



# Health Center Quality Measurement Systems

*A Guide to Clinical Performance Measurement Sets*



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# Health Center Quality Measurement Systems

A Guide to Clinical Performance Measurement Sets

## Introduction to the Toolkit

This toolkit is designed for use by clinical and operational staff working in primary care health center and clinic settings in Northern California. The content of this toolkit was developed by staff from two regional clinic consortia, Health Alliance of Northern California and North Coast Clinic Networks, and Partnership HealthPlan of California (PHC).

This guide is intended for use as a primer on the various quality measurement sets that are currently in use by the Medi-Cal managed care plan and federally qualified health centers. Medi-Cal is California's Medicaid program. The measurement sets reviewed include the following:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Primary Care Provider Quality Improvement Program (QIP)
- Facility Site Review (FSR)
- Uniform Data System (UDS)

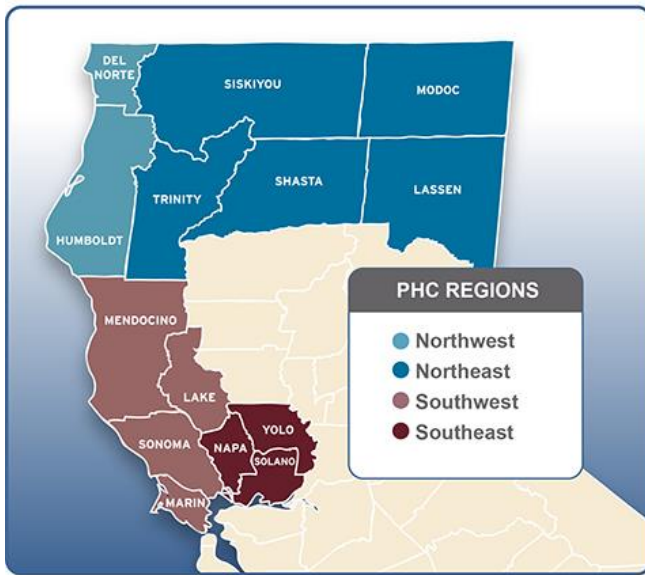
The measurement systems explored in this toolkit are those used by Partnership HealthPlan of California to monitor and incentivize provider performance and improvement in primary care service delivery in the Northern Region (i.e., HEDIS, FSR and QIP) and the federal measurement set for federally qualified health centers (UDS).

This guide is organized into three sections to provide progressively deeper levels of detail on the measurements sets. Each section includes an overview that orients readers to the purpose, content, and suggested use for the material. The three sections include:

1. **Measurement Set Summaries** – provide high-level overviews of each measurement set, how data is collected and reported, and primary purpose for measurement.
2. **Quality Measure Profiles** – explores the importance and impact of health measures through a look at health center performance on 2017 UDS measures.

3. **Quality Measure Specification Comparisons** – serves as a reference with detailed comparisons of measure definitions, documentation requirements, and reporting specifications by measure.

This toolkit is designed specifically for the community clinics and health centers serving a nine county region in Northern California, including Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Trinity. These counties are part of three of Partnership HealthPlan of California’s HEDIS reporting regions: Southwest, Northwest and Northeast (pictured below).



**Figure 1. PHC HEDIS Regions**

Data reported in the Quality Measure Profiles are collected from the health centers serving the counties in the Southwest Region (rose – Mendocino and Lake), Northwest Region (teal – Del Norte and Humboldt counties) and the Northeast Region (blue – Lassen, Modoc, Siskiyou, Shasta, and Trinity).

# Chapter 1: Measurement Set Summaries

## *Brief Overviews of Current Measurement Systems*

### Purpose

To provide a brief and high-level overview of each measurement set to increase understanding of why the measurement sets are in use, how data collection and reporting is managed, and any relevant benchmarks or targets.

### Overview of Content

- Background and Terms
- Review of The Measures
- Minimum Performance Levels and High Performance Levels

### Suggested Uses for This Material

- Use for training new quality improvement staff
- Share with board of directors when presenting quality improvement or other performance measurement reports
- Share with health care clinicians to increase awareness and gain buy-in for improvement efforts on quality measures

This section of the toolkit includes summaries of each quality improvement measurement set. The sets reviewed include the following:

HEDIS	Healthcare Effectiveness Data Information Set
QIP	Partnership HealthPlan of California Primary Care Provider Quality Improvement Program
FSR	Facility Site Reviews
UDS	Uniform Data System

Each summary includes information on the main purpose of the summary, overview of the summary content, and suggestions for use.

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## Healthcare Effectiveness Data Information Set (HEDIS)

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### Background and Terms

HEDIS, developed by the National Committee for Quality Assurance (NCQA) is the most widely used healthcare quality measurement tool in the United States. HEDIS is designed to provide healthcare purchasers, consumers and others with a standardized way to compare health plans. HEDIS data are often used to produce health plan “report cards” and analyze the effectiveness of quality improvement activities. The NCQA library houses 96 measures across 6 domains of care. The 6 Domains of Care are:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported Using Electronic Clinical Data Systems

The Department of Healthcare Services (DHCS) selects a subset of measures across these domains for Managed Care Plans (MCPs) to report annually. Performance measures within these domains provide information about a health plan’s performance in such areas as providing timely access to preventive services, management of members with chronic disease, and appropriate treatment for members with select conditions. While HEDIS data provides an opportunity to compare health plans based on some aspects of health care delivered to members, the intent of the data is not to provide an overall, comprehensive assessment of health care quality for a health plan. DHCS uses HEDIS data as one component of its overall quality monitoring strategy. DHCS and MCPs use MCP-specific data, aggregate data, and comparisons to State and national benchmarks to identify opportunities for improvement, analyze performance, and assess whether previously implemented interventions were effective.

PHC recently achieved NCQA accreditation as a health plan. The importance of HEDIS becomes more prominent as HEDIS scores and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results make up 50% of the accreditation assessment. Becoming accredited requires reporting on an expanded set of HEDIS measures, which began in measurement year 2021.

### HEDIS Annual Project

- NCQA Measure Technical Specifications Released: October of the reporting year
- Measurement year: January 1 – December 31
- Annual Project Timeline: February-May

**Overview:** Each year PHC has less than twelve weeks to execute the HEDIS annual project. This includes capturing data from claims and encounters, supplemental data sources, and through the collection of over 15,000 medical records in an effort to capture the care provided to our members over the measurement year. PHC is required to contract with an external auditing firm, licensed by NCQA to ensure the HEDIS audit is executed according to NCQA guidelines. PHC is also required to use NCQA Certified Software to execute the HEDIS project and calculate rates.

**Medical Record Retrieval Process:** PHC contracts with a medical record retrieval vendor for EMR Remote Access, who also serves as the medical record abstraction vendor to ensure the project is executed within the mandated timeframe. PHC staff partner with the vendor to ensure successful record retrieval and abstraction accuracy. PHC piloted remote access for record retrieval in 2016, and has since expanded EMR Remote Access as the preferred method for medical record retrieval, yielding the best outcomes for both providers and project outcomes. Due to the success of EMR Remote Access, PHC will take the balance of medical record retrieval “in-house” for the annual medical record project.

**DUE each year:** PHC is required to halt the annual project by a designated date in early May to submit the results of its audit to Health Services Advisory Group (HSAG), PHC’s licensed auditing firm. HSAG conducts a Medical Record Review Validation (MRRV) for Hybrid Measures, by selecting specific measures for validation. PHC is required to submit medical record evidence for a specified sample of numerator positive members for the measures selected. Failures in this audit may result in the inability to report performance on the measure. Once this audit is successfully completed, final rates can be calculated, which are reported to PHC and the public in late July/August.

### **Regional Reporting:**

When PHC expanded in 2013 to cover 8 additional counties, PHC received approval from DHCS to allow HEDIS to be reported at a regional level. Please note below the following 4 reporting regions:

Northwest: Humboldt, Del Norte

Northeast: Shasta, Trinity, Modoc,  
Siskiyou, Lassen

Southwest: Sonoma, Marin,  
Mendocino, Lake

Southeast: Solano, Yolo, Napa

This means one rate per measure/per region is publicly reported. Because some counties are more populous within a region, PHC conducts a county level oversample where the denominators are very small, to best gauge county level performance for improvement efforts.

**There are two types of measures for HEDIS, Administrative and Hybrid****Administrative Measures:**

- Measures the entire eligible population, which is measure specific. Each measure has eligible population criteria such as age, continuous enrollment, allowable gap, event, diagnosis, etc.
- Data collected through claims and/or encounter services billed. Look back is defined by measure through 12/31 of the measurement year.
- The health plan looks at the entire eligible population using claims and encounter data, and pharmacy and lab data to satisfy each measure.
- Administrative measures do not allow data to be collected from the medical record.
- Timely and accurate billing practices are important to ensure capture of all services provided to health plan members.

**Hybrid Measures:**

- Measures a statistically significant *sample* of the eligible population.
- Data collected from both claims and/or encounter services billed and data collected from the medical record.
- The health plan's certified software draws a statistically significant sample of the eligible population. Where a sample member was not made compliant by claims and/or encounter data, PHC is able to use medical record data to show compliance. Several measures utilize a combination of both claims and/or encounter data and abstracted medical record evidence to demonstrate measure compliance.
- The stronger the claims data, the fewer medical records need to be collected from provider sites.
- The health plan casts a very wide net to locate the data needed to satisfy the hybrid measures. For example, PHC considers which PCP the member is assigned to and which provider they saw most often during the measurement year. Additionally, if a measure includes services that a specialist provides, PHC considers which specialist(s) the member saw during the measurement year.

It is important to note that enrollment criteria are specific to the measure for both administrative and hybrid measures. PHC's certified software determines appropriate enrollment spans per NCQA guidelines, and excludes those with dual eligibility and share of cost.



**Types of Documentation Collected:**

When collecting medical records, the health plan looks for specific information to satisfy the measure(s). Some examples of what may be collected is:

- History and Physicals
- Progress notes
- Lab reports
- OB flow charts
- Immunization and Disease Registries
- Handouts/counseling documentation

**HEDIS Measures and this Toolkit:**

Given the targeted provider audience for this toolkit, measure details specific to the PCP QIP and UDS are its primary focus. Additionally, PHC is now responsible for performance reporting on a larger HEDIS measure set per NCQA accreditation and DHCS accountability requirements. As a result, the HEDIS measures are not presented in detail in this toolkit but are referenced where similar measures exist in the PCP QIP and UDS.

**Minimum Performance Levels and High Performance Levels:**

DHCS annually establishes a minimum performance level (MPL) and high performance level (HPL) for each required measure. The previous year's audit means, percentiles, and ratios are used to establish the MPLs and HPLs for the current reporting year. In recent years, the MPLs were based on the Medicaid national 25<sup>th</sup> percentiles, and the HPLs were based on the national Medicaid 90<sup>th</sup> percentiles. Per communications from DHCS (2019), the MPLs increased from the Medicaid national 25<sup>th</sup> percentile to the national 50<sup>th</sup> percentile as of the 2020 reporting year. Note, the HEDIS benchmarks may shift year to year based on the average performance of health plans on a national level. MCPs are contractually required to perform at or above the established MPLs. MCPs that have rates below the MPLs are frequently assigned mandated improvement projects by DHCS. With repeated low performance, MCPs risk issuance of a formal DHCS Corrective Action Plan (CAP) as well as financial penalties. MCP performance in relation to the MPL and HPL for each measure becomes public record with the release of each annual HEDIS report.

**Resources:**

<http://www.partnershiphp.org/Providers/Quality/Pages/HEDISLandingPage.aspx>

<http://www.ncqa.org/hedis-quality-measurement>

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>

## Primary Care Provider Quality Improvement Program (PCP QIP)

### Background and Terms

The Primary Care Provider Quality Improvement Program (QIP), designed in collaboration with PHC providers, offers sizable financial incentives and technical assistance to primary care providers. Primary Care Providers include: Pediatric Medicine, Family Medicine, and Internal Medicine. To participate in the QIP, you must be a contracted provider for at least nine months during the measurement year.

QIP program development is managed using a major and minor change timeline. This means major changes are made to the measurement set every other year, with only minor specification changes made in alternate years. Measurement development for the major change year typically starts six months prior to the start of the QIP year. Important stakeholders, both internal and external, come together to select the most meaningful measures. Two workgroups Technical Workgroup (internal) and Advisory Workgroup (external) collaborate to outline the details for the upcoming year. Along with these two groups a provider comment period is held which is typically two weeks long and used to gain additional feedback from our external stakeholders. Recommendations from all of these avenues are then presented to the Physician Advisory Committee (PAC), which is the final approval body for the QIP measurement set.

The QIP serves to increase health plan operational efficiencies by prioritizing areas that drive high quality care and have potential to reduce overall healthcare costs.

#### **In response to the COVID-19 Pandemic:**

The final Measurement Set for the 2020 Measurement Year (MY) was significantly modified in May 2020 in response to the Covid-19 pandemic. DHCS and PHC recognized early on that the pandemic put constraints on providers making more rigorous measure targets very difficult to achieve. Therefore, the measurement set was reduced in the number of accountable measures and measurement targets were lowered.

While the 2021 Measurement Year included a measurement set more aligned with pre-pandemic MYs, the ongoing impact of the pandemic influenced the accountable measures included and setting of measurement targets. For Measurement Year 2023, the measurement set reflects a return to a full set of measures. Thresholds were also increased but are still not up to pre-pandemic targets.

**Reporting Period:** Calendar Year, January 1 – December 31 (12 Months)

### Measurement Set

The Primary Care Provider QIP is comprised of two measurement sets each with its own payment methodology, see below.

The Primary Care Provider QIP Core Measurement Set includes measures in the Clinical, Appropriate Use of Resources, Operations and Access, and Patient Experience domains. For these measures, performance is rewarded based on the points earned and the number of member months accumulated throughout the year. There is a per member per month (PMPM) amount for all sites. The number of member months is multiplied by the PMPM to determine the maximum amount an individual site can earn. That amount is then multiplied by the percentage of points earned through the Core Measurement Set to determine the actual incentive amount.

The Unit of Service measures, the payment is independent of and distinct from the financial incentives a site receives from the Core Measurement Set. A site receives payment according to the measure specifications if the requirements for one or more Unit of Service measures are met.

#### Core Measures

- Clinical Measures
- Non-Clinical Measures
  - Appropriate Use of Resources
  - Patient Experience

#### Unit of Service Measures

- Advanced Care Planning
- Extended Office Hours
- Patient-Centered Medical Home (PCMH) Recognition
- Peer-Led Self-Management Support Groups
- Health Information Exchange Participation
- Health Equity Implementation Plan
- Blood Lead Screening
- Dental Fluoride Varnish Use
- Tobacco Use Screening
- Electronic Clinical Data System (ECDS) Implementation

#### **Provider eligibility criteria:**

All current primary care providers, including pediatric, family, and internal medicine sites, that have capitated Medi-Cal only members assigned and are contracted with PHC for the entire measurement year are automatically enrolled in the QIP. Providers must be contracted with members by October 1 for at least nine months in the measurement year to be eligible for the Core Measurement set.

**Sample Size:** All of the eligible population for the Core Measurement Set. Unit of service measures are optional, therefore the sample size can vary depending on the measure, and provider engagement and participation.

