PHM INITIATIVE

Putting Equity at the Heart of Improvement

June 23, 2026

Visit the **PHMI Cohort Portal** to access the agenda with related materials

Presenters



Kristene Cristobal
She, Siya

Equity SME



Roseanne Ibarra
She, Her, Hers

Equity SME

Learning Objectives

1

Summarize contemporary practices on centering equity in leadership and process improvement.

2

Identify where best practices are currently happening and opportunities to apply additional best practices.

3

Adapt one equity practice to the health center's population health management project.

Agenda

01	Framing + Temperature Check	*8 mins*
02	Progress on Equity Work + Opportunities for Deepening	*7 mins*
03	Adapt an Equity Practice to Your Project	*20 mins*

Framing

Community Health Centers were born out of a bold vision:

That health care is a human right and that communities themselves are the experts in what they need to thrive.

Equity is at the core of your mission

- Delivering whole-person, socially-informed care
- Ensuring language and cultural access
- Sharing power with communities
- Integrating services and redesigning care teams
- Expanding access for marginalized populations

Temperature Check



Type in the chat:

Where do you see your organization still living out its equity roots?

What knowledge, lived experience, or community wisdom do you and your patients hold that should be shaping decisions more powerfully?

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Making Progress on Equity + Opportunities for Deepening

From analyzing data on disparities to testing change strategies that address root causes

PHMI Equity Driver Diagram

Improve quality and equitable health outcomes of people served by health centers

Reduce Inequities for Populations of Focus

- Build data infrastructure, collect accurate REAL, SOGI, and other socio-demographic data, and analyze data collected to identify inequities within population of focus
- Analyze data collected to identify inequities within populations of focus
- Screen for social drivers of health and ensure effective access to social services
- Conduct a root cause analysis of the drivers of inequities ★
- Design and implement equity-focused care interventions that address the root causes in collaboration with patients and other partners ★
- Incorporate an understanding of how technology may reduce or exacerbate inequities

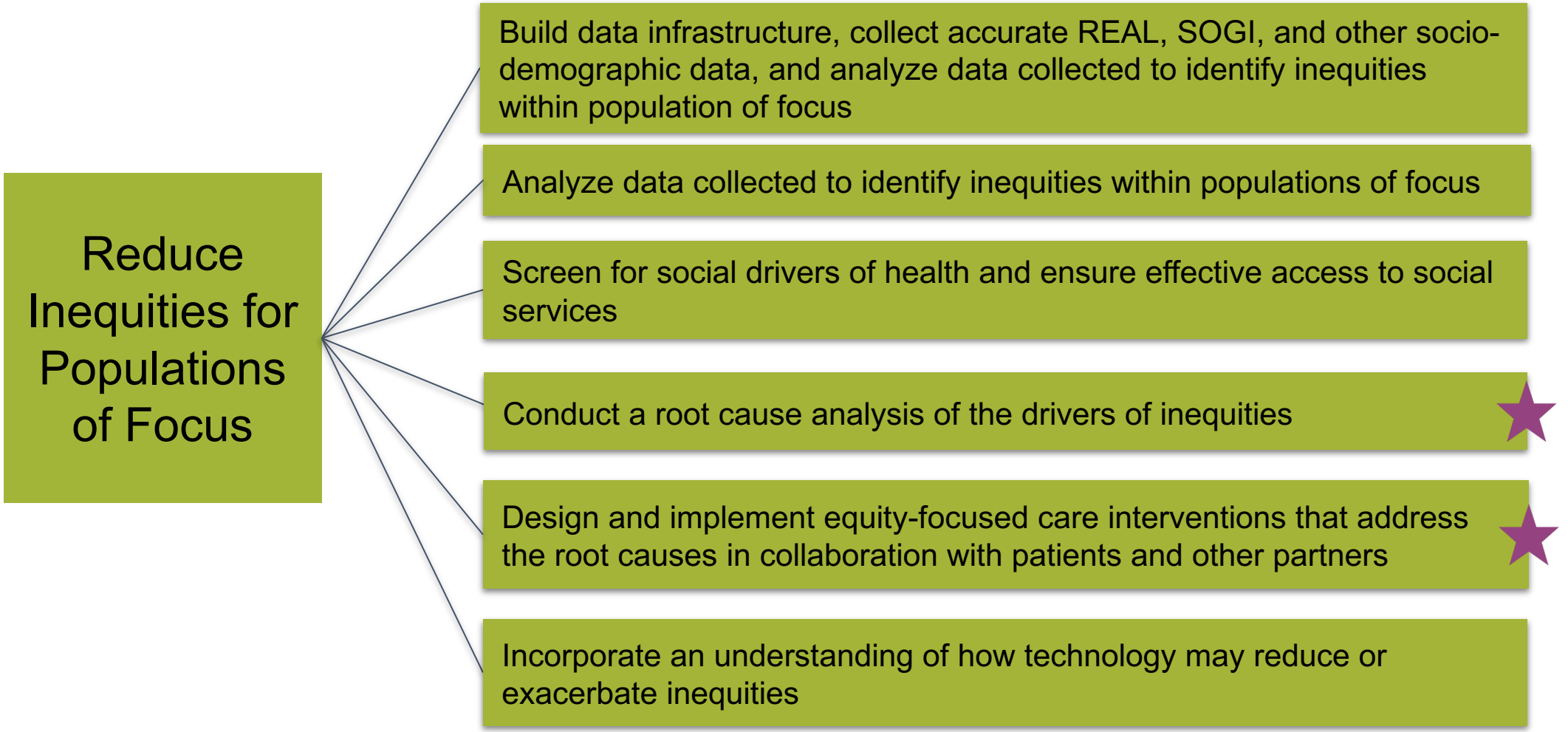
Create a Culture of Equity within the Health Center

