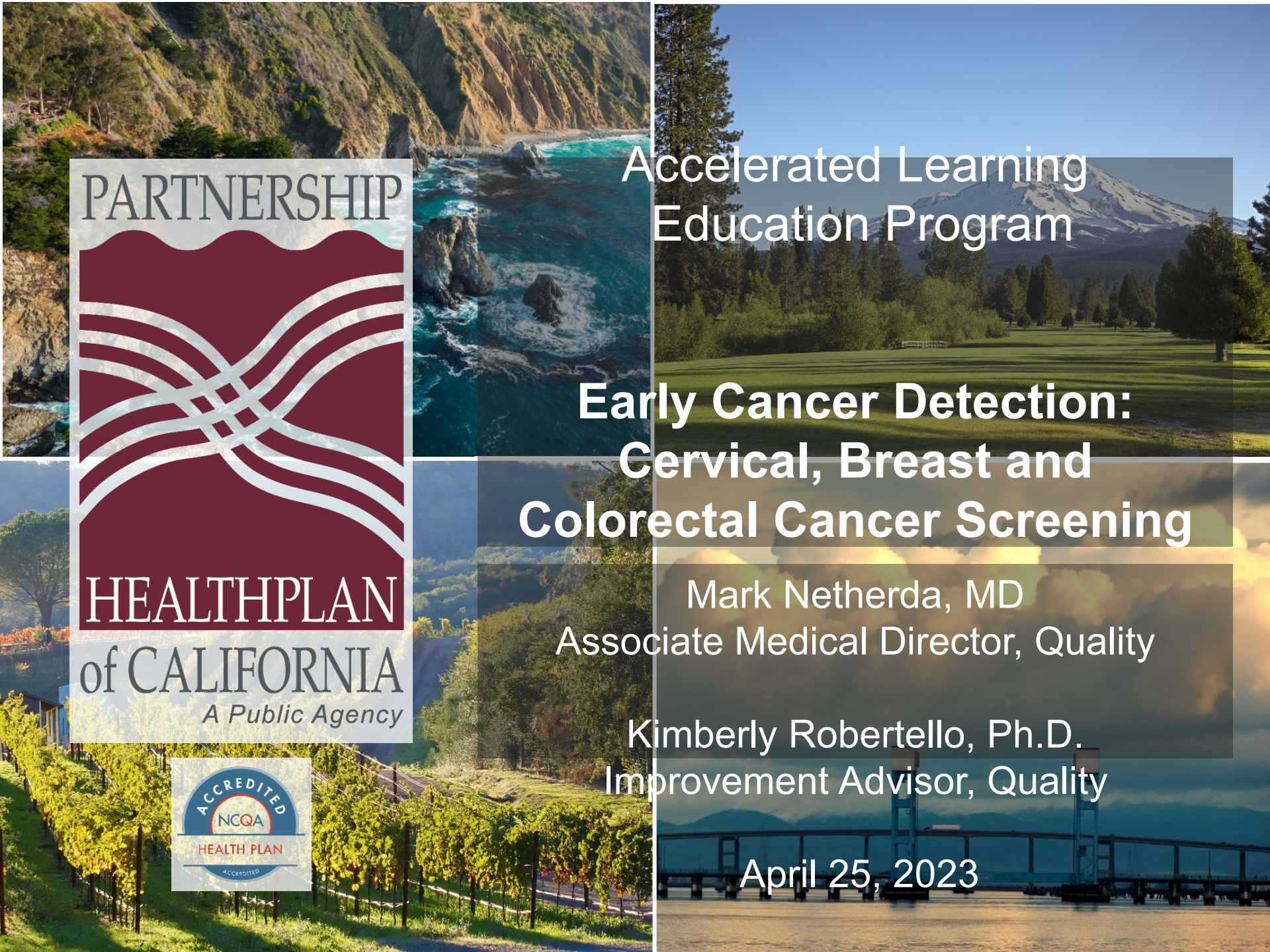

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN

Accelerated Learning Education Program

Early Cancer Detection: Cervical, Breast and Colorectal Cancer Screening

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April 25, 2023

Objectives

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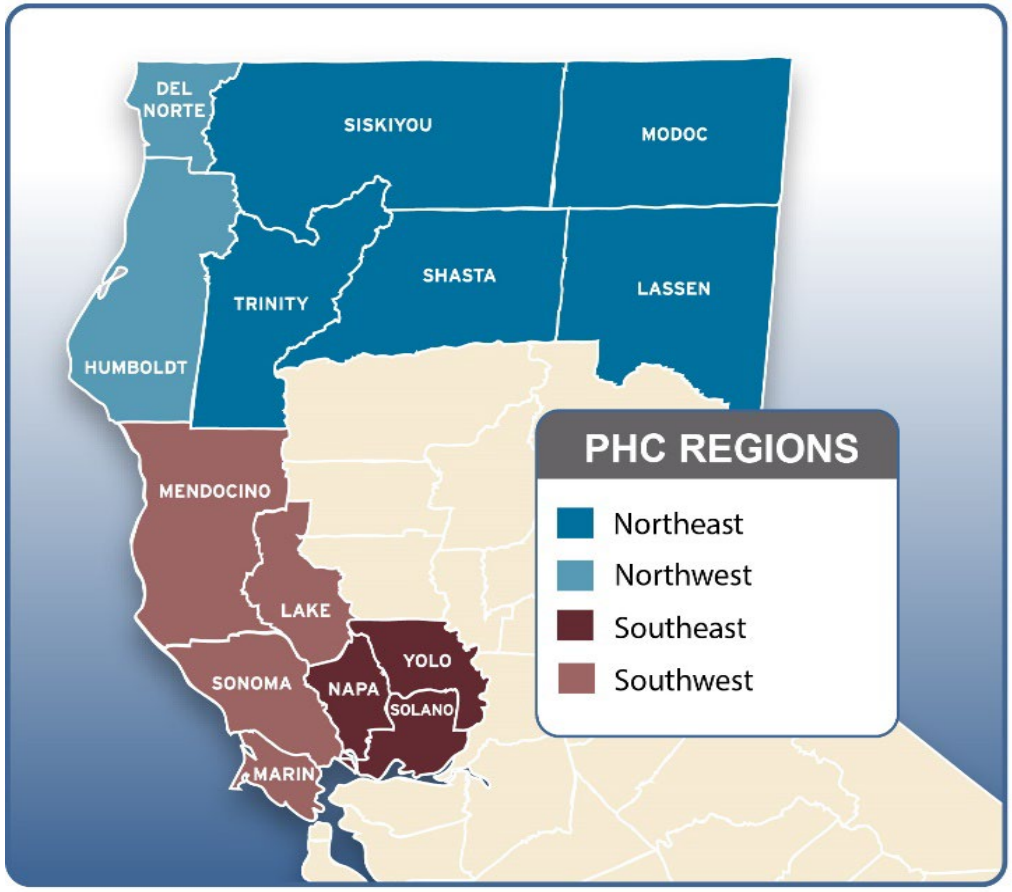
At the end of this activity, you will be able to:

- Understand the clinical background, specifications, and performance threshold definitions of the 2023 PCP QIP *Cervical, Breast* and *Colorectal Cancer Screening* measures.
- Apply documentation requirements to maximize adherence and measure performance in the delivery of cervical, breast, and colorectal cancer screening services.
- Identify best and promising practices that can be used to address clinical work flows, improve interpersonal communication, member and staff education, and improve outreach for patients from groups that have been historically economically, and socially marginalized.
- Provide technical tips to facilitate early cancer detection screening services, especially for populations with higher incidence and mortality rates.

Partnership HealthPlan of California Regions



Southeast: Solano, Yolo, Napa

Southwest: Sonoma, Marin, Mendocino, Lake

Northeast: Lassen, Modoc, Siskiyou, Trinity, Shasta

Northwest: Humboldt, Del Norte

Our Mission, Vision, Focus

Mission

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

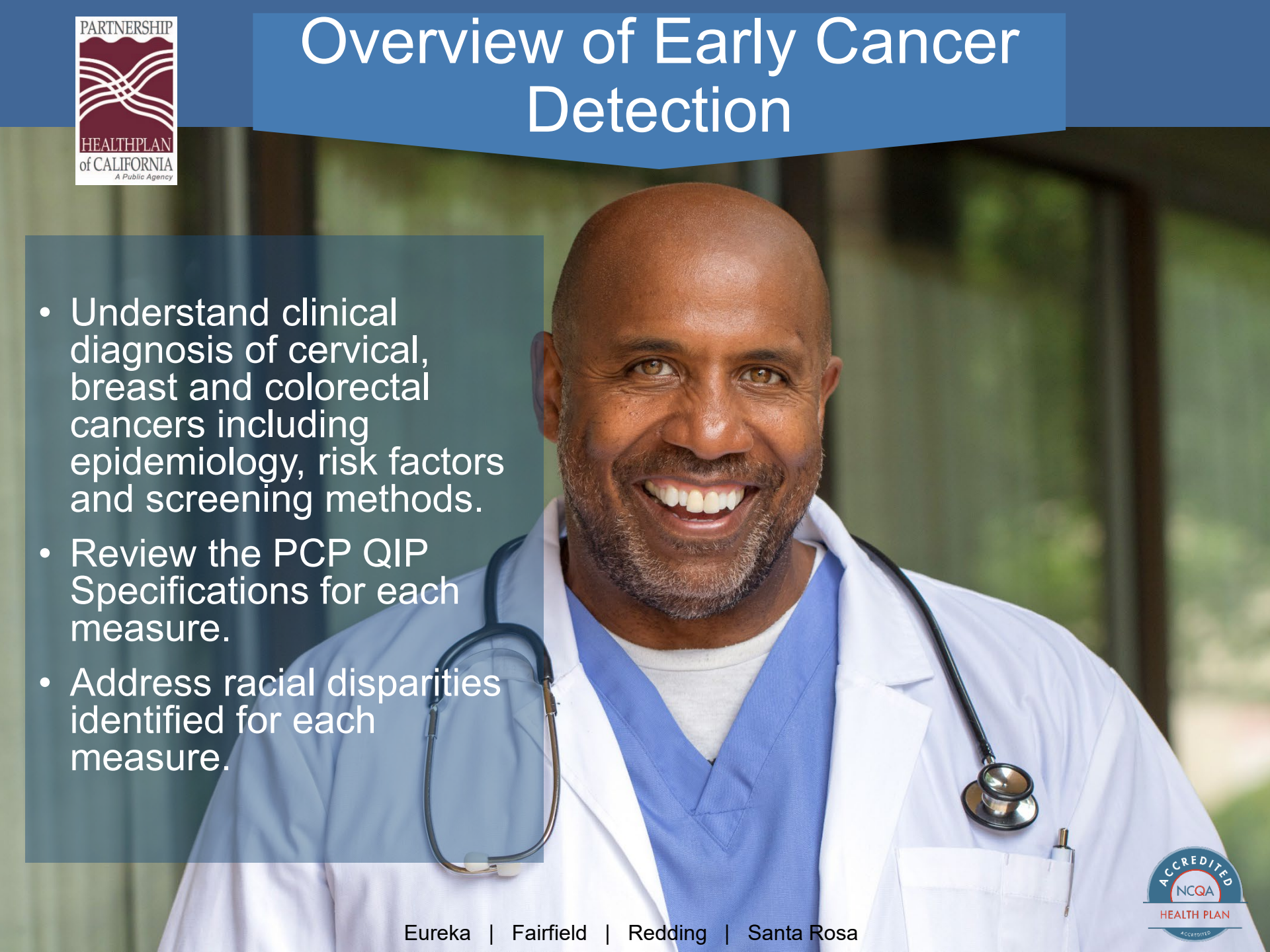
Vision

- To be the most highly regarded managed care plan in California

Focus

- Quality in everything we do
- Operational excellence
- Financial stewardship

Overview of Early Cancer Detection



- Understand clinical diagnosis of cervical, breast and colorectal cancers including epidemiology, risk factors and screening methods.
- Review the PCP QIP Specifications for each measure.
- Address racial disparities identified for each measure.

