

THREE YEARS

Here's what we built

Sacramento Native American Health Center (SNAHC)
Disparity Reduction Plan- Depression Screening

Bryan Williams, Project Manager

Jamie DeJesus, Director of Operations

EPT Final Learning Community · Part 1 - October 1, 2026

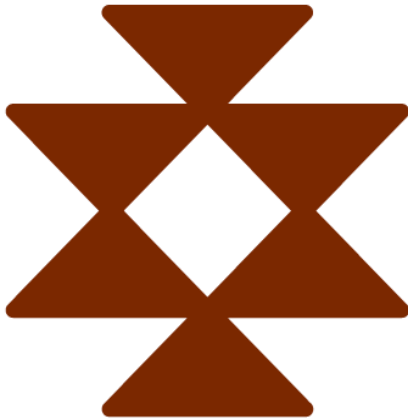


SACRAMENTO NATIVE AMERICAN HEALTH CENTER

WHO SPEAKS HERE
Bryan Williams, Project Manager



Who we are and who we serve



SNAHC
Sacramento Native American Health Center

1	Practice type FQHC providing Medical (Primary Care, Psychiatry & Optometry), Behavioral Health, and Dental services in Sacramento, CA.
2	Patients served 12,000+ Active Patients 90% Medi-Cal 10% Medicare.
3	Our EPT population of focus Adults with chronic conditions – most prevalent population with opportunity to strengthen routine screening.
4	What this storyboard is about Depression Screening – SNAHC Disparity Reduction Plan

Three Years Ago

Who we were before EPT

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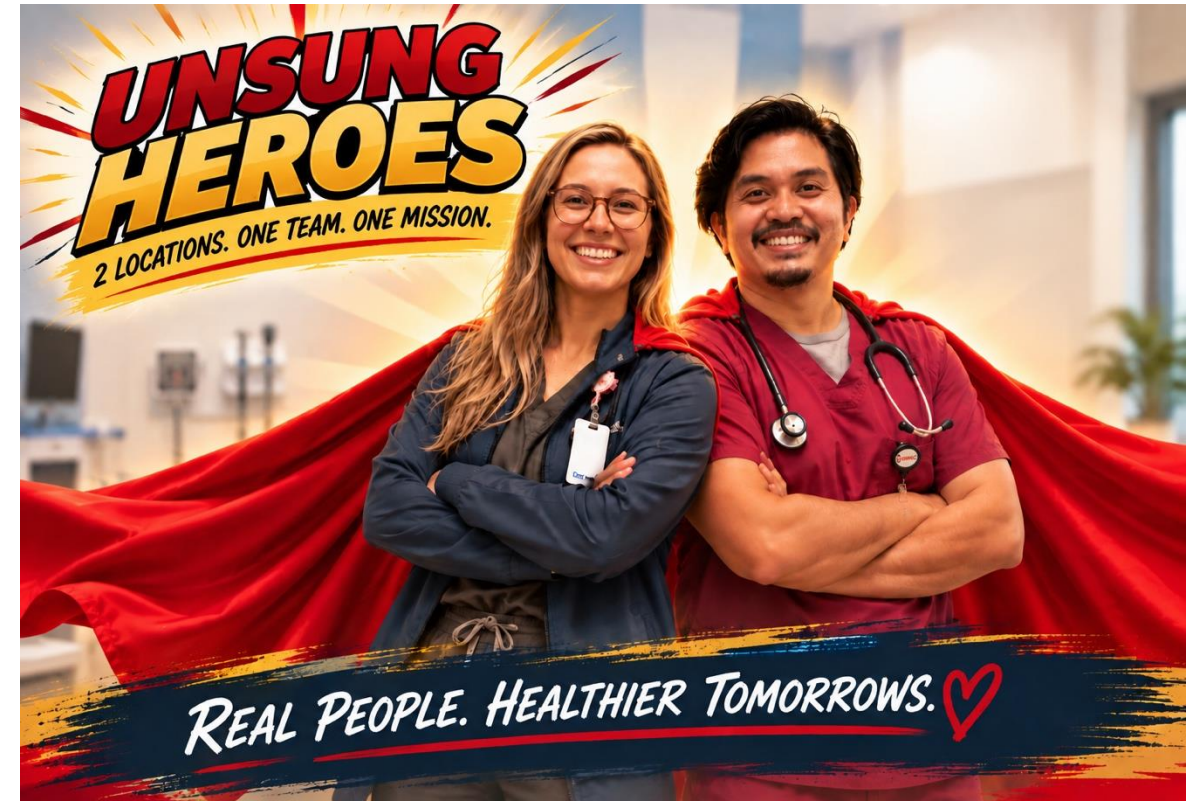


What could you not do in 2023 that this work was going to require?

