



Strengthening Population Health and Patient Care: What Worked and What We Learned

Fall 2026 Learning Communities

September 29 – October 1, 2026 • 2 hours

PART 1 of 2



Disclosure

CPCA staff and speakers have reviewed all financial relationships with ineligible companies and the presenters have no relevant financial relationships to disclose.



Continuing Education Credit (CEC) for Physicians

Credit Type	Profession	Accreditation Statement
AMA PRA Category 1™ (CME)	Physicians	In support of improving patient care, this activity has been planned and implemented by the Population Health Learning Center and the California Primary Care Association. The California Primary Care Association is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team. This activity is approved for 2 AMA PRA Category 1™ Credits.



JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION



To Receive Credit:

- You will need to fill out the evaluation that will be shared at the end of this session.

Continuing Education Credit (CEC) for Nurses

Credit Type	Profession	Accreditation Statement
Nursing ANCC	Nurses	In support of improving patient care, this activity has been planned and implemented by the Population Health Learning Center and the California Primary Care Association. The California Primary Care Association is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team. This activity is approved for 2 ANCC contact hours.

To Receive Credit:

- You will need to fill out the evaluation that will be shared at the end of this session.



JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION



Continuing Education Credit (CEC) for Social Workers

Credit Type	Profession	Accreditation Statement
ASWB ACE Credits	Social Workers	In support of improving patient care, this activity has been planned and implemented by the Population Health Learning Center and the California Primary Care Association. The California Primary Care Association is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) . Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit. Social workers completing this course will receive 2 credits.



JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION



To Receive Credit:

- You will need to fill out the evaluation that will be shared at the end of this session.

Continuing Education Credit (CEC)

- In support of improving patient care, the Learning Center has partnered with the California Primary Care Association (CPCA) to provide continuing education for the healthcare team:
- Accreditation Council for Continuing Medical Education (ACCME)
- Accreditation Council for Pharmacy Education (ACPE)
- American Nurses Credentialing Center (ANCC)

To Receive Credit:

- You will need to fill out the evaluation that will be shared at the end of this session.



JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION



Welcome

While we're waiting, please rename yourself.

RENAME YOURSELF

- 1** Click the Participants icon
- 2** Hover over your name & click rename
- 3** Add your name, pronouns, and organization
- 4** Click OK

**Please no acronyms*

ON PHONE AUDIO?

Here's how to connect.

- 1** Find your participant ID in the top-left of your Zoom window.
- 2** Press #number# (e.g., #24321#) to connect.
- 3** You'll see: "You are now using your audio for your meeting."

Housekeeping Reminders

	Mute	We'll mute lines during the presentation to prevent background noise.
	Questions	Submit questions using the chat feature or unmute and ask!
	Slides + Recording	Slides and recording will be posted to PopHealth Website and emailed out after the session.
	Tech Issues	Private chat Kathleen Figoni for assistance.

Agenda

Agenda Item	Time	Presenter(s)
Welcome & Framing	10 min	Mary Deane
EPT Program: What Changed Over Three Years	15 min	Mary Deane
The State's Perspective	5 min	Jeffrey Norris, MD, Value-Based Payment Branch Chief, DHCS
Where This is Going: IMPACT-CA	5 min	Jennifer Sayles, MD, MPH, Chief Executive Officer, PopHealth Learning Center
Storyboard Rooms	15 min	Mary Deane
Storyboard Round 1	25 min	Practices, Facilitators & Logistical Support
Pick Your Next Room	5 min	Mary Deane
Storyboard Round 2	25 min	Practices, Facilitators & Logistical Support
Final Reflections	10 min	Mary Deane
Close & Next Steps	5 min	Mary Deane

Introduce Yourself in the Chat

IN YOUR MESSAGE, INCLUDE:

1

Your Name

First and last

2

Your Role

e.g. Medical Director, Care Manager

3

Your Organization

Practice Name

4

One thing you're proud of from EPT

Something your practice built, changed, or learned

PopHealth Learning Center's Zoom Meeting



Everyone



New chat

You To Everyone • 10:32 AM

Kathleen Figoni

Senior Program Manager, Learning Center

Proud that we finally closed our BP disparity gap. 🎉



Who can see your messages?