Cervical Cancer Screening

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Cervical Cancer Epidemiology

- Cervical cancer was one of the leading causes of cancer death for American women before the use of the Pap test (50% decrease since the mid-1970s).
- Since 2012, an 11% **decrease** in diagnosis is noted in women 21-24 years of age.
- Incidence is highest for Hispanic women (9.4 per 100,000 women, CA).
- Estimated death rate in 2023 is 4,310 (California)
  - The death rate is 65% higher for Black women than White women.
  - 20% of diagnoses occur in women over the age of 65. Usually these women do not have a history of regular cervical cancer screening.
- 5-year survival rate = 67% (US).

What Causes Cervical Cancer?

- Infection with human papilloma virus (HPV)
- 80% of women are exposed to HPV during their lifetime
- Most of the time, the immune system eliminates 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

- Lack of Immunization
- Early onset sexual activity
  - 2x greater risk for onset before age 18 compared to after 21
- 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 - uncertain

Cervical Cancer Screening

- Looking for precancerous cells, cancer cells, or high risk HPV
- Two tests:
  - Papanicolaou or “Pap” test (cytology testing)
  - High-risk human papillomavirus (hrHPV) testing
- Goal: Find changes in the earliest stages when treatment and cure are possible
- Current recommendation - begin screening at age 21

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 tests 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

PCP QIP Cervical Cancer Screening

Description:
Percentage of women 21- 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21- 64 years of age who had cervical cytology (Pap testing) performed within the last three years.
- Women 30 - 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.
- Women 30 - 64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last five years.

PCP QIP Cervical Cancer Screening

Denominator

The number of assigned women 24 - 64 years of age as of December 31 of the measurement year (DOB between January 1, 1959 and December 31, 1999).

Numerator

The number of assigned women in the eligible population who were appropriately screened according to evidence-based guidelines any time during the measurement year.

Note: Codes to Identify Cervical Cancer Screening and hrHPV Test can be found on the Diagnosis Crosswalk in eReports

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 2023 with last record of HPV testing and results in 2020 (at 29 years of age) = HPV testing does not satisfy the criteria.

Medical Record Documentations

- Documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed

- If the clinician is willing to attest and document permanently in the patient's chart a "complete," "total" or "radical" abdominal or vaginal hysterectomy date and the patient provides limited date information, please use the following for uploading the date into eReports:
  a. Year - (01/01/YYYY) or (12/31/YYYY)
  b. Month and Year - (MM/01/YYYY) or (MM/28,30 or 31/YYYY)

- If the clinician "diagnoses" the patient has no residual cervix, cervical agenesis or acquired absence of cervix, please upload into eReports:
- a. Date of diagnosis - (MM/DD/YYYY)
  b. Do not leave this blank

Cervical Cancer Screening Exclusions

- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (with the date) any time during the member's history through December 31 of the measurement year.
- Documentation of "complete," "total" or "radical" abdominal or "vaginal hysterectomy" (with the date) meets the criteria for hysterectomy with no residual cervix any time during the member's history through December 31 of the measurement year.
- Documentation of a "vaginal Pap smear" in conjunction with documentation of "hysterectomy" (with the date) any time during the member's history through December 31 of the measurement year.
- Documentation of hysterectomy in combination with documentation that the patient no longer needs Pap testing/cervical cancer screening (with the date) any time during the member's history through December 31 of the measurement year.
- Members receiving palliative care during the measurement year.

Cervical Cancer Screening Exclusions

Cervical Cancer Screening in Transgender Individuals:

- Transgender females (born males but currently with gender identity of female):
  - Use diagnosis of “congenital absence of cervix” (ICD10 = Q51.5) to exclude from denominator.

- Transgender males or gender non-conforming (born females but currently with gender identity of male):
  - Should be screened for cervical cancer if the cervix is still intact, but will not be part of the official denominator for this measure due to system constraints.

Cervical Cancer Screening ~ Rates by Region Partnership QIP Data 2022

KR

NE	NW	SE	SW
50.65	51.87	57.81	63.54

NW

Asian/Pacific Islander	50.52
Black	54.75
Chinese	63.16
Filipino	48.00
Hispanic	55.20
Laotian	56.32
Native American	40.32
Other	57.44
Unknown	47.19
White	53.13

NE

Asian Indian	48.98
Asian/Pacific Islander	55.31
Black	46.81
Chinese	52.94
Filipino	58.21
Hispanic	55.46
Laotian	56.40
Native American	40.86
Other	46.72
Unknown	43.46
Vietnamese	47.62
White	50.91

75th%	63.66
50th%	59.12
25th%	51.80
below 25th%	

SW

Asian Indian	55.48
Asian/Pacific Islander	61.50
Black	55.71
Cambodian	60.00
Chinese	50.79
Filipino	58.97
Hawaiian	61.91
Hispanic	74.84
Japanese	54.55
Korean	44.19
Laotian	64.71
Native American	45.31
Other	66.50
Unknown	57.33
Vietnamese	64.75
White	56.67

SE

Asian Indian	59.30
Asian/Pacific Islander	57.25
Black	53.56
Cambodian	60.00
Chinese	54.73
Filipino	47.93
Guamanian	24.00
Hawaiian	57.14
Hispanic	66.75
Japanese	45.16
Korean	50.00
Laotian	58.70
Native American	46.50
Other	54.15
Samoan	45.46
Unknown	58.27
Vietnamese	65.06
White	50.95

Eureka | Fairfield | Redding | Santa Rosa

Breast Cancer Screening

Breast Cancer Epidemiology

- Breast cancer is the **most commonly** diagnosed cancer among women in California regardless of race/ethnicity (ACS, 2023).
- 1 in 8 women (13%) will be diagnosed with breast cancer in their lifetime (National Statistic).
- Black women are more likely to die from breast cancer at any age than white women.
- At the time of diagnosis, approximately 64% of breast cancer patients have local-stage breast cancer, 27% have regional stage, and 6% have distant (metastatic) disease.
- Minority patients (Black, Hispanic, and American Indian/Alaska Native (AIAN)) are less likely to be diagnosed with local-stage disease (56%-60%) compared to white and A/PI patients (64%-66%).

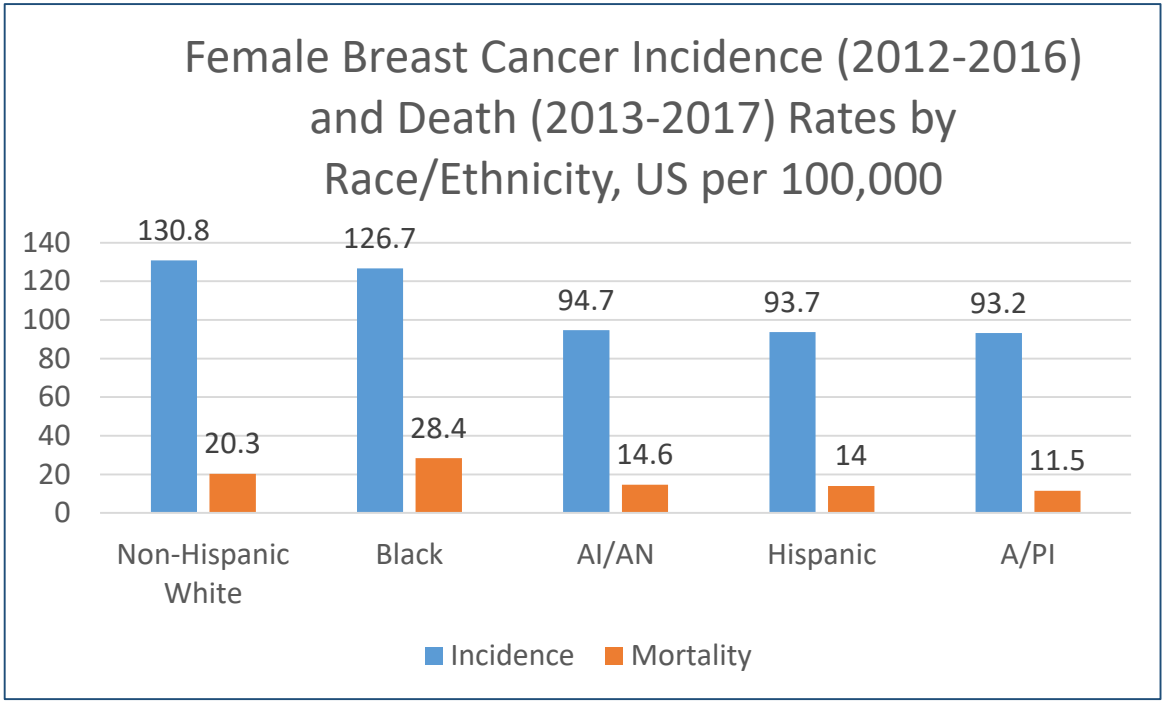
Breast Cancer Epidemiology

- **Second leading** cause of cancer deaths among women in California (2016-2020, ACS).
- Nationally, 1 in 39 women (3%) will die from breast cancer.

The overall breast cancer death rate has decreased 40% from 1975-2017.

