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Health Center Quality Measurement Systems

A Guide to Clinical Performance Measurement Sets



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Health Center Quality Measurement Systems

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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. UDS Quality Measure Profiles – explores the importance and impact of health measure 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).

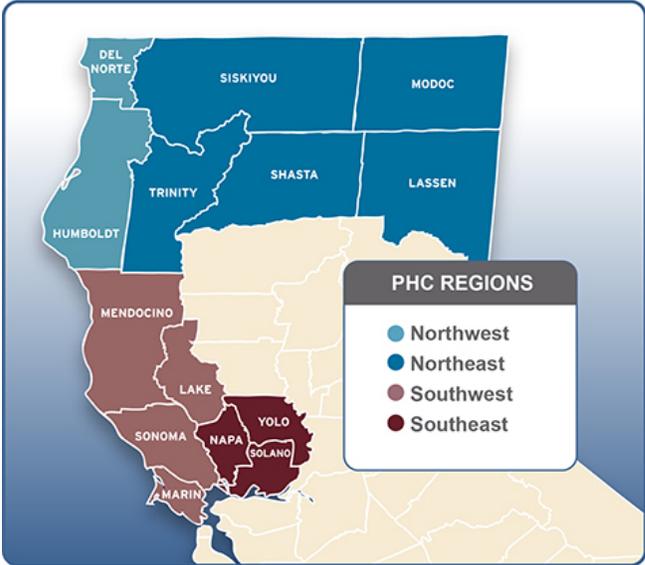


Figure 1. PHC HEDIS Regions

Data reported in the UDS 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.

Healthcare Effectiveness Data Information Set (HEDIS)

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 95 measures across 7 domains of care. The 7 Domains of Care are:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Relative Resource Use
- Health Plan Descriptive Information
- Measures Collected 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.

Given PHC’s goal to achieve NCQA accreditation, 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 will result in reporting on an expanded set of HEDIS measures.

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 both a medical record retrieval vendor and an abstraction vendor to ensure the project is executed within the mandated timeframe. PHC staff partner with each 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. To accommodate this change, PHC contracted with two retrieval vendors in 2018, one specific to remote access. Expanded efforts are planned to shift more record retrieval to EMR Remote access for qualified providers.

DUE each year: PHC is required to halt the annual project on May 9th 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 4 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 denominator for a county is less than 50, 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 so 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 chart
- The health plan's certified software draws a statistically significant sample of the eligible population, and 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. Some measures, such as Controlling Blood Pressure, are solely dependent on medical record evidence. Several other measures utilize a combination of both 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, which provider they saw most often during the measurement year, and if a measure includes services that a specialist provides, which specialist 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

Review of the Measures:

HEDIS Acronyms	Hybrid HEDIS Measures
CBP	Controlling High Blood Pressure
CCS	Cervical Cancer Screening
CIS-3	Childhood Immunization Status – Combo 3
CDC	Comprehensive Diabetes Care
IMA-2	Immunizations for Adolescents
PPC	Prenatal & Postpartum Care
WCC	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents
W-34	Well-Child Visits in the 3 rd , 4 th , 5 th , & 6 th Years of Life

HEDIS Acronyms	Admin HEDIS Measures
ACR	All-Cause Readmissions
AMB	Ambulatory Care
AMR	Asthma Medication Ratio
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
CAP	Children & Adolescents' Access to Primary Care Practitioners
LBP	Use of Imaging Studies for Low Back Pain
MPM	Annual Monitoring for Patients on Persistent Medications:
BCS	Breast Cancer Screening
LBP	Use of Imaging for Lower Back Pain

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. The MPLs for the current reporting year rates are based on the Medicaid national 25th percentiles, and the HPLs were based on the national Medicaid 90th percentiles. Therefore, 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/MMCDQualPerfMsrRpts.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 six 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.

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

Core 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 fixed 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.

Fixed Pool PMPM

- Clinical Measures
- Non-Clinical Measures
 - Appropriate Use of Resources
 - Access & Operations
 - Patient Experience

Unit of Service Measures

- Advanced Care Planning
- Extended Office Hours
- Patient-Centered Medical Home (PCMH) Recognition
- Screening, Brief Intervention, Referral, and Treatment (SBIRT)
- Health Information Exchange Participation
- Initial Health Assessment Improvement Plan
- Timely Data Submission via eReports

Provider eligibility criteria: All current primary care providers, including pediatric, family, and internal medicine sites, that have capitated PHC Medi-Cal only members and are contracted with PHC for at least six months during the measurement year are automatically enrolled in the QIP.

If the provider site is contracted for at least nine out of 12 months during the measurement year, it reports on all applicable measures. If a provider site is contracted for more than six but less than 11 months during the measurement year, it only reports on measures that rely on administrative data; Clinical and Patient Experience measures in the Core Measurement Set do not apply.

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 national averages for Medicaid Health Plans, reported in the year prior to the QIP measurement year. The thresholds used include the 50th, 75th, and 90th percentiles calculated from the previous year's HEDIS data. All new clinical measures are measured against the 50th percentile in their first year, with exception of colorectal cancer screening where a plan-wide target is used.

Providers can earn full points available per measure by meeting the threshold assigned. After a measure's first year in the clinical domain, it will be held against the 75th and 90th percentiles. If the 75th percentile is reached, half of the measures points available are awarded. If the 90th percentile is reached than full points are earned. Points can also be earned by a provider's relative improvement from the year before.

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

- 1) Sites must first meet the 25th percentile performance target, also known as the minimum performance level or MPL.
- 2) A minimum of 15% relative improvement.

Below is calculated by the following formula:

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

Total available relative improvement points: partial points

Payment Methodology: Based on individual sites' performance on Core Measurement set. A single per member per month (PMPM) dollar amount will be established and approved by the PHC Board of Commissioners. 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.

Here is the payment formula:

$$\text{QIP Score \%} * \text{Annual MMs} * \text{PMPM} = \text{Incentive}$$

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, 2018 and December 31, 2018. 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.

2018 Core Measurement Set Breakdown of Points:**Clinical Measures:**

Clinical Measures	Family	Internal	Pediatric	Tracked by
Monitoring Patients on Persistent Medications (MPM)	10	10	n/a	eReports
Cervical Cancer Screening (CCS)	10	10	n/a	eReports
Colorectal Cancer Screening, 51-75 years (COL)	5	5	n/a	eReports
Diabetes - Retinal Eye Exam (CDC – Eye)	5	5	n/a	eReports
Diabetes – HbA1C Control (CDC – A1c)	5	10	n/a	eReports
Diabetes – Nephropathy (CDC – Neph)	5	10	n/a	eReports
Breast Cancer Screening (BCS)	5	5	n/a	eReports
Childhood Immunization Status, Combo 3 (CIS-3)	5	n/a	15	eReports
Well Child Visits, 3-6 years (W34)	5	n/a	15	eReports
Immunizations for Adolescents (IMA)	5	n/a	15	eReports
Asthma Medication Ratio (AMR)	n/a	n/a	15	eReports
Nutrition Counseling, 3-17 years	n/a	n/a	10	eReports
Physical Activity Counseling, 3-17 years	n/a	n/a	10	eReports
Total Points:	65	65	80	

Non-Clinical Measures:

Appropriate Use of Resources	Family	Internal	Pediatric	Tracked by
Admissions/1000	7.5	7.5	n/a	PHC
Readmission Rate	7.5	7.5	n/a	PHC
Total Points:	15	15	0	
Access and Operations	Family	Internal	Pediatric	Tracked by
Primary Care Utilization	10	10	10	PHC
Total Points:	10	10	10	
Patient Experience	Family	Internal	Pediatric	Tracked by
CAHPS Survey <i>or</i> Survey Option	10	10	10	NA/Provider
Total Points:	10	10	10	

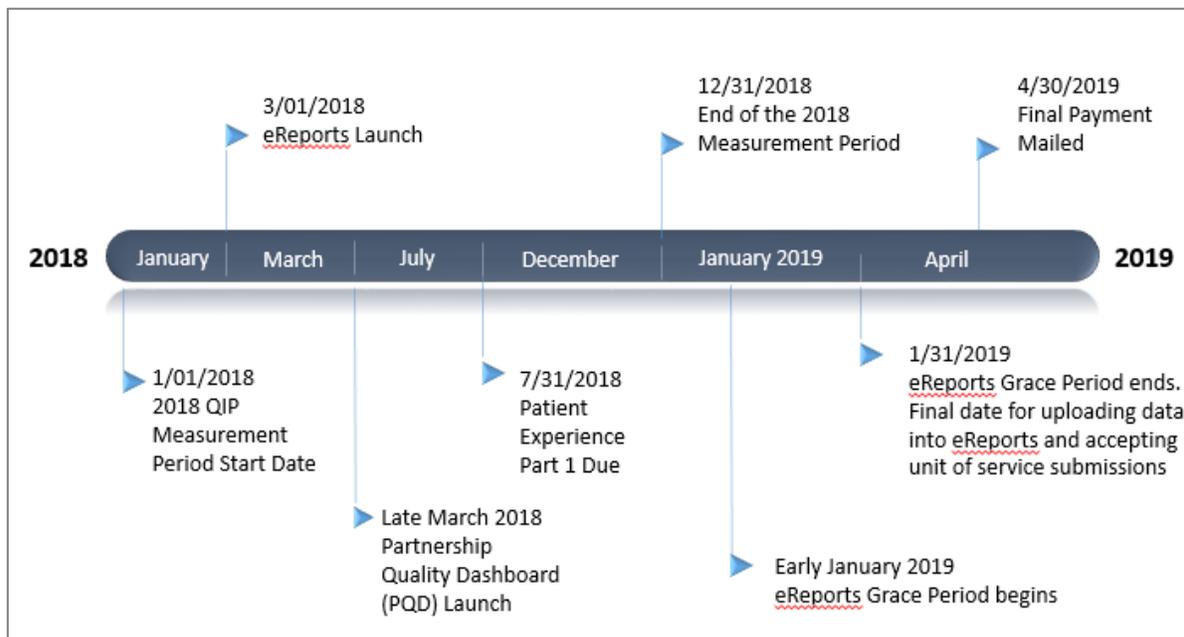
Unit of Service (Optional): Providers receive payment for each unit of service they provide.