Message everyone

T



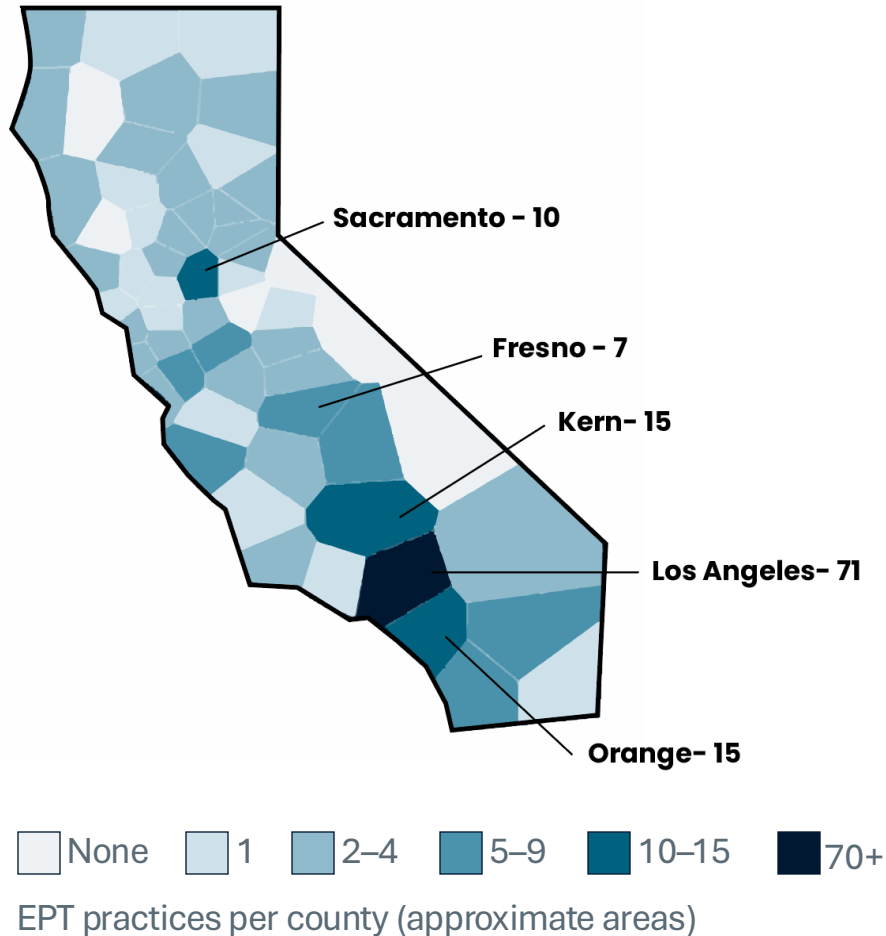
GIF



THANK YOU, AND CONGRATULATIONS



Three years, one cohort: what you built



171

active practices, of 198 in the beginning of EPT

2.1M

Medi-Cal members assigned to your practices

52

counties, from Del Norte to Imperial

3,258

staff (FTE) across the cohort

19

managed care plans as partners

2,800+

milestones earned through May 2026, resulting in **~\$58M+ in directed payments**

Who you are: 90 independent practices · 67 health centers · 9 tribal health programs · 5 public and district hospital systems

Sources: EPT Tracker (Aug 31, 2026), 171 active practices after opt-outs and acquisitions · DHCS milestone history through Cycle 4
Approximate county areas, shaded by number of practices.

Meet Your EPT Program Team



**Tammy
Fisher**
MPH

Chief Program Officer,
Learning Center



**Mary
Deane**
MPH

Sr. Director of
Population Health,
Learning Center



**Kathleen
Figoni**
MS-HCA

Sr. Program Manager,
Learning Center



**Monica
Dedhia**
LCSW

Sr. Program Manager,
Learning Center



**Rima
Sheehab**

Consultant

Today's Facilitators



**Jennifer
Sayles**
MD, MPH

Chief Executive
Officer,
Learning Center



**Jeffrey
Norris**
MD

Value-Based Payment
Branch Chief,
DHCS



**Mary
Deane**
MPH

Sr. Director of
Population Health,
Learning Center



**Kathleen
Figoni**
MS-HCA

Sr. Program Manager,
Learning Center

Thank You to Our Funders

EPT was made possible by the California Department of Health Care Services and Covered California. Thank you for investing in primary care practices and the patients they serve.



Funded EPT statewide, setting a shared vision for stronger, more equitable primary care for Medi-Cal members.



Extended EPT with expert coaching, practice-ready tools and resources, and data support that helped practices go further.

Your support helped practices across California build capabilities that will last beyond EPT.

Thank You to the EPT Clinical Subject Matter Experts

These clinicians helped develop EPT milestones and learning content, reviewed practice submissions, and provided coaching and feedback throughout the program. ***We are grateful for their expertise & partnership!***



**Elizabeth
Horevitz**
PhD, LCSW

Behavioral Health



**Marianna
Kong**
MD

Adults with
Chronic Conditions &
Preventative Needs



**Nathana
Lurvey**
MD

Pregnant People



**Neha
Gupta**
MD

Adults with
Chronic Conditions &
Preventative Needs



**Roberto
Rodriguez**
MD, MPH

Children & Youth

Thank You to the EPT Technical Assistance Partners

Our technical assistance partners helped practices put EPT into action through facilitation, coaching, and hands-on support over the past three years. **THANK YOU!**



Thank You to our MCP Partners

Thank you to our MCP partners for supporting participating practices throughout EPT.



