pop health LEARNING CENTER

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

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

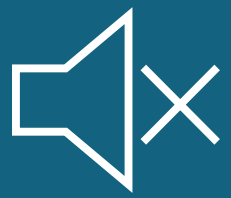
4

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

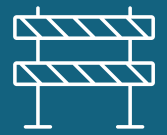
We will mute lines during the presentation to prevent background noise

Questions

Submit questions using the chat feature

Slides + Recording

Slides and recording will be posted PopHealth+



Tech Issues

Private chat Rachel Kochhar for assistance

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*.

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Please chat in!

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

Learning Center Presenters and Facilitators

Tammy Fisher, MPH
Chief Program Officer

Mary Deane, MPH
Director of Programs

Rachel Isaacson, MPH
Senior Program Manager

Monica Dedhia, LCSW
Senior Program Manager

Rachel Kochhar, MPH
Programs Associate

CEPC Presenters

Patricia Mejía
Associate Director of Training

Meghan Elliott
Trainer

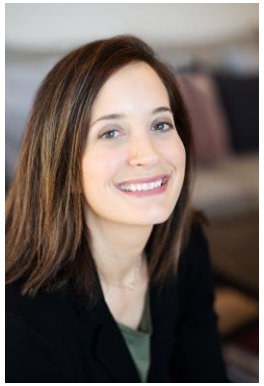
Rachel Willard-Grace
Director

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
Behavorial 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

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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

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

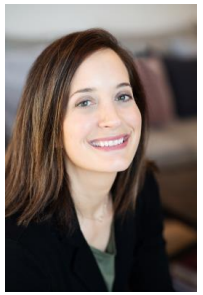
Meghan Elliott
Trainer

Rachel Willard-Grace
Director

Clinical SMEs

Roberto Rodriguez, MD, MPH
Children and Youth

Marianna Kong, MD
Adults with Chronic Conditions and Preventative Needs



Elizabeth Horevitz, PhD, LCSW
Behavioral Health

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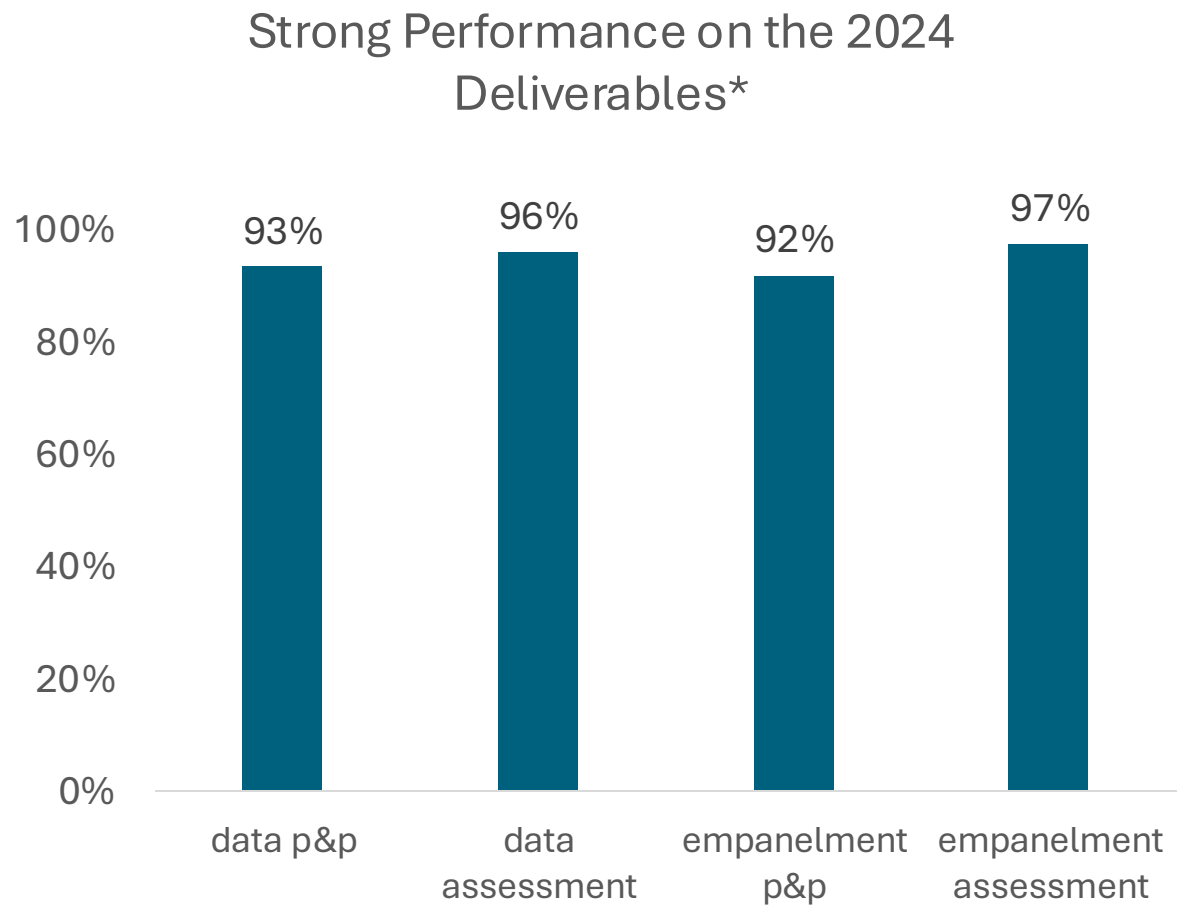
Adults with Chronic Conditions and Preventative Needs

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.

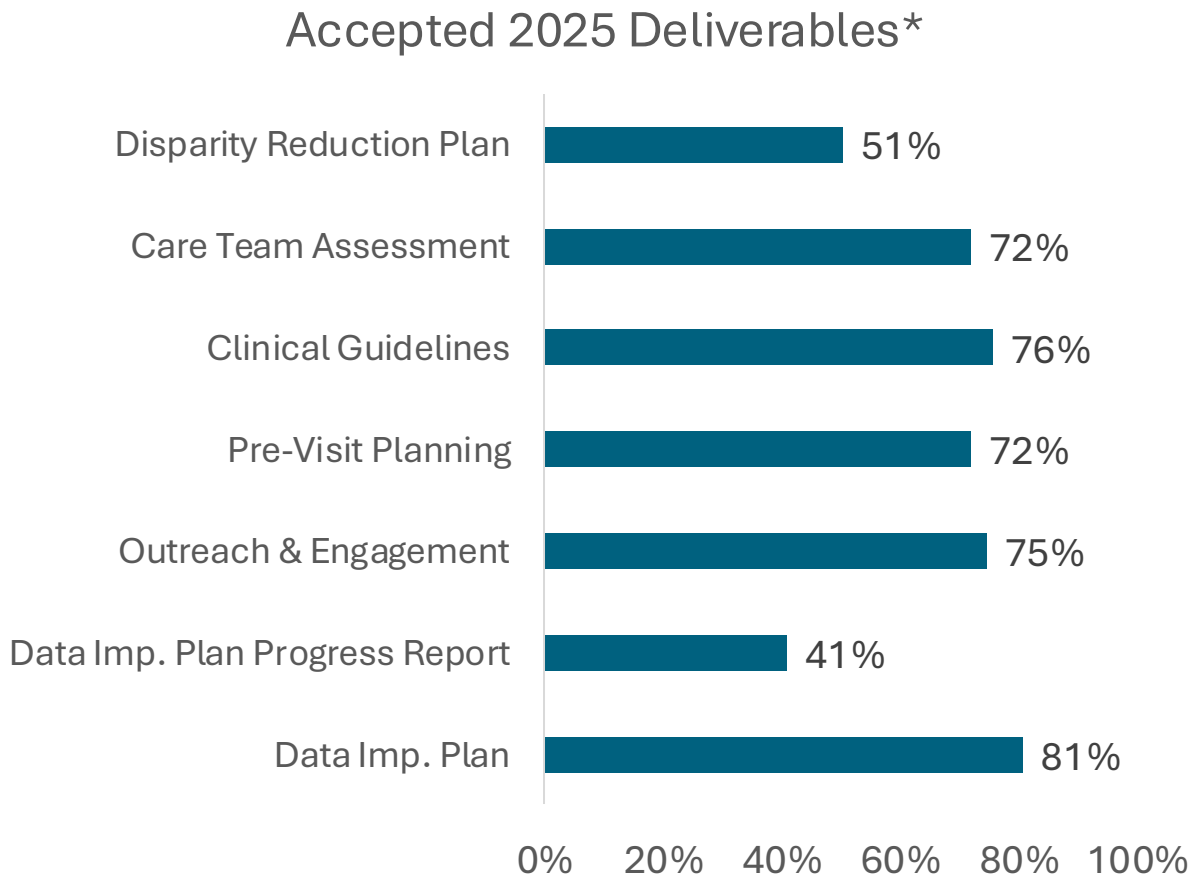


**Denominators are based on practices enrolled when each deliverable was first released (N = 198).*

November 2025 Deliverable Results

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

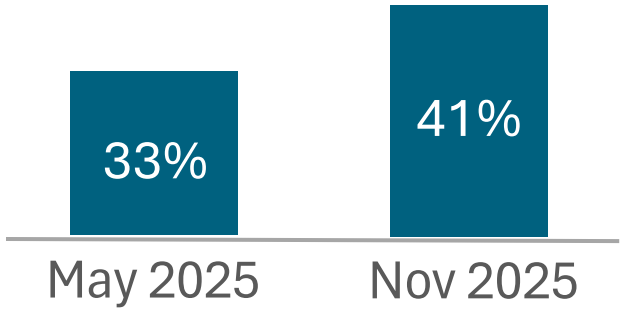
- There were high acceptance rates (72%) for the new Models of Care deliverables, and for the Data Implementation Plan (81%).
- Lower submission and acceptance rates for the Data Implementation Plan Progress Report and Disparity Reduction Plan reflect the depth of work required, including strengthening 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.



