Equity and Practice Transformation Tool Kit

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Updated 02/22/2024

Equity and Practice Transformation Tool Kit

Overview

In July 2023, The Department of Health Care Services (DHCS) announced the Equity and Practice Transformation (EPT) Payment Program, which is a one-time $700 million initiative to advance health equity and reduce COVID-19 driven care disparities by investing in up-stream care models and partnerships to address health and wellness and funding practice transformation. The statewide dollar distribution of this initiative will be allocated in three separate pathways via the Medi-Cal Managed Care Plan (MCP) the *Initial Provider Planning Incentive Payments (IPIP)*, the *EPT Provider Directed Payment Program (PDPP)*, and the *Statewide Learning Collaborative*.

Partnership HealthPlan of California Equity and Practice Transformation Tool Kit is to be used in addition to resources offered by DHCS and the Population Health Learning Center (PHLC), as a tool to help practices participating in the Provider Directed Payment Program meet the milestones of their selected categories and activities.

Practice Transformation Assessment

Equity and Practice Transformation Tool Kit

PhmCAT Completion:
A PhmCAT submission must be completed each year, for years 1 – 5, for continued participation in the Equity and Practice Transformation (EPT) Provider Directed Payment Program (PDPP).

Please reach out to PracticeTransformation@PartnershipHp.org or info@pophealthlc.org if you need assistance in completion of the assessment.

The following information is from the Population Health Management (PHM) Initiative website.

What is the Population Health Management Capabilities Assessment Tool (PhmCAT)?
PhmCAT is a multi-domain assessment that is used to understand current population health management capabilities of primary care practices or Community Health Centers. This self-administered tool can help organizations identify strengths and opportunities for improving population health management. It can also be used to assess changes over time if administered at multiple time points.

How was it developed?
PhmCAT was developed by Kaiser Permanente's Population Health Management Initiative (PHMI) team in consultation with a workgroup comprising representatives from the California Department of Health Care Services (DHCS), California Primary Care Association (CPCA), Partnership HealthPlan, Alameda Health Consortium, and the University of Chicago. The tool assesses eight common domains across PHMI, Alternative Payment Methodology (APM), and Health Equity and Practice Transformation deemed critical for effective population health management:

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

The PhmCAT includes 50 questions total across the eight domains, most from validated or frequently used assessment tools. Each question is rated on a 10-point scale – 1 being low/not in place, 10 being high/in place.

How to complete the phmCAT assessment.
The PhmCAT is designed to be completed by a multi-disciplinary team within a primary care practice or Community Health Center. The assessment asks about organizational systems and practices, as well as clinical practices, so the team must include diverse representation including people with clinical, operational, financial, data and patient-facing experience and expertise. If your organization is

using the PhmCAT to guide improvement activities at a specific site, staff and clinicians from that site or practice should be involved in the team completing the assessment.

Each team member should complete the assessment individually. After completing the assessment individually, the team should get together to discuss responses and come to an agreement for each question. This “consensus conversation” within the team is an important part of the process to learn from each other and reach a common understanding of current state. Results can be used by the team to identify opportunities and priorities for improvement. Many teams find an external coach or facilitator is helpful in guiding this consensus conversation.

What should you consider as you complete the assessment?
When answering each question, select the score that reflects where your practice is in its population health journey as honestly and accurately as possible. Each question has descriptions along the response scale to help explain what a given numerical score means. There is no advantage to overestimating scores, as doing so may make it harder for real progress to be apparent when the assessment is repeated in the future.

For items you don’t have enough information to answer individually, please use the “don’t know” response option. When the group comes together to discuss, the team should be able to determine an accurate rating for each item.

Download the PhmCAT Assessment PDF here.

Empanelment and Access

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The following section includes resources that can be referenced in order to achieve the activities and milestones under the required Empanelment & Access category of the Equity and Practice Transformation (EPT) Provider Directed Payment Program (PDPP). The activities are listed below and the milestones can be found on the Final EPT Activities and Milestones document.