Decreased mortality is due to:

- improvement in treatments
- earlier detection



Some Risk Factors for Breast Cancer

- Advanced age
- Race: White > Black
- Weight and body fat: pre- vs. post-menopause
- 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 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 (PHC PCP QIP)
  - Age 75+ - continue if healthy and life expectancy >10 years
- Frequency
  - No consensus
  - USPSTF - every 2 years

Role of Clinical and Self-Breast Exams

Clinical Breast Exams (CBE)

- Not recommended for average risk women
  - Lack of evidence CBE changes outcomes
- Important for patients with 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!

PCP QIP
Breast Cancer Screening

Description: The percentage of continuously enrolled Medi-Cal women 50 - 74 years of age who had a mammogram to screen for breast cancer.

Denominator: Number of continuously enrolled eligible population 52 - 74 years of age as of the end of the measurement year.

Numerator: The number of members from the eligible population in the denominator with one or more mammograms any time on or between October 1, 2021 and December 31, 2023.

PCP QIP Breast Cancer Documentation

Mammography is the only eligible imaging counted as satisfying the numerator

- All types and methods of mammograms (screening, diagnostic, film, digital, or digital tomosynthesis) qualify for numerator adherence
- Document last mammogram date and results.
- **Note**: Codes to identify Mammogram can be found on the Diagnosis Crosswalk in eReports.

Breast Cancer Screening Exclusions

- Members receiving palliative care during the measurement year.
- Bilateral mastectomy any time during the member's history through December 31, 2023.
- Mammography in Transgender Individuals: Transgender females (born males but currently with gender identity of female): use diagnosis of "congenital absence of breasts" (ICD10 = Q83.8) to exclude from denominator.
- Why not breast cancer?

**Transgender males or gender non-conforming who were born females but currently with gender identity of male should be screened for breast cancer, but they will not be part of the official denominator for this measure due to system constraints.*

Breast Cancer Screening ~ Rates by Region PHC QIP Data 2022

KR

NE	NW	SE	SW
46.75	42.01	56.43	55.98

NW

Asian/Pacific Islander	30.30
Black	40.63
Hispanic	57.41
Native American	27.95
Other	44.19
Unknown	42.01
White	42.03

NE

Asian/Pacific Islander	60.00
Black	47.37
Hispanic	60.66
Laotian	64.05
Native American	35.61
Other	41.38
Unknown	42.67
White	45.61

75th%	58.70
50th%	53.93
25th%	48.07
below 25th%	

SW

Asian Indian	47.46
Asian/Pacific Islander	47.96
Black	49.70
Cambodian	79.49
Chinese	44.86
Filipino	55.84
Hispanic	72.87
Native American	39.60
Other	54.40
Unknown	50.48
Vietnamese	61.27
White	49.49

SE

Asian Indian	58.47
Asian/Pacific Islander	56.29
Black	51.16
Chinese	58.33
Filipino	56.45
Hispanic	69.19
Native American	45.46
Other	50.53
Unknown	54.96
Vietnamese	55.73
White	46.33

Colorectal Cancer Screening

Colorectal Cancer Epidemiology

- Colorectal cancer is the fourth most common new cancer among men and women in California.
  - 15,026 new cases reported (2019, CDC)
- Alaska Natives have the highest incidence and mortality rates in the US; 80% higher than Blacks and more than double the rates of non-Hispanic whites.
- Blacks have the second highest incidence and mortality rates.
  - Their death rate is 40% higher than non-Hispanic whites, and 20% higher that A/PI.
- Approximately 52,550 people will die from colorectal cancers in 2023 (US).
- **Early detection** is key to preventing advanced disease!

Colorectal Cancer Screening Programs

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Factors to Include:

- Assessing Risk - Risk determines age to start, frequency and test to use.
- When to initiate screening - Based on risk.
- When to discontinue screening - Based on health status and projected longevity.
- Choosing a screening test - Based on risk.
- Follow-up of an abnormal test - Essential for all screening programs.

Assessing Risk

When to start identifying risk?

- Age 20 years and older at initial visit and every three to five years.
- Helps identify familial risk factors that may be revealed over time.
- No published guidelines.

Assessing risk: All "no" answers = average risk

- Have you ever had CRC or an adenomatous polyp?
- Have any family members had a polyp or CRC ~ if so at what age and are they 1st degree relatives (FDR)? If yes, what kind of polyp?
- Any family members with known genetic syndromes that cause CRC?
- Do you have inflammatory bowel disease? For how long?
- Did you ever receive abdominal radiation for childhood cancer?
- Are you African American?

Starting Screening

Average Risk adults

45-year-olds per USPSTF, AAFP

Higher than average risk: first degree relatives (FDR) with CRC or Advanced/Serrated Adenoma (documented pathology)

FDR diagnosed at <60 OR 2 + FDR any age: the earlier of: 40 OR 10 years prior to FDR dx

FDR >60 begin screening at 40

High-Risk Familial Colorectal Cancer Syndromes

Lynch Syndrome start at 20-25 years or two to five years prior to earliest CRC dx in family

Inflammatory Bowel Disease

Eight years after dx of IBD or proctitis

Cystic Fibrosis ~ if IBD present follow IBD recommendations

Renal Transplant ~ consider risk as that of individual at least 10 years older

When to STOP Screening

- Recommendation is 75 years of age
- 76 - 85 years - individualize decision based on patient preference, prior tests, comorbidities, life expectancy
- Shortened life expectancy of <5-10 years may not benefit from screening

Choosing a Screening Test

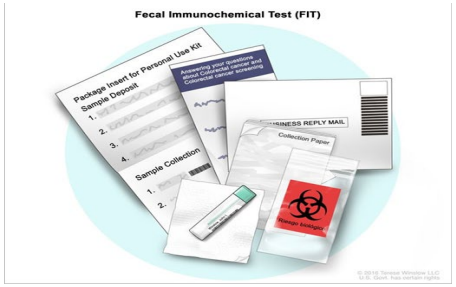
- **FIT Testing – annually***

  Annually once testing is initiated for **average risk** individuals

- **FOBT – annually***

- **FIT/DNA - every three years***

  Cologuard® every three years for **average risk**



- **Colonoscopy - every 10 years**

  For **average or above average** risk individuals

  Frequency is typically every 10 years in individuals with negative exam and no risk factors; more frequent follow up based on findings and risk

- **CT Colonography - every five years***
- **Flexible Sigmoidoscopy - every five years***

  *Positive findings require follow up with colonoscopy

PCP QIP Colorectal Cancer Screening

Description: Percentage of members 45 - 75 years of age who had appropriate screening for colorectal cancer.

Denominator: Number of continuously enrolled members 45 - 75 years of age by December 31 of the measurement year (MY).

Numerator: The number of assigned members 46–75 years of age who had one or more screenings for colorectal cancer according to clinical guidelines.

Note: Codes to identify the tests can be found on the Diagnosis Crosswalk in eReports

PCP QIP Colorectal Cancer Screening

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Numerator:

Percentage of members 46 - 75 years of age who had one or more screenings for colorectal cancer.

Any of the following meet the criteria:

- FOBT or FIT (during measurement year [MY])
- Flexible sigmoidoscopy (during MY or four years prior to MY)
- Colonoscopy (during MY or nine years prior to MY)
- CT Colonography (during MY or four years prior to MY)
- FIT-DNA test/ Cologuard® (during MY or two years prior to MY)

Note: Codes to identify the tests can be found on the Diagnosis Crosswalk in eReports

Medical Record Documentation

- Include a note indicating the date when the screening was performed, the type of screening, and result.

Note: Typically this information is included on health history forms; however, this information is not always provided as part of the record submissions.

Colorectal Cancer Screening Exclusions

- Excludes members with a history of colorectal cancer or total colectomy.
- This measure also excludes members receiving palliative care any time during the measurement year.

Note: Patients are not excluded if they had cancer of the small intestine

Colorectal Cancer Screening ~ Rates by Region
PHC QIP Data 2022

KR

	NE	NW	SE	SW
	37.86	35.30	41.19	41.38

NW

Asian/Pacific Islander	44.44
Black	29.73
Filipino	35.71
Hispanic	40.50
Laotian	39.29
Native American	24.36
Other	40.83
Unknown	35.91
White	35.30

NE

Asian Indian	46.51
Asian/Pacific Islander	53.33
Black	39.10
Chinese	47.22
Filipino	43.59
Hispanic	39.59
Laotian	51.72
Native American	25.53
Other	31.52
Unknown	33.52
Vietnamese	42.86
White	38.16

75th%	47.79
50th%	40.23
25th%	32.80
below 25th%	

SW

Asian Indian	41.54
Asian/Pacific Islander	50.24
Black	38.64
Cambodian	58.57
Chinese	38.27
Filipino	52.59
Hispanic	49.17
Japanese	31.43
Korean	38.24
Laotian	50.00
Native American	32.14
Other	37.23
Unknown	37.38
Vietnamese	46.90
White	39.29

SE

Asian Indian	45.79
Asian/Pacific Islander	39.58
Black	35.36
Chinese	52.83
Filipino	44.69
Hispanic	47.09
Korean	45.10
Laotian	58.33
Native American	30.10
Other	39.32
Unknown	39.17
Vietnamese	50.85
White	36.11

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Best and Promising Practices

- Best practice sharing from a high performing organization
- Promising practices to increase rates

