



February Learning Communities Part 1

Population Health Learning Center
University of California Center for Excellence in Primary Care
Clinical 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



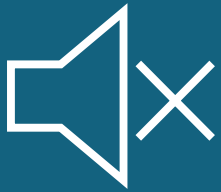
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Click OK

**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



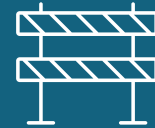
Questions

Submit questions using the chat feature



Slides + Recording

Slides and recording will be posted PopHealth+



Tech Issues

Private chat Rachel Kochhar for assistance

Continuing Education Credit

Licensed Nursing Professionals

- This course meets the qualifications for **2.0 contact hours of continuing education credit** for nurses as required by the California Board of Registered Nursing, Provider #18090. The UCSF Center for Excellence in Primary Care is approved by the California Association of Marriage and Family Therapists (CAMFT) to sponsor continuing education for LMFTs, LCSWs, LPCCs, and/or LEPs. The UCSF Center for Excellence in Primary Care maintains responsibility for this program/course and its content.

Licensed Behavioral Health Providers

- This course meets the qualifications for **2.0 hours of continuing education credit** for LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences, Provider #1032866. Any activities within the program that do not have instructional time are not offered for continuing education credit. Course completion certificates will be awarded upon completion of course evaluations. *Documentation must be retained by the Participant for a period of four years after the conclusion of this program.*

Please chat in!

- Your name
- Role
- Organization
- Who from your organization inspires you?



Learning Center Presenters and Facilitators



Tammy Fisher,
MPH

Chief Program
Officer



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Director of
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Patricia Mejía

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Trainer



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Subject Matter Expert Facilitators



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**
Behavioral Health



Nathana Lurvey, MD
Pregnant People

Part 1 Learning Objectives

- **Describe** how a disparity reduction plan is connected to expanded care team roles, outreach, pre visit planning, implementing clinical guidelines, and KPI improvement.
- **Identify** at least two strategies used by peer practices to address disparities through models of care or workflow changes.

Agenda

Day 1	
Time	Topic
10 min	Welcome + Program Check-In
20 min	Disparity Reduction Planning
40 min	EPT Practice Brightspot Panel
35 min	Breakout Reflection and Application
15 min	Large Harvest & Close

Day 2	
Time	Topic
5 min	Welcome Back & Grounding
5 min	Defining Value Based Payment
10 min	Why is CA Shifting to VBP
15 min	Practice Examples of VBP
15 min	Major VBP Models
10 min	Break
10 min	Core Capabilities for VBP and EPT
20 min	Breakout Groups
5 min	EPT VBP Milestone
10 min	Q&A
15 min	Closing and Next Steps

EPT Quarterly Summary



187 practices are currently enrolled in EPT



EPT facilitated Office Hours, Practice Tracks, Ad-Hoc Webinars, and released new PopHealth+ Modules.



Practices completed November deliverable submission and review cycle



99% of practices met November 2025 deliverables reporting requirements



Two new deliverable templates were released on social health and behavioral health screening and response

How EPT Deliverables are Reviewed



Practices receive milestone templates and corresponding rubrics



Practices complete and submit deliverables during submission cycles (May and November)



SME reviewers provide detailed, actionable feedback



Practices revise and resubmit with TA support (office hours, SMEs)



Deliverables are accepted once requirements are met

- Deliverable review is designed as technical assistance, not a one-time pass or fail.
- The deliverables process functions as a structured improvement cycle, prompting practices to clarify goals, test changes, and strengthen workflows before outcomes are measured.
- High acceptance rates reflect strong practice work, iterative feedback, resubmissions, and engaging in TA.
- Some practices appropriately delay submission rather than submit before they are ready.

Deliverable Design and Review SME Engagement

- Design deliverable templates, reviewed submissions, and provided structured feedback to practices
- Established consistent engagement structures (e.g., 1:1 SME support, peer and group learning, webinars, user groups, and design studios)

TA Partners



Patricia Mejía

Associate Director of Training



Meghan Elliott

Trainer



Rachel Willard-Grace

Director

Clinical SMEs



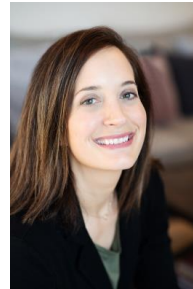
Roberto Rodriguez, MD, MPH

Children and Youth



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Adults with Chronic Conditions
and Preventative Needs



**Elizabeth Horevitz,
PhD, LCSW**

Behavioral Health



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Pregnant People



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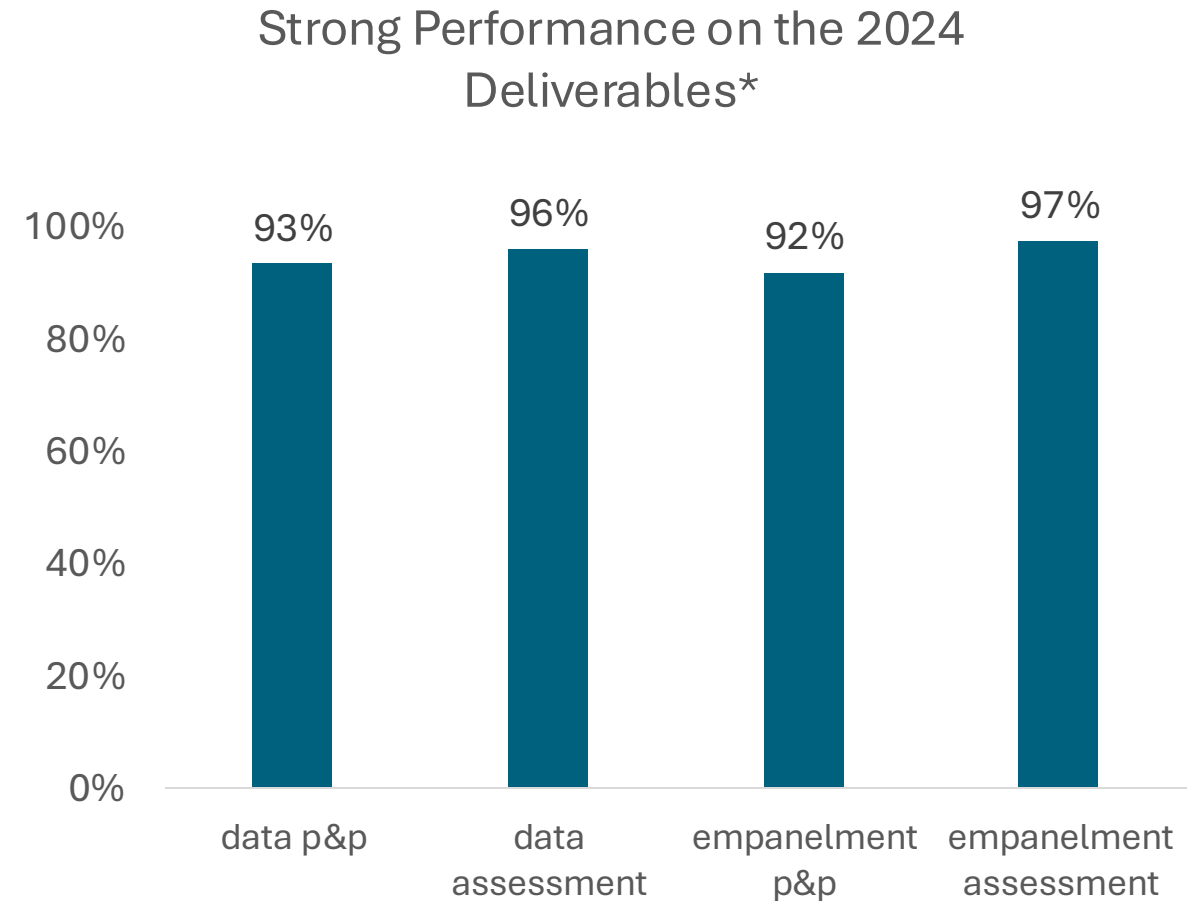
Adults with Chronic
Conditions and
Preventative Needs

November 2025 Deliverable Results

Based on the percentage of accepted deliverables across the EPT cohort

- For practices **currently enrolled in EPT (190)**, acceptance rates for 2024 data and empanelment deliverables are very high (95–100%).
- Acceptance reflects **final outcomes after feedback and resubmission**; variation is driven primarily by **submission timing**, not rejection.
- Deliverables shown as “not submitted” largely reflect practices that **were enrolled when a deliverable was released but later exited the program**.
- By November 2025, **99% of active EPT practices** met the requirement to submit at least one 2024 deliverable and their 2025 PhmCAT.

**Denominators are based on practices enrolled when each deliverable was first released (N = 198).*

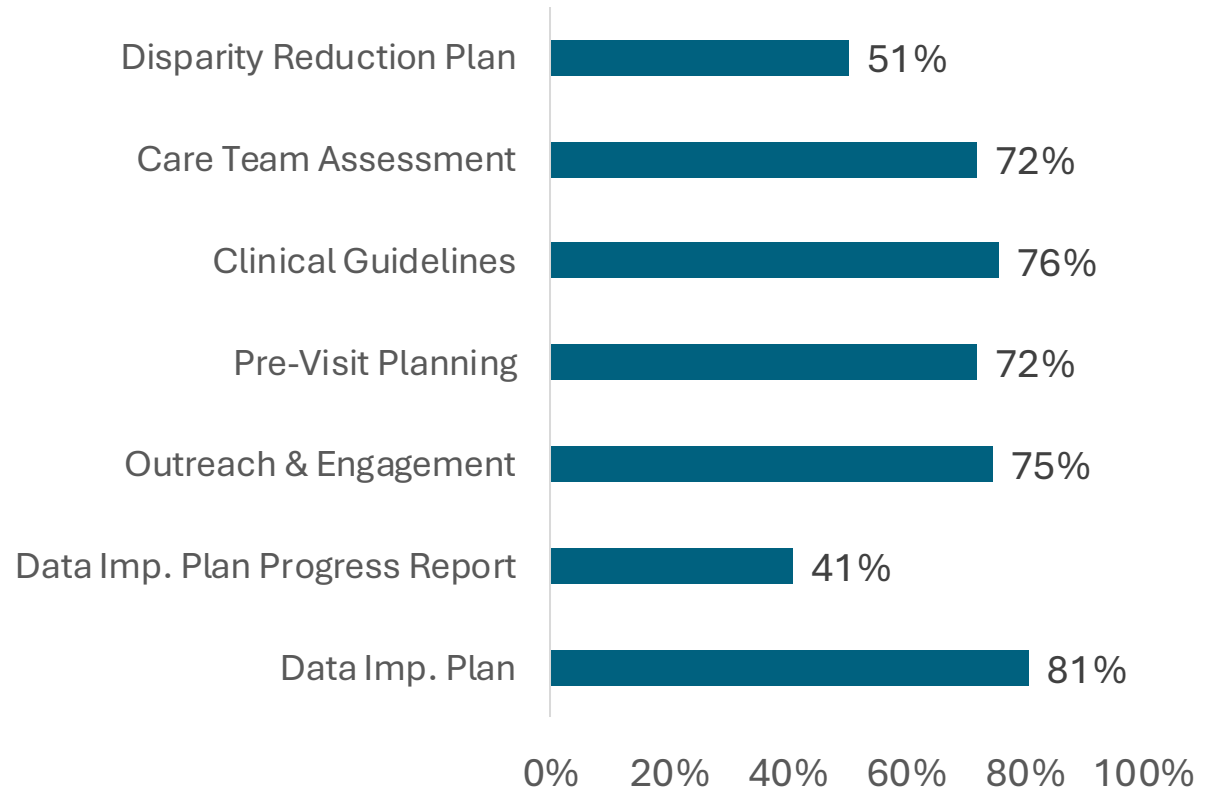


November 2025 Deliverable Results

Based on the percentage of accepted deliverables across the EPT cohort (regardless of submission status)

- There were high acceptance rates (72%) for the new Models of Care deliverables, and for the Data Implementation Plan (81%).
- Lower submission and acceptance rates for the Data Implementation Plan Progress Report and Disparity Reduction Plan reflect the depth of work required, including strengthening data infrastructure and advancing disparity reduction efforts. As a result, many practices are still actively developing or refining these deliverables. These deliverables are designed to mature over multiple cycles.
- When acceptance rates are examined using **only those who submitted** as the denominator, acceptance is high across deliverables (**92% - 100% of submitted deliverables are accepted**), indicating strong quality once practices are ready to submit.
- All outstanding 2024 and 2025 deliverables can be submitted in the upcoming May 2026 cycle.

Accepted 2025 Deliverables*

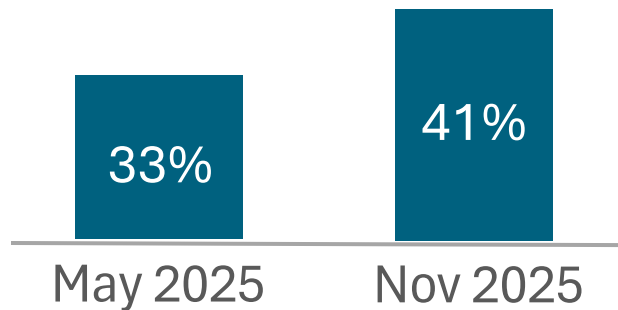


*Denominators are based on the number of practices enrolled during the first cycle that the deliverable was available.

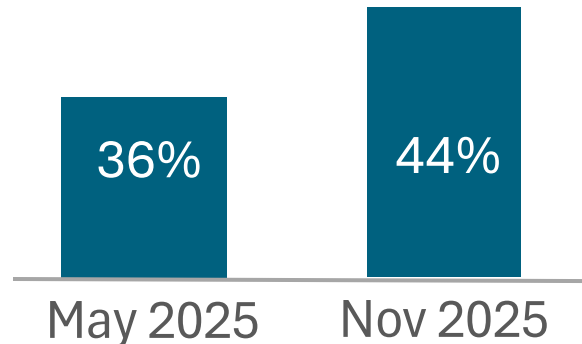
- For the Data Implementation Plan, n=198.
- For all other deliverables, n=190.

Practices Achieving Admin KPIs

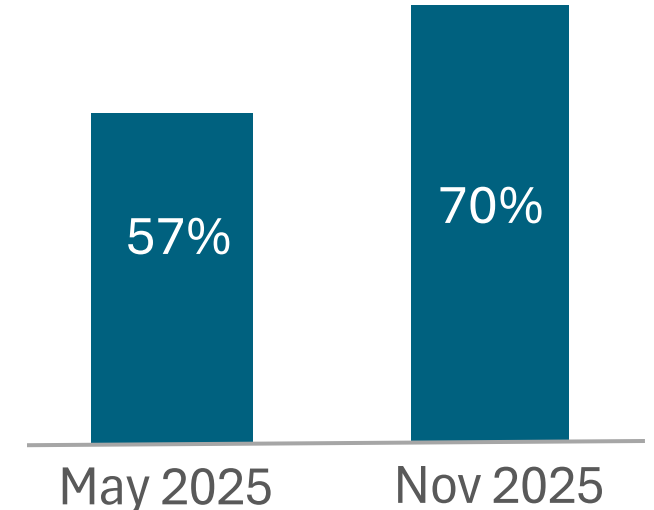
Practices Meeting
Empanelment Milestone
(90% patients paneled at
two time points)



Practices Meeting Continuity
Milestone
(70% continuity at two time
points)



Practices Meeting Access
Milestone
(<10 days to third next available
appointment at two time points)



- **Performance improved across all three administrative KPIs** between May and November 2025.
- **Access improved most rapidly**, while empanelment and continuity show steadier, incremental gains.
- Patterns reflect the **relative complexity of workflow change**, with deeper attribution and continuity work taking longer to mature.
- **NOTE: Practices should continue to submit KPI data even after meeting the milestone**

When to Expect Payment

Submissions accepted for the May 2025 cycle:

- Payment should have been received January 2026

Submissions for the November 2025 cycle

- Payment expected within one month of DHCS payment to MCPs, currently anticipated March 2026

Please reach out directly to your sponsoring MCP and DHCS for questions about payment



Reviewing Disparity Reduction: The Foundation of EPT

University of California Center for Excellence in Primary Care

Intro Disparity Reduction Plan

Disparity Reduction Plan

Understanding Root Causes

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

Journey Phase	Blue	Green	Pink	Orange
Activities What does the person do? What is their role?				
Touchpoints What people, places, or settings do they interact with?				
Needs & Barriers What does the person need to achieve or avoid? What individual and systemic barriers are they facing?				
Feeling & Emotions What is the person's experience?				
Opportunities for Redesign Specific points to consider opportunities for better design.				

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





One Plan, Several Deliverables

Disparity Reduction Plan



Reduce HbA1c > 9% for
Spanish speaking patients

KPI - Disparity

Implementation of Clinical Guidelines

Care Team Assessment & Implementation

Pre-visit Planning

Outreach



Aligning Disparity Reduction Plan & Disparity KPI



EPT Disparity Reduction Data Reporting Template

Selected measure and sub population

An example is provided below for a practice who is focused on increasing rates of depression screening and follow-up for unhoused patients.