Learning Objectives

1	What changed over three years	Describe how EPT practices improved capabilities, access, continuity, and disparities in care over three years.
2	How practices made change happen	Identify the changes, enabling factors, and barriers that influenced outcomes for patients and care teams.
3	What California is learning from EPT	Explain how lessons from EPT are informing California's approach to supporting different practice types and advancing value-based care.
4	What you can take back	Select at least one peer-tested strategy or approach to apply or share within their own organization.
5	Connect and learn from peers	Connect with peers to compare experiences, exchange practical ideas, and identify opportunities for continued collaboration.



EPT Progress: What Changed Over Three Years

Three years of EPT: Nov 2024 – May 2026

Stronger population health capabilities

+15%

higher average capability score

PhmCAT average rose from **6.15** to **7.07**, with gains in all eight areas ranging from +9% to +20%.

For patients: 246,000+ depression and 112,000+ social-needs screens, with follow-up for positive results.

Better access and continuity

5 → 3 days

median wait for a routine appointment

76% → 87% met the 10-day access target

59% → 76% met the continuity target (>70%)

55% → 69% met the empanelment target (>90%)

Share of reporting practices meeting each DHCS target.

More equitable care

60%

narrowed the disparity they targeted

56 of 93 practices with before-and-after data; their focus population's rate improved 14 percentage points on average.

Most chose:

- depression screening
- well-child visits or childhood immunizations
- nearly half focused on Hispanic, Latino or Spanish-speaking patients.

Still to come: final HEDIS-like performance results (2027 evaluation) will give a more complete picture of EPT's impact on clinical outcomes.

Meeting practices where they are: A flexible, responsive TA model

Nearly every practice took part – 96% used two or more types of support.

13 Practice tracks

98% of practices attended at least one

Facilitated peer groups by practice type, size and population of focus, with clinical experts in every round, meeting every other month throughout EPT

6 Learning communities

93% of practices attended at least one

Half-day cohort-wide virtual sessions on the PHM curriculum, with peer sharing on common challenges and new ideas

50+ Office hours

77% of practices attended at least one

Drop-in help with milestones, data and deliverables, including topic sessions before each submission cycle

34 Webinars & workshops

70% of practices attended at least one

Skill-building with subject matter experts on screening workflows, data exchange, Motivational Interviewing, care-gap closure and PDSA

+70 Net Promoter Score for PHLC technical assistance (319 responses, 2026 evaluations)

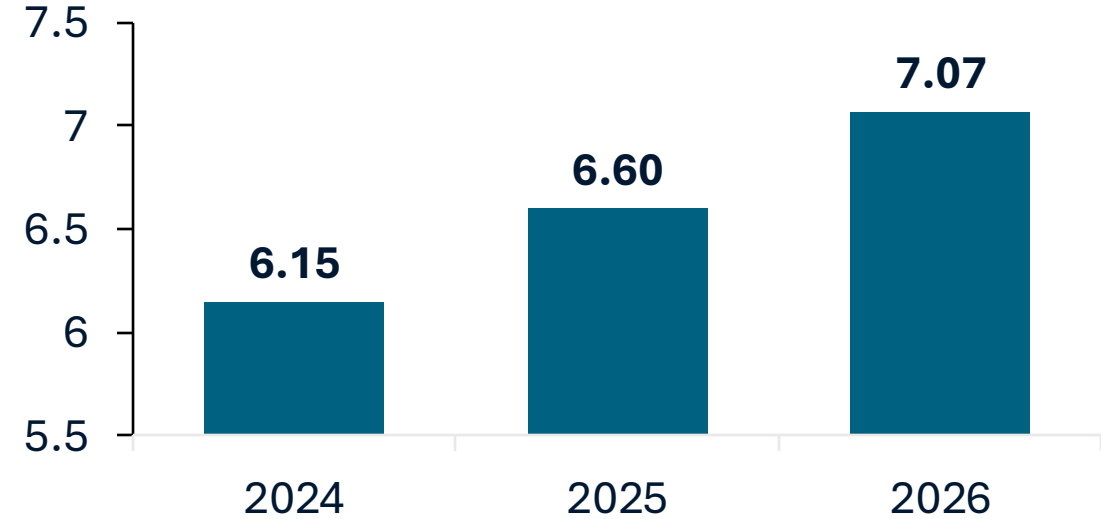
PHM Capability Assessment Tool (PhmCAT)

- 50 questions covering 8 domains reflecting capabilities of PHM
- Multiple staff assess capabilities on scale of 1-10. Different perspectives are discussed and averaged.
- Questions drawn from 9 validated and/or widely used tools across hundreds of practices
- Largest proportion of questions are from items/scales that are linked to patient outcomes

Eight domains for PHM	
Empanelment & access	Business case for PHM
Care Teams	Technology & data infrastructure
Leadership and culture	Patient-centered, population-based care
Social health	Behavioral health

78% of practices improved population health management capability score

Average PhmCAT score, all practices



n = 198 (2024), 193 (2025), 164 (2026) · Source: PHLC TA Dashboard PhmCAT Analysis, 8/28/2026

How to read the score

- Multiple staff at each practice assess capabilities on a scale of 1–10.
- **5–6: the capability is there, but doesn't regularly influence care.**
- **7+: it is integrated into care protocols and reminders.**

78%

of practices raised their score

Practices that improved gained 1.4 points on average on the 1–10 scale.