- Demonstrate senior leadership ownership for and commitment to improving health equity
- Understand and address internalized, personally-mediated, and institutionalized racism
- Build organizational capacity to support efforts to improve health equity
- Establish practices and policies to promote workforce diversity and provide culturally and linguistically appropriate care

Build and Strengthen Cross-Sectoral Partnerships

- Support policy efforts, driven by social health drivers, to eliminate inequities
- Partner with full range of community partners and sectors including DHCS, CPCA, RACs, other health centers, CBOs, and health plans to improve equity

Adapt an Equity Practice to Your Project



For 2026 Goals: Inclusion and Equity in SMARTIEs & Change Strategies

Inclusion ("I")

- Who benefits and who doesn't benefit from the goal?
- Were affected communities involved in setting the goal?
- Are change strategies culturally and linguistically appropriate?
- Are there barriers to participation? (transportation, digital access, trust, etc.)

Equity ("E")

- Does the goal reduce gaps for the population experiencing disparate outcomes?
- What could unintentionally widen disparities?
- Could advantaged groups benefit more quickly?
- Are interventions tailored (e.g., culturally-appropriate care, language access, etc.)
- Do strategies match the root cause?
- Who might benefit less and why?

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POF Equity Analysis Summaries

Visit the **PHMI Cohort Portal** to access the agenda with Zoom links and related materials

Spotlighting Wins and Opportunities that are Common for All 5 POFs

- Clear efforts to incorporate health equity approaches across POFs, e.g.,
  - Using data to drive equity
  - Standardization to reduce bias and missed care, incl. system and workflow improvements
- Opportunities to deepen your health equity efforts include:
  - Cultural and linguistic responsiveness, integrating patient voice

Chronic Conditions – Equity Themes Across 11 Health Centers

Summary: Across all 11 centers, equity is operationalized through data-driven population health management and system-level care coordination, but remains limited by insufficient focus on structural barriers, cultural responsiveness, and patient-centered design needed to ensure patients with the greatest social and access challenges achieve equitable chronic disease outcomes.

Use Data to Drive Equity

- Stratification by race/ethnicity, language, age, payer, or site
- Identification of populations with lower control rates or higher risk

Prioritization of Those Furthest Behind

- Medi-Cal patients
- Patients with uncontrolled chronic conditions
- Patients with high utilization or gaps in care
- Use of registries to identify patients overdue for labs, visits or follow-up

Strong Use of Care Coordination and Team-Based Care

- Strategies include care teams (RNs, MAs, CHWs), panel management
- Equity is operationalized through team-based care that supports patients beyond the provider list

Proactive Outreach and Panel Management

- Use of patient portals, outreach (calls, texts, targeted follow-ups), automated reminders, tracking patients with uncontrolled conditions
- Movement towards proactive, population health management instead of reactive care

System Workflow Optimization

- Standing orders, care gap alerts, standardized workflows
- Reduce missed labs, screenings, and follow-ups
- Addressing operational root causes of poor chronic disease control

Chronic Conditions – Where Equity is Still Developing

Limited Gap-Closing Targets

- Equity is recognized and tracked but not always defined as closing the gap

Limited Patient Co-design

- Equity is designed from the provider and system perspective, not co-created with patients

Inconsistent Cultural & Linguistic Tailoring

- Tailoring is present but uneven
- Some sites include language access and culturally appropriate materials. While others rely on generic outreach.