Reporting and Population Information	Definition	Example	Response
HEDIS-like measure	Include the HEDIS-like measure that your practice is focused on	Depression screening and follow-up	Controlling high blood pressure
Measurement period for reporting	Use a rolling 6 month lookback period that ends the month before the submission	April 1, 2025 – October 1, 2025	10/1/25-3/31/26
Specify how you are stratifying the measure	Race and ethnicity, primary spoken language, sexual orientation, gender identity, housing status, disability, other	Housing status	Race
Specify the sub-population	For example, Black or African American, Latino, Spanish speaking, Bisexual, Nonbinary, Unhoused	Unhoused patients	Black/African American pts



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

Black/African American patients

2. Selected HEDIS®-like Metric * required

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

Metric Name: Controlling high blood pressure



Aligning Intervention to Measure



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

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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: Colorectal cancer screening

3. Identified Disparity * required

Which of these describes an intervention related to the outcomes of colorectal cancer screening?
(Select all that apply)

- a) Sending home testing kits for colorectal cancer screening to patients
- b) Adding gloves to the colorectal cancer screening kit because of concerns about handling stool
- c) Calling patients to remind them to return kits
- d) Getting more patients on the patient portal so they can more easily make appointments

Aligning Intervention to Measure



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

Disparity Reduction Plan Template

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Aligning Process Measure



pop health
LEARNING
CENTER

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: Hemoglobin A1c>9

3. Identified Disparity * required

Which of these describes a process measure related to the metric of Hemoglobin A1c>9? (Select all that apply)

- a) Overall % of patients with Hemoglobin A1c>9 for clinic
- b) % patients with diabetes who bring their glucometer to their appointment
- c) Number of patients with high Hemoglobin A1c who are enrolled in Diabetes class
- d) % patients signed up for MyChart

Aligning Process Measure



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.

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Which of these describes a process measure related to the metric of Hemoglobin A1c>9? (Select all that apply)

- a) Overall % of patients with Hemoglobin A1c>9 for clinic
- b) % patients with diabetes who bring their glucometer to their appointment
- c) **Number of patients with high Hemoglobin A1c who are enrolled in Diabetes class**
- d) % patients signed up for MyChart

Aligning outcome measure



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

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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: Depression follow up for adolescents

3. Identified Disparity *required

Which of these describes an outcome measure and goal related to the outcomes of Depression follow up for adolescents? (Select one)

- a) Third next available appointment for teen wellness visits
- b) % up to date on depression screening
- c) % Closed loop referrals to behavioral health services
- d) # people participating in teen healthy eating classes

Aligning outcome measure



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.)

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Which of these describes an outcome measure and goal related to the outcomes of Depression follow up for adolescents? (Select one)

Third next available appointment for teen wellness visits

% up to date on depression screening

a) % Closed loop referrals to behavioral health services

people participating in teen healthy eating classes

Poll time

What percentage of the Disparity Reduction Plans submitted in November 2025 ultimately passed in that cycle? (Select One)

- a) 30%
- b) 50%
- c) 80%
- d) 90%

Poll time

What percentage of the Disparity Reduction Plans submitted in November 2025 ultimately passed in that cycle? (Select One)

- a) 30%
- b) 50%
- c) 80%
- d) 90%**

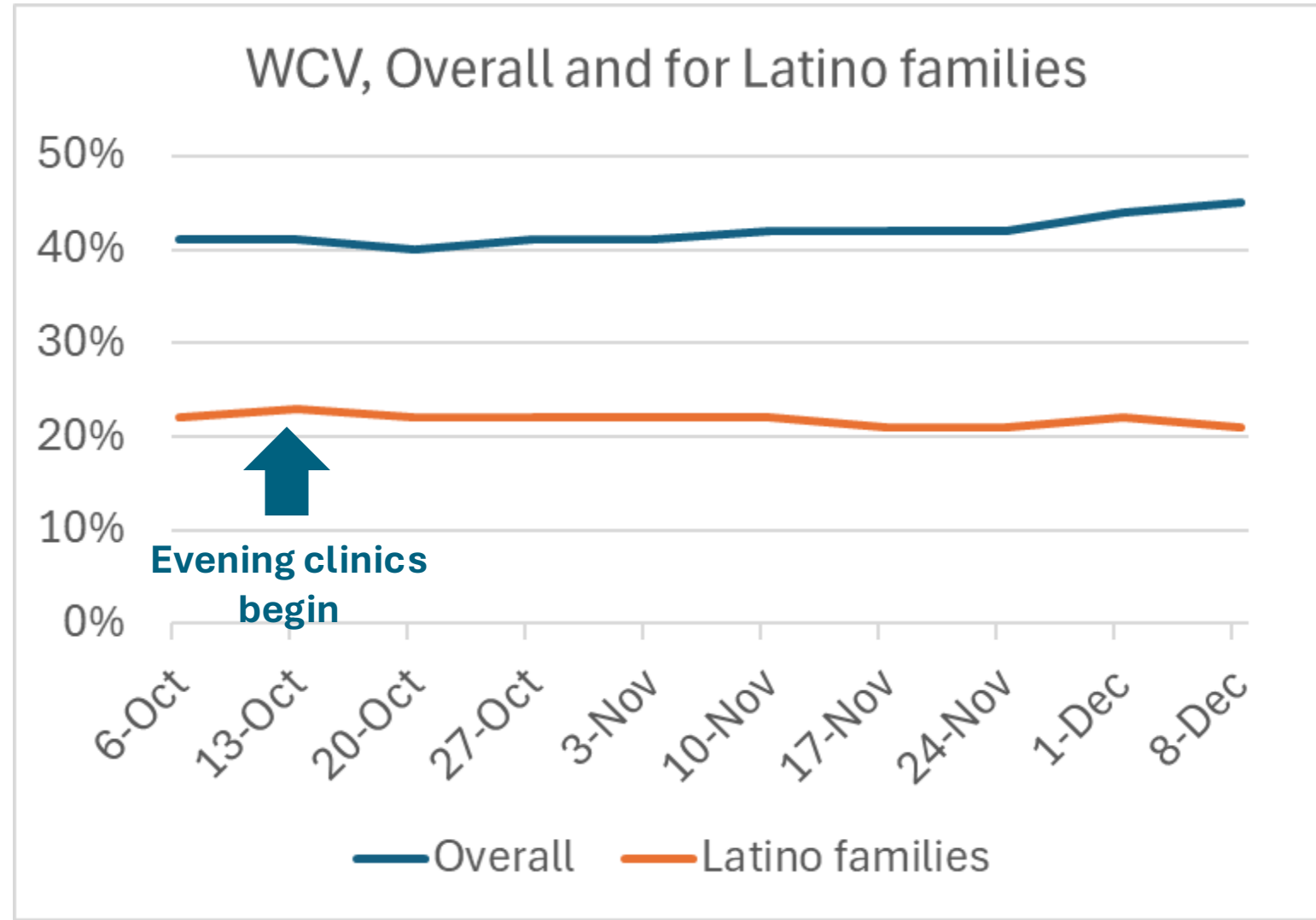
Return to Blue Clinic

Practice Profile: Blue Clinic

Measure: Well Child Visits
(% patients 3-21 with WCV
in last year)

Population of focus: Latino
families

Intervention: Opened up
evening clinics



What might be happening? What would you do next?

Intro Disparity Reduction Plan

Disparity Reduction Plan

Understanding Root Causes

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

Journey Phase	Blue	Green	Pink	Orange
Activities What does the person do? What is their role?				
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Needs & Barriers What does the person need to achieve or avoid? What individual and systemic barriers are they facing?				
Feeling & Emotions What is the person or people feeling?				
Opportunities for Redesign Specific points to consider opportunities for better design.				

Intervention

Implementation of Clinical Guidelines

Care Team Assessment & Implementation

Pre-visit Planning

(Closing the gap for people coming in for care)

Outreach

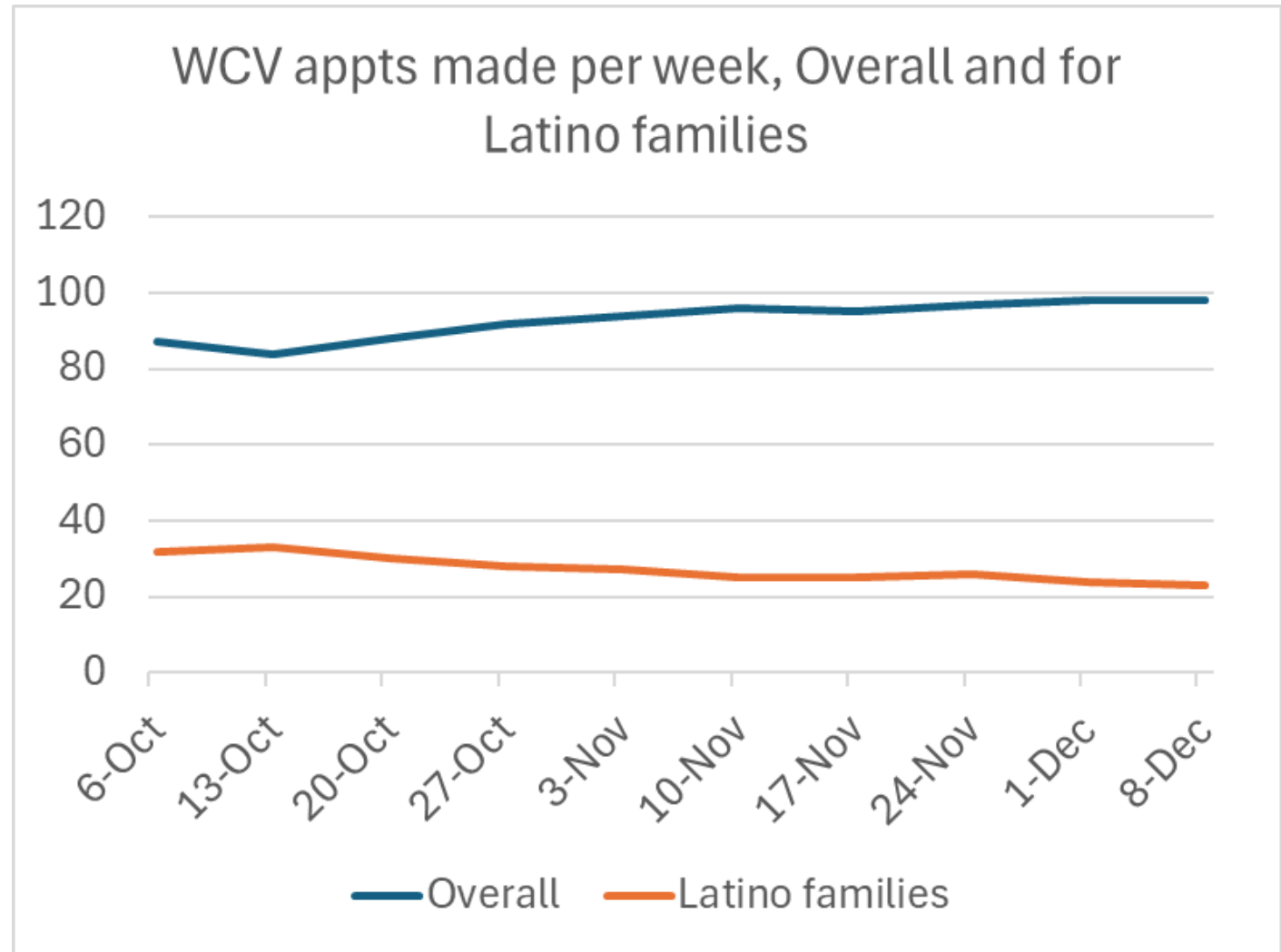
(Closing the gap for people NOT coming in for care)

Plan-Do-Study-Act



Return to Blue Clinic, continued

Process measure:
Appointments made



What might be happening? What would you do next?

Intro Disparity Reduction Plan

Disparity Reduction Plan

Understanding Root Causes

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

Journey Phase	Blue	Green	Pink	Orange
Activities				
Touchpoints				
Needs & Barriers				
Feeling & Emotions				
Opportunities for Redesign				

Intervention

Implementation of Clinical Guidelines

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(Closing the gap for people coming in for care)

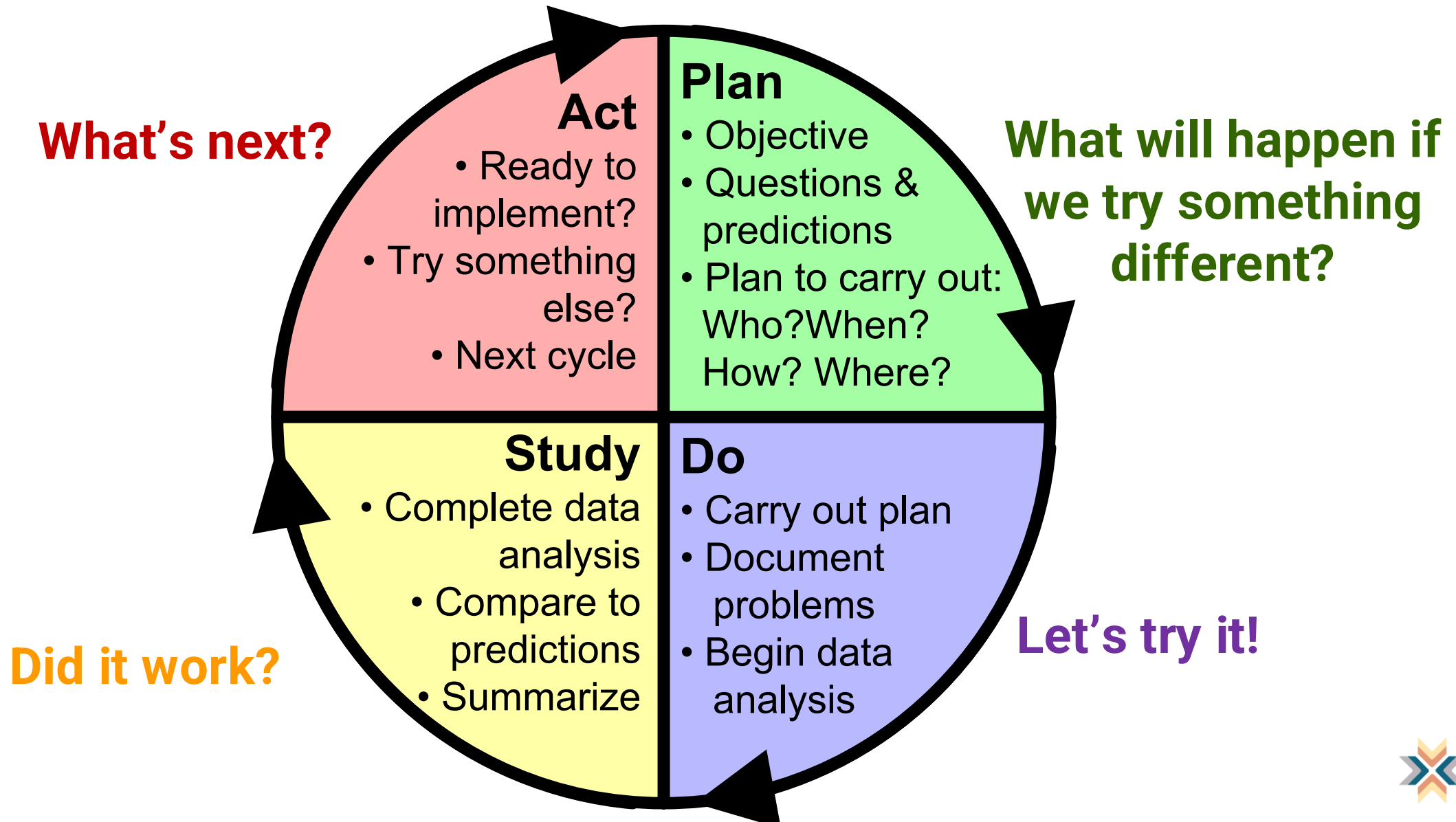
Outreach

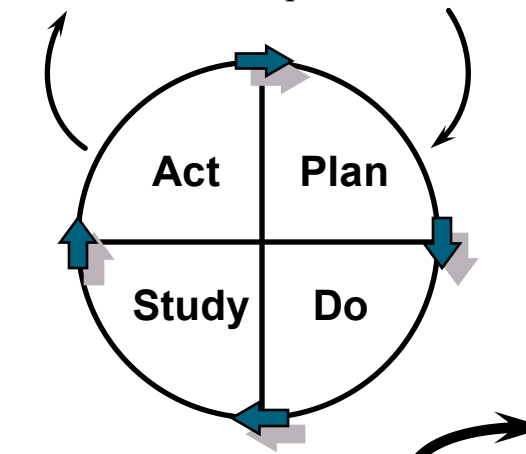
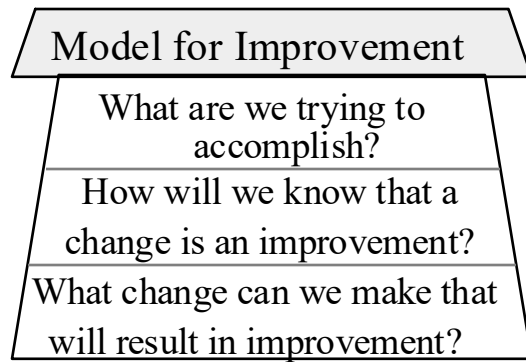
(Closing the gap for people NOT coming in for care)