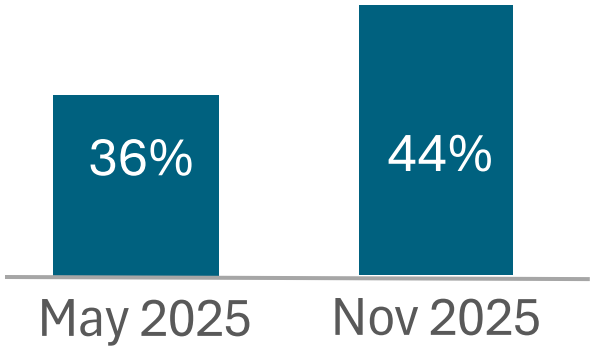
*Denominators are based on the number of practices enrolled during the first cycle that the deliverable was available.
- For the Data Implementation Plan, n=198.
- For all other deliverables, n=190.

Practices Achieving Admin KPIs

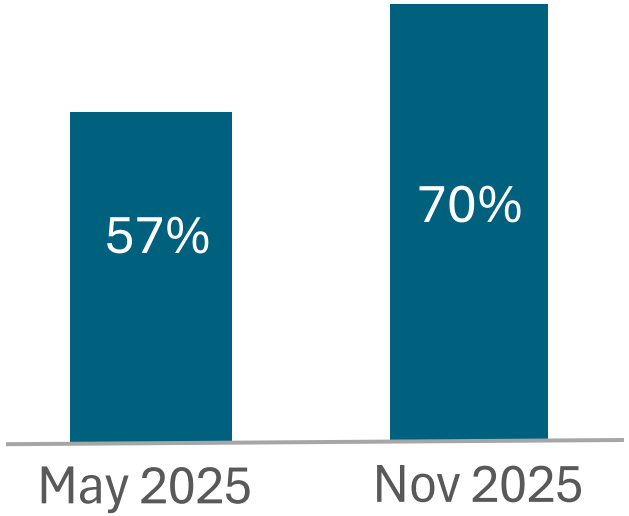
Practices Meeting Empanelment Milestone (90% patients paneled at two time points)



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

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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

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

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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**

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Aligning Disparity Reduction Plan & Disparity KPI

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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

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

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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

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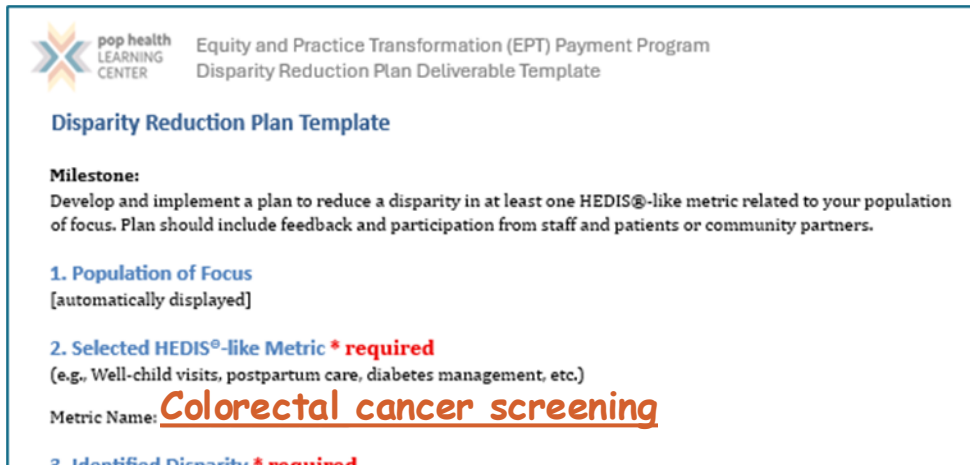
Aligning Intervention to Measure



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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

Which of these describes an <u>intervention</u> 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

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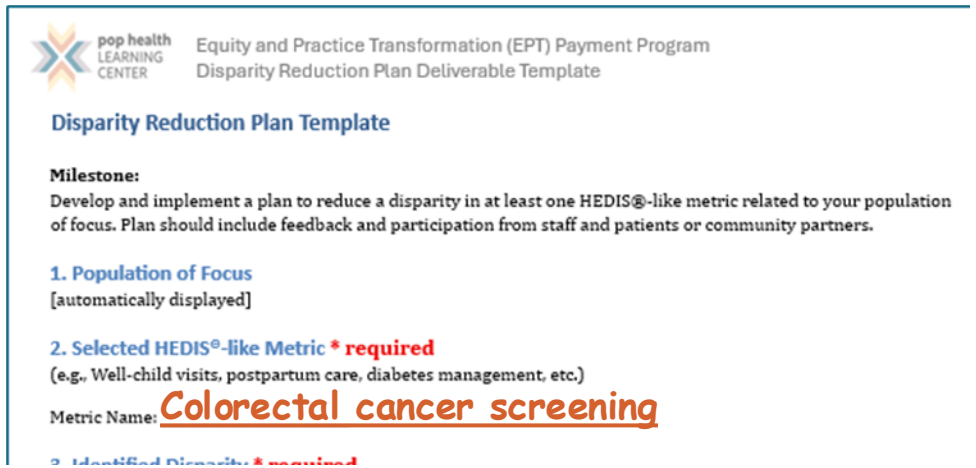
Aligning Intervention to Measure



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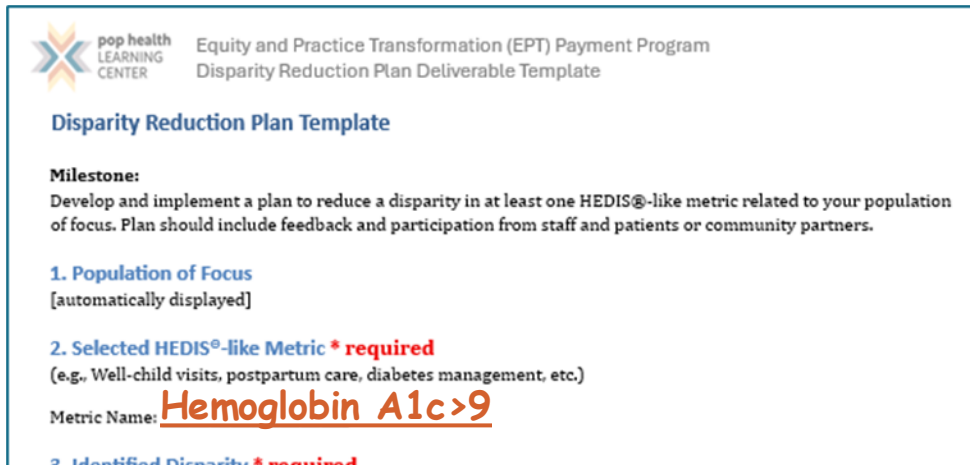
Aligning Process Measure



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Disparity Reduction Plan Deliverable Template

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(e.g., Well-child visits, postpartum care, diabetes management, etc.)
Metric Name: Hemoglobin A1c>9

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

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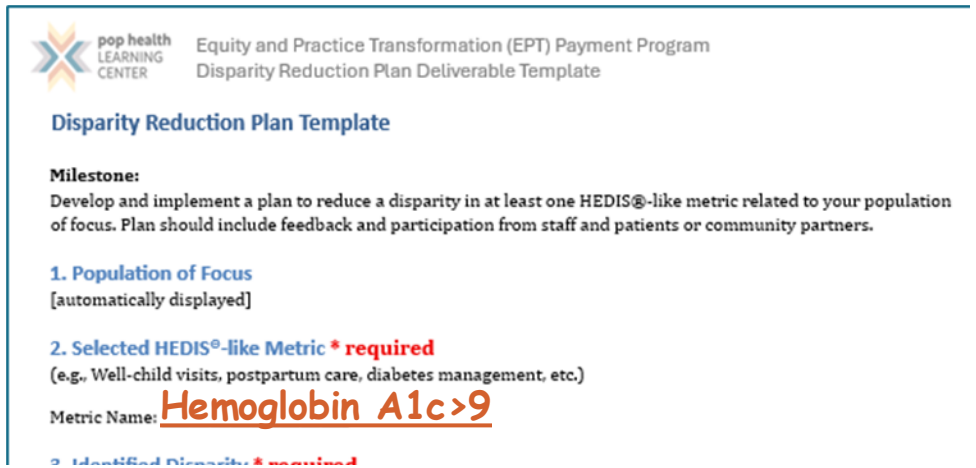
Aligning Process Measure



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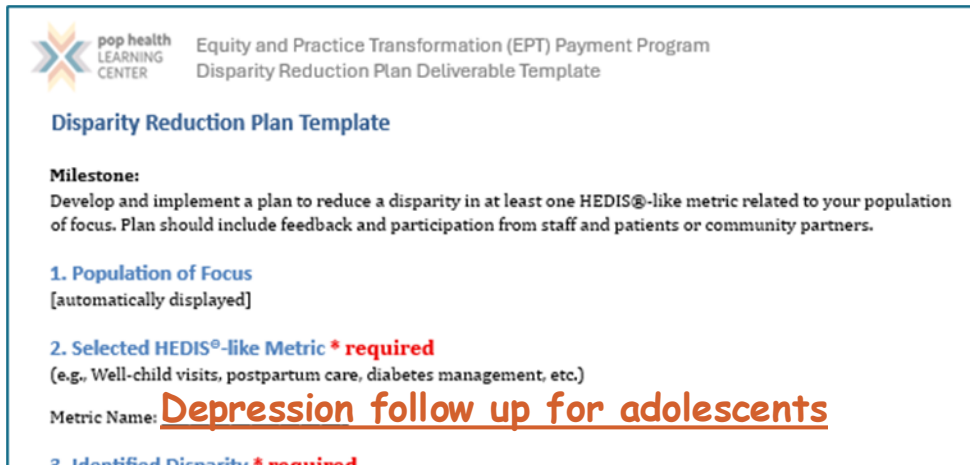
Aligning outcome measure



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2. Selected HEDIS®-like Metric * required
(e.g., Well-child visits, postpartum care, diabetes management, etc.)
Metric Name: Depression follow up for adolescents

Which of these describes an <u>outcome measure and goal</u> 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