**Data Tracking:** Clinical measures are tracked by eReports, an online system developed and maintained internally by PHC's Web Applications IT team. Functions offered to you in eReports are:

- The ability to track your clinical performance in real time
- The ability to download patient reports for each of the clinical measures
- The ability to upload supplemental data for your patients-which is an important feature of eReports.

You can access eReports at: <https://qip.partnershiphp.org/>.

For more information on how to create an eReports account and navigate the site, please refer to the eReports User Manual on the [PHC website through this link](#). Non-Clinical measures are tracked by PHC's QIP Team and specific instructions and timelines can be found on the [PHC website](#).

**Points Calculations:** Points for clinical measures are determined by thresholds obtained from the NCQA HEDIS national percentiles for Medicaid Health Plans, reported in the year prior to the QIP measurement year. The thresholds used typically include the 50<sup>th</sup>, 75<sup>th</sup>, and 90<sup>th</sup> percentiles calculated from the previous year's HEDIS data. Given the ongoing impact of the pandemic, current measurement targets were based primarily on the 50<sup>th</sup> and 75<sup>th</sup> percentiles.

For most existing clinical measures, the full-point target is set at the 75th percentile performance of all Medicaid health plans reporting to NCQA (with the exception of Colorectal Cancer Screening, which is set at the 50<sup>th</sup> percentile); sites can receive partial points on these measures if the 50th percentile performance is met (25<sup>th</sup> percentile for Colorectal Cancer Screening).

**Relative Improvement:** In order to be eligible to earn relative improvement points on a given clinical measure:

- 1) Sites must first meet the 50th percentile performance target. AND
- 2) Sites must demonstrate a minimum of 10% relative improvement.

As calculated by the following formula:

$$\frac{(\text{Current year performance}) - (\text{Previous year performance})}{(100 - \text{Previous year performance})}$$

Total available relative improvement points: full points

**Payment Methodology:** PHC encourages all PCP QIP participants to closely read the payment section in the [Specifications](#) posted on our website.

Based on individual sites' performance on Core Measurement set. Each site's maximum potential earnings will be the PMPM amount multiplied by the number of member months (MM) accumulated over the course of the year.

Starting in 2023, the methodology for calculating the site PMPM amount will have two (2) components:

- A base rate (likely \$4 PMPM) and
- A site adjusted supplemental rate (may range from an additional \$0 to a maximum of \$20 PMPM).

The following six (6) factors will be used to generate the site adjusted supplemental rate:

- An adjustment for unfavorable socio-demographic mix of patient population
- An adjustment for the severity of the patient mix of the site, based on an estimate of the additional workload of caring for that patient population
- An adjustment for the difficulty in hiring primary care clinicians at the site
- An adjustment for low practice resources
- An adjustment for major disruptions in service related to natural disasters
- Only PCPs with at least 100 assigned members as of December of the prior measurement year will be eligible for the above adjustments

Here is the payment formula:

$$\text{QIP Score \%} * \text{Annual MMs} * \text{PMPM (base + supplemental)} = \text{Incentive}$$

### **Key Terms of the PCP QIP:**

**Eligible Population:** Assigned and/or Capitated Medi-Cal members, excludes Medi-Medi or members with other insurance primary, and Special Members.

**Continuous Enrollment:** Members assigned for nine out of the 12 months between January 1 and December 31 of the reporting year. December is the anchor month. Applies to Clinical measures only.

**Member Months (MM):** The sum of monthly enrollment counts over the course of the 12-month measurement period.

- Example: If a site has 1,000 members each month, for the full measurement year the site has accumulated 12,000 member months

Per member per month (PMPM): amount budgeted for the incentive payment

- Note: The per member per month (PMPM) amount may change annually based on the plan's financial performance. It is announced annually at the beginning of the measurement year and may change mid-year pending unforeseen State budget impacts to the plan.

Points Earned: The total number of points earned out of the total available points across the Core Measurement Set. Total available points are 100.

Denominator: The total number of persons during a defined time period who are eligible for the numerator event.

Numerator: The number of persons in the denominator who received the appropriate preventive or diagnostic screening or test.

## 2023 Core Measurement Set Breakdown of Points:

### Clinical Measures:

Clinical Measures	Family	Internal	Pediatric	Tracked by
Asthma Medication Ratio	6	8	13	eReports
Breast Cancer Screening	6	12	n/a	eReports
Cervical Cancer Screening	6	12	n/a	eReports
Child and Adolescent Well Care Visits	9	n/a	16	eReports
Childhood Immunization Status: Combo 10	6	n/a	16	eReports
Colorectal Cancer Screening	5	12	n/a	eReports
Comprehensive Diabetes Care: HbA1c Control	6	11	n/a	eReports
Comprehensive Diabetes Care: Retinal Eye Exam*	5	5	n/a	eReports
Controlling High Blood Pressure	6	10	n/a	eReports
Immunizations for Adolescents - Combo 2	6	n/a	16	eReports

Well-Child Visits in the First 15 Months of Life	9	n/a	16	eReports
Total Points:	70	70	77	

**Non-Clinical Measures:**

Appropriate Use of Resources	Family	Internal	Pediatric	Tracked by
Ambulatory Care Sensitive Admissions	5	5	n/a	PHC
Risk Adjusted Readmission Rate	5	5	n/a	PHC
Total Points:	10	10	0	
Access and Operations	Family	Internal	Pediatric	Tracked by
Avoidable ED Visits/1000	5	5	7	PHC
PCP Office Visits*	5	5	6	PHC
Total Points:	10	10	13	
Patient Experience	Family	Internal	Pediatric	Tracked by
CAHPS Survey <i>or</i> Survey Option	10	10	10	PHC/PCP
Total Points:	10	10	10	

**Unit of Service (Optional):** Providers receive payment for each unit of service they provide.

**2023 Unit of Service breakdown of measures:**

Measures	Incentive Amount	Tracked By	System for Monitoring	System for Submission
Advance Care Planning	Minimum 1/1000th (0.001%) of the sites assigned monthly membership 18 years and older for: <ul style="list-style-type: none"> <li>• \$100 per Attestation, maximum payment \$10,000.</li> <li>• \$100 per Advance Directive/POLST, maximum payment \$10,000</li> </ul>	eReports	eReports	Submission Template
PCMH Certification	\$1,000 yearly for achieving or maintaining certification	PHC QIP Team	Year-end Reports	Submission Template



Peer-Led Self Mgmt. Support Groups	\$1,000 Per Group per Year Maximum of 10 groups per Parent Organization	PHC QIP Team	Year-end Reports	Submission Template
Health Information Exchange Participation	One-time \$3000 incentive for signing on with a local or regional health information exchange; Annual \$1500 incentive for showing continued participation with a local or regional health information exchange. The \$3000 incentive is available once per parent organization.	PHC QIP Team	Year-end Reports	Submission Template
Access/Extended Office Hours	Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours beyond the normal business hours (reference measure specification).	Provider Relations Dept.	Quarterly Reports	Provider Relations Dept.
Health Equity	\$2000 per parent organization for submission of proposed plan to adopt internal best practices supporting a Health Equity initiative.	PHC QIP Team	Year-end Reports	Submission Template
Blood Lead Screening	Tier 1-3, \$1000, \$3000, \$5000 per parent organization for the number of children between 24 to 72 months who had capillary or venous lead blood test for lead poisoning.	PHC QIP Team	Year-end Reports	Submission Template
Dental Fluoride Varnish Use	\$1,000 per parent organization for submission of proposed plan to implement fluoride varnish application in the medical office.	PHC QIP Team	Year-end Reports	Submission Template
Tobacco Use Screening	\$5.00 per tobacco use screening or counseling of members 11– 21 years of age after 3% threshold of assigned members screened.	PHC QIP Team	Year-end Reports	Submission Template
Electronic Clinical Data System (ECDS) Implementation	\$5,000 per parent organization for participating in Electronic Clinical Data System (ECDS) implementation by the end of the measurement year. For parent organizations that submitted initial data for ECDS in the prior measurement year, an additional \$5000 incentive will be available if they continue to submit an ECDS file for 2023 data monthly, starting no later than June of 2023.	PHC QIP Team	Year-end Reports	PHC IT Department

**Program Timeline:****2023**

January 1 – First day of the measurement year.

May 8 – eReports Launch

December 31 – Last day of the measurement year.

**2024**

January 8 – First day of the Measurement Year Grace Period

January 31 – Final Submission Deadline

February 1-9 (approximately) – Clinical (eReports) and Advance Care Planning data validation period.

April 31 – Payment Distribution

**Resources:**

QIP Website:

<http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx>

QIP Inbox: [qip@partnershiphp.org](mailto:qip@partnershiphp.org)

eReports: <https://qip.partnershiphp.org/>

## Facility Site Review

### Background and Terms

Partnership HealthPlan of California (PHC) is mandated by the California Department of Health Care Services (DHCS) to review contracted providers within our Network.

Contracted primary care providers, as well as OB/GYN provider sites, are reviewed as a condition of participation in our provider network. These site reviews are conducted during the initial provider credentialing process. Additional site reviews will be conducted as part of the ongoing provider re-credentialing process at least every three years to assure that each provider continues to meet the standards set forth by local, state, and federal regulations. A registered nurse, certified by the California Department of Health Care Services (DHCS) using the DHCS approved review tools, conducts the review. The review tools and guidelines as well as a preparation checklist are provided to the site at the time the review is scheduled. The **Site Review (SR)** consists of the **Facility Site Review and Medical Record Review**. In addition, a **Physical Accessibility Review Survey (PARS)** is also conducted at the time of the SR.

**What is a Facility Site Review?** The Facility Site Review is an assessment of the facility’s physical site (includes building, accessibility, equipment, and policies/procedures), and the DHCS approved site review tool is used to determine compliance in meeting the standards in the following areas:

- Accessibility/Safety
- Clinical Services
- Personnel
- Preventative Services
- Office Management
- Infection Control

### Benchmarks:

<b>Exempted Pass:</b>	<b>Conditional Pass:</b>	<b>Not Pass:</b>
90% or above without deficiencies in Critical Elements, Pharmaceutical Services or Infection Control	80-89%, or 90% and above with deficiencies in Critical Elements, Pharmaceutical Services or Infection Control	Below 80%

**A corrective action plan (CAP) is required for a Conditional Pass or a Not Pass.**

A CAP for all deficiencies identified for critical element criteria, which are bolded and underlined in the site review tool, should be submitted to the Health Plan within 10 calendar days of the review. A corrective action plan for deficiencies on non-critical element criteria is due to the Health Plan within 30 calendar days from the date of the review.

The nine (9) Critical Element Deficiencies are:

Critical Element	Deficiencies
Access/Safety	1. Exit doors and aisles are unobstructed and egress (escape) accessible.
Personnel	2. Airway management: oxygen delivery system, oral airways, nasal cannula or mask, Ambu bag.
Office Management	3. Only qualified/trained personnel retrieve, prepare or administer medications.
Pharmaceutical Services	4. Physician review and follow-up of referral/consultation reports and diagnostic test results.
Infection Control	5. Only lawfully authorized persons dispense drugs to patients.
	6. Personal protective equipment is readily available for staff use.
	7. Needle-stick safety precautions are practiced on site.
	8. Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate <i>leak proof, labeled</i> containers for collection, handling, processing, storage, transport, or shipping.
	9. Spore testing of autoclave/steam sterilizer with documented results (at least monthly)

Typically, a facility site review takes 3-4 hours to complete. Your site can operate as usual during the review. An office representative that is highly knowledgeable in the site's daily operations and policy/procedures is needed during the review. This person will be called upon to answer questions from the reviewer, demonstrate knowledge of how to use certain types of medical equipment and provide evidence of policies and procedures in place at the facility. The reviewer may also ask additional personnel (i.e. MA/LVN/Receptionist) questions regarding their area of expertise.

***What is a Medical Record Review?*** A Medical Record Review is conducted at primary care provider sites, 3-6 months after an Initial Site Review has been completed, and at least every three years thereafter. The DHCS approved tool and guidelines used by the DHCS-certified nurse reviewer are sent to the site at the time the review is scheduled. A list of patients whose records will be reviewed is provided 1-2 weeks before the review. The records for this type of review are not collected, they are reviewed onsite or through a WebEx meeting.

The specific areas being reviewed are:

- Format
- Documentation
- Continuity of Care
- Pediatric Preventive Care (comparable to HEDIS, QIP, UDS)
- Adult Preventive Care (comparable to HEDIS, QIP, UDS)
- OB/CPSP Preventive Care (comparable to HEDIS, QIP, UDS)

All of the areas are assessed for each record based on the age of the member and age appropriateness of member screenings.

Benchmarks:

<b>Exempted Pass</b> 90% or above: (Total score is $\geq$ 90% and all section scores are 80% or above)	<b>Conditional Pass</b> 80-89%: (Total MRR is 80-89% OR any section(s) score is < 80%)	<b>Not Pass:</b> Below 80%
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*Note: Any section score of < 80% requires a Corrective Action Plan (CAP) for the entire MRR, regardless of the Total MRR score. There are no critical elements in this portion of the review. An MRR CAP must be submitted within 30 calendar days.*

Typically, a medical record review can take up to 5 hours for 10 medical records. The number of providers working at the site determines the number of records to be reviewed which ranges from 10-40 records. Your site can operate as usual during the review. A staff person will be needed to help acquaint the reviewer with the electronic health record layout. PHC recommends conducting the medical record review virtually whenever possible to optimize the review process and impact on staff time.

***What is a Physical Accessibility Review Survey (PARS)?*** This review is unique among the programs included in this overall tool. While an important part of the site review process, there are no corresponding criteria among the other programs covered in this tool.

Physical Accessibility Review Survey (PARS) are conducted for all contracted Primary Care Provider sites, as well as High Volume Ancillary and Specialty Provider (HVASP) sites. The PARS tool was developed by a collaborative coalition made up of staff from the DHCS and Medi-Cal Managed Care Health Plans to address the accessibility of providers' offices, clinics, and other health care providers that provide medical care to seniors and people with disabilities.

Our provider directories are updated with the areas met by each site. The PARS assessment is for informational purposes only and sites are not required to make additional updates based on the PARS review. The reviewer will evaluate accessibility related to the following indicators:

• <b>P</b> = Parking	• <b>EB</b> = Exterior Building	• <b>R</b> = Restroom
• <b>IB</b> = Interior Building	• <b>E</b> = Exam Room	• <b>T</b> = Exam Table/Scale
• ME = Medical Equipment (PCP only):	• Height adjustable exam table	• Wheelchair Accessible Weight scale

### Level of Access

- Basic Access means the facility demonstrates access in regards to all of the mentioned features.
- Limited access means one or more of the features are missing or incomplete.

**Reporting Period:** Every three years.

**DUE each year** on January 31<sup>st</sup> and July 31<sup>st</sup>. PHC must submit the results of our Facility Site Reviews and Medical Record Reviews to DHCS.

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## Uniform Data System (UDS)

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### Background and Terms

The Uniform Data System (UDS) is administered by the U.S. Department of Health & Human Services, Health Resources and Services Administration (HRSA) – Bureau of Primary Health Care as part of the Health Center Program – Section 330 of the Public Health Service Act ([42 U.S.C. §254b](#)).