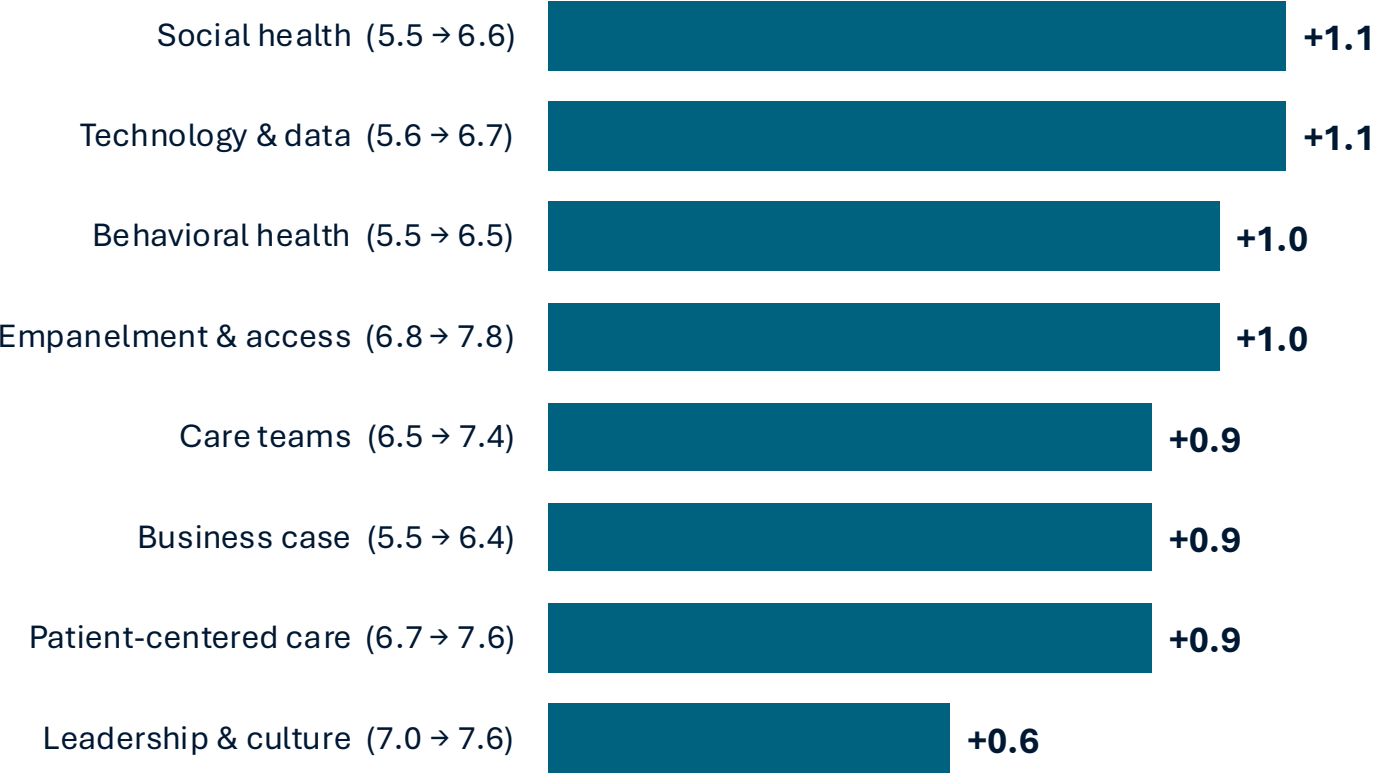
29% → 53%

of practices now score 7 or higher

A 7+ means capabilities are built into routine care. That was fewer than 1 in 3 practices in 2024 and more than half by 2026.

All eight areas improved from 2024 to 2026

Change in average PhmCAT score, 2024 → 2026 (points)



What the scores show

Consistent improvement: every area improved significantly ($p < .001$).

Why a 1-point gain matters

A real change in practice: on the 1–10 scale, a 1-point move (for example, 5 to 6) can mean a capability goes from available but not influencing care to built into care protocols and reminders.

Linked to patient outcomes: in prior work with a similar tool, each 1-point increase was linked to a 1.25% improvement in blood pressure control.

n = 198 (2024), 164 (2026). Source: PHLC TA Dashboard PhmCAT Analysis (8/28/2026).