Where we were

Key Gaps before EPT:

- No standardized PHQ-9 workflow for virtual visits
- Inconsistent criteria for identifying patients who needed screening
- Language and communication barriers affected engagement and follow-up
- No standardized cultural and linguistic process
- Limited tracking of PHQ-9 distribution and completion, making screening gaps difficult to identify



What Was Really Going On

What we found when we looked closer

WHO SPEAKS HERE

Jamie DeJesus,
Director of Operations



Why was the gap there? And how did you find out — did you ask patients, ask staff, dig into the data?

What we learned

- Inconsistent depression screening
- Variations in screening tools and PHQ-9 use
- Gaps in screening and follow-up
- Language barriers affected equitable screening
- Cultural stigma affected mental health discussions

In their words

“

We learned that inconsistent use of the PHQ-2 and PHQ-9, along with challenges identifying patients with existing mental health diagnoses, contributed to our screening gaps. Standardizing the PHQ-9 allowed us to improve both screening and ongoing monitoring.

— Chief Clinical Officer

What We Built

The change we made, and who runs it

WHO SPEAKS HERE

Jamie DeJesus,
Director of Operations



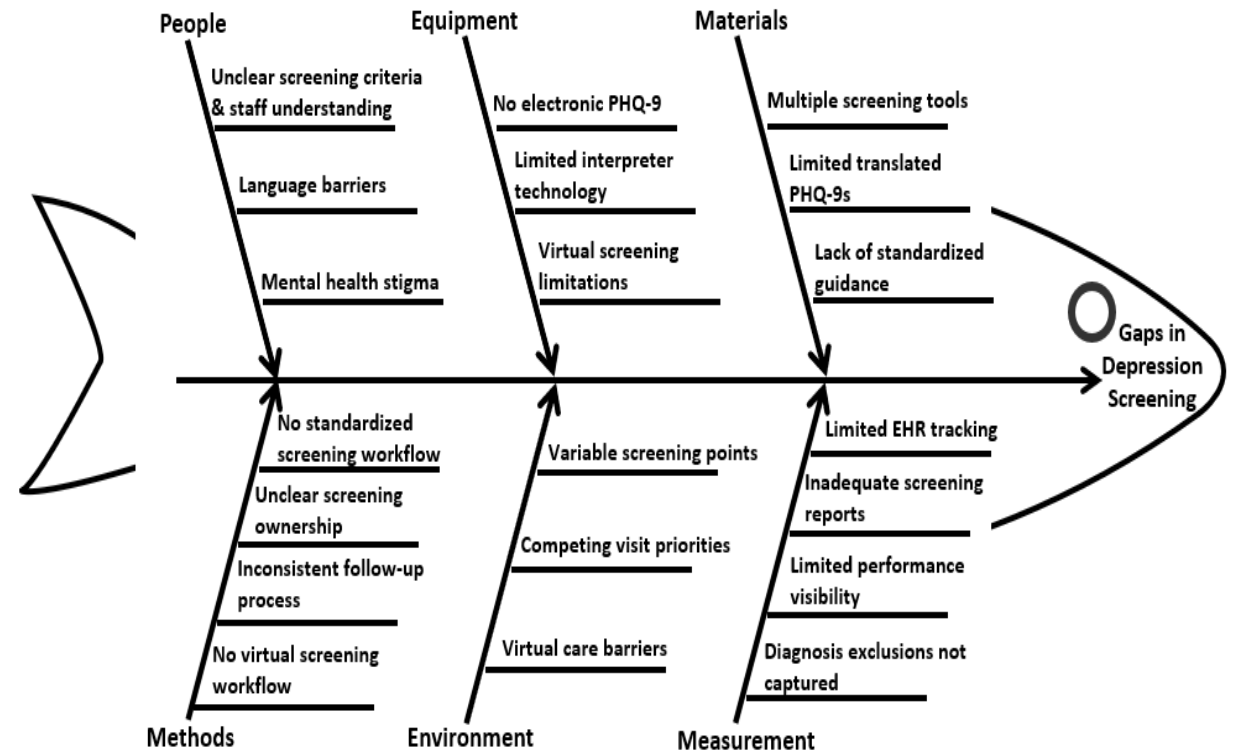
What did you build or change? Name it — then name who does it, and when.

