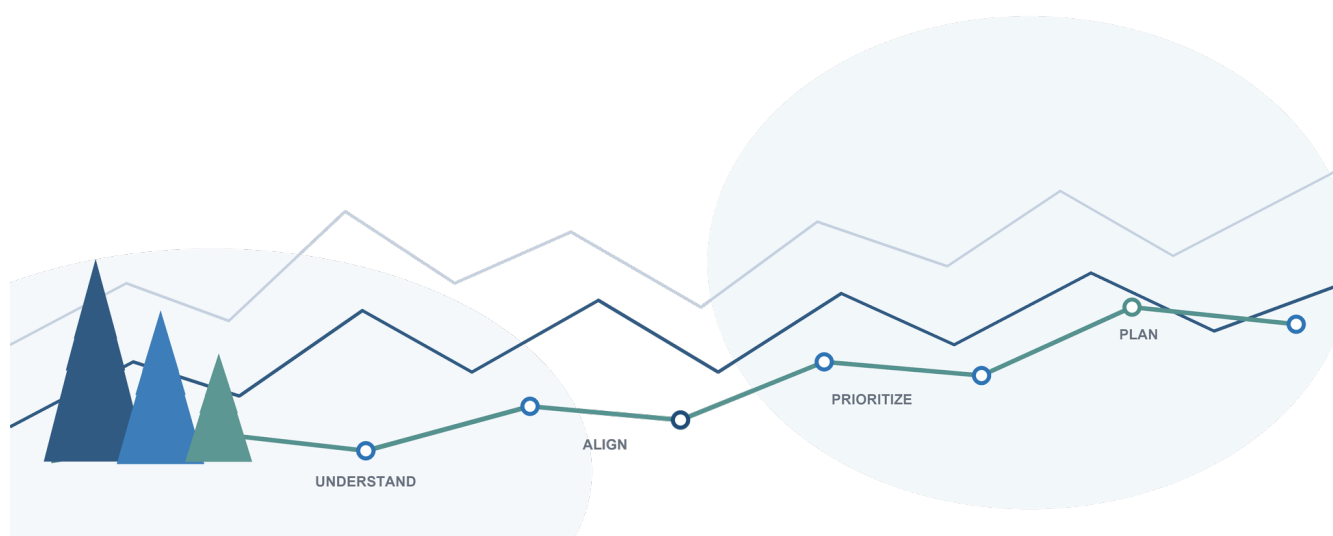


Quality Improvement Measurement Systems Toolkit

UNDERSTAND • ALIGN • PRIORITIZE • PLAN



PREPARED BY

**Health Alliance of Northern California
and North Coast Clinic Network**



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Chapter 1: Health Center Quality Measurement Systems

Understanding the Quality Landscape

Why This Toolkit Exists

Quality leaders in federally qualified health centers (FQHCs) operate in a complex environment. Health centers are accountable to multiple quality measurement and reporting systems, each with different purposes, audiences, and requirements. These systems influence organizational priorities, quality improvement activities, financial incentives, and public reporting.

For FQHCs operating in an increasingly resource-constrained environment, quality performance is no longer solely a compliance function. Quality measures influence reimbursement, value-based payment opportunities, patient outcomes, accreditation readiness, and organizational reputation. Leaders who understand how quality measurement systems intersect are better positioned to focus limited resources where they can produce the greatest impact.

For new quality leaders, the number of measurement programs can feel overwhelming. Teams may find themselves asking:

- Why are we tracking this measure?
- Which measures matter the most?
- How do the different programs relate to one another?
- Where should we focus our improvement efforts?
- How can one improvement project support multiple organizational goals?

The purpose of this toolkit is to help answer these questions.

Rather than viewing quality measurement systems as separate reporting requirements, this toolkit encourages health center leaders to view them as interconnected components of a broader quality, population health, and organizational performance strategy. Understanding how measures align across programs can help health centers focus resources on improvement activities that have the greatest impact on patient outcomes, organizational performance, and financial sustainability.

Using Measurement Systems to Build or Refine a Quality Strategy

Quality measurement programs serve different functions within the health care system. Some programs establish federal accountability for health center performance. Others support health plan oversight, financial incentives, or operational and clinical compliance. While each system has unique requirements, they frequently measure similar aspects of care such as preventive screenings, chronic disease management, immunizations, well child care, and medication management.

A single well-designed improvement initiative can therefore advance multiple objectives simultaneously.

The Health Center Quality Strategy Guide (Figure 1 on the next page) illustrates how quality leaders can move from understanding measurement requirements to selecting strategic priorities and planning improvement activities.

Health Center Quality Strategy Guide

Our goal is healthier patients and thriving health centers

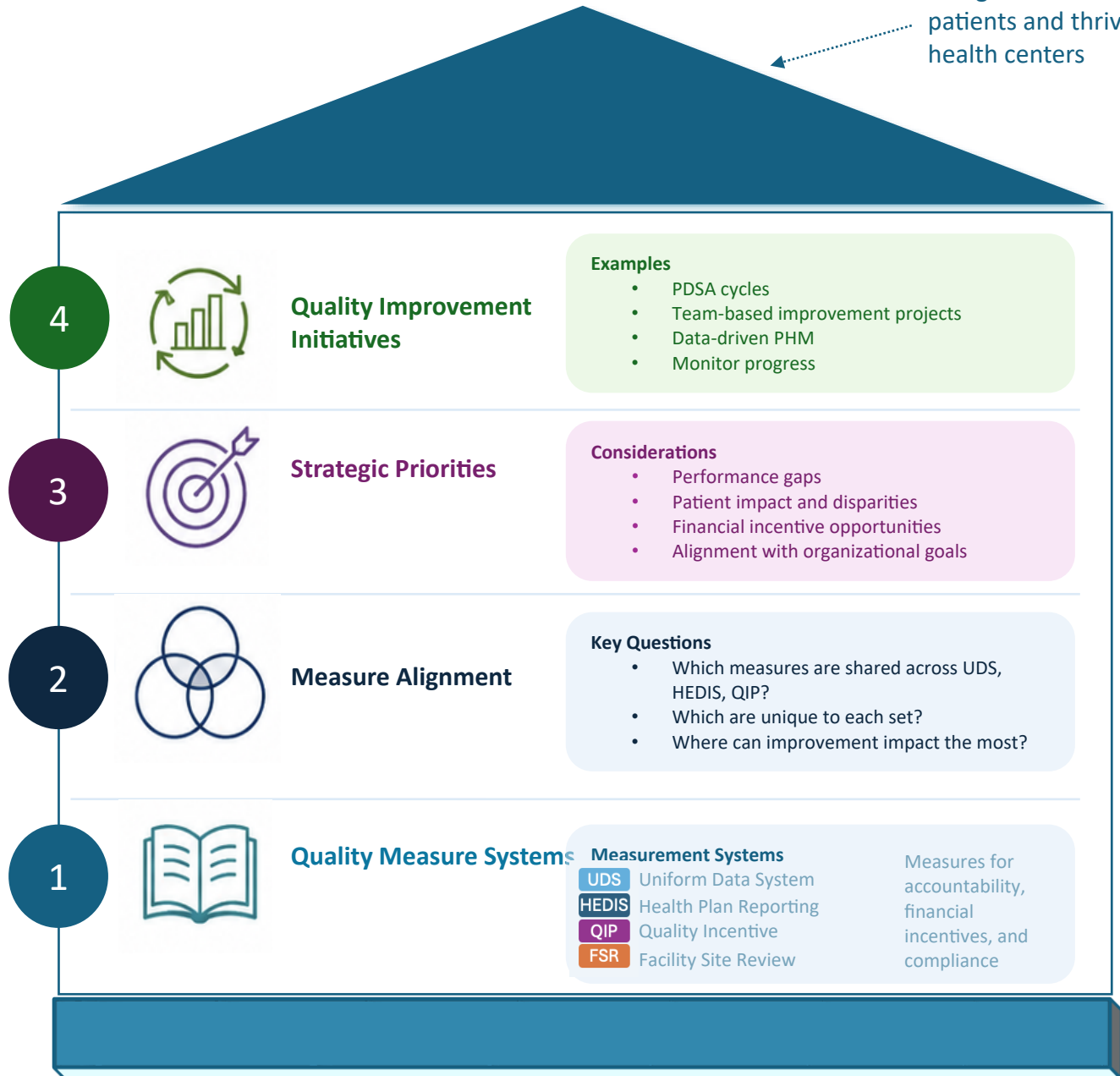


Figure 1. Health Center Quality Strategy Guide

How to Use the Strategy Guide

Quality improvement leaders in rural FQHCs are accountable to multiple entities, with multiple reporting programs, incentive initiatives, and regulatory requirements, each designed to improve different aspects of care. While these programs often measure similar clinical topics, they do so for different purposes, different patient populations, and different stakeholder audiences.

For many rural FQHCs the challenge is not a lack of quality improvement opportunities – it is deciding where to focus limited time, staff, and resources to achieve the greatest impact.

The Health Center Quality Strategy Guide provides a planning framework for organizing quality programs and translating multiple measurement systems into coordinated quality improvement activities as part of a quality strategy. This guide illustrates how the various reporting systems work together to support continuous improvement.

This toolkit is organized into four levels that build upon one another:

Quality Measurement Systems:

Quality leaders begin by understanding the major quality systems that influence health center performance:

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

Each system measures performance for a different purpose and audience.

System	Primary Purpose	Audience
UDS	Federal accountability	HRSA
HEDIS	Quality performance measurement	Health plans
QIP	Financial incentives	Partnership HealthPlan and providers
FSR	Operational and clinical compliance	Partnership HealthPlan and State

Together they create the accountability framework within which FQHCs in the Partnership HealthPlan of California (Partnership) region operate. These measurement systems collectively establish the accountability, performance, and incentive framework that guides primary care quality improvement in the Partnership region.

Measure Alignment:

Once the quality systems are understood, leaders can identify where measures overlap across programs.

Measure alignment helps organizations:

- Focus improvement efforts
- Maximize limited staff resources
- Improve performance across multiple reporting systems simultaneously

Understanding measure alignment is a key responsibility of FQHC quality leaders.

Strategic Priorities:

Some measures require more attention given their importance to patients, the health center, and the health plan.

Quality leaders must evaluate:

- Current performance
- Patient impact and health equity opportunities
- Organizational priorities
- Financial implications
- Available improvement capacity

These considerations help FQHCs determine where to focus their quality improvement efforts.

Quality Improvement Initiatives:

After priorities are selected, teams can begin planning improvement initiatives.

This includes:

- Reviewing baseline performance data
- Understanding barriers to performance
- Identifying key stakeholders
- Establishing improvement aims
- Preparing teams for structure improvement activities, including PDSA cycles

The goal is to move from measurement to meaningful improvement.

About This Toolkit

This toolkit is designed for use by clinical, operational, and quality staff working in FQHCs 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 Clinics Network, and Partnership HealthPlan of California (Partnership).