What change looks like in practice

The three most-improved areas. Score guide: **5–6** = capability is there but doesn't regularly influence care · **7+** = integrated into care protocols and reminders

Technology & data

5.6 → 6.7 (2024 → 2026)

Moving from having the capability to building into routine care

Then: Gap lists built by hand, if at all; staff went into visits not knowing what care was due.

Now:

- **Round Valley:** LVNs pull their own gap reports and build call lists; well-child visits increased **40%**.
- **Family Health Matters:** Care-gap reports trigger standing orders before visits; diabetes foot exams increased **8% → 79%**.

Social health

5.5 → 6.6 (2024 → 2026)

Moving from having the capability to building into routine care

Then: Food and housing needs handled informally, on paper, with no record of who was referred or helped.

Now:

- **El Proyecto del Barrio:** structured PRAPARE screening with closed-loop tracking; 72% of children and families with food insecurity linked to services within 30 days.

Behavioral health

5.5 → 6.5 (2024 → 2026)

Moving from having the capability to building into routine care

Then: Screening depended on the clinician; no standard tool, no translated forms, no follow-up tracking.

Now:

- **SNAHC:** one standardized PHQ-9, translated into the top three languages; completion 11% → 94%.
- **Mommy & Me:** SUD screening sent before the visit, with warm handoffs; 64% → 75%.

Outcome 2 of 3: Better access and continuity



Stronger PHM capabilities

Average PhmCAT score up 15%, with gains in all eight areas

2

Better access & continuity

More practices meet access, continuity and empanelment targets than at the start

3

Disparities reduced

60% of practices narrowed the gap they targeted

More practices meet operational targets than at the start

What the gains mean

5 → 3 days median wait

Access: 76% → 87% of practices offered a routine appointment within 10 days.

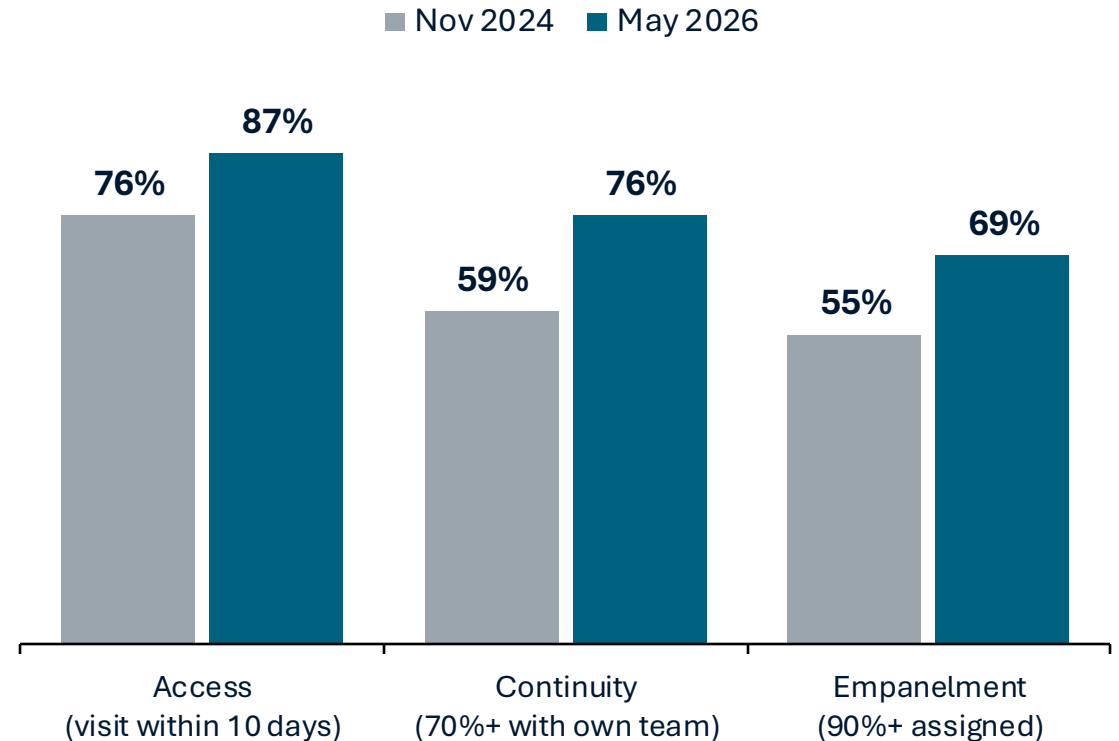
59% → 76% met the continuity target

70%+ of visits with the patient's own provider or care team.

55% → 69% met the empanelment target

90%+ of patients assigned to a provider or care team.