Health centers are non-profit, private or public entities that serve designated medically underserved populations/areas or special medically underserved populations comprised of migrant and seasonal farmworkers, the homeless or residents of public housing. Entities included as a health center are Federally Qualified Health Centers (FQHC's), health center look-alikes, and Bureau of Primary Health Care clinics.

The UDS is a standard data set that is reported annually and provides consistent information about health centers. It is a core set of information, including patient demographics, services provided, clinical processes and results, patients' use of services, costs, and revenues that document how health centers perform. HRSA routinely reports these data and related analyses, making them available to health centers in HRSA's Electronic Handbook (EHB) and to the public through HRSA's Bureau of Primary Health Care (BPHC) website at <http://bphc.hrsa.gov/datareporting/index.html>.

**Reporting Period:** January 1 – December 31 (12 months)

The UDS Report is revised yearly and a Program Assistance Letter or PAL is generally released between February-July and explains changes for the upcoming year. The UDS Manual for the reporting year is generally released between September – December of the year prior. Links to Resources: [UDS PAL & UDS Reporting Resources](#)

**DUE each year** on February 15<sup>th</sup> for the previous calendar year. The report is examined by a HRSA reviewer and they submit questions back to the health center; questions are usually focused on data inconsistencies or clarifications. Health centers must respond to the reviewer's summary, and the UDS report must be finalized by March 31<sup>st</sup>.

### Definitions:

**Visit:** To be counted as having met the visit criteria, the interaction must be:

- Documented
- Individual<sup>1</sup>
- Face-to-face or virtual<sup>2</sup> contact between a patient and a
- Licensed or otherwise credentialed provider, who
- Exercises independent, professional judgment in providing services

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<sup>1</sup> An exception is allowed for behavioral health visits, which may be conducted in a group setting.

<sup>2</sup> Only interactive, synchronous audio and/or video telecommunications systems that permit real-time communication between a provider and a patient.

**Patient:** A patient must have received one or more qualifying/reportable visits during the reporting period to be counted in the UDS report. Each patient is counted once no matter how many visits he/she may have had.

**Number of Records Reviewed:** Health centers have the option of reporting on their entire patient population or a reduced denominator consisting of a minimum of 80% of all medical (or dental for dental sealants) patients. While a reduced universe containing a minimum of 80% of all medical patients is permitted, full EHR or HIT system reporting is preferred.

**UDS Report Tables**

*Note: HRSA is moving towards alignment with CMS and HEDIS measure definitions*

- Patients By ZIP Code
- Table 3A: Patients By Age and by Sex Assigned at Birth
- Table 3B: Demographic Characteristics – Universal (Ethnicity, Race, Linguistic Barriers to Care, Sexual Orientation, Gender Identity)
- Table 4: Select Patient Characteristics – Universal (% Poverty Level, Insurance Status, Managed Care utilization, Special Populations)
- Table 5: Staffing and Utilization
- Table 6A: Select Diagnoses and Services Rendered – Universal

<b>Table 6B: Quality of Care Measures</b>	<b>2022</b>	<b>2023 (Proposed)</b>
Age Categories for Prenatal Patients	<a href="#">Manual</a>	<b>UDS PAL</b>
Trimester of Entry into Prenatal Care	<a href="#">Manual</a>	
Childhood Immunization Status	<a href="#">CMS117v10</a>	
Cervical Cancer Screening	<a href="#">CMS124v10</a>	
Breast Cancer Screening	<a href="#">CMS125v10</a>	
Weight Assessment and Counseling for Children & Adolescents	<a href="#">CMS155v10</a>	
Adult Weight Screening and Follow-Up	<a href="#">CMS69v810</a>	
Tobacco Use Screening and Cessation Intervention	<a href="#">CMS138v10</a>	
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	<a href="#">CMS347v7</a>	
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	<a href="#">CMS164v7</a>	
Colorectal Cancer Screening	<a href="#">CMS130v10</a>	
HIV Linkage to Care – F/U within 30 days of Dx	<a href="#">Manual</a>	
HIV Screening	<a href="#">CMS349v4</a>	
Depression Screening and Follow-Up Plan	<a href="#">CMS002v11</a>	
Depression Remission at Twelve Months	<a href="#">CMS159v10</a>	
Dental Sealants for Children (6-9 years old)	<a href="#">CMS277v0</a>	

- **Table 7: Health Outcomes and Disparities – By Race and Hispanic/Latino Ethnicity**



Deliveries and Births By Weight/Ounces	<a href="#">Manual</a>	<a href="#">UDS PAL</a>
Controlling High Blood Pressure – Hypertension (<140/90)	<a href="#">CMS165v10</a>	
Diabetes: Hemoglobin A1c Poor Control (>9%/No Test)	<a href="#">CMS122v10</a>	

- Table 8A: Financial Costs
- Table 9D: Patient Related Revenues
- Table 9E: Other Revenues
- Appendix: HIT/EHR, Medication-Assisted Treatment, Telehealth, COVID vaccine, Workforce Questionnaires

Technical Assistance: <http://www.bphc.hrsa.gov/datareporting/reporting/index.html>

# Chapter 2: Quality Measure Profiles

## *Datasets that Report Health Center Performance on Clinical Quality Measures*

### Purpose

To provide context for understanding the importance of each clinical measure in health center settings.

### Overview of Content

- Impact of Health Issue in Rural Northern California
- How Health Centers Provide the Necessary Care
- Rural Northern California Health Center Data
- Quality Measure Definitions
- National Quality Goals and Benchmarks

### Suggested Uses for This Material

- Use for training new quality improvement staff
- Share with board of directors when presenting quality improvement reports
- Share with health care clinicians to increase awareness of importance of improvement efforts on UDS measures

This section of the toolkit includes in-depth information on each quality clinical measure. The datasets include health center performance reported through Uniform Data System (UDS), HEDIS or QIP data reports. The datasets included in this section of the toolkit include the following:

#### Primary Prevention

- Cervical Cancer Screening
- Breast Cancer Screening
- Colorectal Cancer Screening
- Prenatal and Postpartum Care
- Depression Screening and Appropriate Follow-Up

#### Immunizations

- Childhood Immunizations
- Immunizations for Adolescents

#### Tertiary Prevention

- Controlling Diabetes
- Controlling High Blood Pressure
- Tobacco Screening and Cessation
- Adult Weight Assessment and Counseling
- Asthma Medication Ratio

#### Well Child

- Child and Adolescent Well Care Visits
- Child and Adolescent Weight Assessment and Counseling

# Cervical Cancer Screening

## Impact of Cervical Cancer in Rural Northern California

- Overall, women in rural areas have significantly higher cervical cancer incidence and mortality<sup>1</sup> than those in urban areas.
- These disparities may be due to a range of factors including variations in cervical cancer screening rates, health insurance coverage, income level, or access to health care.
- Screening rates vary by race/ethnicity in California. Hispanic/Latino women have the highest screening rate (62.3%) and American Indian women the lowest (45.4%).<sup>2</sup>
- Routine cervical cancer screening with the Pap test can identify precancerous lesions or cancer in the early stages when treatment is most effective. Over half (51.4%) of cervical cancer cases in California are diagnosed in an advanced stage, with most (56%) occurring in women who have not had a Pap test in the past three years.<sup>3,4</sup>
- HPV causes almost all cases of cervical cancers.<sup>5</sup> In 2019, 68% of girls and 65% of boys initiated (at least one dose) the HPV vaccine and 49% and 42%, respectively, received both doses before their 13<sup>th</sup> birthday.<sup>6</sup>

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Remind patients through postcards, text messages, or phone calls that it is time for their cervical cancer screening.
- Collect and report data within the health center on provider performance in offering cervical cancer screening to patients.
- Offer women's health fairs or days and provide free cervical cancer screenings and educational materials.
- Provide transportation support to assist women in getting to their screening appointment.
- Provide adolescents and young adults with the HPV vaccine to reduce their risk of HPV infection or for females reducing their risk of developing cervical cancer.
- Run community-sponsored media campaign to highlight the importance of cervical cancer screening and educate women on the current clinical guidelines.

<sup>1</sup> Yu L, Sabatino SA, White MC. Rural-Urban and Racial/Ethnic Disparities in Invasive Cervical Cancer Incidence in the United States, 2010-2014. *Prev Chronic Dis* 2019;16:180447. DOI: <http://dx.doi.org/10.5888/pcd16.180447>

<sup>2</sup> 2020 Health Disparities Report, <https://www.dhcs.ca.gov/Documents/MCQMD/CA2020-21-Health-Disparities-Report.pdf>

<sup>3</sup> CA Cancer Registry. <https://www.ccrca.org/retrieve-data/data-for-the-public/cancer-fact-sheets/>

<sup>4</sup> Leyden WA, Manos MM, Geiger AM, et al. Cervical cancer in women with comprehensive health care access: attributable factors in the screening process. *J Natl Cancer Inst.* 2005;97: 675-683.

<sup>5</sup> Klabunde, PhD, Carrie N. et. al. (2012). CDC Morbidity and Mortality Weekly Report (MMWR), vol.61; no.3 January 27, 2012. (Table 3)

<sup>6</sup> Elam-Evans LD, Yankey D, Singleton JA, et al. National, Regional, State, and Selected Local Area Vaccination Coverage Among Adolescents Aged 13-17 Years – United States, 2019. *MMWR Morb Mortal Wkly Rep* 2020;69:1109-1116.

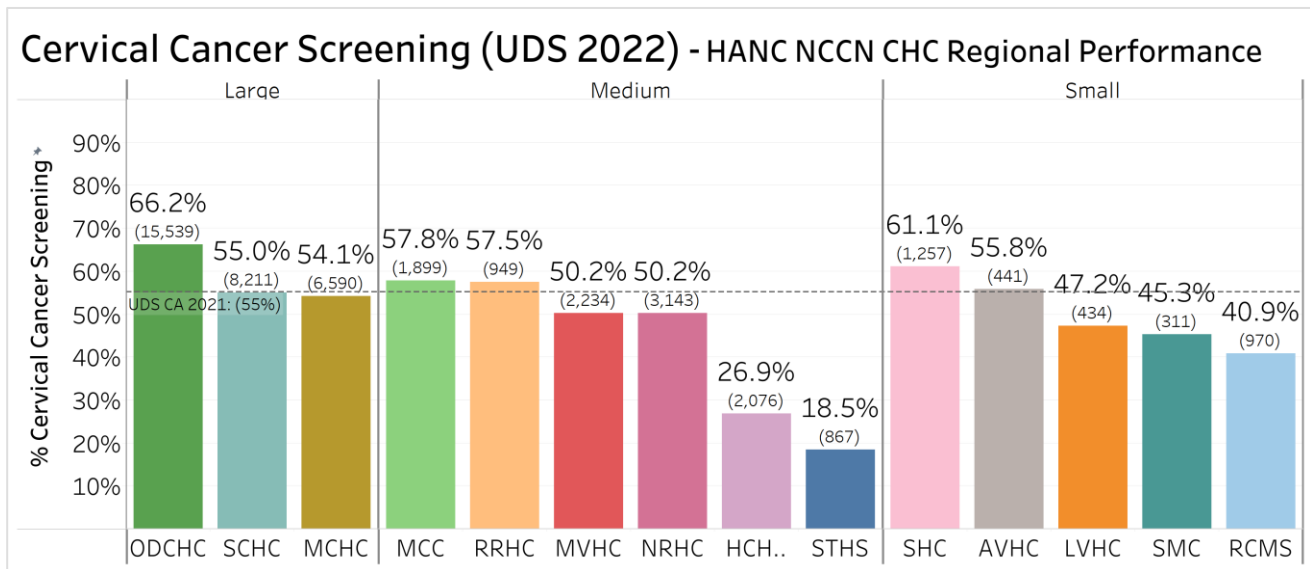
DOI: <http://dx.doi.org/10.15585/mmwr.mm6933a1>

# Cervical Cancer Screening

## Rural Northern California Health Center Data

### Key Points

- Clinical screening guidelines have changed the interval between screenings. Because of this, women may not know when their Pap tests are due. This heightens the importance of patient reminders.
- Some women in rural Northern California receive cervical cancer screenings through their local Planned Parenthood or other women’s health clinic. Challenges with data sharing may lead to incomplete patient health records at the health center.
- Most women with a hysterectomy no longer require regular Pap tests. Thorough review of medical records is important to ensure they reflect medical history.



### Quality Measure Definitions (UDS)

Percentage of women 21\*–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21\*-64 who had cervical cytology performed every 3 years
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

\*Data collected for women with initial age of 23 given 2 year look back period.

### National and State Quality Benchmarks

**UDS 2021 CA Average:** The average performance among health centers in California was 55.2%.

**UDS 2021 US Average:** The average performance among health centers across the U.S. was 53.0%.

### Health Center Quality Measurement Systems Toolkit

AVHC – Anderson Valley Health Center; HCHW – Hill Country Health and Wellness Center; LVHC – Long Valley Health Center; MCC – Mendocino Coast Clinics; MCHC – MCHC Health Centers; MVHC – Mountain Valley Health Center; NRHC – Northeastern Rural Health Clinics; ODCHC – Open Door Community Health Centers; RCMS – Redwood Coast Medical Services; RRHC – Redwoods Rural Health Center; SCHC – Shasta Community Health Center; SHC – Shasta Cascade Health Centers; SMC – Shingletown Medical Center; STHS – Southern Trinity Health Services.

# Breast Cancer Screening

## Impact of Breast Cancer in Rural Northern California

- Breast cancer is the second most common cancer among women in the United States.<sup>1</sup> Breast cancer screening is recommended for women age 50 - 74 in order to catch it early before it has spread when it is easier to treat successfully.<sup>2</sup> Women at higher risk are recommended to begin screening earlier.<sup>3</sup>
- In rural Northern California, the age-adjusted death rate from breast cancer ranges from a high in Lassen County of 36.9 per 100,000 to a low of 15.6 per 100,000 in Mendocino County. The overall death rate in the state is 18.2 per 100,000.<sup>4</sup>
- Less than two-thirds of women (61.7%) in rural Northern California are up-to-date with breast cancer screening.<sup>5</sup>
- Adults with a cancer diagnosis in the rural Northern California region experience significant barriers to accessing needed specialty care.
- The average distance adults living in rural households must travel to access medical providers and emergency care is nearly double that of those in urban households.<sup>6</sup>

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Use a patient registry to track screening due dates, results, and follow-up.
- Remind patients through letters, postcards, or phone calls that it is time for their mammogram.
- Develop close referral relationships with local imaging centers to improve scheduling for patients and sharing of information and documentation between entities.
- Offer patients transportation assistance to mammography services.
- Coordinate mobile mammography services to bring breast cancer screening to rural and frontier health center sites.
- Facilitate women's health days at health centers that offer mammography and cervical cancer screenings, as well as other health and wellness resources.

### *Community Interventions*

- Share patient handouts or videos at community health fairs to increase awareness of breast screening and how to access screening services.
- Participate in women's health and community-based health awareness campaigns to normalize screening and create a culture of prevention.

<sup>1</sup> American Cancer Society. Cancer Facts and Figures 2020. Atlanta, Ga: American Cancer Society; 2020.

<sup>2</sup> U.S. Preventive Services Taskforce, 2016. [Available online.](#)

<sup>3</sup> Saslow D, Boetes C, Burke W, et al. American Cancer Society guidelines for breast screening with MRI as an adjunct to mammography. CA Cancer J Clin. 2007 Mar-Apr;57(2):75-89.