The FQHCs that form the membership of the two clinic consortia serve a 14-county region in Northern California, including the counties of Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Placer, Plumas, Sierra, Shasta, Siskiyou, Trinity, and Yuba. These counties are part of Partnership HealthPlan of California's HEDIS reporting regions: East, Southwest, Northwest and Northeast (pictured below).



Figure 2. Partnership HEDIS Regions

Data reported in this guide are collected from the health centers serving the counties in the Southwest Region (Green – Mendocino and Lake), Northwest Region (Wine – Del Norte and Humboldt counties), the Northeast Region (Blue – Lassen, Modoc, Siskiyou, Shasta and Trinity), and the East Region (Teal – Nevada, Placer, Plumas, Sierra, and Yuba).

Chapter 2: Measurement Set Summaries

Healthcare Effectiveness Data and Information Set (HEDIS)

Purpose

The Healthcare Effectiveness Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA), is the most widely used health care quality measurement system in the U.S. HEDIS is designed to provide a standardized method for evaluating and comparing health plan performance across key areas of care.

In California, the Department of Health Care Services (DHCS) requires Medi-Cal Managed Care Plans (MCPs) to report a subset of HEDIS measures annually. These measures are used to monitor the quality of care delivered to Medi-Cal members and to identify opportunities for improvement.

Audience

HEDIS performance data are used by:

- Medi-Cal Managed Care Plans (MCPs)
- Department of Health Care Services (DHCS)
- National Committee for Quality Assurance (NCQA),
- Health care purchasers and policymakers
- Health care providers and health centers

Why HEDIS Matters to Health Centers

Although HEDIS is a health plan reporting system, it has significant influence on health center quality improvement priorities.

Many of the clinical services measured through HEDIS are delivered in primary care settings, making health centers essential partners in improving performance. Health plans routinely use HEDIS data to identify performance gaps, prioritize improvement efforts, and design provider incentive programs.

Partnership HealthPlan of California (PHP) is an NCQA accredited health plan. The importance of HEDIS becomes more prominent as HEDIS scores and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results make up 50% of the accreditation assessment.

Several measures included in HEDIS also appear in other quality measurement systems, including UDS and the Primary Care Provider Quality Improvement Program (QIP). As a result,

improvement efforts focused on these measures may support multiple organizational objectives simultaneously.

For many health centers these overlapping measures represent some of the highest-leverage opportunities for quality improvement.

The HEDIS measurement set includes measures across six domains of care, including:

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

How Performance is Measured

The HEDIS Annual Project includes a data collection process that is completed between February and May to assess quality in the prior year, also known as the measurement year, January 1 – December 31.

Partnership expanded in 2024 to cover a total of 24 counties. Partnership received approval from DHCS for HEDIS to be reported at a regional level. This map illustrates the regions. Because county populations vary considerably within each region, Partnership conducts county-level oversampling in areas with small denominators to generate more reliable county-level performance data for quality improvement efforts.



HEDIS measures are calculated in one of two ways:

Administrative Measures: which are calculated using claims, encounter, pharmacy, laboratory, and other electronic data sources. Performance is assessed across the entire eligible population.

Hybrid Measures: which combine administrative data with information obtained from medical records for a statistically significant sample of the eligible population. PHC may request documentation from provider organizations to validate care that is not fully captured through claims or encounter data.

Because many HEDIS measures rely on claims and encounter data, accurate documentation and complete encounter submission are important. Health centers play an important role in ensuring that services delivered to patients are reflected in reported performance.

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. Managed care plans are contractually required to perform at or above the established MPLs. Managed care plans that have rates below the MPLs are frequently assigned mandated improvement projects by DHCS. With repeated low performance, managed care plans risk issuance of a formal DHCS Corrective Action Plan (CAP) as well as financial penalties.

QI Leader Takeaways

As a quality leader, it is important to understand how HEDIS influences organizational priorities and aligns with other measurement systems.

When developing a quality strategy:

- Focus on HEDIS measures that are a priority for the Partnership reporting region.
- Identify where measures overlap with UDS and QIP.
- Recognize that strong documentation and encounter data support HEDIS performance.
- Consider HEDIS measures as a part of a broader quality improvement portfolio rather than a stand-alone reporting requirement.

Within this toolkit, HEDIS is most useful when viewed alongside UDS, QIP, and other population health management initiatives. Understanding where measures align across systems can help health centers focus improvement efforts where they will have the greatest impact on patients, organizational performance, and incentive opportunities.

Resources

- <http://www.partnershiphp.org/Providers/Quality/Pages/HEDISLandingPage.aspx>
- <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>
- <http://www.ncqa.org/hedis-quality-measurement>

Primary Care Provider Quality Improvement Program (QIP)

Purpose

The Primary Care Provider Quality Improvement Program (QIP) is Partnership HealthPlan of California's (Partnership) provider incentive program designed to support improvements in quality, access, patient experience, and population health outcomes. The QIP is designed in collaboration with PHC providers.

The QIP combines financial incentives, performance measurement, and technical assistance to encourage primary care providers to focus on areas that have the greatest impact on patient outcomes and health system performance.

Unlike many quality improvement systems that are primarily designed for compliance or accountability, QIP is specifically designed to drive improvement.

Audience

The QIP performance data are used by:

- Partnership HealthPlan of California
- Health center leadership
- Quality improvement teams
- Clinical and operational leaders

Why QIP Matters to Health Centers

For many health centers, QIP represents the most direct connection between quality improvement efforts and financial incentives.

The program rewards organizations for improving performance on measures that are strongly associated with preventive care, chronic disease management, access, and patient experience. Many of these measures also align with UDS and HEDIS reporting requirements.

As a result, QIP can serve as an important strategic tool for focusing improvement efforts.

When health centers improve performance on high-alignment measures – or those that are also aligned with UDS and HEDIS – they may simultaneously improve performance across multiple reporting systems while also increasing eligibility for incentive payments.

For quality leaders, this alignment creates an opportunity to maximize the impact of limited quality improvement resources.

How Performance is Measured

The QIP consists of two primary components:

Core Measurement Set: evaluates provider performance across four domains:

- Clinical Quality
- Appropriate Use of Resources
- Access and Operations
- Patient Experience

Performance is measured across an eligible population. and incentive payments are tied to performance on these measures.

Unit of Service Measures: provide incentives for activities that support infrastructure development, quality improvement capacity, care coordination, and population health management. Examples include:

- Patient-Centered Medical Home (PCMH) certification
- Health Information Exchange (HIE) participation
- Health Equity planning
- Electronic Clinical Data System (ECDS) implementation
- Peer-Led Self-Management and Pediatric Group Visits
- Advanced Care Planning
- Academic Detailing

Together, these two components support both clinical outcomes and the systems needed to sustain improvement.

For the Core Measurement Set, performance is rewarded based on the **points earned** and the **number of member months** accumulated throughout the year. There is a per member per month (PMPM) amount for all sites. The number of member months is multiplied by the PMPM to determine the maximum amount an individual site can earn. That amount is then multiplied by the percentage of points earned through the Core Measurement Set to determine the actual incentive amount.

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

Clinical measures are tracked by eReports, an online system developed and maintained internally by Partnership. Functions offered in eReports to quality leaders include:

- Tracking clinical performance in real time
- Downloading patient reports for each of the clinical measures
- Uploading supplemental data for your patients

For information on how to create and eReports account and manage the site, please refer to the eReports User Manual on the [PHC Website](#). FQHC quality leaders should confirm measure definitions, thresholds, exclusions, and incentive rules against the current Partnership specifications for the applicable measurement year.

Points for clinical measures are determined by thresholds obtained by NCQA. The thresholds used typically include the 75th and 90th percentiles calculated from the previous year's HEDIS data. Health centers can earn points for relative improvement (without meeting the threshold) on a clinical measure by first meeting the 75th percentile performance target and demonstrating a minimum of 15% relative improvement.

Key Terms of the Partnership QIP

- **Eligible Population:** Assigned and/or Capitated Medi-Cal members, excludes Medi-Medi or members with other insurance primary, and Special Members.
- **Continuous Enrollment:** Members assigned for nine out of the 12 months between January 1 and December 31 of the reporting year. December is the anchor month. Applies to Clinical measures only.
- **Member Months (MM):** The sum of monthly enrollment counts over the course of the 12-month measurement period.
 - Example: If a site has 1,000 members each month, for the full measurement year the site has accumulated 12,000 member months
- **Per member per month (PMPM):** amount budgeted for the incentive payment
 - Note: 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.

QIP Leader Takeaways

QIP should not be viewed solely as an incentive program.

Instead, quality leaders can use QIP as a strategic framework for identifying organizational priorities and focusing improvement efforts.

When developing a quality strategy:

- Prioritize measures that align across QIP, UDS, and HEDIS
- Use incentive opportunities that improve patient outcomes and support organizational improvement goals
- Monitor performance regularly to identify emerging gaps
- Develop multi-year strategies for clinical measure improvement

For many health centers, QIP provides a practical mechanism for translating quality goals into action. The most successful organizations organize their quality strategy around strengthening systems of care. Examples include:

- Improving preventive care outreach workflows
- Building robust care gap management processes
- Expanding population health management capabilities
- Strengthening health equity initiatives
- Developing data and reporting infrastructure

Viewed through this lens, QIP becomes more than an incentive program – it becomes a tool for building capacity for continuous improvement.

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 (FSR)

Purpose

The Facility Site Review (FSR) is a regulatory and operational assessment conducted by Partnership HealthPlan of California (Partnership) and required by the California Department of Health Care Services (DHCS).

The purpose of the review is to ensure that provider organizations maintain the systems, policies, procedures, and clinical environments necessary to deliver safe, accessible, and high-quality care.

Unlike HEDIS, QIP, and UDS, which primarily focus on clinical performance and outcomes, the Facility Site Review focuses on the organizational infrastructure that supports quality care delivery.

Audience

The FSR is relevant to:

- Partnership HealthPlan of California
- Health center leadership
- Quality improvement teams
- Clinical and operational leaders

Why FSR Matters to Health Centers

Quality outcomes do not occur in isolation. Strong performance on preventive care, chronic disease management, and patient experience measures depends on reliable systems and operational processes.

The FSR evaluates whether those foundational systems are in place.

The FSR 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.

The review assesses key operational areas including:

- Accessibility / Safety
- Office Management
- Personnel
- Clinical Services
- Preventive Services

- Infection Control

Viewed strategically, FSR helps organizations strengthen the operational foundation upon which quality efforts are built.

How Performance is Measured

The Site Review process includes three related components:

Facility Site Review: evaluates the physical environment, policies, procedures, equipment, and operational practices of the organization. Organizations are scored against DHCS-established standards and may be required to submit corrective action plans if deficiencies are identified.

Medical Records Review: evaluates the completeness and quality of clinical documentation. The areas being reviewed include format, documentation standards, continuity of care, pediatric and adult preventive care, and obstetrics/Comprehensive Perinatal Services Program (CPSP) preventive care. The review is particularly relevant to quality leaders because documentation practices directly influence performance on many HEDIS, UDS, and QIP measures.