Empanelment & Access:
Activity: Identify a staff member who serves as panel manager, conduct initial patient assignment and supply/demand balancing, and implement ongoing management (panel monitoring, access metrics like third-next available appointments, empanelment, reports and panel adjustments).

Advanced Access Webinar Series for Primary Care Providers
Advanced Access was designed to establish and refine the empanelment process; optimize care teams; improve clinical outcomes; and increase patient, provider, and staff satisfaction.

This five-part series provides an overview of the guiding principles of Advanced Access. The webinars cover strategies to reduce delays for appointments, pertinent aims and measures, and resources to support continued improvement.

Barbara Boushon, RN, BSN, was selected as the faculty to lead this webinar series. Barbara is an expert in the field and has over 20 years of experience leading collaboratives, webinars, and training sessions on Advanced Access across the United States.

For additional details regarding each webinar, please visit Partnership's Quality Improvement page here.

Targeted Audience: Primary Care Providers, Nurse Practitioners, Physician Assistants, Registered Nurses, Licensed Vocational Nurses, Medical Assistants, Quality improvement Staff, office managers, and front/back office staff.

Webinar #1: Introduction to Advanced Access
(Length: 1 hour, 3 minutes)
Recording
Presentation

Webinar #2: Reducing Delays for Appointments - Part 1
(Length: 1 hour)
Recording
Presentation

Webinar #3: Reducing Delays for Appointments - Part 2
(Length: 1 hour)
Recording
Presentation

Webinar #4: Reducing Delays for Appointments - Part 3
(Length: 1 hour, 8 minutes)
Recording
Presentation

Webinar #5: Reducing Delays at Appointments
(Length: 59 minutes)
Recording
Presentation

Technology & Data

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The following section includes resources that can be referenced in order to achieve the activities and milestones under the required Technology & Data category of the Equity and Practice Transformation (EPT) Provider Directed Payment Program (PDPP). The activities are listed below and the milestones can be found on the Final EPT Activities and Milestones document.

Data Governance for Population Heath:
Activity: Develop and implement a formal structure for population health and quality improvement, including regular meetings of key practice stakeholders who review data and develop/implement strategies to improve population health, healthcare quality, and health equity.

> Coming soon! If you need support to accomplish the deliverables and milestones within this activity, please reach out to PracticeTransformation@PartnershipHp.org

Dashboards & Business Intelligence:
Activity: Determine the practice's key performance indicators (KPIs, inclusive of HEDIS metrics), collect ongoing data to evaluate KPIs, and present and disseminate KPI reports to stakeholders using business analytics tools (e.g. Excel, Power BI, Tableau, Arcadia, or another similar tool).

2023 eReports Kick-Off Webinar

May 03, 2023
Recording
Presentation

2023 PQD Kick-Off Webinar

July 12, 2023
Recording
Presentation

HEDIS Medical Record Retrieval Webinar for MY2022/RY2023

January 23, 2023
Recording
Presentation

Data and Quality Reporting Gaps:
Activity: Determine, create, and implement a formal strategy to address gaps in data that includes a data validation process that identifies gaps and solutions for improving data quality, such as reconciliation with MCPs; data can refer to quality, operational, billing, population health, or other data.

> Coming soon! If you need support to accomplish the deliverables and milestones within this activity, please reach out to PracticeTransformation@PartnershipHp.org

New/Upgraded Electronic Health Record (EHR), and/or Population Health Management (PHM) Tool:

Activity: Ensure the practice has the EHR and/or population health management tools need to maximize clinical, operational, financial, and population health needs. This activity is considered already met if the practice has all the tools they deem necessary.

> Coming soon! If you need support to accomplish the deliverables and milestones within this activity, please reach out to PracticeTransformation@PartnershipHp.org

Data Exchange:

Activity: Establish, maintain, and use bilateral data feeds with a Data Exchange Framework (DxF) Qualifying Health Information Organization (QHIO), as defined by the current DxF framework and to be further defined in future DxF policies.