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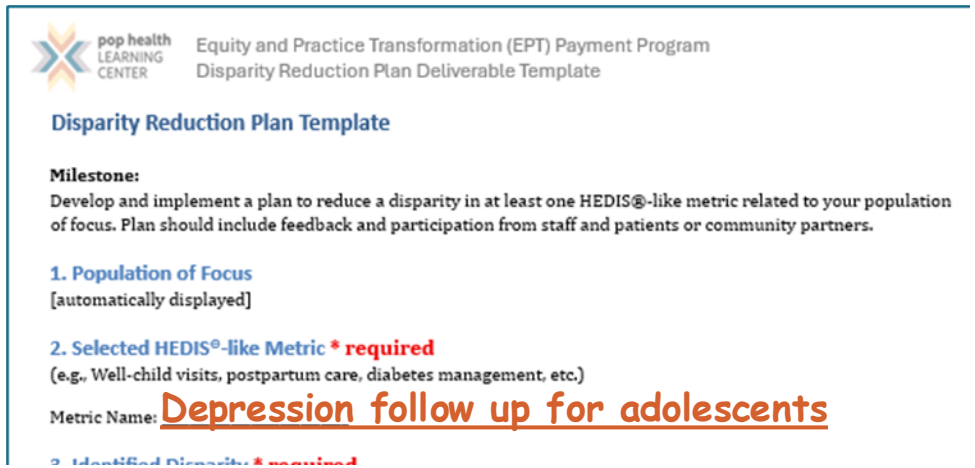
Aligning outcome measure



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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

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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%

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a) 30%

b) 50%

c) 80%

d) 90%

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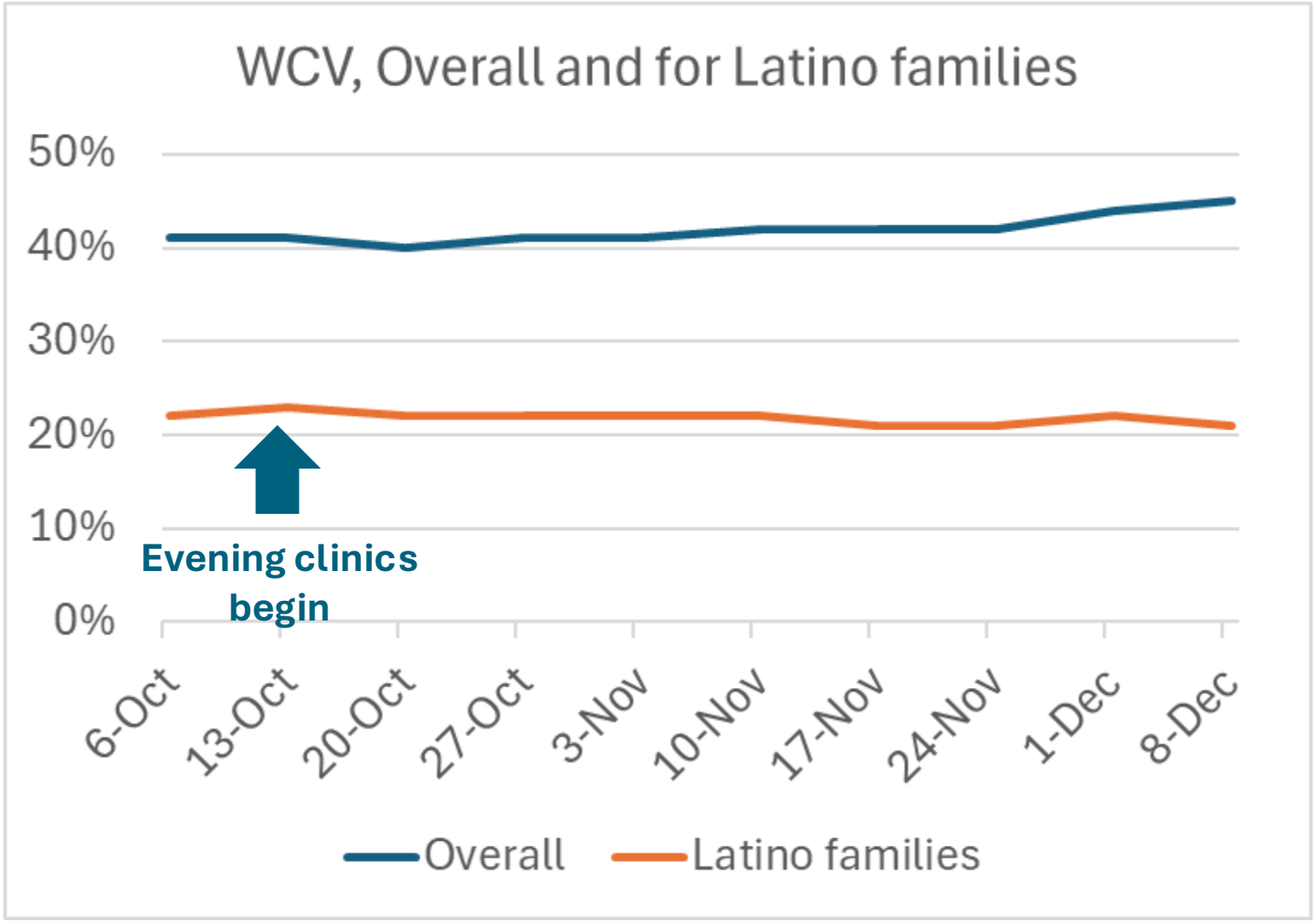
Return to Blue Clinic

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?

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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

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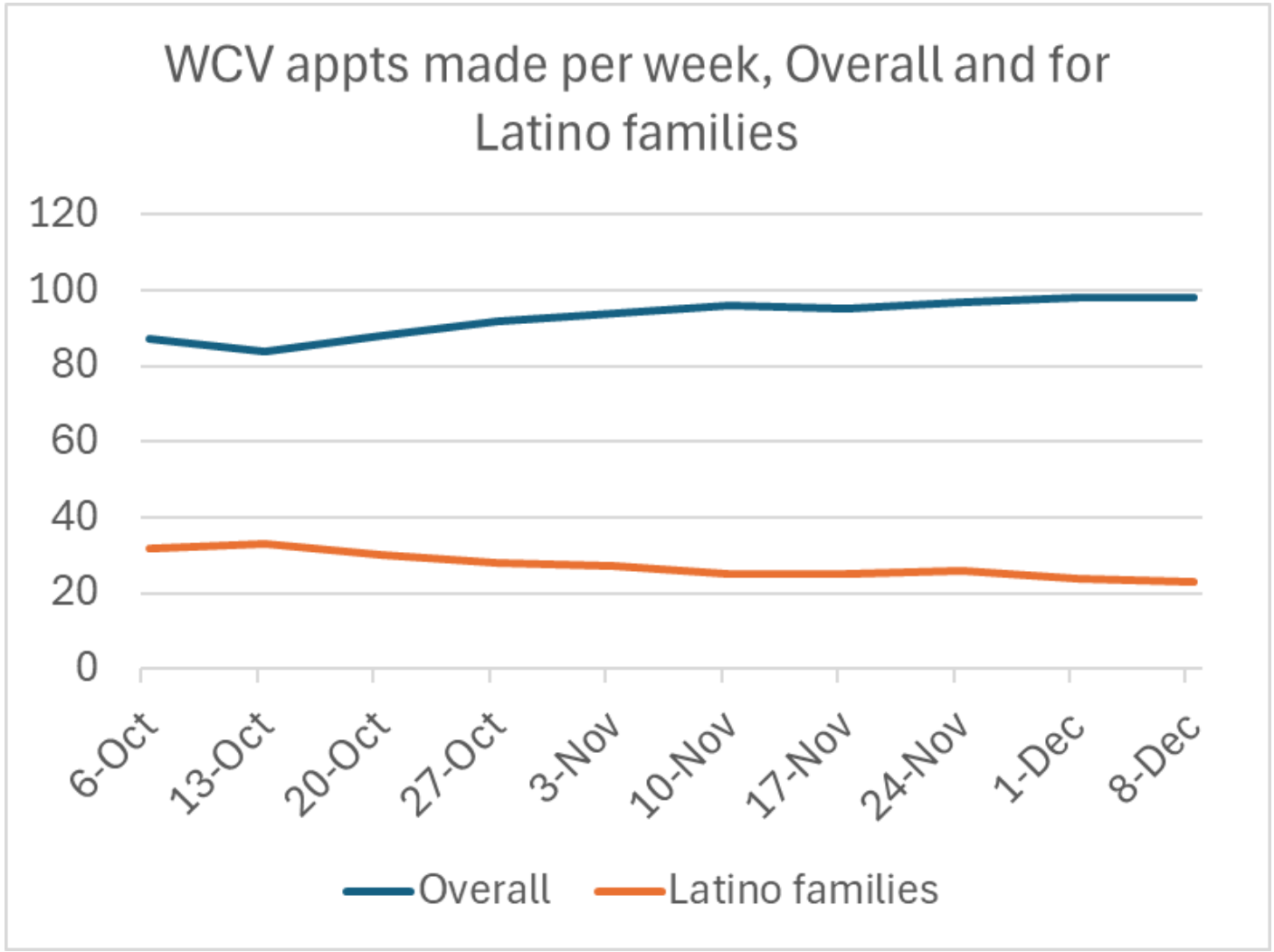
Return to Blue Clinic, continued