Plan-Do-Study-Act

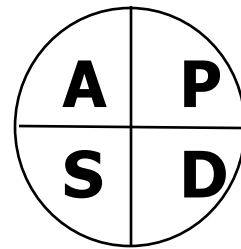


The PDSA Cycle for Learning and Improvement

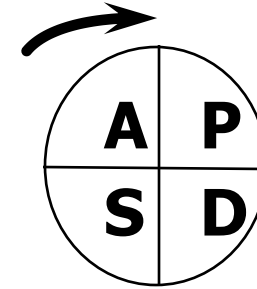
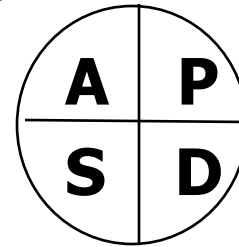
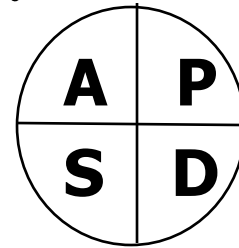




**Theories,
hunches,
& best practices
(start small!!)**



Evidence & Data



**Breakthrough
Results**

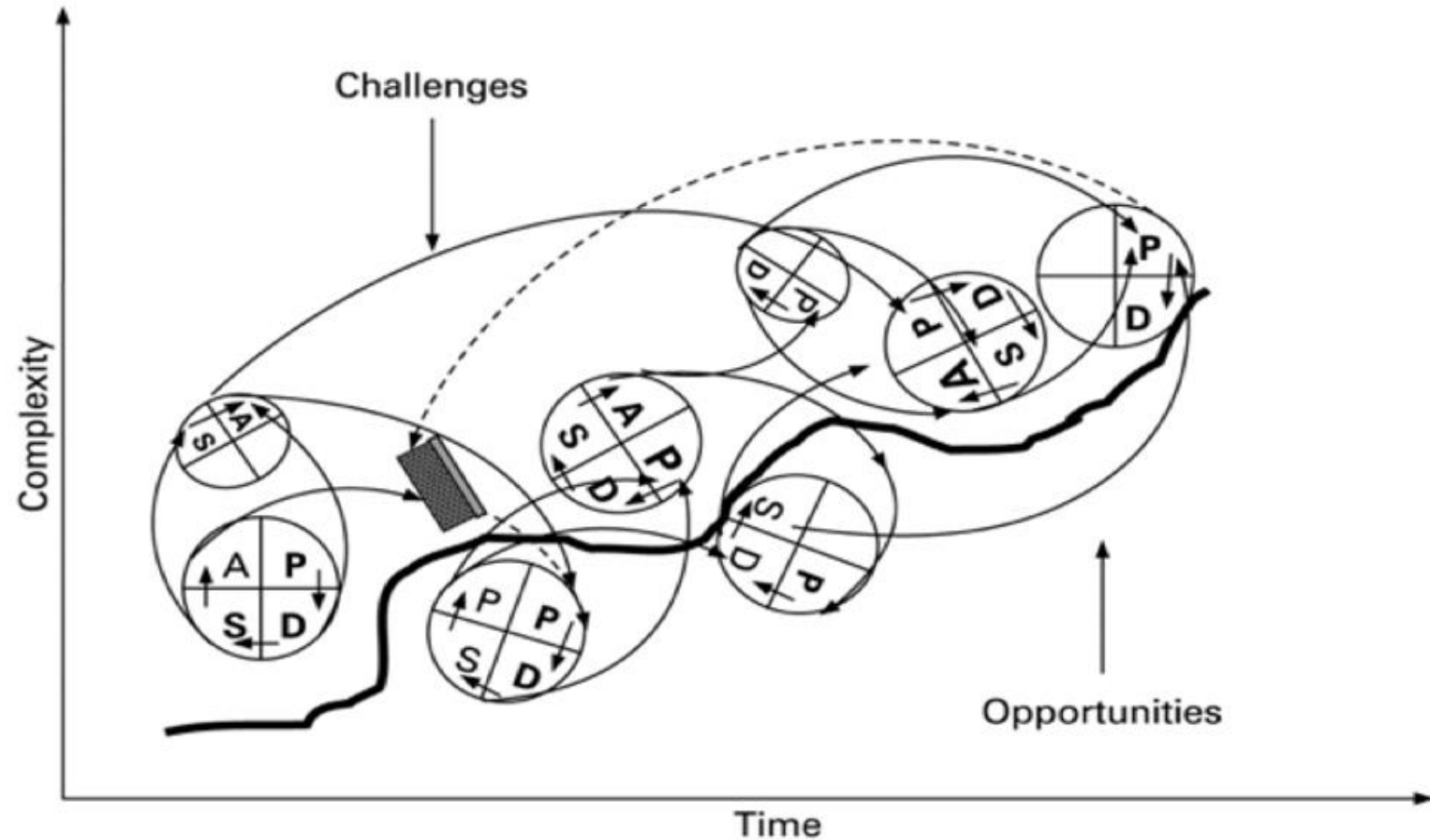
**Implement a
change**

Test a change

Develop a change

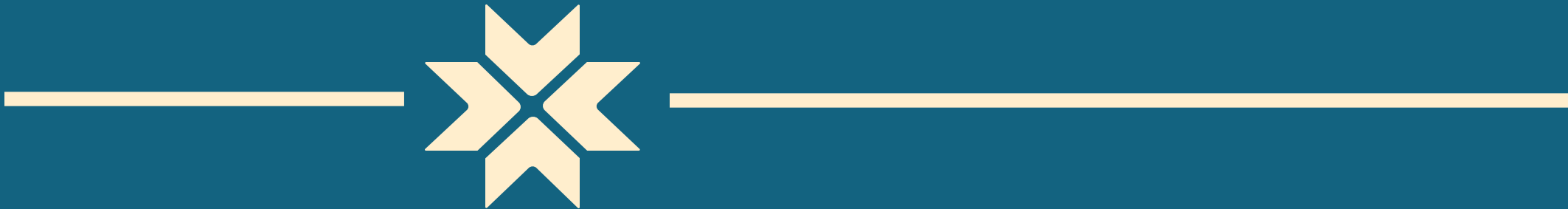
Learning and improvement

Early PDSA tests (*adopt, adapt, abandon*)



Source: A case study of translating ACGME, to a comprehensive curriculum improvement projects as the key component requirements into reality: systems quality practice-based learning and improvement, A M Tomolo, R H Lawrence and D C Aron, *Qual Saf Health Care* 2009 18: 217-224

Bright Spots Panel





Practice Bright Spots: EPT in Action at Kheir Clinic

Floribel Tabizon

Director of Patient Services

Gavin Kwon

Clinic Project Manager

Slide 1



About Kheir Clinic

- Federally Qualified Health Center (FQHC) serving underserved populations
- Population of Focus: Adults with chronic conditions

Disparities in Care Access

- Lower CBP compliance rate among Korean-speaking, tele-health patients (6.59% vs. 64.34%)
- Structural Barriers: transportation, time, language ...

Culturally Responsive Outreach

- Shift from administrative outreach to culturally responsive communication
- Targeted outreach informed by stratification:
Multilingual, staff-led patient messaging,
Language + tone adapted to patient context

Roles & Responsibilities Shifted

- Shared understanding of end-to-end workflows
- Earlier cross-department communication
- Language-aware patient engagement

Data-Driven Outreach & Planning

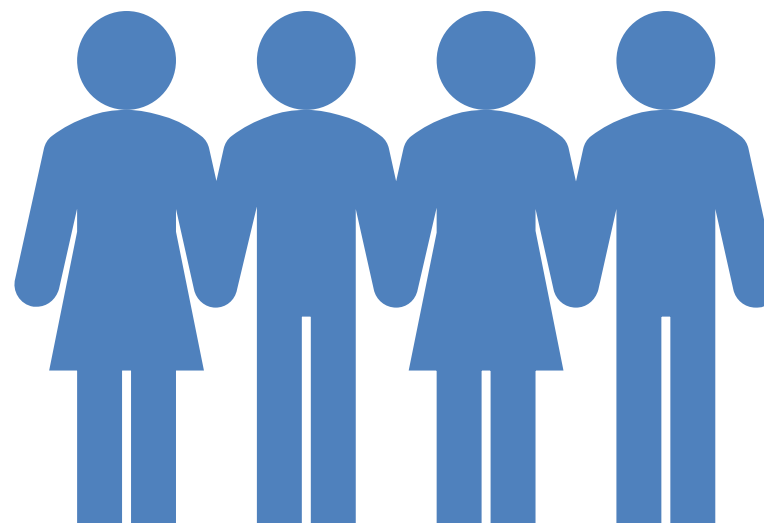
- Stratified Data by age, language, location, chronic condition
- Identification of high-disparity subgroups
- Actionable lists integrated into workflows

Early Signals and Next Steps

- Increased engagement from tele-only patients
- Expanded use of home BP monitors, Improved patient awareness of BP self-management
- Exploring EHR-integrated remote BP solutions



Initiative EPT Program Disparity Reduction



About Our Clinic

- Multi-specialty clinic in Southern California
- Serving diverse communities across five locations
- Population of focus: Pregnant People

Identifying the Disparity

- Overall postpartum depression screening rate: 76%
- Screening rate for Spanish-speaking patients: 69%

How We Identified Barriers



- Pilot study across all five clinics



- Interviewed 10 staff members per clinic



- Spoke with 12 patients who did not complete screening

Barriers Identified

-
- Language differences
-
- Limited knowledge about importance of screening
-
- Difficulty booking or attending postpartum appointments
-
- Financial stress (affecting ~50%), including transportation challenges

Interventions Implemented

- Electronic screenings sent in preferred language before appointments
-

- Staff outreach in patient's preferred language
-

- Increased appointment availability during postpartum period

Tracking Our Interventions



- Monthly reporting by language and screening completion rates



- Monitoring patient engagement and follow-through

Early Outcomes



- Increased screening completion before appointments



- Reduced no-show rates



- Stronger patient-clinic relationships



- Improved compliance and health outcomes

Thank You

Working together to close the screening gap

Continuing the Conversation: Culturally Responsive Follow-Up After Depression Screening

Kathryn Kane
Chief Operating Officer

About DOD

- 9 Hybrid Urgent Care/Primary Care Clinics on the Monterey Peninsula
- Population of Focus: Adults Preventative Needs
- Approximately 20,000 assigned lives



Disparities in Care Access

- Spanish-speaking patients have lower follow-up rates after a positive depression screen (43%) compared to English-speaking patients (58%).
- Structural Barriers: language, cultural stigma, access and visit wait times

Prior vs. Current State

- Built a new EMR work queue for positive depression screens
- Identified dedicated staff to conduct follow up calls
- Standardized outreach calls for patients with positive screens
- Centralized follow-up tracking and accountability
- Connect with CBOs to assist with close the loop referrals

Understanding the Root Causes of the Disparity

- Cultural stigma around mental health treatment
- Concerns about family perception and community judgment
- Scheduling hesitancy due to walk-in–based workflows
- Fear related to ICE activity impacting in-person visits
- Limited understanding of the importance of follow-up care

Improving Access Through Telemedicine

- Identified scheduling and wait-time barriers for in-person visits
- Transitioned follow-up visits to telemedicine when appropriate
- Leveraged telemedicine providers for timely behavioral health follow-up
- Reduced patient friction and increased visit acceptance

Headwinds and Tailwinds

- Headwind:
 - Visit tracking for follow up visits outside of DOD
- Tailwinds:
 - Increased acceptance of telemedicine follow-up visits
 - Improved engagement during follow-up calls
 - Greater staff awareness of cultural and access barriers
 - More consistent follow-up processes across clinics

Goal: <5% difference between Spanish- and English-speaking patients follow up rates



EPT Disparity Reduction: High Blood Pressure Control

Population of Focus:
Hispanic/Latino Patients

Stallant Health and Wellness



Population of Focus



**Hispanic/Latino adult
patients with diagnosed
hypertension**



- Focused on patients with inconsistent blood pressure control and follow up



Why this group?

Identified through EPT reporting and internal quality data



How patients were identified

Reviewed Hispanic patients with hypertension from October-January

We Tracked:



- Most recent BP reading
- Appointment status
- Follow up scheduling
- Language needs





What we heard from patients



Rushed Visits

Some patients felt visits moved too quickly, limiting time for questions.



Clear Instructions & Materials

Patients valued clear instructions and written materials they could reference at home.



More Time, Better Understanding

Others reported better understanding when providers spent additional time.



Interventions performed



Outreach to patients without appointments



Scheduled in clinic visits



Provided BP education



Reinforced medication adherence



Documented education handouts in visits notes



Coordinated follow up timing



Why these interventions?

We prioritized high-impact, low effort changes



Spanish language
blood pressure
education handouts



Use of **tickler
system** to track
hypertension
follow ups



Brief
reinforcement
of **BP goals**
during visits



**Clear
documentation**
of education
provided

What are the wins and what else can we do to improve



Wins

December we had 13 patients with high BP, January that number came down to 9.



Education & Adherence

The patients are getting paper handouts that explain hypertension. Reinforced medication adherence.



Improvement Area

December-January there are the same 10 patients that don't have any upcoming appointments.



Leadership support

After reviewing our focus outreach approach for Hispanic patients with uncontrolled BP, Stallant leadership requested that all hypertension patients be monitored consistently.



Kedren Community Health Clinic

DHCS Pop HLC LA CARE Equity & Practice Transformation Disparity Reduction

by:
Eduardo Alonso
Marti Deacon
Dr. Jerry P. Abraham

PopHealthLC
02.09.2026

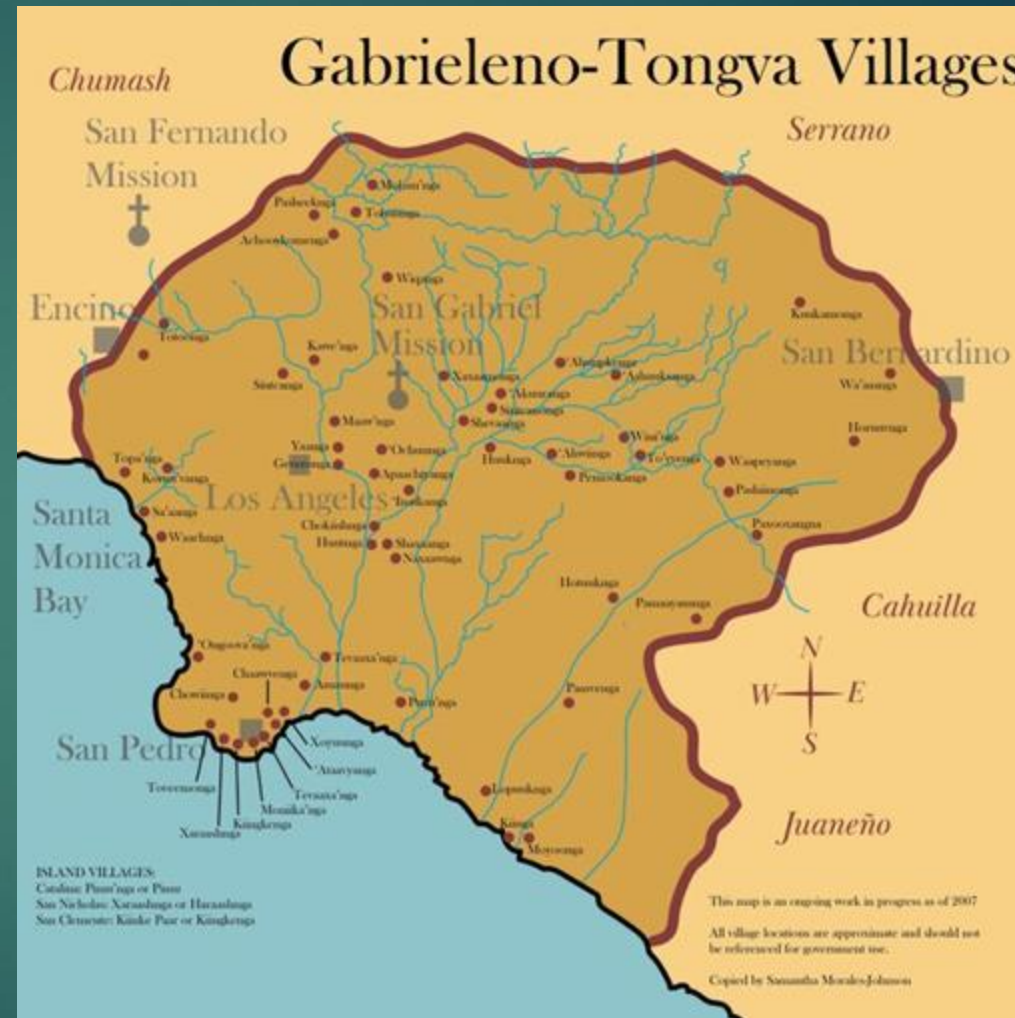


Land & Labor Acknowledgement

We at Kedren & CDU recognize the Gabrieliño Tongva, Chumash, and others as the original and eternal owners of the land that is currently known as Los Angeles. We honor and respect them and their ancestors as the native inhabitants of this region and we are committed to working together to overcome the injustices that are still being experienced today.

We acknowledge the extraction of brilliance, energy and life for labor forced upon people of African descent for more than 400 years. We celebrate the resilience and strength that Indigenous people and descendants of Africa have shown in this country and worldwide. We carry our ancestors in us.

We are committed to working together to overcome the injustices that are still being experienced today, including the harms of racism and human slavery.





Acknowledging Gender Identity



“Trigger Warning”

The following contains information and content that may be viewed as triggering content addressing race-based harms, intergenerational trauma, oppressive historical events, which may be disturbing or re-traumatizing for some. Discretion is strongly advised. This is not political or biased ideology, but only information relevant for healthcare professionals.