Structural Barriers Not Fully Addressed

- Strong focus on clinical workflows, appointments, medication management, data tracking, provider prompts
- Less attention to food insecurity, housing instability, transportation, cost of medications, and work/life constraints.

Limited Focus on Behavioral and Trust-Based Drivers

- Few explicit strategies addressing mistrust of health care, cultural beliefs about disease, health literacy in chronic disease self-management

Reliance on Digital and Clinic-Based Care

- Reliance on phone/text outreach, in-clinic visits, EHR-driven systems
- May exclude patients without stable phones, unhoused patients, and patients with limited digital literacy

Risk that More Advantaged Patients Benefit Faster

- Patients who are already engaged in care, able to attend frequent visits and who have fewer barriers are likely to benefit first

Preventive Care – Equity Themes Across 8 Health Centers

Summary: Across all eight centers, equity is operationalized through data-driven identification of disparities, targeted outreach, and system-level redesign to improve access and completion, but remains limited by inconsistent gap-closing targets, uneven cultural responsiveness, and insufficient focus on structural barriers, trust and community engaged solutions to ensure the highest-barrier populations benefit equitably.

Prioritization of Those Furthest Behind

- Medi-Cal patients
- Age-based gaps
- Racial/ethnic groups with lower screening rates

Use of Data to Drive Equity

- Stratification by race/ethnicity, age, payer, engagement

Shifting Responsibility to the System

- Screening embedded in workflows
- Active outreach and navigation
- Care brought to patients through mobile services and community events

Delivering Patient-Centered, Flexible Care

- Choice in screening options such as self-swab, FIT, mammogram access
- Multiple pathways to complete screening
- Persistent relationship-based follow-up
- Care designed around patient's reality

Standardization to Reduce Bias and Missed Care

- EHR prompts, standing orders, team-based workflows
- Screening embedded into all visits and rooming workflows

Reaching Beyond the Clinic to Reach the Hard-to-Reach

- Outreach to assigned but not yet seen patients
- Community-based events and partnerships
- Intensive follow-up for non-completion

Growing Culturally & Linguistically Responsive Care

- Plain language and translated materials
- Culturally concordant messaging
- Trauma-informed, stigma-aware approaches
- Trusted messengers (CHW and community partners)

Growing Support to Address Structural Barriers (SDOH)

- Transportation, time, childcare, housing barriers
- Navigation and community partnerships
- Incentives and access supports

Preventive Care – Where Equity is Still Developing

Limited Gap-Closing Targets

- Equity is recognized and tracked but not always defined as closing the gap

Limited Patient Co-design

- Equity is system-designed, not co-created with patients

Inconsistent Cultural & Linguistic Tailoring

- Tailoring is present but uneven
- Some sites use culturally appropriate materials others rely on generic outreach

Structural Barriers Not Fully Addressed

- Strong focus in some sites on transportation and mobile services
- Limited in other sites, reliance on digital outreach
- Not fully addressing complex structural barriers

Risk That More Advantaged Patients Benefit Faster

- Strategies rely on phone/text outreach, clinic visits and scheduling systems. Patients who are already engaged in care, those who are digitally connected and have fewer barriers are likely benefit first

Limited Focus on Trust, Stigma, and Lived Experience

- No clear strategies addressing trust (especially for marginalized populations) and cultural beliefs about care

Pregnant People – Equity Themes Across 2 Health Centers

Summary: Across the two centers, equity is operationalized through system-level redesign, language responsive communication, and improved care continuity, but remains limited by insufficient attention to structural barriers, trust, and patient co-design needed to ensure those facing the greatest social and access challenges can fully engage in prenatal and postpartum care.

Strong System and Workflow Improvement Strategies

- Integrated workflows
- EHR automation (risk flagging, reminders)
- Standardized processes (screening, follow-up, scheduling)
- Registry and capacity planning

Proactive Outreach & Follow-Up

- Outreach after missed appointments
- Pre-visit or pre-delivery engagement
- Follow-up tracking and prioritization

Use of Technology to Standardize Care and Reduce Inequities Caused by Inconsistency

- EHR algorithms to flag high-risk patients and automate referrals
- Standard workflows reduce provider variability and inconsistent care

