Performance Improvement Team presents:

Accelerated Learning Education Program

Women's Health: Cervical and Breast Cancer Screening

Dr. Mark Netherda
Associate Medical Director for Quality

Flora Maiki, MHA
Improvement Advisor

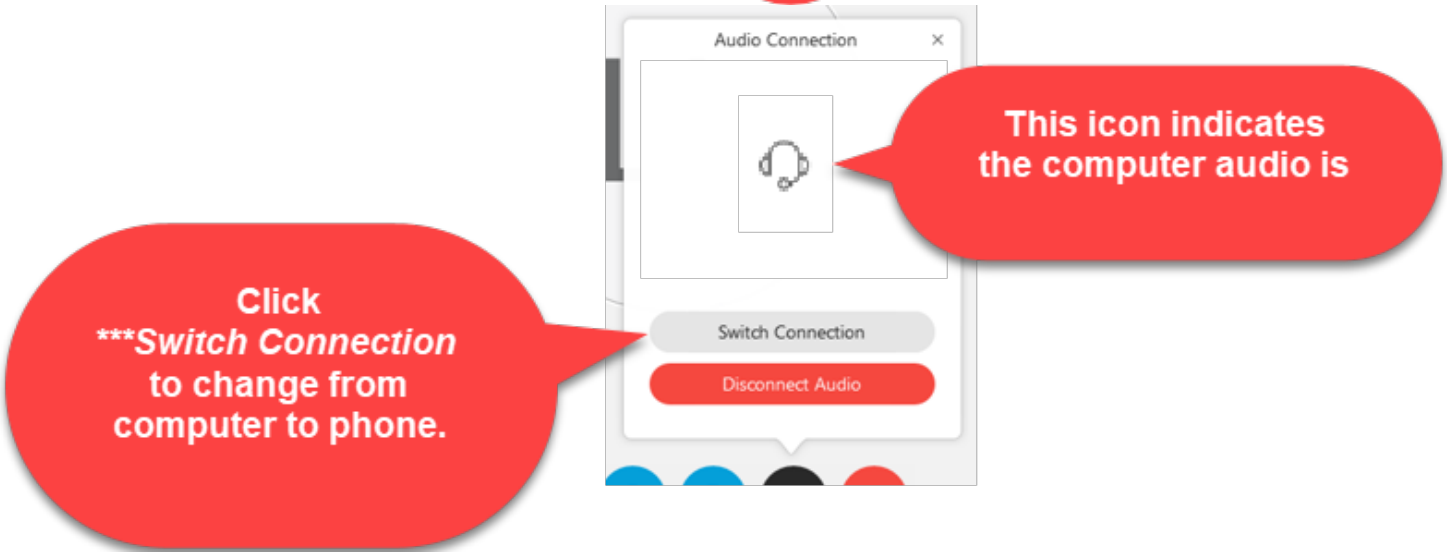
August 25th 2020

Webinar Instructions

To avoid echoes and feedback, we request that you use the telephone audio instead of your computer audio for listening and talking during the webinar.