Physical Accessibility Site Review: evaluates accessibility for patients with disabilities and seniors. Areas assessed include parking, building access, exam rooms, restrooms, and medical equipment accessibility. The review supports efforts to improve access to care and create more inclusive care environments.

QI Leader Takeaways

Quality leaders often focus on clinical performance measures such as blood pressure control or cancer screening. However, sustainable improvement requires strong operational systems.

When reviewing FSR findings, consider:

- Are documentation practices supporting accurate quality reporting?
- Are referral management processes functioning effectively?
- Are clinic workflows supporting preventive care delivery?
- Are staff training and competency processes adequate?
- Are there operational barriers that may be limiting quality performance?

FSR findings can provide valuable insights into root causes that may be contributing to performance challenges. While HEDIS, UDS, and QIP answer questions about outcomes and performance, FSR helps answer questions about operational reliability.

Uniform Data System (UDS)

Purpose

The Uniform Data System (UDS) is the national reporting system used by the Health Resources and Services Administration (HRSA) to monitor the performance of federally funded health centers.

UDS provides a standardized framework for reporting information about the patients served, services delivered, clinical quality outcomes, staffing, utilization, and financial performance of health centers across the country. HRSA's Bureau of Primary Health Care reports UDS data to the public through the website: <http://bphc.hrsa.gov/datareporting/index.html>.

The system allows HRSA, health centers, patients, policymakers, and other stakeholders to understand how health centers are performing and how effectively they are meeting the needs of their communities.

Audience

UDS data are used by:

- Health Resources and Services Administration (HRSA)
- Health center leadership
- Health center boards
- Quality improvement teams
- Policymakers
- Researchers

UDS provides one of the most comprehensive views of FQHC performance available.

Why UDS Matters to Health Centers

UDS provides a unique view of how effectively the health center delivers recommended care to patients who access services. The measure set provides a broad picture of organizational performance across multiple domains, including:

- Preventive care
- Chronic disease management
- Behavioral health integration
- Maternal and child health
- Health outcomes
- Health disparities

Many of the UDS measures also align with HEDIS and QIP requirements, creating opportunities for organizations to improve performance across multiple measurement systems through a single improvement effort.

How Performance is Measured

Health centers report UDS data annually in February based on services delivered during the prior calendar year.

The UDS report includes information across several major categories:

- Patient population and demographics
 - Patients by zip code
 - Patients by age and sex assigned at birth (Table 3A)
 - Demographic characteristics – ethnicity, race (Table 3B)
 - Select patient characteristics – income, insurance, managed care utilization, special populations (Table 4)
- Health center staffing and utilization (Table 5)
- Select diagnoses and services rendered (Table 6A)
- Quality of care measures (Table 6B)
- Health outcomes (Table 7)
- Financial costs (Table 8A)
- Patient related revenue (Table 9D)
- Other revenues (Table 9E)
- Appendix: Health center Health Information Technology (HIT) capabilities

UDS clinical quality measures are aligned with nationally recognized electronic clinical quality measures (eCQMs), Centers for Medicare & Medicaid Services (CMS) measures, and HEDIS specifications. This alignment helps reduce variation across reporting systems and creates greater consistency in quality measurement.

QI Leader Takeaways

Quality leaders should think of UDS as more than an annual reporting requirement.

UDS provides a valuable framework for understanding how well the organization is serving its patient population and where improvement efforts may have the greatest impact.

When reviewing UDS results, consider:

- Which measures align with health center priorities?
- Which measures overlap with HEDIS and QIP?
- Where are the largest performance gaps?
- Are there disparities in outcomes among patient populations?
- Which measure could benefit from focused improvement efforts?

Many health centers use UDS results to inform annual quality plans, strategic planning decisions, and Board-level quality reports.

Resources

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

From Measurement to Improvement: Understanding Measure Alignment and Improvement Strategy

After understanding the purpose of UDS, HEDIS, QIP, and Facility Site Review, the next step for quality leaders is understanding how these measurement systems work together.

Many of the measures included in these programs assess the same clinical topics, such as cancer screening, immunizations, chronic disease management, and depression screening. While these measures may appear similar, they are often measuring different patient populations and supporting different health center goals.

Understanding both the areas of alignment and the differences between measurement systems helps health centers develop more effective quality improvement strategies.

Measure Alignment Across Measurement Systems

The table below highlights the measures included in this toolkit and shows where they align across major reporting and incentive programs.

Themes	Measure Name	FSR	HEDIS	PCP QIP	UDS
Primary Preventive	Cervical Cancer Screening	X	X	X	X
	Breast Cancer Screening	X	X	X	X
	Colorectal Cancer Screening	X	X	X	X
	Prenatal & Postpartum Care - Timeliness of Prenatal Care	X	X	X	X
	Prenatal & Postpartum Care - Postpartum Care		X		
	Birth Weight of Infants				X
	Depression Screening	X			X
	Depression Remission				X
	Dental Sealants	X	X		X
Immunizations	Childhood Immunization Combination 10	X	X	X	X
	Immunizations for Adolescents	X	X	X	
Chronic Disease Management	Diabetes Care - Retinal Eye Exam			X	
	Diabetes Care - HbA1c Control		X	X	X
	Complete Lipid panel	X			
	Hypertension- Controlling High Blood Pressure	X	X	X	X
	Tobacco Use and Cessation	X			X
	HIV Screening				X
	HIV Linkages to Care				X
	Adult Weight Screening and Follow-Up	X			X
Well Child Checks	WCC-BMI	X			X
	Well Child 3-6 Years	X			
	Well Child First 15 Months of Life	X	X	X	
	Child and Adolescent Well Care	X	X	X	
	Lead Screening in Children	X	X	X	
Medication Management	Asthma Medications		X		
	Statin Therapy				X
	Ischemic Vascular Disease (IVD): Aspirin or Anti Thrombotic Therapy				X

* Refer to the full Measure Alignment Crosswalk ([link](#)) for detailed measure specifications and program requirements.

Similar Measures, Different Improvement Strategies

One of the most important concepts for quality leaders is recognizing that measures may align across programs while requiring different improvement approaches. Although many measures appear in UDS, QIP and HEDIS, the populations being measured may be different.

HEDIS and QIP: A Population Health Perspective

HEDIS and QIP primarily evaluate care provided to assigned PHC members. These systems ask:

“How effectively are we managing the health of the population for which we are accountable?”

Success depends on identifying patients who may not be actively seeking care and proactively closing care gaps across the assigned population.

Common quality improvement questions include:

- Which assigned members have care gaps?
- Who is overdue for preventive services?
- Which patients are not engaging in care?
- How effectively are we reaching patients who have not been seen recently?
- Are our outreach and recall systems working?

For many measures the greatest improvement opportunities occur outside the patient visit.

UDS: A Care Delivery Perspective

UDS primarily evaluates care delivered to patients who received services from the health center during the reporting period.

UDS asks the question:

“When patients come to us for care, are we consistently delivering recommended services?”

Success depends on ensuring that every visit is used as an opportunity to provide evidence-based preventive care and chronic disease management.

Common quality improvement questions include:

- Are patients with care gaps being identified during visits?
- Are recommended screenings being offered routinely?
- Are care teams consistently following established workflows?
- Where are missed opportunities occurring?
- Are documentation practices accurately capturing care delivered?

For many UDS measures, the greatest opportunity for improvement occurs in pre-visit planning and during the patient encounter.

Strategic Insight: One Measure, Two Perspectives

Consider colorectal cancer screening.

HEDIS / QIP Perspective <i>Focus is on assigned members</i>	UDS Perspective <i>Focus is on care delivery during visits</i>
Which assigned members are overdue? Have we contacted them? Are outreach efforts effective? Are screening kits being returned?	Are eligible patients being identified prior to or during visits? Are providers recommending screening? Are referrals being placed and tracked? Are opportunities for screening being missed?

Both perspectives are important. Health centers that perform well on quality measures typically combine strong population health management strategies with reliable care delivery processes.

Strategic Measure Profiles and Detailed Measure Crosswalk

Building Your Quality Strategy One Measure at a Time

By now, you have explored the quality measurement systems that influence health center performance and learned how they work together to support a comprehensive quality strategy. You have also seen that many clinical measures align across UDS, HEDIS, QIP, and other quality initiatives, while requiring different improvement approaches depending on the patient population being measured.

The next step is translating those strategic concepts into measure-level planning.

This section of the toolkit provides two practical resources designed to support that work:

- **Strategic Measure Profiles** – concise planning guides that explain why each measure matters, how it aligns across quality measurement systems, and the types of improvement strategies most likely to influence performance.
- **Detailed Measure Crosswalk** – an Excel-based technical reference that compares measure specifications across quality programs and supports quality planning, reporting, and implementation.

Used together, these resources help quality leaders move from understanding quality measurement systems to designing coordinated improvement strategies.

From Quality Strategy to Quality Improvement

The Health Center Quality Strategy Map introduced earlier in this toolkit describes quality planning as a progression.

Understand the Quality Landscape
Identify Strategic Measure Alignment
Establish Organizational Priorities
Prepare for Improvement

The Strategic Measure Profiles and Detailed Measure Crosswalk support the final two steps of this process.

Once organizational priorities have been established, quality leaders need practical tools that help answer questions such as:

- Which measures should we focus on this year?
- Why is this measure strategically important?
- Does this measure align across multiple reporting systems?
- Should our improvement strategy focus on population health outreach, care delivery during visits, or both?

- What technical specifications do our teams need to understand to accurately measure performance?

This chapter provides those tools.

Strategic Measure Profiles

The Strategic Measure Profiles are designed to help quality leaders think beyond measure specifications and understand how each measure contributes to organizational quality strategy.

Each profile follows a consistent format to support annual quality planning.

Each profile includes:

Why This Measure Matters

Provides clinical context, health equity considerations, and the importance of the measure for rural and frontier communities.

Measure Alignment

Shows where the measure aligns across:

- UDS
- HEDIS
- QIP
- Population Health Management initiative (PHMI)

Understanding alignment helps identify opportunities where one improvement effort can support multiple organizational goals.

Understanding the Improvement Strategy

Each profile introduces two complementary improvement perspectives:

Population Health Perspective	Care Delivery Perspective
Focuses on identifying assigned patients with care gaps through outreach, registry management, and panel management.	Focuses on reducing missed opportunities by improving workflows, documentation, and preventive care delivered during patient encounters.

Regional Performance

Regional performance data provide context for understanding variation across Northern California health centers and identifying opportunities for improvement.

Measure Definition and Benchmarks

Each profile concludes with a concise measure definition and key benchmark information to support planning discussions.

Detailed Measure Crosswalk

The accompanying Excel workbook serves as the technical companion to this toolkit by bringing together detailed information about each measure in a single reference.

Measures are organized using the same clinical portfolios introduced throughout the toolkit:

- Primary Prevention
- Immunizations
- Chronic Disease Management and Risk Reduction
- Child and Adolescent Health
- Medication Management

Organizing measures by clinical portfolio reinforces the concept that quality improvement should be organized around patient care priorities rather than individual reporting programs.