Pregnant People – Where Equity Is Still Developing

Limited Gap-Closing Targets

- Equity is recognized and tracked but not always defined as closing the gap

Lack of Patient Co-design

- Equity is system-designed, not co-created with patients

Structural Barriers Not Fully Addressed

- Strong focus on care coordination - workflows, access points, communication
- Not fully addressing social and structural barriers such as transportation, childcare logistics, geographic isolation, financial and time constraints

Limited Focus on Trust, Stigma, and Lived Experience

- No clear strategies addressing trust (especially for marginalized populations) and cultural beliefs about care

Inconsistent Cultural & Linguistic Tailoring

- Tailoring is present but uneven
- Weaker in tailoring interventions for different racial/ethnic groups, socioeconomic barriers, high-risk groups

Risk That More Advantaged Patients Benefit Faster

- Patients who are already engaged in care, those with stable housing/contact information and those with flexible schedules may likely benefit first

Reliance on System Entry Points

- Reliance on entry through pregnancy test or clinic contact and postpartum visit
- Risk – patients who enter late, never enter or disengage after deliver may be missed entirely

Children – Equity Themes Across 3 Health Centers

Summary: Across all three centers, equity is operationalized through data-driven identification of disparities and system-level improvements, but remains limited by lack of caregiver-centered, culturally responsive and structural support strategies needed to ensure families with the greatest barriers can fully access and complete early childhood care.

Strong Use of Data to Identify and Define Disparities

- Black children immunization disparities
- Rural vs. urban differences
- Spanish vs. English

Focus on Early Childhood

- Children ages 0-2, a population that is vulnerable to missed care
- Recognizes high-priority life stage, where early inequities can have long-term consequences

Strong System & Workflow Improvement Strategies

- Pre-visit planning, care gaps and outreach systems
- Scheduling improvements
- Closing the loop on visit completion

Proactive Outreach & Follow-Up

- Text, reminders
- Navigation or follow-up process
- Emphasize closing the loop, not just scheduling

Children – Where Equity Is Still Developing

Limited Caregiver-Centered Design

- Strategies focus on system workflows and clinic processes
- Less focus on caregiver realities such as work schedules, transportation challenges, managing multiple children, stress and competing priorities

Inconsistent Cultural & Linguistic Tailoring

- Reliance on standardized messaging
- Language access, culturally concordant communication and health literacy not explicitly addressed

Limited Gap-Closing Targets

- Equity is recognized and tracked but not always defined as closing the gap

Structural Barriers Not Fully Addressed

- Strong focus on system barriers such as scheduling, reminders and workflow reliability
- Not fully addressing social and structural barriers such as transportation, childcare logistics, geographic isolation, financial and time constraints

Limited Focus on Trust and Vaccine Hesitancy

- No clear strategies addressing caregiver mistrust, vaccine hesitancy and historical inequities (e.g. among Black families)

Reliance on Digital Outreach May Exclude Some Families

- Heavy reliance on text outreach and scheduling systems
- Risk – excluding caregivers with unstable phone access, limited digital literacy and frequent changes in contact information

Risk That More Advantaged Families Benefit Faster

- Families who can plan ahead, have stable schedules, reliable transportation will respond faster to scheduling expansion, reminders and outreach.

Behavioral Health – Equity Themes Across 3 Health Centers

Summary: Across all three centers, equity is operationalized through standardization and system efficiency, which improves consistency in screening but does not fully address disparities. The approaches are strong in reducing process gaps but equity impact is limited by a lack of targeted, culturally responsive, and access-focused strategies for populations facing the greatest barriers – particularly those not engaged in care, experiencing stigma or requiring tailored approaches, such as adolescents.

Strong System Standardization

- Universal or standardized screening
- Hardwired workflows (rooming, EHR templates, protocols)
- Defined follow-up steps
- Monitoring systems for completion and documentation

Workflow Integration Reduces Access Barriers Within Visits

- Screening embedded into routine visits
- Pre-visit planning and monitoring tools
- Same-day follow-up processes

Addressing Operational Root Causes

- Missed screening opportunities
- Lack of standardized processes
- Inconsistent follow-up
- Poor documentation
- Ensures patients who screen positive receive defined next steps

Monitoring and Accountability Systems Are Built In

- Use of HIT tools for tracking screening and monitoring follow-up
- Standardized documentation processes
- Reduces risk of patients “falling through the cracks”

Behavioral Health – Where Equity Is Still Developing

Limited Gap-Closing Targets

- Equity is recognized and tracked but not always defined as closing the gap

Risk That More Advantaged Patients Benefit Faster

- Workflow-based approach favors patients with regular visits
- Technology reliance favors patients with stable engagement
- Gains may concentrate among lower-barrier, more engaged patients