Figure 1

Figure 2

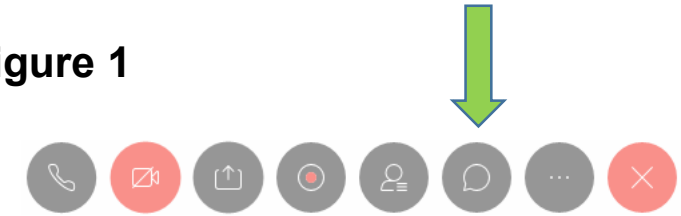


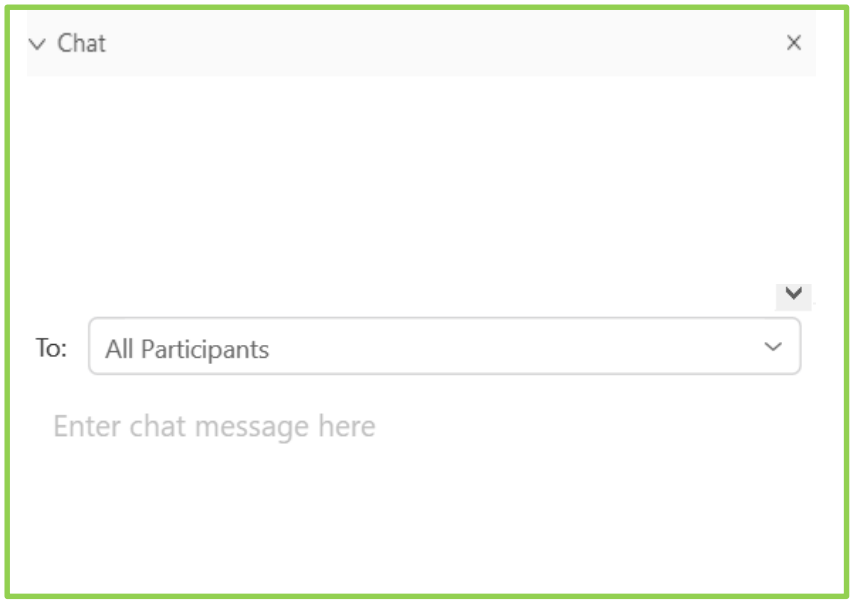
***There are two options to *Switch Connection* to telephone audio.

Webinar Instructions

- All participants have been muted to eliminate any possible noise/ interference/distraction.
- Please take a moment and open your chat box by clicking the chat icon found at the bottom of your screen and as shown in **Figure 1**.
- Be sure to select "**All Participants**" when sending a message.
- If you have any questions, please type your questions into the chat box, and they will be answered throughout the presentation.

Figure 1





Conflict of Interest

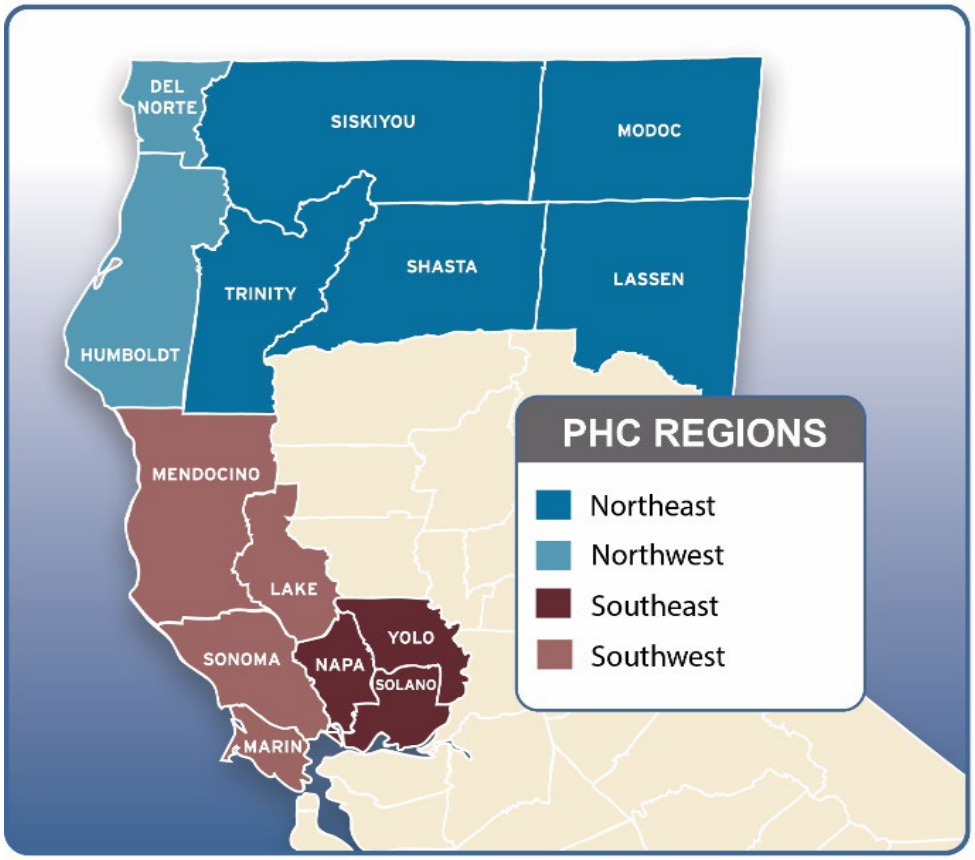
All presenters have signed a conflict of interest form and have declared that there is no conflict of interest and nothing to disclose for this presentation.