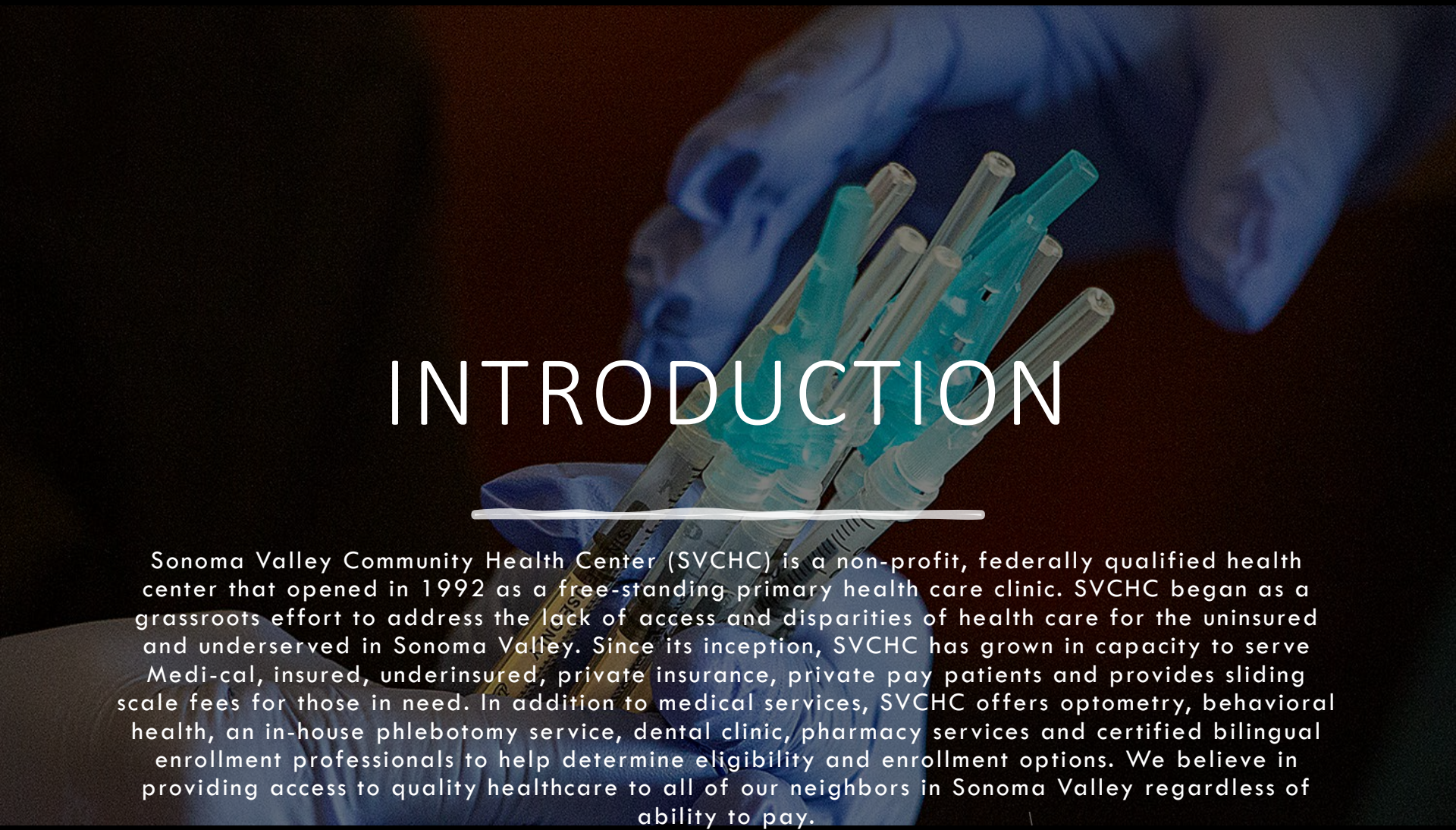
Voices from the Field

SONOMA • VALLEY
COMMUNITY
HEALTH CENTER

CANCER PREVENTION & SCREENING

ROADMAP

- Introduction – SVCHC
- Primary Goals:
- Screening
  - Breast Cancer
  - Cervical Cancer
  - Colorectal (Colon) Cancer
- Data
- Strategies
- Question & Answers



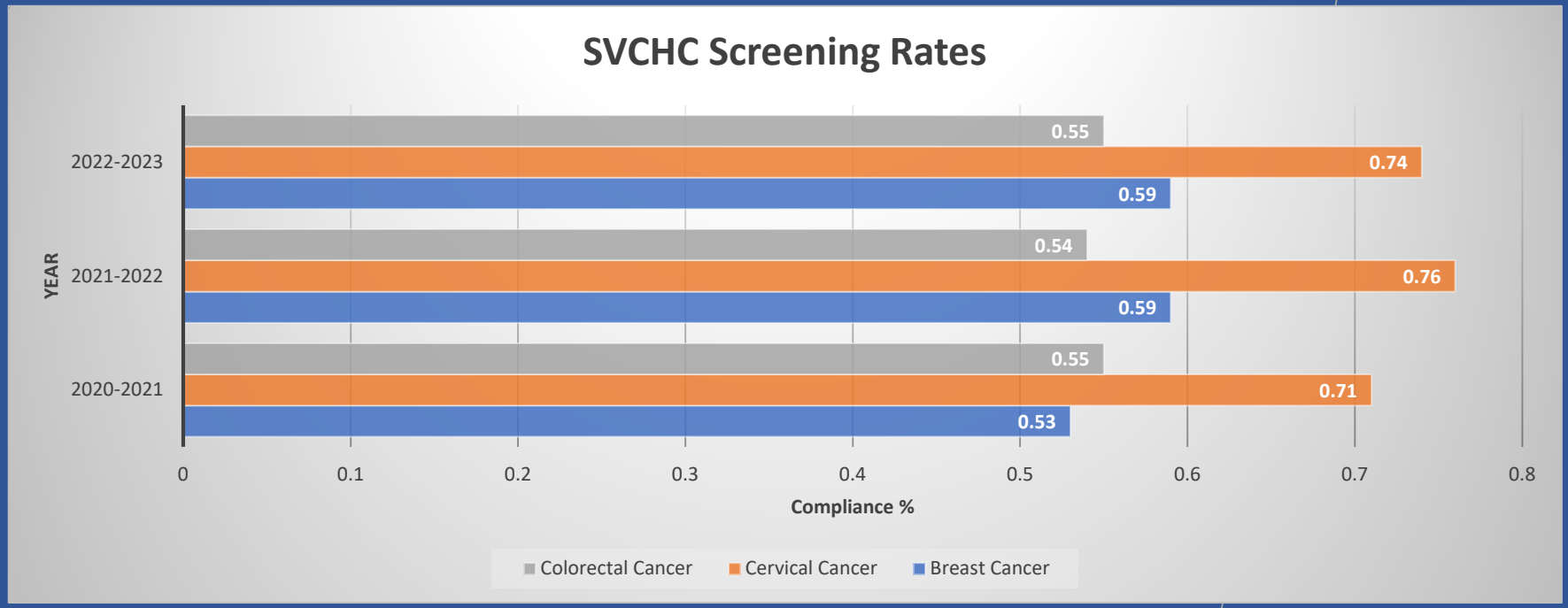
INTRODUCTION

Sonoma Valley Community Health Center (SVCHC) is a non-profit, federally qualified health center that opened in 1992 as a free-standing primary health care clinic. SVCHC began as a grassroots effort to address the lack of access and disparities of health care for the uninsured and underserved in Sonoma Valley. Since its inception, SVCHC has grown in capacity to serve Medi-cal, insured, underinsured, private insurance, private pay patients and provides sliding scale fees for those in need. In addition to medical services, SVCHC offers optometry, behavioral health, an in-house phlebotomy service, dental clinic, pharmacy services and certified bilingual enrollment professionals to help determine eligibility and enrollment options. We believe in providing access to quality healthcare to all of our neighbors in Sonoma Valley regardless of ability to pay.

Cancer Prevention & Screening, 2023


PRIMARY GOAL – Increase the number of preventative cancer screenings in an effort to reduce the number cancer diagnosis among the community.

SVCHC (UNIVERSE) DATA



HOW DID WE GET THERE (4-C'S)

- COMMITMENT FROM PROVIDERS
- COMMITMENT FROM ORGANIZATIONAL LEADERSHIP
- COMMITMENT FROM/WITH COMMUNITY PARTNERS
- COMMITMENT TO PROVIDING THE SERVICES (BOTH PREVENTATIVE & TREATMENT/CARE)

SPECIFIC TACTICAL AREA's

1

WOMEN'S HEALTH DAY

Focus: Breast Cancer Screening & Cervical Cancer Screening

Partners: PHC, Alinea, Sonoma Valley Hospital, SVCHC Clinical and Admin Teams

Frequency: 6 times a year

2

STANDING ORDERS

Focus: Colorectal Cancer Screening & Breast Cancer Screening

Partners: Sonoma Valley Hospital, SVCHC Clinical and Admin Teams

Frequency: Daily

3

INCENTIVES/GRANTS

Focus: Breast, Cervical and Colorectal Cancer Screenings

Partners: Sonoma Valley Hospital/

Foundation, Aliados Health, SVCHC Administration

Frequency: Grants are dependent; but incentives are given quarterly for a CRC drawing as well as lunch and gift bags for Women's Health Day.

FUTURE EXPANSION GOALS

- Small Media Campaigns throughout the year
- Use of direct messaging with patients providing education and awareness (Care Message)
- Push for colonoscopies
- Pilot project for the use of Cologuard

THANK YOU
QUESTIONS & ANSWERS

www.svchc.org

Best and Promising Practices

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Establish the Culture

- Cancer screening becomes standard practice:
  - hrHPV testing, with or without cytology, for members 30 - 64 years of age.
  - Encourage testing for Paps to create opportunities for patients and put them at ease: “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.”
  - Encourage colorectal screenings and give patients choices.
  - Distribution of Fit kits for all eligible patients.
  - Scheduling mammograms for patients using a time block system.

Best and Promising Practices

Visit Prep/During the Visit

- Conduct chart scrubbing prior to visits.
- Schedule cancer screening visits while the member/patient is waiting to be seen by the provider or before the member leaves the office.
- Fully stocked rooms w/ setup speculums/swabs to increase readiness.
- Use of standing orders for internal staff to implement and educate members/patients.

Best and Promising Practices

Communication

- Actively pursue missed appointments with letters and reminder calls.
- Conduct outreach efforts that rely on several communication/touch points. Combined with physician recommendations, these can have a significant cumulative effect.
- Cervical Cancer Screening: Be proactive - contact members before their 21st birthday to let them know its recommended to have regular CCS when they reach 21 years.
- Educate patients that cancer screenings are covered preventive services.
- Use a variety of educational media (by patient preference – electronic, written, etc.).
- Ensure information is person-centered.
- Collaborate with community agencies for outreach.

Best and Promising Practices

Increase Access

- Consider a variety of service options and choices - after hours and same day appointments, weekend women's cancer screening day(s), etc.
- Depending on location, consider mobile mammography services.
- Partner w/ PCP who does Paps.
- Breast Cancer Screening**:** Collaborate with the mammography imaging center/facility - meet with imaging managers to establish the referral process.
  - Coordinate to allow block scheduling at the mammography imaging center scheduling.

Best and Promising Practices

Uncovering Blind Spots - Health Equity Approach

- Consider looking at cancer screening completion rates by such factors as race, ethnicity, location (i.e., zip code), preferred/appropriate language and cultural beliefs.
- Identify and address barriers to care (transportation, hours of operation, child care access, housing/non-housing).
- Ensure member information is consistent, welcoming, plain and person-centered, language appropriate, and delivered in traditional and electronic applications, per patient's preference.
- Discussion with patients what may be keeping them from getting their cancer preventive screening. As people and their environments change, barriers may impact them differently over time.

