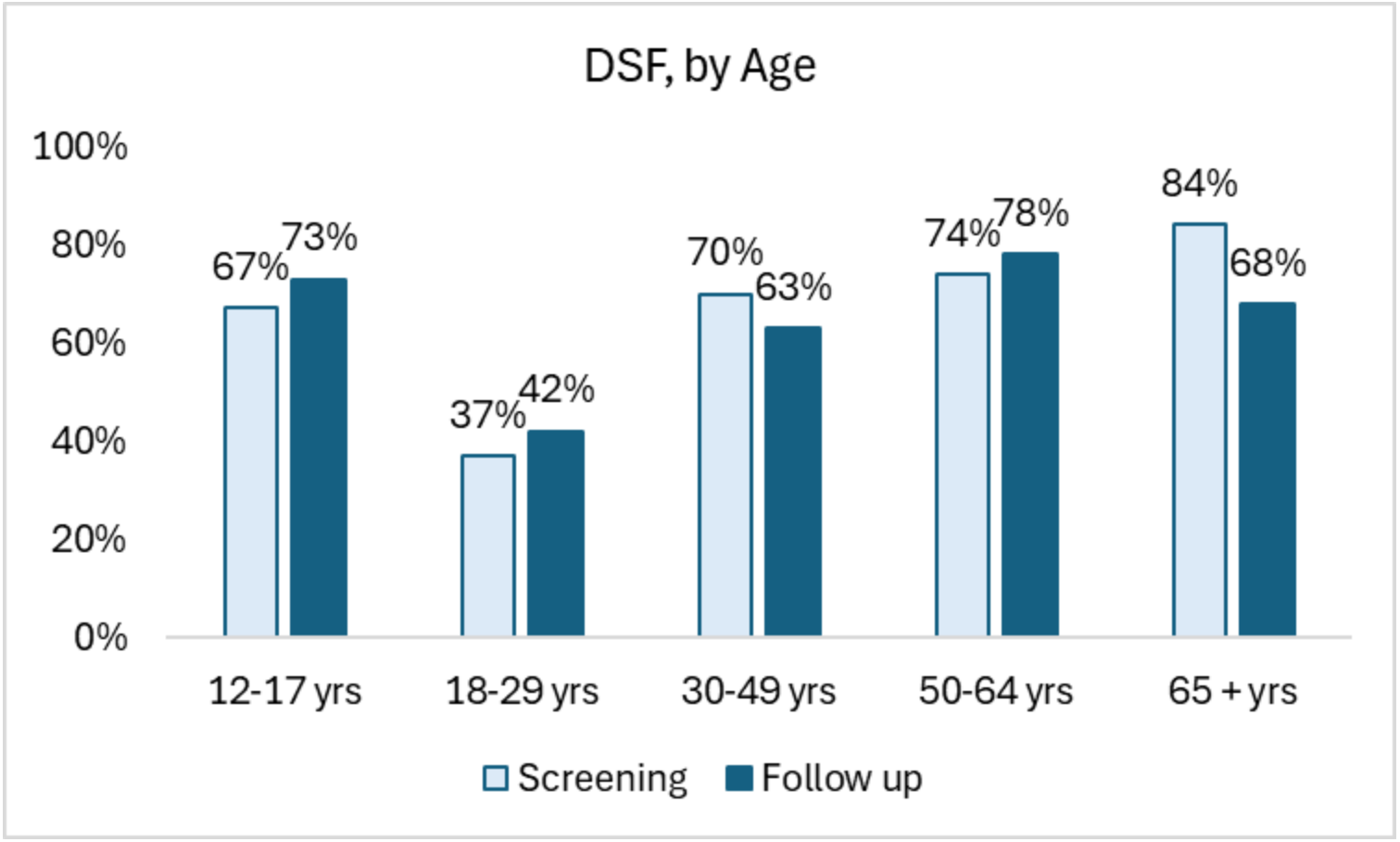
Case Study Part 1

In their May 2025 deliverables for EPT, Blue Clinic identified Depression Screening and Follow up (DSF) as a metric of focus. This is what they found.

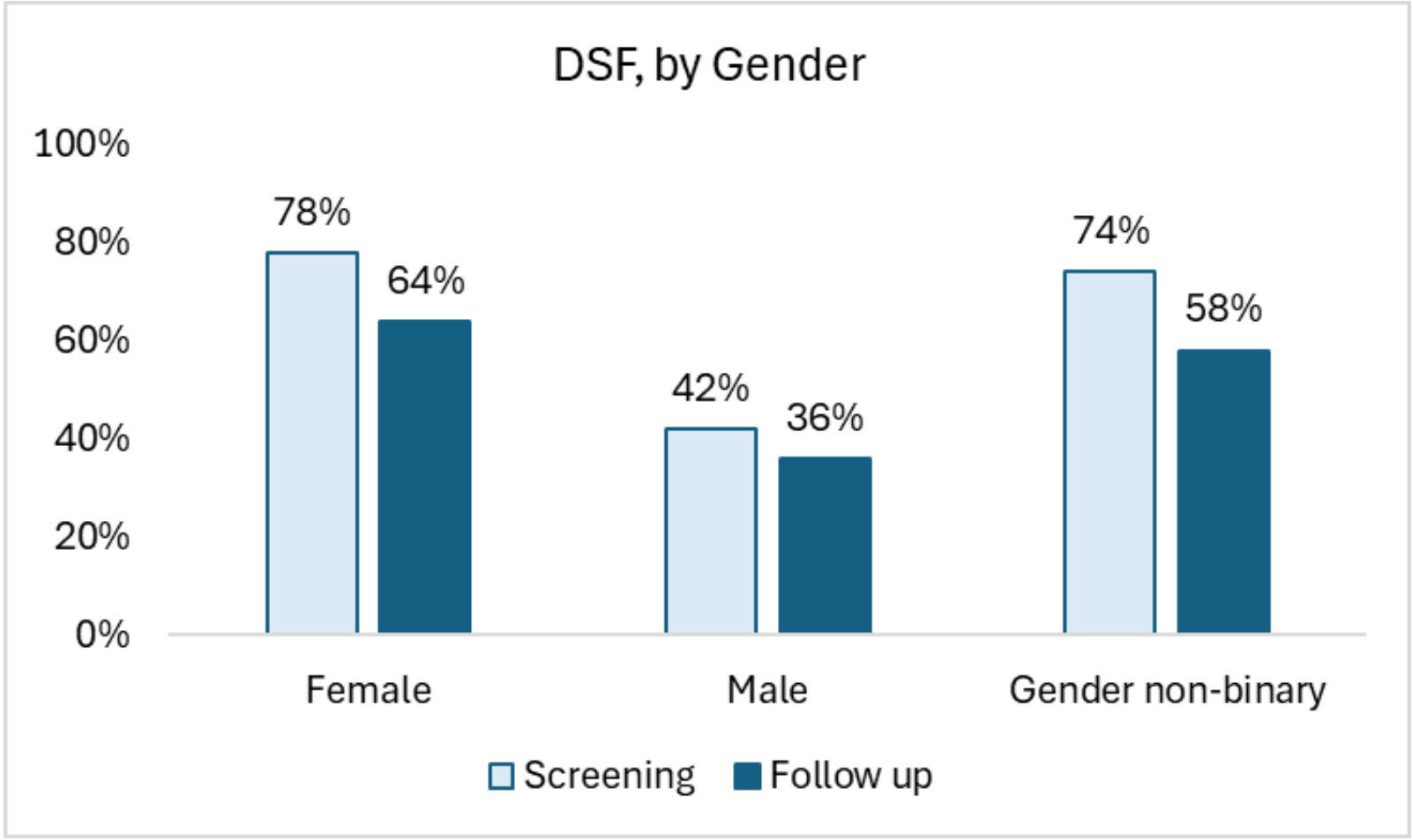
- **What do you observe?**



Case Study Part 1

They also stratified by gender.

- **What do you observe?**



Disparity Reduction Plan

2. Selected HEDIS®-like Metric * required

(e.g., Well-child visits, postpartum care, diabetes management, etc.)

Metric Name: Depression Screening and Follow up

3. Identified Disparity * required

Briefly describe the disparity you're aiming to reduce (e.g., While our overall colorectal screening rate is 63%, the rate for Spanish-speaking patients is 42%)

Tip: Identifying a disparity might require stratifying your population of focus by a demographic variable (ex. gender, race, language, insurance status, etc.) and comparing the outcome of your selected HEDIS metric to average of your clinic/system and/or across groups within this demographic variable of focus in your selected population of focus.

Description:

While our Depression Screening and Follow up (DSF) rate overall is 62%, for 18-29-year-old male-identifying patients, it is 37%.