Kedren: A FQHC & Psych Hospital Prioritizing Black & Latino Health

► Kedren is a FQHC located in South Los Angeles. We have pushed to expand healthcare access to those within underserved populations in a way that always provides conscious, ethical, transparent, and passionate service. Since December 2020, we have provided a safe and approachable space for patients to not only be vaccinated but also obtain accurate and reliable information on COVID-19. One of the first FQHCs to sign HHS Health Sector Pledge. A model for providing care across the health continuum: primary care, mental health, public health & SUD.



Meet The Team

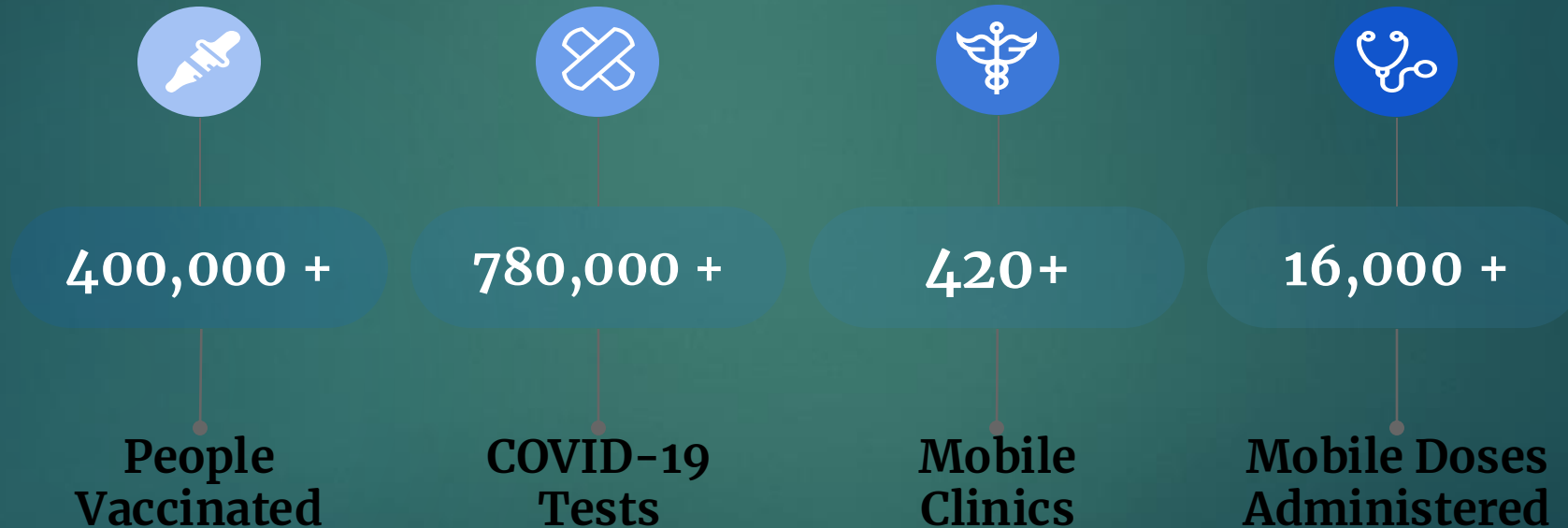
► We at Kedren have dedicated ourselves to revolutionising the healthcare experience by providing value-based care that puts PEOPLE & COMMUNITIES FIRST. We make sure to always put patients at the heart of the care that they are receiving and we are delivering.



Who We Are:

CDU-KEDREN Mobile Street Medicine

Since December 2020 we have delivered mobile street medicine to several communities throughout South Los Angeles, in that time we have...



How We Got Here

- ▶ We were provided the chance to serve as a test kitchen for new technologies, strategies that were created to help fight COVID-19 such as:
 - ▶ LAC DPH Vaccine Equity Committee
 - ▶ CDPH PrepMod, MyTurn, MyCAVax v 0.0
- ▶ Being able to explore and experiment more freely than traditional clinics allowed us to create a model of vaccine delivery that disrupted existing paradigms and created new service lines



Removing Barriers to Care

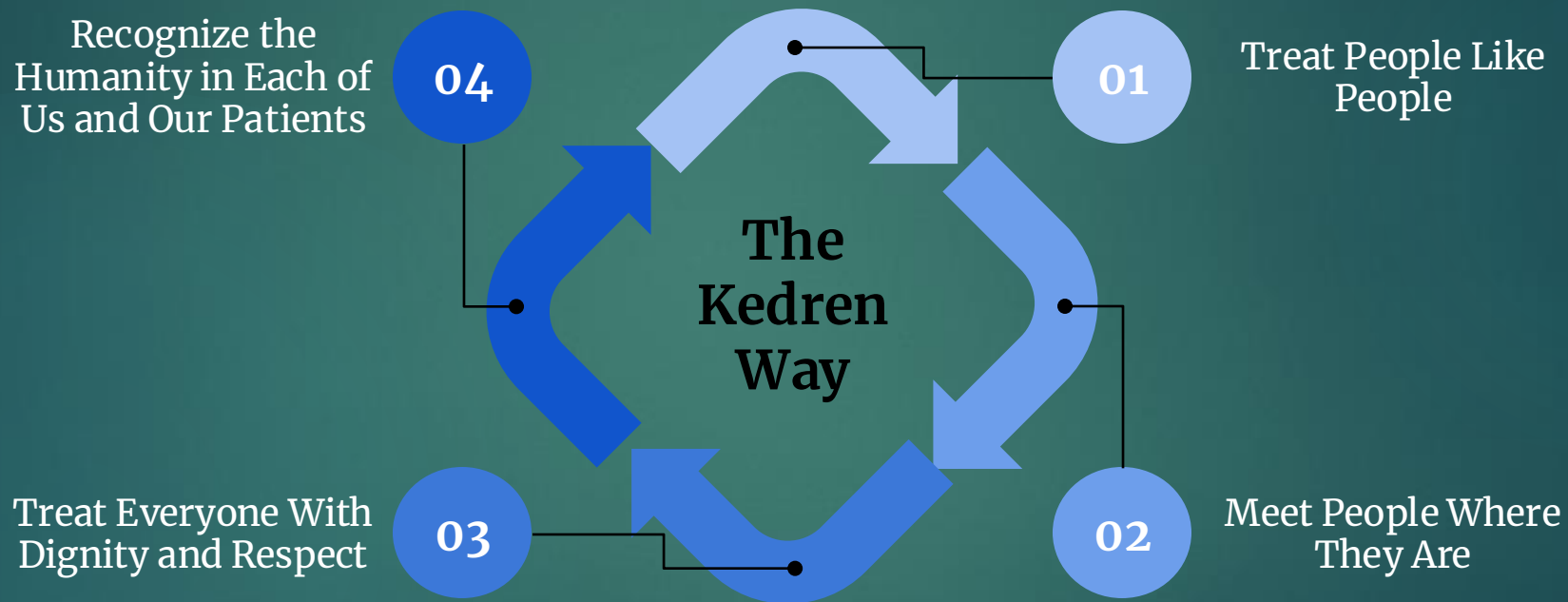
► To truly increase accessibility for all people, every element of the healthcare delivery process had to be considered, such as:

- No Appointments
- Transportation, housing, food issues
- Language barriers
- Barriers for those with disabilities
- Legal documentation status
- Childcare and elder care, PTO

► Ensuring equity for all meant using our creativity to identify groups that are often never considered



What We Believe



Using these values, we create a culture for ourselves and those around us to
ENGAGE, EDUCATE, VACCINATE, and ACTIVATE!

Our Team



Meeting People Where They Are – Democratization & Ubiquitization

We reduce the accessibility burden by bringing primary care, mental health, and public health services directly to where people ...

Live

Spaces meant to promote wellness, security, and health

Work

Business offices and places with high amounts of administrative staff or field workers

Worship

Faith-based spaces such as churches, mosques, temples, and other non-denominational places of prayer



Play

Community centers and special events such as fairs, events, and festivals

Go to School

Local private and public schools within IUSD and LAUSD

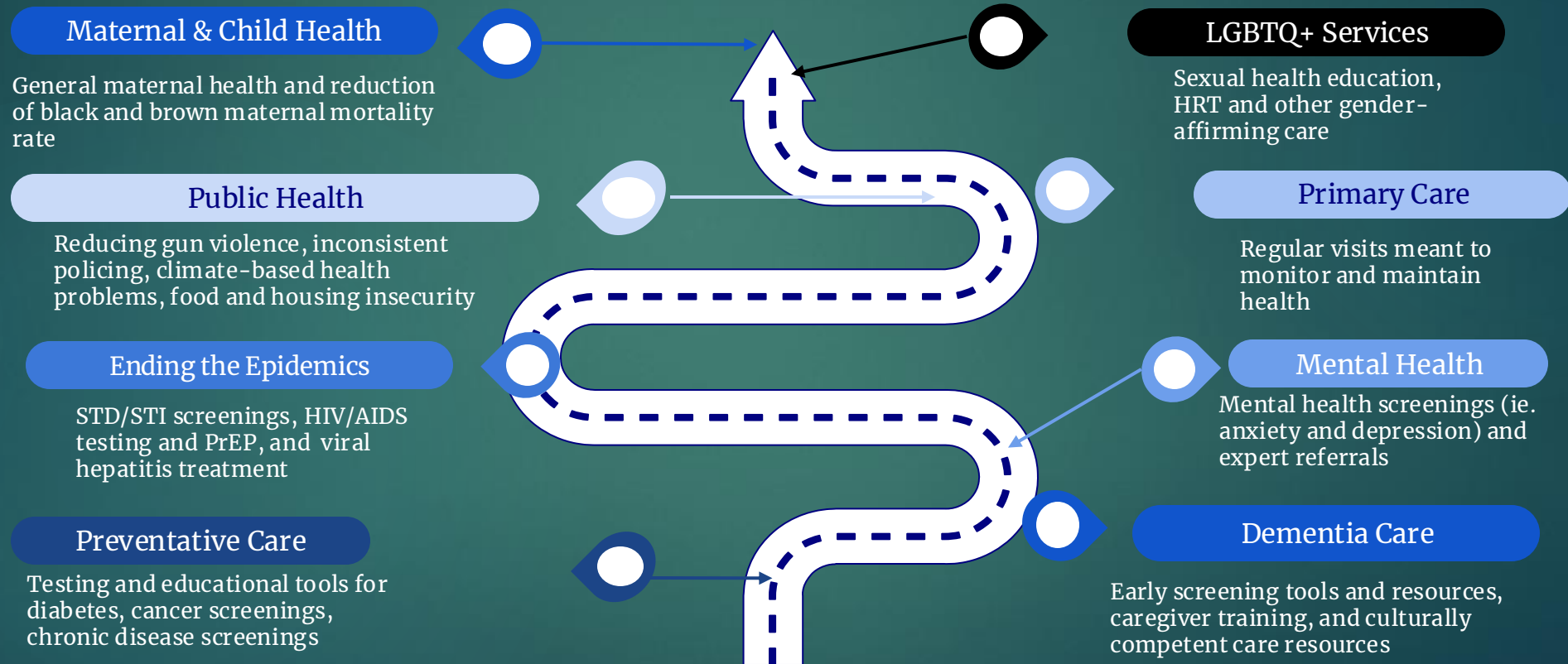
Homebound

Specialized appointments to the neighborhoods of people who cannot leave their homes due to various limitations or disabilities

Our Team



Beyond COVID-19 Expanding Mobile Street Medicine





Intro: An introduction to dementia in LA and barriers to care

EPT Disparity Reduction Plan – Why This Matters

Behavioral Health Equity Performance Target (EPT)

```
graph TD; A[Behavioral Health Equity Performance Target (EPT)] --> B[Metric: Pharmacotherapy for Opioid Use Disorder (MAT)]; B --> C[Focus on reducing continuity and access gaps]; C --> D[Priority population: patients with unstable housing and highly transitory.];
```

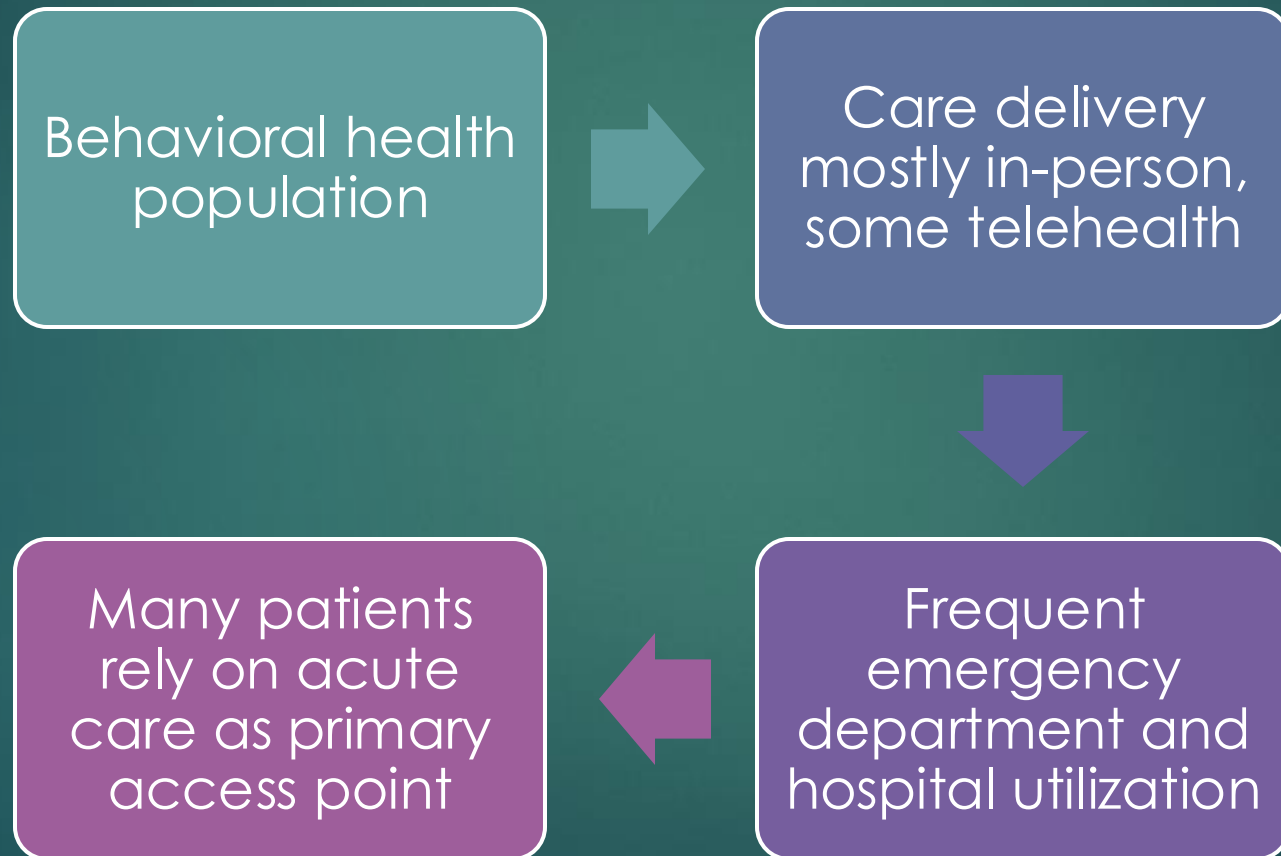
The diagram is a vertical flowchart with four orange rectangular boxes connected by downward-pointing arrows. The boxes are arranged in a descending staircase pattern from top-left to bottom-right. The first box is the darkest orange, and the subsequent boxes become progressively lighter shades of orange and yellow.