Best and Promising Practices

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. Codes can be found on the Diagnosis Crosswalk in eReports.
- Exclude members as appropriate and use coding to reason for exclusion document (e.g., total abdominal or vaginal hysterectomy).
- Compare EHR or lab requisition forms with codes to ensure lab order is in alignment with measure.
- Utilize “flag” alerts in the EMR/EHR system for staff members to identify and communicate with patients/members who are due for their screening services at **every** member encounter.
- Use standardized templates in the EMR/EHR system to guide providers and staff through the visit.

Best and Promising Practices

- Report back to staff on your progress.
- Celebrate success - Schedule a standing meeting with your QI staff to review your progress.

- **Seize every opportunity:**

Establish a practice commitment to update and complete preventive cancer screening services!

Cologuard/Exact Sciences Pilot Project

- Exact Sciences does the initial patient contacts, distribution of kits, follow-ups, monitoring of test kit return, reminder calls and letters, and tracking of the returned product.

- Current results from the first pilot clinic:
  - 614 total orders
  - 567 kits shipped
  - 141 returned kits (not all returns had a valid result)
  - 71 valid results
  - 12.5% adherence rate (# valid results/ # kits shipped)
  - 24.9% return rate (# kits returned/# kits shipped)

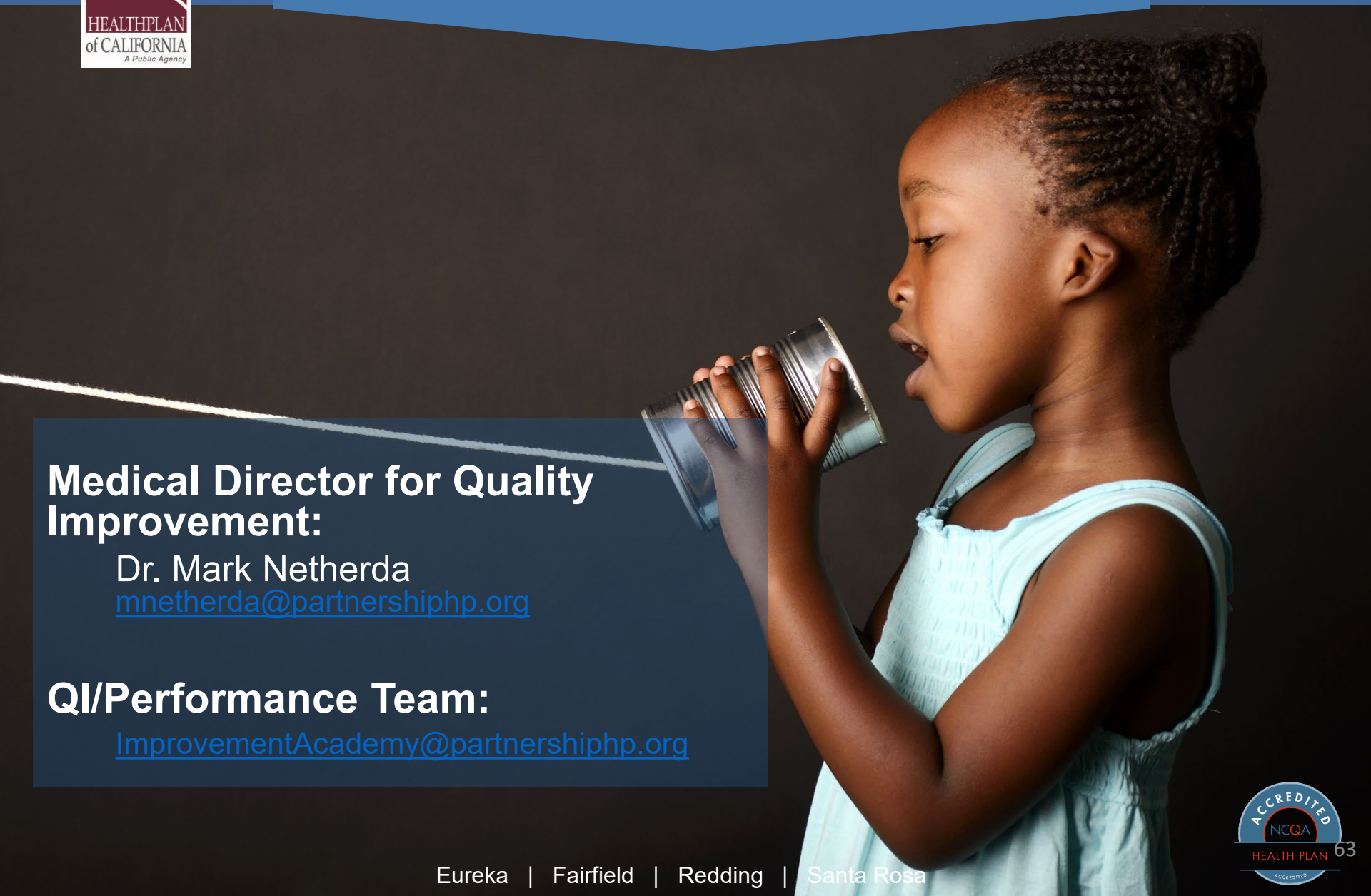
- Contact Tiffany Tryan (ttryan@partnershiphp.org) or Improvement Academy (improvementacademy@partnershiphp.org) for information.

Questions

Evaluation

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

Contact Us



Medical Director for Quality Improvement:

Dr. Mark Netherda
mnetherda@partnershiphp.org

QI/Performance Team:

ImprovementAcademy@partnershiphp.org

Resources

- Upcoming Trainings and Events
- Education Resources
- A Quick Guide to Starting QI Projects
- Summary of 2023 QIP
- Health Equity Resources

Mobile Mammography Sponsorship Opportunity

Looking to Increase Your Organization's Breast Cancer Screening Rates?

Partnership is offering a unique sponsorship opportunity by bringing Alinea Medical Imaging, the sole provider of mobile mammography services in Northern California, to your organization!

If your organization meets the following criteria, contact us to discuss sponsorship opportunities:

- Located in Partnership regions and counties below the 50th percentile benchmark
- Provider locations far below the 50th percentile benchmark
- Provider locations in imaging center "deserts"
  (Patients' travel to imaging center is unusually long or difficult.)
- Provider locations with lack of access at nearby imaging centers
  (More than one month to Third Next Available Appointment.)
- Provider locations with Partnership care gaps to support desired event
  (A full day event would require at least 60 - 90 Partnership members with mammogram care gaps. Providers can also consider partnering with nearby provider organizations in the Partnership network to meet the volume needed for a successful event. The majority of patients served at a Partnership-sponsored event should be Partnership members.)

For further information, contact: mobilemammography@partnershiphp.org

Eureka | Fairfield | Redding | Santa Rosa

Diabetes Management - HbA1C Good Control Self-Study Webinar

View this self-study webinar and complete an evaluation to receive CME/CE credit.

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

Topic: This learning session will cover Partnership HealthPlan of California's Primary Care Provider Quality Incentive Program measures.

Objectives:

- Provide an overview of clinical measure background, specifications, and performance threshold definitions for the 2023 PCP QIP *Comprehensive Diabetes Management - HbA1c Good Control* measure.
- Review documentation requirements to maximize adherence and measure performance for the *Comprehensive Diabetes Management – HbA1c Good Control.*
- Identify best and promising practices including access to care, successful clinical workflows, member and staff education, outreach, addressing social context which influence treatment decisions, referrals to local community resources, disproportionate prevalence and/or rates for diabetes complications, and technical tips to improve *Diabetes Management HbA1c Good Control* rates.

**The AAFP has reviewed Accelerated Learning: Diabetes Management – HbA1c Good Control – Enduring and deemed it acceptable for up to 1.00 Live AAFP Prescribed credits. Term of Approval is from 04/03/2023 to 04/03/2024. Physicians should claim only the credit commensurate with the extent of their participation in the activity. **Partnership HealthPlan of California (PHC) approved by the California Board of Registered Nursing. PHC Number CEP16728, for 1.00 contact hour(s).*

http://phcwebsite/Providers/Quality/Pages/Self-Study-Webinar-Diabetes-Management---HbA1C-Good-Control.aspx

Quality Improvement Trainings

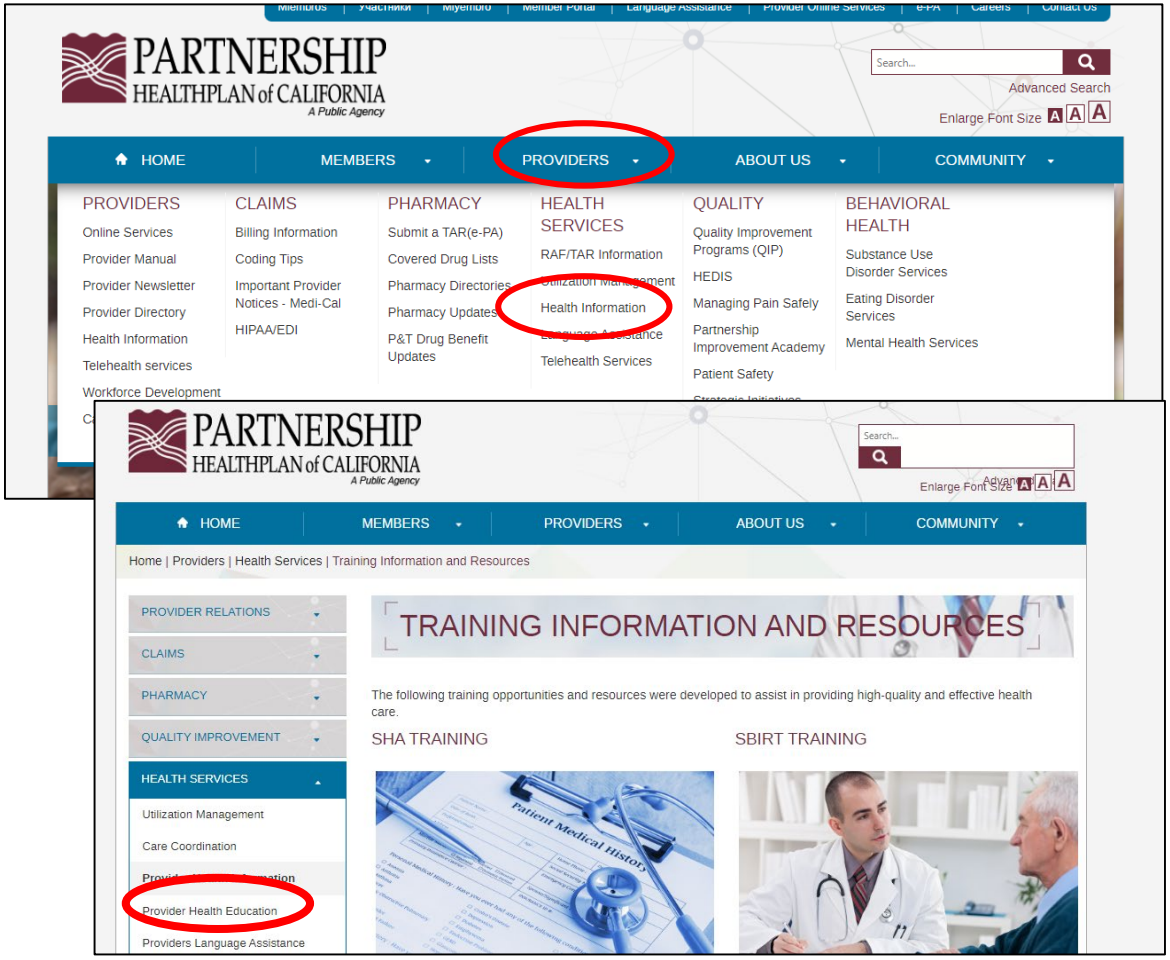
On-Demand Courses

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

- Accelerated Learning
- PCP QIP High Performers - How'd They Do That?
- Project Management 101
- Tools for Prioritizing Quality Measures
- Understanding the Benefits Delivery System