Disparity Reduction Plan: Data dive

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Equity and Practice Transformation (EPT) Payment Program
Disparity Reduction Plan Deliverable Template

4. Understanding the Population of Focus (optional)

Identifying and naming current conditions behind the identified disparity for your population of focus (optional)

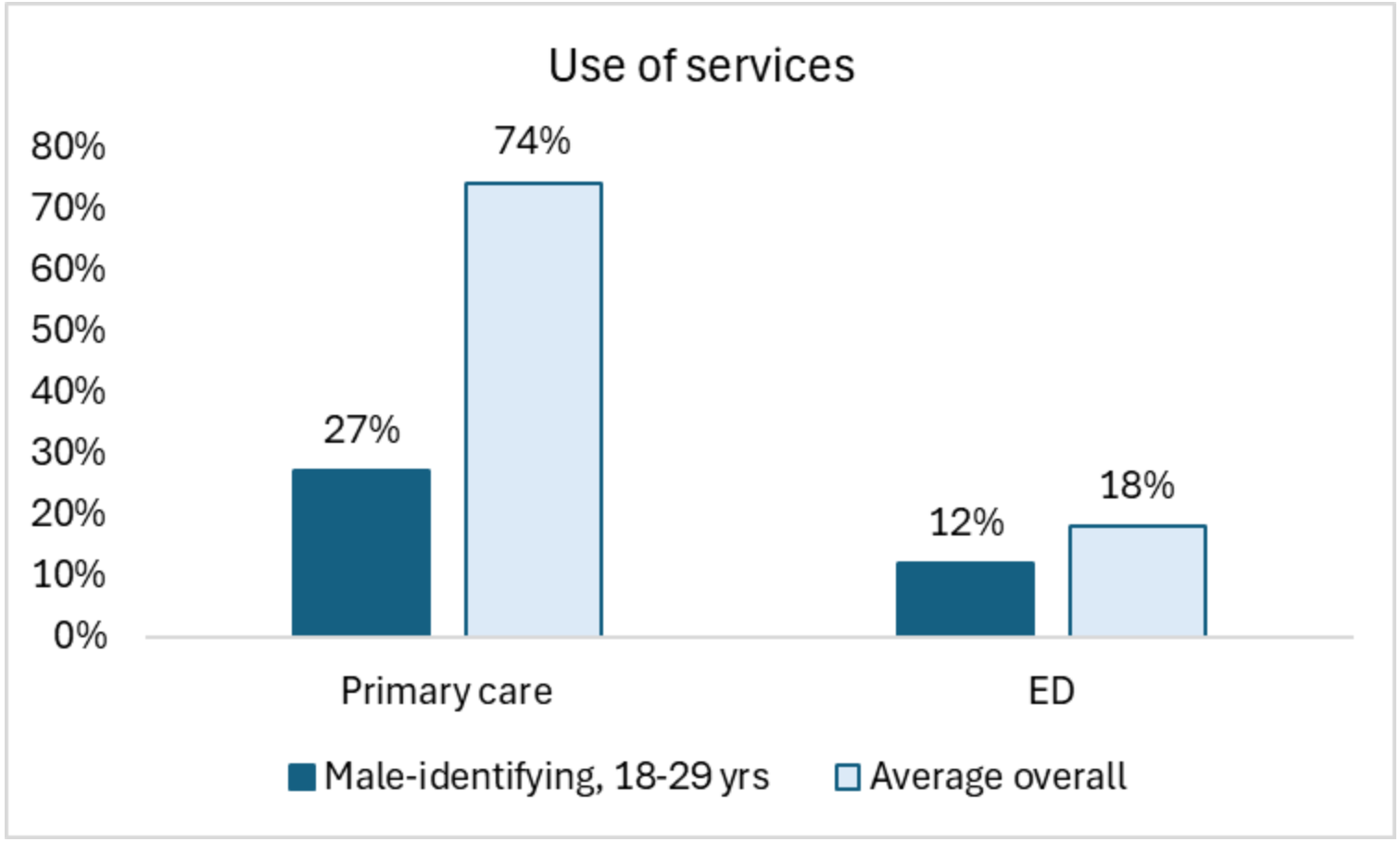
What is known about current conditions in your practice/system in the context of your identified disparity facing your population of focus? Below are questions we **recommend** you reflect on to help you develop a broad understanding of the disparity of focus:

How does this population receive care? (ex. telephone vs. video calls, in-person, etc.)	
How often is this population of focus going to the emergency room and/or being hospitalized?	
How consistently are patients in this population following up with your practice/system after a hospitalization?	
How successfully are patients in this population scheduling appointments for PCP-placed referrals (ex. registered dietician appointments, neurology referral, DM pharmacy visit, etc.)?	
If social quality metrics are available, what social barriers is affecting this population? (ex. 60% of this population screened high risk for financial stress, 50% of this population has transportation difficulties, etc.)	

Case Study Part 2

The Blue Clinic team delved into the data for young, male-identifying patients. This is some of what they saw.

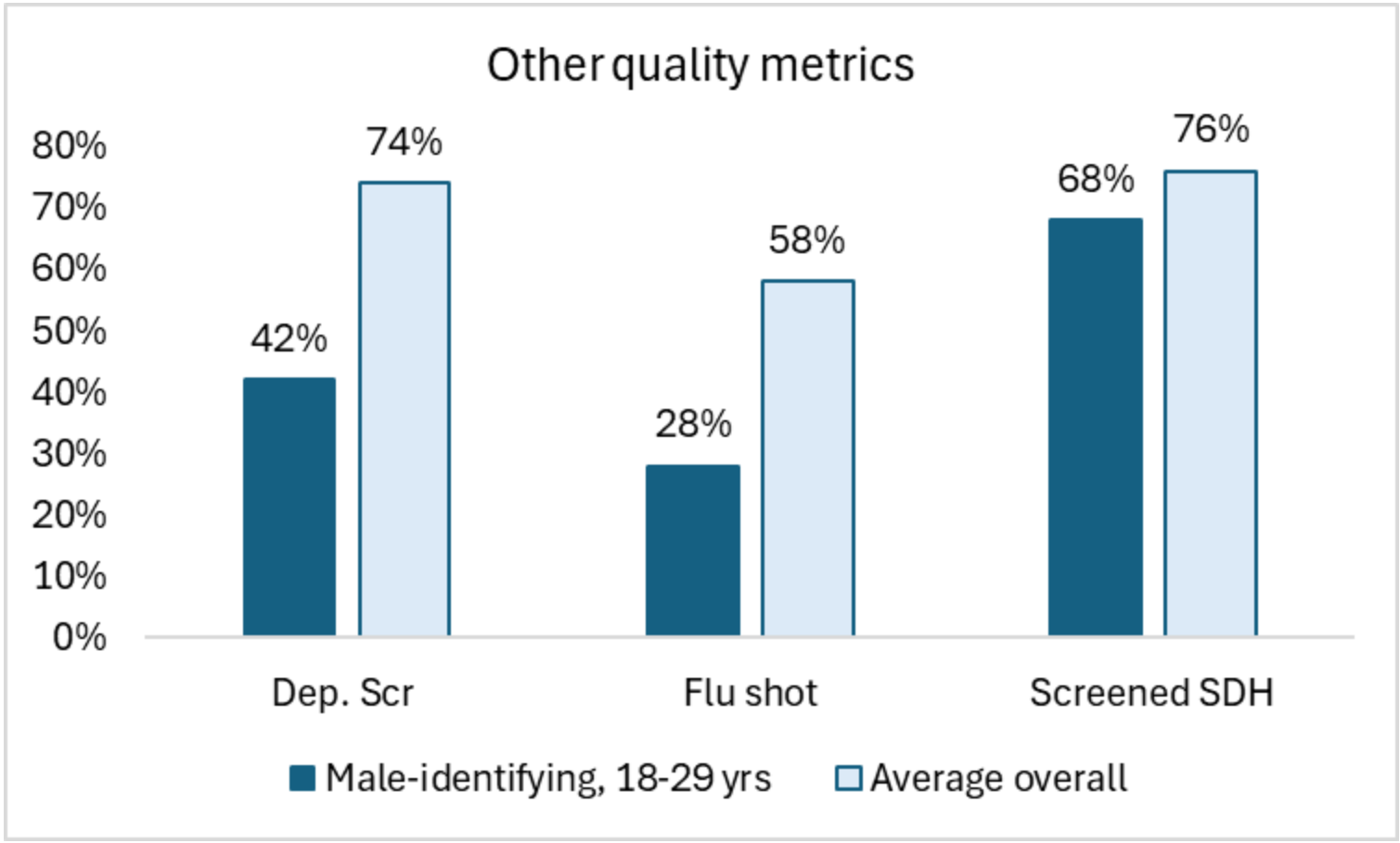
- **What do you notice?**



Case Study Part 2

They also looked at other quality metrics for the population of focus.

- **What do you notice?**
- **What implications does this have for what it will take to move the needle?**



Disparity Reduction Plan: Seek Staff input

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Equity and Practice Transformation (EPT) Payment Program
Disparity Reduction Plan Deliverable Template

5. Root Cause Exploration

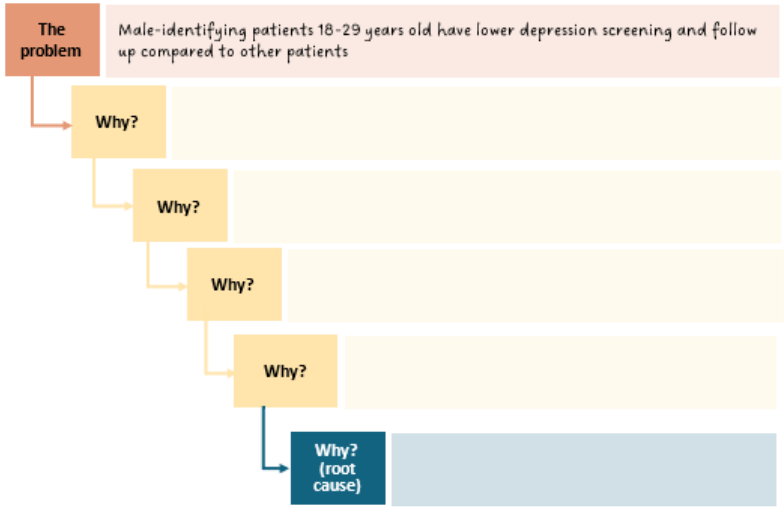
Identifying possible causes from staff

Share the information you have gathered with staff. You might ask questions such as:

- What have you observed that might help us understand the factors contributing to this disparity?
- What factors could make it hard for people to access care?
- Is this care that people have been declining? If so, what have they shared about their reasons?

Try using the **Five Why's** to dig deeper together...

What are the Five Why's? A way to dig deeper into the root or systematic causes of a disparity or gap. It seeks to continue to question why (at least five times) to uncover "latent" or hidden problems that drive the problem on the surface.