Metric: Pharmacotherapy for Opioid Use Disorder (MAT)

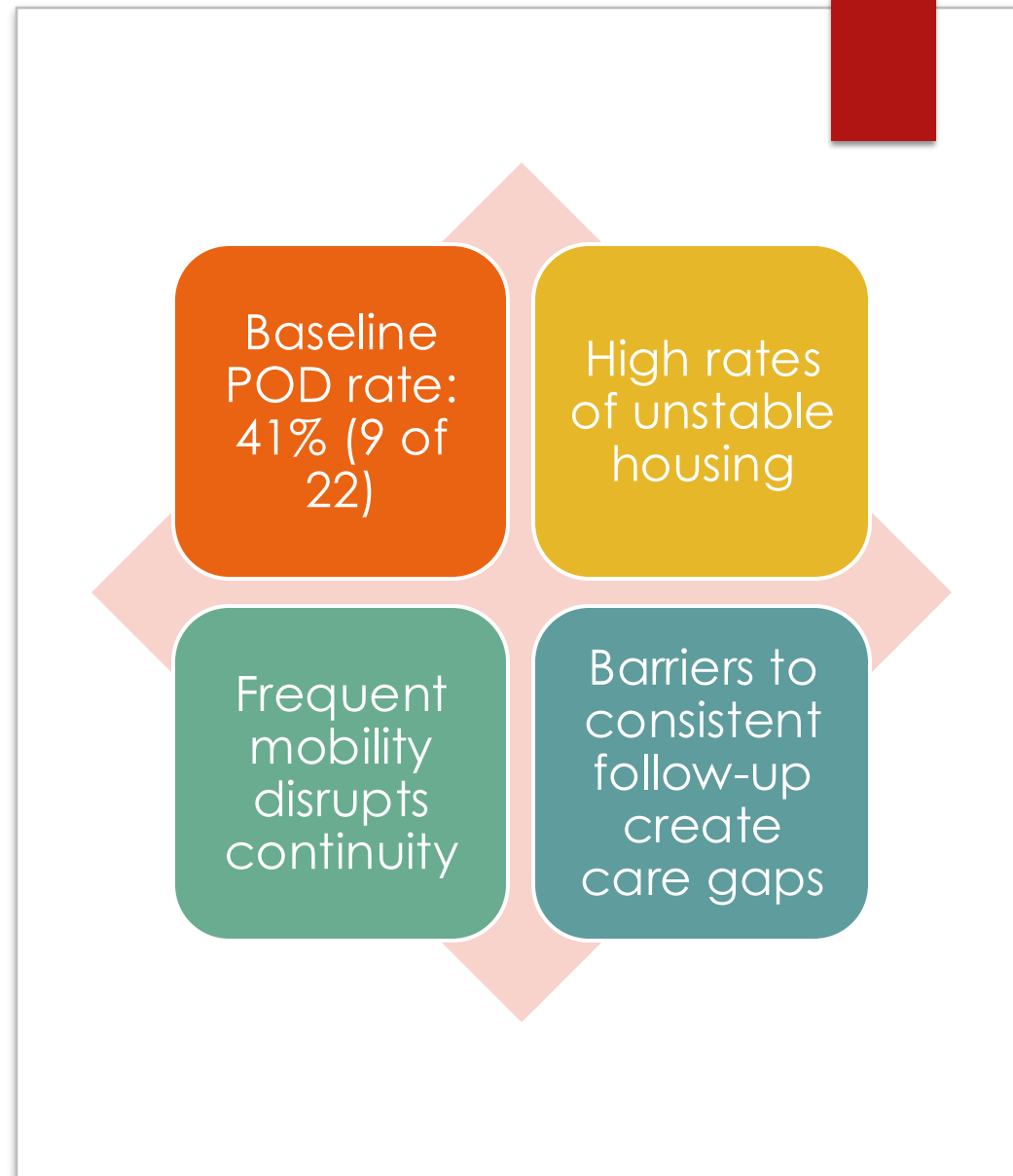
Focus on reducing continuity and access gaps

Priority population: patients with unstable housing and highly transitory.

Population of Focus



Baseline Disparity



Aim Statement

01

Increase POD
rate from 41% to
≥50%

02

Strengthen
outreach and
patient
navigation

03

Expand field-
based follow-up

04

Implementation
period:
Calendar Year
2025

Barrier Assessment



SOCIAL BARRIERS:
HOUSING, FOOD,
TRANSPORTATION,
FINANCES



PATIENT DISTRUST AND
ENGAGEMENT
CHALLENGES



TRANSPORTATION
LIMITATIONS



REFERRAL SCHEDULING
REQUIRES WARM HAND-
OFFS

Root Causes of Disparity



Stakeholder Input

- ▶ Staff interviews identified outreach strain
- ▶ Need for improved coordination and follow-up
- ▶ Patient interviews highlighted relocation and phone access issues
- ▶ Survival needs frequently take priority over appointments



Intervention Strategy



Consistent outreach across encampments and shelters



Case management and patient navigation



Backup staff coverage for continuity



Trauma-informed, flexible field-based care



Standardized documentation and care coordination

Key Workflow Changes

- ▶ Shared field tracker for outreach and follow-up
- ▶ Scheduled check-ins and backup assignments
- ▶ Warm hand-offs for high-risk patients
- ▶ Weekly huddles to confirm continuity actions



Measurement Plan

- ▶ Process: outreach attempts, documented follow-ups
- ▶ Process: appointment coordination notes
- ▶ Outcomes: kept appointments and MAT continuation
- ▶ Outcomes: psych follow-ups and primary care linkage
- ▶ Weekly reviews and monthly trend analysis



Targets and Definition of Success



90% of street-based patients have documented outreach



$\geq 30\%$ increase in follow-ups and MAT retention

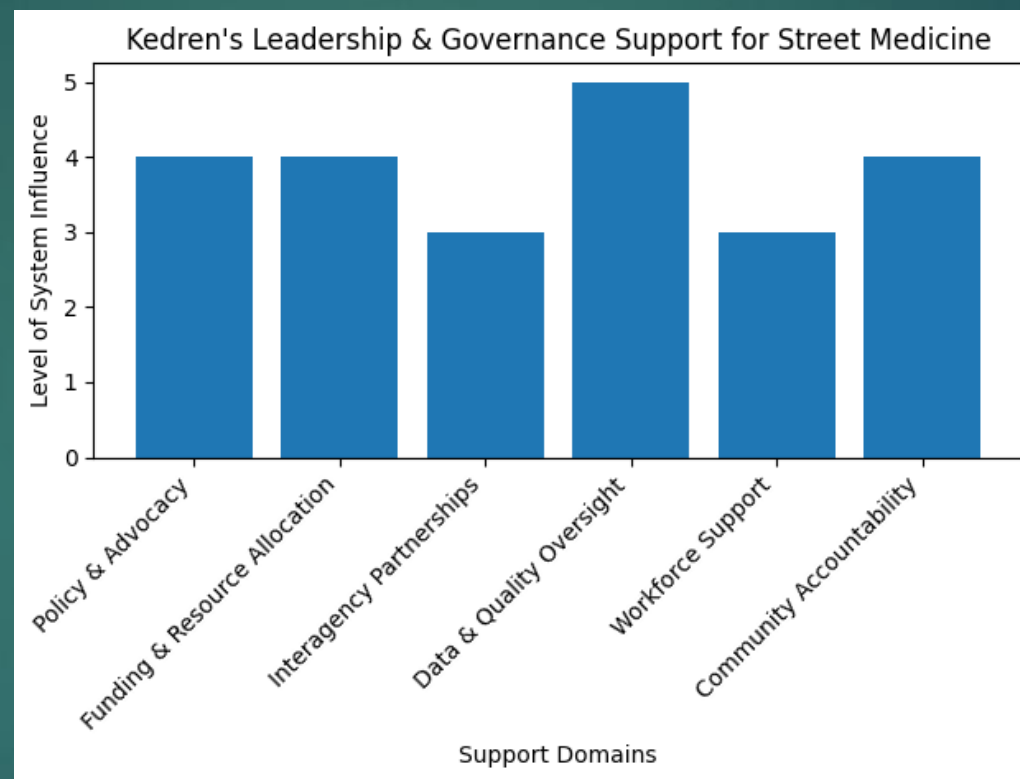


Improved behavioral health engagement



Equity gap vs clinic average reduced to $< 2\%$

Leadership and Governance Street Medicine



Higher numbers indicate domains where governance plays a more active, structured, and sustained role in enabling street medicine success.

PDSA Learnings and Next Steps



Structured communication improves continuity



Shared documentation reduces missed contacts



Mobility and phone access remain challenges



Next steps: strengthen backup coverage



Simplify documentation and proactive scheduling

Take A Deep Breath

Almost to the finish line,
take a moment to breathe
and process.



We Are In This Together

Remember, you are not alone.

Whether you feel moral injury, burnout, exploitation, ...

We are all in this profession to make the world a healthier, better place. It is up to us to support each other in making that shared dream a reality.





Ubuntu: You're a person, because I am a person,
I am a person because you are a person.

We are all people together.

Zulu/Xhosa/Bantu Proverb

Thank You!

Questions?

Contact Us

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Kedren Community Health Center

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KedrenHealth

Small Harvest



Breakout Instructions

There are 6 breakout groups led by a designated facilitator

Prompts:

- 1 Round robin introductions + which bright spot resonated most and why
- 2 What ideas are you taking away to test/try?
- 3 What updates can you share about your disparity reduction plan?

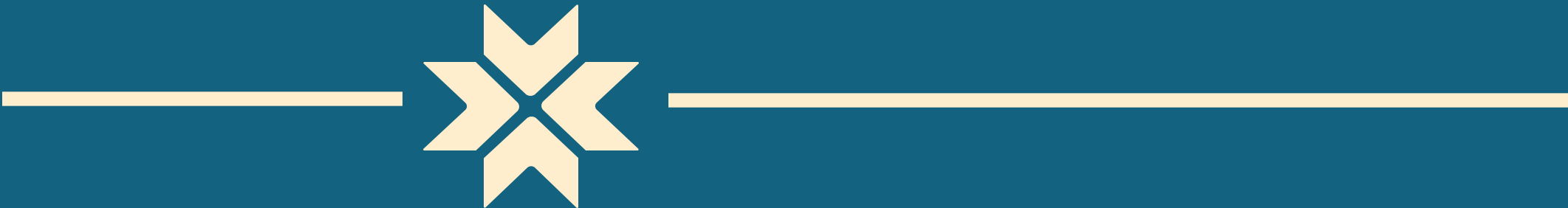
You should be automatically assigned to a breakout group. If not, please stay in the main room and we will assign you.

Small Harvest

Prompts:

- 1 Round robin introductions + which bright spot resonated most and why
- 2 What ideas are you taking away to test/try?
- 3 What updates can you share about your disparity reduction plan?

Large Harvest



Share Out

- Share themes, reflections, actions from today's breakout groups



Closeout + Day 2 Preview



Part 1 Evaluation

- We want to hear from you!
- <https://form.jotform.com/260358158211150>
- Please check Part 1 – February 10 as the date

Summary of Day 1, February Learning Community



Describe how a disparity reduction plan is connected to expanded care team roles, outreach, pre-visit planning, implementing clinical guidelines, and KPI improvement.



Identify at least two strategies used by peer practices to address disparities through models of care or workflow changes.

Key Objectives for Day 2, February Learning Community

By the end of tomorrow's Learning Community, you will be able to:

- **Explain why California is shifting toward value-based payment (VBP)**, and what this means for independent practices and community health centers.
- **Describe the difference between VBP and value-based care (VBC)**, and how they work together in practice.
- **Recognize the predominant VBP models used in California** and how they fit along a continuum from fee-for-service to population-based payment.
- **Identify core capabilities that support success in VBP**, such as attribution, data use, quality and equity stratification, team-based care, and financial literacy, and how these capabilities build on work many practices are doing through EPT.
- **Understand how your EPT work connects to VBP readiness**, including how existing milestones and activities align with core capabilities.
- **Understand the purpose of the VBP Capacity Assessment and what comes next in EPT**, so you know how today's content fits into the broader program and upcoming support.

Thank You!





February Learning Communities Part 2

Welcome to Value-Based Payment (VBP) 101: An Orientation for EPT Practices

Population Health Learning Center
California Medical Association
California Primary Care Association



**PHYSICIAN SERVICES
ORGANIZATION**



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



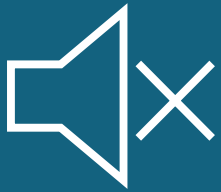
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Click OK

**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



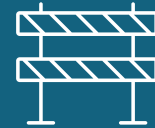
Questions

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
- What are you looking forward to about today's session?

Learning Community Part 2 Presenters and Facilitators



Rachel Proud, MPH

Associate Director of
Practice Transformation
Services, California Medical
Association



Jess Clark, LVN

Associate Director of
Business Intelligence,
California Medical
Association



Melissa Marshall, MD

Chief Medical Officer,
California Primary Care
Association



Allie Budenz

Vice President of Health
Center Optimization and
Legal Affairs, California
Primary Care Association

What You'll Walk Away With Today

By the end of today's Learning Community, you will be able to:

- **Explain why California is shifting toward value-based payment (VBP)**, and what this means for independent practices and community health centers.
- **Describe the difference between VBP and value-based care (VBC)**, and how they work together in practice.
- **Recognize the predominant VBP models used in California** and how they fit along a continuum from fee-for-service to population-based payment.
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- **Understand how your EPT work connects to VBP readiness**, including how existing milestones and activities align with core capabilities.
- **Understand the purpose of the VBP Capacity Assessment and what comes next in EPT**, so you know how today's content fits into the broader program and upcoming support.

Let's take a poll

Which of these best describes how you think about VBP? Select all that apply

- We've heard the term but aren't totally sure what it means
- Paying based on quality or outcomes, not just visits
- Quality bonuses layered on top of FFS payments
- Sharing in savings or being accountable for cost and quality for a population
- FQHC APMs are a form of VBP
- We participate in an ACO



Defining Value Based Payment

Definitions: VBP vs. VBC

VALUE-BASED PAYMENT (VBP)

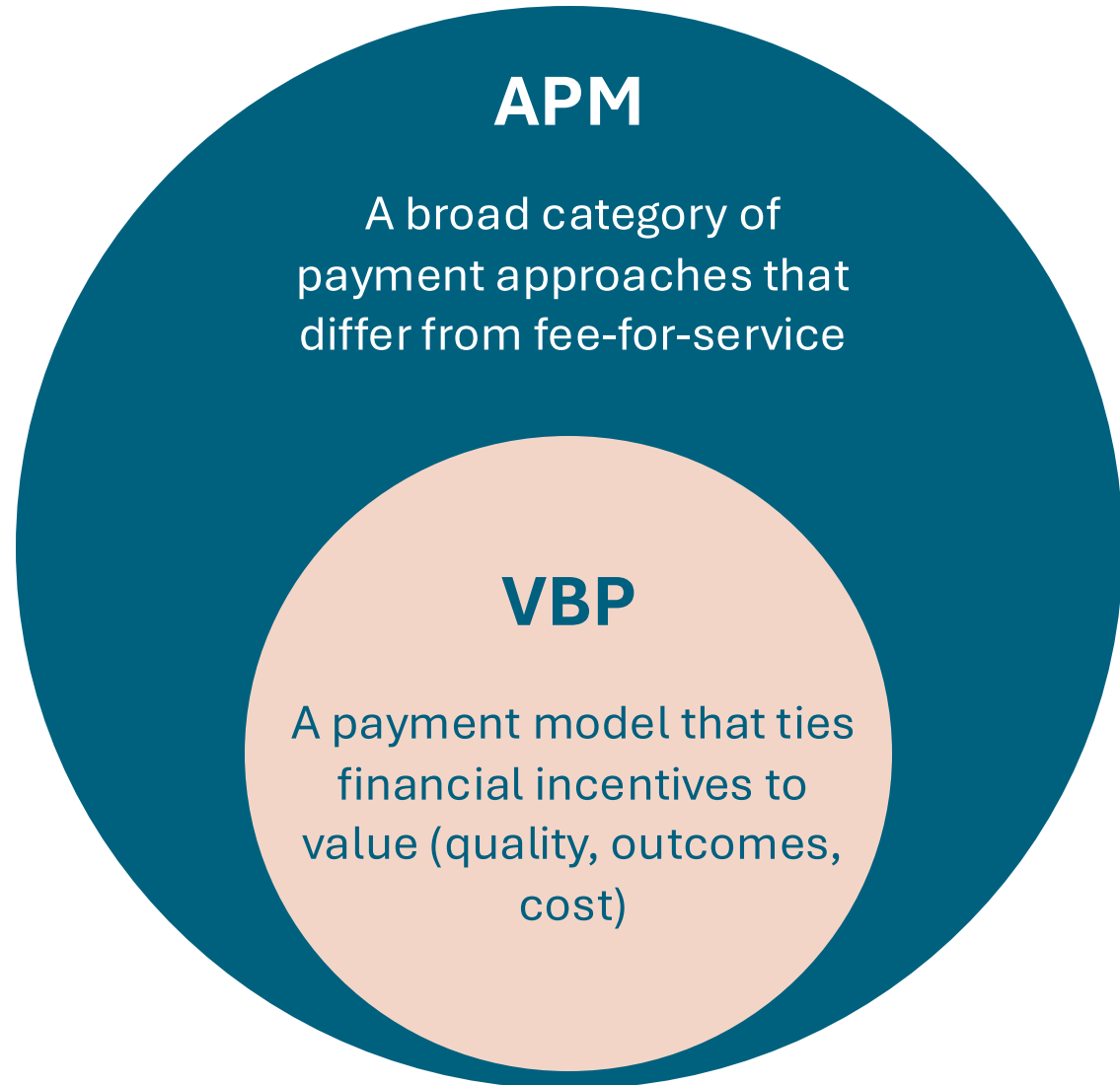
- How care is **financed**
- Financially rewards providers for:
 - Cost efficiency
 - Quality outcomes
 - Patient experience
- Key features:
 - Financial model
 - Payment tied to performance
 - May involve shared savings or risk
 - Patient attribution to a practice

VALUE-BASED CARE (VBC)

- How care is **delivered**
- Focuses on process/practice improvements that result in:
 - Better health outcomes
 - High-quality care
 - Patient experience
- Key features:
 - Care model
 - Team-based, coordinated
 - Emphasis on prevention, population health