What's Included in the Detailed Measure Crosswalk

The Detailed Measure Crosswalk compares quality measures across reporting systems and includes information such as:

- Measure alignment across UDS, HEDIS, QIP, and other programs
- Reporting periods
- Numerator and denominator definitions
- Look-back periods
- Exclusions
- Data sources
- Documentation requirements
- Benchmark information
- Related measure specifications

This resource is intended to complement—not replace—the official specifications published by HRSA, DHCS, NCQA, and Partnership HealthPlan.

Using These Resources Throughout the Quality Planning Cycle

The Strategic Measure Profiles and Detailed Measure Crosswalk are designed to support quality leaders throughout the year, not just during annual reporting.

During the Quality Planning Cycle...	Use the Strategic Measure Profiles to...	Use the Detailed Measure Crosswalk to...
Review organizational performance	Understand why measures matter and how they align across programs.	Compare technical specifications and reporting requirements.
Select annual priorities	Identify high-leverage measures and appropriate improvement approaches.	Confirm measure definitions and reporting differences.
Plan improvement initiatives	Discuss population health and care delivery strategies with improvement teams.	Review numerator, denominator, exclusions, and documentation requirements.
Engage clinical teams	Explain the clinical importance of measures and why they have been prioritized.	Answer detailed measure questions and support EHR reporting.
Monitor improvement	Interpret performance trends within the context of organizational strategy.	Validate data and ensure consistent measurement over time.

Quality Leadership in Practice

One of the themes of this toolkit is that quality leadership extends beyond reporting performance.

Quality leaders help organizations translate multiple reporting requirements into a coordinated improvement strategy that supports patients, clinicians, and organizational goals.

The Strategic Measure Profiles and Detailed Measure Crosswalk are intended to support that work by helping quality leaders:

- Connect individual measures to broader organizational priorities.
- Recognize opportunities where one improvement effort can influence multiple reporting systems.
- Select improvement approaches that match the population being measured.
- Build a shared understanding of quality measures across clinical, operational, and executive teams.
- Prepare improvement initiatives using consistent technical specifications and performance data.

When used together with the Health Center Quality Strategy Map, these resources provide a common framework for moving from quality measurement to quality improvement.

Looking Ahead

Quality improvement is an ongoing process of learning, prioritizing, and adapting to changing patient and organizational needs. While reporting requirements and measure specifications will continue to evolve, the principles presented in this toolkit remain constant:

- Understand the quality landscape.
- Identify where measures align.
- Focus improvement efforts where they will have the greatest impact.
- Use data to guide continuous learning and improvement.

The Strategic Measure Profiles and Detailed Measure Crosswalk are intended to be practical resources that support this work and help quality leaders build a coordinated, patient-centered quality strategy that advances the mission of California's federally qualified health centers.

Cervical Cancer Screening

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Cervical cancer is one of the most preventable forms of cancer when screening is completed according to recommended guidelines. Women living in rural communities experience higher rates of cervical cancer incidence and mortality than those in urban areas. Delayed screening, transportation barriers, limited access to women's health services, and challenges navigating the healthcare system can contribute to these disparities.

Routine cervical cancer screening with the Pap test can identify precancerous lesions or cancer in the early stages, when treatment is most effective. More than half (51.4%) of cervical cancer cases in California are diagnosed at an advanced stage, and most (56%) occur among women who have not had a Pap test in the past three years.

Improving cervical cancer screening can reduce preventable illness and death while advancing preventive care, health equity, and population health goals.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS ✓ QIP ✓ UDS ✓ PHMI	Primary Prevention	HIGH

Cervical Cancer Screening is a high-leverage quality measure that aligns across multiple quality measurement systems. Improvement efforts can simultaneously support federal reporting, managed care quality performance, provider incentive programs, and population health initiatives.

Understanding the Improvement Strategy

HEDIS & QIP	UDS
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which assigned eligible patients have an open cervical cancer screening care gap?	Key question: When eligible patients are seen in the clinic, are we consistently offering cervical cancer screening?
COMMON STRATEGIES • Patient outreach and reminders • Registry management • Care gap reports • Health fairs or screening days	COMMON STRATEGIES • Pre-visit planning • Clinical reminders • Standing orders • Reliable documentation and data capture

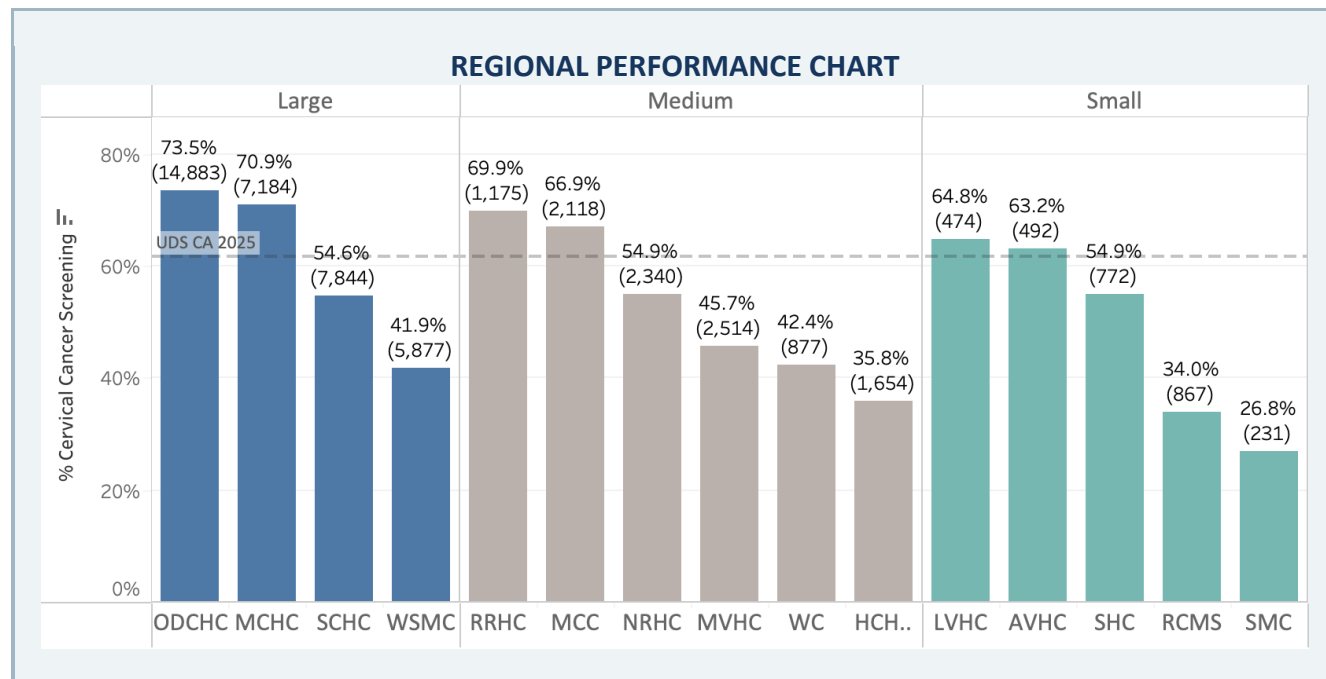
Strategic takeaway: Strong performance requires both proactive outreach to patients who are overdue and reliable clinical processes that reduce missed opportunities during visits.

Rural Northern California Performance

Regional Insights

- Clinical guidelines have lengthened the interval between screenings. Patients may not know when they are due, making reminders important.
- Patients may receive screenings outside their assigned primary care provider, creating documentation and data-capture challenges.
- Accurate documentation of hysterectomy status is essential for appropriate denominator management.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers?
- Are gaps concentrated among particular patient populations or clinic sites?
- Are screenings completed outside the health center being captured reliably?
- Should Cervical Cancer Screening be considered an enterprise quality improvement priority?

Quality Measure Definition (UDS)

Percentage of women 21*–64 years of age who were screened for cervical cancer: women age 21*–64 who had cervical cytology every 3 years, or women age 30–64 who had cervical cytology/HPV co-testing every 5 years. *Data collected for women with an initial age of 23, given the 2-year look-back period.

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	75th percentile nationally for Medicaid health plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.
California and U.S. UDS	CA UDS 2025: 61.7% US UDS 2025: 57.0%

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Breast Cancer Screening

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Breast cancer is the second most common cancer among women in the United States and remains one of the leading causes of cancer-related death. Regular mammography screening allows breast cancer to be detected earlier, when treatment is more effective and survival rates are highest. Women at increased risk may benefit from earlier or more frequent screening based on clinical recommendations.

Women living in rural Northern California often face additional barriers to breast cancer screening, including limited access to mammography services, transportation challenges, workforce shortages, and long travel distances to imaging facilities. These barriers contribute to lower screening rates and may delay diagnosis and treatment.

Improving breast cancer screening is an important opportunity to reduce preventable cancer deaths while advancing preventive care, health equity, and population health goals.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS ✓ QIP ✓ UDS ✓ PHMI	Primary Prevention	HIGH

Breast Cancer Screening is a high-leverage quality measure that aligns across multiple quality measurement systems. Improvement efforts can simultaneously support federal reporting, managed care quality performance, provider incentive programs, and population health initiatives.

Understanding the Improvement Strategy

HEDIS & QIP	UDS
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which assigned patients have an open breast cancer screening care gap?	Key question: When eligible patients are seen in the clinic, are we consistently addressing breast cancer screening?
COMMON STRATEGIES • Patient outreach and reminders • Care gap reports and registries • Recall systems • Mobile mammography outreach	COMMON STRATEGIES • Pre-visit planning • Clinical reminders • Standing orders and team-based workflows • Documentation of mammograms completed outside the health center

Strategic takeaway: Strong performance requires both proactive outreach to patients who are overdue and reliable clinical processes that reduce missed opportunities during visits.