CME credit is for physicians, physician assistants and other healthcare professionals whose continuing educational requirements can be met with AAFP CME.

Agenda

- Accelerated Learning Education Program
- Cervical and Breast Cancer Screening Measures - Clinical Significance and Specifications
- Review/Share Best and Promising Practices
- Commitment - one change to make screening an easier choice for members/patients
- Resources/Offerings
- Evaluation and CME/CE Credit
- Questions

Partnership HealthPlan of California (PHC) Regions



Southeast: Solano, Yolo, Napa

Southwest: Sonoma, Marin, Mendocino, Lake

Northeast: Lassen, Modoc, Siskiyou, Trinity, Shasta

Northwest: Humboldt, Del Norte

PHC's Mission, Vision, and Focus

Mission

To help our members, and the communities we serve, be healthy

Vision

To be the most highly regarded managed care plan in California

Focus

1. Quality in everything we do
2. Operational excellence
3. Financial stewardship

Objectives

At the end of this activity, you will be able to:

- Define the Healthcare Effectiveness Data and Information Set (HEDIS®) specifications, timeframes, and documentation to maximize measure adherence.
- Identify best and promising practices that providers can use to address clinical process, interpersonal communication, education/outreach, and technical barriers in cancer screening services.
- Commit to one change you will test in your practice site to make cervical and breast cancer screening an easier choice for members/patients.

Accelerated Learning Program

- Quality Incentive Technical Session: eReports and PQD
- Women's Health Focus Measures: Cervical and Breast Cancer Screening
- Pediatric Preventive Care Focus Measures: Childhood Immunization Status Combination-10, (CIS-10)
- Pediatric Preventive Care Focus Measures: Well-Child Visits (W15)
- Colorectal Cancer Screening
- Asthma Medication Ratio

Cervical Cancer Screening (CCS)

Cervical Cancer Epidemiology

- Currently - US – 13,000 cases per year and 4,100 deaths
    - Third most common gynecological cancer after uterine and ovarian
- Cervical cancer was the leading cause of cancer deaths in women in the United States (U.S.) until increased Pap testing resulted in significant decreases in the number of cervical cancer cases and deaths[1]
- In the U.S., Latino women are most likely to get cervical cancer, followed by African-Americans/Blacks, Whites, American Indians/ Alaskan Natives, and Asians/Pacific Islanders[2]
- Six out of 10 cervical cancers occurred in women who had never had a Pap test or who had not been screened in the past 5 years[3]
- Regular Pap testing can detect cervical cancer in its early stages, which is highly treatable. The five-year relative survival rate for early stages of invasive cervical cancer is 93%.[4]

What Causes Cervical Cancer?

- Infection with Human Papilloma Virus (HPV)
- 80% of women are exposed to HPV during their lifetimes
- Most of the time, the immune system suppresses it
- However, HPV is found in 99.7% of cervical cancers[5]
- HPV vaccination of pre-teens/teens is very important!

Risk Factors for Cervical Cancer

- Early onset sexual activity
  - 2X greater risk for onset before age 18 years compared to after 21 years.
- Multiple sexual partners
- High risk sexual partners
- History of Sexually Transmitted Disease (STD)
- History of vulvar or vaginal cancer
- Immunosuppression (HIV)
- Socioeconomic status
- Use of oral contraceptives
- Genetics?