Definition: APM vs. VBP

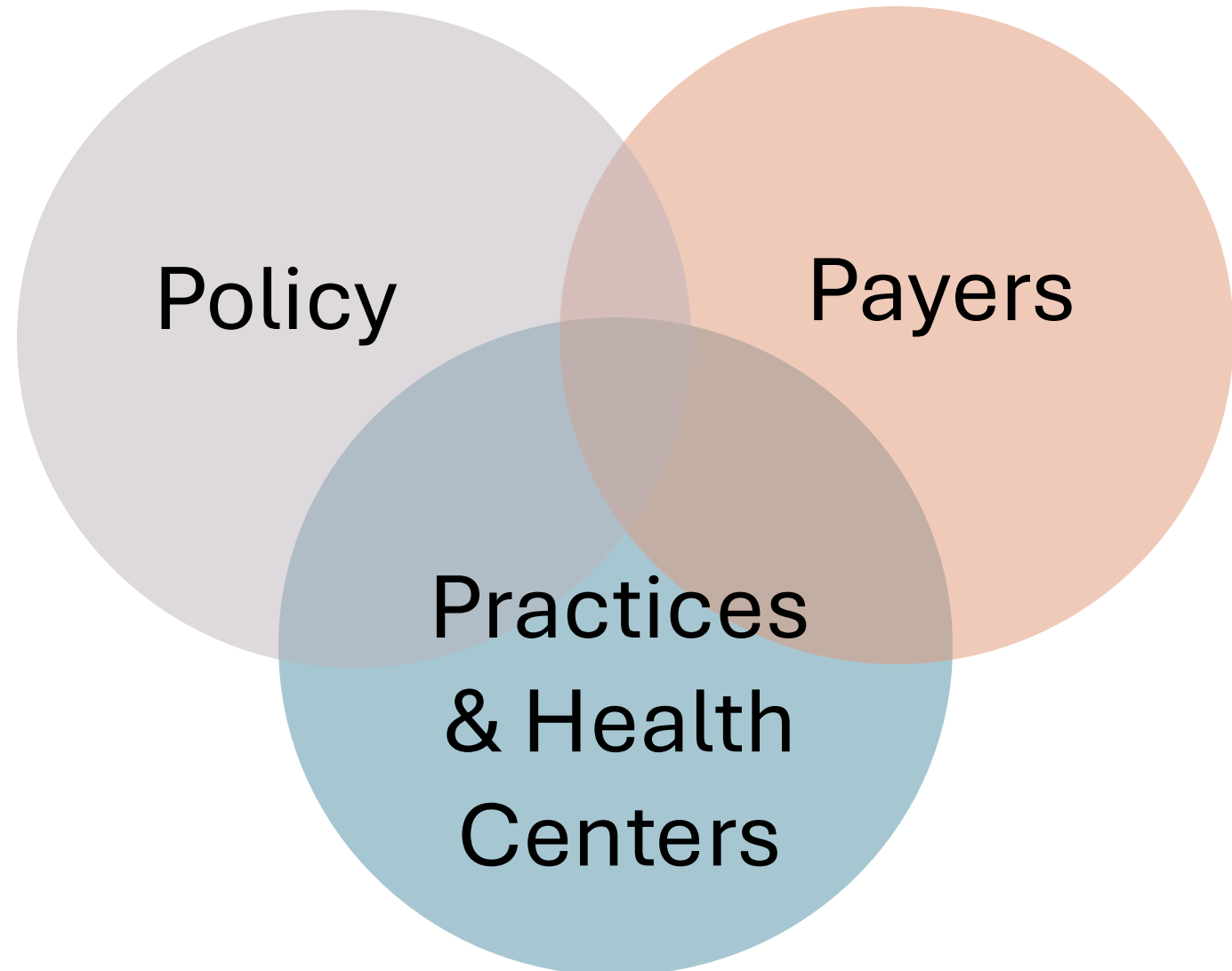
- ▶ **All VBP models are alternative payment models (APMs)**
- ▶ **Not all APMs = VBP**



Why California Is Shifting Toward VBP

Why VBP is Accelerating in California

- ▶ **Why** is VBP becoming the dominant way primary care is being paid in California?
- ▶ **Why** does that matter to your organization right now?



OHCA Standards: Why This Matters in California

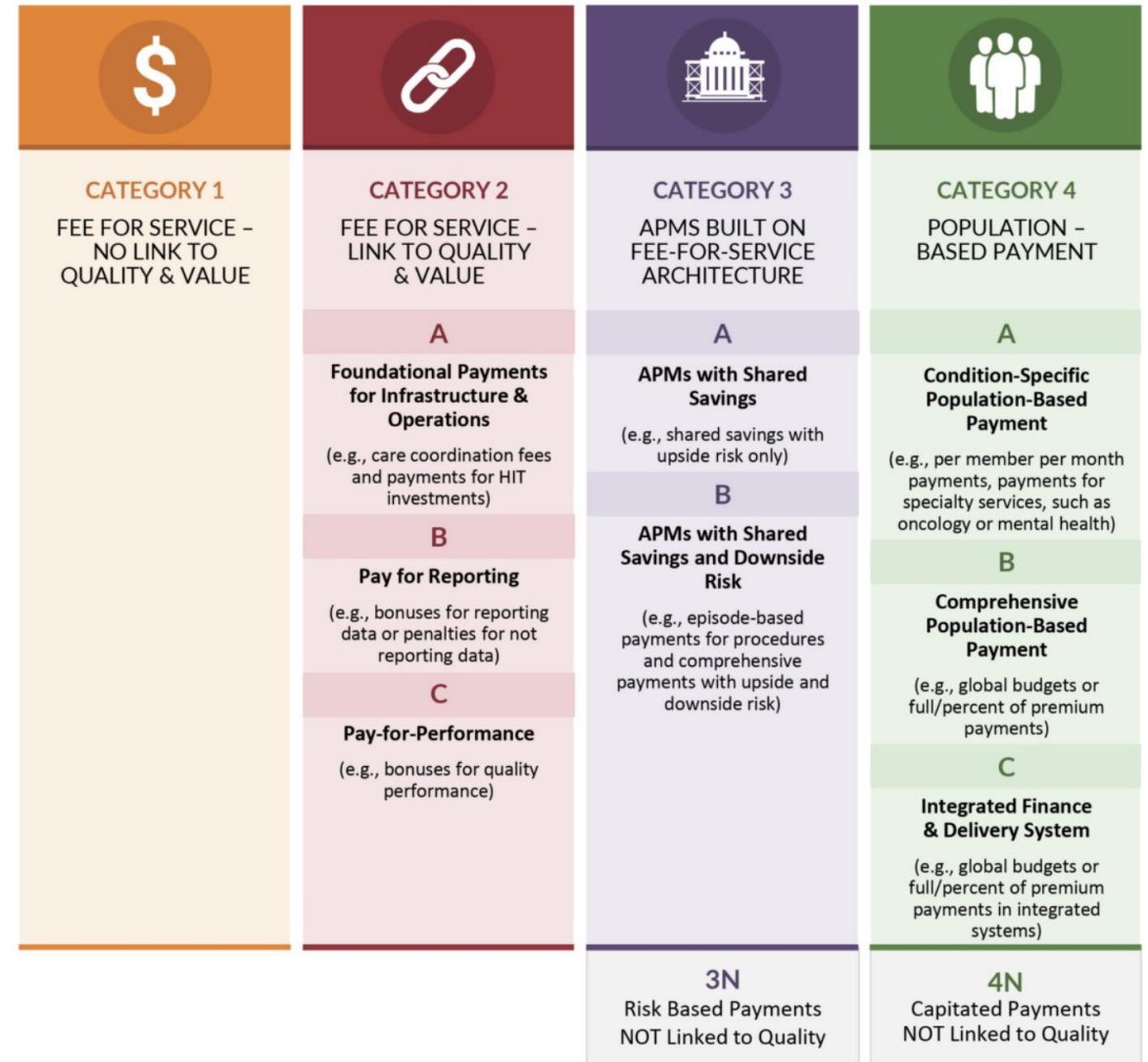
Who: The Office of Health Care Affordability (OHCA) sets statewide targets to improve affordability, quality, and equity across California's health care system.

What is OHCA focusing on?

- Increasing investment in primary care
- Expanding the use of value-based payment models across payers
- Support long term affordability by slowing the cost trend

Why it matters: These standards (DHCS + OHCA) influence how payers design contracts and incentives.

Health Care Payment Learning and Action Network (HCPLAN): APM Framework



OHCA Targets: How California is Increasing Investment in Primary Care

VBP Adoption Targets →

California is using VBP as a lever to increase and stabilize investment in primary care, bend the cost trend, and strengthen accountability for outcomes and equity.

Medi-Cal: Percent of Members Attributed to HCP-LAN Categories 3 and 4:

- 2026: 55%
- 2028: 60%
- 2030: 65%
- 2032: 70%
- 2034: 75%

Primary Care Investment Targets →

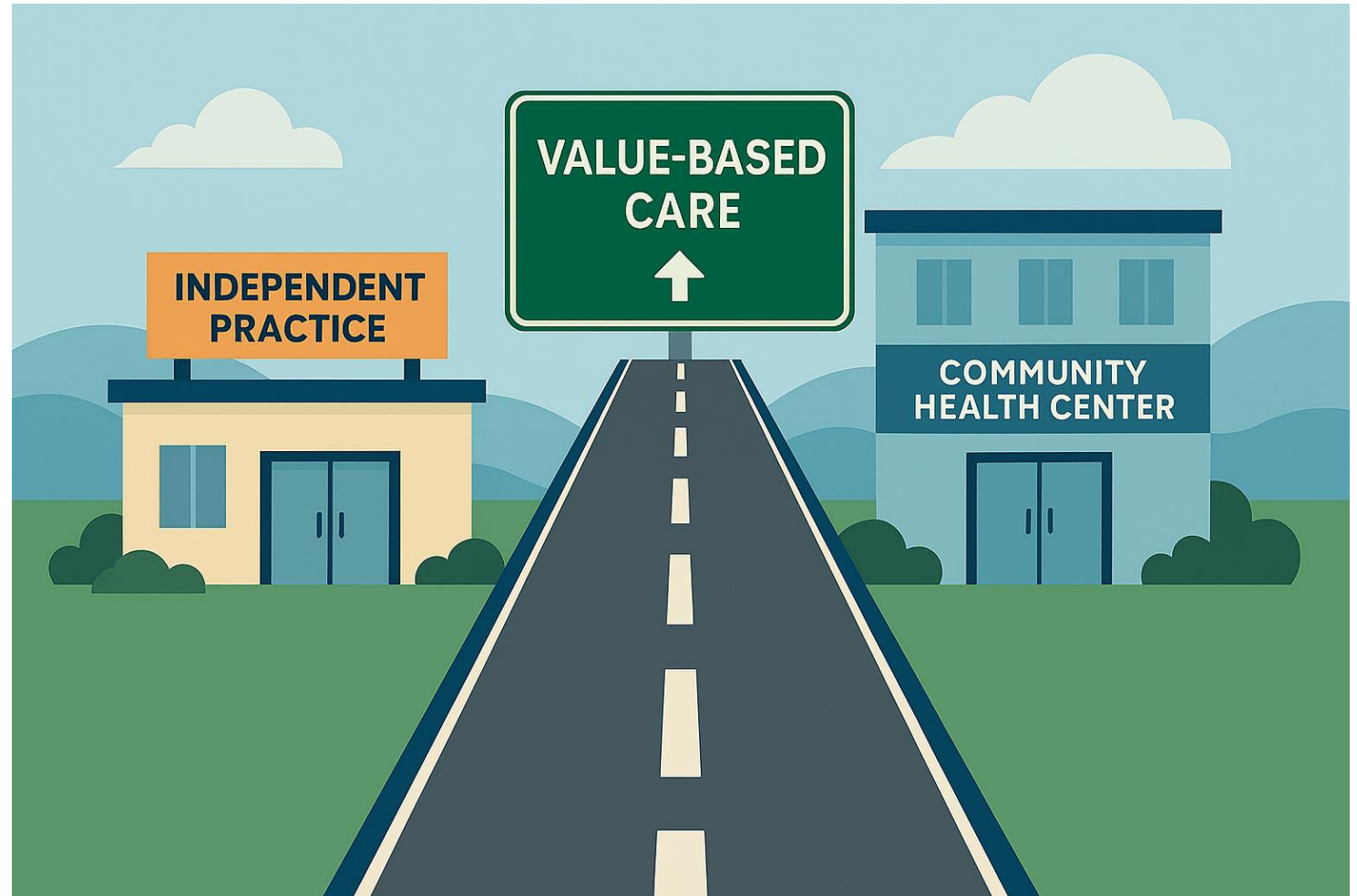
- **Annual improvement benchmark:** 0.5 – 1 percentage point increase in primary care spending as a percent of total medical expense for each payer for performance years 2025-2033.
- **Statewide investment benchmark:** 15% of total medical expense allocated to primary care for all payers by performance year 2034.

How VBP Can Support Primary Care Practices

- VBP presents opportunity to **increase revenue** when health care spend is flat or decreasing and practices must do more with the same or less.
- VBP models enable high value care. Flexible payment enables practices to put the patient at the center of care, gain efficiencies in care delivery, and focus on outcomes. **(Able to do what works)**
- VBP in a multi-payer environment can reduce administrative overhead, redundancies, and the busy work that overwhelms the health care workforce and kills joy in work. **(Increase efficiency, retain workforce)**
- VBP models can offer **consistent, reliable payment**

Different Starting Points, Shared Direction

- Independent practices and community health centers (CHCs) operate under different payment structures *but* are asked to build many of the same core capabilities.
- For CHCs, this work occurs within the Prospective Payment System (PPS) and wraparound payments; this shapes how VBP models are designed and implemented.



Building Capacity for VBP

These benefits reflect capabilities that support VBP, while also strengthening the delivery of VBC

- Proactive outreach and registries reduce avoidable urgent care
- Fewer “surprise” gaps in chronic care

Care Delivery (VBC)



- Clearer team roles and workflows
- Less reactive work; more planned, team-based care
- Providers spend more time at top of license
- Improved practice experience

Operations & Workforce



- Better performance in quality and incentive programs
- More predictable incentive-related cash flow
- Stronger position in payer conversations over time

Financial & Strategic Positioning



Aligning VBP For CHCs

Structural Realities



CHCs deliver comprehensive, high-acuity care to priority populations, often under significant operational and reporting requirements

PPS provides a critical financial foundation but does not always support a full range of care coordination, outreach, and population health activities

CHCs manage complex accountability across multiple programs, including federal, state, and payer-specific expectations

Workforce and infrastructure investments are essential to sustain access, equity, and quality in a challenging operating environment

How VBP Can Support CHCs



- ▶ Additional resources that complement PPS to support infrastructure and services
- ▶ Alignment across quality, equity, and payment
- ▶ Flexible funding pathways that respect PPS/ APM structures
- ▶ Incremental participation options

HEALTH CENTER FINANCIAL SUSTAINABILITY: *the* **PYRAMID OF SUCCESS**

Layers of CHC Funding

Risk Arrangements & Infrastructure

1. Medicare and/or Medi-Cal ACOs, PACE, other Value-Based Care Models
2. RBOs (IPA/Clinically Integrated Networks)

Diversification

1. MCO Rate increases (TRI)
2. Maximizing health plan contracts (ECM, Covered CA, commercial, Medicare)
2. Directed Payments (340B, Prop 35 CHC Quality Incentive Program)

PPS Sustainability

1. Payment of "necessary and proper" and "reasonable" costs for covered benefits
2. Equitable and consistent scope change process
3. Clear and well-defined Medi-Cal policies
4. APMs

VBP Capabilities Can Support Sustainability for Independent Practices

Structural Realities



How VBP Can Support Practices



Patient demand remains strong, but revenue can be increasingly unpredictable due to visit-based payment and payer mix



Stable Revenue

Care and performance data are often fragmented across multiple payers, making it difficult to get timely, actionable insight at the practice level



Aligned Performance & Accountability

Clinical and administrative teams spend significant time on reactive care tasks (referrals, follow-ups, refills), limiting capacity for proactive population management



Proactive Population Health

Workforce shortages constrain flexibility, making it harder to expand team-based workflows under traditional fee-for-service structures



Increased Flexibility & Infrastructure Support

Practice Experience With VBP

Plazita Medical Clinic's VBP Experience

- **Practice type:** Independent practice
- **Location:** Santa Cruz County
- **Size:** Medium (5 provider FTEs)
- **EPT POF:** Adults with Chronic Conditions
- **Sponsor Medi-Cal Managed Care Plan:** Central California Alliance for Health (CAAH)
- **Types of VBP arrangements:**
 - Medi-Cal capitation and CCAH Care-Based Incentive program
 - Medicare ACO (Aledade)



Plazita's VBP Journey

Getting started

- VBP is a way to maintain financial health and stability.
- We started with our CCAH's Care-Based Incentive program and later joined an ACO.
- One of our physicians, Dr. D, helped get us started and became our clinic champion. We also had to gain staff buy-in, especially from our clinic owner and medical director.

Maintaining momentum and success

- Staff have regular training and coaching sessions to teach what's needed for success and explain why we're doing things differently. Work is distributed to create a sense of shared ownership and to reduce burden.
- We have regular meetings with our ACO representative to review progress and gaps. Our rep will do in-person training/coaching to help solidify understanding of measures/goals.
- Daily we use tools to help track progress and target efforts, including for gaps in care lists, performance data, and our huddle tool.

Plazita's VBP Journey

What are the benefits and value of VBP?

- Encourages us to practice good medicine. VBP is an incentive to support control of A1C, blood pressure, and other key measures. It helps us focus and educate patients to be proactive with their health.
- The incentives contribute to our financial wellness; capitation alone is not enough.

What lessons learned can you share with other EPT practices?

- Use available tools to track your progress.
- Incorporate data into daily clinic operations.
- Find your clinic champion(s).
- Engage your whole team, acknowledge growth and celebrate success.

What do different VBP models look like at Plazita?