2018 Unit of Service breakdown of measures:

Measures	Incentive Amount	Tracked By	System for Monitoring	System for Submission
Advance Care Planning	\$5,000 for 50-99 Attestations \$10,000 for 100+ Attestations And \$5,000 for 50-99 Advance Directive or POLST \$10,000 for 100+ Advance Directive or POLST	PHC QIP Team	Summary & Quarterly Checks	Submission Template
PCMH Certification	\$1,000 yearly for maintaining certification	PHC QIP Team	Year-end Reports	Submission Template
Peer-Led Self Mgmt. Support Groups	\$1,000 Per Group per Year Maximum of five groups per site	PHC QIP Team	Year-end Reports	Submission Template
Timely Data Submission via eReports	1% of site's potential earning pool or \$1000 whichever is higher	PHC QIP Team	Year-end Reports	eReports
Access/Extended Office Hours	Equivalent Payment of 10% Capitation Must meet: 1) Earned at least 35% in previous measurement year 2) Open for extended office hours <8 hours beyond business hours	PHC QIP Team	Year-end Reports	Provider Relations Dept.
Initial Health Assessment	\$2,000 for submitting all required parts of improvement plan	PHC QIP Team	Year-end Reports	Submission Template
SBIRT	\$5 Per Screening	PHC QIP Team	Year-end Reports	Claims
Health Information Exchange	1x \$2500 incentive for signing on with a local or regional HIE	PHC QIP Team	Year-end Reports	Submission Template

Program Timeline:

The figure below displays the current PCP QIP program cycle.

**Resources:****QIP Website:**

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

QIP Inbox: 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 provider sites are reviewed as a condition of participation in our provider network. Other contracted provider sites, like OB/GYN providers will also have an Initial Site Review conducted. 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:

Exempted Pass:	Conditional Pass:	Not Pass:
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.

A corrective action plan (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 business days of the review. A corrective action plan for

deficiencies on non-critical element criteria is due to the Health Plan within 45 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. 2. Airway management: oxygen delivery system, oral airways, nasal cannula or mask, Ambu bag.
Personnel	3. Only qualified/trained personnel retrieve, prepare or administer medications.
Office Management	4. Physician review and follow-up of referral/consultation reports and diagnostic test results.
Pharmaceutical Services	5. Only lawfully authorized persons dispense drugs to patients.
Infection Control	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) 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. Only the score of the review is submitted to DHCS.

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)

Benchmarks:

Exempted Pass 90% or above: (Total score is ≥ 90% and all section scores are 80% or above)	Conditional Pass 80-89%: (Total MRR is 80-89% OR any section(s) score is < 80%)	Not Pass: 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 45 calendar days.

Typically, a medical record review can take up to 4 hours for 10 records. The number of physicians working at the site determines the number of records to be reviewed which ranges from 10-30 records. Your site can operate as usual during the review. A staff person may be needed to help acquaint the reviewer with the electronic health record layout (only a few minutes) if applicable.

The records are assessed for compliance in the areas listed above: Format, Documentation, etc. All of the areas are assessed for each record as applicable based on the age of the member.

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. Due to barriers, individuals with disabilities are less likely to get routine preventative medical care than people without disabilities.

Our provider directories are updated with the areas met by each site. The reviewer will evaluate accessibility related to the following indicators:

• P = Parking	• EB = Exterior Building	• R = Restroom
• IB = Interior Building	• E = Exam Room	• T = 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.

* The assessment is for informational purposes only.

Reporting Period: Every three years.

DUE each year on January 31st and July 31st PHC must submit the results of our Facility Site Reviews to DHCS.

Uniform Data System (UDS)

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 released around February 1st and explains changes for the upcoming year. The UDS Manual is generally released between September – December of the reporting year.

DUE each year on February 15 (The report is examined by a HRSA reviewer and they submit possible problems with your report based on trend data or inconsistencies. The health center must respond to the reviewer's summary and the UDS report must be finalized by March 31)

Definitions:

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

- Documented,
- Face-to-face contact between a patient and a
- Licensed or otherwise credentialed provider, who
- Exercises independent, professional judgment in the provision of services to the 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.

Sample Size:

- Scientifically drawn random *sample of 70* patients selected from all patients who fit the criteria, *-or-*
- A number equal to or greater than 80% of all patients who fit the criteria

A review of a sample of charts must be used in lieu of full universe reporting from an EHR if:

- The EHR does *not include* a minimum of 80% of health center patients who meets the criteria described below for inclusion in the specific measure's universe.
- The EHR does *not exclude* every single health center patient who meets one or more exclusion criteria from the universe (e.g. EHR report cannot distinguish between medical and dental-only patients for childhood immunization measure or for a chart review, a dental-only patient can be excluded from the sample for the childhood immunization measure).
- The look-back period data necessary for many of the UDS clinical quality measures has not been in place in the EHR long enough to be able to find the data required in prior year's activities or this documented data was not collected from the patient as part of the visit.
- The required data were not collected from the patient as part of the visit.

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 5A: Tenure for Health Center Staff
- Table 6A: Select Diagnoses and Services Rendered – Universal
- **Table 6B: Quality of Care Measures**

Measure	2017	2018 (Proposed)
➤ Section A: Age Categories for Prenatal Patients	Manual	HRSA PAL
➤ Section B: Trimester of Entry into Prenatal Care	Manual	HRSA PAL
➤ Section C: Childhood Immunization Status	CMS117v5	CMS117v6
➤ Section D: Cervical Cancer Screening	CMS124v5	CMS124v6
➤ Section E: Weight assessment and counseling for children and adolescents	CMS155v5	CMS155v6
➤ Section F: Adult weight screening and follow-up	CMS69v5	CMS69v6
➤ Section G: Tobacco Use Screening and Cessation Intervention	CMS138v5	CMS138v6
➤ Section H: Use of Appropriate Medications for Asthma	CMS126v5	CMS126v5
➤ Section I: Coronary Artery Disease (CAD): Lipid Therapy	Manual	HRSA PAL
➤ Section J: Ischemic vascular disease: Use of Aspirin or Another Antithrombotic	CMS164v5	CMS164v6
➤ Section K: Colorectal Cancer Screening	CMS130v5	CMS130v6
➤ Section L: HIV Linkage to Care – F/U within 90 days of diagnoses	Manual	HRSA PAL
➤ Section M: Depression Screening and Follow-up	CMS2v6	CMS2v7
➤ Section N: Dental Sealants for children	CMS277	CMS277

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

➤ Section A: Deliveries and Births By Weight/Ounces	No eCQM	HRSA PAL
➤ Section B: Controlling High Blood Pressure – Hypertension (<140/90)	CMS165v5	CMS165v6
➤ Section C: Diabetes: Hemoglobin A1c Poor Control (<8%, >9%/No Test)	CMS122v5	CMS122v6

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

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

Chapter 2: UDS 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 UDS clinical measure. The datasets include health center performance reported on 2015 Uniform Data System (UDS) reports. The datasets included in this section of the toolkit include the following:

Primary Prevention

- Cervical Cancer Screening
- Colorectal Cancer Screening
- Prenatal and Postpartum Care

Immunizations

- Childhood Immunizations
- Immunizations for Adolescents

Tertiary Prevention

- Controlling Diabetes
- Controlling High Blood Pressure
- Tobacco Screening and Cessation
- Monitoring for Patients on Persistent Medications
- Adult Weight Assessment and Counseling
- Use of Appropriate Medications for Asthma

Well Child

- Well Child Visits Age 3-6
- 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 incidence¹ and mortality² 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 a routine/consistent source of health care.
- Women who are uninsured or have no routine/consistent source of care are less likely to be up-to-date on their cervical cancer screening³.
- Routine cervical cancer screening with the Pap test can identify precancerous lesions or cancer in the early stages when treatment is most effective.
- Between 60% and 80% of women with advanced cervical cancer have not had a Pap test in the past five years⁴.
- HPV causes almost all cases of cervical cancers⁵. Encouragingly, within just 6 years of vaccine introduction in 2006, there was a 64% decrease in vaccine type HPV prevalence among females aged 14 to 19 years and a 34% decrease among those aged 20 to 24 years⁶.

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 adolescent girls and young adults with the HPV vaccine to reduce their risk of developing cervical cancer.
- Access the Partnership HealthPlan of California [Cervical Cancer Screening Driver Diagram online](#).
- Run community-sponsored media campaign to highlight the importance of cervical cancer screening and educate women on the current clinical guidelines.

¹ Benard, V. B., Coughlin, S. S., Thompson, T., & Richardson, L. C. (2007). Cervical cancer incidence in the United States by area of residence, 1998-2001. *Obstet Gynecol*, 110(3), 681-686.

² Singh GK. (2012). Rural-Urban Trends and Patterns in Cervical Cancer Mortality, Incidence, Stage, and Survival in the United States, 1950-2008. *J Community Health*, 37(1), 217-223.

³ Klabunde, PhD, Carrie N. et. al. (2012). *CDC Morbidity and Mortality Weekly Report (MMWR)*, vol.61; no.3 January 27, 2012.

⁴ American Cancer Society (2011). *Cancer Prevention & Early Detection Facts & Figures 2011*. [Accessed online](#).

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

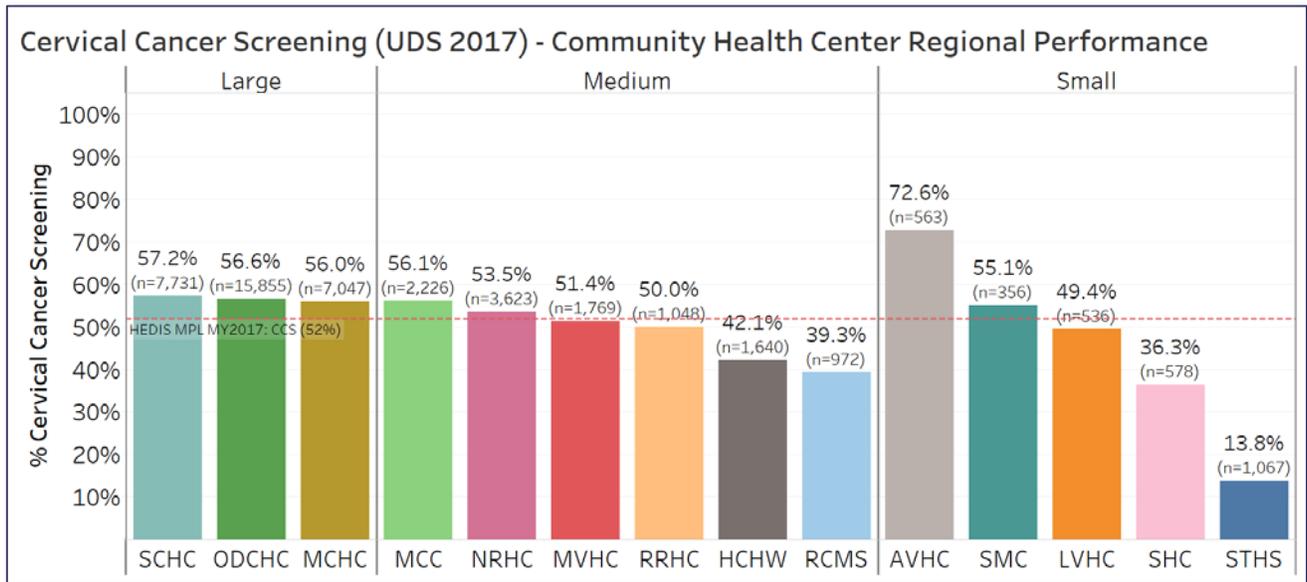
⁶ Markowitz LE, Liu G, Hariri S, et al. (2016). Prevalence of HPV After Introduction of the Vaccination Program in the United States. *Pediatrics*. 2016;137(2):e20151968.