<sup>4</sup> California Department of Public Health. County Health Status Profiles, 2022.

<sup>5</sup> California Health Interview Survey. CHIS Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research, April 2020.

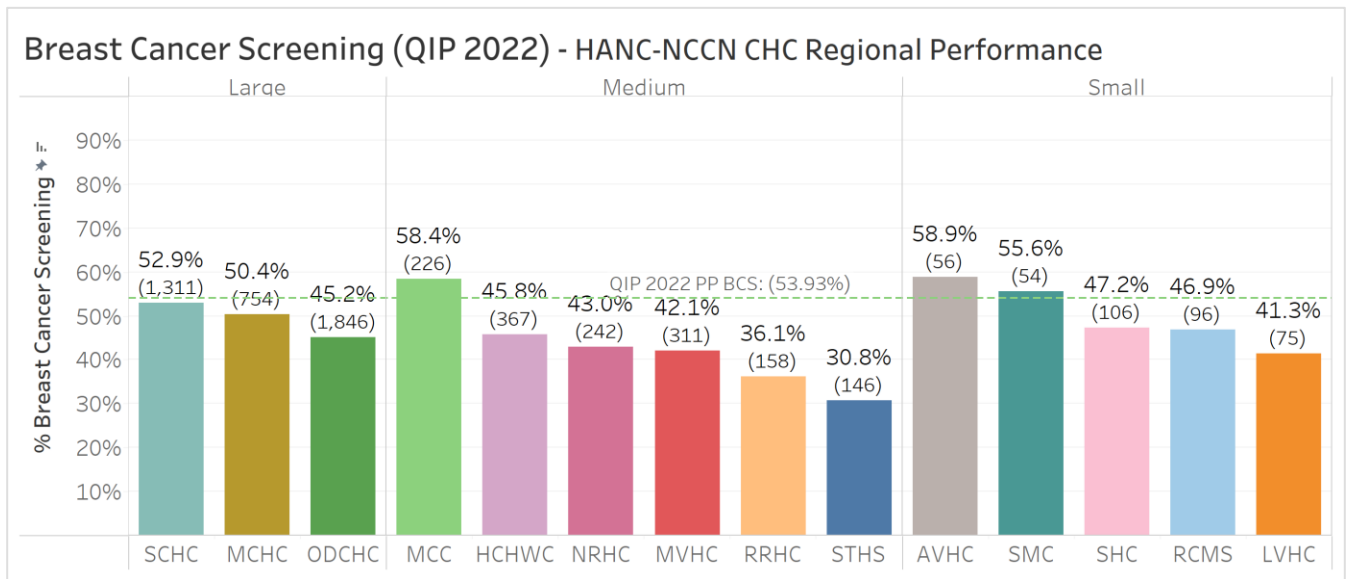
<sup>6</sup> Edelman MA, Menz BL. Selected comparisons and implications of a national rural and urban survey on health care access, demographics and policy issues. J Rural Health 1996;12:197-205.

# Breast Cancer Screening

## Rural Northern California Health Center Data

### Key Points

- Mammography appointments, and in particular mobile mammography appointments, are associated with high no-show rates. Patient reminders and/or incentives may help to improve screening rates.
- Access is a significant barrier to regular breast cancer screening. Transportation support to appointments or mobile mammography services are key for increasing screening rates in rural communities.



### Quality Measure Definitions (UDS)

The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.

### National and State Quality Benchmarks

**Partial Points Threshold for QIP Measurement Year 2023:** 51.0% represents the 50<sup>th</sup> percentile nationally for Medicaid Health Plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.

# Colorectal Cancer Screening

## Impact of Colorectal Cancer in Rural Northern California

- Colorectal cancer is currently the fourth leading cause of cancer death in the United States.<sup>1</sup> Colorectal cancer screening in adults between 50 and 75 years of age can catch and remove dangerous polyps before they become cancerous, or can detect colorectal cancer in its early stages, when treatment is most effective.
- In rural Northern California, the age-adjusted death rate from colorectal cancer ranges from a high in Lake County of 17.9 per 100,000 to a low of 9.7 per 100,000 in Lassen County. The overall death rate in the state is 12.1 per 100,000.<sup>2</sup> In California, African American males have the highest mortality rate (26.7).<sup>3</sup>
- Low-income adults are less likely to receive colorectal cancer screenings. Less than half (48.4%) of low-income adults in rural Northern California are up-to-date with colorectal cancer screening.<sup>4</sup>
- Adults with a cancer diagnosis in the rural Northern California region experience significant barriers to accessing needed specialty care.

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Integrate the use of Cologuard, a non-invasive screening option, that is available by prescription, as an alternative to colonoscopy when clinically appropriate.
- Use a patient registry to track screening due dates, results, and follow-up.
- Remind patients through letters, postcards, or phone calls that it is time for their colorectal cancer screening. This is particularly effective with fecal occult blood testing, paired with patient incentives. Two-week follow-up reminders have been found to be helpful with screening completion.
- Annual flu shot campaigns are an opportunity to reach people who are also due for colorectal screening (e.g., Flu/FIT Campaign).
- Provide education and counseling to patients to reduce fear of and prepare for scheduled screening procedures. Review FIT instructions with the patient while they are still in the office and check for patient understanding and engagement.

### *Community Interventions*

- Share patient handouts or videos at community health fairs and senior centers to increase awareness of colorectal screening and how to access screening services.
- Participate in health care and community-based health awareness campaign to normalize screening and create a culture of prevention.

<sup>1</sup> CDC. Colorectal Cancer Statistics. March 2019.

<sup>2</sup> California Department of Public Health. County Health Status Profiles, 2021.

<sup>3</sup> Source: CA Cancer Registry. <https://www.ccrca.org/retrieve-data/data-for-the-public/cancer-fact-sheets/>

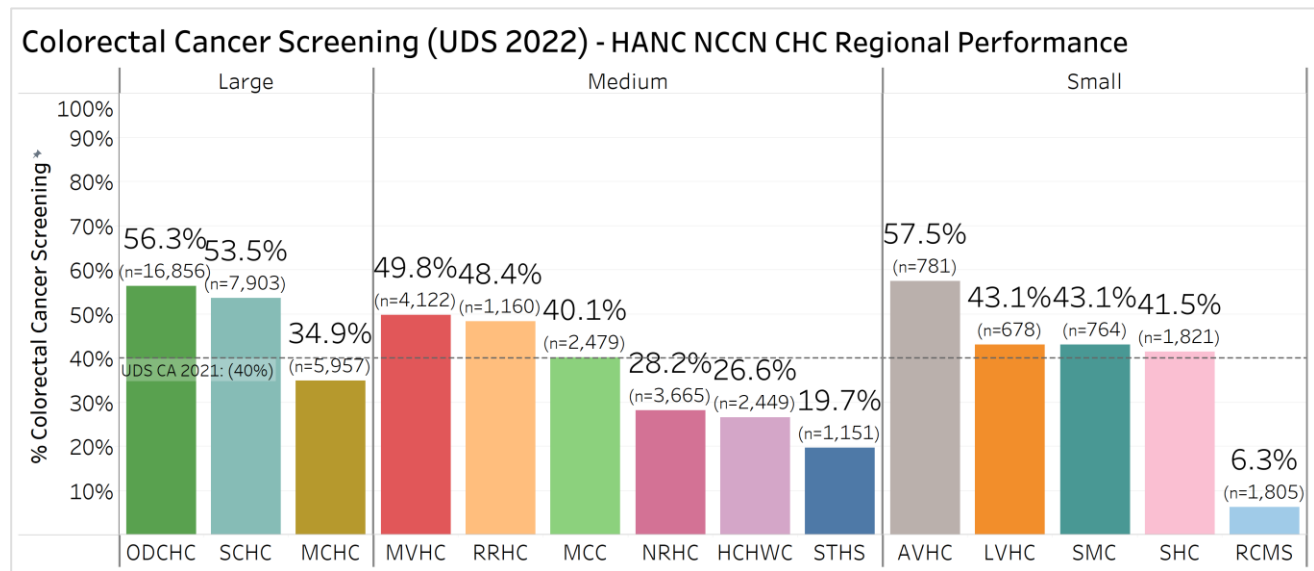
<sup>4</sup> California Health Interview Survey. CHIS Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research, April 2020.

# Colorectal Cancer Screening

## Rural Northern California Health Center Data

### Key Points

- The demographics of the communities served may impact screening rates, as communities with more retirees and older adults may be more receptive to colorectal cancer screening.
- Access and cost are significant barriers to regular colorectal cancer screening. Fecal Immunochemical Tests (FIT) / Fecal occult blood test (FOBT) offer less invasive screening options. Patient education in plain language on how to complete the test and test kits sent by mail to be conducted at home supports screening efforts.
- While FIT/FOBT test is a lower cost option, the lack of access to specialists for appropriate follow-up and/or treatment creates barriers to routine screening.



### Quality Measure Definitions (UDS)

The percentage of adults aged 50-75 who had appropriate screening for colorectal cancer. Appropriate screening methods may include one of the following:

- Fecal occult blood test (FOBT) within 1 year;
- Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA) within 3 years;
- Flexible sigmoidoscopy within 5 years;
- Computerized tomography (CT) colonography within 5 years;
- Colonoscopy within 10 years

### National and State Quality Benchmarks

**UDS 2021 CA Average:** The average performance among health centers in California was 41.9%.

**UDS 2021 U.S. Average:** The average performance among health centers in the U.S. was 39.9%.



# Prenatal and Postnatal Care

## Access to Prenatal Care in Rural Northern California

- Healthy pregnancies occur when comprehensive, routine prenatal care begins early in pregnancy. Receiving prenatal care during the first trimester improves maternal and infant health. Women who do not receive prenatal care are at almost three times the risk of having a low-birthweight infant and increasing risk for poorer health outcomes.
- Women who are uninsured or those with no regular source of care prior to pregnancy are more likely to enter into prenatal care after their first trimester.<sup>1,2</sup>
- Smoking and alcohol use in the three months before pregnancy and during pregnancy are more prevalent health behaviors of women in rural Northern California than in other areas of the state.<sup>3</sup>
- One of the most common complications for pregnant and postpartum women is depression. Studies show 14-23% of pregnant woman and as much as 25% of postpartum women experience depression.<sup>4</sup>

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Offer contraceptive services, pregnancy testing, and preconception counseling for all reproductive age women.
- Recommend that all reproductive age women take a multi-vitamin that includes a folic acid supplement. Adequate intake of folic acid may help prevent some birth defects.
- Ask all pregnant patients about tobacco, alcohol and other drug use and provide appropriate counseling or treatment interventions.
- For Partnership members, introduction to PHC's Maternal Child Health Program/Growing Together Program (GTP), which offers incentives for timely prenatal and postpartum care.
- Schedule postpartum visit 3-5 weeks after delivery to allow time for rescheduling if needed.
- Piggyback scheduling of infant and postpartum visits (if same provider) during prenatal visits and prior to hospital discharge.

### *Community Interventions*

- Share patient handouts, brochures, or videos at community health fairs to raise awareness about everyday strategies to support healthy pregnancy, such as eating a balanced diet, staying active, and taking nutritional supplements.
- Provide health insurance information, public benefit programs, and enabling service enrollment support to patients.

<sup>1</sup> Kaiser Family Foundation. Promoting Access to Prenatal Care: Lessons from the California Experience. Spring 2003.

<sup>2</sup> Braveman P et al., Barriers to timely prenatal care among women with insurance: the importance of pregnancy factors, *Obstetrics & Gynecology*, 2000, 95(6):874-880.

<sup>3</sup> Ibid.

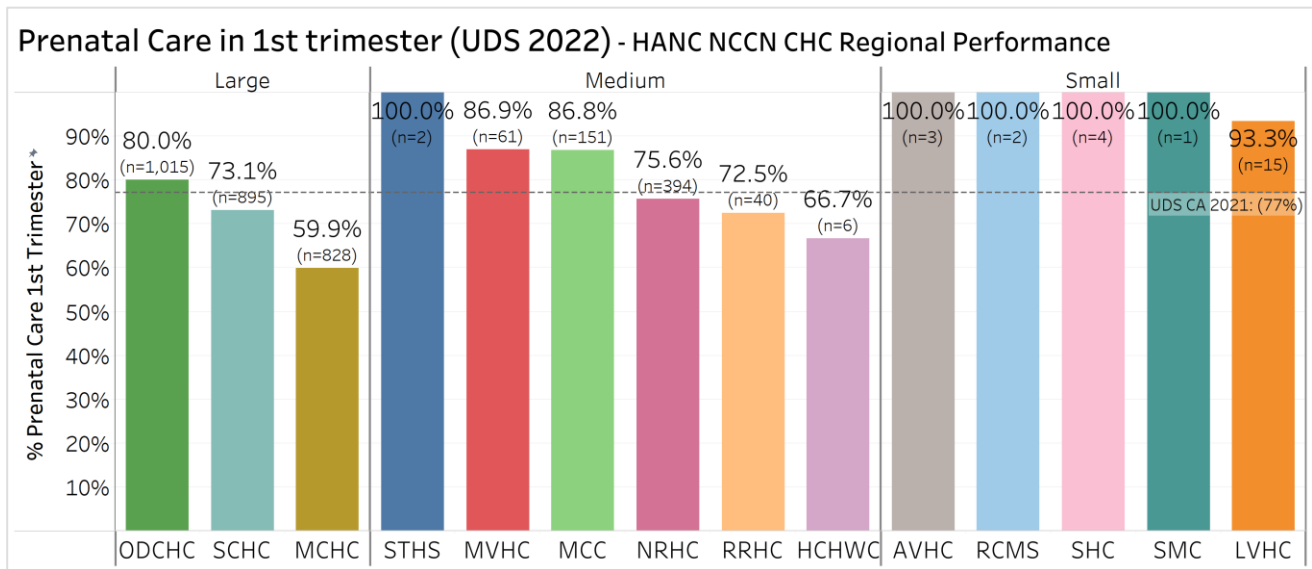
<sup>4</sup> Kaiser Family Foundation. Medicaid and Health Coverage for Low-Income Women in Pregnancy and After Childbirth. 10 Sep 2019.

# Prenatal and Postnatal Care

## Rural Northern California Health Center Data

### Key Points

- Health centers often have pregnant women come in for prenatal care as new patients; some don't seek care until after their first trimester.
- Women choosing alternative care from a midwife or other practitioner may come to the health center during pregnancy for screenings or medical attention their primary practitioner cannot offer.
- Many Health centers in rural communities provide prenatal care to a relatively small population of women. Even one late entry can have a significant impact on these results.



## Quality Measure Definitions (UDS)

The percentage of prenatal care patients who entered treatment during their first trimester.