	Capitation	Pay for Performance	Shared Savings
Overview	Flat rate per patient, per month, regardless of services rendered	Payment if quality measure benchmarks are reached	Performance-based incentives and shared savings
Line of Business	Medi-Cal Managed Care	Medi-Cal Managed Care	Primarily Medicare
Payer / ACO	Central California Alliance for Health (CCAH)	CCAH	Aledade
Sample Quality Measures	N/A	Preventive Screenings, Immunizations, Physical Exams, CBP, A1C, Depression	CACP referrals, AWWs, TCMs, TOC, CBP
Staff Roles & Tools	- Office manager provides oversight - All staff engaged - Supported by portals, reports, health information exchange	- CCAH provider portal used by front office, MAs, & administrators to track and guide progress toward meeting benchmarks. - CHW submits monthly data on depression screening.	- Aledade app used daily by all staff. - Medical director & office manager attend bi-monthly Board Meetings. - Office manager is our practice champion leading this work. - Office manager & CHW meet every other week with Aledade rep to review progress and identify strategies for improvement.
Payment Structure	PMPM	Monthly Care-Based Incentive program payments	Annual payment. Funding is based on the entire ACO group's (45 practices) performance and dispersed based on achievement.

VBP Implementation at CHCs

How is what we heard from Plazita different in a health center environment?

How does EPT build the capabilities health centers need to succeed in VBP contracts?

WHY SHASTA COMMUNITY HEALTH CENTER PURSUED VALUE-BASED PAYMENT

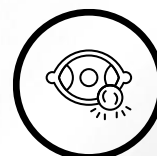
- Mission-driven interest in complementing PPS reimbursement with outcome-focused models
- PPS supports access, but does not fully support:
 - Proactive population health management
 - Longitudinal care coordination
 - Investment in prevention and quality infrastructure
- Entered a Medicare ACO partnership with Aledade
- Goal: improve patient outcomes while responsibly managing total cost of care



Shasta Community Health Center
a california^{health} center



HOW EPT WORK SUPPORTS OUTCOMES AND VALUE-BASED PAYMENT READINESS



EPT builds capacities that PPS alone does not fund:

- Population health infrastructure
- Data-driven quality improvement
- Team-based, equity-focused care



EPT supports:

- Closing care gaps and managing chronic conditions
- Improving patient experience and outcomes



EPT prepares practices to succeed under value-based contracts while advancing mission and vision



Major Types of VBP Models

Major VBP Models in the U.S.

Model	Pay-for-Performance (P4P)	Hybrid Models	Bundled Payments	Shared Savings (Upside-Only ACO)	Shared Savings + Shared Risk (Two-Sided ACO)	Primary Care Capitation/ PMPM	Professional or Global Capitation
How Payment Works	Bonuses or penalties based on quality performance	Combination of FFS, PMPM, and performance incentives	Single payment for all services in an episode	Providers keep a portion of savings if spending below benchmark	Providers share in savings and losses	Prospective per-member-per-month payment for population management	Fixed PMPM payment for professional services or facility + professional
Risk Level	Low 2C	Low – Moderate 2C-3A	Moderate 3A	Low 3A	Moderate 3B	Moderate 4A	High 4B/C



Increasing Financial Risk

In Medi-Cal, most primary care VBP focuses on capitation and performance incentives, with limited use of shared savings or downside risk.



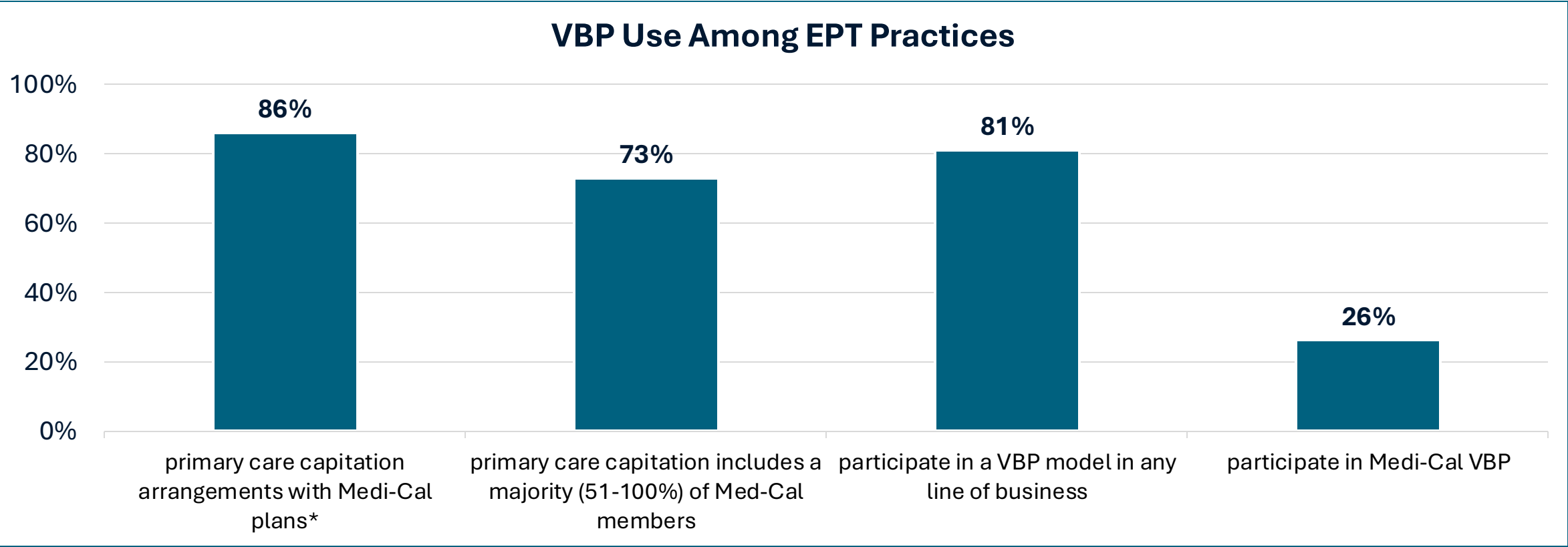
Organizations that participate successfully in more advanced VBP models typically rely on shared infrastructure, data support, and staged risk approaches.

CHC- and practice-led networks in other states show that VBP can generate reinvestment in primary care when models are designed with safety nets and equity in mind.

These experiences reinforce that building core capabilities is a prerequisite to effective VBP participation, regardless of model type.

EPT VBP Survey Results

In December 2025, 69 EPT practices described their current VBP use.

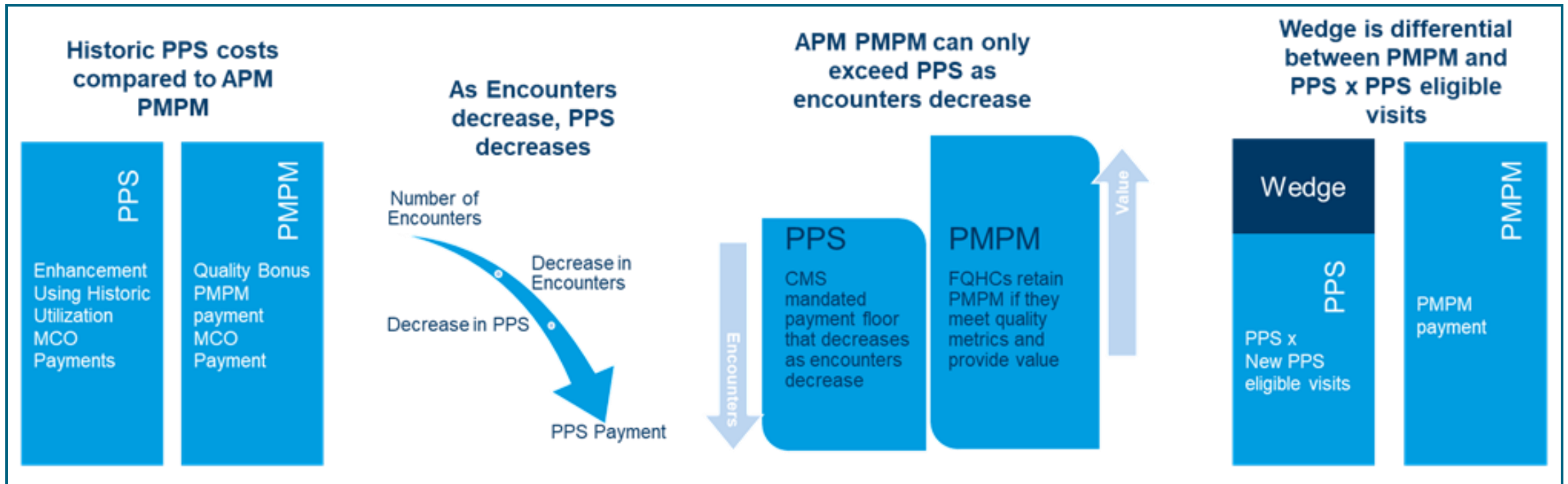


* Note: While MCPs may reimburse FQHCs/RHCs through capitated primary care contracts, this is considered an interim payment and visits are ultimately reconciled to PPS.

Example: California Capitated FQHC APM (methodology)

Methodology

- PPS converted into PMPM for all Medi-Cal Managed Care assigned patients
- Incentive to convert PPS-eligible visits to alternative touches (e.g., nurse or CHW visits)
- Clinics keep the differential (aka “wedge”) between PMPM and actual PPS x PPS eligible visits based on performance (assuming decrease); reconciled to actual PPS (assuming increase in PPS-eligible visits).
- Continued participation tied to access and quality outcomes



Note: CMS allows the “wedge” to be at risk

A Note About PPS and FQHC APM (methodologies)

- The Prospective Payment System (PPS) is the federally mandated reimbursement for FQHCs/RHCs.
- Federal Authority for authorizing:
 1. The health center must be paid at least as much under the APM as they would have been paid for qualifying PPS visits. The State must develop a process to demonstrate this to CMS; attestation is not sufficient.
 2. Voluntarily agreed to by the state and the health center.
 3. Codified in federal approval through a state plan amendment or waiver.

Examples

- California Capitated FQHC APM
- Same-day dyadic care visits
- Adverse Childhood Experience and Developmental Screening Supplemental Payments

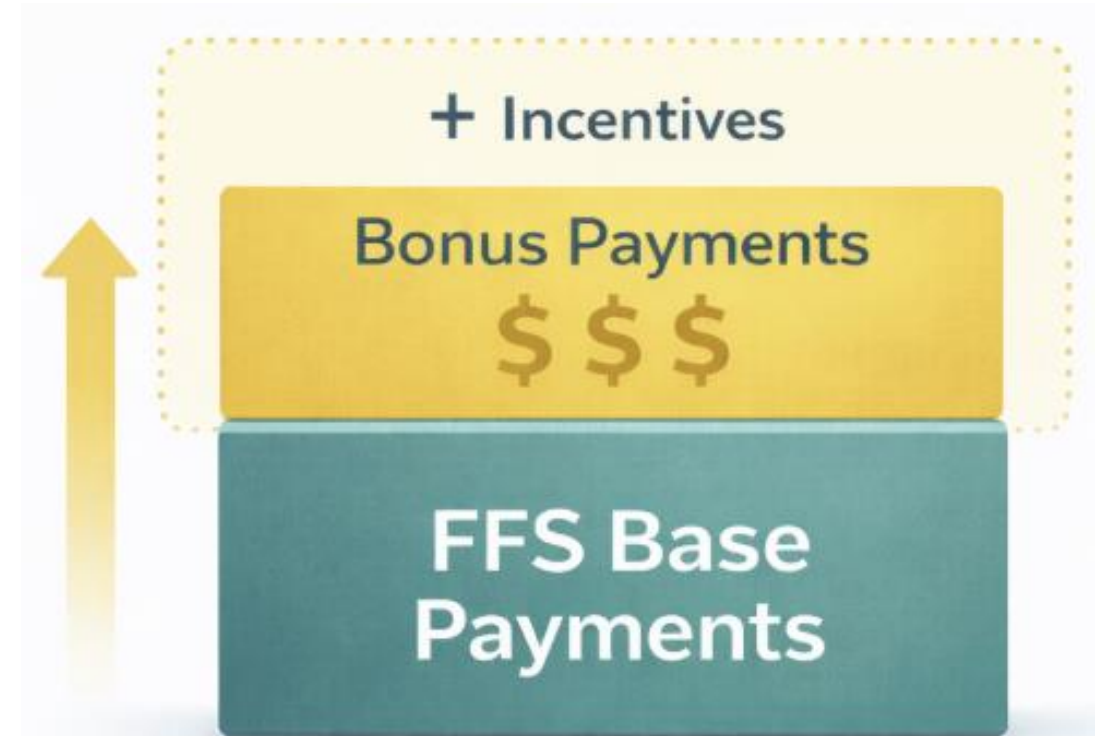
Category 2: Performance-Based Incentives (P4P)

Characteristics

- Underlying payment remains fee-for-service (e.g., PPS for FQHCs/RHCs or Medi-Cal FFS rates)
- Additional incentive payments tied to performance on selected quality or utilization measures
- No change to core payment methodology or financial risk

Examples

- HEDIS-based incentive programs
- Quality pools or bonus payments



For FQHCs/RHCs in Medi-Cal Managed Care, DHCS provides [specific guidance](#) on the structure of P4P payments to ensure alignment with PPS requirements.

Category 3: Shared Savings Models

Model Design

- Total cost of care is measured for a defined population
- Spending is compared to a benchmark (risk-adjusted)
- Quality gates determine whether savings can be earned

Two Common Structures (nationally)

- Shared savings: Upside-only (share in savings if targets are met)
- Shared savings: Upside + downside risk (share in savings and losses)

Category 4: Population-Based Payments

Characteristics

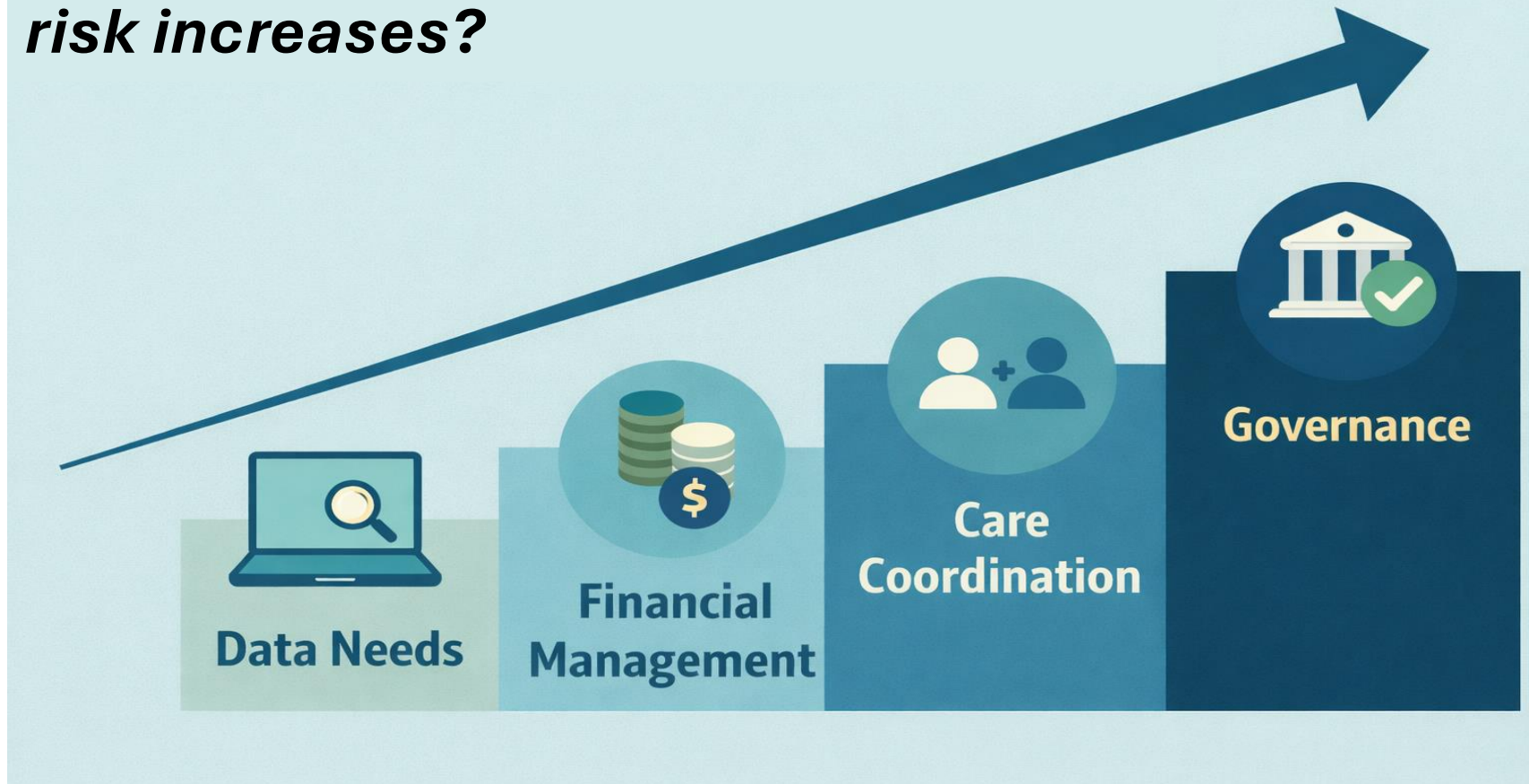
- Payments are tied to a defined population, not individual visits
- Typically paid as per-member per-month (PMPM)
- Greater flexibility in *how* care is delivered, paired with broader accountability for outcomes and cost

Examples

- Condition-based PMPMs (e.g., maternity, behavioral health, complex care)
- Comprehensive population payments (total primary care or global budgets)
- California example: FQHC Capitated APM (with PPS protections)

As Financial Risk Increases, Expectations Become More Formal & Integrated

What becomes more demanding as risk increases?