Cervical Cancer Screening

Rural Northern California Health Center Data

Key Points

- Clinical screening guidelines have lengthened the interval between screenings. Because of this, women may not remember 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.
- Some women with a hysterectomy no longer require regular Pap tests. Medical records must be updated to reflect medical history.



Quality Measure Definitions (UDS)

Percentage of women 23–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 23-64 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

National Quality Goals and Benchmarks

HEDIS 25th (MPL) for Measurement Year 2017: HEDIS is a national data set that measures the performance of health plans on quality of care. The Minimum Performance Level (MPL), or 25th percentile, for Cervical Cancer Screening is 51.82%.

Colorectal Cancer Screening

Impact of Colorectal Cancer in Rural Northern California

- Colorectal cancer is currently the second leading cause of cancer death in the United States⁷.
- In rural Northern California, the age-adjusted death rate from colorectal cancer ranges from a high in Butte County of 15.7 per 100,000 to a low of 8.5 per 100,000 in Trinity County. The overall death rate in the state is 12.8 per 100,000⁸.
- 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.
- Low-income adults are less likely to receive colorectal cancer screenings. Less than half (44.7%) of low-income adults in rural Northern California are up-to-date with colorectal cancer screening⁹.
- 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 households¹⁰.

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 colorectal cancer screening. This is particularly effective with fecal occult blood testing paired with patient incentives.
- 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.

Community Interventions

- Share patient handouts, brochures, or videos at community health fairs and senior centers to increase awareness in adults of colorectal screening and how to access screening services.
- Teach 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 community farmers markets and encourage healthy diets including vegetables and other high fiber foods.

⁷ CDC. Colorectal Cancer Statistics. March 2018.

⁸ California Department of Public Health. County Health Status Profiles, 2018.

⁹ California Health Interview Survey. CHIS Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research, June 2018.

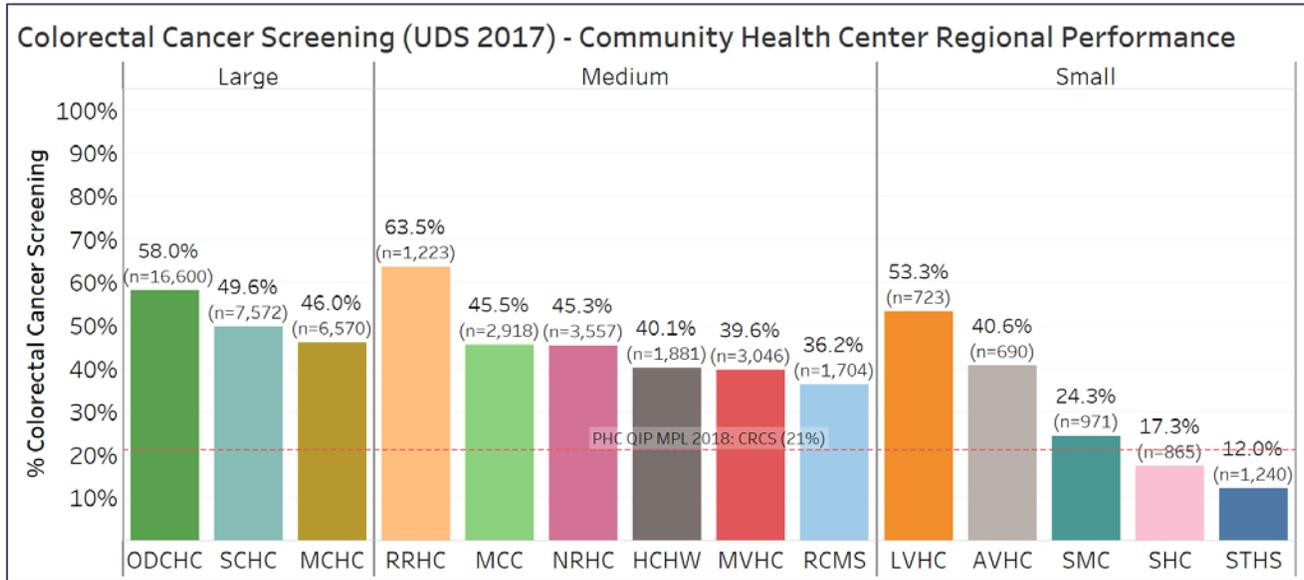
¹⁰ Edelman MA, Menz BL. Selected comparisons and implications of a national rural and urban survey on health care access, demographics and policy issues. J Rural Health 1996;12:197-205.

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.
- While Fecal Immunochemical Tests (FIT) 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:

- (1) Colonoscopy within the past 10 years;
- (2) Flexible sigmoidoscopy within the past 5 years, or
- (3) Fecal immunochemical test (FIT/iFOBT) within the past year.

National Quality Goals and Benchmarks

PHC 2018 Quality Improvement Program (QIP) MPL: This measure is included in the PHC 2018 Quality Improvement Program measurement set. The Minimum Performance Level (MPL), or 25th percentile, for Colorectal Cancer Screening is 21.0%.

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 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.^{11,12}
- Women who do not receive prenatal care are at almost three times the risk of having a low-birthweight infant. This puts infants at increased risk for poorer health outcomes.
- 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 state¹³.

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 Growing Together Perinatal Program (GTPP), 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.

¹¹ Egerter S, Braveman P, Marchi K. (2002). Timing of Insurance Coverage and Use of Prenatal Care among Low-Income Women. *Am J Public Health*. 2002 March; 92(3): 423-427.

¹² Braveman P et al., Barriers to timely prenatal care among women with insurance: the importance of prepregnancy factors, *Obstetrics & Gynecology*, 2000, 95(6):874-880.

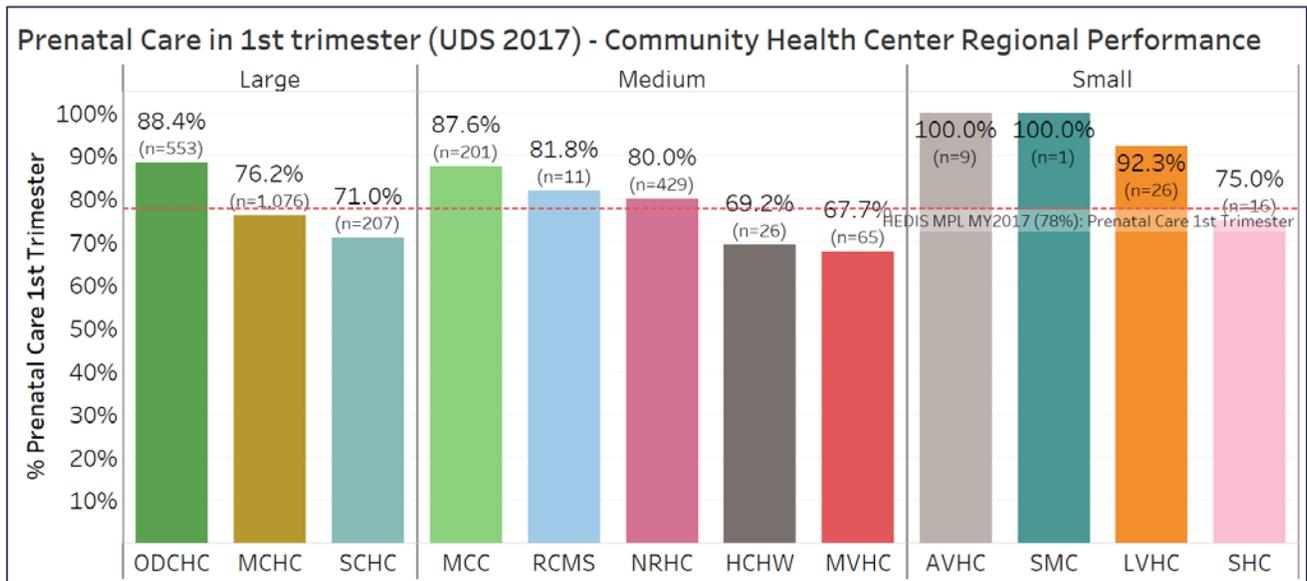
¹³ Ibid.

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.
- Health centers in rural Northern California provide prenatal care to a relatively small population of women. Even one patient entering care late can have a significant impact on these results.



Quality Measure Definitions

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.¹⁴
- Maternal hospital stays with pregnancy and delivery-related complicating conditions account for \$17.4 billion in hospital costs in the U.S.¹⁵

National Quality Goals and Benchmarks

HEDIS 25th (MPL) for Measurement Year 2017: HEDIS is a national data set, which measures the performance of health plans on quality of care. The Minimum Performance Level (MPL), or 25th percentile, for Timeliness of Prenatal Care is 77.66%.

¹⁴ Lantos JD, Lauderdale DS. What is Behind the Rising Rates of Preterm Birth in the United States? RMMJ

¹⁵ 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>

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 birthday¹⁶.
- 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”)¹⁷.
- 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 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.
- Immunization services are also offered 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.
- 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 3rd 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.

¹⁶ Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP) Immunization Schedules, 2014. www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html.