Does Not Address Key Behavioral Health Barriers to Participation

- No explicit strategies to address stigma, fear of disclosure and mistrust of mental health care
- Patients may decline screening
- Patients may underreport symptoms

Minimal Cultural and Linguistic Responsiveness

- No clear mention of culturally adapted approaches
- No clear mention of interpreter integration
- No clear mention of translated screening tools

Lack of Personalized Approaches Reduces Effectiveness for Vulnerable Groups

- Interventions are standardized rather than targeted
- No differentiation for adolescents versus adults
- Does not account for differences in comfort with screening, access to follow-up care

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Adapt One Equity Practice

To your population health management project

How Might We Test Change Strategies That Address The Root Causes Of Disparities?

Ways to uncover root causes

- Consult the 'equity considerations' in your POF change package that reflect the literature
- Partner with patients to develop insights that will help you develop successful strategies; e.g., through interviews, focus groups, patient advisory groups (see Appendix)
- Create a visual map that can highlight root causes, e.g., fishbone diagram, patient centered journey map (see Appendix)
- 5 Whys (see Appendix)
- Understand how interconnected social, economic, cultural, and healthcare access factors may be impacting the health outcome (i.e., structural competence)

Test change strategies informed by understanding of root causes

- Create a driver diagram to address your POF disparity; the drivers are aimed to mitigate root causes; develop change ideas that advance the drivers

Let's Practice (Groups of 3)

Individually (4 min)

- Jot down 1 or more groups of patients that you've identified as experiencing disparities in your PHM project.
- Take note of your 'hunches' of what the root causes might be contributing.
- What is an idea to test related to cultural and linguistic responsiveness (through patient voice)?
  - Review your PoF equity analysis summary for your PHM project *(scan the QR code below to access your PoF handout)*
  - Can use an equity lens on a current change strategy

With your group (15 min)

- Each person take ~4-5 min to share: (1) the disparity you're working on, (2) possible root cause(s) of the disparities, (3) at least one idea you would like to test that could address the disparity.

Visit the **PHMI Cohort Portal** to view your PoF handout

Your Next Steps

- Share your ideas with your teammates and your Coach.
- Identify how you will deepen understanding about root causes, incorporating patient voice.
- Document or describe the equity-centered change strategies you'll test in your implementation plans.
- Lean on your Coach or Roseanne and Kristene as thought partners.



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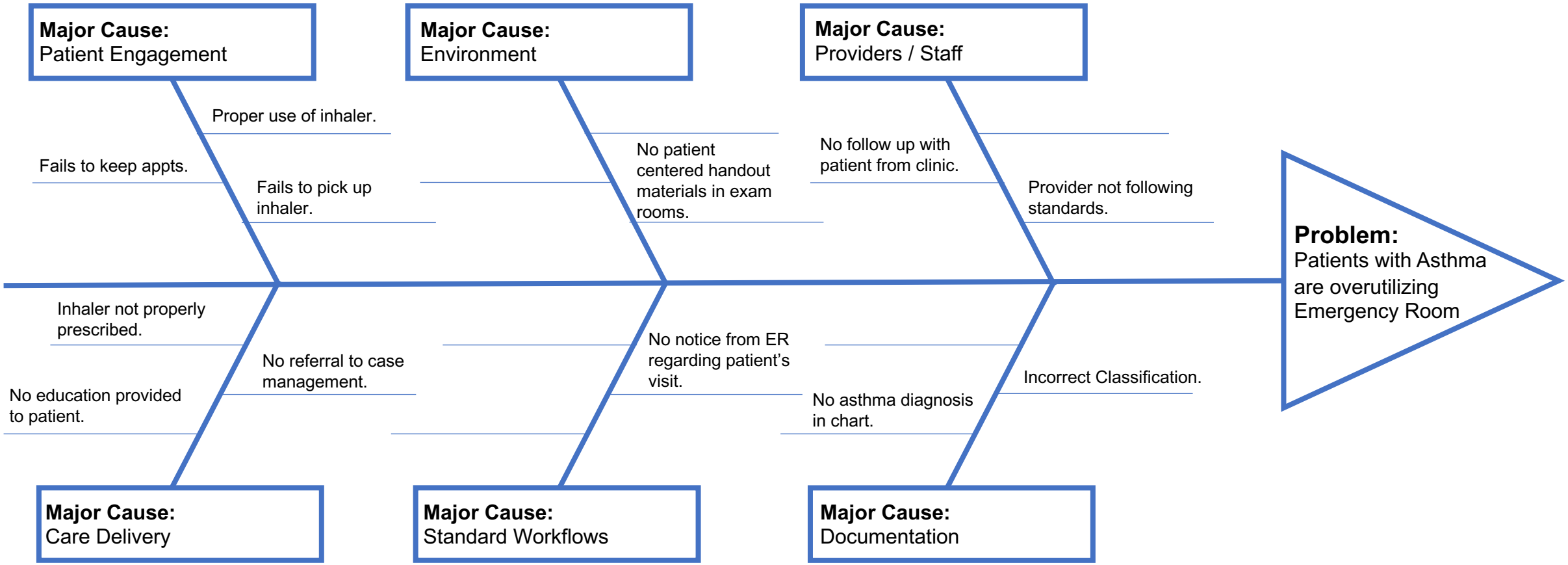
Appendix