Cervical Cancer Screening

- Looking for precancerous cells and cancer cells

- Two tests:
  - Papanicolaou or “Pap” test/smear (cytology testing)
  - High-risk human papillomavirus (hrHPV) testing

- Goal: find changes in the earliest stages when treatment and cure possible
  - Reduce premature deaths

Who Should Be Screened?

- Women age 21- 64
- Age 21-30 years
  - **Pap test within the last three years**
    - Department of Healthcare Services (DHCS) and the Healthcare Effectiveness Data and Information Set (HEDIS®) follow the U.S, Preventive Services Task Force (USPSTF) guidelines
- Age >30 years through age 64 years
  - Co-testing, Pap and high-risk human papillomavirus (hrHPV) within the last five years (for HEDIS**)**
  - High-risk human papillomavirus (hrHPV) test alone within the last five years
  - Pap test alone within the last three years

When to Stop Cervical Cancer Screening?

- Depends on prior results
- Shared decision – life expectancy, risk factors
- Age 65 recommended, but some screen until 75
- Adequate prior screening scenarios:
  - Two consecutive negative co-test (Pap and HPV) within the past 10 years, with one in the past five years
  - Three consecutive negative Pap test in the past 10 years, with one in the past three years
  - Two consecutive negative HPV tests in the past 10 years, with one in the past five years

Cervical Cancer Screening (CCS)

Description:

Percentage of members 21-64 years of age who were screened for cervical cancer according to evidence-based guidelines

Denominator:

Number of members 21-64 years of age as of measurement year (MY)

Cervical Cancer Screening (CCS)

Numerator:

Number of members in the eligible population who were appropriately screened according to evidence based-guidelines

Step 1: Members age 21-64 who had Pap performed within the last three years (screening 2020, 2019, or 2018)

Step 2: Members age 30-64 who had Pap and HPV co-testing within the last five years (2020, 2019, 2018, 2017 or 2016)

Step 3: Members age 30-64 who had high-risk human papillomavirus (hrHPV) testing performed within the last five years (2020, 2019, 2018, 2017 or 2016)

Medical Record Documentation

CCS is a hybrid measure = review medical record, claims and lab data used in the denominator

- Members who do not have a cervix can be identified by the ICD 10 code Z90.71 and the date or approximation of the date of the acquired absence of cervix
- Documentation for eReports includes:
  - Entry of the date that is as defined as the date of surgery (operative report); OR
  - Identify a close date, could be month and year - use the last date of the month (e.g., May 31, 2001). Or, if only a year is known, use the last date of that year (e.g., 12/31/2001)

Medical Record Documentation

- Pap findings to include date screening was performed **and** test results/findings
- Biopsies are non-adherent documentation - they are diagnostic and therapeutic only
- Check your lab results - ensure that it states that there was adequate cervical cells present and the test was completed
- Check the minimal age at the date of testing; for example, a person 32 years of age in 2019 last record of HPV testing and results is in 2016 when person was 29 years of age. The HPV testing does not satisfy the criteria.

Cervical Cancer Screening Exclusions

- Documentation of “complete,” “total,” or “radical,” abdominal or “vaginal hysterectomy” meet criteria for hysterectomy with no residual cervix
- Cervical agenesis (born without a cervix)
- Documentation of hysterectomy in combination that the patient no longer needs Pap testing/cervical cancer screening
- Documentation of “vaginal Pap smear” along with documentation of “hysterectomy”
- Members in hospice, receiving **palliative care**, and those with terminal illness (required exclusions)

Word about Chlamydia Screening

WHY IT MATTERS

Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. (6)

It occurs most often among adolescent and young adult females.

Screening is important, as approximately 75% of chlamydia infections in women and 95% of infections in men are asymptomatic. (7)

Chlamydia

Description: The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year

Denominator:
Number of continuously enrolled eligible Medi-Cal population 16-24 years of age as of the end of measurement year (MY)

Breast Cancer Screening (BCS)

Breast Cancer Epidemiology

In the United States, breast cancer is the most common female cancer.