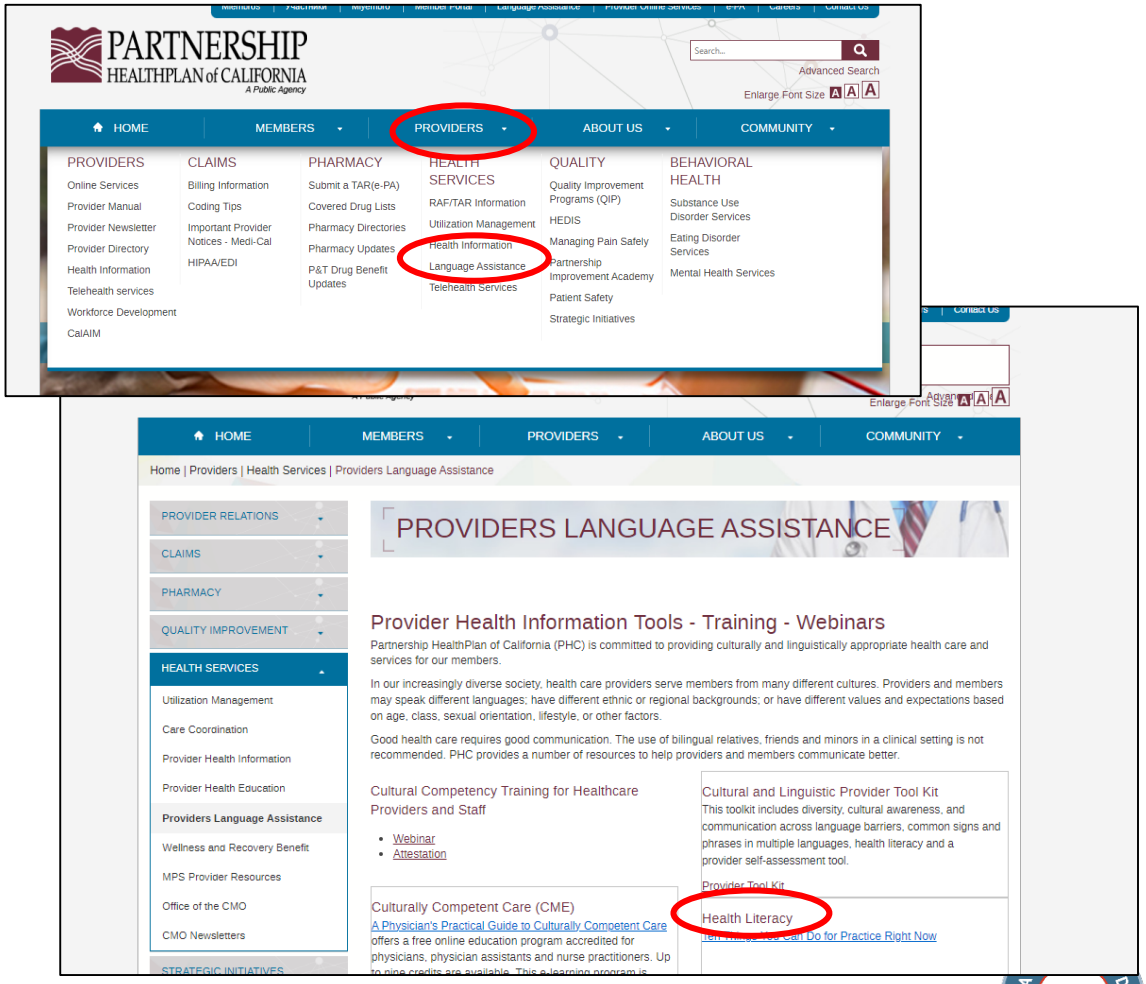
Health Education Resources

- Provider health education materials are accessible on PHC's website partnershiphp.org.



Provider Language Assistance

- Provider language assistance materials are also accessible on PHC's website, partnershiphp.org.



PHC Mammography Resources

- Patient materials on mammography screenings can be found on PHC's website:

http://www.partnershiphp.org/Members/Medi-Cal/Pages/Health%20Education/Routine-Mammogram-Screenings.aspx

ROUTINE MAMMOGRAM SCREENINGS

Routine Mammogram Screening Exams Are Important

Mammogram screening exams can find early signs of breast cancer. Breast cancer is a disease that makes cells in the breast grow out of control. The cancer cells can spread to other parts of the body. Screening mammogram exams and check-ups help find health issues before you know something is wrong. It is important that you continue preventive care.
Mammograms are a covered PHC benefit.

Mammogram Facts

A mammogram is an x-ray of your breast. It is the best way to detect breast cancer.

Breast cancer is the second most common cancer in women. The sooner you have a mammogram, the greater your chances are for finding cancer in its early stages.

When to get mammogram screening exams

- If you are between the ages of 50 and 75, you can get a mammogram every 2 years.

How to get a mammogram

- Talk to your health care provider about your risk for breast cancer and decide the best screening plan for you.
- Call a radiology or imaging center near you to make an appointment. You can find a radiology or imaging center in the PHC Provider Directory.

What to expect when getting a mammogram screening exam

- The American Cancer Society has a list of tips on what to expect during your screening, you can access the tips by clicking here.

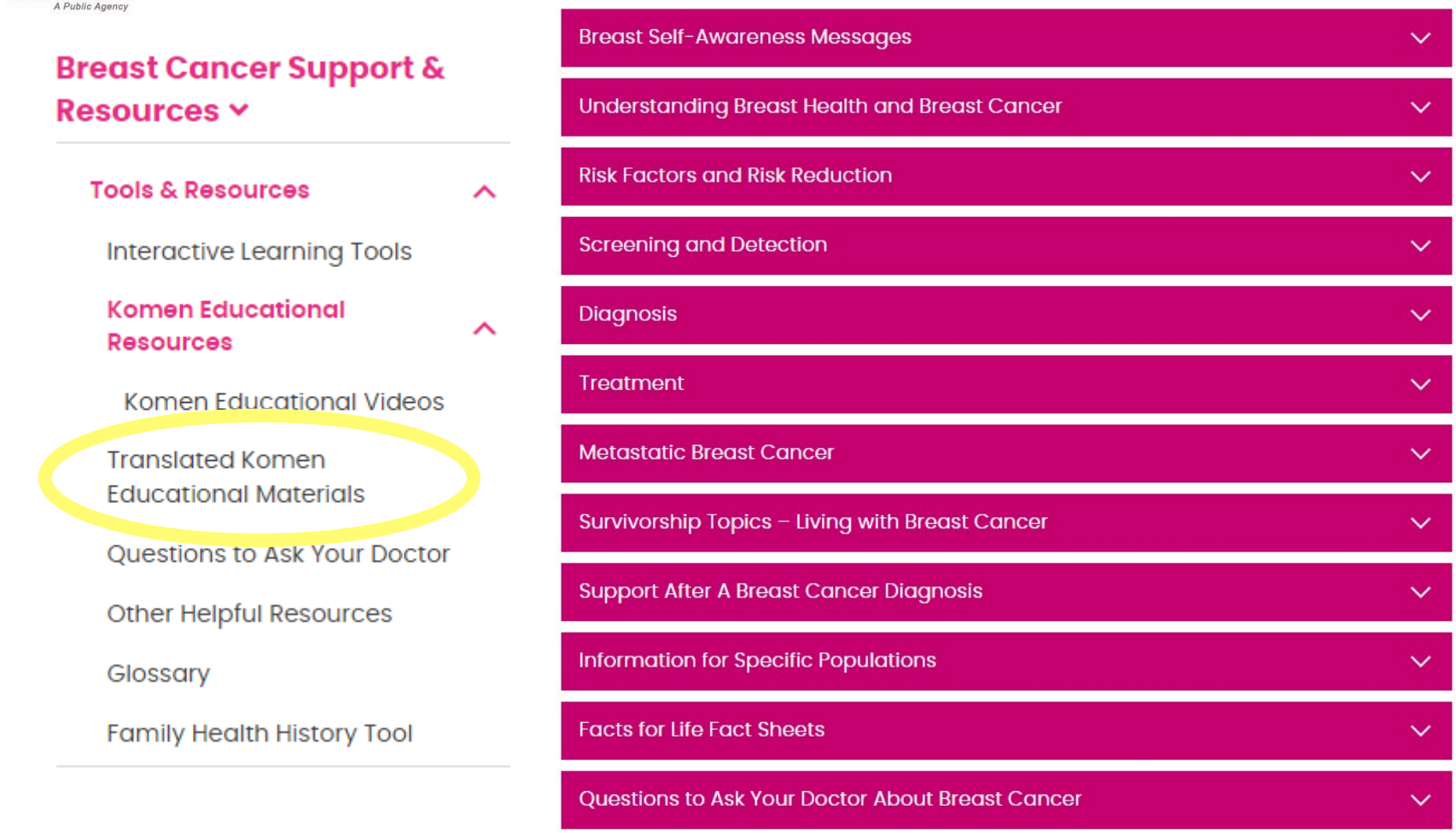
Mammogram Appointments

- Mammograms are not done during a normal health care provider office visit. You will need to make an appointment with a facility that provides mammograms like an imaging or radiology center.
- If you need transportation to the appointment, please call MTM at least 5 days before your appointment at **(888) 828-1254**. You can find more MTM information here.
- If you need an interpreter for American Sign Language or your preferred language, let the imaging center staff know when you make your appointment. You can also call PHC Member Services at **(800) 863-4155** or TTY/TDD users can call the California Relay Services at **(800) 735-2929** or **711**.
- If you have a disability that would make it hard for you to undress or stand during the exam, let the imaging center know when you make your appointment.
- Your health care provider's office may have new hours or safety guidelines in place for patient visits due to COVID-19. Check with the imaging center on how they plan to keep you safe during the visit.