The change

- Standardized screening using only the PHQ-9
- Translated PHQ-9 forms into our top 3 languages
- Expanded translation services through Propio and LanguageLine
- Targeted providers serving the highest volume of non-English-speaking patients
- Tested workflow changes through 2 PDSA cycles across PCP visits

From the person who runs it

“The translated PHQ-9 forms reduced the time needed for translation services. -Medical Assistant



The Patient Behind the Number

One story behind the numbers

“

Receiving the PHQ-9 helped me take the first step toward getting the support I had needed for some time.”

— SNAHC Patient in her early 40's

And the story around it

Our patient stated that she had been trying to figure out how to access one of our behavioral health or psychiatric providers. She reported that receiving the PHQ-9 questionnaire helped her initiate the process of connecting with the appropriate support. This sentiment was expressed, in person, to our clinic manager in one of our exam rooms.

WHO SPEAKS HERE

Bryan Williams, Project Manager



What We Can Do Now

The capability we did not have before

WHO SPEAKS HERE

Bryan Williams, Project Manager



Finish this sentence: “We can now...”

Standardize. Translate. Track. Identify. Improve.

- Consistently identify patients who may need behavioral health support
- Provide more equitable screening across language needs
- Support PHQ-9 screening during virtual visits
- Track screening and follow-up outcomes
- Use data to identify disparities and guide improvement

What it feels like now

“

Inconsistent PHQ-9 completion was due to a lack of standardized intake, clear patient criteria, and follow-through. Now our care teams are aligned on when a patient needs to be screened and who will do it.

- Medical Clinic Manager



And who does it reach?

A standardized approach helps ensure patients are screened consistently, regardless of language, visit type, or existing linkage to mental health care.

What It Took to Keep It Going

What it took, and what makes it sustainable

WHO SPEAKS HERE
Jamie DeJesus,
Director of Operations



What did it take to build and run, and what will keep it going? Dollars, FTEs, or hours all count, and estimates are fine.

What it took

Existing clinical, operations, and quality staff developed and tested the standardized PHQ-9 workflow through two PDSA cycles. The work included staff training, translated PHQ-9 forms, expanded interpreter resources, workflow development, and quality reporting. No dedicated FTE was added; the work was integrated into existing roles.

What makes it sustainable

The PHQ-9 is now embedded in the standard primary care workflow, with clinical teams owning screening and follow-up and Quality monitoring performance. Standardized workflows, translated forms, and established accountability allow the process to continue beyond EPT.

Focused Staff Time
Planning • PDSAs • Training
to build, one time

Existing Resources
No dedicated FTE
to keep it running

Quality & Equity
Better QI measures • Consistent screening
what it gives back

Say it in one sentence
With no dedicated FTE, SNAHC used existing resources to standardize and embed PHQ-9 screening into primary care, creating a sustainable workflow that improves screening consistency, equity, and quality performance.

What We'd Tell You

What we'd tell another practice

WHO SPEAKS HERE

*Jamie DeJesus,
Director of Operations*



1 If you were doing this over, what is one thing you would do differently?

We would establish the core team earlier, engage key stakeholders from the start, and clearly define roles and responsibilities. A RACI and stakeholder map would strengthen ownership and accountability throughout the project.

2 Where would you like to build on this, or grow next?

Building on our EPT work, we want to move beyond screening to strengthen follow-up and address barriers to care. Our next steps include developing a PCP-aligned Care Coordinator model and expanding our HRSN transportation work across service lines to improve access, engagement, and whole-person care.

3 Steal this from us.

Our PDSA workflow and tracking framework provide a practical approach for testing changes and monitoring progress. This can be adapted to fit your organizations unique workflows and patient populations. Early clinical team and stakeholder buy-in is key to successful implementation and sustainability.

Your 90-Second Preview

Before rooms open, you pitch your story so people can choose where to go.

You will not present this slide — draft what you will say here. We will help you polish it.

Three years ago, we identified an opportunity to strengthen and standardize depression screening in our organization. Through EPT and our quality improvement work, we took a deeper look at our data and workflows to identify gaps and target opportunities for improvement.

Our first PDSA cycle was a wake-up call. Our PHQ-9 completion rate dropped to just 11%, compared with our historical average of about 75%. We used this as an opportunity to understand what wasn't working. We identified inconsistent screening practices, language barriers, unclear ownership, and workflow challenges. After making targeted changes, our next PDSA cycle reached a 94% completion rate.

But the bigger story goes beyond the numbers. We learned what it takes to turn a gap into sustainable change, from engaging clinical teams and addressing disparities to building better workflows and using data to guide improvement. Join our session and leave with practical strategies you can adapt to your own organization to test what works, improve equity, and build changes that last.

**End on what they will get, not on what you did.
That is what makes people choose your room.**

THANK YOU

Questions?

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