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Case Study Part 3

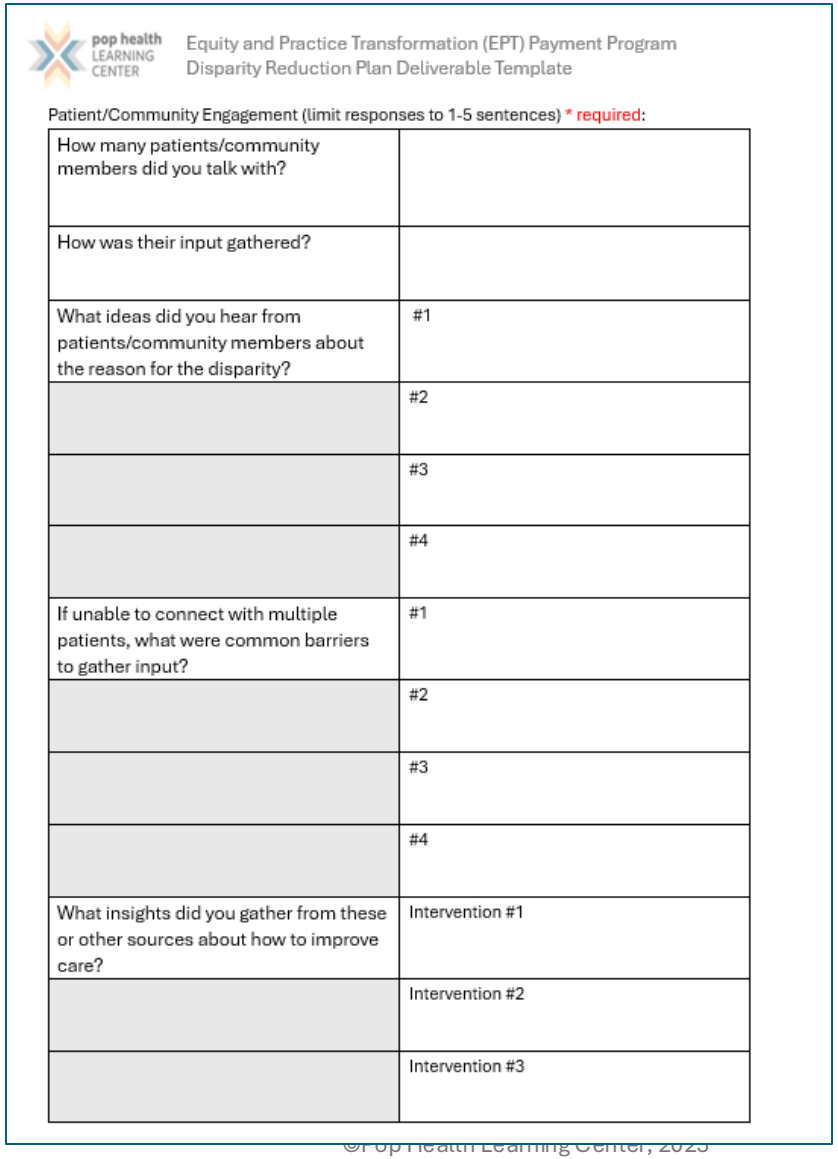
Blue Clinic takes what they have learned to their team. As a small practice, this means having lunch together with 2.5 full time providers, two medical assistants, and the office manager. When the office manager shares what they have found:

One of the MAs observes: "I've had people say, 'Why are you asking these questions? I just came in because of my knee pain.' I'm never sure what to say."

A provider says, "Some of the younger men I see are especially reluctant to talk about depression. They'll tell me, 'I don't need therapy, and I don't want any pills.' I'm not sure what to do when they screen high for depression, so to be honest with you, I kind of avoid it."

- **What needs do you hear expressed?**
- **What other barriers have you experienced for depression screening & follow up?**

Disparity Reduction Plan: Seek patient input



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Disparity Reduction Plan Deliverable Template

Patient/Community Engagement (limit responses to 1-5 sentences) * required:

How many patients/community members did you talk with?	
How was their input gathered?	
What ideas did you hear from patients/community members about the reason for the disparity?	#1
	#2
	#3
	#4
If unable to connect with multiple patients, what were common barriers to gather input?	#1
	#2
	#3
	#4
What insights did you gather from these or other sources about how to improve care?	Intervention #1
	Intervention #2
	Intervention #3

Case Study Part 4

Blue Clinic knows that they need to gather some kind of patient feedback for EPT. But the practice manager says:

> "I've done focus groups with patients before, and put out surveys, but honestly, it can be a huge amount of work. What exactly do I need to do for EPT?"

- **What advice might you give Blue Clinic on low-cost ways to gather patient feedback?**
- **In this case, whose perspective do you need to get?**

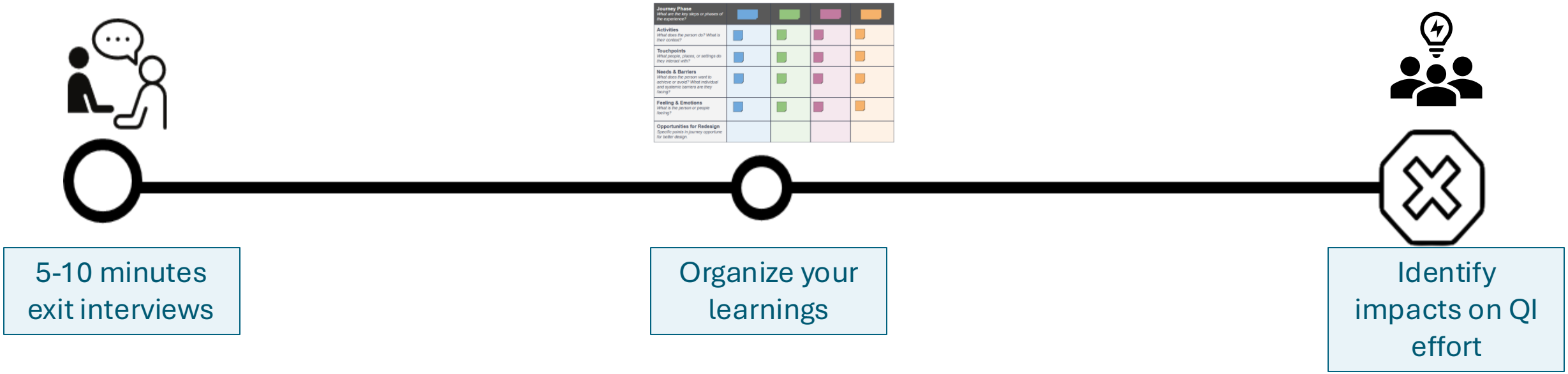
Mini Patient Journey Map

A **Journey Map** is a tool that allows care teams to understand the current state of their processes through lived experiences of their patients, staff, community, etc.

The insights uncovered through a journey map help teams enhance and improve their workflows.

Introducing the Mini Journey Map

The **Mini Journey Map** is a rapid interview/analysis process to gather patient perspectives.

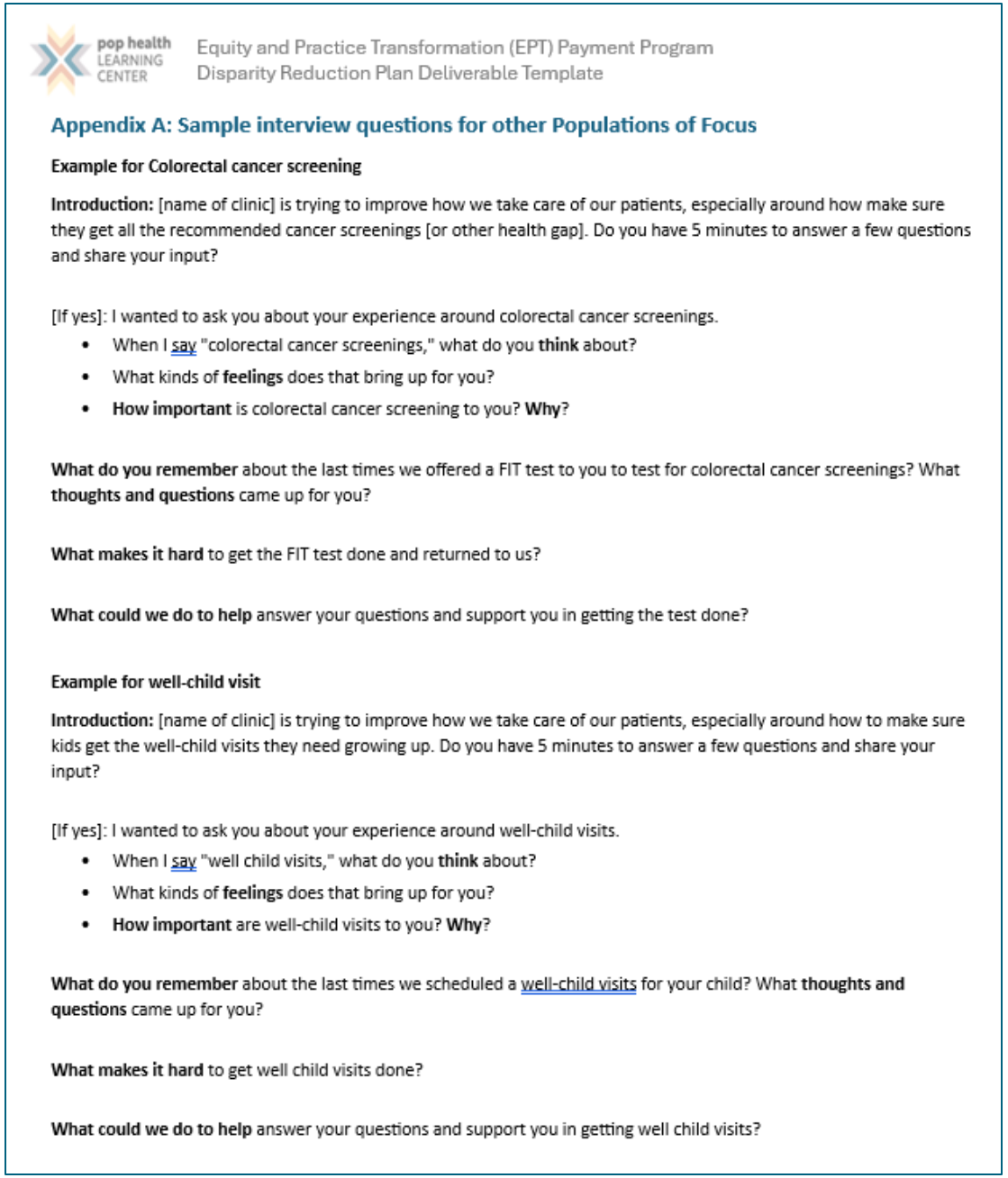


Exit interviews

- The **Exit Interview** is a quick conversation, often as a patient is leaving an appointment, to get their perspective.
- **How long?** As short as 5 minutes
- **How many do I need to talk to?** Aim for 5 people, but if you can get 2, that's still valuable
- **Who does it?** Often a front office manager or medical assistant
- **Who are you talking to?** People who have the care gap you are working to close (for example, have NOT gotten the influenza vaccine or colorectal cancer screening).

