PopHealth LEARNING CENTER

Reducing Health Disparities in Primary Care

LESSONS FROM THE EQUITY AND PRACTICE TRANSFORMATION PROGRAM

POPULATION HEALTH LEARNING CENTER

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How to Use this Report

Who Is This Report For?

This report is for primary care practices and the health plans, associations, and others that support them in improving clinical quality. This report includes insights from primary care practices across California working to understand and reduce disparities in health outcomes among their patients as part of the state's Equity and Practice Transformation program. If you are looking for ideas on how to identify a sub-population of patients that may not be sharing in your clinical quality gains or for ideas for practical changes you can make to reduce the gaps you found, this is the guide for you. Stories from different kinds of practices tackling different health disparities offer inspiration to get started.

At a Glance

The most important takeaway is that busy primary care practices can reduce disparities in health outcomes by using a structured approach to **identify**, **understand**, and **address differences.**

Identify: Practices in EPT addressed an array of quality measures where disparities were present, most often depression screening and follow-up, child and adolescent well-care visits, and controlling high blood pressure. Typically, EPT practices identified disparities using race, ethnicity, or language stratification of Healthcare Effectiveness Data and Information Set (HEDIS)-like quality measures.

Understand: Practices in EPT used both quantitative data and qualitative information from patients and staff to understand the root causes of care gaps.

Address: Sixty-one percent of practices used four or more strategies to reduce disparities that target both patient and practice-level improvements. Five common strategies of exemplary health disparity reduction plans include:

1. engage a broad array of staff in disparity reduction activities;
2. define patient subpopulations narrowly;
3. work directly with patients to understand gaps in care;
4. leverage technology to support workflows; and
5. use small tests of change to make improvements.

Three case studies highlight how a small independent practice, a large rural health care network, and a community health center each addressed a different gap in care: colorectal cancer screening, postpartum follow-up, and well-child visits, respectively. All three practices prioritized action over perfection: starting small, partnering with patients, and testing different approaches to reduce disparities.

Going Deeper

These early findings suggest that busy primary care practices can improve care for priority subpopulations by using stratified data, engaging patients and care team members in problem-solving, and incorporating targeted changes into everyday workflows. Primary care practices participating in the EPT program received technical assistance and aligned payment for accomplishing up to 25 milestones over three years from 2024 to 2026. This report presents quantitative and qualitative findings from three of the 25 milestones related to health disparities, including thematic analysis of 20 exemplary health disparity plans selected from among 147 approved plans, and in-depth case studies of three primary care practices tackling different health disparities in their patient populations.

For More Information

The Equity and Practice Transformation (EPT) program is a $140 million, three-year directed payment program supported by the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) that aims to improve health and reduce disparities in 198 diverse primary care practices across California including independent practices, community health centers, tribal health centers, and health system-affiliated clinics. For more information, check out **www.pophealthlc.org**.

1 Health Disparities in California

California is the nation's largest—and one of the most racially, ethnically, and economically diverse—states,[1] so improving health and well-being for all 39 million residents requires creative, coordinated, and data-driven strategies. Recently, California residents have seen significant gains in access to care, care quality, and population health,[2] but those gains have not been experienced equally across communities. For example, Black children experience asthma-related emergency department visit rates at nearly six times those of White children.[3] Black and Latinx Californians are more than twice as likely as White Californians to undergo diabetes-related amputations, an outcome preventable through effective primary care and chronic disease management.[4]

> **"Health disparities[5] are the differences in health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors."**

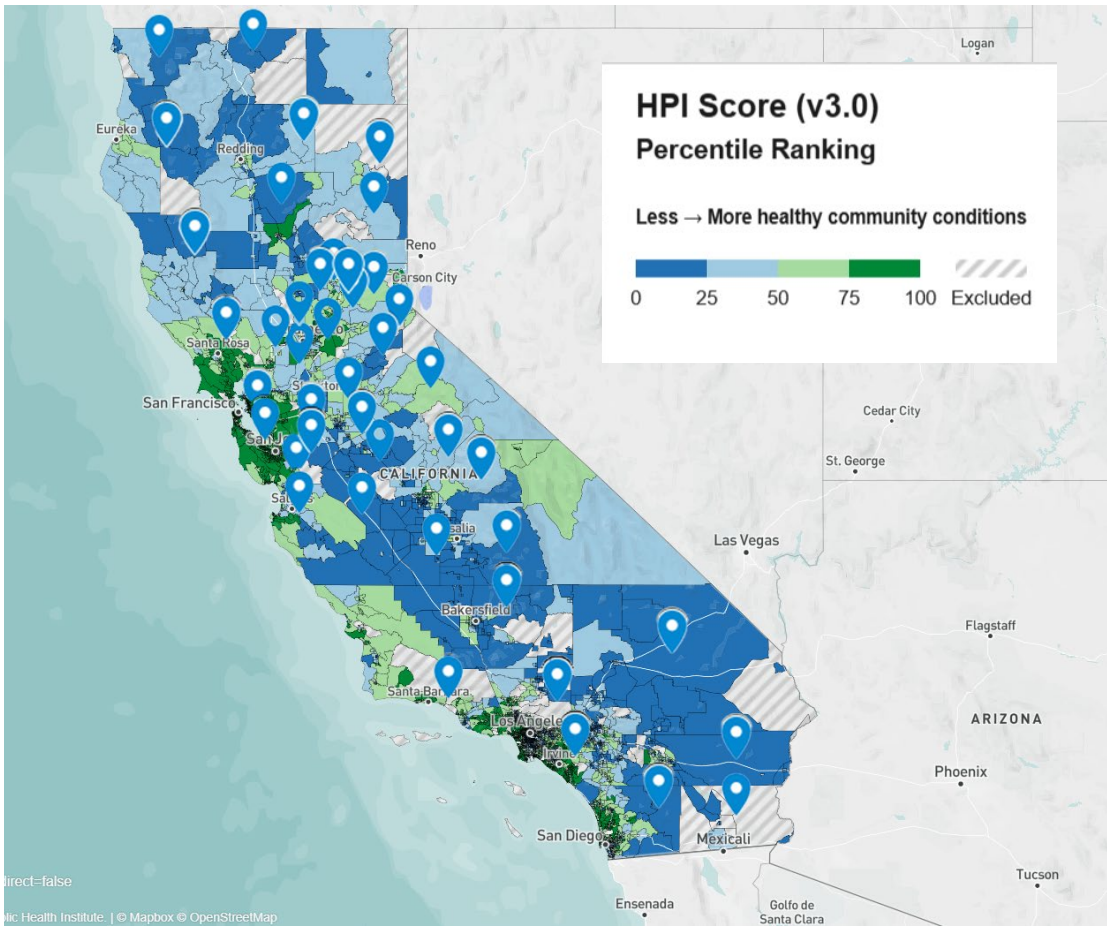
To address avoidable disparities like these, many recent California initiatives include disparity identification and reduction as part of their quality improvement and care transformation goals. Most notably, the state's Section 1115 Medicaid waiver, **California Advancing and Innovating Medi-Cal (CalAIM)**, explicitly targets social determinants of health by integrating physical, behavioral, and social health care services. CalAIM is a part of the Department of Health Care Services (DHCS) **Comprehensive Quality Strategy**, which identifies health equity as a core dimension of quality and advances demographic data collection, stratified measurement, and targeted quality improvement. Public purchasers have aligned to amplify these efforts. Covered California's **Quality Transformation Initiative (QTI)** establishes direct financial incentives for contracted health plans to improve quality and reduce disparities on a focused set of quality measures.