Process measure:
Appointments made



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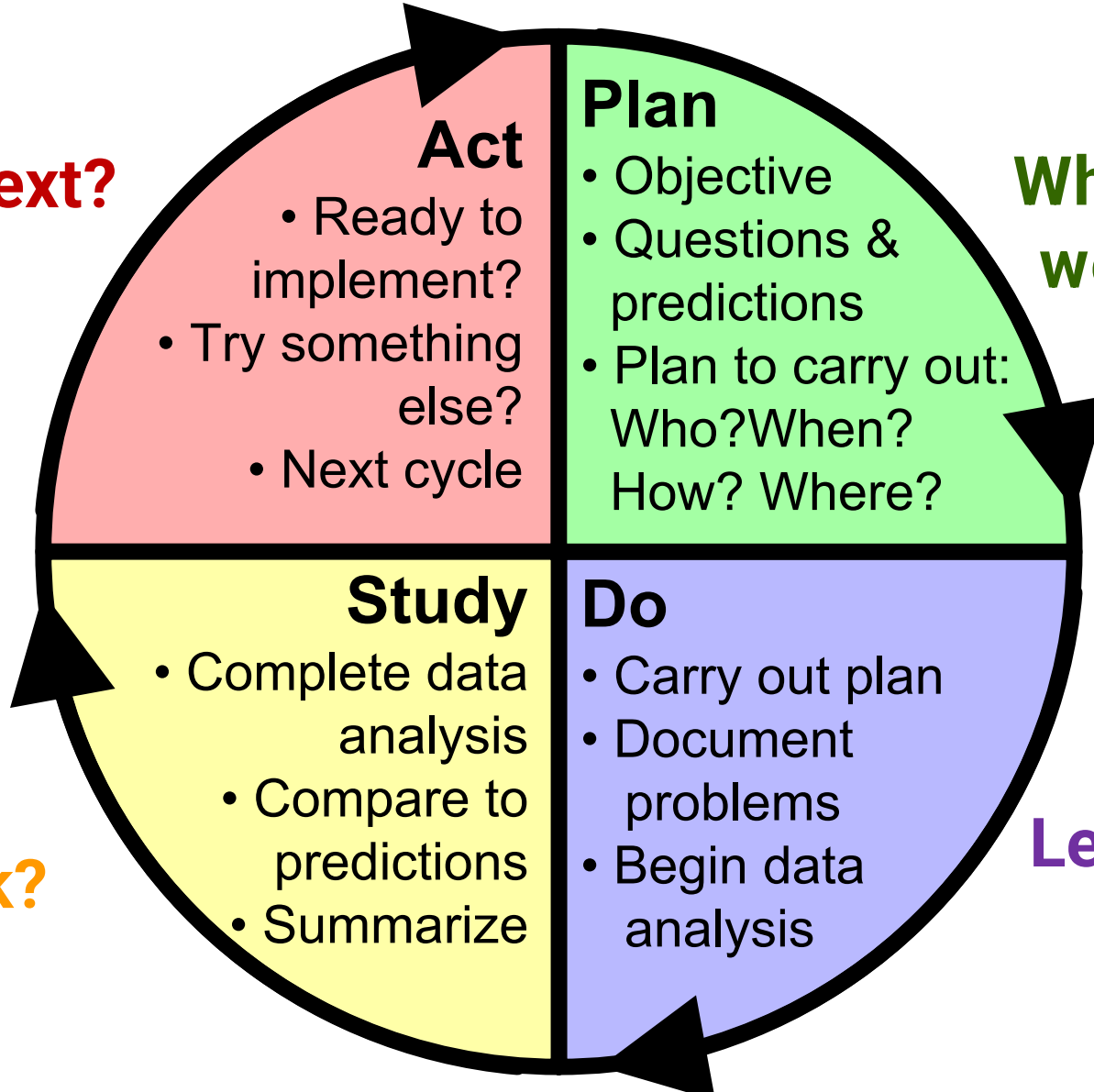
The PDSA Cycle for Learning and Improvement



What's next?

What will happen if we try something different?

Let's try it!

Did it work?

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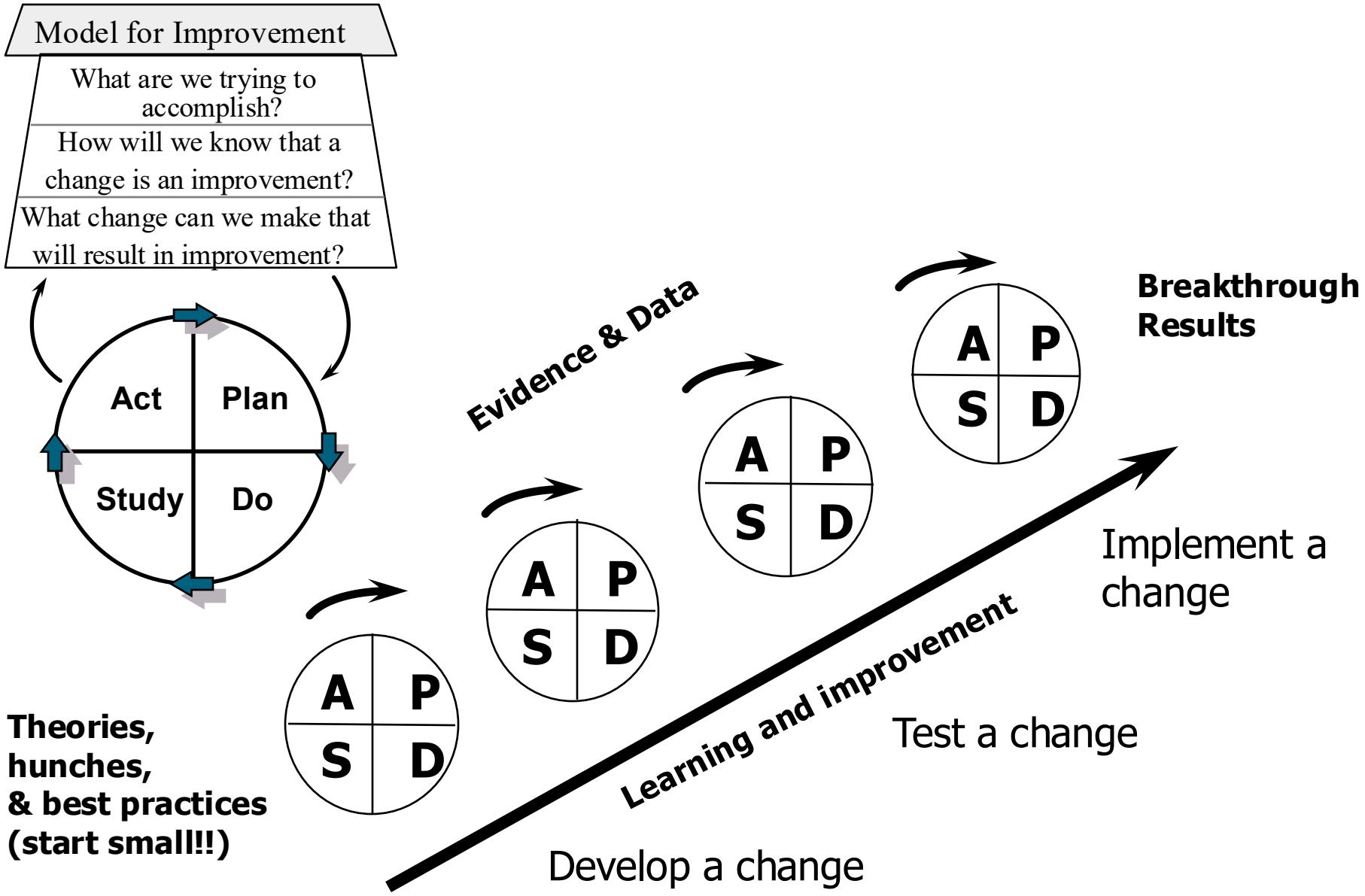
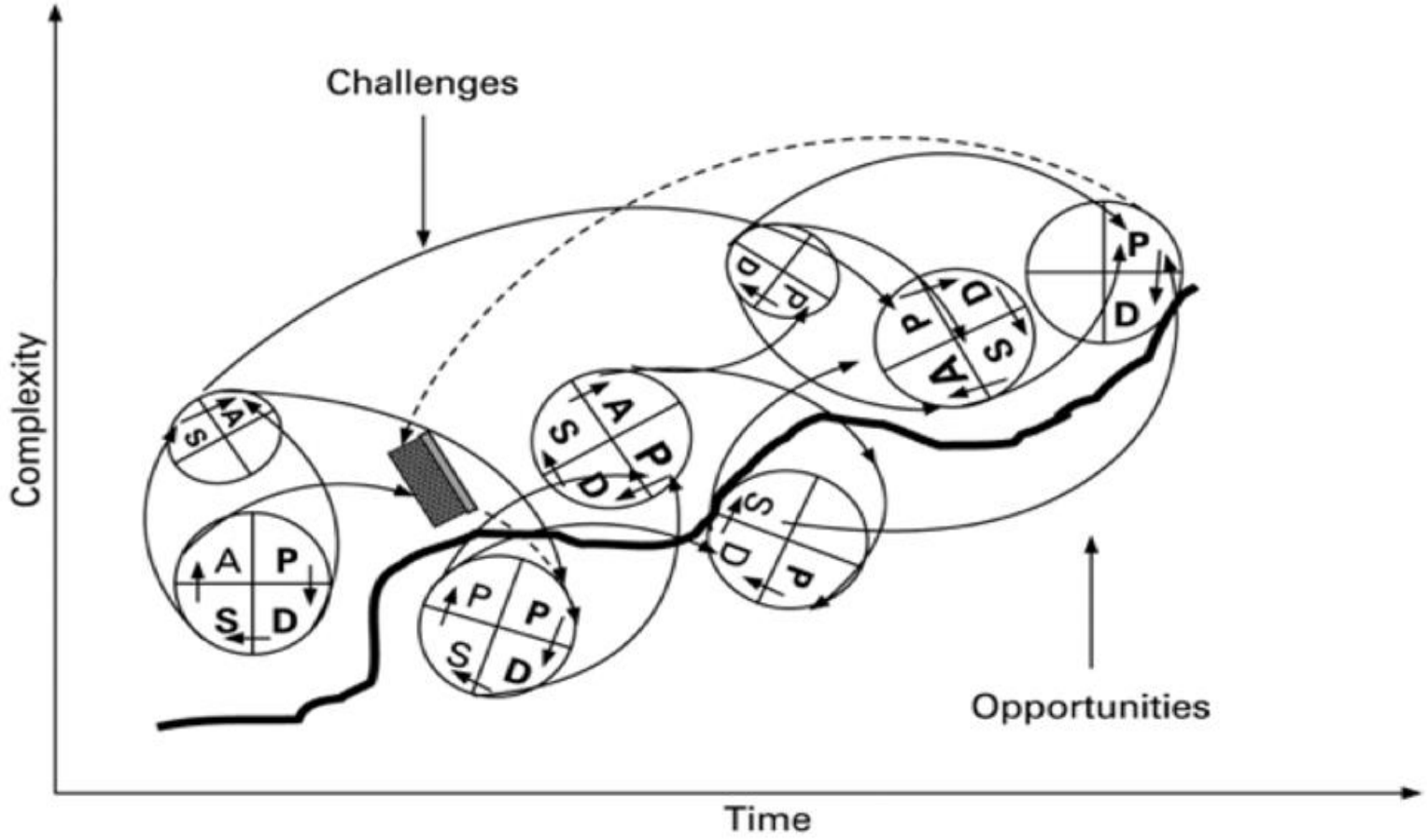

Model for Improvement
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?
Act
Plan
Study
Do
Evidence & Data
A
P
S
D
Breakthrough Results
Implement a change
Learning and improvement
Test a change
Develop a change
Theories, hunches, & best practices (start small!!)