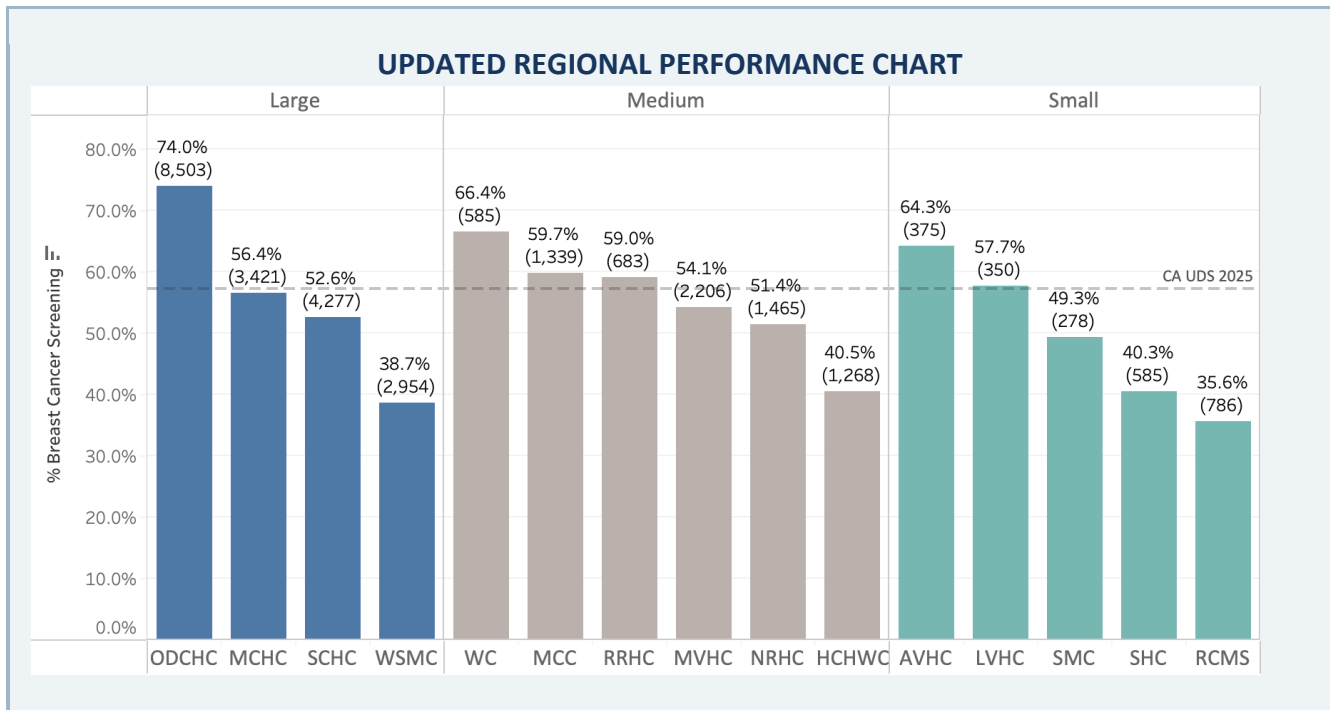
Rural Northern California Performance



Regional Insights

- Access to mammography remains a significant challenge for many rural and frontier communities because of travel distance and limited availability of imaging services.
- Mobile mammography services and coordinated referral partnerships can improve access for patients living in remote areas.
- Mammography appointments often have higher no-show rates than other preventive services, making patient reminder systems and navigation particularly important.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers?
- Are differences in performance driven primarily by access barriers or care delivery processes?
- Are patients completing mammograms that are not being documented in the EHR?
- Should Breast Cancer Screening be considered an enterprise quality improvement priority?

Quality Measure Definition (UDS)

Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer during the 27 months prior to the end of the measurement period.

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	75th percentile nationally for Medicaid health plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.
California and US UDS average	CA UDS 2025: 59.4% US UDS 2025: 56.0%

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Colorectal Cancer Screening

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Colorectal cancer is a leading cause of cancer-related death in the United States. Screening can identify and remove dangerous polyps before they become cancerous or detect cancer at an earlier stage, when treatment is most effective.

Rural Northern California communities face important disparities in colorectal cancer outcomes. The age-adjusted death rate ranges from 17.9 per 100,000 in Lake County to 9.7 per 100,000 in Lassen County, compared with 12.1 per 100,000 statewide. Low-income adults are also less likely to be up to date with screening, and patients diagnosed with cancer may face substantial barriers to specialty care.

Improving colorectal cancer screening is an opportunity to prevent cancer, reduce avoidable deaths, and advance preventive care and health equity—particularly when health centers make screening options and follow-up pathways easier to access.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS ✓ QIP ✓ UDS ✓ PHMI	Primary Prevention	HIGH

Colorectal Cancer Screening is a high-leverage quality measure that aligns across multiple quality measurement systems. Improvement efforts can simultaneously support federal reporting, managed care quality performance, provider incentive programs, and population health initiatives.

Understanding the Improvement Strategy

HEDIS & QIP	UDS
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which assigned eligible patients have an open colorectal cancer screening care gap?	Key question: When eligible patients are seen, are we consistently offering and completing an appropriate screening option?
COMMON STRATEGIES • Patient outreach and reminders • Registry and care gap management • Mailed FIT/FOBT kits • Flu/FIT and community campaigns	COMMON STRATEGIES • Pre-visit planning and reminders • Offer appropriate screening options • Clear test instructions and teach-back • Track results and diagnostic follow-up

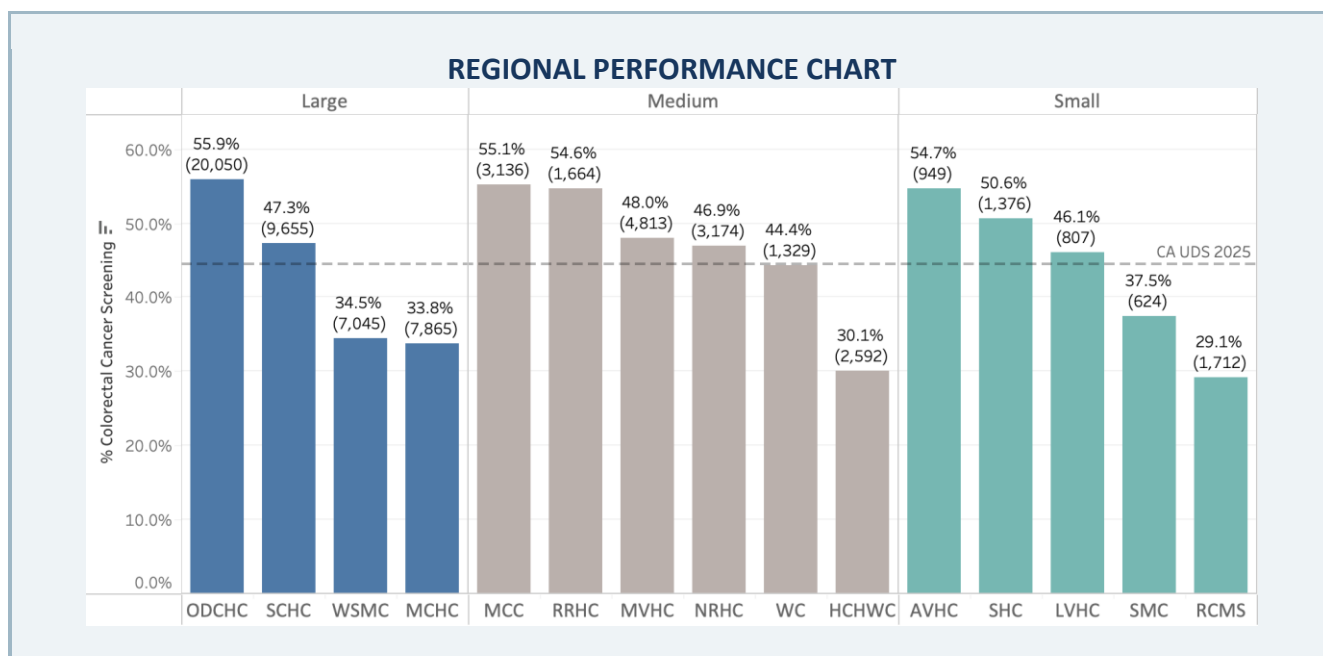
Strategic takeaway: Strong performance requires proactive outreach, accessible screening choices, reliable test completion, and closed-loop follow-up after abnormal results.

Rural Northern California Performance

Regional Insights

- Communities with more retirees and older adults may be more receptive to colorectal cancer screening, while local demographics can influence screening rates.
- Cost and access remain significant barriers. FIT-DNA/FOBT offers a less invasive option, and plain-language instructions, mailed kits, and timely reminders can support completion.
- Limited access to specialists for diagnostic follow-up and treatment can weaken the screening pathway even when lower-cost tests are available.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers?
- Which screening options are most accessible and acceptable to our patients?
- Are positive stool-based tests consistently tracked through diagnostic colonoscopy?
- Should Colorectal Cancer Screening be considered an enterprise quality improvement priority?

Quality Measure Definition (UDS)

Percentage of adults age 45–75 who had appropriate colorectal cancer screening: FOBT within 1 year; FIT-DNA within 3 years; flexible sigmoidoscopy within 5 years; CT colonography within 5 years; or colonoscopy within 10 years.

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	75th percentile nationally for Medicaid health plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.
California and U.S. UDS	CA UDS 2025: 44.4% US UDS 2025: 44.9%

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Prenatal and Postnatal Care

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Healthy pregnancies are supported when comprehensive prenatal care begins early and continues through pregnancy, delivery, and the postpartum period. First-trimester prenatal care helps identify risks, connect patients with needed services, and improve maternal and infant outcomes. Patients who receive no prenatal care are nearly three times as likely to have a low-birthweight infant.

Patients who are uninsured or lack a regular source of care before pregnancy are more likely to enter prenatal care after the first trimester. Rural communities may also face transportation, workforce, and specialty-access barriers. Tobacco and alcohol use around pregnancy are more prevalent in rural Northern California than in other areas of the state, and depression affects an estimated 14–23% of pregnant patients and up to 25% of postpartum patients.

Improving timely prenatal and postpartum care strengthens continuity, supports early risk identification, and creates opportunities to address behavioral health, substance use, nutrition, family planning, and social needs.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS ✓ QIP ✓ UDS ✓ PHMI	Maternal Health	HIGH

Prenatal and Postnatal Care aligns maternal health priorities across multiple measurement systems. Coordinated improvement can support timely entry into care, continuity through the postpartum period, managed care performance, and broader maternal and infant health goals.