Share of practices meeting each measure target



Source: July 2026 DHCS KPI file. Analysis cohort: 179 practices. Reporting denominators vary by measure and cycle

Outcome 3 of 3: More equitable care



Stronger PHM capabilities

Average PhmCAT score up 15%, with gains in all eight areas



Better access & continuity

More practices meet access, continuity and empanelment targets than at the start

3

Disparities reduced

60% of practices narrowed the gap they targeted

Most practices reduced disparity gaps in selected measures

60%

of practices reduced disparities on their measure of choice, such as depression screenings

56 of 93 practices

+14 pts

average improvement from baseline to remeasurement

Among the 56 that improved: each practice's rate at remeasurement vs. its baseline, for their selected measure and sub-population.

47%

of practices focused on Hispanic, Latino or Spanish-speaking patients

94 of 198 practices. Most common measures: well-child visits, childhood immunizations and depression screening.

How practices got there:

85% stratified their quality data by race/ethnicity and a second variable (169 of 198)

147 built a disparity reduction plan for one HEDIS-like measure and one population of focus

What practices changed to reduce their disparity gap

Teen depression screening

Black/African American youth ·
pediatric practice

2% → 64%

screened for depression

171 teens screened, up from 3

- Screen at every visit, not only well visits, with one standard workflow
- Translated tools and materials in plain-language
- Motivational interviewing training to address stigma

Colorectal cancer screening

Spanish-speaking adults ·
independent practice

26% → 56%

screened for colorectal cancer

45 adults screened, up from 17

- Monthly list of who is due, built from the EHR and plan rosters
- Daily outreach by a bilingual staff member
- A shared workflow for missed appointments and no-shows

Timely postpartum care

Mixtec-speaking patients · health
center

33% → 85%

had a timely postpartum visit

92 patients, up from 53

- Bi- and tri-lingual navigators call patients instead of waiting for them to call
- One tracking list for every delivery: 100% scheduled, 87% completed
- Texting alone did not work; a person speaking the patient's language did

Common thread: a list of who is overdue, outreach in the patient's language, and a care team that is prepped and ready before the patient arrives.

What this meant for patients and care teams



Stronger PHM capabilities

Average PhmCAT score improved by 15%, with statistically significant gains in all eight domains



Better access & continuity

More practices meet access, continuity and empanelment targets than at the start



Disparities reduced

60% of practices with baseline and re-measurement data narrowed the gap they targeted

Two short clinic videos, then the practices themselves in the storyboard rooms. Listen for what is different now for patients and staff.

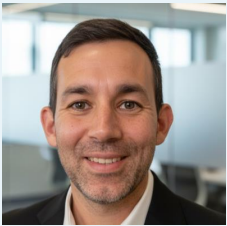
What it meant for patient care and their teams

Testimonials from Eastern Plumas Health Care

Listen for: *what's different now for patients and staff that wasn't before?*



What California is learning from EPT, and what comes next



Jeffrey Norris, MD

Value-Based Payment Branch Chief, DHCS

THE STATE'S PERSPECTIVE

- What three years of investment in primary care has meant for Medi-Cal practices and patients
- Recognition of the work 171 practices have put in, and the final cycle still ahead
- What comes next: increasing and sustaining investment in primary care, alongside a shift toward a primary care value strategy



Jennifer Sayles, MD, MPH

Chief Executive Officer, PopHealth Learning Center

WHERE THIS IS GOING: IMPACT-CA

- **Payment alone does not transform care.** Practices also need the capabilities, infrastructure, and support to use that investment well.
- **EPT helped practices build many of the foundations needed for value-based care**—empanelment, access, care teams, population health data, pre-visit planning, and closing care gaps.
- The next opportunity is to **align payment, practice support, and expectations across plans and purchasers** so practices can sustain and deepen this work.

As EPT wraps up, where is your practice?

A

Yes, regardless

We'll continue this work regardless, because it's part of how we care for patients now.

B

Yes, with support

We want to continue, but it depends on dedicated funding or investment.

C

Goals reached

We achieved what we set out to do and don't plan to continue this kind of work.

D

Not sure yet

We haven't decided whether or how we'll continue this work.

Answer in the Zoom poll now.

There are no wrong answers. This helps us understand where practices are as EPT comes to a close.



Storyboard Rooms

Hear how practices made change happen: what they changed, what helped, what got in the way, and what it meant for patients and care teams.

How the Storyboard Rooms Run

1

Hear the previews

In the main room, the PHLC team gives a one-minute preview of each practice's story.

2

Join a room

Pick the story you most want to hear and join its Zoom breakout room.

3

Story + Q&A

The practice shares its story for 10 minutes, then 15 minutes of open Q&A.

Two rounds today (25 min each).

After Round 1, we'll bring everyone back. Then join a different room to hear a second story.

Today's Storyboard Previews

Five practices, five stories. Listen for the one you most want to hear first.

HEALTH-RELATED SOCIAL NEEDS

El Proyecto del Barrio

From paper applications to closed-loop tracking: 72% of children and families with food insecurity linked to services within 30 days.