Building on this foundation, the **Equity and Practice Transformation (EPT)** program was launched in 2024 to improve population health capabilities, advance quality, and reduce disparities in 198 primary care practices serving two million Medi-Cal members across California. This report shares bright spots and lessons learned from participating primary care teams who have made significant efforts—in the context of busy clinical care—to identify and address differences in clinical care among their patients. Their efforts point the way forward for other primary care practices and their partner health plans to meaningfully close inequitable care gaps.

2 The EPT Program and Reducing Disparities

The EPT program is a three-year (2024–2026) $140 million directed payment program established by the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) to improve population health capabilities in primary care, advance quality, and reduce disparities. Nearly 200 primary care practices and 19 sponsoring managed care plans participate across 52 California counties (see Figure 1 for map). The participating primary care practices varied in practice type and size, with 55% classified as independent practices, 37% as community health centers, 6% as tribal practices, and 3% as health system-affiliated practices (together referred to as “practices” or “participants”). More than a third of participants report having three or fewer clinicians on staff.

Figure 1. Map of 198 Participating Practices in Counties with Healthy Places Index (HPI) Score (Map created by PopHealth Learning Center, 2026)



The **Population Health Learning Center (PHLC)** serves as the program office and helps practices achieve up to 25 milestone-based payments by providing technical assistance through coaching, peer learning, office hours, and electronic learning tools.

Three of the EPT program's 25 milestones are directly focused on disparity reduction:

1. Stratifying quality measures
2. Developing and implementing a disparity reduction plan
3. Reporting progress on disparity reduction over time

Through these milestones, practices follow a structured disparity reduction framework that includes:[6]

- Using demographic data, such as race, ethnicity, or language, to examine differences in performance
- Stratifying quality measures within a selected population of focus (POF)
- Identifying a priority subpopulation experiencing a disparity
- Investigating root causes with input from patients and staff
- Developing and testing targeted interventions through rapid Plan-Do-Study-Act (PDSA) cycles
- Tracking whether the disparity narrows over time

To review the methodology, see **Report Methods** on page 32.

3 Common Measures, Populations, and Disparity Reduction Interventions

Across the 198 practices in the EPT program, 147 have submitted and received approval on their health disparity reduction plans. Those plans provide a window into how practices across California propose to apply a common disparity reduction framework within different communities and care settings.

Stratify Quality Measures Within a Selected Population of Focus

Each primary care practice worked to improve care for one of five populations of focus (POF) throughout the EPT program. Table 1 shows the array of POFs for participating practices with approved disparity reduction plans. Most practices addressed children or adults with preventive care or chronic care needs (together, 89%).

Table 1. Populations of Focus in the 147 Practices with Approved Disparity Reduction Plans

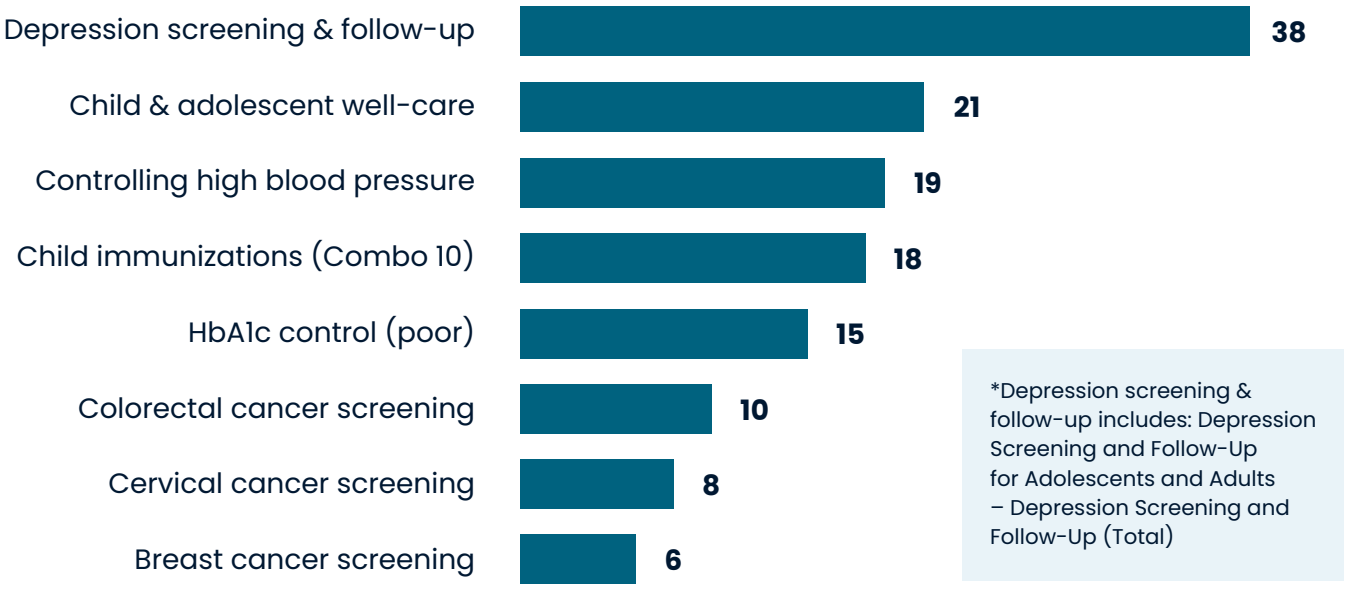
Population of Focus	Number of Practices (n=147)	Percentage of Practices
Children and Youth	56	**38%**
Adults with Chronic Conditions	46	**31%**
Adults with Preventive Care Needs	30	**20%**
People with Behavioral Health Needs	8	**5%**
Pregnant People	7	**5%**

Health Disparity Reduction Plans, PHLC 2026.