Share in chat



- ▶ What about the VBP models or practice examples felt most relevant or most different from how your practice operates today?

Time for a Break



Continuing Education Credit

Licensed Nursing Professionals

- This course meets the qualifications for **2.0 contact hours of continuing education credit** for nurses as required by the California Board of Registered Nursing, Provider #18090. The UCSF Center for Excellence in Primary Care is approved by the California Association of Marriage and Family Therapists (CAMFT) to sponsor continuing education for LMFTs, LCSWs, LPCCs, and/or LEPs. The UCSF Center for Excellence in Primary Care maintains responsibility for this program/course and its content.

Licensed Behavioral Health Providers

- This course meets the qualifications for **2.0 hours of continuing education credit** for LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences, Provider #1032866. Any activities within the program that do not have instructional time are not offered for continuing education credit. Course completion certificates will be awarded upon completion of course evaluations. *Documentation must be retained by the Participant for a period of four years after the conclusion of this program.*

Core Capabilities for VBP – And How We've Built Them Through EPT

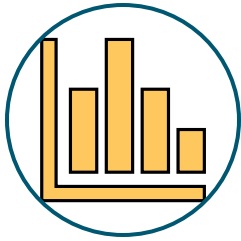
How EPT Work Builds Capabilities Needed for VBP

Many capabilities needed for VPB are the same activities practices are building through EPT



Milestones & assessments to support readiness and planning

- PhmCAT



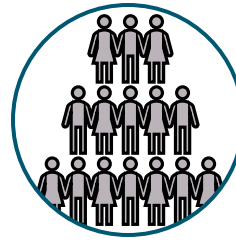
Data-informed quality improvement

- Data Implementation Plan & Progress Report
- Stratified HEDIS-like measures



Equity stratification & targeted improvement

- Disparity Reduction Plan
- Disparity Reduction KPI



Empanelment to manage your patient population

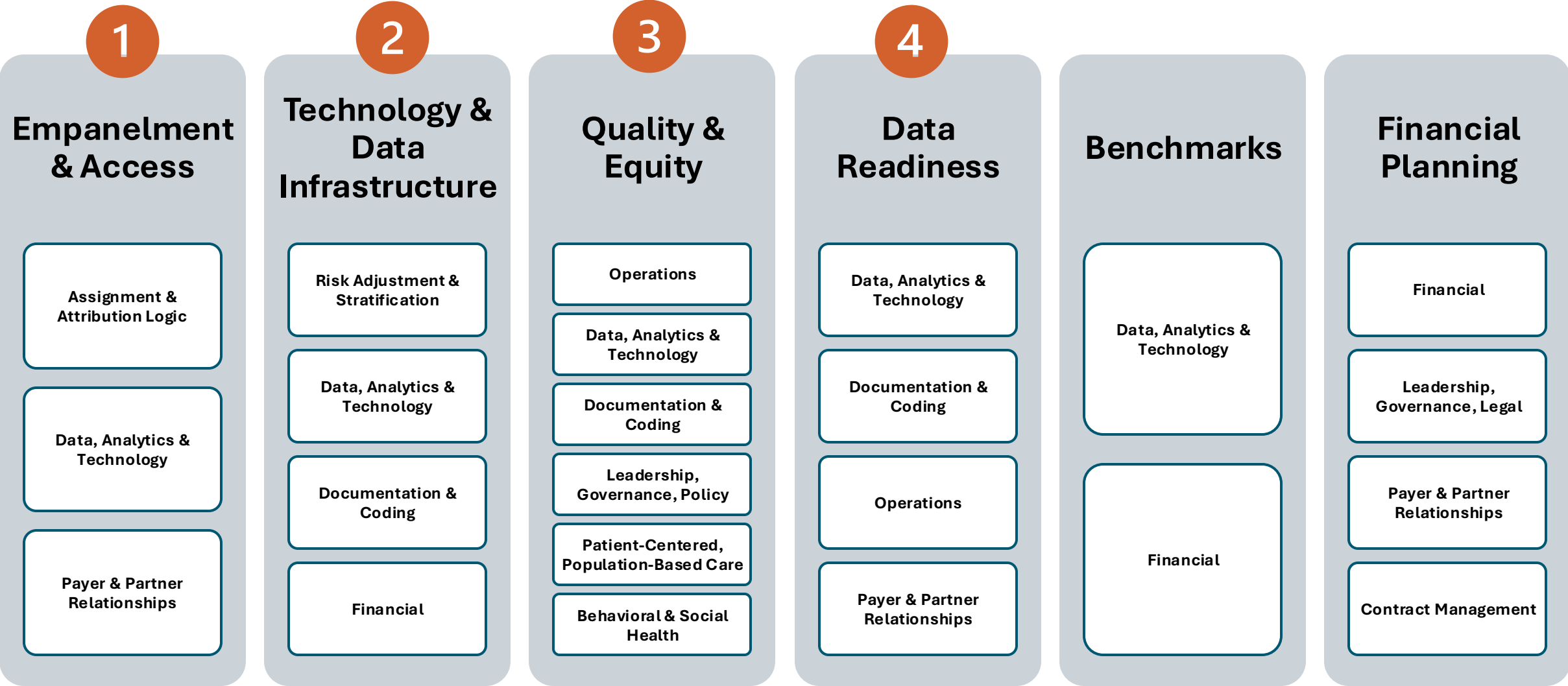
- Empanelment & Access P&P
- Empanelment & Access KPIs



Team-based care & care coordination

- Model of care deliverables (e.g., care team assessment, pre-visit planning)

Critical Capabilities for Engaging in VBP



Domains where VBP capabilities typically show up

Who Counts as Your Population? Why Does That Matter For VBP?

Attribution *defines* which patients you are accountable for in a VBP model

Assignment (patients are linked to a practice in advance)	Attribution (patients are linked based on where they actually receive care)
• Often prospective • Defines who is on the roster • Drives payment eligibility • Common in Medi-Cal primary care models • Critical for CHCs (site/NPI-level)	• Often retrospective • Uses claims data to determine provider accountability for patient's overall care • Defines how performance is measured • Used for quality and cost evaluation • Common across shared savings models • May change over time

Risk Adjustment: Why Patient Complexity Matters for Medicare VBP

Patient A: Medically uncomplicated

- No chronic conditions
- One annual wellness visit
- Occasional urgent care visit
- No hospitalizations



Adjustment for Risk: 0.6
(Below average expected cost)

Adjusted expected cost:
 $\$5,000 \times 0.6 = \text{\textcolor{teal}{\$3,000}}$

This patient rarely uses care beyond preventive services.

Patient B: Medically complex

- Type 2 diabetes
- Hypertension
- COPD
- Depression
- Two ED visits last year
- One hospitalization



Adjustment for Risk: 1.8
(Above average expected cost)

Adjusted expected cost:
 $\$5,000 \times 1.8 = \text{\textcolor{red}{\$9,000}}$

This patient needs frequent visits, labs, medications, care coordination, and follow-up.

Quality & Equity: How Performance Is Interpreted

In VBP, quality performance is evaluated across populations, not as overall averages

- Quality measures reflect outcomes, processes, and patient experience.
- Under VBP, performance is increasingly examined:
 - Across different patient groups
 - By race, ethnicity, language, and other characteristics
- This helps identify where care is working well and where gaps persist.



Equity matters in performance evaluation

- Aggregate scores can mask meaningful differences in outcomes.
- Practices serving higher-need or historically marginalized populations may face structural barriers that affect results.
- Equity stratification helps ensure performance comparisons are fair and actionable.

EPT activities (e.g., data stratification, priority population focus, equity-driven improvement) directly support how quality is assessed under VBP.

Data Readiness: Making Information Usable for VBP

What Matters Most

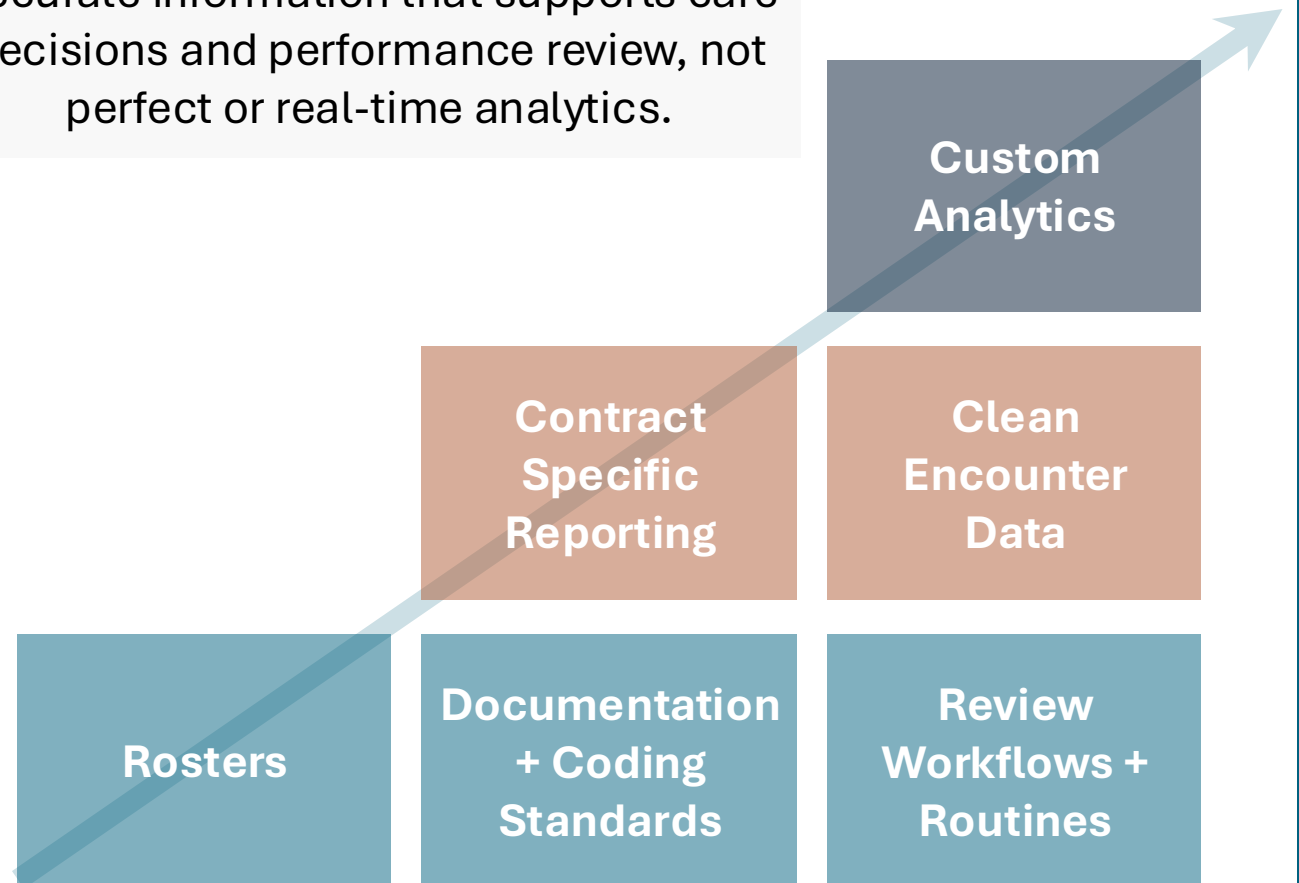
- Reliable rosters
- Gaps-in-care lists
- Accurate documentation & coding (clean encounter data)
- Regular review routines

What Can Come Later

- Advanced dashboards
- Predictive modeling
- Custom analytics
- Contract-specific reporting

Start with what you have. Build capabilities as needed.

Data readiness means having timely, accurate information that supports care decisions and performance review, not perfect or real-time analytics.



Breakout Group Discussions

Instructions for Breakouts

Breakout groups are based on practice type and size:

- 1. Health Centers, Public/District Hospitals (2 groups)**
- 2. Tribal Health Clinics**
- 3. Medium and Large Independent Practices (5+ FTEs)**
- 4. Small Independent Practices (less than 5 FTEs)**

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

Let's discuss!

We will have 15 minutes for a breakout groups based on practice type and size

What work have you done through EPT that prepares your practice for VBP?

Based on what you heard, what areas may still need work to advance your readiness?

EPT Milestone and Deliverable

EPT Value-Based Pay Milestone

The milestone can be submitted in May 2026 or November 2026

Milestone description

Conduct assessment of VBP capabilities, identify gaps, and develop an action plan to improve readiness for VBP contracting.

Milestone components

Complete a 32-item assessment to understand VBP core capabilities: leadership, operations, data, financial, & partnerships.

Use the results to identify areas and a plan for improvement.

What the milestone is not

A requirement to enter into a new VBP contract.

Value-Based Pay Capability Assessment Tool (VaPCAT)

VaPCAT Overview

- The VaPCAT complements population health domains in the PhmCAT by adding core capabilities needed to be successful with VBP.
- The VaPCAT will help practices identify what capabilities are important to have in place to participate in a range of VBP contracts, and how they are currently performing across those core capabilities.
 - Capabilities will be assessed across leadership, operations, data, financial, & partnerships.
- On the VBP Deliverables template, practices will analyze their VaPCAT results and identify concrete steps to improve VBP readiness.
- It's recommended to take a team-based approach to completing the VaPCAT.
- The VaPCAT will be distributed after the Learning Communities; it will also be built into the EPT Deliverable Portal for the May deliverables cycle. EPT practices will submit 1 response per practice.

Development Process

- Questions were based on "Building Bridges to Value: Infrastructure Essentials" with adaptations and additions from other tools.
- 8 EPT practices and additional stakeholders (MCPs, associations, and more) provided feedback on the questions and wording.

VPB Next Steps

- 1 Review the Value-Based Pay Capability Assessment Tool (VaPCAT).
- 2 Attend office hours on March 11, 2-3pm for a review of the VaPCAT and VBP deliverables template. The template will include:
 - VaPCAT
 - Identification of any gaps
 - Creating a plan for improvement
- 3 Bring your thoughts on areas of strength and opportunity related to VBP capabilities to your March practice track.

Reflections, Commitments, Next Steps



Part 2 Evaluation

- <https://form.jotform.com/260358158211150>
- Please check Part 2 – February 11 as the date

Reflections from Day 2, February Learning Community

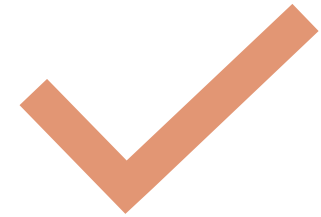
Chat in your responses to the discussion questions



What will you take back to your team?

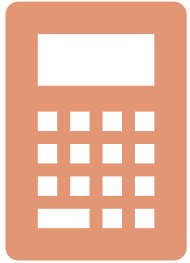


What's your next small test of change?

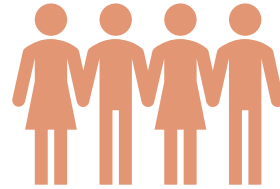


What will you do by next Tuesday?

What Should Your Team Focus On Now?



Review the EPT VBP Assessment – identify core capabilities and areas of improvement



Continue working to close your identified disparity



Create a plan to submit the May EPT milestones

Milestones Required for May 2026

Requirements are designed to ensure practices earn directed payment, make progress in population health management, and meet DHCS requirements.

May 2026 Milestone Requirements	2026 PhmCAT – open for submissions this spring!
	Data Policy & Procedure;
	Empanelment Policy & Procedure;
	Data Implementation Plan;
	Disparity Reduction Plan; and
	At least one Model of Care deliverable.
How is your practice doing?	Check the Deliverables Portal and identify if there are any outstanding milestones.
	Submit required milestones before working on the new EPT milestones (BH, SH, VBP).

Behavioral Health and Social Health TA

Social Health & Behavioral Health Skill Building Workshops with HealthBegins

- February 26 & March 2
- March 11 & 25
- April 8 & 22

SUD Skill Building Workshops with Dr. Lizzie Horevitz

- Improve your ability to work with patients with SUD through this skill building workshop. Part 1 – March 12, Part 2 – March 31.

Social Health PopHealth+ Modules developed with HealthBegins

- Understand Social Needs (HRSN), developed practice workflows and enhance data integration and community partnership

Behavioral Health PopHealth+ Modules developed with Dr. Lizzie Horevitz

- Describe Integrated Behavioral Health (IBH) workflows, care models using motivational interviewing, and implementing Depression and SUD Screening and follow up.



Additional TA

Office Hours

- March 4: Portal review
- March 12: Data Implementation Plan and Progress Report
- March 19: Outreach and Engagement
- March 26: Clinical Guidelines
- April 2: Care Team Assessment
- April 9: Pre-Visit Planning

PDSA Application Lab (March)

Many disparity reduction plans and DIPs lacked concrete change strategies and clear documentation. This session will provide a refresher on PDSAs, examples from EPT practices, small-group peer review, and how to document PDSA progress for DIP submissions.



Thank You!