CARE TEAM ASSESSMENT

Round Valley Indian Health Center

LVN-led pre-visit planning and outreach brought 40% more children in for well-child visits.

PRE-VISIT PLANNING

Family Health Matters

Pre-visit planning with standing orders took diabetes foot exams from 8% to 79% and HIV screening from 34% to 83%.

BEHAVIORAL HEALTH

Aria Community Health Center

Depression screening rose from 55% to 69% in one year with a PHQ-2 at every visit and centralized referral tracking.

PERSISTENCE

Sacramento Native American Health Center

A standardized, translated PHQ-9 took depression screening completion from 11% to 94%.

Join Your First Room

Breakout rooms are open. Pick the story you most want to hear.

YOU HAVE

25

minutes in this room

HOW TO JOIN

- 1 Click **Breakout Rooms** in your Zoom toolbar (or under **More**).
- 2 Find the room for your topic, like **Behavioral Health**.
- 3 Hover over the room and click **Join**.

***Need help?** Stay in the main room and we'll move you to a room.*

HEALTH-RELATED SOCIAL NEEDS

El Proyecto del Barrio

CARE TEAM ASSESSMENT

**Round Valley Indian Health
Center**

PRE-VISIT PLANNING

Family Health Matters

BEHAVIORAL HEALTH

Aria Community Health Center

PERSISTENCE

**Sacramento Native American
Health Center**



Round 2: Join a Different Room

OCTOBER 1



Quick Debrief

And select which presentation you want to hear next

HEALTH-RELATED SOCIAL NEEDS

El Proyecto del Barrio

From paper applications to closed-loop tracking: 72% of children and families with food insecurity linked to services within 30 days.

CARE TEAM ASSESSMENT

Round Valley Indian Health Center

LVN-led pre-visit planning and outreach brought 40% more children in for well-child visits.

PRE-VISIT PLANNING

Family Health Matters

Pre-visit planning with standing orders took diabetes foot exams from 8% to 79% and HIV screening from 34% to 83%.

BEHAVIORAL HEALTH

Aria Community Health Center

Depression screening rose from 55% to 69% in one year with a PHQ-2 at every visit and centralized referral tracking.

PERSISTENCE

Sacramento Native American Health Center

A standardized, translated PHQ-9 took depression screening completion from 11% to 94%.

Join a Different Room

Same five practices. Pick a story you didn't hear in Round 1.

YOU HAVE

25

minutes in this room

HOW TO JOIN

- 1 Click **Breakout Rooms** in your Zoom toolbar (or under **More**).
- 2 Find the room for your topic, like **Behavioral Health**.
- 3 Hover over the room and click **Join**.

***Need help?** Stay in the main room and we'll move you to a room.*

HEALTH-RELATED SOCIAL NEEDS

El Proyecto del Barrio

CARE TEAM ASSESSMENT

**Round Valley Indian Health
Center**

PRE-VISIT PLANNING

Family Health Matters

BEHAVIORAL HEALTH

Aria Community Health Center

PERSISTENCE

**Sacramento Native American
Health Center**



Final Reflections

Thank you!

Five practices shared their stories today. Please help us thank them.

HEALTH-RELATED SOCIAL NEEDS

El Proyecto del Barrio

Closed-loop food-insecurity referrals; 72% linked in 30 days

CARE TEAM ASSESSMENT

Round Valley Indian Health Center

LVN-led pre-visit planning; 40% more well-child visits

PRE-VISIT PLANNING

Family Health Matters

Standing orders; diabetes foot exams 8% → 79%

BEHAVIORAL HEALTH

Aria Community Health Center

Behavioral health screening as a routine part of the visit

PERSISTENCE

Sacramento Native American Health Center

Standardized, translated PHQ-9; completion 11% → 94%

IN THE CHAT:

Please help us thank our storytellers in chat!

What are you carrying forward?

IN THE CHAT:

What's one thing you learned today that you'll take back and apply in your organization?

Feel free to unmute and share as well

NEED A STARTING POINT?

Think about...

- A **specific approach** a practice used that you'd like to try
- **Something in the data** the surprised you
- A **moment or quote** that resonated with you



Close & Next Steps

NEXT STEPS

Post-Event Survey

Please fill out the post-event survey.

Choose Session **1A (September 29)**.

Interested in CEs?

When completing the post-event survey, you will need to confirm that you would like to receive CECs and provide the necessary information to receive them. **Please complete it no later than end of day October 6th.**

The link will be posted in the chat and shared in the follow up email.