> Coming soon! If you need support to accomplish the deliverables and milestones within this activity, please reach out to PracticeTransformation@PartnershipHp.org

Patient-Centered, Population-Based Care

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The following section includes resources that can be referenced in order to achieve the activities and milestones under the required Patient-Centered, Population-Based Care category of the Equity and Practice Transformation (EPT) Provider Directed Payment Program (PDPP). The activities are listed below and the milestones can be found on the Final EPT Activities and Milestones document.

Care Team Design and Staffing:
Activity: Define and implement a care team that addresses population health management functions (e.g., gaps in care closure, care coordination) and team-based care for the population of focus.

> Coming soon! If you need support to accomplish the deliverables and milestones within this activity, please reach out to PracticeTransformation@PartnershipHp.org

Stratification to Identify Disparities:
Activity: Use data to stratify services and/or outcomes measures by variables that might demonstrate health disparities (e.g. race/ethnicity, sexual orientation/gender identity, etc.), and implement a strategy to decreases any disparities identified.

> Coming soon! If you need support to accomplish the deliverables and milestones within this activity, please reach out to PracticeTransformation@PartnershipHp.org

Clinical Guidelines:
Activity: Choose and implement evidence-based clinical guidelines.

> The 2023 Measure Best Practices documents are resources for the Primary Care Provider Quality Improvement Program (PCP QIP) measure set, which aligns closely with the Managed Care Accountability Set (MCAS) measures for which Partnership HealthPlan of California is held accountable by the Department of Health Care Services (DHCS). Each Measure Best Practice document includes Partnership tools and resources, guidelines to facilitate optimal member care, opportunities for patient education, outreach, and equity, data and coding resources, and helpful links to improve measure performance.
> Asthma Medication Ratio
> Breast Cancer Screening
> Cervical Cancer Screening
> Child & Adolescent Well Care
> Childhood Immunizations Status
> Colorectal Cancer Screening
> Controlling Blood Pressure
> Comprehensive Diabetes Care: HbA1c - Good Control
> Comprehensive Diabetes Care: Retinal Eye Exam
> Immunizations for Adolescents
> Unit of Service Blood Lead Screening
> Unit of Service Dental Flouride Varnish
> Well Child Visits 15 Months

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Implement Condition-Specific Registries:
Activity: Create, implement, and use condition-specific registries.

Coming soon! If you need support to accomplish the deliverables and milestones within this activity, please reach out to PracticeTransformation@PartnershipHp.org

Proactive Patient Outreach and Engagement:
Activity: Create and implement a formal strategy to better engage and outreach to patients, including patients assigned but not seen.

Coming soon! If you need support to accomplish the deliverables and milestones within this activity, please reach out to PracticeTransformation@PartnershipHp.org

Pre-visit Planning and Care Gap Reduction:
Activity: Create and implement a formal process for pre-visit planning (that at minimum addresses gaps in care).

Coming soon! If you need support to accomplish the deliverables and milestones within this activity, please reach out to PracticeTransformation@PartnershipHp.org

Care Coordination:
Activity: Create and implement a formal strategy to address care coordination needs for patients with more complex health and health-related social needs.

Partnership's Care Coordination Department offers a variety of evidence-based services and interventions to coordinate care for members. Our team of Case Managers, Medical Social Workers, and Health Care Guides help to ensure services are coordinated for the member across the healthcare continuum through the use of an Individualized Care Plan (ICP) and member-centric goals.
For additional information, visit Partnership's Care Coordination page. To contact the Care Coordination Department and refer by telephone, please call **(800) 809-1350**.
Click here to download the Southern Region Form
Lake, Marin, Mendocino, Napa, Solano, Sonoma, and Yolo Counties
Complete the form and send with pertinent health records by securely faxing to (707) 863-4502 or securely emailing the Care Coordination Southern Region Inbox.

Click here to download the Northern Region Form
Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, Tehama and Trinity Counties
Complete the form and send with pertinent health records by securely faxing to (530) 245-0612 or securely emailing the Care Coordination Northern Region Inbox.