Example Interview

Sample scripts are in your Disparity Reduction Plan



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Disparity Reduction Plan Deliverable Template

Appendix A: Sample interview questions for other Populations of Focus

Example for Colorectal cancer screening

Introduction: [name of clinic] is trying to improve how we take care of our patients, especially around how make sure they get all the recommended cancer screenings [or other health gap]. Do you have 5 minutes to answer a few questions and share your input?

[If yes]: I wanted to ask you about your experience around colorectal cancer screenings.

- When I say "colorectal cancer screenings," what do you **think** about?
- What kinds of **feelings** does that bring up for you?
- **How important** is colorectal cancer screening to you? **Why**?

What do you remember about the last times we offered a FIT test to you to test for colorectal cancer screenings? What **thoughts and questions** came up for you?

What makes it hard to get the FIT test done and returned to us?

What could we do to help answer your questions and support you in getting the test done?

Example for well-child visit

Introduction: [name of clinic] is trying to improve how we take care of our patients, especially around how to make sure kids get the well-child visits they need growing up. Do you have 5 minutes to answer a few questions and share your input?

[If yes]: I wanted to ask you about your experience around well-child visits.

- When I say "well child visits," what do you **think** about?
- What kinds of **feelings** does that bring up for you?
- **How important** are well-child visits to you? **Why**?

What do you remember about the last times we scheduled a well-child visits for your child? What **thoughts and questions** came up for you?

What makes it hard to get well child visits done?

What could we do to help answer your questions and support you in getting well child visits?

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Organize your learnings

Summarize what you hear in a **"flow chart"** of patient experience

Columns are the key steps or phases in that experience

Cells capture descriptions or quotes from interviews, feedback and observations

Rows are aspects of their experience

Organize your learnings: Depression screening example

Journey Phase *What are the key steps or phases of the experience?*	**Before visit**	**At visit**	**Follow up**	
Activities *What does the person do? What is their context?*		Loads of paperwork before visit	Calls to get appointment with therapist	
Touchpoints *What people, places, or settings do they interact with?*		MA gives them screening questions	Nancy calls from PCP office to follow up	
Needs & Barriers *What does the person want to achieve or avoid? What individual and systemic barriers are they facing?*	Don't want to be judged	Want to talk about side effects, but nervous to ask	What do I say when I call for an appointment?	
Feeling & Emotions *What is the person or people feeling?*	Feeling stuck I need help	Please don't make me ask for help!	I REALLY don't want my friends to know about this	
Opportunities for Redesign *Specific points in journey opportune for better design.*				

Identify impact on quality improvement effort

Review your map as a team

- What challenges are patients and staff sharing with us?
- What information do they need?
- What might we do to help them?
- Identify 1-2 ideas to try

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Organize your learnings: Depression screening example

Journey Phase *What are the key steps or phases of the experience?*	**Before visit**	**At visit**	**Follow up**	
Activities *What does the person do? What is their context?*		Loads of paperwork before visit	Calls to get appointment with therapist	
Touchpoints *What people, places, or settings do they interact with?*		MA gives them screening questions	Nancy calls from PCP office to follow up	
Needs & Barriers *What does the person want to achieve or avoid? What individual and systemic barriers are they facing?*	Don't want to be judged	Want to talk about side effects, but nervous to ask	What do I say when I call for an appointment?	
Feeling & Emotions *What is the person or people feeling?*	Feeling stuck I need help	Please don't make me ask for help!	I REALLY don't want my friends to know about this	
Opportunities for Redesign *Specific points in journey opportune for better design.*		MA training – patient friendly intro, normalizing FAQs	Script for patient to call therapist?	

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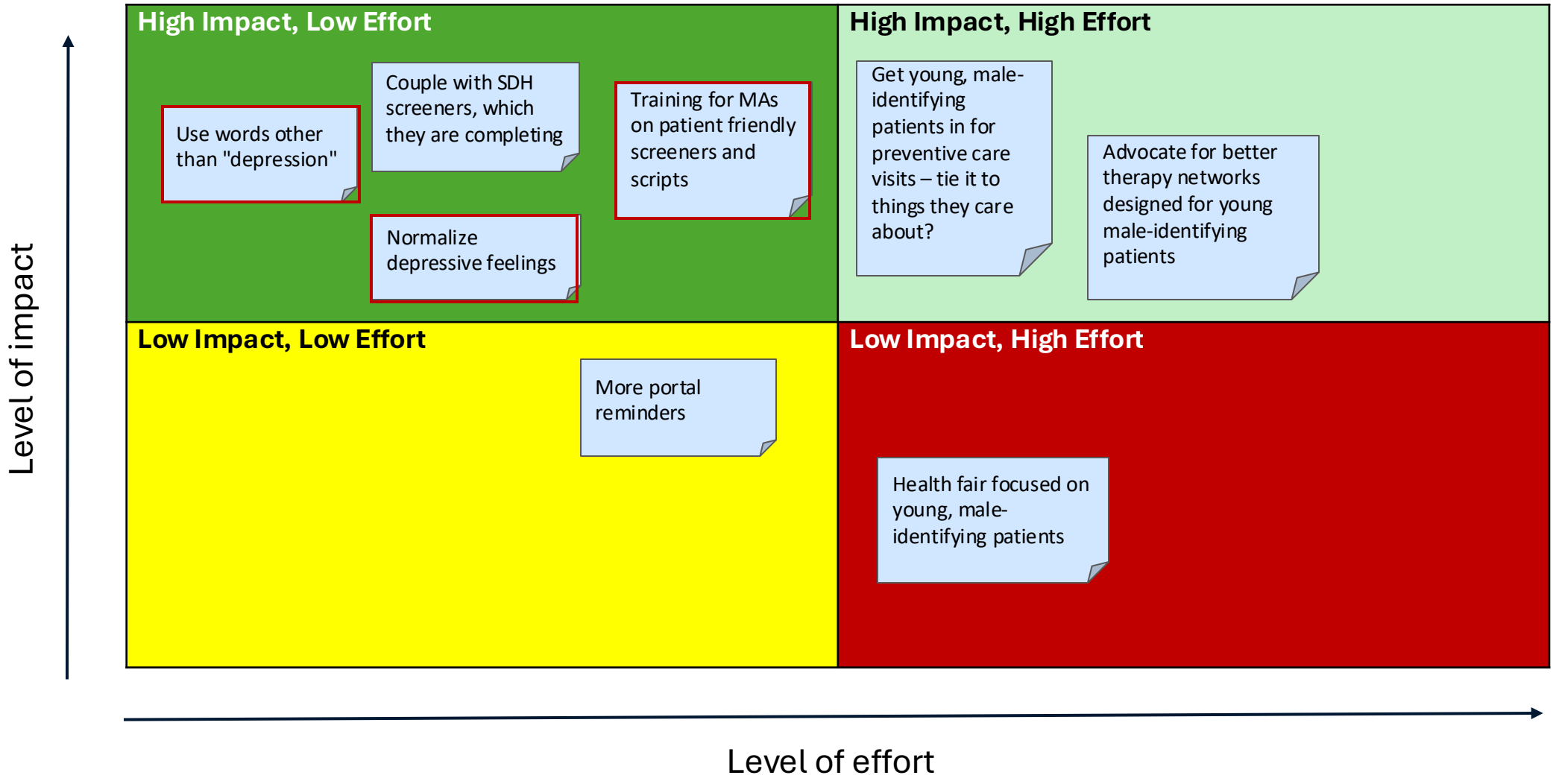
Disparity Reduction Plan: Prioritize interventions



Testing: PDSA Cycles

Equity Disparity — pop health LEARNING CENTER — and Practice Transformation (EPT) Payment Program Reduction Plan Deliverable Template

Appendix E: Template PDSA Short-Form

For instructions to use this tool, please see the *QI Essentials Toolkit*.

Date: _____ Change Idea: _____ PDSA#: _____

Objective (What question(s) do we want to answer?): _____

4) Act: "What's next?"

- Adapt? Adopt? Abandon? Run again?

1) Plan: "What will happen if we try something different?"

- What will you do? When and where will you do it? Who will do it?
- What data will you collect and how will you collect it?
- What do you predict will happen?

Nancy will write an intro script and practice it with the MAs by next Friday.

Measures: Screening complete, MA confidence pre/post

3) Study: "What happened?"

- Did the test go as planned?
- What did you learn?
- Was your prediction right or wrong?

2) Do: "Let's try it."

- Run the test: Carry out the plan. Collect and record the data.

Joann will set up meeting in 3 weeks to check in and look at measures

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Disparity Reduction Plan: PDSA Reflection

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Disparity Reduction Plan Deliverable Template

8. Reflections at end of first PDSA cycle

Amazing work! Your team has nearly completed a full PDSA cycle. At this point, your team has planned an intervention, implemented it, and evaluated it. Now, it is crucially important to reflect on the outcomes of your intervention. The PDSA template provided in Appendix D provides a framework to guide your team on asking key questions on your first PDSA cycle including:

(Limit responses to 1-5 sentences) * required:

What worked or did not work in your first effort at your disparity reduction plan?	MAs said it helped to have better script to normalize depression screening, but that term "well-being" still didn't resonate with young, male-identifying patients
How were patients impacted?	Depression screening for target population was 64% of people who came in for a visit, versus 42% before
How were staff impacted?	Said they felt more confident
What change will you make in the next attempt (PDSA Cycle)?	Talk to target population about better term for "depression screening" We really need to reach all those young men who are NOT coming in for visits!

BREAK

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Care Team Assessment and Implementation Deep Dive

Care Team Assessment

Disparity Reduction Plan

Understanding Root Causes

- Looking at your data
- Staff and patient perspectives
- Mini-Journey Mapping

Intervention

Implementation of Clinical Guidelines

Care Team Assessment & Implementation

Pre-visit Planning
(Closing the gap for people coming in for care)

Outreach
(Closing the gap for people NOT coming in for care)

Plan-Do-Study-Act

Care Team Assessment & Implementation Deep Dive

Blue Clinic is seeking to understand the roles of each team member in depression screening and follow up. Here are their results for the Care Team Assessment.