Each POF is associated with a set of four to eight quality measures that practices work to improve. These measures are aligned with Healthcare Effectiveness Data and Information Set (HEDIS) specifications but are applied at the practice level (termed "HEDIS-like" in the remainder of the report). In total, there are 21 measures across the five populations of focus that practices are working on.[7] Some measures are shared across multiple populations of focus.

For the disparity reduction plans, practices were encouraged to pick one measure where disparities were evident. Table 2 shows the measures most commonly selected in the disparity reduction plans. Depression screening and follow-up for adolescents and adults was the most common measure addressed across all populations of focus (38 of 147 practices).

Table 2: Most-Targeted HEDIS-Like Measures, The Top Eight Measures (n=147)



*Depression screening & follow-up includes: Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening and Follow-Up (Total)

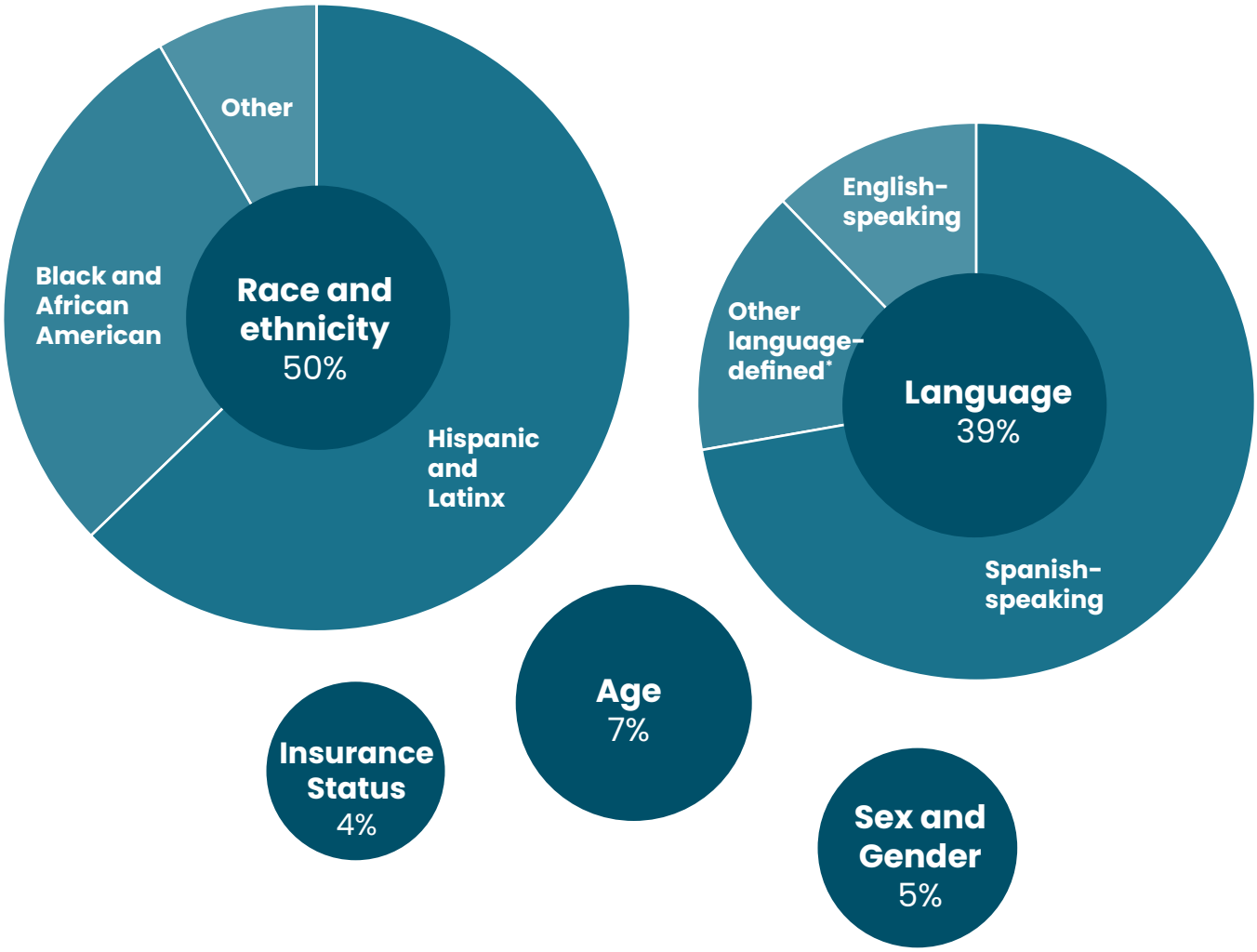
Health Disparity Reduction Plans, PHLC 2026.

Identify a Priority Subpopulation Experiencing a Disparity

Practices varied in how they defined the populations experiencing disparities on their selected measure. For the purposes of the disparity reduction plan, priority subpopulations were identified by demographic, social, or care-related characteristics. Half of the practices (50%) used race or ethnicity to explore disparate outcomes. Hispanic or Latinx patients were the most frequently identified specific subpopulation (31%), followed closely by Spanish-speaking patients (29%). Black and African American patients were identified by 14% of

practices. Practices also identified disparities among populations defined by age, sex, gender, insurance and housing status, geography, and other characteristics. Table 3 shows the top five patient subpopulations addressed by practices in their disparity reduction plans. Because some practices focused on populations defined by multiple characteristics, these categories are not mutually exclusive.

Table 3: Top Five Selected Subpopulation Dimensions and Examples (n=147)
(multiple dimensions may be selected)



Health Disparity Reduction Plans, PHLC 2026

*E.g., Mixtec, Russian, Dari/Pashto, Mandarin, Mandarin and Cantonese, Vietnamese

Select Strategies to Address Identified Disparities

After identifying a priority measure and patient subpopulation, practices were encouraged to investigate the factors contributing to the disparity and document that in their plans. Termed "root cause analysis," this investigation, when done well, involves both talking to patients about their experiences and examining clinical workflows and organizational processes. Practices then translate those findings into strategies, which can be tested in practice with defined activities, responsibilities, timelines, and measures of progress. Standard quality improvement approaches, such as **Plan-Do-Study-Act (PDSA)** cycles, help practices test small changes, learn from implementation, and refine their approach over time.

Table 4 shows the types of strategies that practices tested as part of the PDSA cycles to reduce disparities. Similar strategies were grouped into nine cross-cutting themes, as defined below. Strategies were not mutually exclusive; care teams within a single practice often incorporated multiple strategies to address both patient and organizational-level needs in their disparity reduction plan (93% of EPT program participants applied two or more strategies; 61% applied four or more).