- The Institute of Medicine estimates that every \$1 invested into proper prenatal care results in a savings of \$3.37 in neonatal care.<sup>5</sup>
- Maternal hospital stays with pregnancy and delivery-related complicating conditions account for \$17.4 billion in hospital costs in the U.S.<sup>6</sup>

## National and State Quality Benchmarks

**UDS 2021 CA Average:** The average performance among health centers in California was 77.1%.

**UDS 2021 U.S. Average:** The average performance among health centers across the U.S. was 74.1%.

<sup>5</sup> Lantos JD, Lauderdale DS. What is Behind the Rising Rates of Preterm Birth in the United States? RMMJ

<sup>6</sup> Elixhauser A. (AHRQ) and Wier LM. (Thomson Reuters). *Complicating Conditions of Pregnancy and Childbirth, 2008*. HCUP Statistical Brief #113. May 2011. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.hcup.us.ahrq.gov/reports/statbriefs/sb113.pdf>

# Depression Screening and Appropriate Follow-Up

## Impact of Depression in Rural Northern California

- One in twelve adults nationally report having depression, and one in nine women experience postpartum depression.<sup>1</sup> Depression is associated with higher risk of suicide and cardiovascular death.
- In rural Northern California, 37.9% of low-income adults and 33.7% of teens reported needing help with emotional/mental health problems.<sup>2</sup>
- Among California adults who report needing help for behavioral health problems 86% had one or more visits to a provider. One-quarter of adolescents who reported needing help received no psychological or emotional counseling.<sup>3</sup>
- The Northern and Sierra region of California has the highest rate of suicide (21.1 per 100,000), twice that of the state average of 10.4.<sup>4</sup>
- Most people who attempt suicide make some type of healthcare visit in the weeks or months before the attempt.<sup>5</sup>

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Integrate appropriate screening tools for adolescents and adults, such as PHQ-2, PHQ-9, and PHQ-A, into the electronic health record along with templates for documentation and tracking of follow-up care.
- Screen women for depression at initial visit for prenatal care and at the 0-15 month well-child visits and beyond the postpartum period.
- Implement integrated care models in which a care team coordinates care with social workers and behavioral health specialists to assist with housing, food security, life skills and mental health supports.
- Utilize reminders and recall systems to monitor depression screening, follow-up plan, and depression status.
- Train clinicians and care team members regularly on current research about depression identification, suicide prevention, and evidence-based strategies.

### *Community Interventions*

- Collaborate with health system and community-based organizations on health awareness campaign to reduce stigma regarding depression and seeking mental health care.
- Participate in Mental Health Awareness Month annually in May.

<sup>1</sup> Brody, Debra J, Pratt, Laura A, Hughes, Jeffery. Prevalence of Depression Among Adults Aged 20 and Over: United States, 2013-2016. National Center for Health Statistics Data Brief No. 303. Feb 2018.

<sup>2</sup> California Health Interview Survey. CHIS 2021 Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research.

<sup>3</sup> California Health Interview Survey. CHIS 2021 Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research.

<sup>4</sup> California Healthcare Foundation. California Health Care Almanac. Mental Health in California: For Too Many, Care Not There. March 2018.

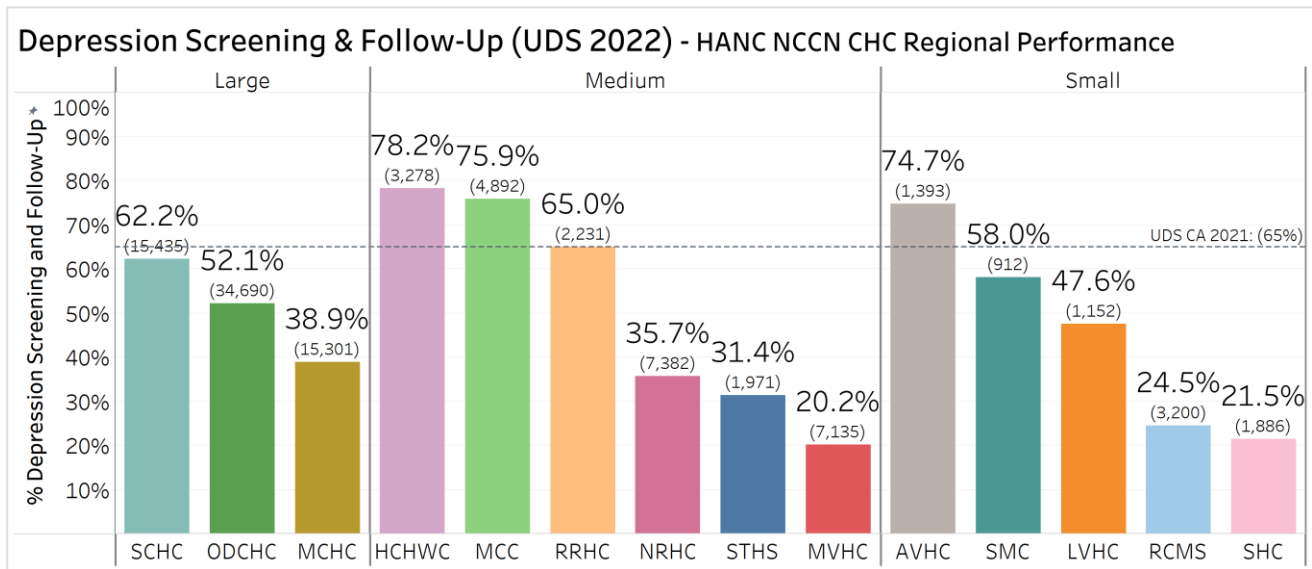
<sup>5</sup> Brian K. Ahmedani, Christine Stewart, Gregory E. Simon, Frances Lynch, et al. Racial/Ethnic Differences in Health Care Visits Made Before Suicide Attempt Across the United States. Medical Care, 2015; 53 (5): 430 DOI: 10.1097/MLR.0000000000000335

# Depression Screening and Appropriate Follow-Up

## Rural Northern California Health Center Data

### Key Points

- Electronic health records (EHRs) have integrated health maintenance alerts to support clinicians and care teams to conduct at least annual depression screening.
- Not all EHRs have standardized documentation processes for capturing follow-up interventions, requiring many health centers to develop manual or complex reporting mechanisms to track medication, service, or referrals related to screening results.
- As health centers in the region have moved to greater integration of primary care and behavioral health, the region has seen increases in measure performance.



## Quality Measure Definitions (UDS)

The percentage of patients aged 12 years and older screened for depression on the date of the visit using an age-appropriate standardized depression screening tool **and** if positive, a follow-up plan is documented on the date of the positive screen.

- Screening paired with medication, lifestyle changes, and/or therapy has shown to be effective in adults: 25-30% are likely to achieve full remission and an additional 15-30% show a response to treatment over the course of 3–6 months.<sup>6</sup>

## National Quality Goals and Benchmarks

**UDS 2021 CA Average:** The average performance among health centers in California was 65.0%.

**UDS 2021 U.S. Average:** The average performance among health centers across the U.S. was 67.4%.

<sup>6</sup> Corey-Lisle PK, Nash R, Stang P, Swindle R. Response, partial response, and nonresponse in primary care treatment of depression. Arch Intern Med. 2004;164:1197-1204.

# Childhood Immunization Status

## Childhood Immunization Care in Rural Northern California

- Children are recommended to receive 21-25 doses of vaccinations for 10 childhood diseases by their second birthday.<sup>1</sup>
- Communities with unvaccinated or under-vaccinated populations are at increased risk for outbreaks of vaccine-preventable diseases.
- Approximately 85-95% of a community must be immunized for the entire community to be protected from disease outbreaks (“community immunity”).<sup>2</sup>
- Health insurance reforms under the Affordable Care Act require health plans to cover recommended immunizations without co-pays.
- As of January 2016, parents in California may no longer obtain a personal belief exemption for 10 school-required vaccinations, unless students have a medical exemption or are home schooled.

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Utilize all encounters with a child to screen and, when indicated, immunize.
- Make immunization services readily available, including during non-traditional times such as weekends, evenings and lunch-hours.
- Offer immunization services as “walk-in” services with minimal or no wait time.
- Utilize provider reminders: computer-generated lists are used to notify providers of children whose vaccines are past due.
- Utilize Immunization Dose Report from Partnership HealthPlan to plan outreach to parents for scheduling immunizations.
- Use parent reminders when immunizations are due and recall notices when they are past due (telephone calls, postcards or letters).
- Exchange immunization records for children through the California Immunization Registry (CAIR). This promotes care coordination and improved access to a child’s immunization history.
- Talk with pregnant patients during their 3<sup>rd</sup> trimester to raise awareness about the important role of immunizations in promoting their new child’s health.

### *Community Interventions*

- Offer education on childhood immunizations and recommended schedules at community health fairs.
- Participate/initiate community coalition of stakeholders to address local immunization rates.

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<sup>1</sup> Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP) Immunization Schedules, 2020. <https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html>.

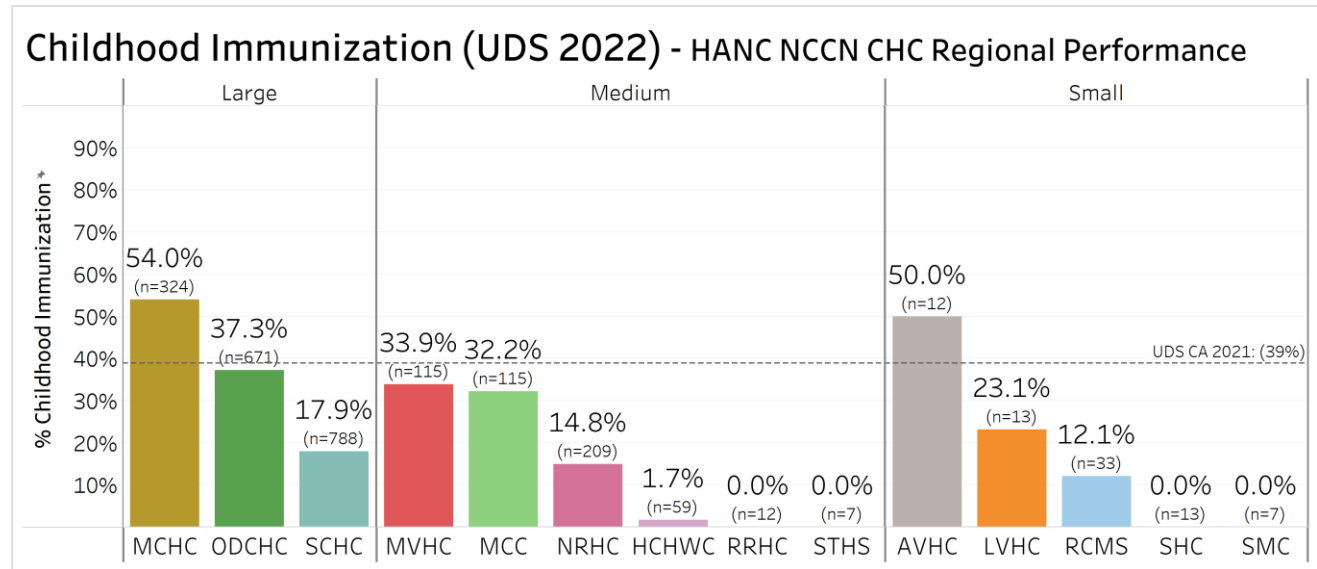
<sup>2</sup> Committee on the Assessment of Studies of Health Outcomes Related to the Recommended Childhood Immunization Schedule; Board on Population Health and Public Health Practice; Institute of Medicine. Washington (DC): National Academies Press (US); 2013 Mar 27.

# Childhood Immunization Status

## Rural Northern California Health Center Data

### Key Points

- Misinformation on vaccines and vaccine hesitancy among parents has presented challenges, particularly in rural communities for childhood immunization.
- Early and consistent education for parents on the importance of immunizations is essential to ensuring young patients receive all vaccinations by age 2.



### Quality Measure Definition (UDS)

Percentage of children who were fully immunized before their **2<sup>nd</sup> birthday**. Documented evidence of all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1 VZV, 4 PCV, 1 HepA, 2-3 Rotavirus, 2 flu vaccines.

### National and State Quality Benchmarks

**UDS 2021 CA Average:** The average performance among health centers in California was 38.9%.

**UDS 2021 US Average:** The average performance among health centers in the U.S. was 38.1%.

# Adolescent Immunization Status

## Immunization Care for Adolescents in Rural Northern California

- Communities with unvaccinated or under-vaccinated populations are at increased risk for outbreaks of vaccine-preventable diseases.
- Studies have shown that young adults have significantly lower rates of overall health services usage, lower rates of office-based utilization, and higher rates of emergency department visits, making it critical for health care providers to empower parents to access immunizations and well visits.<sup>1</sup>
- Health insurance reforms under the Affordable Care Act require health plans to cover recommended immunizations without co-pays.
- As of January 2016, parents may no longer obtain a personal belief exemption for 10 school-required vaccinations, unless students have a medical exemption or are home schooled.

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Utilize all encounters with an adolescent to screen and, when indicated, immunize.
- Make immunization services readily available, including during non-traditional times such as weekends, evenings and lunch-hours.
- Offer immunizations as “walk-in” services with minimal or no wait time.
- Utilize provider reminders: computer-generated lists are used to notify providers of adolescents to be seen in clinic whose vaccines are past due.
- Use parent reminders when immunizations are due soon and recall notices when they are past due such as telephone calls, postcards or letters.
- Exchange immunization records for adolescents through the California Immunization Registry (CAIR2). This promotes care coordination and improved access to an adolescent’s immunization history.
- Utilize a personalized, presumptive recommendation from physician to parent for adolescents to receive Tdap, Meningococcal and HPV vaccines, in addition to employing empathetic, motivational interviewing strategies to discuss parent concerns.

### *Community Interventions*

- At community health fairs offer education on adolescent immunizations and recommended schedules.
- Participate in community awareness campaigns on vaccine safety.

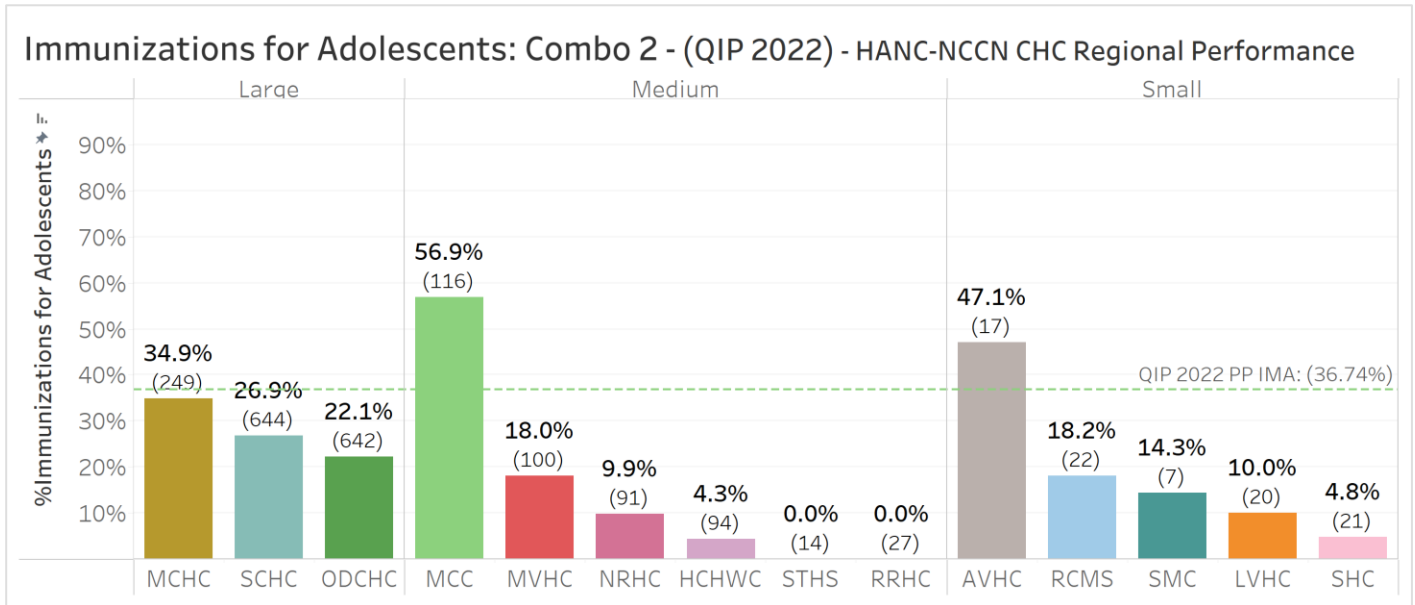
<sup>1</sup> Ziv A, Boulet JR, Slap GB. Utilization of physician offices by adolescents in the United States. *Pediatrics*. 1999;104(1 pt 1):35-42pmid:1039025

# Adolescent Immunization Status

## Rural Northern California Health Center Data

### Key Points

- Targeted outreach to patients between the ages of 9 to 11 can help to achieve completion of all vaccines by age 13.
- Some health centers use sports physicals or special adolescent immunization clinics as an opportunity to vaccinate adolescents.