- Second most common cause of cancer deaths in women
- 260,000 cases per year
- 40,000 deaths per year [(8)] [(9)]
- Mortality decreasing
  - Better screening
  - Better treatments

Some Risk Factors for Breast Cancer

- Increasing age
- Race: White > Black
- Weight and Body Fat – pre- vs. post-menopause
- Tall stature
- Estrogen levels
- Dense breast tissue
- Higher Bone Density
- Early menarche / late menopause
- Infertility / Nulliparity / advanced age at first pregnancy
- Personal history of breast cancer
- Family history of breast cancer

Lifestyle Risks and Breast Cancer

Some lifestyle choices **increase** a woman's risk for breast cancer

- Alcohol consumption
- Smoking
- Night-shift work
- Ionizing radiation exposure

Some lifestyle choices **decrease** a woman's risk for breast cancer

- Breast feeding
- Physical activity

(Caffeine - a number of studies have failed to show any effect)

Breast Cancer Screening (BCS)

- Decisions regarding breast cancer screening should be individualized, and based on personal and family history
- Each woman should be evaluated for risks before recommending a screening program
- Shared decision making should be standard

Breast Cancer Screening – Average Risk

Age based

- Different expert groups have different recommendations
  - Most “individualize” the decision age 40-49
  - Some start at 45
  - Most stop at 74
- US Preventive Services Task Force (USPSTF)
  - All – Age 50-74
  - Age 75+ – continue if healthy and life expectancy >10 years

Frequency

- Again – no consensus
- USPSTF – every 2 years

Roles of Clinical and Self-Breast Exams

Clinical Breast Exams (CBE)

- Not recommended for average risk women
  - Lack of evidence CBE changes outcomes
- Important for women complaining of pain, mass, discharge

Breast Self-Exams (BSE)

- Not routinely recommended
  - Studies show lack of benefit
  - Increased biopsy rate
- If done, careful instruction is important

Take-home message:

Breast exams are not substitutes for mammograms!

Breast Cancer Screening (BCS)

Description:

Percentage of eligible population 50-74 who had a mammogram from October 1 two years prior to the measurement year (MY) and December 31 of the MY

Denominator:

Number of continuously enrolled eligible population 52-74 years of age as of the end of the measurement year (MY)

Breast Cancer Screening (BCS)

Numerator:

Number of eligible population in the denominator with one or more mammograms any time on or between October 1, 2018 and December 31, 2020

- Continuous enrollment: October 1, two years prior to the measurement year through December 31 of the measurement year (MY)

Documentation

- BCS is a administrative measure = claims data used in the denominator

- All types and methods of mammograms (screening, diagnostic, film, digital, or digital tomosynthesis) qualify for numerator adherence

- Document last mammogram date and results

Breast Cancer Screening Exclusions

- Bilateral mastectomy, two unilateral mastectomies, unilateral mastectomy with a bilateral modifier
- There are a number of exclusions that involve patients with frailty and advanced illness who are 66 years of age and older as of December 31 of the measurement year (MY)
- Example: Required exclusion, patients receiving **Palliative Care** during the measurement year (MY)

Monitoring Measures

Monitoring Measures (Not in the Core Clinical Measurement Set)						
Measure	QIP Score	Numerator	Denominator	25th Threshold %	25th(Target/Achieved)	50th Threshold %
Adolescent Well Care 2020	9.47 %	617	6514	NA	NA	54.26%
Breast Cancer Screening 2020	50.97 %	735	1442	NA	NA	58.67%
Cervical Cancer Screening 2020	57.50 %	3752	6525	NA	NA	60.65%
Diabetes - Retinal Eye exam 2020	26.43 %	327	1237	NA	NA	58.88%
Immunization for Adolescents 2020	29.63 %	227	766	NA	NA	34.43%
Well Child 3-6 Years 2020	16.61 %	473	2848	NA	NA	72.87%

Intentions for the Monitoring Measurement Set

- Not part of the Core Measurement Set.
- No points assigned for incentive dollars.
- Ability to monitoring your performance with access to the member gap in-care lists.