Table 4: How Practices Are Working to Reduce Disparities: Share of 147 Disparity Reduction Plans that Incorporate Each Strategy

Strategy Theme	Definition	Percent (#) of 147 Plans
Care Team and Workflow Redesign	Changes to how care or disparity reduction work is organized or delivered, including new or reassigned staff roles, hiring, standardized workflows, and process changes.	88% (130)
Patient Education and Support	Patient- or family-facing education, counseling, coaching, decision support, or self-management support.	71% (104)
Language Access	Adaptations to communication or care based on language needs, including translated materials, interpreters, bilingual staff, and preferred language outreach.	51% (75)
Targeted Outreach	Proactive identification and contact of priority patients who are due or overdue for care or experiencing a care gap.	45% (66)

Continued on next page

Strategy Theme	Definition	Percent (#) of 147 Plans
Care Coordination, Navigation, and Access	Strategies that connect patients to social services, community resources, or other supports, including active navigation or coordination, referrals, assistance accessing services, and intentional provision of information about available resources.	39% (57)
Community Trust	Strategies explicitly intended to strengthen patient trust, safety, comfort, or confidence in engaging with care.	33% (48)
Culturally Responsive Care	Care, communication, or engagement explicitly adapted to patients' cultural identities, beliefs, experiences, or preferences.	28% (41)
Follow-Up and Re-Engagement	Reconnecting with patients after missed, incomplete, or unsuccessful care or engagement, such as no-shows, unreturned tests, incomplete referrals, or unsuccessful outreach.	22% (33)
Remote Monitoring	Structured monitoring of clinical indicators outside the practice, such as home blood pressure monitoring, with practice support or follow-up.	8% (12)

Health Disparity Reduction Plans, PHLC 2026

Across the 147 plans, care team and workflow redesign was the most common strategy, appearing in 130 plans (88%). This strategy included changes to staff roles and responsibilities, standardized workflows, dedicated staffing, and technology-enabled processes. Patient education and support strategies appeared in 104 plans (71%), followed by language access in 75 plans (51%), and targeted patient outreach in 66 plans (45%).

4 Key Insights from Practices Working to Reduce Disparities

Subject matter experts identified 20 exemplary approaches to reducing health disparities across the EPT program. Although these practices served different populations and addressed different measures, their plans shared common approaches to understanding disparities, translating findings into action, and sustaining improvement. These common factors of exemplary disparity reduction approaches may provide practical insights that other practices can adapt to their own settings. These examples underscore the importance of cultivating the conditions for improvement, including protecting time and space for teams to engage in disparity reduction work, providing access to stratified data, providing opportunities for patients to talk about their experiences, and offering resources to strengthen staffing and workflows.

Insight 1: Practices Involved a Broad Group of Staff in Exploring and Addressing Disparities

Across the highest quality health disparity reduction plans, practice teams described engaging an array of staff across roles and functions to identify the gaps in care and to brainstorm solutions, rather than delegating these activities to a quality improvement team, a single department, or an individual champion.

FOR EXAMPLE

One practice addressed disparities in postpartum care by gathering input from all 20 staff members in order to understand the gap and shape a response. Ultimately, the practice leaders expanded the role of a community health navigator who shared the language and cultural background of the practice's priority subpopulation. This community health navigator worked closely with clinical care teams to review disparity data and redesign care. In their disparity reduction plan, the practice team observed that staff were coming to work increasingly motivated, aware, and solution-oriented in improving health outcomes. Rather than placing responsibility for disparity reduction on one team or individual, the practice created a coordinated response that leveraged knowledge across staff roles and backgrounds.

Insight 2: Practices Defined Their Priority Population Narrowly and Described a Clear Direction for Action

A recurring theme across practices with strong health disparity reduction plans was the ability to clearly define a priority subpopulation of patients to work with in closing gaps in care. Identifying broad subpopulations can be useful for exploring where a disparity exists, but that can still leave practices with a large and heterogeneous group of patients, making it harder to understand why the gap exists and how best to intervene. Those practice teams who spent time further narrowing their focus uncovered more specific disparities and gained a better understanding of the experiences of their patients, which enabled them to more clearly define a response. In this way, narrowing patient subpopulations is not simply an analytic exercise; it can make each subsequent stage of disparity reduction more focused and actionable.

FOR EXAMPLE

One practice team that focused on adults with chronic conditions narrowed its disparity reduction target to improving blood pressure control for Korean-speaking patients receiving care through telehealth. In that practice, Korean-speaking patients receiving telehealth-only care had a blood pressure control rate of 6%, compared with 64% of all patients. After noticing the gap, the clinical team distributed home blood pressure monitors and applied education as a first step toward a structured remote blood pressure monitoring program where data could be shared with providers in real time. Rather than approaching hypertension broadly—or even focusing only on Korean-speaking patients or patients receiving care through telehealth—the practice team identified a specific breakdown in care and designed their response around it. Starting small can give practice teams a manageable entry point for understanding a disparity in greater depth, testing a targeted response, and identifying which activities may be useful to sustain or expand.

Insight 3: To Understand Care Gaps, Practices Talked Directly with Patients

All approved disparity reduction plans required practices to use quantitative data to identify a gap in care for a particular patient subpopulation. In exemplary plans, practice teams reached out directly to patients to understand why the gap existed and asked for their input in how best to help address it. This detailed patient input helped teams distinguish between barriers rooted in patient experience, care delivery, or organizational processes and conditions that extended beyond the practice. These patient perspectives pushed practices to think beyond their assumptions and allowed them to shape relevant and feasible responses to patient needs.

FOR EXAMPLE

One pediatric care team within a practice identified Hispanic or Latinx children as their priority subpopulation for the child immunization status (Combo 10) measure after identifying a large gap in performance. Rather than relying on the stratified data alone, the team paired their quantitative findings with staff interviews and surveys of patients' families to better understand what might be contributing to the disparity. Patient feedback helped the practice team better understand concerns about vaccine hesitancy and to tailor education, literacy materials, and communication to families. Pairing quantitative findings with qualitative insights can help practices ground their approach in the experiences of those affected and the teams responsible for addressing the disparity and support more effective interventions.

Insight 4: Practices Leveraged Technology to Sustain Improvement

Within practices with strong disparity reduction plans, teams described using electronic health record (EHR) prompts, tracking systems, automated outreach, translation services, home-monitoring tools, and other technology supports to better care for patients.

FOR EXAMPLE

One pediatric practice added an EHR prompt to improve depression screening among Spanish-speaking adolescents. In addition to the prompt, workflows were designed so that Spanish-speaking medical assistants could describe the importance of the screening to patients during check-in and make language-concordant screening forms consistently available. Leveraging automated tools with culturally aligned patient support was a hallmark of strong plans.



Insight 5: Practices Tested Small Changes to Inform Improvements

Strong disparity reduction plans described an iterative approach to testing changes in care, studying what happened, and deciding whether to adapt, adopt, or move away from the approach. In this context, an unsuccessful first, second, or third attempt was not viewed as a failure, nor did it deflate a practice's commitment to this work; these attempts generated information that sharpened the next attempt and propelled the work forward.