## Quality Measure Definitions (QIP)

The percentage of adolescents **13 years of age** who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), **and** two doses of the human papillomavirus (HPV) by their 13th birthday.

## National Quality Goals and Benchmarks

**Partial Points Threshold for QIP Measurement Year 2023:** 35.0% represents the 50<sup>th</sup> percentile nationally for Medicaid Health Plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.



# Controlling Diabetes

## Impact of Diabetes in Rural Northern California

- Diabetes is a leading cause of disability and death in far Northern California, affecting about 9.3% of adults.<sup>1</sup> Overall, the prevalence of Diabetes in rural areas is 17% higher than in urban cities.<sup>2</sup>
- Obesity and sedentary lifestyle are associated with Type 2 Diabetes.<sup>3</sup> These factors are significant in rural areas as more than 2 in 3 adults are overweight (33.0%) or obese (32.4%).<sup>4</sup>
- It is common for individuals with diabetes to have additional chronic health problems. More than 80% of Medicaid enrollees with diabetes have at least one additional chronic illness.<sup>5</sup>
- The average medical expenditures among people with diabetes are more than twice that of people without diabetes.<sup>6</sup>

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Use a continually updated registry to plan and track care for diabetic patients.
- Implement pre-visit summary reports to review the needs of patients coming to the health center to ensure that patient care is in accordance with clinical guidelines.
- Follow evidence-based clinical guidelines on retinal screening, foot care, lab testing, and glycemic management including improved support for patient self-management.
- Redesign clinical practice to encourage group visits for diabetic patients, nurse-led education and self-managements visits, and medical assistant led foot exams.
- Utilize care coordinators and patient navigators to monitor the health of patients and coordinate care during any encounter with a patient, even visits unrelated to diabetes.

### *Community Interventions*

- Screen adults with high blood pressure (> 139/89) for type 2 diabetes at health fairs.
- Teach at-risk adults how to incorporate physical activity into their daily routines. Set up walking groups or other programs to support positive behavior change.
- Provide access to fresh foods through farmers markets and offer nutrition education.

<sup>1</sup>California Health Interview Survey. CHIS 2019 Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research. [Note: "Far northern California" = all counties in the Northwest and Northeast HEDIS reporting regions for Partnership HealthPlan of California: Del Norte, Humboldt, Siskiyou, Trinity, Shasta, Modoc, and Lassen.]

<sup>2</sup>The Changing Landscape of Diabetes Mortality in the United States Across Region and Rurality, 1999-2016. Journal of Rural Health. 25 February 2019.

<sup>3</sup>Barnes AS. The epidemic of obesity and diabetes: trends and treatments. *Tex Heart Inst J.* 2011;38(2):142-144.

<sup>4</sup>California Health Interview Survey. CHIS 2019 Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research.

<sup>5</sup>Kaiser Commission on Medicaid and the Uninsured. The Role of Medicaid for People with Diabetes. The Henry J. Kaiser Family Foundation, Washington DC, November 2012.

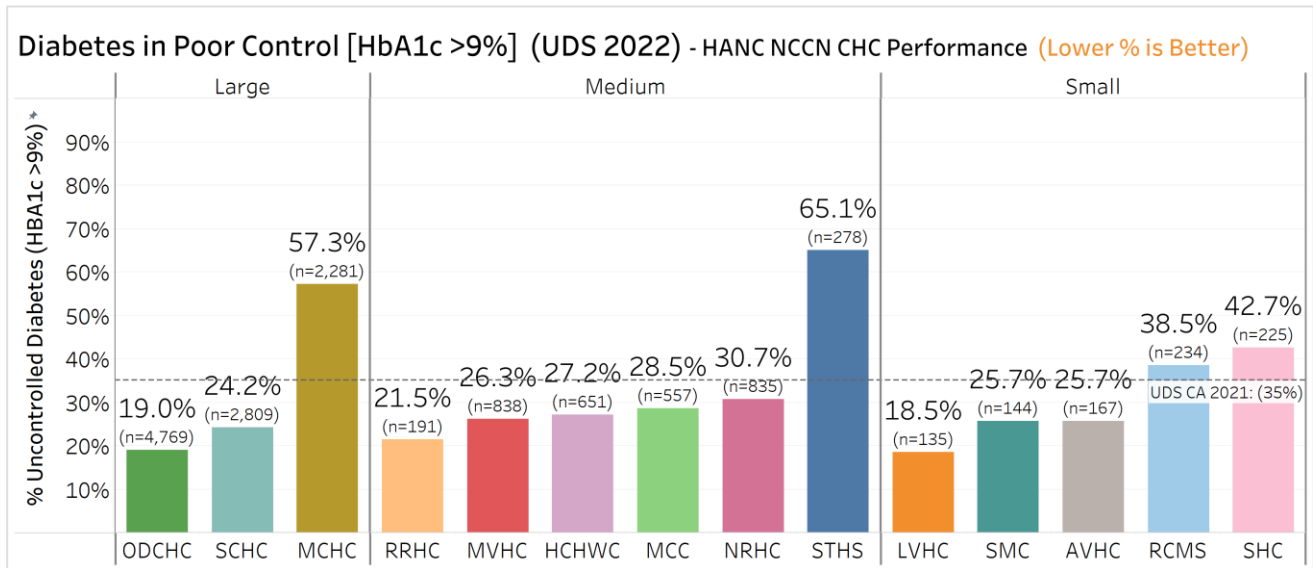
<sup>6</sup>American Diabetes Association. Economic Costs of Diabetes in the U.S., 2017. Diabetes Care 2018 Mar; <https://doi.org/10.2337/dci18-0007>

# Controlling Diabetes

## Rural Northern California Health Center Data

### Key Points

- Health centers in rural Northern California serve low-income and uninsured populations that are heavily affected by diabetes and other chronic health conditions. Adults with diabetes are more likely to report cost as a barrier to taking medications as prescribed.<sup>7</sup>
- There are significant racial/ethnic health disparities. Rates of diabetes are 2 times higher among Native Americans and adults of Hispanic origin than among whites. Lack of access to health care among migrant or seasonal farm workers places them at risk for diabetes related premature death.<sup>8</sup>



### Quality Measure Definition (UDS)

The percentage of patients age 18-75 with diabetes who had a Hemoglobin A1c (HbA1c) test of greater than 9.0 percent or who had no test conducted during the measurement period.

- For every 1% reduction in HbA1c, the risk of developing eye, kidney, and nerve disease decreases by 40% and the risk of heart attack decreases by 14%<sup>9</sup>.
- Note this is a “negative” measure, which means the *lower* the number of patients with a HbA1c greater than 9.0 percent, the better the performance on the measure.

### National and State Quality Benchmarks

**UDS 2021 CA Average:** The average performance among health centers in California was 35.1%

**UDS 2021 U.S. Average:** The average performance among health centers across the U.S. was 32.3%.

<sup>7</sup> Kaiser Family Foundation and Peterson Center on Health Care. Health System Tracker. How Have Diabetes Costs and Outcomes Changed Over Time in United States. 15 Nov 2019.

<sup>8</sup> Center for Disease Control and Prevention. National Diabetes Statistics Report. 2020.

<sup>9</sup> UK Prospective Diabetes Study (UKPDS) Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33)

# Controlling High Blood Pressure

## Impact of Heart Disease in Rural Northern California

- One in three U.S. adults will develop hypertension in their lifetime<sup>1</sup> and more than half of Americans with high blood pressure do not have it under control.<sup>2</sup>
- In Rural Northern California 49.0% of adults aged 55 and older have ever been diagnosed with high blood pressure.<sup>3</sup>
- High blood pressure that is left untreated can result in heart attack, stroke, vision loss, memory loss and congestive heart failure.
- Proper management of hypertension, along with adopting healthy lifestyle behaviors, correlates with the prevention of 80% percent of all cardiovascular diseases and a 64% reduction in the development of heart failure.<sup>4</sup>

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Provide at least annual blood pressure screenings for adults 18 and older.
- During the primary care visit, take multiple blood pressure readings to accurately assess the patient's status, especially when blood pressure is 140/90 or higher. Breathing exercises may help some patients relax and lower blood pressure.
- Screen men aged 35 and older for lipid disorders and screen women 45 and older for lipid disorders if they are at increased risk for heart disease.
- Integrate evidence-based guidelines and treatment support tools into the electronic health record and conduct annual proper blood pressure technique trainings for care teams.
- Actively engage patients in their own care by providing home blood pressure monitoring kits, offering nurse education visits, and regular communication with the care team via appointment or patient portal.

### *Community Interventions*

- Educate patients about maintaining a healthy diet, reducing sodium intake to no more than 2,300 mg per day, and including at least 30 minutes of physical activity most days of the week.
- Promote meditation and other relaxation methods to support healthy blood pressure.
- Disseminate smoking cessation materials at health fairs and community events.

<sup>1</sup> Nelson, Sarah, Whitsel, Laurie, et al. Projections of Cardiovascular Disease Prevalence and Costs: 2015-2035. Nov 2016.

<sup>2</sup> National Center for Health Statistics. Centers for Disease Control and Prevention and Nutrition Examination Surveys. 2013-2016. 2017 ACC/AHA Criteria Hypertension Guidelines applied.

<sup>3</sup> California Health Interview Survey. CHIS 2021 Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research.

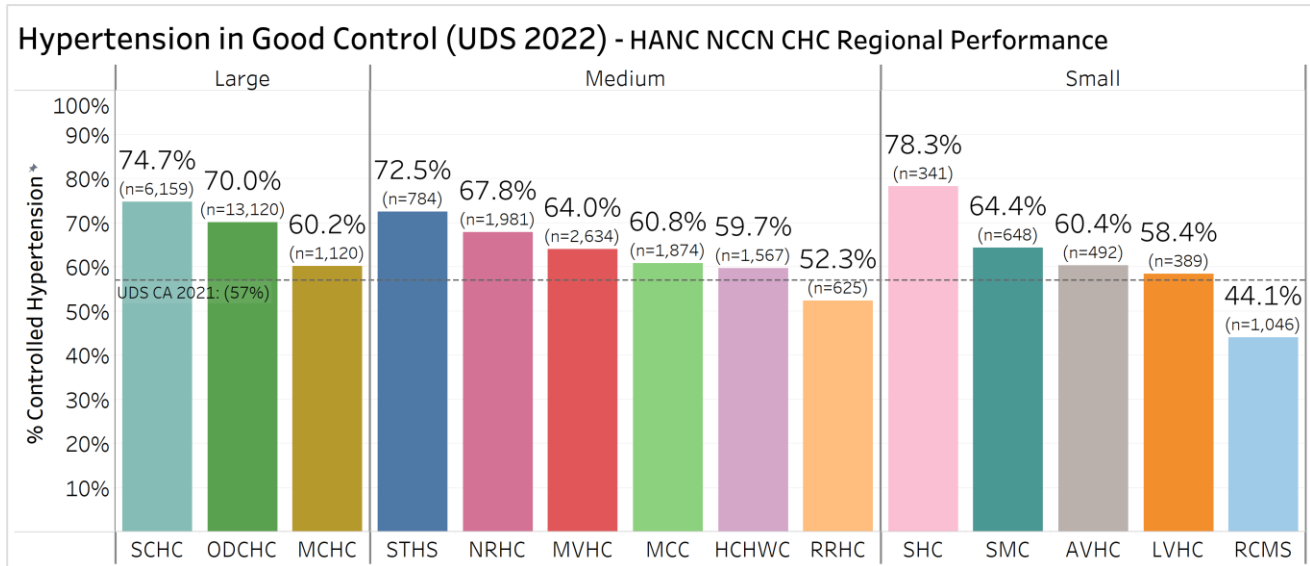
<sup>4</sup> Tackling G, Borhade MB. Hypertensive Heart Disease. [Updated 2019 May 5]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK539800/>

# Controlling High Blood Pressure

## Rural Northern California Health Center Data

### Key Points

- Many patients experience “white coat hypertension,” causing them to be anxious as they arrive for their primary care visit. This can contribute to elevated blood pressure readings.
- There is no cure for hypertension, unless a specific cause is found and corrected. Medical therapy and/or lifestyle modification can control hypertension and, in many cases, prevent complications.<sup>5</sup>



### Quality Measure Definition (UDS)

The percentage of adults aged 18-85 who have received a diagnosis of hypertension and whose blood pressure is less than 140/90 mm Hg.

- Normal blood pressure levels are less than 120/80 mmHg.
- Hypertensive patients who reduce their blood pressure to less than 140/90 are considered under control.

### National and State Quality Benchmarks

**UDS CA 2021 Average:** The average performance among health centers in California was 56.9%.

**UDS U.S. 2021 Average:** The average performance among health centers across the U.S. was 60.2%.

<sup>5</sup> Medline Plus U.S. National Library of Medicine National Institutes of Health Updated July 13, 2016 retrieved from web July 26, 2016. [www.nlm.nih.gov/medlineplus](http://www.nlm.nih.gov/medlineplus)

# Tobacco Use Screening and Cessation Intervention

## Impact of Tobacco Use in Rural Northern California

- Cigarette smoking is one of the leading causes of preventable disease and death in the United States, accounting for more than 480,000 deaths every year, or 1 of every 5 deaths.<sup>1</sup>
- At the state level, each year Californians spend over \$13 billion on health care and other costs associated with smoking and suffer an average of 40,000 smoking attributed deaths.<sup>2</sup>
- Rural communities across California have higher rates of smoking than urban communities. For example, in the state's largely rural northern counties the current smoker rate is 10.6%, higher than the state's average of 6.2%.<sup>3</sup>
- Low-income adults in the Rural Northern region are more likely to be current smokers compared to the low-income population statewide (16.2% vs. 8.8%).<sup>4</sup>
- Rural Northern California communities also have higher rates of e-cigarettes and smokeless tobacco use.<sup>5</sup>
- In the recent years, there has been an explosion of e-cigarette/vaporizer tobacco products that can be attractive to youth.<sup>6</sup>

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Utilize one of the recommended smoking cessation models (5 A's, AAR, AAC)<sup>7</sup>:
  - Ask every patient about tobacco use.
  - Advise all smokers to quit.
  - Assess smokers' willingness to quit.
  - Assist smokers with treatment and referrals.
  - Arrange follow-up contacts.
- Make tobacco assessment part of the patient intake process and use automated provider reminders to assess tobacco users' willingness to quit.
- Provide patients with quit packet (gum, toothpicks, etc.), educational materials, and information about the California Smokers' Helpline at time of visit if patient is open to quitting.
- Utilize motivational interviewing to support patients in setting goals for quitting.
- Follow-up with patients making a quit attempt. Contact patient within 1 week and 1 month to monitor progress.