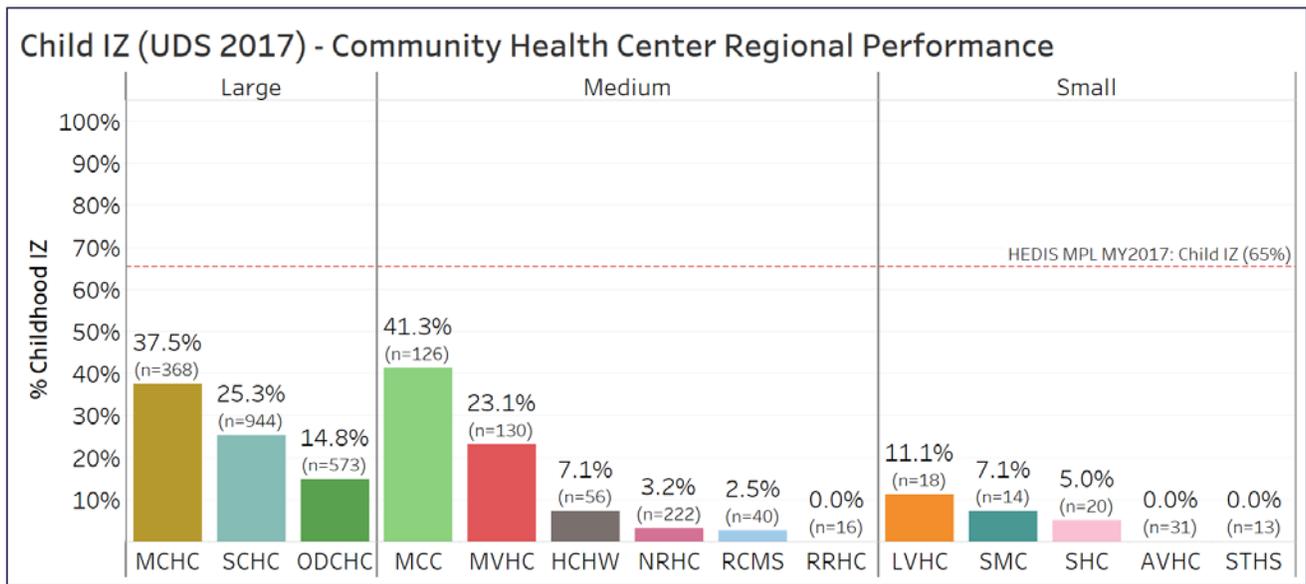
¹⁷ Committee on the Assessment of Studies of Health Outcomes Related to the Recommended Childhood Immunization Schedule; Board on Population Health and Public Health Practice; Institute of Medicine. Washington (DC): National Academies Press (US); 2013 Mar 27.

Childhood Immunization Status

Rural Northern California Health Center Data

Key Points

- The definition for this measure has changed significantly over the past few years. These variations have led to challenges in accurately collecting and reporting data.
- Some health centers in the region serve small numbers of children, which can lead to wide variation in the result for this quality measure.
- Health centers in Rural California are monitoring the impacts of AB277 vaccine law, eliminating personal belief exemption.



Quality Measure Definition

- UDS** Children who were fully immunized before their **2nd 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 or 3 Rotavirus, 2 flu vaccines
- HEDIS & QIP** Children who were fully immunized before their **2nd birthday**. Documented evidence of all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1 VZV, and 4 PCV

National Quality Goals and Benchmarks

HEDIS 25th (MPL) for Measurement Year 2017: HEDIS is a national data set, which measures the performance of health plans on quality of care. The Minimum Performance Level (MPL), or 25th percentile, for the Childhood Immunization Status (CIS-3) – Combo 3 Immunizations measure is 65.25%.

Immunizations for Adolescents

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.
- 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 (CAIR). This promotes care coordination and improved access to an adolescent’s immunization history.
- When adolescents come in for a Tdap for entry to 7th grade, remind them that they are also due for the Meningococcal vaccine.

Community Interventions

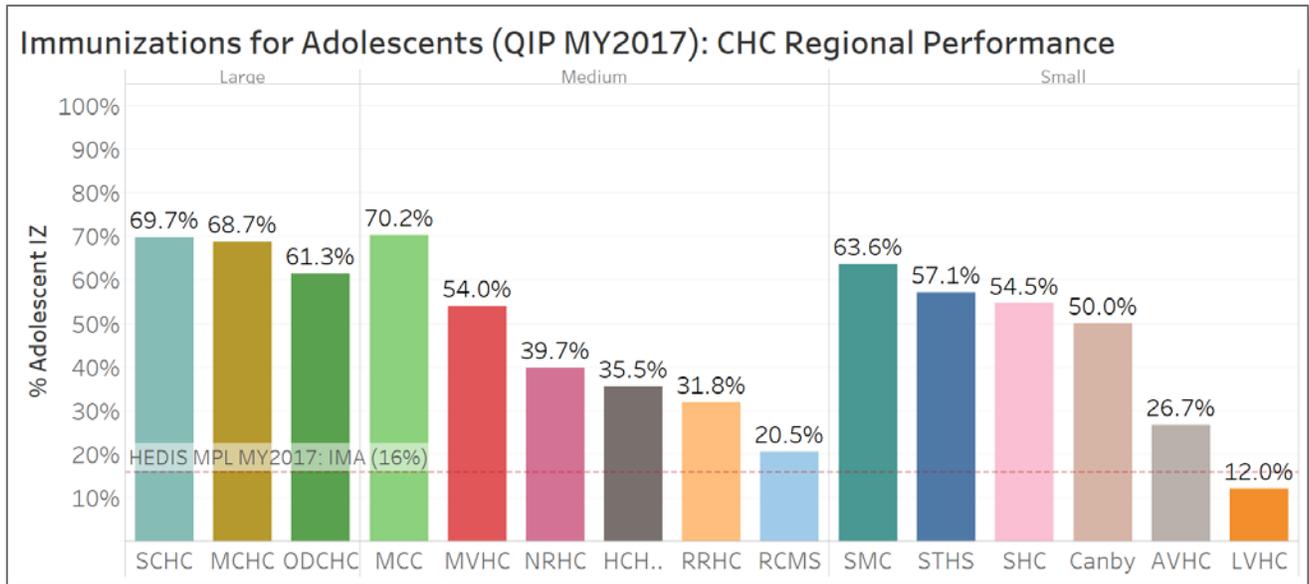
- At community health fairs offer education on adolescent immunizations and recommended schedules.

Immunizations for Adolescents

Rural Northern California Health Center Data

Key Points

- It can be challenging to bring adolescents in for vaccinations. Some health centers use sports physicals 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.

- Adolescents ages 10-13 years old need to have one dose of Tdap vaccine
- Adolescents ages 11-13 years old need to have one dose of Meningococcal vaccine
- Adolescents ages 11-12 years old need to have two doses of HPV vaccine

National Quality Goals and Benchmarks

HEDIS 25th (MPL) for Measurement Year 2017: HEDIS is a national data set, which measures the performance of health plans on quality of care. The Minimum Performance Level (MPL), or 25th percentile, for the Immunizations for Adolescents measure is 15.87%.

Controlling Diabetes

Impact of Diabetes in Rural Northern California

- Diabetes is a leading cause of disability and death in far Northern California, affecting about 8.1% of adults¹⁸. Overall, the prevalence of Diabetes in rural areas is 30% higher than in urban cities.¹⁹
- Obesity and sedentary lifestyle are associated with Type 2 Diabetes²⁰. These factors are significant in rural areas as nearly 2 in 3 adults are overweight (34%) or obese (29%).²¹
- 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.²²
- The average medical expenditures among people with diabetes are more than twice that of people without diabetes.²³

How Health Centers Provide the Necessary Care

Clinical Interventions

- Use a continually updated online registry to plan and track care for diabetic patients.
- 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 promotores to monitor the health of patients and coordinate their care during any encounter with a patient, even visits unrelated to their diabetes.
- 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.

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.

¹⁸ California Health Interview Survey. CHIS 2009 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.]

¹⁹ Schiller JS, Lucas JW, Ward BW, Peregoy JA. Summary health statistics for U.S. adults: NHIS, 2010. National Center for Health Statistics. Vital Health Stat 10(252). 2012.

²⁰ Mokdad, AH, Bowman BA, Ford ES, et al. The continuing epidemics of obesity and diabetes in the U.S. Journal of the American Medical Association 286(10):1195-1200, 2001.

²¹ California Health Interview Survey. CHIS 2009 Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research, March 2013.

²² 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.

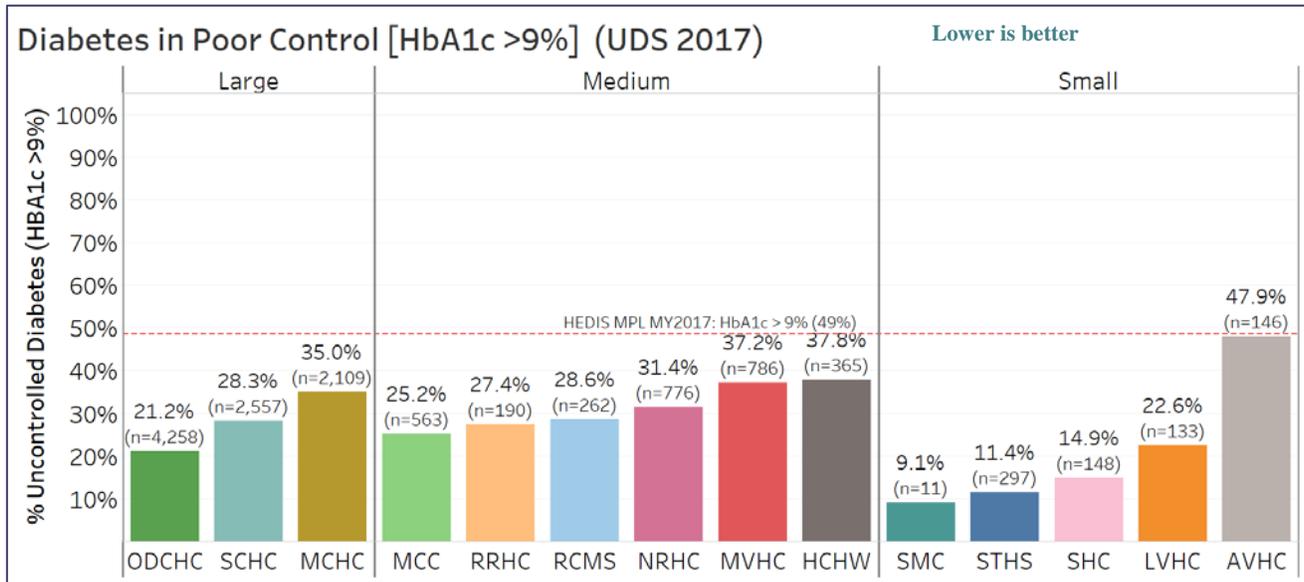
²³ Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

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.
- There are significant racial/ethnic health disparities. Rates of diabetes are 2 to 5 times higher among Native Americans and 87% higher among Mexican Americans than among whites. Lack of access to health care among migrant or seasonal farm workers places them at risk for diabetes related premature death.