Best and Promising Practices

Seize every opportunity:

Establish a practice commitment to cancer screening!

- ✓ Utilize “flag” alerts in the EMR/EHR system that each staff member can use to identify and communicate to patients/members who are due for their screening services at **every** member encounter
- ✓ Conduct chart scrubbing prior to the visit to determine if screening / preventive services are due
- ✓ Combine cervical cancer screening with breast cancer screening visits if possible. Or, schedule future visits while the member/patient is waiting to be seen by the provider or before the member leaves the office
- ✓ Use standardized templates in the EMR/EHR system to guide providers and staff through the visit to ensure all components were met and documented

Best and Promising Practices

- ✓ Actively pursue missed appointments with letters and reminder calls: Designate staff member to outreach.
  - ➢ Reminder calls by office staff tend to be more effective than robo-calls.
  - ➢ Reminder calls made later in the day or early evening may result in more contacts made to members.
  - ➢ Reminder or due letters that are personalized/signed by clinician make a positive impact.

Increase Access:

Consider a variety of service options and choices - after hours and same day appointments, weekend cervical and/or breast cancer screening day(s)

Best and Promising Practices

- ✓ CCS: Be proactive - contact members before their 21st birthday to let them know its recommended to have regular CCS when they reach 21 years
- ✓ Explore possible barriers that may impact screening services, such as access to care, cultural diversity, anxiety, embarrassment. Offer choices of gender and spoken language of provider.
- ✓ Work with the mammography/imaging facility

Communication/Education:

- ✓ Use person-centered plain language and educational information to members in appropriate language; use high and low tech outreach options
- ✓ Collaborate with community agencies for outreach

Best and Promising Practices

- ✓ BCS: Collaborate with the referral mammography imaging center/facility - meet with imaging managers
- ✓ BCS: Place last mammography date sticker on health card

Strengthen Internal Operating Practices:

- ✓ Submit timely claims and encounter data within 90 days of service
- ✓ Use complete and accurate codes to capture clinical services completed
- ✓ Report back to all levels of staff on your progress to meet measures. Builds common language for quality improvement.
- ✓ Schedule a standing meeting with your QI staff to review the resources offered by PHC (e.g., coaching support, maximizing eReports and PQD usage)

Best and Promising Practices

- ✓ Commit to one change you will test in your practice site to make women's health cancer screening adherence an easier choice for members/patients.

Voices from the Field

Voices from the Field

Michelle Ghidinelli, MPH
Population Health Manager
Santa Rosa Community Health

Breast & Cervical Cancer Screening:
Tips from an FQHC

Michelle Ghidinelli, MPH
Population Health Manager
Santa Rosa Community Health

Santa Rosa COMMUNITY HEALTH

About Santa Rosa Community Health

- FQHC in Sonoma County
- We see 1 in 4 people in Santa Rosa
- 42,000 pts/year
- 8 campuses
- Services: Primary care, pediatrics, dental, IDD, MH/BH, CPSP, MAT, Homeless campus, CAM, residency (MD & NP), COVID Testing Site, Care Coordination, IOPCM, Transitions,

Pap Successful Strategies

- Take advantage of “pap-portunities”
- Phrasing “I’ve done 5 of these this week, if you haven’t prepped it’s not a big deal. Let’s just get it done so you don’t have to come back”
- Fully stocked rooms w/ setup diagrams
- Resident Pap Clinic
- Partner w/ PCP who DOES do paps

Pap Successful Strategies

- Show data - # of positives or cases prevented
- Highlight pt stories – patients are our families
- Individual data- start with clinic, then team, then provider
- Review labs that appear not done but might be
- ROI to get records from outside (like Planned Parenthood)

Pap Successful Strategies

- Homelessness- pair with shower clinic & fem hygiene gift bag
- Care gaps/Alerts- will be due in 3 months
- Texts/emails/robocalls to remind patients (save valuable staff time since patients often don’t answer phone)
- Give PCPs Pop Mgmt time to review lists

Mammo Successful Strategies

- Consider mobile mammo van
- Partner with mammo facility – ask for a day you can schedule (so pt leaves w/appt card)
  - Make reminder calls for mammo appts, remind that at a different facility
- Report – Mammos referred – then search for records
- Pair with National Prev. Health Months to use educational materials

Evaluations

Please complete your evaluation. Your feedback is important to us!