### *Community Interventions*

- Participate in American Cancer Smoke Out campaign and conduct educational outreach during health fairs and other community events.

<sup>1</sup> U.S. Department of Health and Human Services (2014). The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2016 Mar 14].

<sup>2</sup> SAMMEC Smoking Attribute Expenditures 2009. CDC State Highlights: California

<sup>3</sup> California Health Interview Survey. CHIS 2011 Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research.

<sup>4</sup> Ibid. [Note: Low-Income was defined as <200% FPL for these calculations].

<sup>5</sup> Ibid.

<sup>6</sup> Olson, S. (2014). E-Cigarettes Anger Candy and Cookie Makers with Infringing Flavor Names. Medical Daily. May 27, 2014. See also Dennis, B (2014). Booming e-cigarette market in need of greater oversight, studies say. The Washington Post. June 27, 2014.

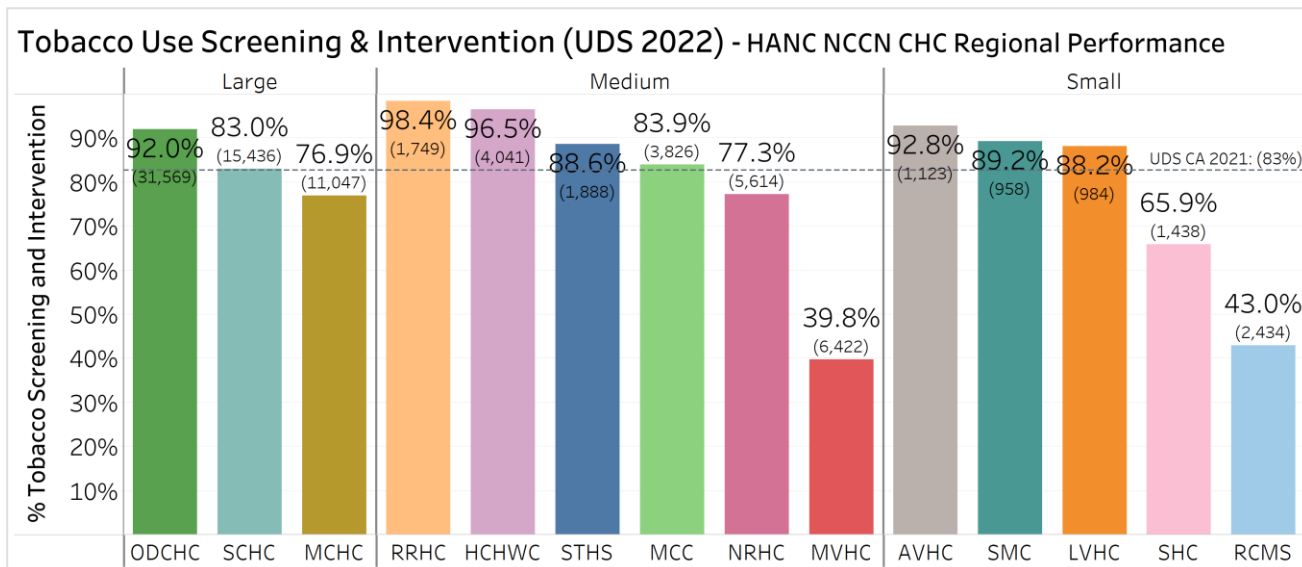
<sup>7</sup> U.S. Department of Health and Human Services. Smoking Cessation: A Report of the Surgeon General. Public Health Service. Office of Surgeon General. Rockville, MD. 2020

# Tobacco Use Screening and Cessation Intervention

## Rural Northern California Health Center Data

### Key Points

- Identifying tobacco users and tracking cessation counseling and interventions can be a challenge due to limitations in some EHR configurations. New EHR updates help improve documentation.
- Health centers in rural Northern California have successfully incorporated regular tobacco use assessment and cessation interventions into primary care practice.



## Quality Measure Definition (UDS)

The percentage of patients 18 and over:

- Who were screened for any and all forms of tobacco use one or more times within 24 months; **and**
- Who received tobacco cessation counseling intervention and/or pharmacology if identified as a tobacco user.
  - Current research shows that provider participation and advice lead to a greater likelihood of successfully quitting smoking by as much 66 percent.<sup>8</sup>
  - As few as three minutes of counseling or other primary care interventions can increase the success rate of smoking cessation.<sup>9</sup>

## National and State Quality Benchmarks

**UDS 2021 CA Average:** The average performance among health centers in California was 82.7%.

**UDS 2021 U.S. Average:** The average performance among health centers in the U.S. was 82.3%.

<sup>8</sup> USPSTF. 2010. What to tell your patients about smoking: A report of the surgeon general: How tobacco smoke causes disease. Available at: [http://www.cdc.gov/tobacco/data\\_statistics/sgr/2010/clinician\\_sheet/pdfs/clinician.pdf](http://www.cdc.gov/tobacco/data_statistics/sgr/2010/clinician_sheet/pdfs/clinician.pdf)

<sup>9</sup> Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women, Topic Page. April 2009. U.S. Preventive Services Task force. <http://www.uspreventiveservicestaskforce.org/uspstf/uspstbac2.htm>

# Adult Weight Assessment and Follow-up

## Impact of Obesity in Rural Northern California

- Obesity increases the risk of many health conditions and contributes to some of the leading causes of preventable death, posing a major public health challenge.<sup>1</sup>
- 43.0% of Rural Northern California adults report a BMI of 27.5+ (high risk).<sup>2</sup>
- California had nearly 430,000 hospital admissions due to obesity-related conditions (2014) and approximately 21.6% of charges were paid by Medi-Cal.<sup>3</sup>
- Early screening and careful monitoring of BMI will help health care providers identify adults who are at risk and provide focused advice and services to help them reach and maintain a healthier weight.

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Document BMI for all adults at least annually and incorporate counseling on nutrition and physical activity into all health center visits.
- Write prescriptions for physical activity for patients with a BMI that is out of the healthy range.
- Collaboratively develop wellness plans that support patients in adopting changes for a healthy diet and integrating exercise into their lives. Equip patients with pedometers and assist them in setting and achieving activity goals.
- Convene nutrition counseling and/or exercise support groups to promote healthy behaviors.
- Offer integrated behavioral health services to patients that support and promote wellness.

### *Community Interventions*

- Assist patients and community members in using apps through their mobile phone to track calorie consumption and/or physical activity.
- Support development of local, community gardens, farmers markets, or community food co-ops that increase access to fresh foods and encourage healthy diets including vegetables and other high fiber foods.
- Conduct community cooking classes to promote healthy eating.
- Explore opportunities to develop joint use agreements with local schools to provide access to community facilities for physical activity.

<sup>1</sup> <https://www.cdph.ca.gov/programs/cpns/Documents/ObesityinCaliforniaReport.pdf>

<sup>2</sup> CA Health Interview Survey. CHIS 2021 Adult Public Use Files. Los Angeles, CA: UCLA Center for Health Policy Research.

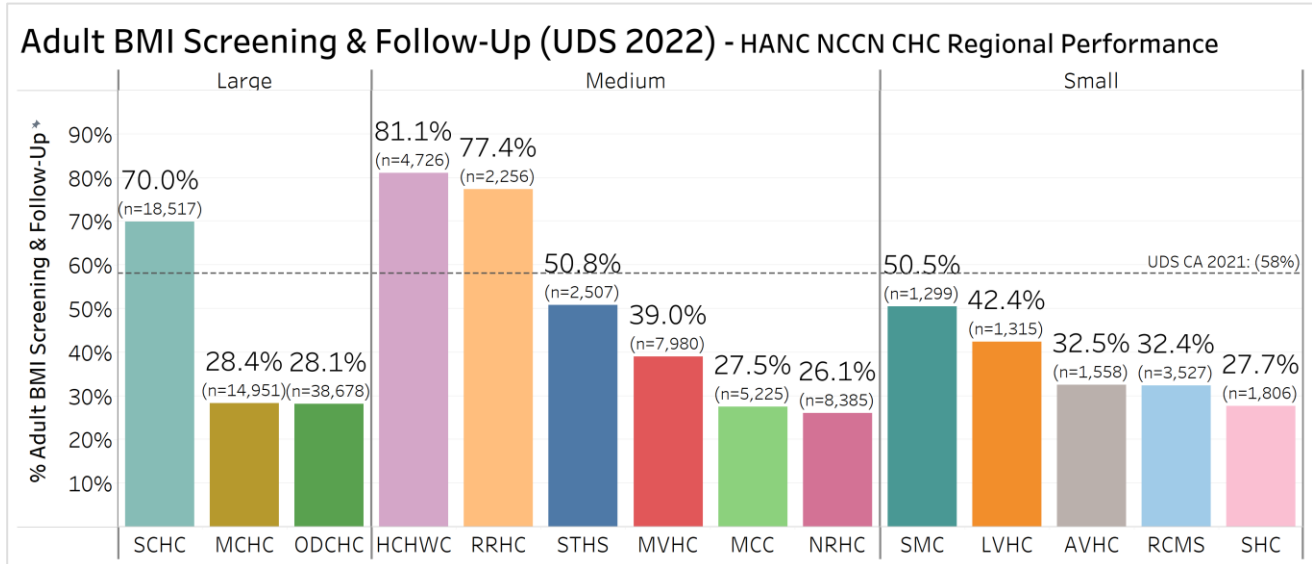
<sup>3</sup> California Department of Public Health (2016). Obesity in California: The Weight of the State, 2000-2014. [Available Online](#).

# Adult Weight Assessment and Follow-up

## Rural Northern California Health Center Data

### Key Points

- Any patient seen at the health center, including those only seen for an acute care visit (e.g. cold or flu) are included in this measure. Health centers are challenged to integrate nutrition and physical activity counseling into all encounters with patients.
- Health centers have achieved improvement over the past few years in providing weight assessments and counseling for adults. A heightened awareness of the issue, automated reminders, and documentation enhancements in electronic health record systems may have contributed to the improved performance.



### Quality Measure Definition (UDS)

Percentage of patients aged 18 and older with (1) a documented BMI during the most recent visit or within the 12 months prior to that visit, and (2) when the BMI is outside of normal parameters a follow-up plan is documented (for adults age 18 and over BMI between 18.5 – 25.0 kg/m<sup>2</sup>).

- The U.S. Preventive Task Force recommends that clinicians screen all adult patients for obesity and offer counseling and behavioral interventions to promote weight loss. Body Mass Index (BMI) provides weight ranges correlated to height and gender. A higher BMI correlates to being overweight or obese.

### National and State Quality Benchmarks

**UDS 2021 CA Average:** The average performance among health centers in California was 58.1%.

**UDS 2021 U.S. Average:** The average performance among health centers across the U.S. was 61.3%.



# Child and Adolescent Well Care Visits

## Impact of Annual Well Care Visits in Rural Northern California

- Rural counties perform significantly worse than urban counties on many health factors measures that can influence the health of children including: adult smoking, teen births, uninsured rate, children in poverty, education, and injury deaths.<sup>1</sup>
- There is a substantial and growing body of evidence that Adverse Childhood Experiences (ACEs), which fall in the categories of abuse, household challenges, and neglect have lasting effects on health outcomes with the number of ACEs linked to higher rates of chronic disease and early death. <sup>2</sup> [ACEs Aware](#)
- Given all of these factors contributing to poor health outcomes in rural areas, it is critical to get children to their well care visits in order to receive immunizations, discuss milestones, social behavior, and learning difficulties to allow for early detection of developmental problems, screen for diseases, and address potential ACEs before they accumulate.
- Regular well care visits as recommended by the American Academy of Pediatrics create strong, trustworthy relationships among physicians, parents and children. A team approach to well-child care is best for the physical, mental and social health of children.

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Provide annual visits, an opportunity for timely, recommended immunizations that prevent illness for children and communities.
- Utilize appointment reminders, patient portal notices, and recall phone calls to assist parents in scheduling and attending annual well care visits.
- Discuss milestones, social behavior, and learning difficulties, which allows for early detection of developmental problems and screening for diseases.
- Collaboratively discuss with parents important safety concerns, such as use of seat belts, as well as appropriate amounts of screen time, physical activity, and healthy eating.
- Offer group well care visits that encourage parent driven conversations, increased care team and provider contact, and additional time to convey anticipatory guidance.

### *Community Interventions*

- Using media campaigns and radio public service announcements to raise awareness of parents about the importance of annual well care visits as part of raising healthy kids.
- Partnering with early childhood education programs or mom and baby programs to share information on the importance of annual well care visits.
- Providing information about food, housing, and social connection programs at community events supports families in connecting to needed enabling services.

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<sup>1</sup> University of Wisconsin Population Health Institute. *County Health Rankings*. California. 2017-2018.

<sup>2</sup> Childhood adversity and adult chronic disease: An update from ten states and the District of Columbia, 2010.

Gilbert L.K., Breiding M.J., Merrick M.T., Thompson W.W., Ford D.C., Dhingra S.S., Parks S.E.

(2015) *American Journal of Preventive Medicine*, 48 (3), pp. 345-349.

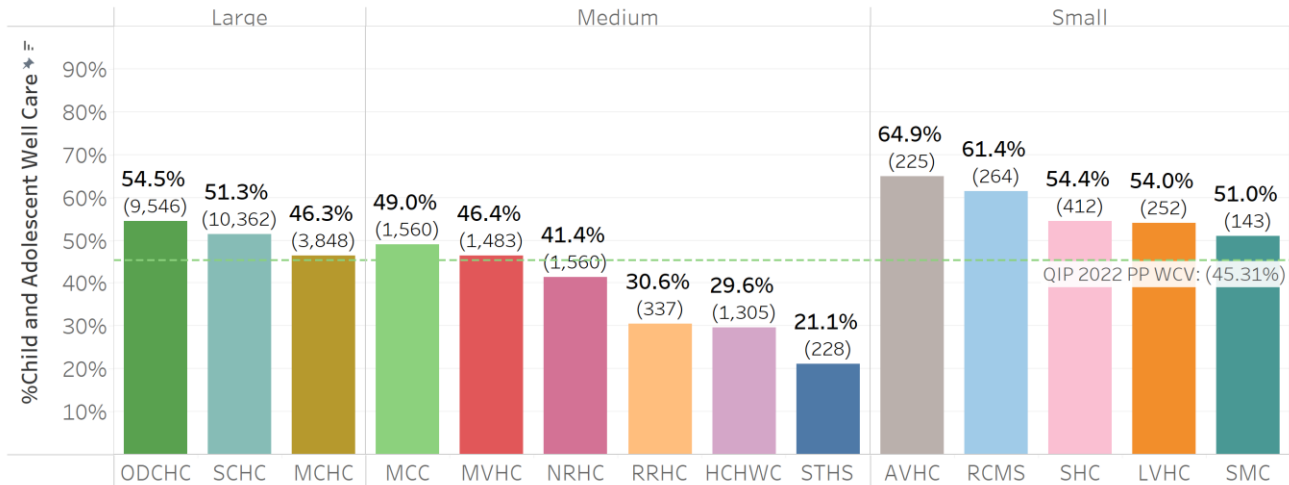
# Child and Adolescent Well Care Visits

## Rural Northern California Health Center Data

### Key Points

- Rural and frontier patients report that transportation is a barrier to accessing services.
- Access to Well Care Visits continues to be a challenge due to workforce shortages and increased demand for services with the closure of private provider offices.