FOR EXAMPLE

One practice team that addressed a substantial disparity in blood pressure control among Native American patients developed a standardized workflow that included culturally tailored education, blood pressure rechecks, home monitoring, and scheduling follow-up visits before patients left the visit. As the practice team tested the approach, staff found that blood pressure rechecks and education were being carried out consistently, but follow-up communication was unreliable and some patients needed additional education. Rather than treat those mixed results as a failure, the practice team applied what it learned to shape its next improvement attempt cycle. They strengthened the process for scheduling follow-up calls, added a checklist to support consistent patient education, and expanded culturally tailored educational materials. In doing so, the practice team refined their approach and translated what they learned into a more reliable and routine way of delivering care.



5 Disparity Reduction Case Studies

The following case studies illustrate how three practices of varying sizes, types, and geographies, working across different populations of focus and measures, translated the principles and approaches described above into action. These examples reflect a broader truth: Progress is not always linear, root causes can be nuanced, and some of the most important outcomes may involve changes in patient trust, workflow, organizational capacity, or how teams understand and respond to inequities over time. What makes these practices promising is not that the teams' journeys are flawless or complete, but that they surface lessons others can recognize, adapt, and carry forward.

CASE STUDY 1

Kaweah Health

5 sites | Postpartum care

CASE STUDY 2

Isaias De Guzman Para Jr., MD Inc.

2 sites | Colorectal cancer screening

CASE STUDY 3

University Muslim Medical Association (UMMA)

7 sites | Well child visits, 15-30 months

Kaweah Health
MORE THAN MEDICINE. LIFE.

Case Study 1: Kaweah Health

Kaweah Health serves Tulare County, located in California's Central Valley, where residents are dispersed across small cities and rural communities with a large agricultural worker population. Within Kaweah Health's Rural Health Clinics, approximately two-thirds of patients are Hispanic or Latinx, more than half of patients speak a language other than English, and nearly 60% are insured by Medi-Cal. For patients across these communities, the Rural Health Clinics provide local access to primary care and other services within a much larger regional health system.



Case at a Glance

Practice:	Kaweah Health
Location:	Tulare County, Central Valley (population: ~485,000)
Setting:	Regional health care system; 5 locations; 5,000+ employees
EPT POF:	Pregnant people
HEDIS-Like Measure:	Postpartum care (PPC)
Priority Subpopulation:	Patients with ethnicity recorded as unknown or declined
Baseline Disparity:	44% postpartum care completion among the priority subpopulation compared to 77% completion overall
Strategies:	Community trust; patient education and support; care team and workflow redesign; language access



Finding a Disparity Others Might Overlook

Pregnant people were a natural starting point for Kaweah Health's EPT program work. Maternal health was already an organizational priority, with many efforts underway to improve care for pregnant people, including a community health worker pilot program serving pregnant farmworkers in Tulare County. Kaweah Health selected pregnant people as its EPT program population of focus to continue developing an area where the health system was already deeply invested.

For disparity reduction, Kaweah Health homed in on postpartum care (PPC) as its HEDIS-like measure, which represents the percentage of eligible deliveries with a postpartum visit between seven and 84 days after childbirth. When the team stratified their data, only 44% of those whose ethnicity was recorded as unknown or who declined to answer met the measure, compared with 77% overall. The team chose to investigate this gap more closely. In doing so, Kaweah Health also observed lower performance among patients with unknown or declined demographic information in their prenatal care data. Sonia Duran-Aguilar, MSN, MPH, RN, PHN, CNL, Kaweah Health's director of population health, recalled hearing fellow staff member Missa Leyva, outpatient business analyst, recommend "looking at the unknowns" and prioritizing learning more about the experiences these patients. To explore what was driving the difference in performance, the team began asking what an unknown or declined ethnicity response meant for patients. Could understanding why patients chose not to disclose their race and ethnicity reveal something important about their interactions with the health system?

Looking Beyond the Data to Understand Community Needs

Kaweah Health's team sensed heightened fear and uncertainty in the communities they serve. They had heard patients express fears about encountering newly expanded Immigration and Customs Enforcement (ICE) agents which led to some patients skipping appointments and avoiding health care and community outreach activities. Against this backdrop, the team suspected that questions about race, ethnicity, language, and other demographic information carried greater significance for patients who already felt uncertain about whether it was safe to engage with health care.

Patient feedback gathered by the Kaweah Health team confirmed these concerns. Some patients questioned why demographic information was being collected and whether it would be shared. Duran-Aguilar emphasized that the gaps in prenatal and postpartum care for people worried about sharing their demographics. "[It] did not happen in a vacuum. It happened within the context of our community," Duran-Aguilar said.

For Kaweah Health, that feedback raised the possibility that an unknown or declined ethnicity field represented a lot more than a data completeness exercise; it reflected a reasonable hesitation about why information was being requested and how it would be used. That interpretation focused the team's attention on improving interactions with patients, such as reviewing how questions were phrased, coaching staff on how to explain the purpose of collecting demographic information, and proactively reaching out to concerned patients. Duran-Aguilar said, "We need to build trust in order to gather better data and to get our patients to come in and see us."

> **"We need to build trust in order to gather data and to get our patients to come in and see us."**
>
> Sonia Duran-Aguilar, MSN, MPH, RN, PHN, CNL, Director of Population Health, Kaweah Health

Trust at the First Point of Contact

Kaweah Health started with patient access staff responsible for registration and check-in, the "very first face that patients see," as Leyva described. The practice team established a workflow in which patient access staff would ask about a patient's ethnicity information if their record showed *unknown* or *declined to answer* during the visit's check-in procedure. The key change was moving this conversation from one focused on completing a form to one focused on building a trusting patient and care team relationship. The staff were trained to provide verbal education about why the information was collected and how to respond to patient concerns. Site managers also placed signage in English and Spanish in patient care areas that read: *We ask because we care.*

As much as possible, patient access staff were hired to reflect the communities they served. In recalling her own experience working at the front desk, Leyva noted that, before she became comfortable communicating fully in Spanish, some Spanish-speaking patients would wait to speak with a bilingual colleague, even when she was available. After improving her Spanish, she described the difference in those interactions as "night and day," with patients more willing to engage with her. That experience informed how Leyva approached the disparity work. A registration field may appear in the data as simply *unknown* or *declined*, but the information is gathered in a person-to-person interaction. Leyva's own experience had shown her how differently those interactions could unfold when the focus of the conversation was about building trust.