Click here to download the Eastern Region Form

Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, and Yuba Counties
Complete the form and send with pertinent health records by securely faxing to (530) 351-9088 or securely emailing the Care Coordination Eastern Region Inbox.

Evidence-Based Models of Care

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The following section includes resources that can be referenced in order to achieve the activities and milestones under the optional Evidence-Based Models of Care category of the Equity and Practice Transformation (EPT) Provider Directed Payment Program (PDPP). The activities are listed below and the milestones can be found on the Final EPT Activities and Milestones document.

New/Expanded Care Delivery Model:
Activity: Choose and implement an evidenced-based model for focus population (e.g. Dyadic Care, Centering pregnancy, group visits for conditions like diabetes, Project Dulce, collaborative care model for behavioral health, Medication Assisted Treatment, etc.).

ABCs of Quality Improvement – On Demand
Targeted Audience: Clinicians, practice managers, quality improvement teams, and staff who are responsible for participating and leading quality improvement efforts within their organization.

Session 1 of 5: Introduction to Quality and Goal Setting
May 18, 2022
Presentation
Recording

Session 2 of 5: Using Data for Quality Improvement
May 25, 2022
Presentation
Recording

Session 3 of 5: Understanding the Role of Measurement in Quality Improvement
June 1, 2022
Presentation
Recording

Session 4 of 5: What Changes Can We Make That Will Result in Improvement?
June 8, 2022
Presentation
Recording

Session 5 of 5: What Change Can We Make that Will Result in Improvement?
June 22, 2022
Presentation
Recording

Value-Based Care & Alternative Payment Methodologies

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The following section includes resources that can be referenced in order to achieve the activities and milestones under the optional Value-Based Care & Alternative Payment Methodologies category of the Equity and Practice Transformation (EPT) Provider Directed Payment Program (PDPP). The activities are listed below and the milestones can be found on the Final EPT Activities and Milestones document.

Federally Qualified Health Centers Alternative Payment Methodology (FQHC APM):
Activity: For FQHCs only, complete readiness activities for the APM, apply for the FQHC APM, prepare for APM implementation, and implement the APM (FQHCs who have applied for and been accepted CAN still choose this activity).

Coming soon! If you need support to accomplish the deliverables and milestones within this activity, please reach out to PracticeTransformation@PartnershipHp.org

Value-Based Payment:
Activity: Complete readiness activities and then begin a value-based contract with at least one Medi-Cal Managed Care Plan (MCP) (consistent with HCP-LAN category 3 or 4).
*Please note, Partnership does not recommended non-FQHC's to select Value-Based Payment as an activity at this time.

Coming soon! If you need support to accomplish the deliverables and milestones within this activity, please reach out to PracticeTransformation@PartnershipHp.org

Leadership & Culture

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The following section includes resources that can be referenced in order to achieve the activities and milestones under the optional Leadership & Culture category of the Equity and Practice Transformation (EPT) Provider Directed Payment Program (PDPP). The activities are listed below and the milestones can be found on the Final EPT Activities and Milestones document.

Diversity, Equity, Inclusion and Belonging (DEIB) Strategy:
Activity: Create and implement an organizational-wide strategy to work on diversity, equity, inclusion, and belonging (DEIB).

Advancing Health Equity: Linking Quality and Equity in QI Projects
This webinar presents information from the Roadmap to Advance Health Equity developed by Advancing Health Equity: Leading Care, Payment and Systems Transformation (AHE). The webinar will discuss key topics including: discovering and prioritizing differences in care, outcomes, and/or experiences across patient groups; planning equity-focused projects; and measuring impact.

Target Audience: Quality improvement staff, team leaders, managers, and front-line staff
Presented by: The Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN)
Recording
Presentation

Incorporating Equity into PDSAs: Linking Quality and Equity in QI Projects
This webinar discusses strategies to incorporate healthy equity into existing and future Plan-Do-Study-Act (PDSA) and quality improvement projects. Key topics will include using data to identify health disparities, incorporating equity lens into PDSAs, and selecting measures to monitor improvements over time.
Presented by the Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN)
Recording
Presentation

Strategic Planning:
Activity: Create and implement a formal process to address the practice's strategic planning (which must, at minimum, address DEI and patient and community partnership/engagement, patient access, quality metrics, health equity, workforce satisfaction and retention, and value-based care).