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

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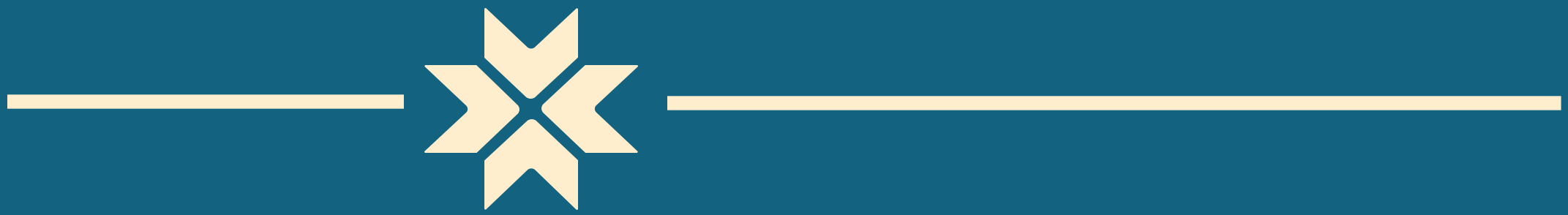
Bright Spots Panel



Kheir Clinic
이웃케어클리닉
Clínica Kheir

Practice Bright Spots: EPT in Action at Kheir Clinic

Floribel Tabizon
Director of Patient Services

Gavin Kwon
Clinic Project Manager

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Kheir Clinic
이웃케어클리닉
Clínica Kheir

About Kheir Clinic

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

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Kheir Clinic
이웃케어클리닉
Clínica Kheir

Disparities in Care Access

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

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Kheir Clinic
이웃케어클리닉
Clínica Kheir

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

pop health LEARNING CENTER

Kheir Clinic
이웃케어클리닉
Clínica Kheir

Roles & Responsibilities Shifted

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

pop health LEARNING CENTER

Kheir Clinic
이웃케어클리닉
Clínica Kheir

Data-Driven Outreach & Planning

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

pop health LEARNING CENTER

Kheir Clinic
이웃케어클리닉
Clínica Kheir

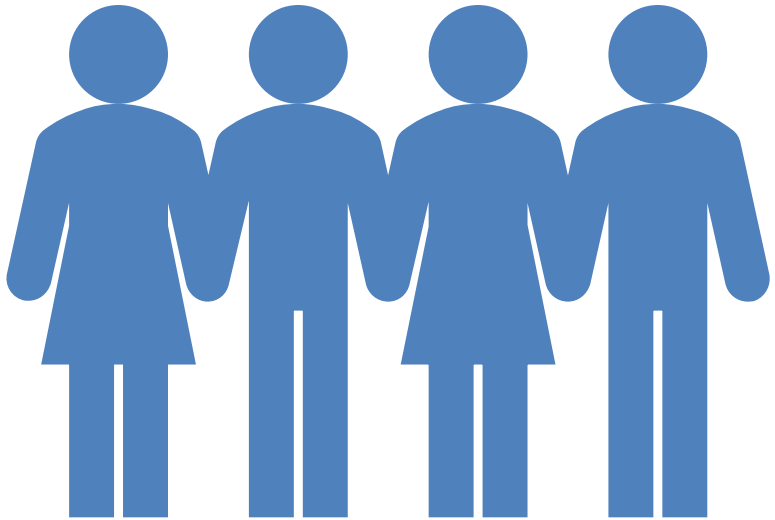
Early Signals and Next Steps

- 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

pop health LEARNING CENTER

Mommy & Me
Medical Group Inc.

Initiative
EPT Program
Disparity
Reduction



Mommy & Me
Medical Group Inc.

About Our Clinic

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

Mommy & Me
Medical Group Inc.

Identifying the Disparity

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

Mommy & Me
Medical Group Inc.

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

Mommy & Me
Medical Group Inc.

Interventions Implemented

- Electronic screenings sent in preferred language before appointments

- Staff outreach in patient's preferred language

- Increased appointment availability during postpartum period

Mommy & Me
Medical Group Inc.

Tracking Our Interventions

- Monthly reporting by language and screening completion rates

- Monitoring patient engagement and follow-through

Mommy & Me
Medical Group Inc.

Early Outcomes

- Increased screening completion before appointments
- Reduced no-show rates
- Stronger patient-clinic relationships
- Improved compliance and health outcomes

Mommy & Me
Medical Group Inc.