Partnership Provider Cervical Cancer Screening Awareness Toolkit

- Multiple formats available: posters, infographics, social media images, online web ads, posters and more
- Available in multiple languages
- Available at http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Cervical-Cancer-Screening-Awareness.aspx

Susan G. Komen Educational Resources



https://www.komen.org/support-resources/tools/komen-education-materials/

Online Resources

Building HPV Vaccine Confidence: An Educational Toolkit online activity

Download this toolkit to access:

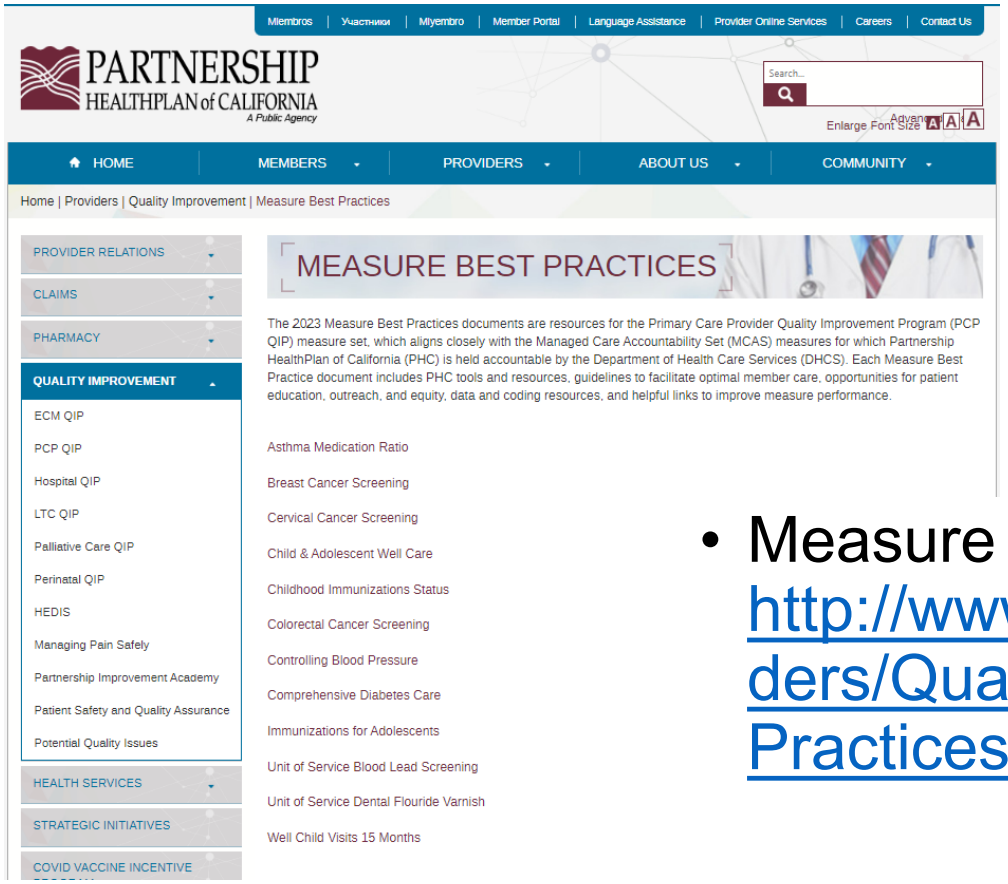
- Patient-friendly materials for sustainable patient education
- Guidance for implementing action plans to support HPV vaccination
- Access the accompanying video tutorial to hear evidence-based strategies for building vaccine knowledge and confidence among patients and their families.

QI Resources

A Quick Guide to Starting Your Quality Improvement Projects

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

Measure Best Practices 2023



- Measure Best Practices direct link: http://www.partnershiphp.org/Providers/Quality/Pages/Measure-Best-Practices.aspx

QI Resources

- **Quality Improvement Program email:** QIP@partnershiphp.org
- **2023 PCP QIP Webpage:** http://www.partnershiphp.org/Providers/Quality/Pages/PCP-QIP-2022.aspx
- **Measure Highlights:** http://www.partnershiphp.org/Providers/Quality/Pages/Quality-Measure-Highlights.aspx
- **QI Monthly Newsletters:** http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPMonthlyNewsletter.aspx

Partnership Resources

QI/Performance Team: ImprovementAcademy@partnershiphp.org

Quality Improvement Program: QIP@partnershiphp.org

2022 PCP QIP Webpage:
http://www.partnershiphp.org/Providers/Quality/Pages/PCP-QIP-2022.aspx

QI Monthly Newsletters:
http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

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

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

Resources

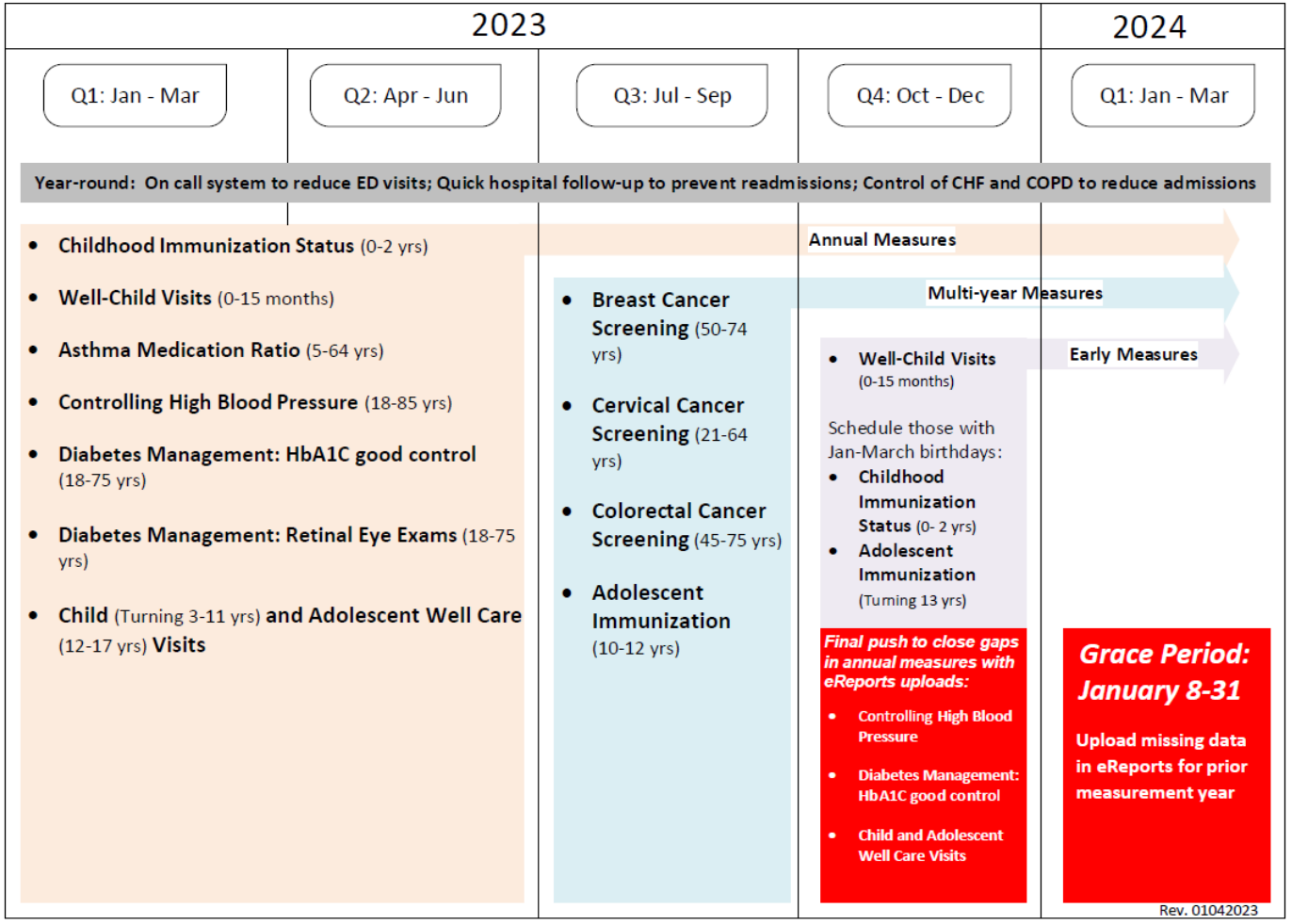
Northwest Regional Telehealth Resource Center, *Quick Start Guide to Telehealth During the Current Public Health Emergency March 2020*
https://nrtrc.org

California Primary Care Association
www.CPCA.org

Center for Care Innovations
https://www.careinnovations.org/wp-content/uploads/Sample-Remote-Visit-Workflow.pdf

Timeline for Addressing 2023 and 2024 PCP QIP Measures

Timeline for addressing 2023 and 2024 PCP QIP Measures



PCP QIP Cervical Cancer Screening

Cervical Cancer Screening

PCP QIP 2023	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Medicine	6 points	62.53%	75th
	Internal Medicine	12 points		
Partial Points	Family Medicine	4 points	57.64%	50th
	Internal Medicine	9 points		

Relative Improvement

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for IR points on the measure **AND**
- Have an RI score of 10% or higher, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.
  Please note: If a provider site was not eligible for payment for a specific measure in the previous measurement year, the site is not eligible for earning points through the relative improvement in the current measurement year.

PCP QIP Breast Cancer Screening

Breast Cancer Screening

PCP QIP 2023	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Medicine Internal Medicine	6 points 12 points	56.52%	75th
Partial Points	Family Medicine Internal Medicine	5 points 9 points	50.95%	50th

Relative Improvement

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for IR points on the measure **AND**
- Have an RI score of 10% or higher, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.
  Please note: If a provider site was not eligible for payment for a specific measure in the previous measurement year, the site is not eligible for earning points through the relative improvement in the current measurement year.

PCP QIP Colorectal Cancer Screening

Colorectal Cancer Screening

PCP QIP 2023	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Medicine	5 points	40.23%	50th
	Internal Medicine	12 points		
Partial Points	Family Medicine	4 points	32.80%	25th
	Internal Medicine	9 points		

Relative Improvement

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for IR points on the measure **AND**
- Have an RI score of 10% or higher, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.
  Please note: If a provider site was not eligible for payment for a specific measure in the previous measurement year, the site is not eligible for earning points through the relative improvement in the current measurement year.