References

References:

National Committee on Quality Assurance (NCQA) HEDIS® 2020 Vol 2 Technical Specifications for Health Plans; NCQA HEDIS 2018 Vol 1 Narrative. HEDIS® is a registered trademark of NCQA.

National Committee on Quality Assurance (NCQA) HEDIS® 2019 Vol 2 Technical Specifications for Health Plans; NCQA HEDIS 2018 Vol 1 Narrative. HEDIS® is a registered trademark of NCQA.

1. American Cancer Society. Cervical cancer prevention and early detection. http://www.cancer.org/acs/groups/cid/documents/webcontent/003167-pdf.pdf. Published December 2014.
2. Centers for Disease Control and Prevention. Cervical cancer rates by race and ethnicity. http://www.cdc.gov/cancer/cervical/statistics/race.htm. Published January 2008.
3. Women with disabilities. Centers for Disease Control and Prevention Web site. http://www.cdc.gov/ncbddd/disabilityandhealth/women.html. Updated March 31 2014.
4. National Cancer Institute. SEER Stat fact sheets: Cervical uteri cancer. http://seer.cancer.gov/statfacts/html/cervix.html.
5. Wallboomers, Jacobs, Bosch, et al., J Pathol. 1999;189(1):12
6. Centers for Disease Control and Prevention (CDC). 2014. “Sexually Transmitted Diseases: Chlamydia—CDC Fact Sheet.” http://www.cdc.gov/std/chlamydia/STDFact-chlamydia-detailed.htm
7. National Chlamydia Coalition. 2010. “Research Briefs: Developments in STD Screening: Chlamydia Testing.” 2010 Series, No.1.
8. Centers for Disease Control and Prevention (CDC) 2018. “ What is Breast Cancer?” http://www.cdc.gov/cancer/breast/basic_info/screening.htm
9. American Cancer Society. 2015. “Breast Cancer Facts & Figures 2015-2016.”

PHC QI Resources

QI/Performance Team:

ImprovementAcademy@partnershiphp.org

Quality Improvement Program: QIP@partnershiphp.org

2020 PCP QIP Webpage:

http://www.partnershiphp.org/Providers/Quality/Pages/PCP-QIP-2020.aspx

QI Monthly Newsletters:

http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPMonthlyNewsletter.aspx

Measure Highlights:

http://www.partnershiphp.org/Providers/Quality/Pages/Quality-Measure-Highlights.aspx

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

PHC QI Resources

A Quick Guide to Starting Your Quality Improvement Projects

http://www.partnershiphp.org/Providers/Quality/Pages/PIAcademyLandingPage.aspx

Upcoming QI Events

Training & Education Coming Soon: 12:00- 1:00 pm

Accelerated Learning Education Program:

- Well Child Visit = Sept. 22nd
- Childhood Immunization = Oct. 6th
- Asthma Medication Ratio- Academic Detailing Webinar= Oct. 20th

Virtual ABCs of Quality Improvement: Oct. 7th, 14th, 21st, 28th, Nov. 4th, and 12th

2019 PCP QIP High Performers - How'd They Do That? Sept.17th, Oct. 8th, Nov. 5th

http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx

Contact US

Associate Medical Director of Quality:

Mark Netherda, MD **(mnetherda@partnershiphp.org)**

Quality Improvement Advisors:

Farashta Zainal (fzainal@partnershiphp.org)

Flora Maiki (fmaiki@partnershiphp.org)

Joy Dionisio (jcdionisio@partnershiphp.org)

QI/Performance Team:

ImprovementAcademy@partnershiphp.org

Q & A

What questions do you have for us?