Thank You

Working together to close the screening gap

DOCTORS ON DUTY

Salinas Valley HEALTH

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

Kathryn Kane
Chief Operating Officer

DOCTORS ON DUTY

Salinas Valley HEALTH

About DOD

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

DOCTORS ON DUTY

Salinas Valley HEALTH

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

DOCTORS ON DUTY

Salinas Valley HEALTH

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

DOCTORS ON DUTY

Salinas Valley HEALTH

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

DOCTORS ON DUTY

Salinas Valley HEALTH

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

DOCTORS ON DUTY

Salinas Valley HEALTH

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

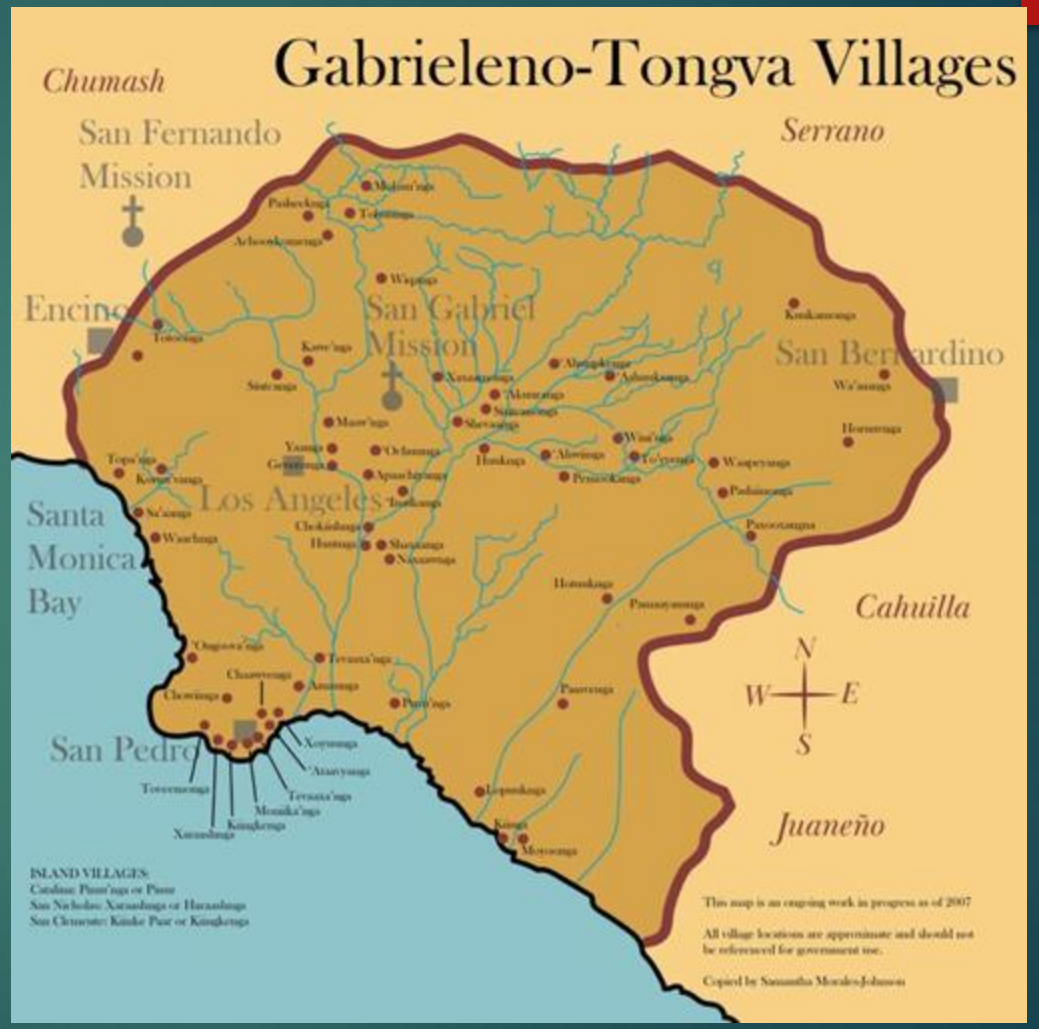
PopHealthLC
02.09.2026

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

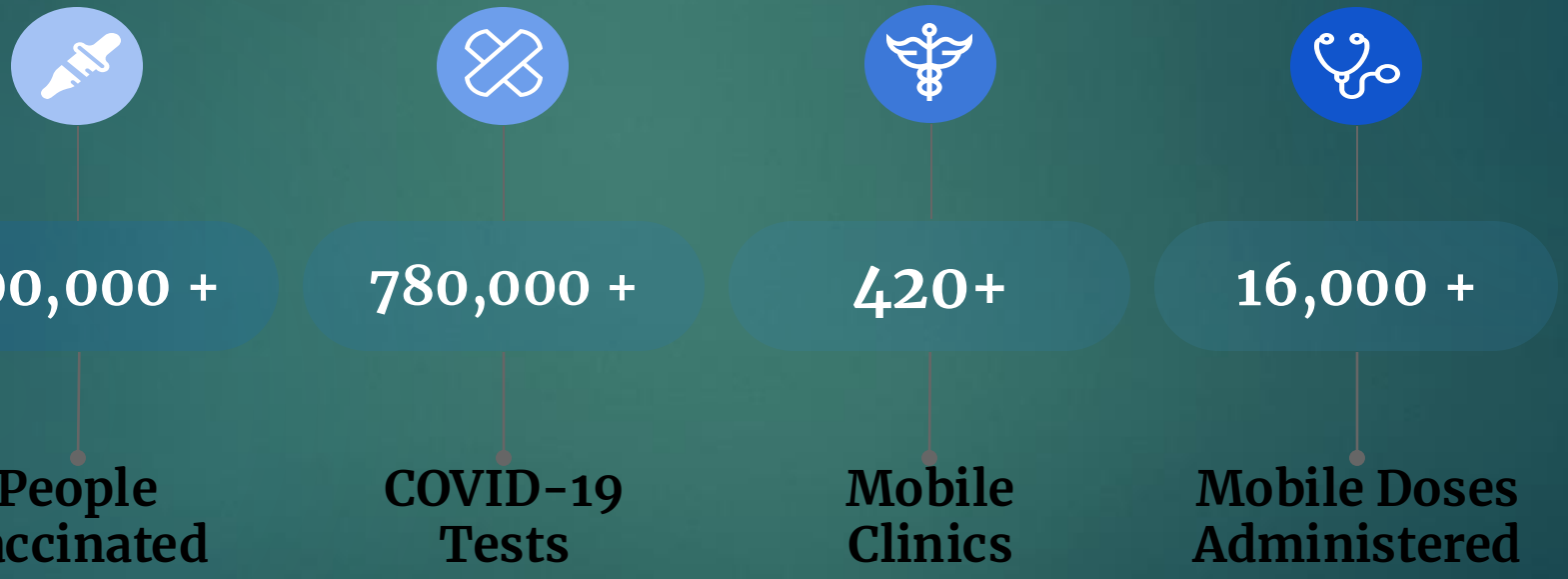
- Kedren is a FQHC located in South Los Angeles. We have pushed to expand healthcare access to those within underserved populations in a way that always provides conscious, ethical, transparent, and passionate service. Since December 2020, we have provided a safe and approachable space for patients to 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…



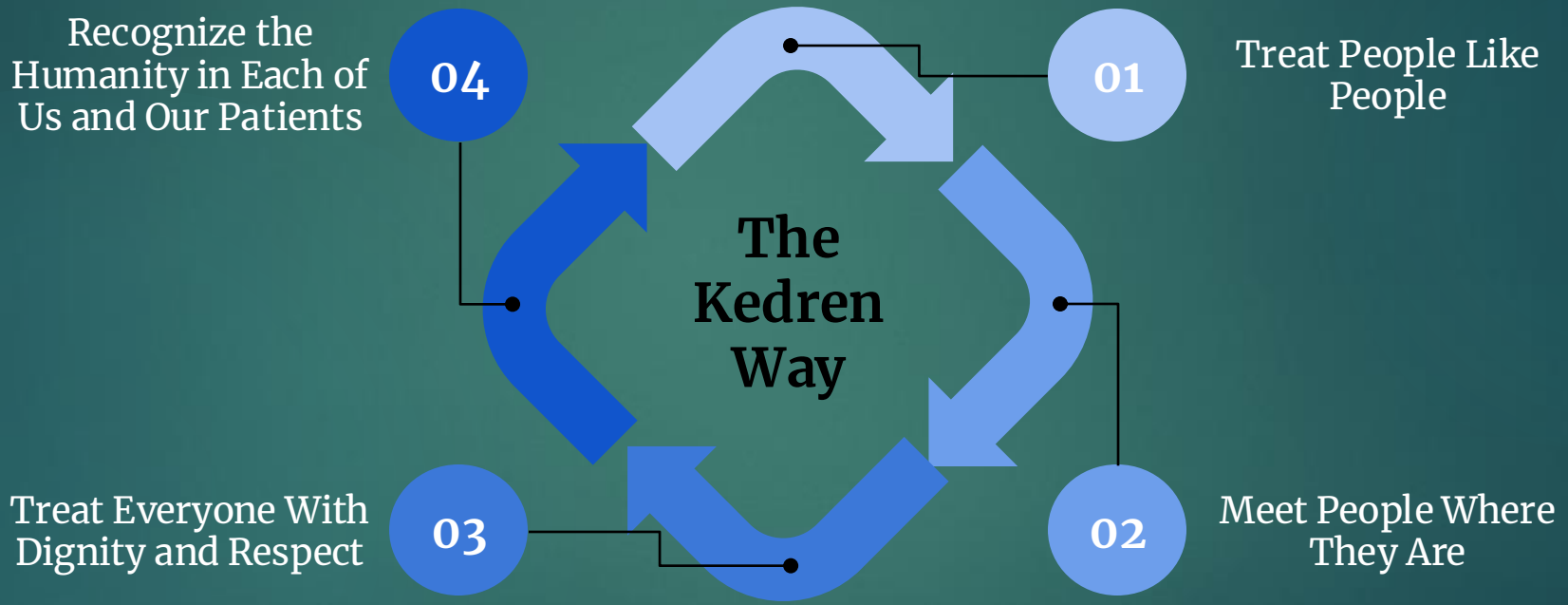
How We Got Here

- 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 then 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

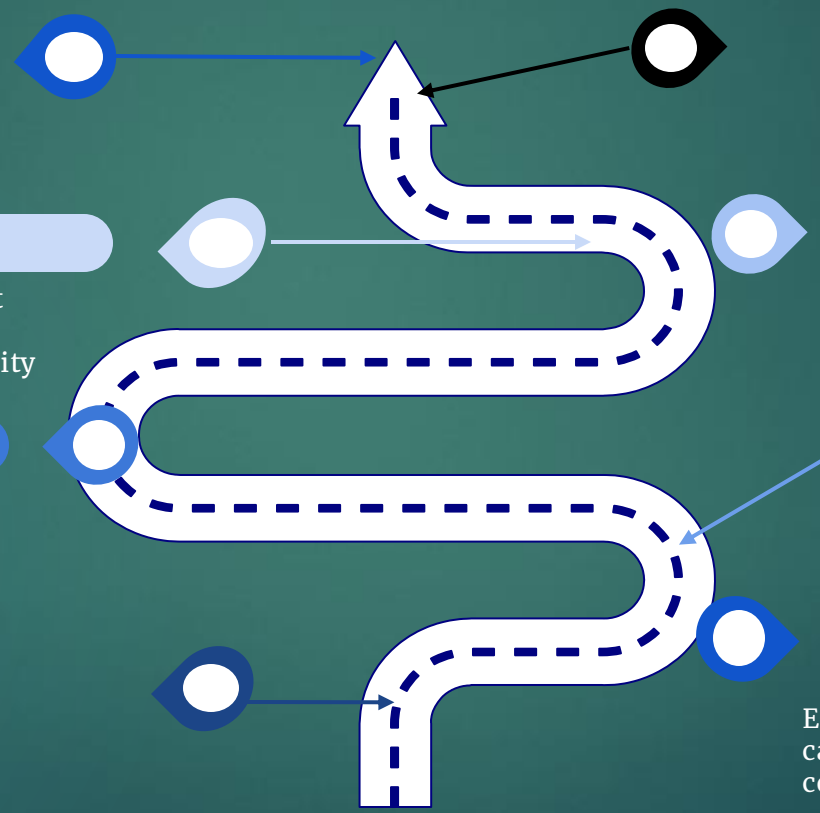
Play
Community centers and special events such as fairs, events, and festivals

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



Maternal & Child Health

General maternal health and reduction of black and brown maternal mortality rate

Public Health

Reducing gun violence, inconsistent policing, climate-based health problems, food and housing insecurity

Ending the Epidemics

STD/STI screenings, HIV/AIDS testing and PrEP, and viral hepatitis treatment

Preventative Care

Testing and educational tools for diabetes, cancer screenings, chronic disease screenings