The Role of Leadership in Quality Improvement Efforts Interview with Top-Performing Leaders
Leaders from top-performing organizations will share how they were able to build a culture of quality.
Target Audience: This course is intended for executive leaders, managers, and supervisors.

The focus of this training is to:

- Understand the role of leadership in quality
- Learn how to successfully build a culture of quality from proven leaders
- Understand how a culture of quality impacts an organization
- Learn the key principles to improving quality

Petaluma Health Center
September 23, 2021
Leadership includes CEO and CMO
Recording
Community Medical Centers Leaders
October 05, 2021
Recording
Change Management, Change Fatigue & QI
Recording
Change Management Learning Resources
Mindfulness Resources
Template for Exercises
Process Observation Handout
Force Field Analysis-Instructions and Templates

Patient and Community Partnership/Engagement:
Activity: Choose and implement a strategy to ensure patient and community input on practice governance and decision making (e.g., a patient advisory committee, seeking to increase patient representation on the organization's board, etc.).

Engaging Patients in Quality Improvement
This training session will introduce the concept of patient engagement in quality improvement with the goal to improve patient experience and health outcomes.
Participants will be able to:

- Explain why engaging patients in quality improvement is important.
- Describe several strategies to engage patients in improvement.
- Describe aspects of care that could be improved through the involvement of patients.

Recording
Presentation

Behavioral Health

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The following section includes resources that can be referenced in order to achieve the activities and milestones under the optional Behavioral Health category of the Equity and Practice Transformation (EPT) Provider Directed Payment Program (PDPP). The activities are listed below and the milestones can be found on the Final EPT Activities and Milestones document.

Behavioral Health Integration (BHI) in Primary Care:

Activity: Integrate behavioral health into primary care practice to provide more comprehensive care for patients.

CalAIM Initiative

To better recognize and manage Partnership HealthPlan of California's members' risk and needs for health and behavioral conditions, access to care, chronic diseases, and disabilities, DHCS is organizing a whole system, person-centered approach that leads to a better quality of life for our Partnership members, as well as long-term cost savings and avoidance. The elements of this enhanced whole system include:

- A statewide population health management strategy
- A statewide Enhanced Care Management (ECM) benefit
- Implementation of optional Community Supports (ILOS)
- Implementation of incentive payments for plans and providers
- Participation in the Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) demonstration
- Required screening and enrollment for Medi-Cal prior to release from county jail
- Pilot full integration of physical health, behavioral health and oral health under one contracted entity in a county

The key elements of the CalAIM initiative are built off the previous federal waiver programs success, which includes but are not limited to, Whole Person Care (WPC) and Health Homes Program (HHP). Partnership was part of the WPC program but did not participate in the HHP. The WPC program was county based and the five Partnership participating counties were Marin, Mendocino, Napa, Shasta, and Sonoma. Throughout this new DHCS initiative, services provided under programs such as WPC for Partnership members will be transitioned under CalAIM and also made available to more of Partnership's members.

CalAIM Related Material

- Enhanced Care Management
- Community Supports (ILOS)

Have a question or concern related to CalAIM? Please feel free to contact CalAIM@PartnershipHp.org

Social Health

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The following section includes resources that can be referenced in order to achieve the activities and milestones under the optional Behavioral Health category of the Equity and Practice Transformation (EPT) Provider Directed Payment Program (PDPP). The activities are listed below and the milestones can be found on the Final EPT Activities and Milestones document.

Social Needs/Risk Screening & Intervention:
Activity: Create and implement a formal process for screening for and intervening on patients' social needs/risks

Mobile Mammography Event Sponsorship
Partnership is offering a unique sponsorship opportunity by bringing Alinea Medical Imaging to eligible provider organizations. If you are interested in learning more about our Mobile Mammography Program, please reach out to MobileMammography@PartnershipHp.org
Eligibility Criteria for Sponsorship:

- Provider locations far below the 50th percentile benchmarks.
- Provider locations in imaging center "deserts".
- Provider locations with lack of access at nearby imaging centers.
- Provider locations with Partnership care gaps to support desired event.