Understanding the Improvement Strategy

HEDIS & QIP	UDS
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which pregnant or postpartum patients need timely outreach, enrollment support, or follow-up?	Key question: Are reliable workflows connecting patients to early prenatal care and a completed postpartum visit?
COMMON STRATEGIES • Pregnancy and postpartum registries • Early outreach and appointment reminders • Insurance and benefit enrollment support • Maternal health program referrals	COMMON STRATEGIES • Pregnancy testing and rapid scheduling • Screen for tobacco, alcohol, drugs, and depression • Schedule postpartum care before discharge • Coordinate maternal and infant visits

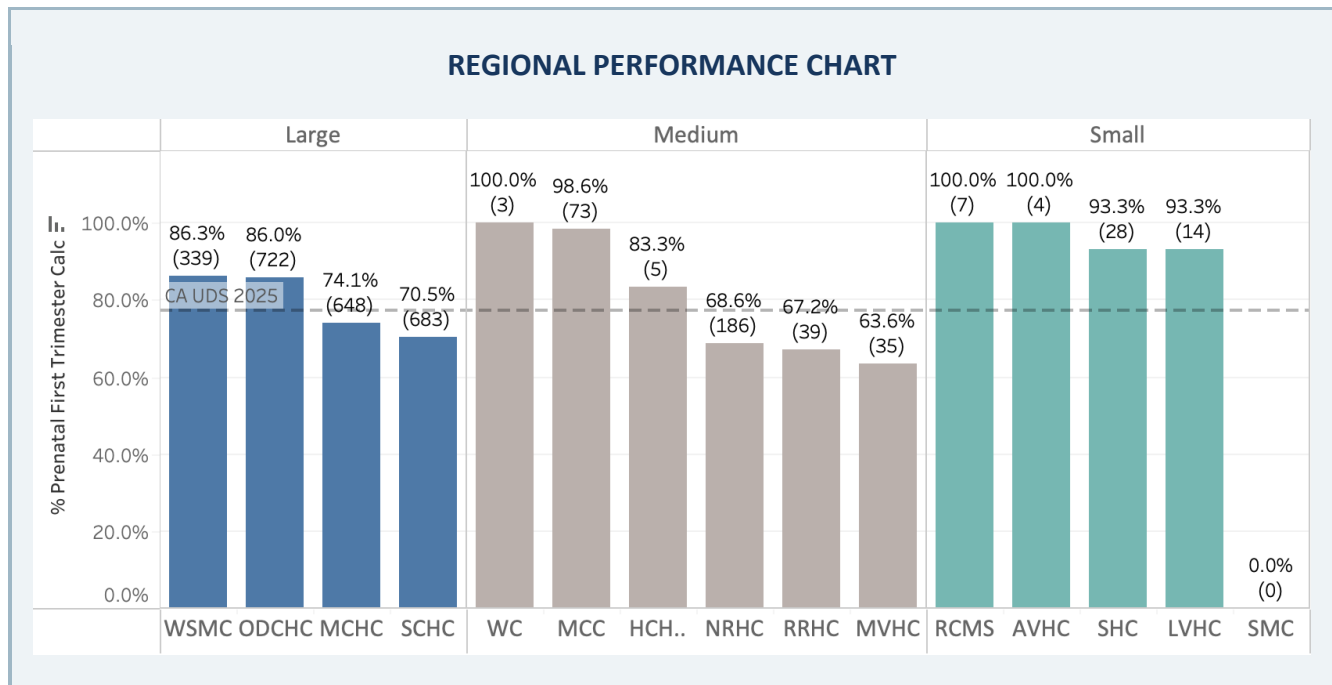
Strategic takeaway: Strong performance requires early identification, proactive outreach, rapid access to prenatal care, and reliable continuity through the postpartum period.

Rural Northern California Performance

Regional Insights

- Health centers often see pregnant patients as new patients, and some do not seek care until after the first trimester.
- Patients receiving primary maternity care from a midwife or another practitioner may use the health center for screenings or services not available through that provider.
- Many rural health centers serve relatively few prenatal patients; even one late entry can meaningfully affect reported performance.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers?
- How quickly can a newly identified pregnant patient obtain a first prenatal appointment?
- Are referrals, outside prenatal care, and postpartum visits documented reliably?
- Should Prenatal and Postnatal Care be considered an enterprise quality improvement priority?

Quality Measure Definition (UDS)

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

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	75th percentile nationally for Medicaid health plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.
California and U.S. UDS	CA UDS 2025: 77.2% US UDS 2025: 73.4%

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Depression Screening and Follow-Up

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Depression is common, treatable, and associated with serious health risks, including suicide and cardiovascular death. Nationally, approximately one in 12 adults reports depression, and one in nine women experiences postpartum depression. Screening creates an opportunity to identify symptoms earlier and connect patients with effective follow-up care.

Behavioral health needs are substantial in rural Northern California: 37.9% of low-income adults and 33.7% of teens report needing help with emotional or mental health problems. The Northern and Sierra region has a suicide rate of 21.1 per 100,000—about twice the California average of 10.4. Many people who attempt suicide have a healthcare visit in the preceding weeks or months.

Improving depression screening and follow-up strengthens early identification, supports suicide prevention, and helps health centers connect patients with medication, therapy, behavioral health services, and social supports.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS X QIP ✓ UDS ✓ PHMI	Behavioral Health	MODERATE

Depression Screening and Follow-Up aligns behavioral health priorities across multiple measurement systems. Improvement requires both broad screening reach and reliable action when a screen is positive, supporting reporting, managed care performance, integrated care, and patient safety.

Understanding the Improvement Strategy

HEDIS	UDS
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which eligible patients have not been screened, and which positive screens still need documented follow-up?	Key question: At each eligible visit, are we screening with a standardized tool and acting on positive results?
COMMON STRATEGIES - Population lists and care gap reports - Outreach and appointment reminders - Track positive screens and follow-up status - Monitor disparities by population	COMMON STRATEGIES - PHQ-2, PHQ-9, or PHQ-A workflows - EHR prompts and documentation templates - Same-day follow-up plan for positive screens - Integrated primary and behavioral health care

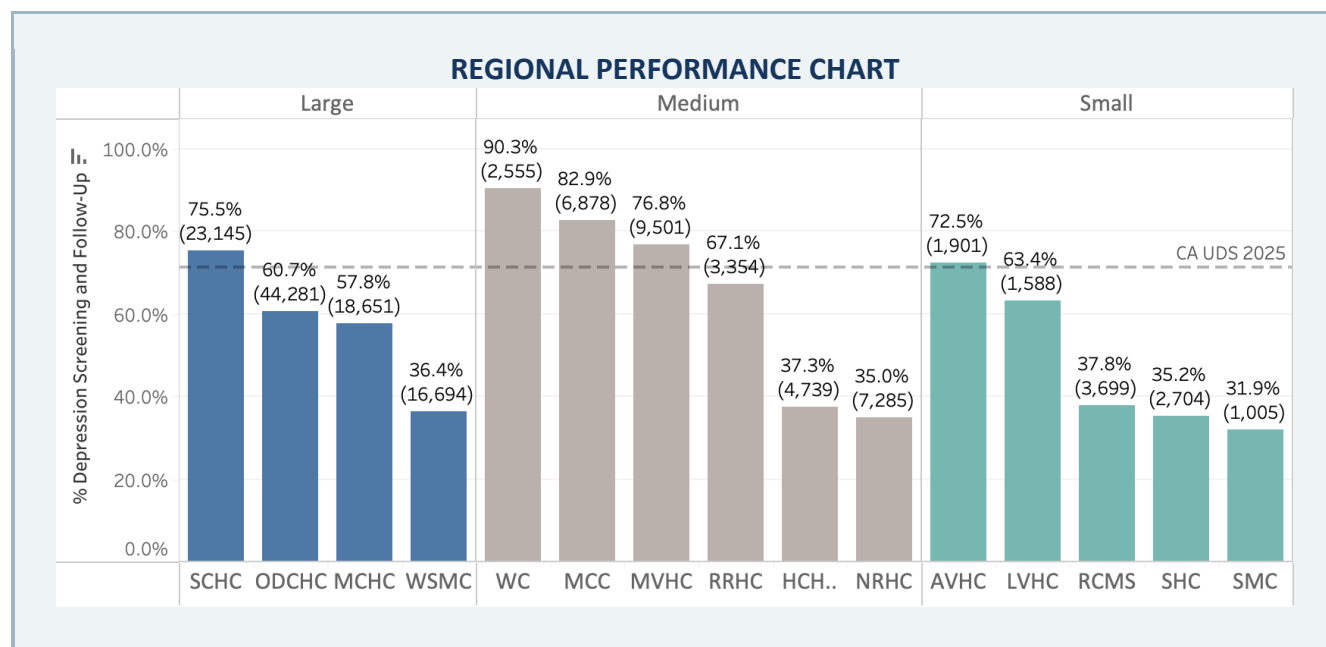
Strategic takeaway: Strong performance requires consistent standardized screening and a documented, clinically appropriate follow-up plan on the date of every positive screen.

Rural Northern California Performance

Regional Insights

- EHR health-maintenance alerts can help clinicians and care teams complete at least annual depression screening.
- Not all EHRs reliably capture follow-up interventions, requiring some health centers to develop manual or complex processes for medications, services, and referrals.
- As regional health centers have increased integration of primary care and behavioral health, measure performance has improved.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers?
- Are positive screens receiving a documented follow-up plan on the same date?
- Do documentation or referral workflows create avoidable reporting gaps?
- Should Depression Screening and Follow-Up be considered a quality improvement priority this year?

Quality Measure Definition (UDS)

Percentage of patients age 12 and older who were screened for depression on the date of the visit using an age-appropriate standardized tool and, if positive, had a follow-up plan documented on the date of the positive screen.

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	75th percentile nationally for Medicaid health plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.
California and U.S. UDS	CA UDS 2025: 71.2% US UDS 2025: 75.3%

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Childhood Immunization Status (CIS Combo 10)

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Childhood immunizations protect children from serious, preventable diseases and help protect the broader community. By the second birthday, children are recommended to receive a coordinated series of vaccines against 10 childhood diseases. Completing the full series on time requires reliable care-team workflows across many visits and doses.

Communities with unvaccinated or under-vaccinated populations are at greater risk for outbreaks. Approximately 85–95% of a community must be immunized to provide community-level protection, depending on the disease. Rural health centers may face additional barriers, including vaccine hesitancy, misinformation, transportation challenges, missed well-child visits, and incomplete records across care settings.

Improving Childhood Immunization Status prevents avoidable illness, supports school readiness, advances health equity, and strengthens trust between families and care teams. Success depends on both proactive outreach to families and reliable vaccination opportunities at every eligible encounter.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS ✓ QIP ✓ UDS ✓ PHMI	Immunizations	HIGH

Childhood Immunization Status is a high-leverage pediatric quality measure that aligns across federal reporting, managed care, incentive, and population health priorities. Improvement efforts can close individual care gaps while strengthening preventive-care systems for the entire pediatric population.