### Child and Adolescent Well Care (WCV) - (QIP 2022) - HANC-NCCN CHC Regional Performance



### Quality Measure Definition (QIP)

Percentage of assigned members 3 - 17 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

### National Quality Goals and Benchmarks

**Full Points Threshold for QIP Measurement Year 2023:** 57.44% represents the 75<sup>th</sup> percentile nationally for Medicaid Health Plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.

**Partial Points Threshold for QIP Measurement Year 2023:** 48.93% represents the 50<sup>th</sup> percentile nationally for Medicaid Health Plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.

# Asthma Medication Ratio

## Impact of Asthma in Rural Northern California

- Asthma is one of the most common chronic diseases and has been recognized as a growing public health concern. The effects of asthma include missed school and work days, disruption of sleep and daily activities, urgent medical visits for asthma exacerbations, and even death.
- Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives. However, only 39.8% of adults and 36.0% of children report proper use of controller medications.<sup>1</sup>
- Seventeen percent of low-income children and adults in rural Northern California have asthma.<sup>2</sup>
- Environmental and socioeconomic factors contribute to the incidence of asthma in rural Northern California. Factors such as poor air quality, exposure to second hand smoke, and poor housing quality may increase risk for asthma.
- Rural counties in Northern California and the Central Valley have the highest adolescent asthma rates in the state.<sup>3</sup>

## How Health Centers Provide the Necessary Care

### *Clinical Interventions*

- Integrate decision support tools into the electronic medical record to assist clinicians in diagnosing and managing asthma according to current guideline and evidence-based practices.
- Identify the type of asthma and associated triggers. Develop written asthma action plans in partnership with patients.
- Increase asthma medication adherence by educating patients on the difference between rescue and controller medications as well as on following their asthma action plan.
- Conduct regular asthma medication evaluations and collect patient feedback.
- Offer provider and nurse education on the identification and management of asthma.

### *Community Interventions*

- At community health fairs offer free pulmonary screenings and education on environmental asthma triggers.
- Display and distribute asthma educational brochures and free environmentally safe products at community centers or other popular gathering places in the community. Offer home environmental assessments and trigger reduction assessments for patients.

<sup>1</sup> California Department of Public Health. Asthma in California: A Surveillance Report. May 2013.

<sup>2</sup> California Health Interview Survey. CHIS 2021 Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research, Apr 2020.

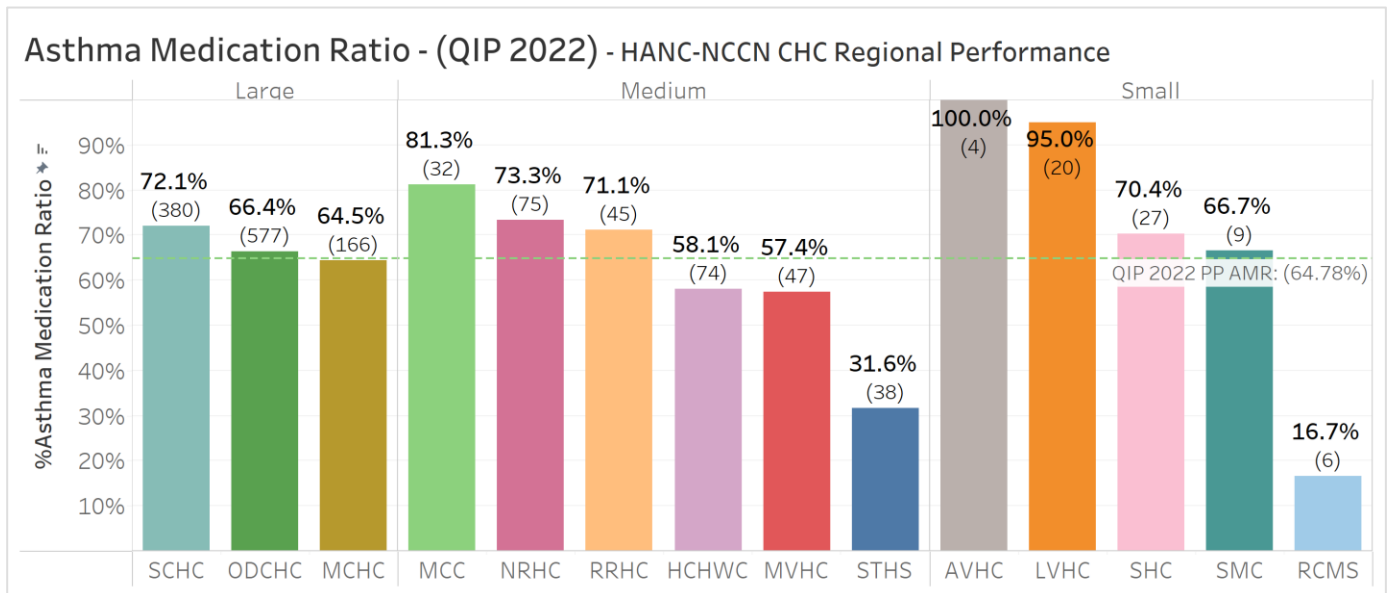
<sup>3</sup> Capitman J., Tyner T. (2011). The Impacts of Short-term Changes in Air Quality on Emergency Room and Hospital Use in San Joaquin Valley. San Joaquin Valley Air Pollution Control District. Fresno, CA.

# Asthma Medication Ratio

## Rural Northern California Health Center Data

### Key Points

- There has been an increase in wildfires in the region in the past few years. These events have contributed to the incidence and severity of asthma in rural Northern California.
- Wood-burning stoves are used commonly in rural and frontier areas, which may also contribute to asthma symptoms.
- Developing regular reports on asthma medication refills can support providers in delivering education to patients.



### Quality Measure Definition (QIP)

Percentage of patients 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater.

### National Quality Goals and Benchmarks

**Partial Points Threshold for QIP Measurement Year 2023:** 64.26% represents the 50<sup>th</sup> percentile nationally for Medicaid Health Plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.

## Chapter 3: Detailed Quality Measure Crosswalk

### Purpose

To provide detailed comparisons of measure definitions, sampling methodology, and data sources for each measure across the multiple measurement systems.

### Overview of Content

- Reporting period
- Measure description, definition, and look back period
- Sampling methodology
- Evidence and data sources
- Related benchmarks

### Suggested Uses for This Material

- Use for training new quality improvement staff
- Use to assist in identifying quality improvement targets and priorities
- Inform the development of queries or quality reports
- Reference when answering questions for staff or providers about the differences in quality measure definitions between two measurement sets (e.g. UDS and QIP)

This final section of the toolkit includes in-depth information on each UDS or QIP clinical measure, which are contained in a spreadsheet attached as an appendix file to this toolkit. The spreadsheet organizes measures in separate tabs by category as described below.

#### Primary Prevention

- Cervical Cancer Screening
- Breast Cancer Screening
- Colorectal Cancer Screening
- Prenatal and Postpartum Care
- Birthweight of Infants
- Depression Screening
- Depression Remission
- Dental Sealants

#### Immunizations

- Childhood Immunizations
- Immunizations for Adolescents

**Tertiary  
Prevention**

- Diabetes Care – Retinal Eye Exam
- Diabetes Care - Controlling Diabetes
- Complete Lipid Panel
- Controlling High Blood Pressure
- Tobacco Screening and Cessation
- HIV Screening
- HIV Linkage to Care
- Adult Weight Assessment and Counseling

**Well Child**

- Child and Adolescent Weight Assessment and Counseling
- Well Child Visits 0-15 Months
- Well Child Visits 3-6 Years
- Child and Adolescent Well Care 3-17

**Medication  
Management**

- Asthma Medication Ratio
- Statin Therapy
- Ischemic-Vascular Disease

## Detailed Measure Crosswalk: How to Use the Attached Spreadsheet

A summary crosswalk of measurement sets provides an overview of alignment between measurement systems.

MEASUREMENT SYSTEMS CROSSWALK - 2023						
Note: This crosswalk is for informational purposes only, always reference source documents for making final reporting decisions. Links Below. Reference to HEDIS measures are included in this Summary tab only. More information is available through the HEIDS link below.						
Themes	Measure Name	Description	Site Review (SR)	HEDIS	PCP QIP (2023)	UDS (2022)
Primary Preventive	Cervical Cancer Screening	HEDIS: 21-64 y/o QIP: 21-64 y/o Family & Internal Medicine MU: CMS124v8	X	X	X	X
	Breast Cancer Screening	HEDIS: 50-74 y/o QIP: 50-74 y/o Family & Internal Medicine MU: CMS125v8	X	X	X	X
	Colorectal Cancer Screening	QIP: 50-75 y/o Family & Internal Medicine MU: CMS130v8	X	X	X	X
	Prenatal & Postpartum Care - Timeliness of Prenatal Care		X	X		X
	Birth Weight of Infants					X
	Depression Screening	MU: CMS2v9	X			X
	Depression Remission	MU: CMS159v8				X
Dental Sealants	MU: CMS277v0	X			X	
Immunizations	Childhood Immunization Combination 10	UDS: DTP/Dtap, IPV, MMR, Hib, HepB, VZV, PCV, HepA, Rotavirus, Influenza QIP: Birth-2 y/o Pediatrics & Family DTP/Dtap, IPV, MMR, Hib, HepB, VZV, PCV, HepA, RV, Influenza	X	X	X	X
	Immunizations for Adolescents	QIP: 9-13 y/o Pediatrics & Family	X	X	X	
	Diabetes Care - Retinal Eye Exam	QIP: 18-75 y/o Family & Internal Medicine MU: CMS131v6		X	X	
	Diabetes Care - HbA1c Control	QIP: 18-75 y/o Family & Internal Medicine MU: CMS122v8		X	X	X
	Complete Lipid panel		X			

Provides a summary of which measures are included in each measurement system

This figure provides tips on how to use the Detailed Measure Crosswalk appendix file.

Cervical Cancer Screening	Site Review (SR)	QIP 2023	UDS 2022
<b>Reporting Period</b>	Time period from previous site review to current. Duration of time between site reviews	January - December of the measurement year.	January - December
<b>Description</b>	Percentage of women 21-65 years of age who are sexually active and have a cervix, that received one or more Pap tests to screen for cervical cancer.  <i>As of July 1, 2020:</i> Women 30-65 with cytology and HPV cotesting every 5 years.  Women who are 21 to 64 years of age received screening for cervical cancer with cytology (PAP smear), in one of the following ways: 1.) 21-65 years of age, cytology every 3 years, 2.) 30-65 years of age, cytology and human papillomavirus (HPV) co-testing every 5 years.	The percentage of Medi-Cal women 21 - 64 years of age who were screened for cervical cancer according to evidence-based guidelines:  - Women age 21 - 64 who had cervical cytology performed every three years. - Women age 30 - 64 who had cervical cytology and human papillomavirus (HPV) co-testing performed every five years. - Woman age 30 - 64 who had high-risk human papillomavirus (hrHPV) testing performed every five years.	Percentage of women 21* - 64 years of age who were screened for cervical cancer using <b>either</b> of the following criteria:  - Women age 21* - 64 who had cervical cytology performed every 3 years - Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.  *Use age 23 for assessment due to 2-year look-back period.
<b>Lookback Period</b>	For a regular PAP test, the measurement year or during the 2 prior calendar years.  1.) 21-65 years of age, cytology every 3 years 2.) 30-65 years of age, cytology and human papillomavirus (HPV) co-testing every 5 years	Either the measurement year or during the 2 prior calendar years (Pap Test), or the measurement year or during the 4 prior calendar years (hrHPV).	Either the measurement year or during the 2 prior calendar years (Pap Test), or the measurement year or during the 4 prior calendar years (Pap/HPV co-testing).
<b>Sample Size</b>	• 1-3 Providers will be 10 records • 4-6 Providers will be 20 records • 7+ Providers will be 30 records	The entire denominator	70 charts or at least 80% of denominator population in EHR
<b>Numerator</b>	Routine screening for cervical cancer with PAP test is done on all women who are sexually active or 21 years old (which ever comes first) and have a cervix.  <i>As of July 1, 2020:</i> Routine Cervical cancer screening is done on all women 21-65 years old.  The number of women in the denominator who were appropriately screened for cervical cancer	See Measure Description	Number of female patients 23-64 years of age with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:  - Cervical cytology performed during the measurement period or the 2 years prior for women who are at least 21 years old at the time of the test - Cervical cytology/human papillomavirus (HPV) co-
<b>Denominator</b>	Number of all female patients age 21-65 years of age assigned to the PCP office and seen within the last 3 years.  Number of patients, pulled at random, who meet the parameters for cervical cancer screening	The number of continuously enrolled Medi-Cal women 24-64 years of age as of December 31, 2018 (DOB between January 1, 1954 and December 31, 1994).	Number of all female patients age 23-64 years of age during the measurement year who had at least one medical visit during the reporting year.
<b>Evidence</b>	1.) PAP test results in chart 2.) Documentation signed by the provider stating when PAP was done and results.	<b>Women under 30 years old:</b> Administrative data or a note indicating the date when the cervical cytology was performed and the result or finding.  <b>Women 30 years old or older:</b> A note in the medical record indicating the date when the cervical cytology and the hrHPV test co-test were performed and the results or findings. Or administrative data or a note indicating the date when the cervical cytology was performed and the result or finding.	A patient is counted as having had a Pap test if a visit contains a related ICD-9, ICD-10, and/or CPT code or if a copy of a lab test performed by another provider is in the chart. Documentation in the medical record of a test performed outside of the health center must include the date the test was performed, who performed it, and the result of the test.
<b>Exclusions</b>	Women who have had a hysterectomy and who have no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year.  • Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. The following also meet criteria: • Documentation of a "vaginal Pap smear" in conjunction with documentation of hysterectomy.	Women who have had a hysterectomy and who have no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year.  • Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. The following also meet criteria: • Documentation of a "vaginal Pap smear" in conjunction with documentation of hysterectomy.	Women who have had a hysterectomy and who have no residual cervix or a congenital absence of cervix. Look for evidence of a hysterectomy as far back as possible in the patient's history through either administrative data or medical record review. See UDS manual for Surgical Codes. NOTE: because very few health centers perform hysterectomies, the measure excludes these CPT codes as well. The measure excludes these CPT codes as well. The measure excludes these CPT codes as well.
<b>CPT Codes/Other</b>		Codes located in the Diagnosis Crosswalk via eReports	<a href="#">Link to UDS Manual (see page 91)</a>

Provides details on the definition specifications for the measure

Describes who should be excluded from measurement and key terms to look for in the record

Offers tips on documentation required to meet the measure