Examples + tips for incorporating patient voice

Fishbone Diagram Worksheet

A fishbone diagram is a visual tool designed to help your team identify and organize potential causes of a problem, making it easier to uncover root causes. Start by clearly defining the problem at the head of the diagram. Then, label the main factors contributing to the issue as the "bones" and list possible sub-causes under each category. After completing the diagram, review and analyze the information to gain insights that can guide the development of effective solutions.



Example sourced from Armstorff Consulting Organization

Journey Mapping Template

Day 2 Patient Journey:

Arrival at clinic for MAT care from/to community partner referral

	Before arriving at clinic		Arrival at clinic for MAT care from/to community partner referral	
Journey Phase *What are the key steps or stages of the experience?*				
Actions *What does the person do? What is their context?*				
Touchpoint *What people, places, or settings do they interact with?*				
Needs & Barriers *What does the person want to achieve or avoid? What individual and systemic barriers are they facing?*				
Feeling & Emotions *What is the person feeling?*				
Opportunities *What could we improve or introduce?*				
Ownership *Who is the lead on this? What key partners might be involved?*				

Five Whys

This five whys worksheet is designed to help your team work through problems and dig deeper until the underlying cause is identified. After each answer, ask yourselves: If this issue were resolved, would the problem still occur? If the answer is yes, it's likely a contributing factor rather than the root cause.

Problem Statement	Patients are waiting over 45 minutes past their scheduled appointment times to see a doctor.
Why? Why are patients waiting so long?	The doctor is running behind schedule.
Why? Why is the doctor running behind schedule?	Appointments are taking longer than expected.
Why? Why are appointments taking longer than expected?	The doctor is spending extra time gathering patient information during the visit.
Why? Why does the doctor need to gather so much information during the visit?	Patients are not filling out their pre-visit forms completely or accurately.
Why? Why are patients not completing their pre-visit forms properly?	The forms are unclear, and some patients don't understand how to fill them out.
Root Cause(s) To validate root causes, ask: Would removing this root cause have prevented the event or problem?	The pre-visit forms are unclear and difficult for patients to complete, leading to longer appointment times and delays.

Tips: Developing Insights with Patients

Identify and Recruit Patients with Lived Experience

- Partner with community organizations and other trusted messengers
- Compensate participants

Design Engagement for Psychological Safety and Equity

- Create an inclusive environment (e.g., interpreters, translated materials)
  - Avoid clinical jargon
- Flexible formats (e.g., virtual, in-person, by phone)
- Trauma-informed facilitation
- Cultural humility

Conduct Empathy-Building Activities

- Journey mapping (e.g., before, during, after interaction with healthcare system)
- Storytelling interviews
- “Day in the life” exercises

Synthesize into Insights (Not Just Themes)

- Cluster observations
- Identify tensions or contradictions
- Ask: What surprised us?
- Ask: What is the underlying human need?
- Formula: “Because [context], patients [behavior], which reveals [unmet need or inequity].”

Scan to access PHMI Patient Engagement Affinity Group Resources

Tips: Co-Create Solutions with Patients

"How might we..." exercises

- How might we make follow-up care easier for people with unpredictable schedules?
- What would an ideal experience look like?

Patients are the decision-makers, *not* advisors

Include frontline staff for feasibility

Prioritize solutions using equity criteria

- Does it reduce disparities?
- Does it improve access for the most vulnerable?
- Does it address root causes?
- Is it culturally appropriate?

Validate with patients & iterate

- Ask: "Would this actually work for you?"
- Methods: rapid prototyping, feedback sessions, pilot programs