- **What stands out to you?**

Function	Who performs this now? (Title)
Checks care gaps to determine if due for BH screening	Nobody
Administers behavioral health screening (e.g., PHQ2, PHQ9, AUDIT)	MA or provider
Addresses positive behavioral health screening (including evaluation, diagnosis, referrals, etc)	Provider
Manages "simple" behavioral health needs (e.g. mild depression or anxiety managed in primary care)	Provider
Coordinates with external MH/SUD services, including closing the loop on new referrals, coordinating ROIs	Provider or MA provide a list of resources
Conducts outreach to patients on MAT or BH registry and schedules follow-up	Nobody

Why teams in primary care?

Efficiency of practice

Improving quality of care

PRACTICE PROFILE

By Karen Nelson, Maria Pitaro, Andrew Tzellas, and Audrey Lum

PRACTICE PROFILE

Transforming The Role Of Medical Assistants In Chronic Disease Management

ORIGINAL INVESTIGATION

HEALTH CARE REFORM

Electronic Medical Record Reminders and Panel Management to Improve Primary Care of Elderly Patients

Timothy S. Loo, MD; Roger B. Davis, ScD; Lewis A. Lipsitz, MD; Julie Irish, PhD; Carol K. Bates, MD; Kathryn Agarwal, MD; Lawrence Markson, MD, MPH; Mary Beth Hamel, MD, MPH

Background: Most elderly patients do not receive recommended preventive care, acute care, and care for chronic conditions.

Methods: We conducted a controlled trial to assess the effectiveness of electronic medical record (EMR) reminders, with or without panel management, on health care proxy designation, osteoporosis screening, and influenza and pneumococcal vaccinations in patients older than 65 years. Physicians were assigned to 1 of the following 3 arms: EMR reminder, EMR reminder plus panel manager, or control. We assessed completion of recommended practices during a 1-year period.

plus panel manager arm ($P=.02$). Pneumococcal vaccine was given to 13.1% of patients in the control arm, 19.5% of the EMR reminder arm, and 25.6% of the EMR reminder plus panel manager arm ($P=.02$). Influenza vaccine was given to 46.8% of patients in the control arm, 56.5% of the EMR reminder arm, and 59.7% of the EMR reminder plus panel manager arm ($P=.002$). Results were similar when adjusted for individual physician performance in the preceding year, patient age, patient sex, years cared for by the practice, and number of visits.

Conclusions: Electronic medical record reminders alone facilitated improvement in vaccination rates and, when aug-

Harnessing skills and expertise of other care team members

Population of Focus Breakouts

Reimagining the care team

Breakout Instructions

There are five breakout groups:

1. Adults with Chronic Conditions
2. Adults with Preventive Care Needs
3. Children and Youth
4. People with Behavioral Health Needs
5. Pregnant People

You should be automatically assigned to a breakout based on your selected **PoF**. If not, please stay in the main room and we will assign you.

Breakout: Share the Care

• 20 minutes

You will be placed in facilitated breakout rooms by PoF. Your facilitator will share their screen and guide you through the activity.

Share the Care

- Begin by deciding which clinic will be used for the Share the Care exercise.

- **Part 1:** Determine who is <u>currently</u> responsible for primary functions.

- **Part 2:** Consider who <u>could</u> perform these functions under optimal circumstances.

Share the Care: Children & Youth

Function	No one	Front office	MA	RN	Behavioral Health Clinician	PCP	Health Coach	Other: PharmD, Social Worker, etc.
Tracks well-child visits care gaps (maintains list of patients, well-child visits, and immunization due dates)								
Conducts outreach to schedule well-child visits	✓	💡						
Conducts pre-visit prep for non WCC visits (e.g., to prompt IZs, scheduling for WCC visit)								
Obtains newborn / birth history for newborns new to practice								
Addresses abnormal developmental screens (including evaluation, diagnosis, referrals, etc.)								
Behavioral health screening								
Addresses positive behavioral health screening (including evaluation, diagnosis, referrals, etc.)								
(FOCUS ON LIST ABOVE FOR BREAKOUT ACTIVITY)								

Report Out and Discussion

Culture shift: Share the Care

From “I”
Clinician makes all decisions and non-clinician staff helps the clinician

To “We”
The entire team shares responsibility for the health of their patient panel

Sharing the Care is not only delegating tasks to non-clinician team members; it is reallocating responsibilities

Care Team Assessment

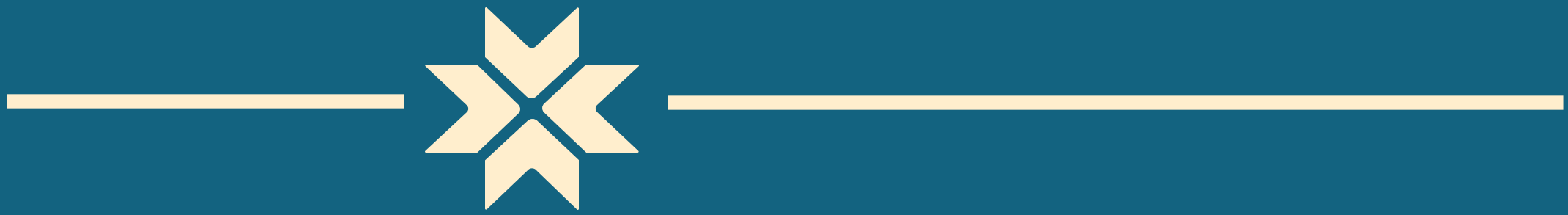
Step 2: Implementation Plan – Action Items to Optimize Care Team Model

Equity and Practice Transformation (EPT) Payment Program
Care Team Assessment & Implementation, Adopting Clinical Guidelines, Implementing Enhanced Outreach and Engagement, Implementing Pre-Visit Planning

*To meet this milestone requirement, practices must implement **at least two NEW actions** (since the start of EPT) by **November 2025**.*

Gap Identified in Table 2	Action Taken or Planned	Team Role(s) Added or Changed	Training or Support Needed	Implementation Status (since start of EPT) ☐ Previously Implemented ☐ In Progress ☐ Planned
Checks care gaps to determine if due for screening	MAs will check care gaps	MA	Practice checking care gaps in EHR	☐ Previously Implemented ☐ In Progress ☐ Planned
Conducts outreach to patients on MAT or BH registry and schedules follow up	Stephanie (MA) will conduct follow up with patients and schedule appointment if needed	MA	Using BH registry Using script to conduct follow-up	☐ Previously Implemented ☐ In Progress ☐ Planned

Closeout + Day 2 Preview



Summary of Day 1, June Learning Community

Understand **where we are in the EPT program**, including our accomplishments and the work ahead.

Introduce the Disparity Reduction Plan and show interconnections between the Care Team Assessment, Pre-visit Planning, and Outreach Plan.

Conduct a Care Team Assessment & Implementation Deep Dive through the Share the Care activity.

Key Objectives for Day 2, June Learning Community

Adopting Clinical Guidelines to Standardize Practice.

Overview of core clinical guidelines across populations of focus.

Spotlight on workflow and EHR integration examples from an EPT practice.

Pre-Visit Planning to Close Gaps.

Identify key components of an effective pre-visit planning (PVP) workflow.

Describe how clinical alerts and care gap reports can be leveraged through EHR optimization.

Discuss resource considerations and tradeoffs.

Share tools, workflows, and automation strategies from their own settings

Part 1 Evaluation

- We want to hear from you!
- https://form.jotform.com/251707296009156
- Please check June 24rd Part 1 as the date

Thank You!

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UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

June Learning Communities Part 2

Population Health Learning Center
University of California Center for Excellence in Primary Care
Subject Matter Experts

Welcome

While we're waiting, please:

Rename yourself

1

Click the Participants icon

2

Hover over your name & click Rename

3

Add your name, pronouns and organization's name

Please no acronyms

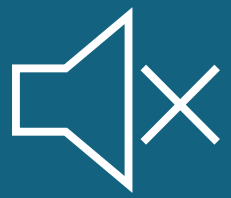
4

Click OK

If you connected to the audio using your phone

- Find your participant ID; it should be in the top left of your Zoom window
- Once you find your participant ID, press: #number# (e.g., #24321#) to connect your audio and video
- The following message should briefly appear: "You are now using your audio for your meeting"

Housekeeping Reminders



Mute

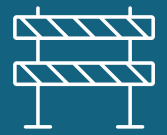
We will mute lines during the presentation to prevent background noise

Questions

Submit questions using the chat feature

Slides + Recording

Slides and recording will be posted PopHealth+



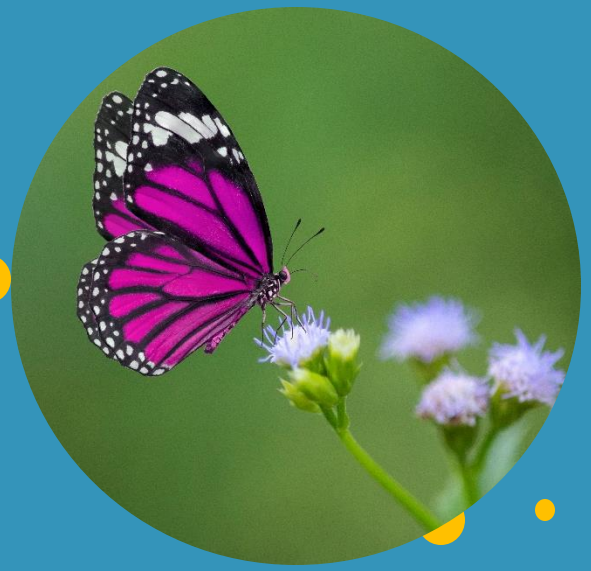
Tech Issues

Private chat Rachel Kochhar for assistance

Ice Breaker!