Quality Measure Definitions

The percentage of patients age 18-75 with diabetes who had poor control of blood sugar levels as measured by 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%²⁴.
- Note this is a “negative” measure, which means the *lower* the number of patients with poor control, the better the performance on the measure.

National Quality Goals and Benchmarks

HEDIS 25th (MPL) for Measurement Year 2017: HEDIS is a national data set, which measures the performance of health plans on quality of care. The Minimum Performance Level (MPL), or 25th percentile for the Comprehensive Diabetes Care: HbA1c Poor Control (>9%) measure is 48.57%.

²⁴ Center for Disease Control and Prevention. National Diabetes Fact Sheet. 2011.

Controlling High Blood Pressure

Impact of Heart Disease in Rural Northern California

- One in three U.S. adults will develop hypertension in their lifetime²⁵ and more than half of Americans with high blood pressure do not have it under control.²⁶
- In Rural Northern California 1 in 2 adults age 55 and older have been diagnosed with high blood pressure.²⁷
- High blood pressure that is left untreated can result in heart attack, stroke, vision loss, memory loss and congestive heart failure.
- Heart disease affects more than 30,000 adults in Rural Northern California.²⁸

How Health Centers Provide the Necessary Care

Clinical Interventions

- Provide 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. 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.
- The use of aspirin may reduce the risk for some men age 45 to 79 of myocardial infarctions and in some women age 55 to 79 years of ischemic stroke.
- Educate adults in the community on reducing sodium intake to no more than 2,300 mg per day.

Community Interventions

- Educate patients about maintaining a healthy diet 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 educational materials on smoking cessation at health fairs and community events.

²⁵ Appel LJ, ED Frolich, JE Hall, TA Pearson, RL Sacco, DR Seals, FM Sacks, SC Smith Jr., DK Vafiadis, LV Van Horn. The Importance of Population-Wide Sodium Reduction as a Means to Prevent Cardiovascular Disease and Stroke: A Call to Action from the American Heart Association. *Circulation*. 2011;123:1138-1143; originally published online January 13, 2011. doi: 10.1161/CIR.0b013e31820d0793

²⁶ Ostchega Y, Yoon SS, Hughes J, et al. Hypertension awareness, treatment, and control—continued disparities in adults: United States, 2005–2006. [NCHS Data Brief] Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Health and Nutrition Examination Surveys; 2008. Available from: <http://www.cdc.gov/nchs/data/databriefs/db03.pdf> [PDF - 1.16 MB]

²⁷ California Health Interview Survey. CHIS 2009 Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research, April 2013.

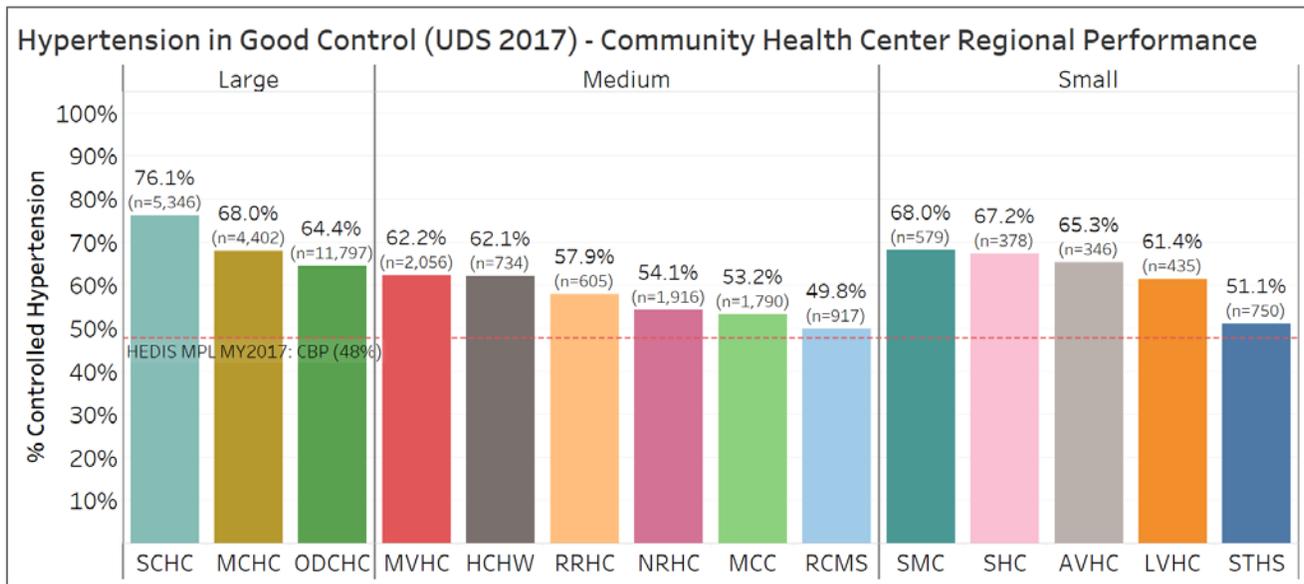
²⁸ Ibid.

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.²⁹



Quality Measure Definitions (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 Quality Goals and Benchmarks

HEDIS 25th (MPL) for Measurement Year 2017: HEDIS is a national data set, which measures the performance of health plans on quality of care. The Minimum Performance Level (MPL), or 25th percentile for the Controlling High Blood Pressure measure is 47.69%.

²⁹ 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

Tobacco Use Screening and Cessation Intervention

Impact of Tobacco Use in Rural Northern California

- Cigarette smoking is the leading cause of preventable disease and death in the United States, accounting for more than 480,000 deaths every year, or 1 of every 5 deaths.³⁰
- 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.³¹
- 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 20.4%, much higher than the state's average of 12.5%.^{32,33,34}
- Low-income adults in the area are twice as likely to be current smokers (31%) compared to the state low-income population (15%); that means roughly one in three adults living below the poverty level in northern California smoke.³⁵
- Rural Northern California communities also have higher rates of smokeless tobacco use.³⁶
- In the recent years, there has been an explosion of e-cigarette/vaporizer tobacco products often marketed as harmless or less harmful, less addictive, and with flavors that can be attractive to youth.³⁷

How Health Centers Provide the Necessary Care

Clinical Interventions

- Utilize the U.S. Public Health Service recommended “5 A’s”:
 - 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.
- 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.

³⁰ 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].

³¹ SAMMEC Smoking Attribute Expenditures 2009. CDC State Highlights: California

³² “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.

³³ The California Department of Public Health, California Tobacco Control Program. (2015). California Tobacco Facts and Figures 2015.

³⁴ California Health Interview Survey (2012-2014). CHIS Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research.

³⁵ Ibid. [Note: Low-income was defined as <200% FPL for these calculations].

³⁶ Ibid.

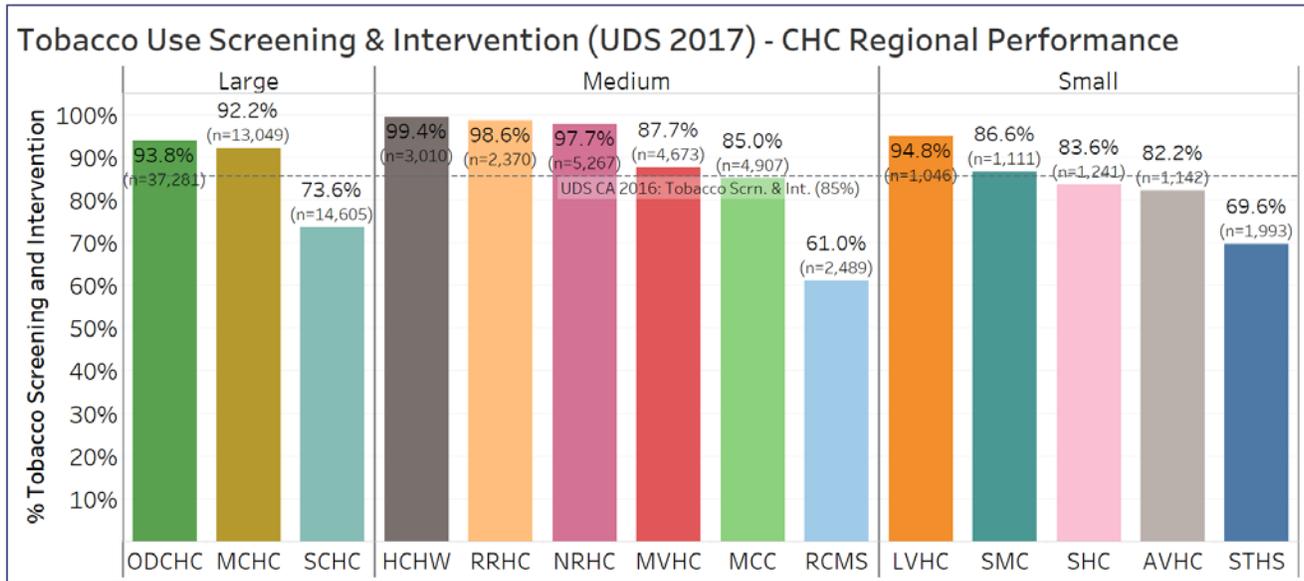
³⁷ Olson, S. (2014). E-Cigarettes Anger Candy and Cookie Makers with Infringing Flavor Names. Medical Daily. May 27, 2014. ; see also Dennis, B (2014). Booming e-cigarette market in need of greater oversight, studies say. The Washington Post. June 27, 2014.

Tobacco Use Screening and Cessation Intervention

Rural Northern California Health Center Data

Key Points

- These indicators were added to the UDS dataset in 2011. Measuring performance may have supported increased assessment of tobacco use across member clinics.
- Identifying tobacco users and tracking cessation counseling and interventions can be a challenge due to limitations in EHR configuration. EHR updates are helping to improve documentation.
- Definitions for cessation counseling and interventions may differ between providers, which may lead to variation in the data across health centers.



Quality Measure Definitions (UDS)

- The percentage of patients 18 and over who were screened for any and all forms of tobacco use one or more times within the past 2 years; **and**
- The percentage of patients who were identified as users of any and all forms of tobacco who received tobacco use intervention (cessation counseling, medication or a smoking cessation agent).
 - Current research shows that provider participation and advice lead to a greater likelihood of successfully quitting smoking by as much 66 percent.³⁸
 - As few as three minutes of counseling or other primary care interventions can increase the success rate of smoking cessation.³⁹

National Quality Goals and Benchmarks

California UDS Average (CA UDS Average 2016): The average performance among health centers in California for 2016 was 85.5%.