2023 PCP QIP Targets

CLINICAL DOMAIN										
Practice Type			Measure	Measure Category	Age Range	Targets		Full / Partial Points		
Family	Internal	Peds				Full	Partial	Family	Internal	Peds
✓	✓	✓	Asthma Medication Ratio	CHRONIC DISEASE MANAGEMENT		69.67%	64.26%	6 / 4	8 / 6	13 / 10
✓	✓		Comprehensive Diabetes Care: HbA1c Control			64.48%	60.10%	6 / 4	11 / 8	–
✓	✓		Comprehensive Diabetes Care: Retinal Eye Exams			56.51%	51.06%	5 / 3	5 / 3	–
✓	✓		Controlling High Blood Pressure			65.10%	59.85%	6 / 4	10 / 8	–
✓		✓	Childhood Immunization Status: Combo 10	PREVENTATIVE SCREENING		42.09%	34.79%	6 / 5	–	16 / 12
✓		✓	Immunizations for Adolescents: Combo 2			41.12%	55.72%	6 / 5	–	16 / 12
✓	✓		Breast Cancer Screening			56.52%	50.95%	6 / 5	12 / 9	–
✓	✓		Cervical Cancer Screening			62.53%	57.64%	6 / 4	12 / 9	–
✓	✓		Colorectal Cancer Screening			40.23%	32.80%	5 / 4	12 / 9	–
✓		✓	Child and Adolescent Well Care Visits	UTILIZATION		57.44%	48.93%	9 / 7	–	16 / 12
✓		✓	Well-Child Visits in the First 15 Months of Life			61.19%	55.72%	9 / 7	–	16 / 12

Summary of 2023 QIP

Practice Type			NON-CLINICAL			Full / Partial Points		
Family	Interna	Peds				Family	Internal	Peds
Access and Operations								
✓	✓	✓	Avoidable ED Visits	Full Point Target TBD	Partial Point Target TBD	5 / 4	5 / 4	7 / 5
✓	✓	✓	PCP Office Visits	Greater than 1.8 visits PMPY on average	Between 1.5 and 1.8 visits PMPY on average	5 / 3	5 / 3	6 / 4
Appropriate Use of Resources								
✓	✓	✓	Ambulatory Care Sensitive Admissions	Full Point Target TBD	Partial Point Target TBD	5 / 4	5 / 4	–
✓	✓	✓	Risk Adjusted Readmission Rate	Full Point Target TBD	Partial Point Target TBD	5 / 4	5 / 4	–
Patient Experience								
✓	✓	✓	Patient Experience (CAHPS)	50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	25th Percentile (Access 37.86%) 25th Percentile (Communication 66.34%)	10 / 8	10 / 8	10 / 8
✓	✓	✓	Patient Experience (Survey)	Submits Parts 1 and 2	Submits Parts 1 or 2	–	–	–

Summary of 2023 QIP

UNIT OF SERVICE - ALL PRACTICE TYPES	
Measure	**Criteria**
Advance Care Planning	Minimum 1/1000th (0.001%) of the sites assigned monthly membership 18 years and older for: · $100 per Attestation, maximum payment $10,000. · $100 per Advance Directive/POLST, maximum payment $10,000
Extended Office Hours	Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification).
PCMH Certification	$1000 yearly for achieving or maintaining PCMH accreditation.
Peer-led Self-Management Support Groups	$1000 per group, either new or existing. (Maximum of 10 groups per parent organization).
Health Information Exchange	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. This incentive is available at the parent organization level.
Health Equity	$2000 per parent organization for submission of a report of their implementation of their Health Equity initiative.
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.
Dental Varnish	$1000 per parent organization for sucmission of proposed plan to implement fluoride varnish application in the medical office.
Tobacco Screening	$5.00 per tobacco use screening or counseling of members 11-21 years of age after 3% threshold of assigned members screened.
Electronic Clinical Data System (ECDS)	$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 prior year, they are also eligible for the $5000 incentive if they continue to submit an ECDS file for 2023 data monthly, starting no later than Jun of 2023.

2023 Core Measurement Set - Family Medicine

Core Measurement Set – Family Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (69.67%)	50th Percentile (64.26%)	6	4
Breast Cancer Screening	75th Percentile (56.52%)	50th Percentile (50.95%)	6	5
Cervical Cancer Screening	75th Percentile (62.53%)	50th Percentile (57.64%)	6	4
Child and Adolescent Well Care Visits	75th Percentile (57.44%)	50th Percentile (48.93%)	9	7
Childhood Immunization Status: Combo 10	75th Percentile (42.09%)	50th Percentile (34.79%)	6	5
Colorectal Cancer Screening	50th Percentile (40.23%)	25th Percentile (32.80%)	5	4
Comprehensive Diabetes Care: HbA1c Control	75th Percentile (64.48%)	50th Percentile (60.10%)	6	4
Comprehensive Diabetes Care - Retinal Eye Exams	75th Percentile (56.51%)	50th Percentile (51.09%)	5	3
Controlling High Blood Pressure	75th Percentile (65.10%)	50th Percentile (59.85%)	6	4
Immunizations for Adolescents – Combo 2	75th Percentile (41.12%)	50th Percentile (35.04%)	6	5
Well-Child Visits in the First 15 Months of Life	75th Percentile (61.19%)	50th Percentile (55.72%)	9	7
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES[2]				
Ambulatory Care Sensitive Admissions	TBD	TBD	5	4
Risk Adjusted Readmission Rate	TBD	TBD	5	4
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS				
Avoidable ED Visits	TBD	TBD	5	4
PCP Office Visits	Greater than 1.8 visits per member per year on average	Between 1.5 and 1.8 visits per member per year on average	5	3
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	25th Percentile (Access 37.86%) 25th Percentile (Communication 66.34%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

2023 Core Measurement Set - Internal Medicine

2023 Core Measurement Set – Internal Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (69.67%)	50th Percentile (64.26%)	8	6
Breast Cancer Screening	75th Percentile (56.52%)	50th Percentile (50.95%)	12	9
Cervical Cancer Screening	75th Percentile (62.53%)	50th Percentile (57.64%)	12	9
Colorectal Cancer Screening	50th Percentile (40.23%)	25th Percentile (32.80%)	12	9
Comprehensive Diabetes Care: HbA1c Control	75th Percentile (64.48%)	50th Percentile (60.10%)	11	8
Comprehensive Diabetes Care - Retinal Eye Exams	75th Percentile (56.51%)	50th Percentile (51.09%)	5	3
Controlling High Blood Pressure	75th Percentile (65.10%)	50th Percentile (59.85%)	10	8
NON-CLINICAL DOMAIN:APPROPRIATE USE OF RESOURCES				
Ambulatory Care Sensitive Admissions	TBD	TBD	5	4
Risk Adjusted Readmission Rate	TBD	TBD	5	4
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS				
Avoidable ED Visits	TBD	TBD	5	4
PCP Office Visits	Greater than 1.8 visits per member per year on average	Between 1.5 and 1.8 visits per member per year on average	5	3
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	25th Percentile (Access 37.86%) 25th Percentile (Communication 66.34%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

2023 Core Measurement Set - Pediatrics

2023 Core Measurement Set – Pediatrics

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (69.67%)	50th Percentile (64.26%)	13	10
Child and Adolescent Well Care Visits	75th Percentile (57.44%)	50th Percentile (48.93%)	16	12
Childhood Immunization Status: Combo 10	75th Percentile (42.09%)	50th Percentile (34.79%)	16	12
Immunizations for Adolescents – Combo 2	75th Percentile (41.12%)	50th Percentile (35.04%)	16	12
Well-Child Visits in the First 15 Months of Life	75th Percentile (61.19%)	50th Percentile (55.72%)	16	12
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [4]				
Avoidable ED Visits	60th Percentile (9.18)	70th Percentile (11.44)	7	5
PCP Office Visits	Greater than 1.5 visits per member per year on average	Greater than 1.5 visits per member per year on average	6	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	25th Percentile (Access 37.86%) 25th Percentile (Communication 68.34%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

Resources on Health and Racial Equity

- **California Improvement Network (CIN):** https://www.chcf.org
- **Toolkit to Advance Racial Health Equity in Primary Care Improvement** https://www.chcf.org/publication/toolkit-racial-equity-primary-care-improvement/
- **American Medical Association**: https://www.ama-assn.org/about/ama-center-health-equity AMA Center for Health Equity: The AMA Center for Health Equity works to embed health equity across the AMA organization so that health equity becomes part of the practice, process, action, innovation, and organizational performance and outcomes. Also jointly released with Association of American Medical Colleges, led by its Center for Health Justice, a new health equity guide to language, narrative, and concepts entitled, "Advancing Health Equity: A Guide to Language, Narrative, and Concepts."
- **Center for Health Care Strategies : https://www.chcs.org/**
- **Diversifying Medicaid's Leaders to Better Address Health Equity** - Highlights strategies for ensuring a robust pipeline of strong and diverse Medicaid leaders. See also a related **infographic**.
- **Words Matter: How Language Used in Health Care Settings Can Impact the Quality of Pediatric Care** -This webinar featured perspectives on the impact of language used during care and in medical records, and how provider interactions rooted in respect can support health and well-being. This is not exclusive to pediatric delivery.
- **Health Begins**: https://healthbegins.org
- Health Equity Strategies from the AHC Model: Working with Mathematica on behalf of the Centers for Medicare & Medicaid Services (CMS), Health Begins has this tip sheet provides a multi-level framework for understanding health equity, including actionable strategies related to social needs interventions that organizations such as health systems, payers, and community service providers can leverage to improve health equity.

Resources on Health and Racial Equity

- **Implicit Bias Association Test** https://implicit.harvard.edu/implicit/takeatest.html.
- Tool for showing bias and how our unconscious drives our day to day decision making. This tool was developed by a group of researchers from Harvard University and has proven validity. The test is free and results are kept confidential, but tagged for research purposes. Please refer to the disclaimer.

- **Diversity Science**: https://www.diversityscience.org/equal-perinatal-care/
- Developed an interactive training courses and resources for perinatal providers focused on implicit bias and reproductive justice. These resources are developed in accordance with the training requirements outlined in the California Dignity in Pregnancy and Childbirth Act (Senate Bill 464).

Contact Us

FM

Medical Director of Quality

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Improvement Advisor:

Kimberly Robertello (krobertello@partnershiphp.org)

QI/Performance Improvement Team:

ImprovementAcademy@partnershiphp.org

- **Quality Improvement Program:** QIP@partnershiphp.org