In the chat, please share:

- Your name, clinic, pronouns (if comfortable)
- What is one thing that is **bringing you joy?**



Agenda

Day 2	
Time	Topic
15 min	Welcome Back + Key Themes from Day 1
40 min	Adopting Clinical Guidelines to Standardize Practice
10 min	Break
40 min	Pre-Visit Planning to Close Gaps
15 min	Reflection + Commitments

PHLC Presenters

Tammy Fisher, MPH
Chief Program Officer

Mary Deane, MPH
Director of Programs

Rachel Kochhar, MPH
Programs Associate

Jennifer Sayles, MD, MPH
Chief Executive

CEPC Presenters

Patricia Mejía
Associate Director of Training

Meghan Elliott
Trainer

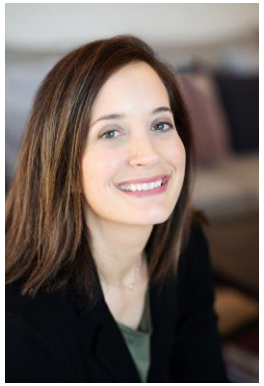
Rachel Willard-Grace
Director

Subject Matter Expert Presenters

Roberto Rodriguez, MD, MPH
Children and Youth

Marianna Kong, MD
Adults with Chronic Conditions and Preventative Needs

Neha Gupta, MD
Adults with Chronic Conditions and Preventative Needs

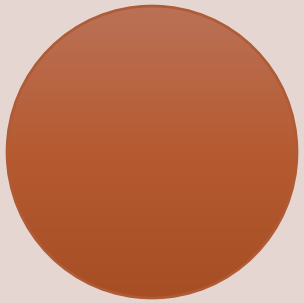


Elizabeth Horevitz, PhD, LCSW
Behavorial Health

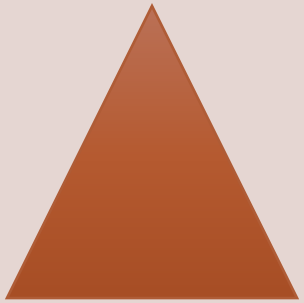
Nathana Lurvey, MD
Pregnant People

Debrief on Day 1, June Learning Community

What are your reflections from Day 1? In the chat, please share…



What is still circling? Do you have any outstanding questions?



What are three takeaways from Day 1?

What feels squared away after Day 1?

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Adopting Clinical Guidelines to Standardize Practice

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University of California Center for Excellence in Primary Care
Subject Matter Experts

Implementation of clinical guidelines

Disparity Reduction Plan

Understanding Root Causes

- Looking at your data
- Staff and patient perspectives
- Mini-Journey Mapping

Intervention

Implementation of Clinical Guidelines

Care Team Assessment & Implementation

Pre-visit Planning
(Closing the gap for people coming in for care)

Outreach
(Closing the gap for people NOT coming in for care)

Plan-Do-Study-Act

Revisiting Blue Clinic

Blue Clinic is seeking to adopt clinical guidelines for depression screening and follow up. One of their providers asks:

> Okay, so we are agreeing to screen for depression yearly and follow up on positive screens. But what exactly does it mean to "adopt clinical guidelines"? What do we need to do next?

What does it mean to "implement clinical guidelines"?

Why This Matters

- Clinical guidelines = the bridge between evidence and action
- Standardization supports equity, quality, and payment
- Getting credit means making the work *visible* in documentation & data

Clinical Guidelines Advisory Group (CGAG)

- Background Challenges at Community Health Centers:
  - Wide variation in clinical guideline usage; many CHCs lack a formal process to adopt CGs.
  - CG development often happens in silos, creating duplication and staff burden.
- 2022 PHMI survey findings:
  - 56% don’t follow a formal CG adoption process.
  - 64% don’t monitor CG use.
  - 65% don’t integrate CGs into EHR/PHM systems.
  - 63% of providers reference CGs individually (e.g., UpToDate).
- CGAG Purpose:
  - Standardize CG review and adoption across PHMI CHCs.
  - Facilitate peer learning and shared best practices.
  - Informed by guidance from Southern California Permanente Medical Group

CGAG Approach, Focus Areas, and Outcomes

- CGAG Process:
  - 32 CHCs represented; 11 primary reviewers.
  - Reviewed national CGs (e.g., USPSTF, AAP, ADA, ACOG, Kaiser).
  - Consensus-based endorsement with secondary reviewer vote.
  - CHCs may exceed guideline standards based on clinical judgment.
- Focus Areas:
  - Children: Well-child visits (W30, WCV), adolescent immunizations (IMA)
  - Pregnant People: Prenatal/postpartum care (PPC), depression screening (PND-E, PDS-E)
  - Adults: Screenings (BCS, CCS, COL), chronic conditions (CBP, HBD)
  - Behavioral Health: Depression screening and remission (DSF, DRR)
- 2023 Survey Results:
  - 90%: CGs align with CHC priorities
  - 100%: Desire to continue participation
  - 70%: Satisfied with CG review process
  - 67%: Confident in implementation

Children

Population	Related HEDIS Measure	CGAG Supported Recommendations	Source
Children	Well Child Visits in the First 30 Months of Life (First 15 Months)	Conduct well child visits as a newborn, at three to five days old, by one month, and then at two, four, six, nine, 12 and 15 months. See Full Recommendation	American Academy of Pediatrics (AAP) / Bright Futures (2024)
	Child and Adolescent Well Visits	Conduct annual well child visits for persons three to 21 years of age. See Full Recommendation	American Academy of Pediatrics (AAP) / Bright Futures (2024)
	Immunizations for Adolescents	• Tetanus, diphtheria, and pertussis (Tdap) vaccination. • Human papillomavirus vaccination (HPV). • Meningococcal serogroup A,C,W,Y vaccination. See Full Recommendation	Centers for Disease Control and Prevention/Advisory Committee on Immunization Practices (2024)

Pregnant People

Population	Related HEDIS Measure	CGAG Supported Recommendations	Source
Pregnant People	Prenatal and Postpartum Care (Prenatal)	Ensure a prenatal care visit occurs 280 to 176 days prior to delivery (or estimated delivery date (EDD)) for pregnant persons. See Full Recommendation	National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) (2019)
	Prenatal and Postpartum Care (Postpartum)	For persons who have delivered a live birth in any setting, conduct a postpartum visit with a maternal care provider within 21 days of delivery. After the initial visit, provide ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. See Full Recommendation	American College of Obstetricians and Gynecologists (ACOG) (2018)
	Perinatal Depression Screening and Follow-Up	• Prenatal depression screening is recommended in the first 12 weeks (Kaiser Permanente Southern California). • Postpartum depression screening is recommended once during the postpartum period (ACOG). See Full Recommendation	Kaiser Permanente Southern California (November 2021) American College of Obstetricians and Gynecologists (ACOG) (2018)

Adult Prevention

Population	Related HEDIS Measure	CGAG Supported Recommendations	Source
Adults with Preventive Care Needs	Breast Cancer Screening	• Biennial mammography screening is recommended for women aged 40 to 74 years (USPSTF). • Transmasculine individuals are recommended to follow the guidelines for cisgender women (USPSTF). • Risk assessment by age 25 is recommended to determine if screening earlier than age 40 is needed (American College of Radiology/Society of Breast Imaging). See Full Recommendation	United States Preventive Services Task Force (USPSTF) (2024) American College of Radiology/Society of Breast Imaging (2023)
	Cervical Cancer Screening	• Screen women aged 21 to 65. • Recommends against screening in women younger than 21 years and for women who meet specific criteria. See Full Recommendation	United States Preventive Services Task Force (USPSTF)(2018 - update in progress)
	Colorectal Cancer Screening	Conduct a colorectal cancer screening for persons aged 45 to 75 using any of the following screening modalities and intervals: • High-sensitivity guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) every year. • Stool DNA test with FIT (sDNA-FIT) every one to three years. • Computed tomography (CT) colonography every five years. • Flexible sigmoidoscopy every five years. • Flexible sigmoidoscopy every 10 years and FIT every year. • Colonoscopy every 10 years. See Full Recommendation	United States Preventive Services Task Force (USPSTF)

Chronic Conditions

Population	Related HEDIS Measure	CGAG Supported Recommendations	Source
Adults Living with Chronic Conditions	Controlling High Blood Pressure	Follow recommended guidelines respectively for each element of blood pressure control: • Blood pressure screening. • Hypertension definition. • Treatment initiation. • Treatment target. • Initial pharmacotherapy. • Follow-up. See Full Recommendation	Kaiser Permanente National Guideline Program (February 2021)
	Hemoglobin A1c Control for Patients with Diabetes (Poor Control >9%) (HBD)	Follow recommended guidelines respectively for each element of diabetes control: • Screening (USPSTF). • Diagnosis (ADA). • Glycemic control and treatment target (Kaiser Permanente National Guideline Program). • Self-monitoring: blood glucose (ADA). • Self-monitoring: continuous glucose monitoring (ADA). • Initial pharmacotherapy (ADA). See Full Recommendation	USPSTF (2021) American Diabetes Association (ADA) (2023) Kaiser Permanente National Guideline Program (April 2022)

Behavioral Health

Population	Related HEDIS Measure	CGAG Supported Recommendations	Source
People with Behavioral Health Conditions	Depression Screening and Follow-Up for Adolescents and Adults	Complete a depression screening annually for persons 12 years of age and older (a specific screening questionnaire is not endorsed). Although USPSTF does not specify frequency, the group endorsed the recommendation to screen annually. See Full Recommendation	United States Preventive Services Task Force (USPSTF)(2016)
	Depression Remission or Response for Adolescents and Adults	Measurement-Based Care • In adults with Major Depressive Disorder (MDD), use the Patient Health Questionnaire-9 (PHQ-9) or other validated tool to quantitatively measure depression severity in initial treatment planning. • In adults with MDD, use the PHQ-9 to monitor treatment response at four to six weeks, after each change in treatment, and until full remission (i.e., sustained PHQ-9 at zero to four weeks for a minimum of two months) is achieved. • At a minimum, assessments should include a measure of symptoms, as well as adherence to treatment, emergence of adverse effects, and the therapeutic alliance. See Full Recommendation	Kaiser Permanente National Guideline Program (September 2023)

Clinical Guidelines Adoption Framework

Clinical care guideline review and adoption

- If multiple guidelines, which guideline will your practice adopt? Who will make the decision?
- What training & education will take place to support the adoption of new guidnelines?
- How are guidelines updated and who is responsible for this, how often?
- How do you monitor internal adherence to clinical guidelines?