Accelerated Learning Education Program
These learning sessions cover the Primary Care Provider Quality Incentive Program measures.

Targeted Audience: Clinicians, practice managers, quality improvement teams, and staff who are responsible for participating and leading quality improvement efforts within their organization.

Early Cancer Detection: Cervical, Breast, and Colorectal Cancer Screening
April 25, 2023
Recording
Presentation

Asthma Medication Ratio
March 29, 2023
Recording
Presentation

Comprehensive Diabetes Care HbA1c Good Control <9.0%
March 15, 2023
Recording
Presentation

Controlling High Blood Pressure
February 22, 2023
Recording
Presentation

Pediatric Health: Pediatric Care for 3 - 17 Year Olds
February 8, 2023
Recording
Presentation

For any information about CPT codes, please reference the Diagnosis Crosswalk in eReports or the non-clinical codes set on the Partnership QIP webpage. Any other questions can be routed to the Partnership Claims Department.

Pediatric Health: Preventative Care for 0 to 2 Year Olds
January 26, 2023
Recording
Presentation

The PowerPoint slide content has been edited since the original presentation date. For any information about CPT codes in the original slides, please reference the Diagnosis Crosswalk in eReports or the non-clinical codes set on the Partnership QIP webpage. Any other questions can be routed to the Partnership Claims Department.

Lead Toxicity and Screening for Elevated Lead Levels
Lead screening is far below average in the Partnership service area. Dr. Moore presented a comprehensive clinical summary of the evidence on lead toxicity and effects of elevated blood lead on pediatric development. The recorded webinar includes details on State, Federal and Partnership regulatory requirements.
Recording
Presentation

Additional Resources

Equity and Practice Transformation Tool Kit

Upcoming Partnership Events
Partnership HealthPlan of California offers a variety of Quality and Performance Improvement webinars, in-person trainings, and conferences. Review upcoming events and details here.

PHMI - Population Health Management Resources

- Building the Foundation – Introduction Guide
  Series of tools and materials that are designed to support organizations in building a foundation for strong population-based care. This document educates organizations about the Population Health Management Initiative (PHMI) and its many partners across the state of California who are working together to support improved care for Medi-Cal members.

- Data Quality and Reporting Guide
  Helps practices enhance capacity to report and monitor PHMI/HEDIS quality measures for populations of focus using standardized measurement specifications and a data mapping assessment, and use it to improve quality of care.

- Empanelment Guide
  Helps practices select and implement a methodology to create patient panels and develop continuity reports.

- Care Teams and Workforce Guide
  Helps practices assess current care team roles and functions, identify gaps, and develop and execute a workforce plan.

- Business Case Guide
  Helps practices develop their financial model for population health management sustainability. This tool is currently designed for community health centers and how they are paid, but can be adapted by other practices.

- Clinical Guidelines
  This set of clinical guideline recommendations were chosen based by the populations of focus and clinical conditions that are the focus of PHMI. PHMI plans to support community health centers in using these clinical guidelines to guide care.

- Population of Focus
  Resources coming soon!

Oregon Community Health Information Network (OCHIN)

OCHIN's Mission Statement: Our *mission* is providing knowledge solutions to drive health equity with a *vision* of achieving well-being and good health for everyone.

To achieve activities and milestones under the Technology & Data requirement, OCHIN would be a useful resource for data, building patient acuity registries, using telehealth, Health Information Exchanges (HIEs) and much more.

Frequently Asked Questions (FAQs)

Thank you for your hard work and dedication towards Practice Transformation. Should have you any further questions, please do not hesitate to reach out to Partnership HealthPlan of California or the Department of Health Care Services below.

PracticeTransformation@PartnershipHp.org
EPT@DHCS.ca.gov