³⁸ 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

³⁹ 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>

Monitoring for Patients on Persistent Medications

Impact of Medication Monitoring in Rural Northern California

- Patient safety is highly important, especially for patients at increased risk of adverse medication events from long-term use. This warrants monitoring and follow-up by the prescribing provider to assess for side-effects and adjust medications accordingly. These medications have more detrimental effects in the elderly.
- The costs of annual monitoring are offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications.
- According to the Agency for Healthcare Research and Quality, total costs of medication-related problems due to misuse of medications in the ambulatory setting has been estimated to exceed \$76 billion annually.
- Appropriate monitoring of medication therapy remains a significant issue to guide therapeutic decision-making and provides largely unmet opportunities for improvement in care for patients on persistent medications.

How Health Centers Provide the Necessary Care

Clinical Interventions

- Face-to-face provider education, to ensure understanding of the need for yearly blood testing for patients on medications such as angiotensin-converting enzyme inhibitors (ACE inhibitors) to monitor blood levels and organ functioning.
- Utilize clinical care guideline tools that are embedded within electronic health records systems to create provider alerts when an annual blood test is due for a patient.
- Educational interventions for providers should include prescribing products that simplify the medication regimen or the practice of sending refill reminders. Although these interventions are less effective than direct patient contact, they are often more cost-effective.

Community Interventions

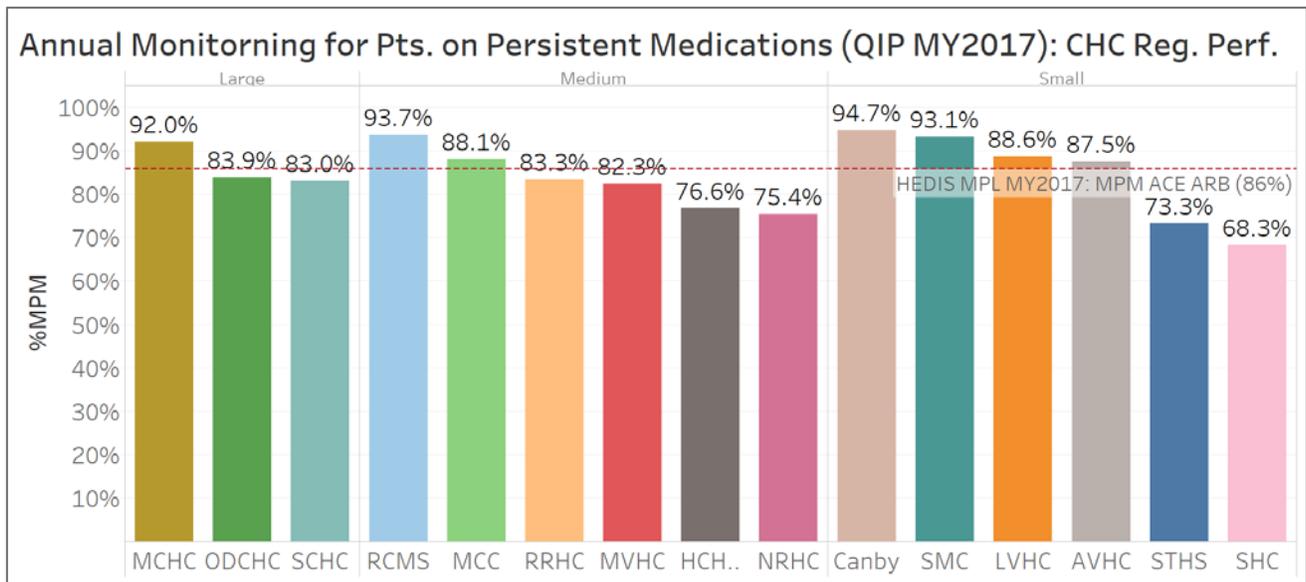
- Partner with local pharmacists to coordinate patient education efforts around the importance of completing annual lab tests that help monitor patients on persistent medications.

Monitoring for Patients on Persistent Medications

Rural Northern California Health Center Data

Key Points

- This is a new measure for health centers in the region. Despite this many perform close to the minimum performance level.
- Best practices for ensuring annual monitoring of patients are being identified and shared throughout the Northern Region.



Measure Definition (QIP)

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report as a total rate:

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).
- Annual monitoring for members on diuretics.

National Quality Goals and Benchmarks

HEDIS 25th (MPL): HEDIS is a national data set, which measures the performance of health plans on quality of care. The Minimum Performance Level (MPL), or 25th percentile, for monitoring for patients on persistent medications for ACE/ARB is 85.93% and for Diuretics is 85.52%.

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.⁴⁰
- 25% of Rural Northern California adults report a BMI of 30+ (obese), while the California average is 23%⁴¹ and the US average is 37.7%.⁴²
- California has the highest obesity-related costs in the United States, estimated at \$15.2 billion with 41.5% of these costs financed through Medicare and Medi-Cal.⁴³
- 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.
- Develop wellness plans that guide patients in adopting changes for healthy diet and exercise. 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.

Community Interventions

- Set up walking groups or other programs to support positive behavior change.
- 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.

⁴⁰ <https://www.cdph.ca.gov/programs/cpns/Documents/ObesityinCaliforniaReport.pdf>

⁴¹ <http://www.countyhealthrankings.org/app/california/2016/measure/factors/11/map>

⁴² National Health and Nutrition Examination Survey (NHANES), CDC/NCHS

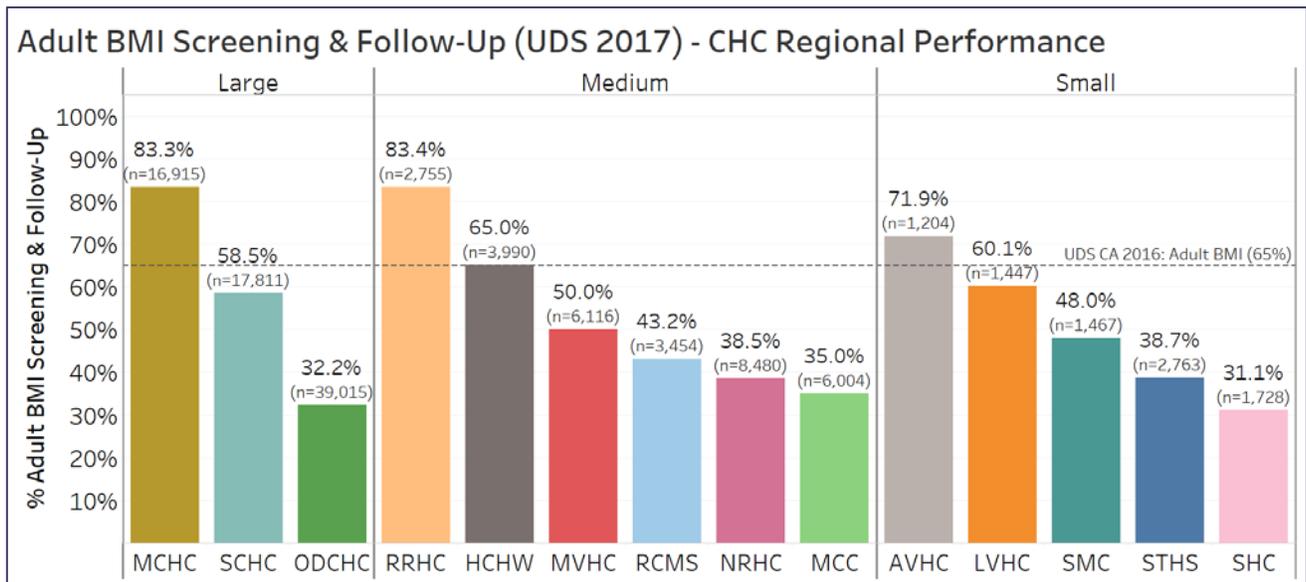
⁴³ Trogdon JG, Finkelstein EA, Feagan CW, Cohen JW. State- and payer-specific estimates of annual medical expenditures attributable to obesity. *Obesity*. Jan 2012;20(1):214-220

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.



Measure Definition (UDS 2017)

Percentage of patients aged 18 and older with (1) a documented BMI during the most recent visit or within the 6 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/m²).

- 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 Quality Goals and Benchmarks

California UDS Average (CA UDS Average 2016): The average performance among health centers in California for 2016 was 64.9%.

Use of Appropriate Medications for Asthma

Impact of Asthma in Rural Northern California

- Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.
- One-quarter of low-income children and adults in rural Northern California have asthma. And one in five patients served by community clinics and health centers in the region has asthma. ⁴⁴
- 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. ⁴⁵

How Health Centers Provide the Necessary Care

Clinical Interventions

- Identify the type of asthma and associated triggers. Develop written asthma action plans.
- Conduct regular asthma medication evaluation and collect patient feedback.
- Offer provider education on the identification and management of asthma.
- Educate patients on using peak flow meters and following their asthma action plan.

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.

⁴⁴ California Health Interview Survey. CHIS 2009 Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research, May 2013.

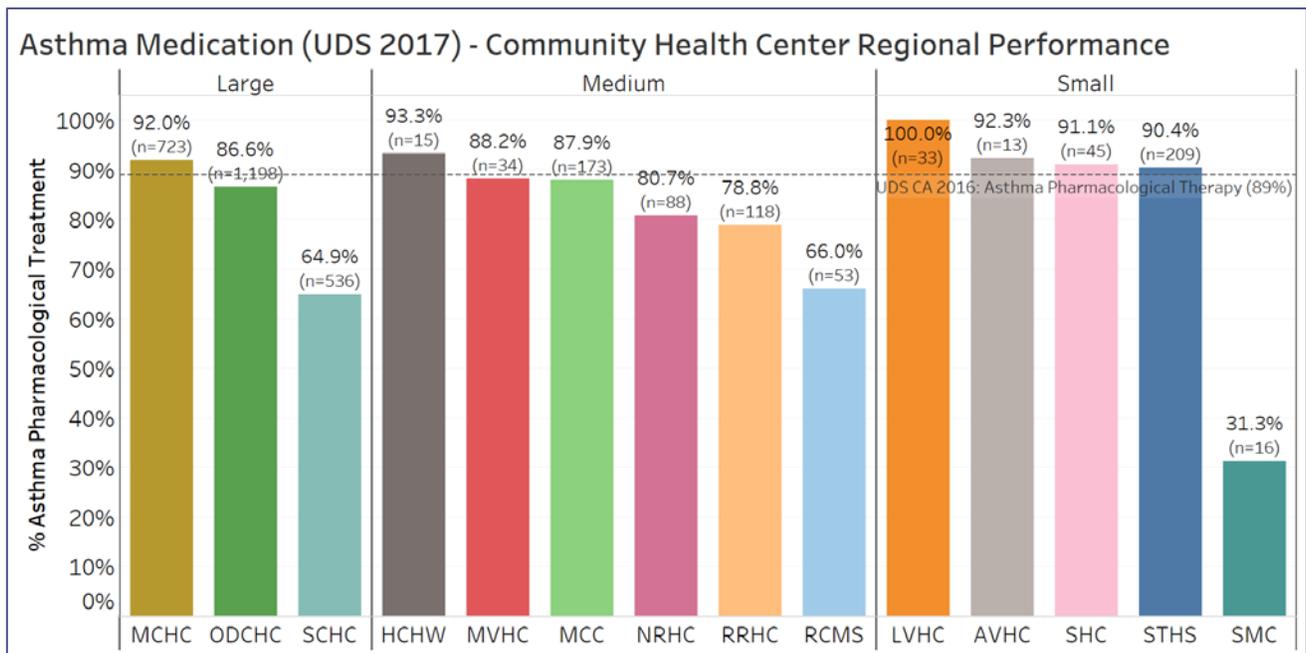
⁴⁵ Cpitman, J, Tyner T (2011). The Impacts of Short-term Changes in Air Quality on Emergency Room and Hospital Use in San Joaquin Valley. San Joaquin Valley Air Pollution Control District. Fresno, CA.