Clinical decision support

- How does the care team know a patient is due for preventative care before or during the visit?
- How are guideline-based flowsheets and registries used to optimize tracking and outreach at appropriate intervals for care gaps?

Share the care workflows

- Who places orders for preventative care?
- How is addressing care gaps incorporated into pre-visit planning workflows and outreach protocols?
- How is efficiency optimized?
- How does the loop get closed?

"Getting credit" - Documentation in the EHR

- How are structured fields and proper coding used to capture work being done?
- How are exclusions documented?
- How are outside studies entered into the EHR and communicated to health plans?
- How do you use MCP feedback and reports to validate and align performance data?

Clinical Guidelines Adoption Framework

Clinical care guideline review and adoption

- If multiple guidelines, which guideline will your practice adopt? Who will make the decision?
- What training & education will take place to support the adoption of new guidnelines?
- How are guidelines updated and who is responsible for this, how often?
- How do you monitor internal adherence to clinical guidelines?

Consider:

- *Forming interdisciplinary clinical review teams*
  - *Can include PCPs, MAs, Nurses, QI leads*
- *Adopting / tailoring guidelines based on:*
  - *Staffing models and workflows*
  - *Specific population needs*
  - *Visit modality (e.g., in-person vs video)*
- *Multi-pronged approach to training*
  - *Create job aids and visual workflows*
  - *Incorporate into staff onboarding*
  - *Use team huddles and meetings for reinforcement*
- *Auditing & feedback*
  - *Dashboards and score cards*
  - *Real-time "process measures"*
  - *Random chart sampling*
  - *Monitor by role and care team*

Clinical Guidelines Adoption Framework

Clinical decision support

- **Patients seen**: How does the care team know a patient is due for preventative care before or during the visit?
- **Patients not seen**: How are guideline-based flowsheets and registries used to optimize tracking and outreach at appropriate intervals for care gaps?

Consider:

- *Checklist-based pre-visit chart prep*
- *Embedded tools in the EHR: Best practice advisories, care gap flags, rooming workflows, etc*
- *Registries based on health care maintenance needs, chronic conditions, etc*
- *Use of registries to send mass patient communication (email, text, portal)*
- *Outreach scripts*
- *Enable structured documentation*
- *Templates*
- *Bulk-orders*

Clinical Guidelines Adoption Framework

Share the care workflows

- Who places orders for preventative care?
- How is addressing care gaps incorporated into pre-visit planning workflows and outreach protocols?
- How is efficiency optimized?
- How does the loop get closed?

Consider:

- *Pended / standing orders*
- *Nursing protocols*
- *Order sets, single-click orders*
- *FIT-reminder calls*
- *Intra-visit mammogram scheduling*

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Clinical Guidelines Adoption Framework

"Getting credit" - Documentation in the EHR

- How are structured fields and proper coding used to capture work being done?
- How are exclusions documented?
- How are outside studies entered into the EHR and communicated to health plans?
- How do you use MCP feedback and reports to validate and align performance data?

Consider:

- *Chart audits to validate MCP data*
- *Supplemental data file for MCP*
- *Tip sheets for diagnosis codes etc commonly needed to satisfy quality measures*
- *Regular, recurring meetings with MCPs*

Video Spotlight: Clinical Guideline Integration in Action

Large Group Debrief

- How do you review and tailor guidelines to your clinic setting?
  - How do you communicate to/train staff around guidelines?
- How are you tracking adherence and what do you do with that information?
- How are you capturing the service in your EHR/PHM?

BREAK

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Pre-Visit Planning to Close Gaps

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Subject Matter Experts

Pre-Visit Planning

Disparity Reduction Plan

Understanding Root Causes

- Looking at your data
- Staff and patient perspectives
- Mini-Journey Mapping

Intervention

Implementation of Clinical Guidelines

Care Team Assessment & Implementation

Pre-visit Planning
(Closing the gap for people coming in for care)

Outreach
(Closing the gap for people NOT coming in for care)

Plan-Do-Study-Act

Pre-Visit Planning to Close Gaps

Blue Clinic is trying to use pre-visit planning to close gaps for depression screening and feedback.

- **What do you recommend they do to standardize depression screening and follow up?**

Pre-Visit Planning

- Planning ahead to make patient visits as meaningful and productive as possible
- Systematically identifying care gaps and making a plan to close them
- Can involve:
  - EHR clinical alerts, dashboards
  - Care gap/registry reports
  - Checklists
  - Huddles
  - Standing orders

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Pre-Visit Planning Goals

- Save time, reduce costs, improve patient care, improve clinic efficiency
- AMA StepsForward Pre-Visit Planning module

  https://edhub.ama-assn.org/steps-forward/module/2702514

Pre-Visit Planning Workflow

- Who?
- When?
- What care gaps addressed?
- What tools/data used?
- What steps taken?

Pre-Visit Planning Tools – Patient checklist

Date of previous visit:	Date of next visit:

Preventive screenings				
	Due	Up to date	N/A	Target population and recommendation
PAP				Age 21 to 65 years Every 3 years without HPV co-testing Every 5 years with HPV co-testing
Mammogram				Age 50 to 75 years Every 1 to 2 years For those 40 to 50 and >75, screening on patient-by-patient basis
Colonoscopy				Age 45 to 75 years Every 10 years (more frequent if history of colon polyp or family history of colon cancer)
Bone density scan (DEXA)				Age 65 years Every 3-5 years
Abdominal aortic aneurysm				Age 65 to 75 years One-time screening for men who have ever smoked
Visual acuity				Age >65 years (new Medicare enrollees) Can be completed during the "Welcome to Medicare" visit
Immunizations				
	Due	Up to date	N/A	Target population and recommendation
Tdap vaccine				Age >19 years Every 10 years
Influenza vaccine				Age >6 months Annually
Shingles vaccine				Age >50 years Series of 2 doses
Pneumococcal vaccine (PCV13 or PPSV23)				Age >65 years Patients age 18 to 65 with a chronic or immunocompromising condition

https://edhub.ama-assn.org/steps-forward/module/2702514

Pre-Visit Planning Tools – Clinic scrub report/huddle checklist

Huddle Warm-Up

Scrub Report for:_____ Clinic Date: _____ Completed by: _____

Appt Time	Last Name/ Last 4 MR	New or F/U Last seen?	Confirmed Appt	Pre-Clinic Labs	Pertinent Lab Values	Screening/ Immunizations Needed	Health Coaching/ Patient Concerns/ Consults/Etc.	FOLLOW UP (Post Huddle or Appt)
		D New Patient D F/U last Seen:	D Yes D No D Cancelled D Resched	D Completed D Not Done D Pt called D N/A-no orders		D Td / TdaP D CRC D Pneumovax D Mammo D Influenza/H1N1 D Pap D Other:		
		D New Patient D F/U last seen:	D Yes D No D Cancelled D Resched	D Completed D Not Done D Pt called D N/A-no orders		D Td / TdaP D CRC D Pneumovax D Mammo D Influenza/H1N1 D Pap D Other:		
		D New Patient D F/U last seen:	D Yes D No D Cancelled D Resched	D Completed D Not Done D Pt called D N/A-no orders		D Td / TdaP D CRC D Pneumovax D Mammo D Influenza/H1N1 D Pap D Other:		

https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Healthy_Huddles_Warm_Up_14-0602.pdf

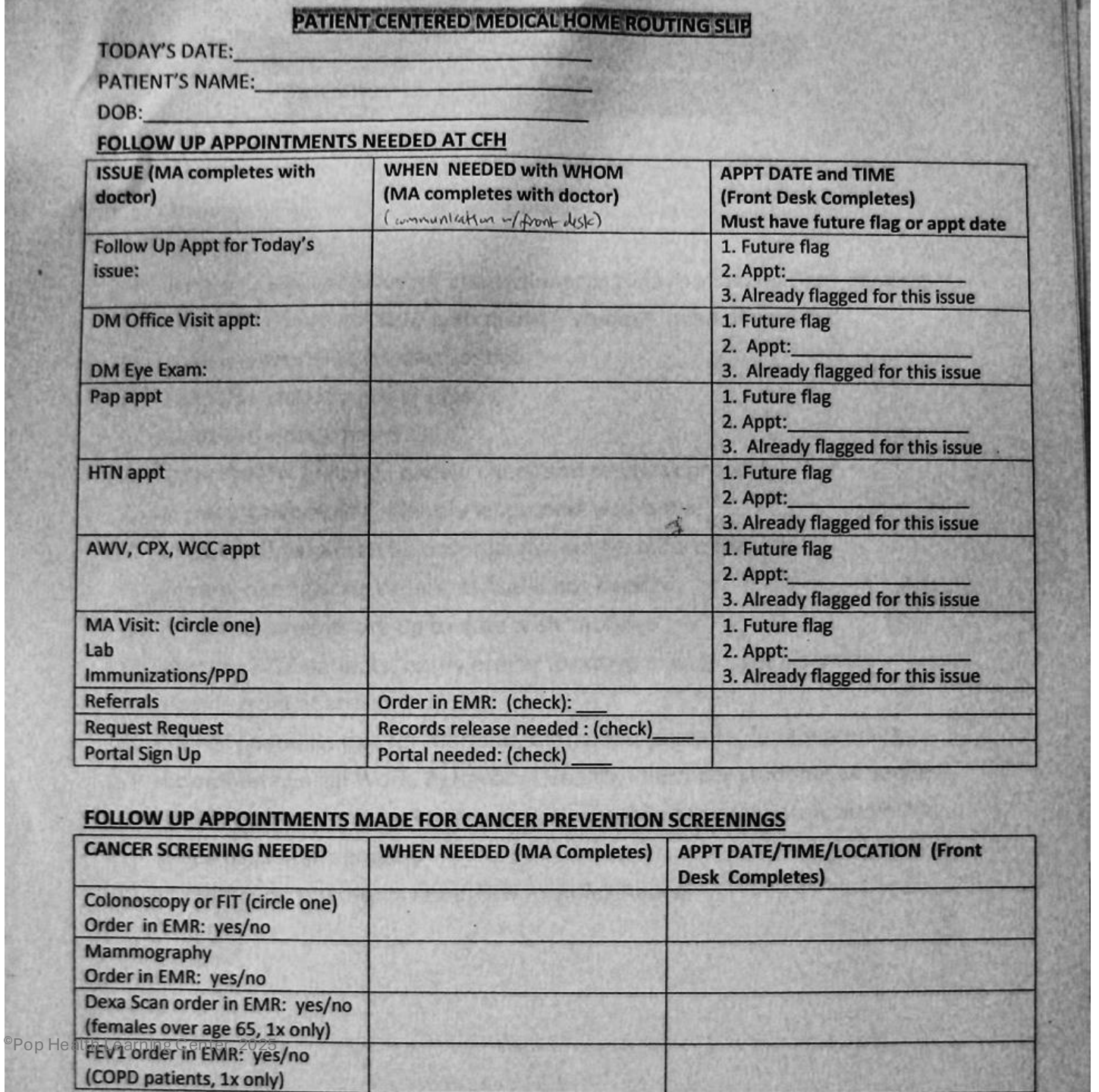
Pre-Visit Planning Tools - EHR flowsheet