Would you like Continuing Education Credits? *

☒ Yes

☐ No

What type of CECs are you requesting? *

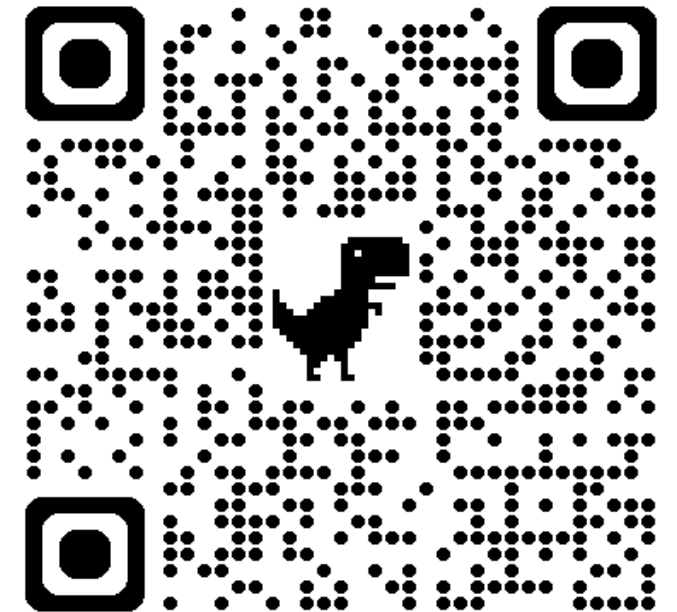
What is your license number? *

First Name *

Last Name *

Email *

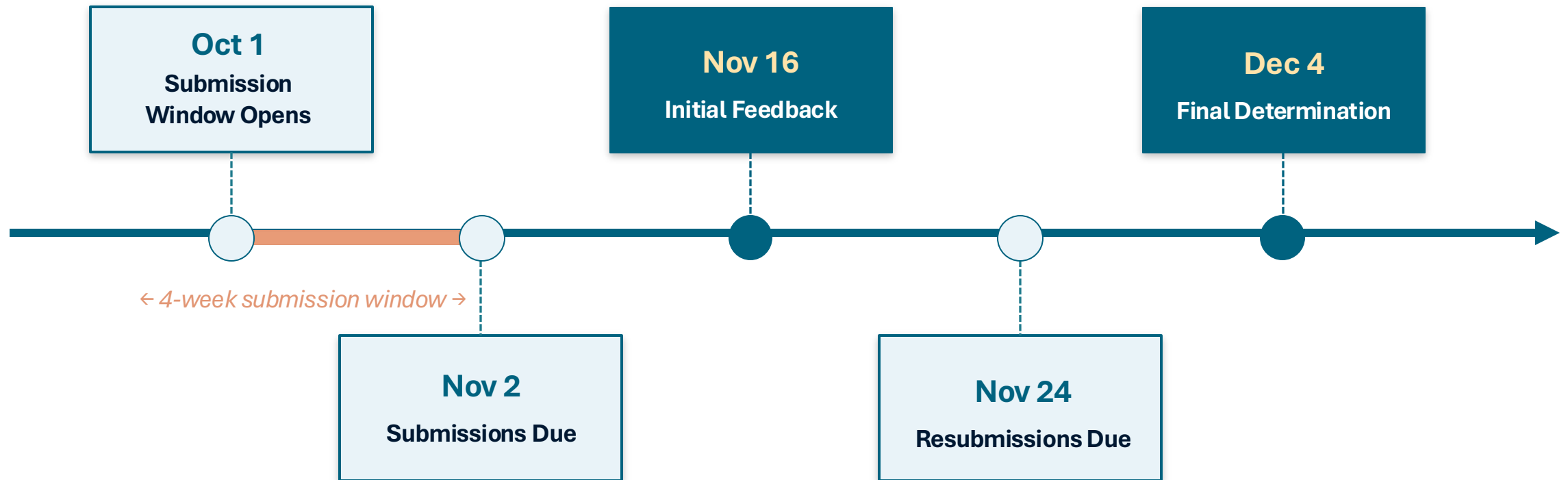
Organization *



Post-Event Survey

Final Submission Cycle

October 1, 2026 – December 4, 2026



Key Reminders

1	Learning Community Part 2	Please register and attend our Final Learning Community Part 2 Part 2 (select one) • Session A: Tuesday, October 6 3:00 – 5:00PM • Session B: Thursday, October 8 11:00 – 1:00PM
2	Final Submission Cycle	The final submission cycle opens October 1, 2026 and closes November 2, 2026.
3	Office Hours	We are offering weekly drop-in office hours throughout the month of October during our final submission cycle.

Holding the Gains: Sustaining & Spreading

WHAT WE'LL WORK ON

- **Mini Teaching:** Sustainability & spread frameworks for making improvements last — carried through a mock scenario with “Blue Clinic.”
- **Working Breakouts:** In each room, the group works a volunteer’s real improvement through the frameworks together — learning to apply them in real time.
- **Your Plan + Celebration:** Leave with a post-program sustainability plan, and close with a celebration of three years of work.

PART 2 DATES

SESSION A

Tuesday, October 6

3:00 – 5:00 PM PT

SESSION B

Thursday, October 8

11:00 AM – 1:00 PM PT



Thank you!