Use of Appropriate Medications for Asthma

Rural Northern California Health Center Data

Key Points

- There has been an increase in wildfires in the region in the past few years. This contributes to the incidence and severity of asthma in rural Northern California.
- Wood-burning stoves are used commonly in rural and frontier areas, which may contribute to asthma symptoms.
- Patient medical records often do not reflect a diagnosis of persistent asthma due to issues related to medical coding. This may lead to variation in the data as it often is collected through chart review and provider inquiry.



Measure Definition (UDS 2017)

The Percentage of patients aged 5 through 40 with a diagnosis of mild, moderate, or severe persistent asthma who received or were prescribed accepted pharmacologic therapy.

- Accepted pharmacologic therapy may include prescription for an inhaled corticosteroid or prescription for an alternative pharmacological agent (i.e., Cromolyn)

National Quality Goals and Benchmarks

California UDS Average (CA UDS Average 2016): The average performance among health centers in California for 2016 was 89.0%.

Well Child Visits in Children Age 3-6 Years

Impact of Annual Well Child Visits in Rural Northern California

- Rural counties perform significantly worse than urban counties on many health factor measures that can influence the health of children including: adult smoking, teen births, uninsured rate, children in poverty, education, and injury deaths.⁴⁶
- 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.⁴⁷
- Given all of these factors contributing to poor health outcomes in rural areas, it is critical to get children to their Well Child Visits in order to 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 Child 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

- Annual visits provide the opportunity for timely, recommended immunizations 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 child visits.
- Discussing milestones, social behavior, and learning difficulties allows for early detection of developmental problems and screening for diseases.
- Parents and physicians can discuss important safety concerns such as use of seat belts, and protective sports equipment, as well as appropriate amounts of screen time, physical activity, and healthy eating habits.
- Regular visits 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.

Community Interventions

- Using radio public service announcements to raise awareness of parents about the importance of annual well child 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 child visits.

⁴⁶ University of Wisconsin Population Health Institute. *County Health Rankings* Key Findings 2016.

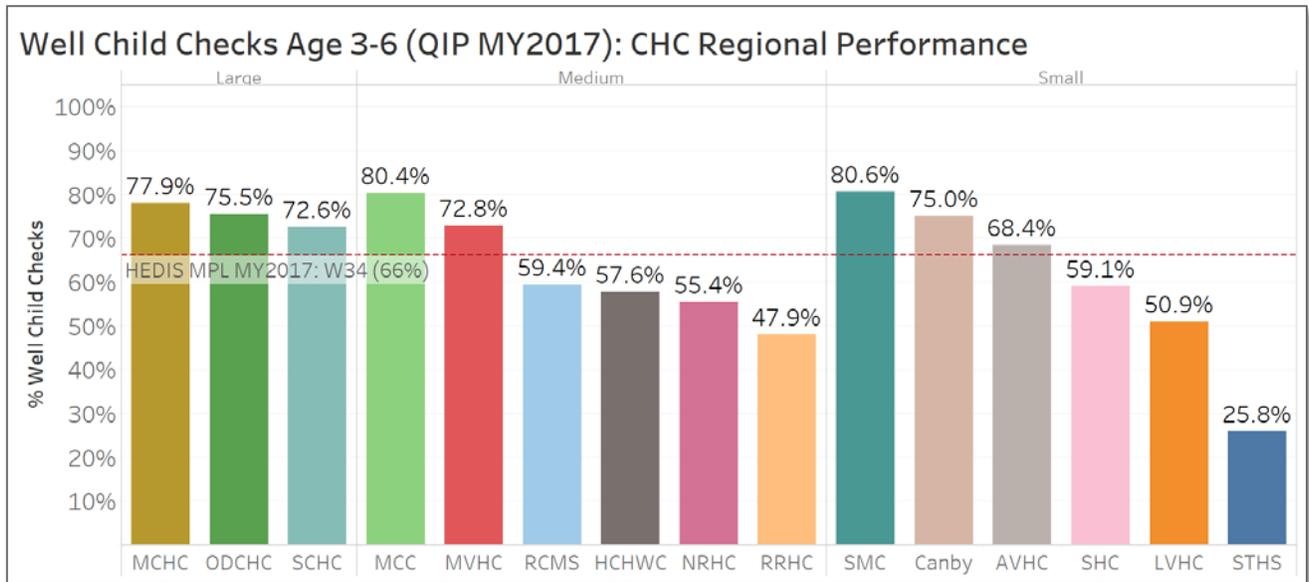
⁴⁷ Childhood adversity and adult chronic disease: An update from ten states and the District of Columbia, 2010 Gilbert L.K., Breiding M.J., Merrick M.T., Thompson W.W., Ford D.C., Dhingra S.S., Parks S.E. (2015) *American Journal of Preventive Medicine*, 48 (3) , pp. 345-349.

Well Child Visits in Children Age 3-6 Years

Rural Northern California Health Center Data

Key Points

- Differing periodicity schedules between the Child Health and Disability Prevention Program (CHDP) and the American Academy of Pediatrics has led to challenges in effectively meeting this measure for health centers.
- Policy changes that align guidance for schedule of annual visits will likely have a positive impact on performance in the Northern Region.



Measure Definition (QIP)

The National Committee for Quality Assurance (NCQA) recommends children be seen for well-child visits every year, between the ages of 3 and 6. To qualify as a well-child visit, the following areas must be assessed:

- Physical exam and health history
- Physical and mental development,
- Health education and anticipatory guidance.

National Quality Goals and Benchmarks

HEDIS 25th (MPL) for Measurement Year 2017: HEDIS is a national data set, which measures the performance of health plans on quality of care. The Minimum Performance Level (MPL), or 25th percentile for the Well Child Visits in Children Age 3-6 is 66.18%.

Weight Assessment and Counseling – Children & Adolescents

Impact of Obesity in Rural Northern California

- Over the last 3 decades, childhood obesity has more than doubled in children and tripled in adolescents in the US.⁴⁸ In 2013-14, 17.2% of children and adolescents aged 2-19 years were considered obese.⁴⁹
- Studies have shown that 16.5 percent of rural children are obese compared to 14.4 percent of urban children.⁵⁰
- Children and adolescents who are obese are more likely to be obese as adults and are therefore at risk for health problems, such as heart disease, type 2 diabetes, stroke and several types of cancer.⁵¹
- Healthy lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases.¹ Obesity can become a lifelong health issue; therefore, it is important to monitor weight problems in children and adolescents and provide guidance for maintaining a healthy weight and lifestyle.⁵²

How Health Centers Provide the Necessary Care

Clinical Interventions

- Document BMI percentile, preferably on a plotted graph, for all children and adolescents - 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.
- Develop wellness plans that guide patients in adopting changes for healthy diet and exercise. 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.

Community Interventions

- Set up walking groups or other programs to support positive behavior change.
- 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.
- 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.

⁴⁸ Centers for Disease Prevention and Control. 2013. "Antibiotics Aren't Always the Answer." <http://www.cdc.gov/features/getsmart/> (June 19, 2014)

⁴⁹ National Health and Nutrition Examination Survey (NHANES). CDC/NCHS

⁵⁰ The 2011 Report to the Secretary: Rural Health and Human Services Issues. The Nat'l Advisory Committee on Rural Health and Human Services.

⁵¹ Centers for Disease Prevention and Control. 2013. "Antibiotics Aren't Always the Answer." <http://www.cdc.gov/features/getsmart/> (June 19, 2014)

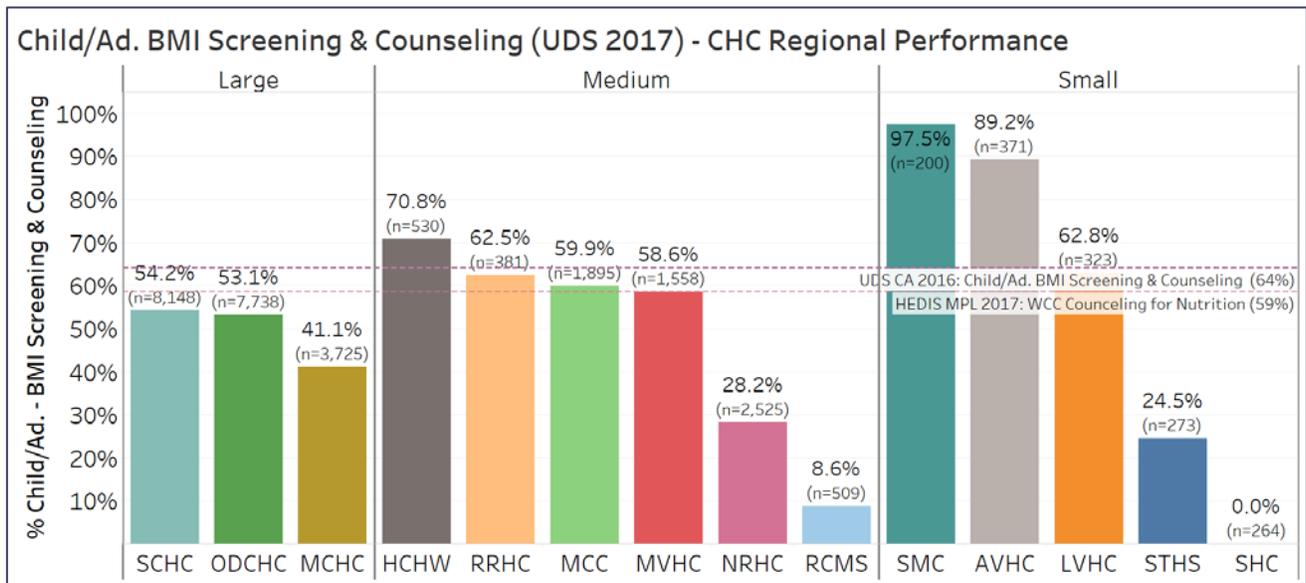
⁵² CDC. 2012. "NCHS Data Brief: Physical Activity in U.S. Youth Aged 12–15 Years, 2012." <http://www.cdc.gov/nchs/data/databriefs/db141.htm> (June 4, 2014).