Understanding the Improvement Strategy

HEDIS & QIP	UDS
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which assigned children are missing one or more doses needed to complete CIS Combo 10 by age two?	Key question: At every eligible encounter, are we reviewing the immunization history and administering all vaccines that are due?
COMMON STRATEGIES - Immunization registries and care gap reports - Parent reminders and recall outreach - Partnership immunization dose reports - Monitor disparities and missed-dose patterns	COMMON STRATEGIES - Assess immunization status at every visit - Standing orders and EHR reminders - Walk-in and extended-hour vaccination access - Document and reconcile records through CAIR

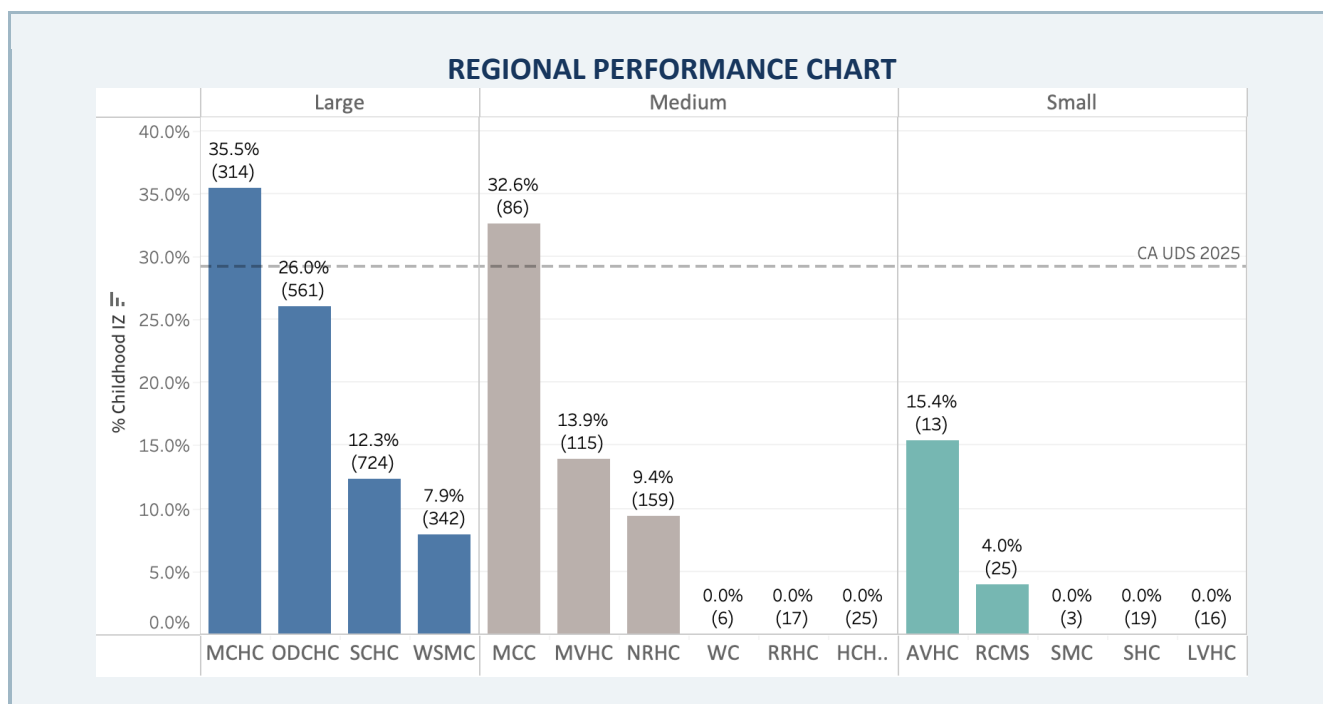
Strategic takeaway: Strong performance requires population-level tracking of every missing dose and dependable care-delivery workflows that assess and vaccinate children at every appropriate encounter.

Rural Northern California Performance

Regional Insights

- Vaccine misinformation and hesitancy among parents continue to create challenges, particularly in rural communities.
- Early, consistent, and respectful education is essential to helping families understand the recommended schedule and complete every dose by age two.
- Accurate exchange of immunization histories through the California Immunization Registry (CAIR) helps reduce missed doses, duplicate vaccination, and reporting gaps.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers?
- Which vaccine doses and age milestones create the largest care gaps?
- Are vaccines administered outside the health center consistently captured through CAIR and the EHR?
- Should Childhood Immunization Status be considered a quality improvement priority this year?

Quality Measure Definition (UDS)

Percentage of children who were fully immunized by their second birthday, with documented evidence of: 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1 VZV, 4 PCV, 1 HepA, 2–3 rotavirus, and 2 influenza vaccines.

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	75th percentile nationally for Medicaid health plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.
California and U.S. UDS	CA UDS 2025: 29.2% US UDS 2025: 29.5%

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Immunizations for Adolescents (Combo 2)

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Adolescent immunizations protect young people from serious, vaccine-preventable diseases and reduce the risk of outbreaks in the broader community. Combo 2 assesses whether adolescents receive meningococcal conjugate, Tdap, and the complete HPV vaccine series by their 13th birthday.

Adolescents use office-based healthcare less often than younger children and have higher rates of emergency department use, creating fewer routine opportunities to vaccinate. Rural communities may face additional barriers, including transportation, limited appointment availability, incomplete records across care settings, vaccine misinformation, and concerns about HPV vaccination.

Improving adolescent immunization coverage prevents avoidable illness and cancer, supports school readiness, and strengthens lifelong preventive-care engagement. Success depends on beginning outreach before age 11, using every encounter to assess vaccine status, and offering clear, confident recommendations to families.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS ✓ QIP X UDS ✓ PHMI	Immunizations	MODERATE

Immunizations for Adolescents is a high-leverage pediatric quality measure aligned across HEDIS, QIP, and population health priorities. Improvement can close individual care gaps while strengthening outreach, access, documentation, and preventive-care systems for adolescents.

Understanding the Improvement Strategy

HEDIS & QIP	CARE DELIVERY
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which adolescents are missing Tdap, meningococcal, or HPV doses needed to complete Combo 2 by age 13?	Key question: At every adolescent encounter, are we reviewing vaccine status and administering all vaccines that are due?
COMMON STRATEGIES • Outreach beginning at ages 9–11 • Registry and care gap reports • Parent reminders and recall notices • Monitor gaps by vaccine and population	COMMON STRATEGIES • Assess status at every encounter • Presumptive, bundled vaccine recommendation • Walk-in and extended-hour access • Reconcile records through CAIR2

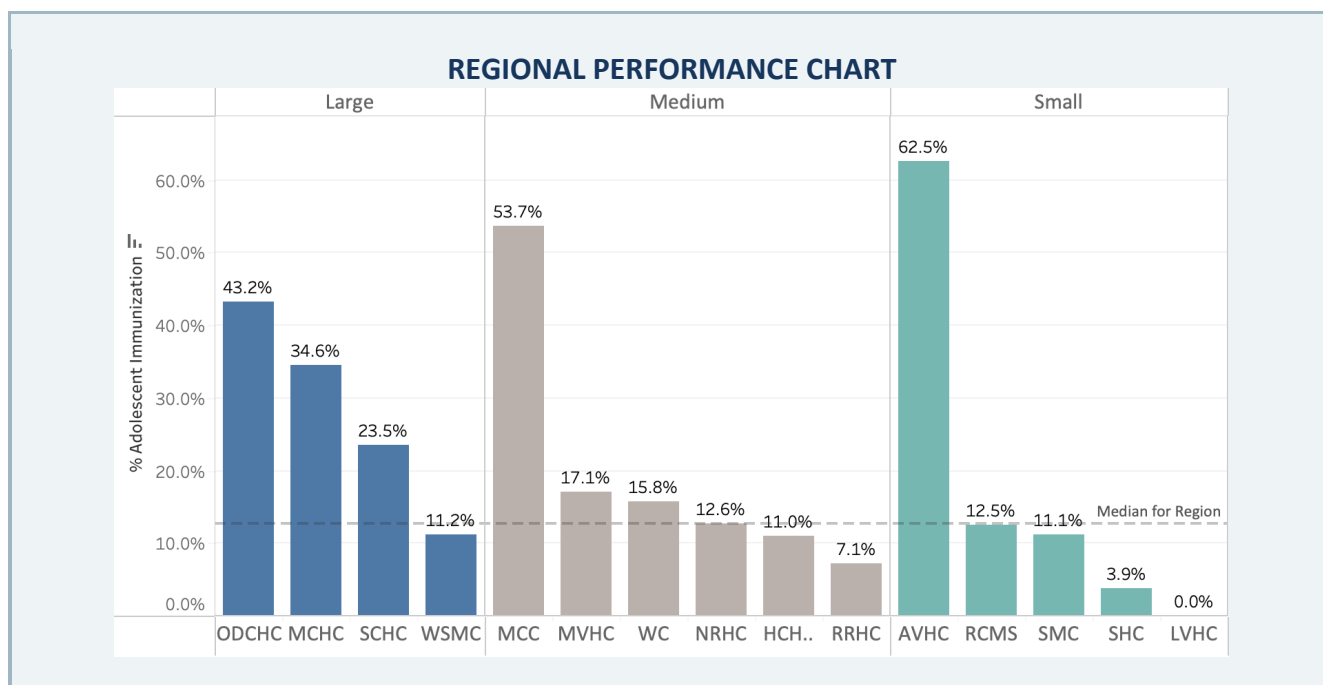
Strategic takeaway: Strong performance requires early population-level outreach and dependable care-delivery workflows that assess, recommend, and administer all due vaccines at every appropriate encounter.

Rural Northern California Performance

Regional Insights

- Targeted outreach beginning at ages 9–11 can create enough time for adolescents to complete all required doses by their 13th birthday.
- Sports physicals, well visits, and dedicated adolescent immunization clinics provide important opportunities to vaccinate adolescents who may have few routine visits.
- A personalized, presumptive recommendation—paired with empathetic discussion of parent concerns—can improve acceptance of Tdap, meningococcal, and HPV vaccines.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers?
- Which vaccine component—Tdap, meningococcal, or HPV—creates the largest care gap?
- Are sports physicals, well visits, and other encounters consistently used to vaccinate?
- Should Immunizations for Adolescents be considered a quality improvement priority this year?

Quality Measure Definition (QIP)

Percentage of adolescents age 13 who received one meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), and two doses of human papillomavirus (HPV) vaccine by their 13th birthday.

National Quality Benchmark

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	75th percentile nationally for Medicaid health plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.
UDS benchmark	Not applicable

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Diabetes: Poor Control (HbA1c >9%)

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Diabetes is a leading cause of disability and death in rural Northern California, affecting approximately 9.3% of adults. Diabetes prevalence in rural areas is higher than in urban communities, and many patients also live with other chronic conditions that make care more complex.

Rural patients may face cost barriers to medications, limited access to healthy food and physical activity, transportation challenges, and difficulty obtaining specialty services. Diabetes also disproportionately affects Native American and Hispanic communities, while migrant and seasonal farmworkers may experience additional barriers to continuous care.

Improving glycemic control reduces preventable complications and avoidable healthcare costs. For every one-percentage-point reduction in HbA1c, the risk of eye, kidney, and nerve disease decreases substantially, and the risk of heart attack also declines.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS ✓ QIP ✓ UDS ✓ PHMI	Chronic Disease Management	HIGH

Diabetes: Poor Control is a high-leverage chronic disease measure aligned across federal reporting, managed care, incentive, and population health priorities. Because it is an inverse measure, improvement means reducing the percentage of patients with HbA1c above 9% or without a documented test.