Building Momentum

Though patient access staff were responsible for the conversations with patients at check-in, site managers were assigned to check on progress and patient feedback monthly. Creating a regular opportunity to hear what staff were learning from those conversations prompted a shift in how the team thought about disparities. Leyva described the tendency to look at a lower-performing population and ask why patients were not performing as well as they should. Her takeaway was to flip the script and say, "Maybe, it's us." Rather than beginning with a goal to change patient behavior, the team thought about what practices could change, including how questions were asked, how concerns were received, and whether the team's interactions made it easier or more difficult for patients to feel comfortable engaging with care.

Findings and Next Steps

From 2024 to 2025, Kaweah Health increased postpartum visits for patients with unknown ethnicity to

100%

Interim data shows Kaweah Health made tremendous progress in assuring patients with unknown ethnicity received guideline-based postpartum care: from 50% of patients in 2024 to 100% of patients in 2025. Though the total number of patients reached was small (less than 20) the team noticed real changes in patient and staff interactions. Patients were gaining a better understanding of why demographic information was collected, while patient access staff felt better supported in explaining its intended use, responding to concerns, and providing reassurance to patients. The team also described greater staff engagement in understanding which patient populations were experiencing disparities. These observations demonstrated improvement in the compassionate discussions occurring at the center of the team's strategy.

The Kaweah Health team is thinking about how they might spread lessons learned from this work to other frontline staff, help them to reshape their approach to building trust through patient conversations, and create the potential to influence data completeness, patient experience, and engagement in other areas of care.

"Look a little bit further than the data, because sometimes it just comes down to the way that you treat people."

Missa Leyva, Outpatient Business Analyst

Advice for the Field

Prioritizing the gaps in care for people with unknown or declined race or ethnicity was an unconventional approach. By choosing to lead with curiosity, the Kaweah Health team surfaced questions about trust and safety that they believed were important to understanding their patients' experiences. Leyva advises other practices to do the same. "Look a little bit further than the data, because sometimes it just comes down to the way that you treat people," Leyva said.

The Kaweah Health team's experience also reinforced the value of giving disparity reduction work the time its underlying challenge requires. The team described building trust as work that warranted more time than it might typically give to other improvement efforts, especially given that the political landscape around immigration has only intensified since this work with EPT began in 2024. For the Kaweah Health team, working to narrow a postpartum care gap was just the beginning of an ongoing effort to strengthen the trusting relationships between patients and care teams.

Case Study 2: Isaias De Guzman Para Jr., MD Inc.

Isaias De Guzman Para Jr., MD Inc. is a small independent practice serving communities in Los Angeles County. The practice serves 2,562 assigned Medi-Cal patients with a team of roughly 10 staff and providers. The practice offers a strong example of how a smaller team can undertake structured disparity reduction work alongside the demands of day-to-day patient care in a complex urban environment.



Case at a Glance

Practice:	Isaias De Guzman Para Jr., MD Inc.
Location:	Two sites in Los Angeles County (Central LA; Long Beach)
Setting:	Small independent private practice
EPT POF:	Adult preventive care
HEDIS-Like Measure:	Colorectal cancer screening (COL)
Priority Subpopulation:	Spanish-speaking Latino men
Baseline Disparity:	~10% colorectal cancer screening completion among Spanish-speaking Latino men, compared with 36% among Latinx patients overall, and 100% for White patients
Key Approaches	Care team and workflow redesign; patient education and support; language access; follow-up and re-engagement

Starting with Stubborn Gaps

Colorectal cancer screening (COL) had long been known as one of the practice's most persistent preventive care challenges. Among the measures that the team tracked, including mammography, cervical cancer screening, and colorectal cancer screening, Susan Manabo, NP, MSN, the practice's managing partner, nurse practitioner, and EPT lead, said that colorectal screening, "was the lowest that we have." Manabo and Dr. Isaias De Guzman Paja Jr, MD, noticed the problem in day-to-day care. Patients received fecal immunochemical test (FIT) kits, but some did not understand the instructions or why screening was important, and others had difficulty completing or returning specimens.

A closer look at the practice data alongside health plan performance information revealed a disparity in colorectal cancer screening by race and ethnicity. The practice reported completed colorectal cancer screening for 36% of Latinx patients, compared with 100% of White patients. For Spanish-speaking Latino men, the gap was even larger with a completion rate of only 10%.

"Find out [first] what's causing the issue…and then you will understand how to approach it."

Susan Manabo, NP, MSN, EPT Lead and Managing Partner at Isaias De Guzman Para Jr., MD Inc.

Slowing Down the Process

Upon discovering the disparity, Manabo's first instinct was to act; she described her response as *let's do, let's do, let's do*. But the disparity reduction process introduced an important counterweight to that urgency: Before deciding what to do, the team needed to understand what was driving the gap. Rather than moving immediately from a low screening rate to a solution, the practice team first examined why screening completion was low. Manabo said, "Find out [first] what's causing the issue, or why is it so low, and then you will understand how to approach it."

Instead of assigning blame to patients for not completing the tests, the practice team began by exploring if they were giving sufficient language-concordant information and support to do so.

The root cause process informed how the team addressed the problem. Patients noted that language access was one barrier. Spanish-speaking patients did not always receive screening information and FIT instructions in language that was clear and accessible to them. In addition, Manabo recalled that, sometimes, patients left without sufficient explanation about what to do with the kit or why it was important to complete and return it. Reflecting on feedback from patients and staff, she said, "We were not doing it the right way. We were not giving the highest level of care we can give." Instead of assigning blame to patients for not completing the tests, the practice team began by exploring if they were giving sufficient language-concordant information and support to do so. The team saw opportunities to

strengthen how screening was explained to patients, make communication more accessible for Spanish-speaking patients, create greater consistency across staff, and provide more support after patients left the visit with a FIT kit. Spending time unpacking the disparity in this way did not lessen the urgency to improve colorectal cancer screening rate; it gave the practice team a more developed foundation for deciding what to change and how to put those changes into practice.

Turning Root Causes into a Team-Wide Workflow

Manabo established a shared goal with the whole team, discussed the disparity across the practice, and made sure everyone understood what they were collectively trying to change.

From there, Manabo and the team built a clearer workflow with specific accountabilities by role. Before scheduled visits, staff reviewed which patients were due for colorectal cancer screening. Medical assistants helped to identify screening needs, provided FIT kits, and explained how to complete them; clinicians placed screening orders; schedulers contacted patients; and front desk staff checked clinical decision support reminders in the EHR. The team also looked for screening opportunities beyond annual wellness visits and used other patient encounters as another chance to identify and address outstanding care gaps. Colorectal cancer screening was more intentionally built into the regular work of the practice.



In addition, the practice team developed a Spanish-language verbal script for medical assistants, translated lower-literacy educational materials, and created educational videos to help patients understand both why colorectal cancer screening mattered and how to complete the FIT test. Rather than simply handing patients a kit, staff were expected to explain the process and reinforce its purpose in language that patients could understand.