Weight Assessment and Counseling – Children & Adolescents

Northern California Health Center Data

Key Points

- Weight assessments and counseling are commonly included in well child check-ups.
- Any patient aged 3 to 17 seen at the health center, including those only seen for an acute care visit (e.g. ear ache) are included in this measure. Health centers are challenged to integrate nutrition and physical activity counseling into all encounters with patients.
- Health centers showed improvement in providing weight assessments and counseling for children and adolescents. Automated reminders and documentation enhancements in electronic health record systems may have contributed to the improved performance.



Quality Measure Definitions (UDS, HEDIS & QIP)

Children and Adolescents: Percentage of patients aged 3-17 who had: (1) evidence of BMI percentile documentation, (2) documentation of counseling for nutrition, and (3) documentation of counseling for physical activity.

- The U.S. Preventive Task Force recommends that clinicians screen all patients for obesity and offer counseling and behavioral interventions. BMI provides weight ranges correlated to height by gender. Higher BMI correlates to being overweight or obese.

National Quality Goals and Benchmarks

HEDIS 25th (MPL) for Measurement Year 2017: HEDIS is a national data set, which measures the performance of health plans on quality of care. The Minimum Performance Level (MPL), or 25th percentile for the Weight Assessment and Counseling – Nutrition Counseling for Children and Adolescents is 58.56% and for Physical Activity Counseling is 49.06%.

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 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
- Colorectal Cancer Screening
- Prenatal and Postpartum Care

Immunizations

- Childhood Immunizations
- Immunizations for Adolescents

Tertiary Prevention

- Controlling Diabetes
- Controlling High Blood Pressure
- Tobacco Screening and Cessation
- Managing Persistent Medications
- Adult Weight Assessment and Counseling

Well Child

- Well Child Visits Age 3-6
- Child and Adolescent Weight Assessment and Counseling

Detailed Measure Crosswalk: How to Use the Attached Spreadsheet

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

Themes	Measure Name	Description	Site Review	HEDIS	QIP	UDS
Primary Preventive	Cervical Cancer Screening	HEDIS: 21-64 y/o QIP: 21-64 y/o MU: CMS124V3 #0032 QIP: Family & Adult	X	X	X	X
	Colorectal Cancer Screening	2015/2016, Ages 50-75 MU: CMS130V3 #0034 QIP: Family & Adult	X		X	X
	Prenatal & Postpartum Care - Timeliness of prenatal care		X	X		X
	Birth Weight of Infants					X
	Depression Screening					X
	Dental Sealants					X
Immunizations	Childhood Immunizations DTaP	DTaP: By 2nd birthday QIP: Family & Pediatrics			X	
	Childhood Immunizations MMR	MMR: By 2nd birthday QIP: Pediatrics			X	
	Childhood Immunization Combination 3	Dtap, IPV, MMR, HiB, HepB, VZV, PCV	X	X		X
	Immunizations for Adolescents	10-13 y/o QIP: Pediatrics	X	X	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)	HEDIS	QIP	UDS
Reporting Period	Time period between site review visits, typically 3 years	January - December	July - June	January - December
Description	Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.	Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.	The percentage of continuously enrolled Medi-Cal women 21-64 years of age who were screened for cervical cancer according to the evidence based guidelines: • 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.	Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.
Lookback Period	Either the measurement year or during the 2 prior calendar years (Pap Test), or the measurement year or during the 4 prior calendar years (HPV test).	Either the measurement year or during the 2 prior calendar years (Pap Test), or the measurement year or during the 4 prior calendar years (HPV test).	Either the measurement year or during the 2 prior calendar years (Pap Test), or the measurement year or during the 4 prior calendar years (HPV test).	Either the measurement year or during the 2 prior calendar years (Pap Test), or the measurement year or during the 4 prior calendar years (HPV test).
Sample Size	3 to 12 charts depending on number of providers.	Each measure and reporting region begin its first year with 411 medical records being sampled. After the first year being measured, there is a table that NQQA has provided to give future required samples, based off of previous performance. Sample requests could vary from 1 to 1,500 total per site.	The entire denominator	70 charts or at least 80% of denominator population in EHR
Numerator	The number of women chosen for chart review who were screened for cervical cancer, as identified below. •Step 1: Identify women 21-64 years of age who had cervical cytology during the measurement year or the 2 years prior to the measurement year. (Pap smears should begin at age 21 or within 3 years of onset of sexual activity). •Step 2: From the women who did not meet step 1 criteria, identify women who were 30-64 years of age at the time of the test who had cervical cytology and a human papilloma virus (HPV) test with service dates four or less days apart during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of both tests.	The number of women in the denominator who were appropriately screened for cervical cancer, as identified below. •Step 1: Identify women 24-64 years of age as of June 30 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year •Step 2: From the women who did not meet step 1 criteria, identify women 30-64 years of age as of June 30 of the measurement year who had cervical cytology and a human papilloma virus (HPV) test with service dates four or less days apart during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of both tests.	The number of women in the denominator who were appropriately screened for cervical cancer, as identified below. •Step 1: Identify women 24-64 years of age as of June 30 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year •Step 2: From the women who did not meet step 1 criteria, identify women 30-64 years of age as of June 30 of the measurement year who had cervical cytology and a human papilloma virus (HPV) test with service dates four or less days apart during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of both tests. •Step 3: Add the numbers from Steps 1-2 to obtain a total rate for women who were identified with appropriate screening for cervical cancer.	Number of female patients 24-64 years of age receiving one or more documented Pap tests during the measure year or during the 2 calendar years prior among those women included in the denominator, or, for women who were 30 years of age or older at the time of the test who choose to also have an HPV test performed simultaneously, if the test was done during the measurement year or during the 4 calendar years prior.
Denominator	Number of all female patients age 21-64 years of age assigned to the PCP office and seen in the last 3 years.	Number of all female patients age 24-64 years of age during the measurement year	The number of Medi-Cal women 24-64 years of age as of the end of the measurement year.	Number of all female patients age 24-64 years of age during the measurement year who had at least one medical visit during the reporting year.
Evidence	Women under 30 years old: A note indicating the date when the cervical cytology was performed and the result or finding. Women 30 years old or older: A note indicating the date when the cervical cytology and the HPV test were performed and the results or findings. The cervical cytology and HPV test must be from the same data source. Do not count lab results that state "sample was inadequate", or "no cervical cells Present". Note: "No endocervical cells" may be used if a valid result was reported. Pathology reports may be provided as evidence. * Do not count biopsies as they are considered diagnostic and therapeutic only.	Women under 30 years old: A note indicating the date when the cervical cytology was performed and the result or finding. Women 30 years old or older: A note indicating the date when the cervical cytology and the HPV test were performed and the results or findings. The cervical cytology and HPV test must be from the same data source. Do not count lab results that state "sample was inadequate", or "no cervical cells Present". Note: "No endocervical cells" may be used if a valid result was reported. Pathology reports may be provided as evidence. * Do not count biopsies as they are considered diagnostic and therapeutic only.	Women under 30 years old: A note indicating the date when the cervical cytology was performed and the result or finding. Women 30 years old or older: A note indicating the date when the cervical cytology and the HPV test were performed and the results or findings. The cervical cytology and HPV test must be from the same data source. Do not count lab results that state "sample was inadequate", or "no cervical cells Present". Note: "No endocervical cells" may be used if a valid result was reported. Pathology reports may be provided as evidence. * Do not count biopsies as they are considered diagnostic and therapeutic only.	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 finding. A chart note which documents the name, date, and results from a test performed by a nother provider which is based on communications between the clinic and the provider is also acceptable. To see relevant codes, access 2015 UDS manual.

Provides details on the sampling methodology for the measure

Offers tips on documentation required to meet the measure

Cervical Cancer Screening	Site Review (SR)	HEDIS	QIP	UDS
Exclusions	Women who have had a hysterectomy and who have no residual cervix. Documentation of "complete," "total," or "radical" abdominal or vaginal hysterectomy any time during the member's history. Documentation of hysterectomy alone does not meet criteria, as it does not indicate the cervix was removed. (Women after 64 who had regular previous normal screenings).	Women who have had a hysterectomy and who have no residual cervix. Documentation of "complete," "total," or "radical" abdominal or vaginal hysterectomy any time during the member's history through December 31 of the measurement year. Documentation of hysterectomy alone does not meet criteria, as it does not indicate the cervix was removed.	Women with evidence of a hysterectomy with no residual cervix any time during the member's history through the end 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" • Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening. • Documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.	Women who have had a hysterectomy and who have no residual cervix and for whom the administrative data does not indicate a Pap test was performed.
CPT Codes/Other data sources	No administrative data	No administrative data	QIP Code List	The following ICD-9, ICD-10, and/or CPT codes are evidence of meeting the measurement standard: • CPT: PAP = 88141-88155, 88164-88167, 88174-88175, HPV = 87620-87622 • ICD-9-CM: 91.46, V72.32; ICD-10-CM: Z01.42 • CPT-II: 30153 = Pap test
Benchmarks	Exempted Pass: 90% or above (Total score is ≥ 90% and all section scores are 80% or above) Conditional Pass: 80-89% (Total score is 80-89% or any section(s) score is < 80%)	25th Percentile: 54.33% 50th Percentile: 60.98% 75th Percentile: 67.88% 90th Percentile: 73.08%	75th Percentile (Half Points): 67.9% 90th Percentile (Full Points): 73.1%	Natl UDS 2014: 56.3% CA UDS 2014: 58.6% HP2020: 93%

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

Identifies specific codes to use in query reports or provides links to code lists