Courtesy of: Crozer Keystone Center for Family Health

Pre-Visit Planning Tools – Huddle sheet

Courtesy of: Crozer Keystone Center for Family Health

- MAs prepare huddle sheet for each patient ahead of time, whether patient is due or up to date for each item/when patient needs appointments.
- Discusses with provider at huddle.
- Goes to front desk to make appointments upon patient checkout.



PATIENT CENTERED MEDICAL HOME ROUTING SLIP

TODAY'S DATE:_____

PATIENT'S NAME:_____

DOB:_____

FOLLOW UP APPOINTMENTS NEEDED AT CFH

ISSUE (MA completes with doctor)	WHEN NEEDED with WHOM (MA completes with doctor) (communication w/front desk)	APPT DATE and TIME (Front Desk Completes) Must have future flag or appt date
Follow Up Appt for Today's issue:		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
DM Office Visit appt: DM Eye Exam:		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
Pap appt		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
HTN appt		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
AWV, CPX, WCC appt		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
MA Visit: (circle one) Lab Immunizations/PPD		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
Referrals	Order in EMR: (check):___	
Request Request	Records release needed : (check)____	
Portal Sign Up	Portal needed: (check) ____	

FOLLOW UP APPOINTMENTS MADE FOR CANCER PREVENTION SCREENINGS

CANCER SCREENING NEEDED	WHEN NEEDED (MA Completes)	APPT DATE/TIME/LOCATION (Front Desk Completes)
Colonoscopy or FIT (circle one) Order in EMR: yes/no		
Mammography Order in EMR: yes/no		
Dexa Scan order in EMR: yes/no (females over age 65, 1x only)		
FEV1 order in EMR: yes/no (COPD patients, 1x only)		

Pre-Visit Planning Tools – EHR checklist

[redacted] for visit on 5/30/2025

Pre-Visit Planning Checklist

Please complete the following items 1-2 days prior to the appointment:

Care Gaps Pended via SDOs	**Yes** No
Open Orders Reviewed	Yes **No**
External Records Retreived and Reviewed	Yes **No**
Forms Needed	Yes **No**
Screenings Due	**PHQ** Edinburgh SDOH
Patient needs interpreter?	**Yes** No
Language	spn
Room Setup Needs	

Comments for This Visit

Insert SmartText 100%

Last WCC: 7/1/2024
Last PHQ-A: 1 (7/1/2024)
Last Hearing & Vision Screen: 7/1/2024
Hearing:
Right 1000hz: Pass
Right 2000hz: Pass
Right 4000hz: Pass
Left 1000hz: Pass
Left 2000hz: Pass
Left 4000hz: Pass
Vision:
Right Eye: 20/50
Left Eye: 20/50
Both Eyes: 20/50

✓ PVP Complete

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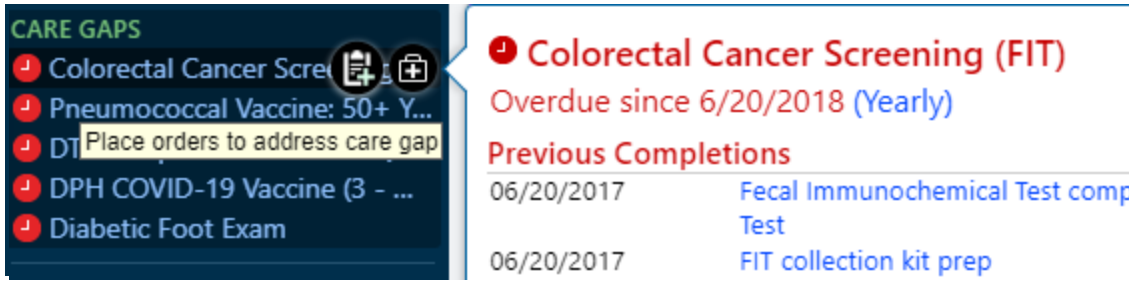
Pre-Visit Planning Tools – EHR Care gaps linked to orders



Pre-Visit Planning Breakouts

PVP Breakout Check-In

💬 “Let’s start with a quick check-in in the chat!”

Please share:

- Your name
- Your role
- Your organization
- On a scale of 1–10, how confident are you in your current pre-visit planning (PVP) process? *(1 = we’re just getting started, 10 = we’ve got a solid system that works well)*

Breakout Questions

- What does PVP look like at your site?
  - Who does it, when, and what care gaps do you cover?
- What strengths or best practices in PVP have you found?
- What challenges or questions around PVP do you have for the group?

For the breakout rooms – we want your cameras ***on*** if you can do so!

Debrief

Reflection + Commitments

Reflections from Day 2, June Learning Community

Chat in your responses to the discussion questions

What will you take back to your team?

What's your next small test of change?

What will you do by next Tuesday?

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November 2025 Milestones

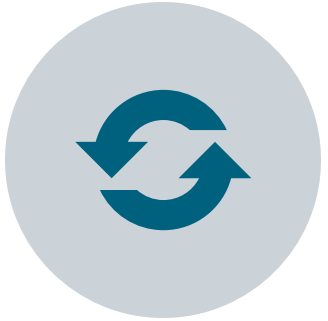
	Milestone
8.	**Develop plan to reduce disparity:** Develop and implement a plan to reduce a disparity in at least 1 HEDIS®®-like metric related to the population of focus; plan should include feedback and participation from staff and patients or community partners. *Note: Before completing this Milestone, the team needs to have submitted Milestone 7: Stratify HEDIS®-like measures*
9.	**Care team assessment and implementation:** Assess current core and expanded care team roles to identify gaps in functions and roles needed to manage the population of focus. Identify and implement new core and expanded care team model to address identified gaps.
10.	**Adopt clinical guidelines:** Adopt evidenced-based clinical guideline(s) related to KPI metrics for selected population of focus. Monitor adherence to guideline(s) for providers to ensure standardization in practice. This includes communication of guidelines to staff, adapting workflows based on clinical guidelines for patients seen and not seen in clinic, integration of guidelines into the EHR, and tracking provider/care team adherence to guidelines.
11.	**Implement enhanced outreach and engagement:** Develop and implement outreach strategy for population of focus to ensure access to evidence-based care using clinical guidelines and to address disparities. This should include review of reports of patients assigned but not seen and patients with care gaps, development of workflows, and identification and training of care team members to do the work.
12.	**Implement Pre-visit planning:** Implement pre-visit planning for scheduled patient care for population of focus to reduce disparities and improve receipt of evidence-based care using clinical guidelines. This should include development of workflows, including how patient-level health maintenance reports are reviewed and utilized, and identification and training of care team members to do the work.
13.	**Progress report on implementing data improvement strategies:** Demonstrate evidence of implementing at least 3 strategies from the data implementation plan including: • Identifying and outreaching to the assigned but unseen population • Using gaps in care reports that include practice and MCP data • Data exchange with 2 external partners, at least 1 of which is a Qualified Health Information Organization (QHIO) *Note: Before completing this Milestone, the team needs to have submitted Milestone 6: Data Implementation Plan*
18, 19, 20, 21	**Submit KPI updates** • Empanelment • Continuity • Third Next Available Appointment • Disparity Reduction *Note: achievement/improvement must be sustained over two consecutive submissions or met in the final submission.*

Cross-Cutting Priorities

Integration: Align workflows for screening, outreach, clinical practice

Engagement: Include staff, patient, and community voices

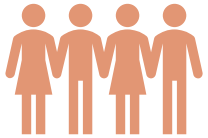
Data: Improve interoperability and reporting



Adaptation: Apply learning and feedback iteratively

What Should Your Team Focus On Now?

Disparity reduction plan linked to clinical outcomes



Care teams aligned to meet PoF needs

EHR configured for screenings, referrals, pre-visit planning

KPI progress and timely data submission

Support & Next Steps

- Attend TA sessions and office hours
- Contact program team with questions (info@pophealthlc.org)
- Access updated resources and templates
- Learn from and share with other clinics
- Keep testing and trying new ideas

Upcoming EPT TA

Population of Focus Practice Tracks

- Clinical subject matter experts and practice track facilitators will be leading peer sharing and content presentation for the EPT models of care content.

EHR User Groups Designed to Support Optimal Use and EPT Reporting

- NextGen: July 14, August 5, August 26
- eClinical Works: July 14, August 4, August 25

Office Hours

- Monthly sessions focused on Access with Coleman Associates
- Bimonthly sessions with the Learning Center for general EPT questions

- Coach Café on Improving Care Gap Closure: Focused on improving care gap closure and sharing real-time stories, challenges, and solutions:
- The Clinicians AI ToolBox - This session reviews current generative AI tools that can help reduce workforce burnout and advance value-based care.

Next Learning Community

- The next Learning Community will be in late September/early October to help practices prepare for the Nov deliverables cycle

Part 2 Evaluation

- https://form.jotform.com/251707296009156

- Please check June 26th Part 2 as the date

Thank You!