Because completing a FIT test requires patients to take the kit home and return or mail the specimen, the team recognized that handing out the kit was only the beginning. If a specimen had not been returned after approximately two weeks, staff followed up through phone calls or text messages and continued reminding patients, as needed. Manabo described the practice as intentionally using communication methods that were more accessible to their patient

population rather than relying on email. She identified this persistent follow-up as one of the components she believed helped move screening rates. She said, “We pursue, pursue, pursue, pursue.”

Making the new process routine was another challenge. With limited staffing and employees already managing multiple responsibilities, Manabo spread the new responsibilities across existing roles, recurring meetings, and everyday workflows. Over time, what began as an additional improvement effort became more integrated into how the team identified, educated, and followed up with patients experiencing gaps.

Meaningful Progress and Continued Refinement

The practice recorded meaningful improvement in the months that followed. Screening among Spanish-speaking Latino men increased from approximately 10% at baseline to 23.7% six months later. That improvement translated to 66 of 279 patients in the selected subpopulation meeting the measure, an improvement of roughly 13 percentage points.

More than
doubled
the number of Spanish-speaking Latino men who underwent colorectal cancer screening.

For Manabo, seeing movement on a measure that had long been one of the practice’s most difficult preventive care challenges was significant. Colorectal cancer screening had stood out as one of the lowest performing preventive measures across the practice, and she recalled the team being excited when the new results came in. More important than the percentage itself was what it represented: More patients who needed screening were being reached. Manabo described the improvement as evidence that the team’s hard work was beginning to “pay off a little bit” and it reinforced her belief that, “if we work together as a team, we can make some improvement.”

The team also heard evidence of that change directly from patients. Manabo recalled one Spanish-speaking man who had gone without colorectal cancer screening for some time. After the practice changed how it communicated about screening, he told her that learning why the screening was important and receiving directions in a way he could understand had made a difference.

At the same time, the practice did not view the improvement as an endpoint. It continues to work to close the gap with Spanish-speaking Latino men who still were not current with screening and to stay consistent with the use of EHR clinical decision support. “Sustaining is the hard part,” Manabo said.

Looking Ahead and Advice for the Field

For the team, one of the most important outcomes of the work was learning a process that they could use again. Manabo described the experience of reducing disparities in colorectal cancer screening as a framework that could be applied elsewhere: Examine the data more closely, understand the barriers and root causes behind a gap, involve patients and staff, test changes, and continue refining the workflow based on what the team learns. “I will have this as my template,” she said, pointing to cervical cancer screening, mammography, and other measures where the practice continues to see room for improvement.

Building that new improvement capacity was particularly meaningful for an independent private practice working with limited staff and resources. Manabo credited EPT program training, coaching, and implementation resources with giving the team tools to address problems it already knew it wanted to solve. She described the experience as one that “opened our eyes,” helped the practice uncover gaps in its existing processes, and provided a structured and replicable approach to addressing them together. Manabo said, “We learn so much. It’s not the I, but it’s we as a team.”

Her advice to other practices is simple: Be patient with the process and persistent about the goal. Improvement will not always work exactly as planned, and practice teams should expect to learn from what does not work. Rather than treating those moments as failures, Manabo encouraged teams to adjust and try again. “If you make mistakes, correct the mistake, and then do another PDSA,” she said. For a small practice like hers, the work was not easy, but the lesson was that meaningful improvement did not require getting everything right the first time. It required a team willing to keep examining, testing, learning, and trying again.

Case Study 3: University Muslim Medical Association (UMMA)

University Muslim Medical Association (UMMA) is a community health center serving communities across South Los Angeles with an additional location in San Bernardino. UMMA has grown rapidly in recent years. In 2025, the organization served approximately 9,180 patients, a 25% increase from just two years prior, with 80% of its patient population insured by Medi-Cal. More than half (59%) of UMMA's patients identify as Hispanic or Latinx; children comprise roughly one-third of the patients UMMA serves. UMMA provides pediatric and adult primary care alongside prenatal care, urgent care, dentistry, podiatry, and other wellness and community-based services.



Case at a Glance

Practice:	University Muslim Medical Association (UMMA)
Location:	South Los Angeles, plus a San Bernardino location
Setting:	Community health center (CHC); four locations and three school-based health centers
EPT POF:	Children and youth
HEDIS-Like Measure:	Well child visits, 15-30 months (W30B)
Priority Subpopulation:	Children from Spanish-only-speaking families
Baseline Disparity:	61.1% of well child visit completion among children with Spanish-speaking-only parents, compared with 69.6% among children whose parents reported a spoken language including English (8.5% gap)
Key Approaches:	Targeted outreach; follow-up and re-engagement; care team and workflow redesign; language access; patient education and support

Growing Fast and Looking Beyond the Aggregate

UMMA's disparity reduction work took place during a period of significant organizational growth. Priscilla Monserrate-Sanders, MPH, UMMA's senior director of quality and population health and the EPT program implementation lead, recalled that the organization had historically strong performance on pediatric well child measures, but that performance became more difficult as new sites, patients, staff, and workflows were incorporated into the system. New care teams needed time to learn established processes from more experienced staff, while patients needed time to build relationships and trust with newly established teams. Monserrate-Sanders said, "We used to score much higher when we were two clinics, but we went from two to seven in 18 months."

UMMA teams were engaged in disparity reduction and quality improvement work among their adult population. According to Monserrate-Sanders, the EPT program created an opportunity to focus intentionally on pediatrics and to leverage UMMA's growing data capabilities to "drill down and look beyond the aggregate." For their disparity reduction plan, UMMA focused on well child visits for children aged 15 to 30 months (W30B). Overall, 65.9% of eligible children received well child visits, but stratifying the measure by language revealed a disparity: 69.6% of children whose parents reported a spoken language including English met the measure, compared with 53.1% of children whose parents reported Spanish as their only spoken language.

Making a Small Population Visible

UMMA brought the stratified data to a cross-functional group that included medical assistants, nurses, clinicians, operational and population health staff, and leadership. The team then used patient and staff interviews, workflow mapping, root cause analysis, fishbone diagrams, and prioritization exercises to better understand what was driving the gap. As Monserrate-Sanders explained, the goal was to "present the data to a group that represents the system" and incorporate key informant interviews to "give color to the data."



When looking at their stratified population level data, UMMA saw the disparity, but staff in the meeting noted that children of Spanish-speaking-only parents were not visible in the day-to-day outreach lists they used to organize their work. Instead, the population of children whose families spoke only Spanish were dispersed throughout much larger care gap and outreach lists. As a result, these families could be visible analytically while still being difficult for outreach staff to identify and contact in practice.