LGBTQ+ Services

Sexual health education, HRT and other gender-affirming care

Primary Care

Regular visits meant to monitor and maintain health

Mental Health

Mental health screenings (ie. anxiety and depression) and expert referrals

Dementia Care

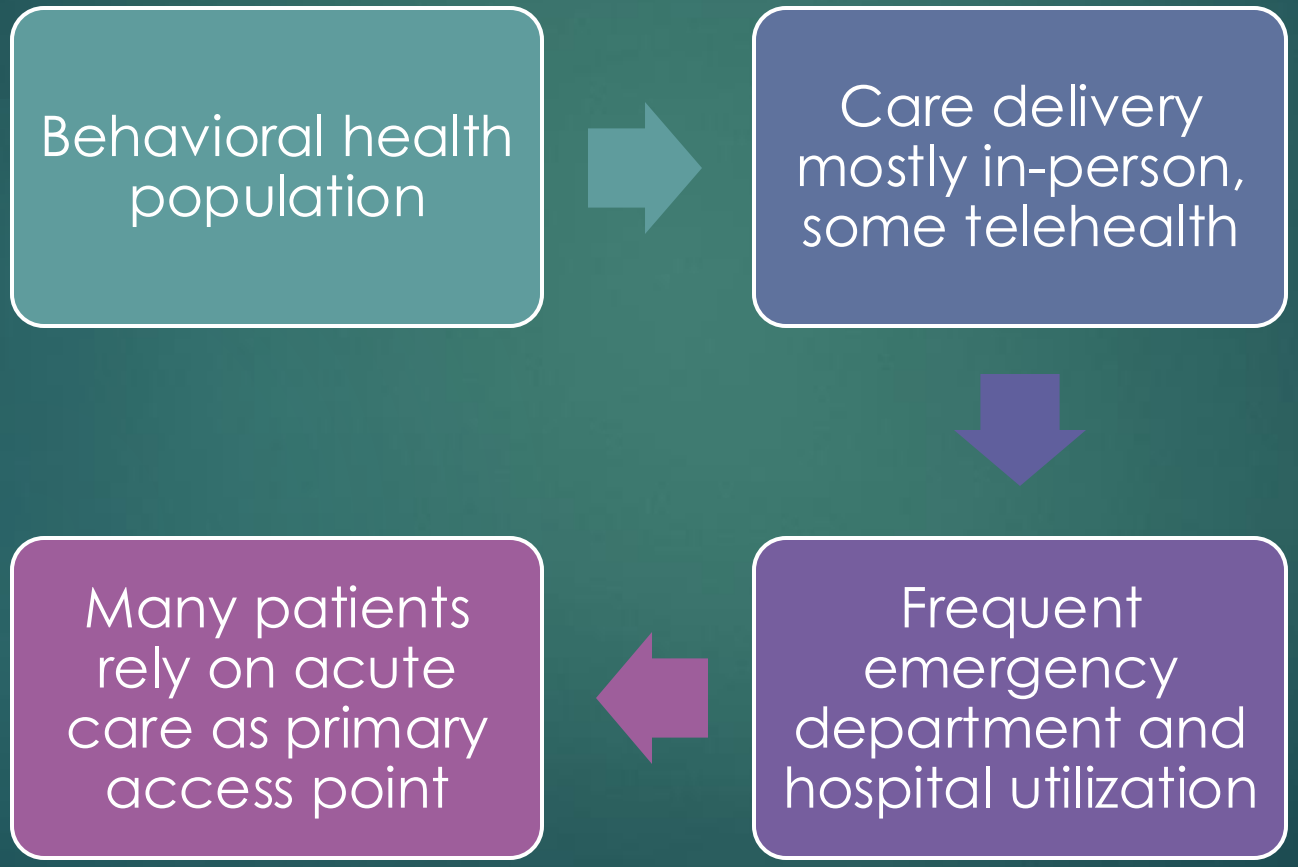
Early screening tools and resources, caregiver training, and culturally competent care resources

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

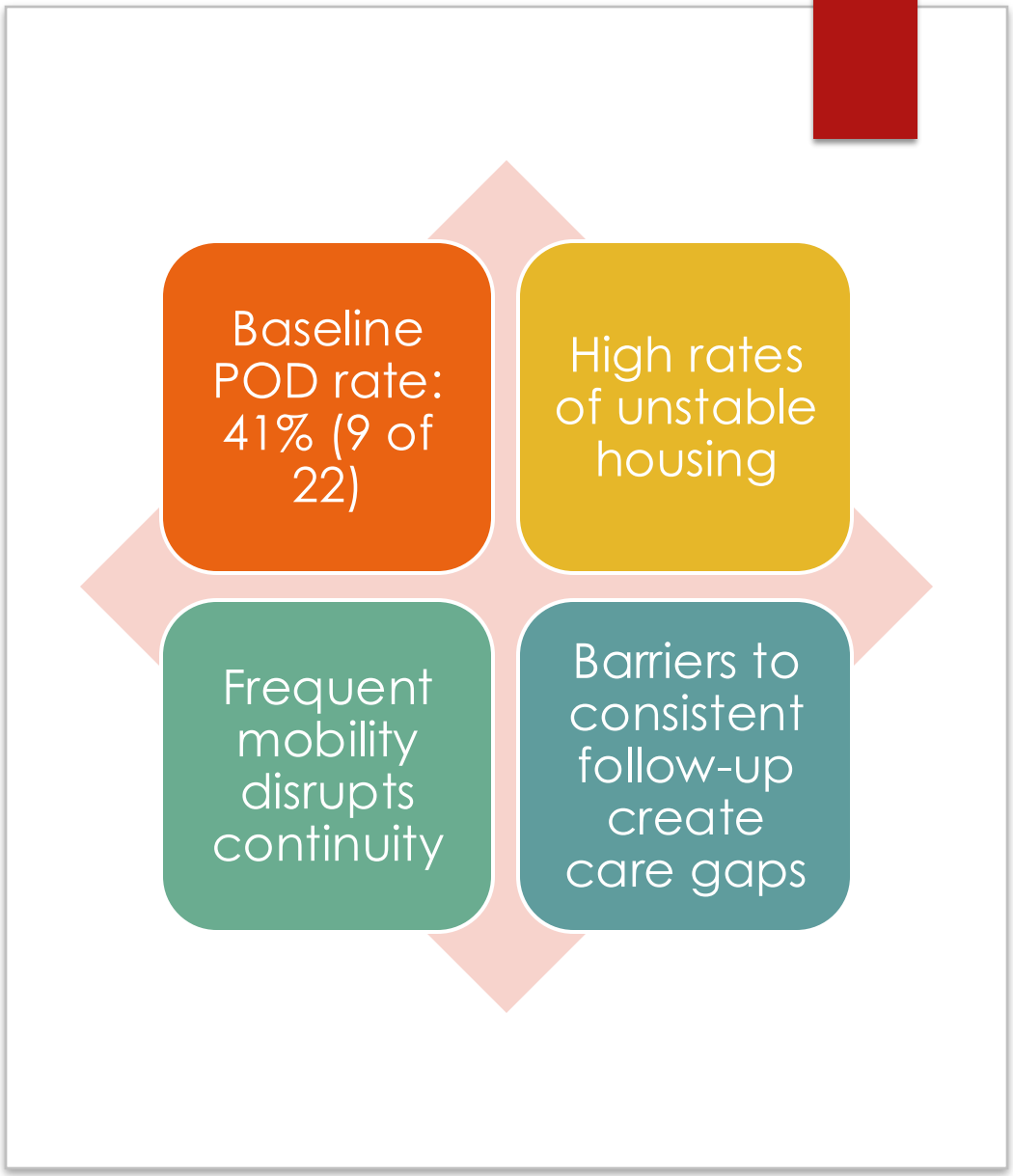
EPT Disparity Reduction Plan – Why This Matters

- Behavioral Health Equity Performance Target (EPT)
- 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

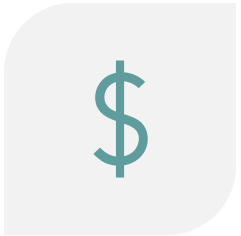
03

Expand field-based follow-up

04

Implementation period: Calendar Year 2025

Barrier Assessment



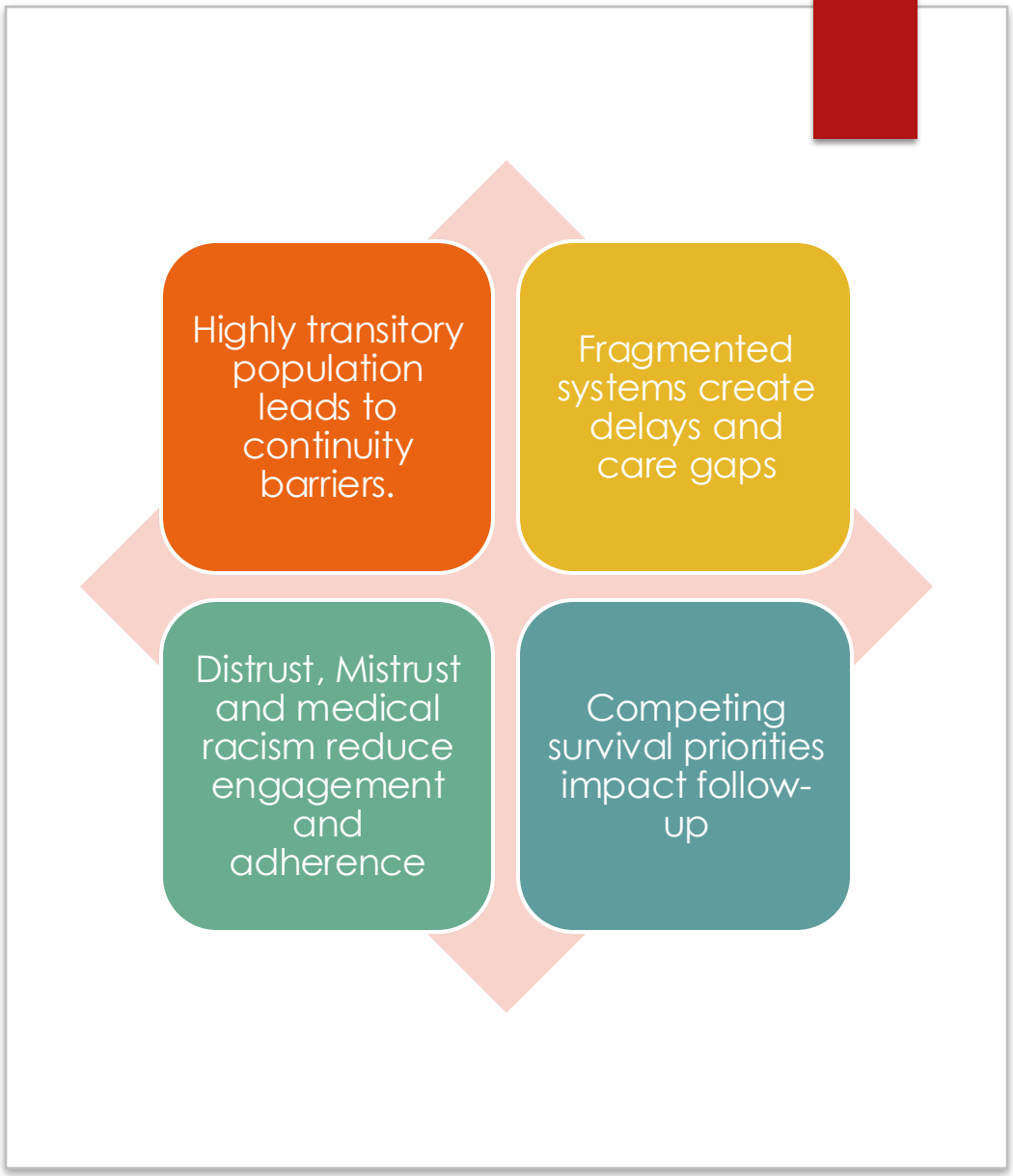
SOCIAL BARRIERS: HOUSING, FOOD, TRANSPORTATION, FINANCES

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

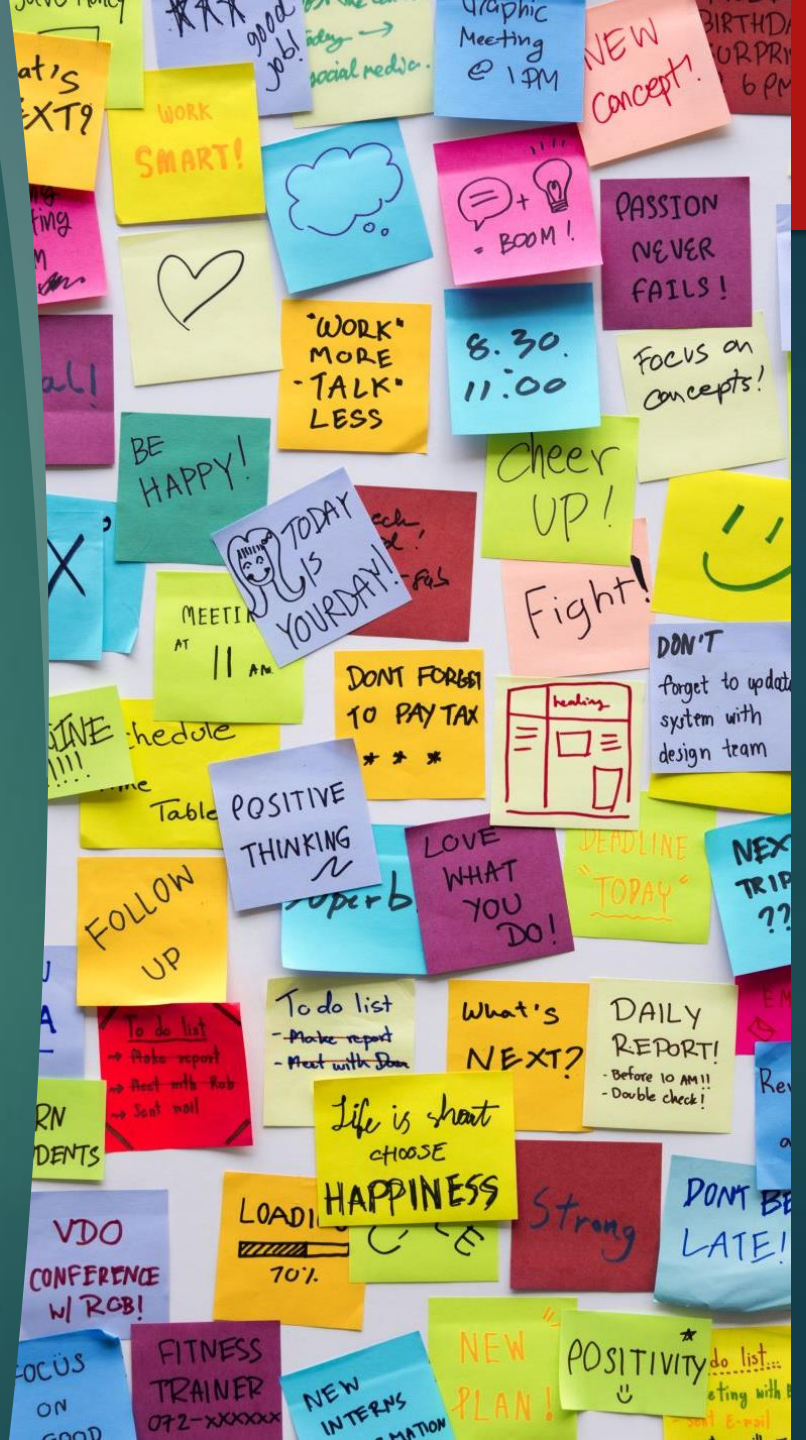
- Consistent outreach across encampments and shelters
- Case management and patient navigation
- Backup staff coverage for continuity
- Trauma-informed, flexible field-based care
- Standardized documentation and care coordination

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

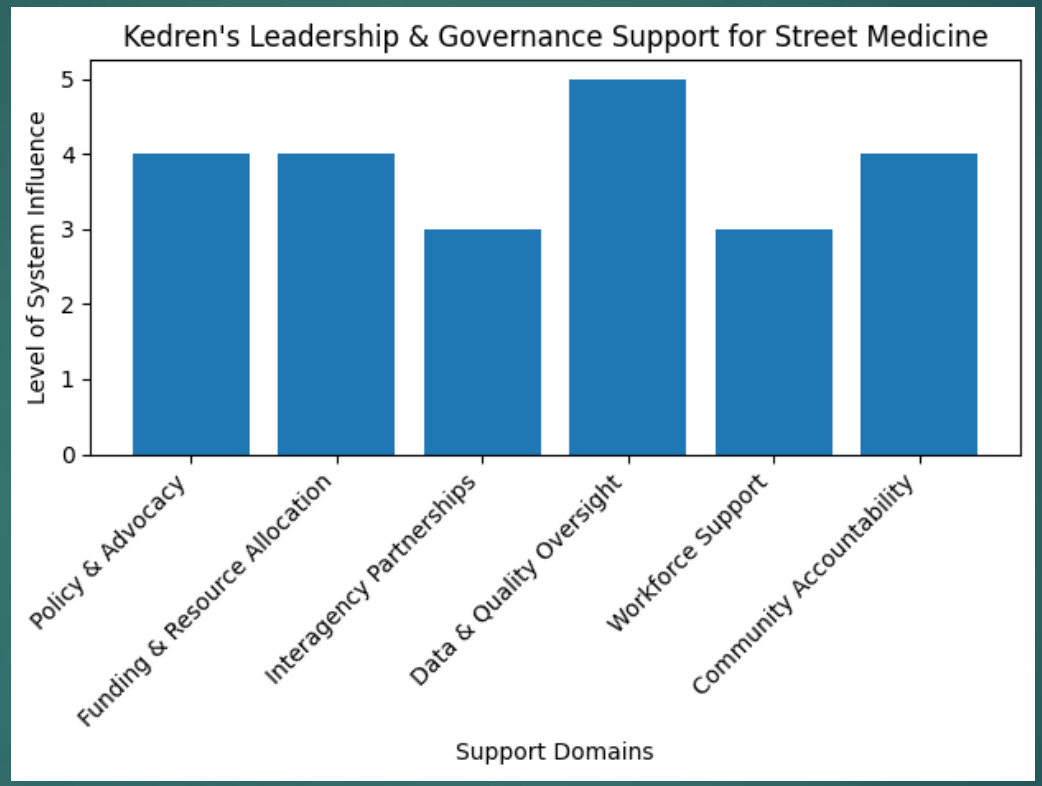
90% of street-based patients have documented outreach

≥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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Kedren Community Health Center

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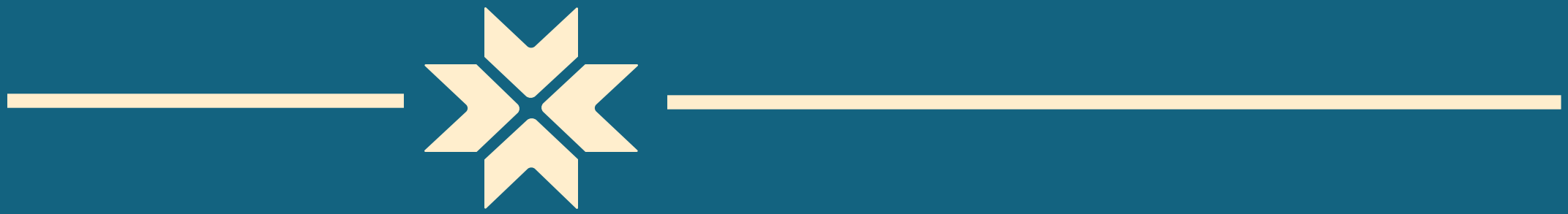
Small Harvest



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.

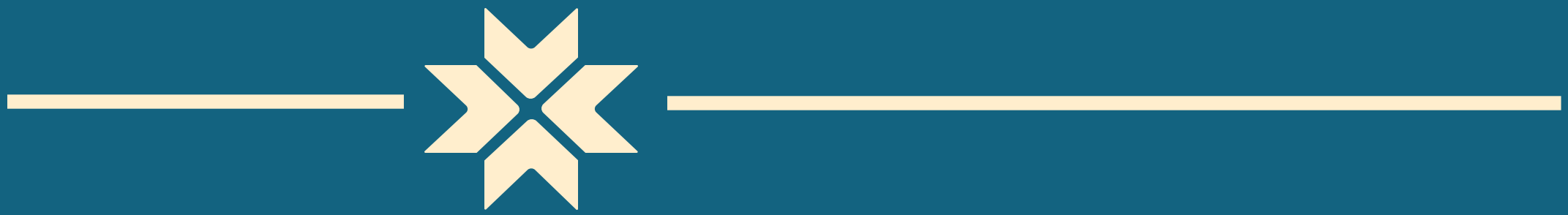
pop health LEARNING CENTER

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 reductionplan?

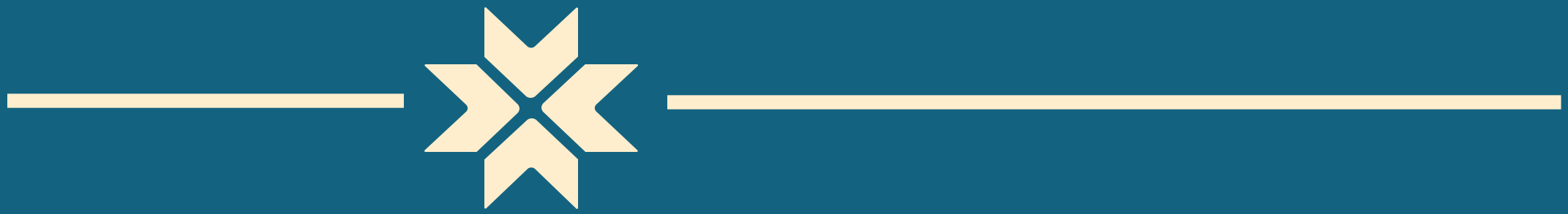
Large Harvest



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!