Conversations with Spanish-speaking-only patients amplified the message that they were not effectively being reached. They noted that they did not fully understand what they were being asked to do or did not realize that additional well child visits were needed. Together, the staff and patient findings gave UMMA a more precise target for improvement. The challenge was for teams to conduct more targeted patient outreach by identifying the Spanish-speaking-only families within existing workflows and outreach lists; to strengthen language-concordant communication; and to create clearer roles and responsibilities for reaching out to patients for follow-up.

Transforming Data and Root Causes into an Integrated Intervention

UMMA translated its findings into a coordinated outreach strategy built around four components: a pediatric tracking tool aligned with the **Bright Futures schedule**, standardized outreach scripts in English and Spanish, a dedicated patient outreach coordinator, and a more structured process for reminders and follow-up after missed appointments. This strategy gave the team a more consistent way to identify, prioritize, communicate with, and follow up with families who were falling behind on well child visits.

One central change UMMA made was intentionally elevating the subpopulations with the biggest care gaps in their outreach lists. Rather than working through general care gap lists, the team identified and prioritized Spanish-speaking-only families. Initially, staff manually searched the care gap lists and identified the Spanish-speaking-only families. Then the team worked with their population health platform to automate it so that patients beginning to fall behind could rise to the top of outreach lists. In this way, technology facilitated the sustainment of a process the team had already developed and tested.

Next, UMMA tested outreach to Spanish-speaking-only families led by language-concordant medical assistants (MAs). Competing clinical responsibilities made it difficult for the MAs to consistently attend to the outreach work, so UMMA secured additional funding to hire a dedicated patient outreach coordinator. This dedicated staff member created clearer responsibility for proactive outreach, maintained the tracking process, followed up with families, and monitored completion of recommended well child visits.

The intervention continued to evolve through successive PDSA cycles. The team continued to adjust responsibilities, refine processes for patient follow-up, and share back insights about their improvements to the broader care team. What began as a targeted response to one disparity became a more integrated system for using data to decide who needed attention, assigning responsibility for reaching those patients, and learning from what happened next.

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Progress and Challenges

UMMA saw improvement in well child visits for its priority subpopulation. Among children with Spanish-speaking-only parents, completed well child visits increased from 53.1% in November 2025 to 72.2% in the May 2026, a 19.1 percentage point improvement.

almost
50%
Improvement of well child visits following this intervention.

The experience also gave UMMA a clearer sense of what it takes to make disparity reduction actionable. Working with a targeted subpopulation allowed the team to closely observe how changes in outreach, prioritization, and follow-up translated into movement in the measure, while also reinforcing the importance of monitoring both rates and the individual patients behind them. For Monserrate-Sanders, the work demonstrated the value of pairing stratified data with a disciplined improvement process and sustaining the team's attention on whether the gap was being closed.

Looking Ahead and Advice for the Field

UMMA is already carrying lessons from the project into its broader pediatric improvement work. Close tracking revealed that some children were returning for sick visits or follow-up appointments while still missing well child care, which prompted the team to work with their pediatric clinical lead to identify additional opportunities to address preventive needs during those encounters. UMMA subsequently developed age-specific follow-up templates that incorporated anticipatory guidance and health education, which were to be shared with patients regardless of the visit type. Monserrate-Sanders described developments like these as the project's ripple effect. The experience has prompted UMMA to look for disparities in other measures and demographic groups. As Monserrate-Sanders said, the original work became "much bigger than our pediatric population" and created new ways for the team to examine disparities by race, ethnicity, language, and other characteristics and to adjust their outreach accordingly.

Conclusion

The experiences described in this report offer early examples of how primary care practices can move from identifying disparities to taking action. Across different settings and patient populations, promising approaches paired stratified data with insights from patients and staff, translated those insights into specific changes in care delivery, and applied small tests of change to inform the work over time. These efforts helped practices look more closely at who was missing recommended care and what their teams could do differently to reach them.

The three case studies illustrate both the potential of this work and the persistence it requires. All three practices reported improved completion of recommended care among their priority subpopulations. Together, their experiences show why progress must be assessed through continued measurement alongside attention to what patients and staff are learning. Improvements in care for a priority subpopulation are encouraging; determining whether disparities narrow requires tracking the gap over time.

For other primary care practices, these findings offer practical strategies: Identify a specific gap, involve the people experiencing it, and build a response into the everyday work of the care team. Health plans and organizations supporting primary care practices can help create the conditions for that work through access to usable data, coaching, and resources for implementation. As practices in the EPT program continue their efforts, their experiences can deepen understanding of how targeted improvements can be sustained and contribute to more equitable care.

Report Methods

Data for this report come from the three Equity and Practice Transformation (EPT) program milestones related to health disparities. Of the 198 practices that participated in the program, 85% (169 of 198) were able to stratify their quality data by race, ethnicity, language, or another factor. From there, 162 practices submitted a health disparity reduction plan. Each plan was reviewed by subject matter experts (SMEs) with expertise in primary care and disparity reduction, and practices were given feedback and a chance to revise and resubmit their plans. As of the publication of this report, 147 practices had their health disparity reduction plans approved by the SMEs, meaning that the plans were sufficiently detailed to demonstrate a complete understanding of and appropriate tracking mechanism for implementation of health disparity reduction activities. More plans may be submitted or approved by the end of the initiative. The 147 approved plans were reviewed and characterized in Common Measures, Populations, and Disparity Reduction Interventions.

To identify promising approaches to disparity reduction, the 147 approved health disparity reduction plans were further reviewed by SMEs and program office staff for exemplary disparity identification, alignment between identified root causes and intervention strategies, and thoughtful or transferable approaches to implementation. This review surfaced 20 exemplary health disparity reduction plans submitted by practices that spanned a range of settings, populations, and clinical priorities. These 20 plans were reviewed, and thematic analysis conducted, to surface cross-cutting approaches to disparity reduction. Insights from these plans are shared in Key Insights from Practices Working to Reduce Disparities.

From the 20 practices that submitted exemplary health disparity reduction plans, three were recruited for 60-minute, semi-structured interviews conducted by the authors to gather more information about their disparity reduction work, including implementation successes, challenges, and lessons learned. Each practice was offered a $250 gift as a thank you. Their stories are reflected in the Disparity Reduction Case Studies.

Limitations

Thematic analysis across exemplary health disparity reduction plans does not necessarily reflect measurable reductions in health disparities; final data on health disparity reduction is still being collected as part of the EPT program. However, all three case studies feature practices that reported increases in the percentage of patients in their selected subpopulations who received the recommended care in interim data. Readers should regard the findings presented here as promising early learning, not as definitive approaches empirically proven to reduce disparities.

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