Understanding the Improvement Strategy

HEDIS & QIP	UDS
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which assigned patients have poor control, an overdue HbA1c test, or no documented result?	Key question: At every eligible encounter, are we addressing testing, treatment, complications, and self-management needs?
COMMON STRATEGIES - Diabetes registries and care gap reports - Outreach for overdue HbA1c testing - Risk-stratify patients with poor control - Monitor disparities by population and site	COMMON STRATEGIES - Pre-visit planning and point-of-care testing - Evidence-based medication management - Retinal, foot, and kidney-care workflows - Team-based education and self-management support

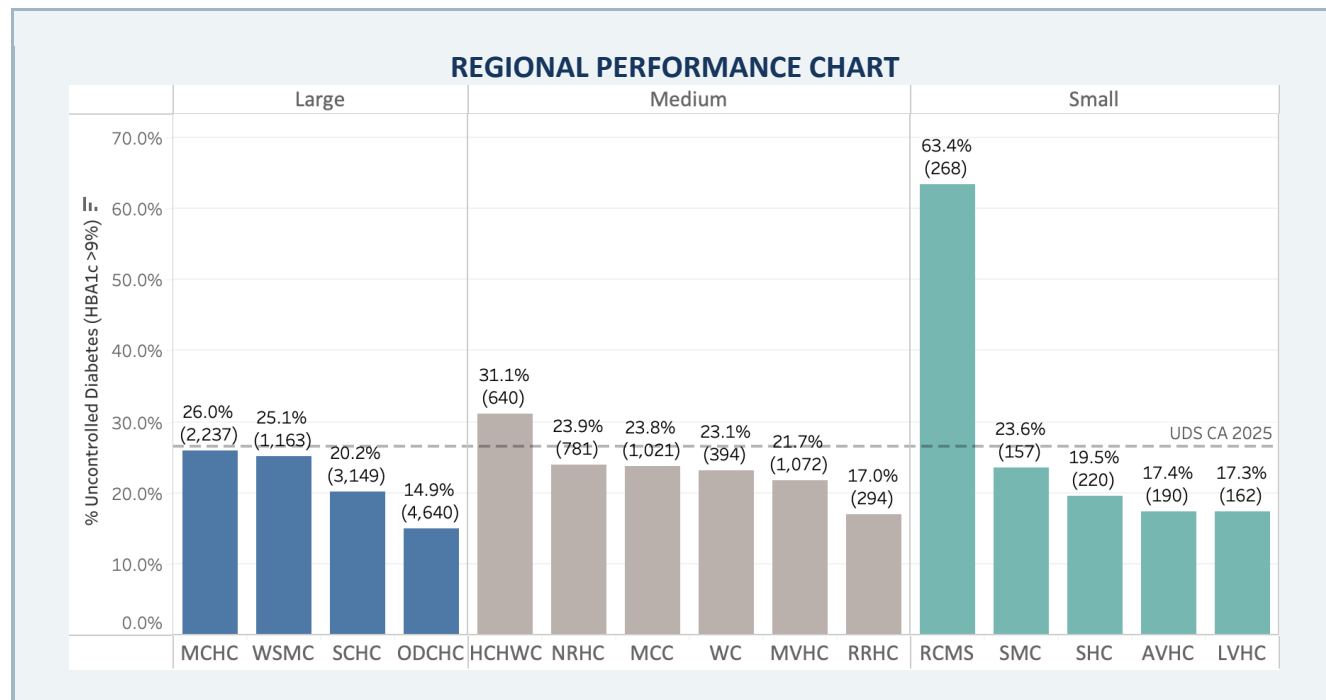
Strategic takeaway: Strong performance requires proactive identification of patients with overdue testing or poor control and reliable team-based care that supports medication management, follow-up, and self-management.

Rural Northern California Performance

Regional Insights

- Rural health centers serve many low-income and uninsured patients who are heavily affected by diabetes and other chronic conditions; medication cost can interfere with adherence.
- Significant racial and ethnic disparities persist, with diabetes rates substantially higher among Native American and Hispanic adults than among White adults.
- This is an inverse measure: **lower** percentages indicate **better** performance.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers?
- How many patients are included because no HbA1c test was documented?
- Which populations or clinic sites experience the greatest disparities in poor control?
- Should Diabetes: Poor Control be considered a quality improvement priority this year?

Quality Measure Definition (UDS)

Percentage of patients age 18–75 with diabetes whose most recent HbA1c was greater than 9.0%, or who had no HbA1c test documented during the measurement period. This is an inverse measure: lower performance rates are better.

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	75th percentile nationally for Medicaid health plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.
California and U.S. UDS	CA UDS 2025: 26.5% US UDS 2025: 26.3%

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Controlling High Blood Pressure

STRATEGIC MEASURE PROFILE

Why This Measure Matters

High blood pressure is a major risk factor for heart attack, stroke, vision loss, cognitive decline, and heart failure. More than half of Americans with hypertension do not have it under control, and approximately 49% of adults age 55 and older in rural Northern California report having been diagnosed with high blood pressure.

Hypertension often has no symptoms and requires ongoing monitoring, medication management, and lifestyle support. Accurate measurement is essential: anxiety, improper positioning, cuff size, insufficient rest, and failure to repeat an elevated reading can affect results and create missed opportunities for treatment.

Improving blood pressure control prevents serious cardiovascular complications. Effective management combines reliable clinical processes with patient engagement, home monitoring, medication adherence, healthy eating, physical activity, smoking cessation, and regular follow-up.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS ✓ QIP ✓ UDS ✓ PHMI	Chronic Disease Management	HIGH

Controlling High Blood Pressure is a high-leverage chronic disease measure aligned across federal reporting, managed care, incentive, and population health priorities. Improvement efforts strengthen both population-level management and the reliability of blood pressure assessment and treatment during every encounter.

Understanding the Improvement Strategy

HEDIS & QIP	UDS
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which assigned patients have uncontrolled blood pressure, overdue follow-up, or gaps in treatment?	Key question: At every eligible encounter, are we measuring accurately and acting on elevated results?
COMMON STRATEGIES - Hypertension registries and care gap reports - Outreach for overdue follow-up - Risk-stratify patients with poor control - Monitor disparities by population and site	COMMON STRATEGIES - Standardized measurement and repeat readings - Evidence-based medication management - Home blood pressure monitoring - Team-based education and lifestyle support

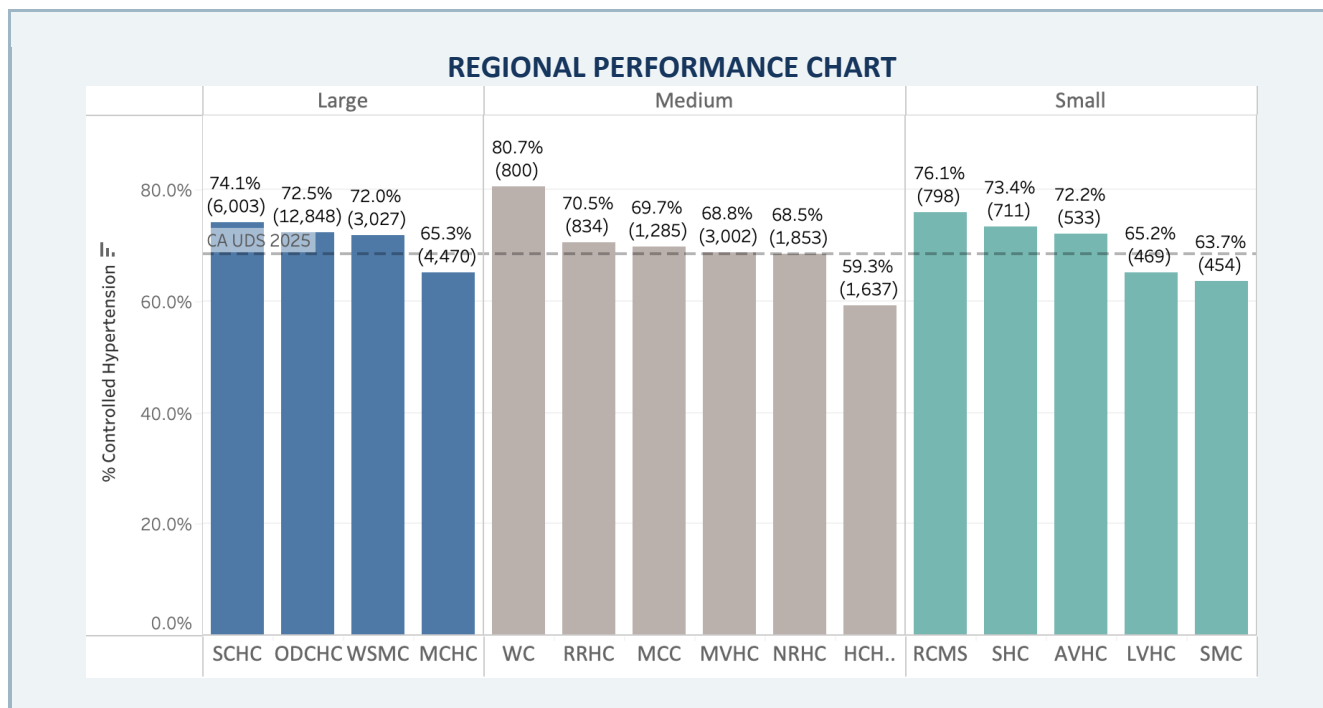
Strategic takeaway: Strong performance requires proactive identification of patients with uncontrolled blood pressure and dependable care-delivery workflows for accurate measurement, treatment intensification, follow-up, and self-management.

Rural Northern California Performance

Regional Insights

- White-coat hypertension and anxiety during clinic visits can contribute to elevated readings, making rest and repeat measurement important.
- Standardized technique—including correct positioning, cuff size, and multiple readings—supports accurate diagnosis, treatment decisions, and reporting.
- Hypertension usually requires long-term medication and lifestyle management; home blood pressure monitoring and regular care-team communication can strengthen control.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers?
- Are elevated readings consistently repeated using standardized measurement technique?
- Which populations or clinic sites experience the greatest disparities in blood pressure control?
- Should Controlling High Blood Pressure be considered a quality improvement priority this year?

Quality Measure Definition (UDS)

Percentage of adults age 18–85 with a diagnosis of hypertension whose blood pressure was adequately controlled at less than 140/90 mm Hg during the measurement period.

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	75th percentile nationally for Medicaid health plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.
California and U.S. UDS	CA UDS 2025: 68.4% US UDS 2025: 69.1%

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Tobacco Use Screening and Cessation

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Tobacco use remains a leading cause of preventable disease and death in the United States. Cigarette smoking contributes to more than 480,000 deaths nationally each year, while Californians experience substantial healthcare costs and tens of thousands of smoking-attributable deaths.

Rural California communities have higher smoking rates than urban communities. In the largely rural northern counties, current smoking is more common than statewide, and low-income adults in the region are especially affected. Rural communities also experience higher use of e-cigarettes and smokeless tobacco, including products that may appeal to youth.

Routine screening and brief cessation intervention can meaningfully increase quit attempts and successful cessation. Health centers can reduce tobacco-related illness by identifying every form of tobacco use, advising patients to quit, providing counseling or medication, and arranging follow-up support.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS X QIP ✓ UDS ✓ PHMI	Primary Prevention	MODERATE

Tobacco Use Screening and Cessation is a high-leverage preventive-care measure aligned across federal reporting, managed care, and population health priorities. Improvement requires both broad screening reach and reliable counseling or pharmacotherapy for every identified tobacco user.

Understanding the Improvement Strategy

HEDIS	UDS
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which assigned patients have not been screened, and which tobacco users still need cessation support?	Key question: At every eligible encounter, are we screening for tobacco use and intervening when use is identified?
COMMON STRATEGIES - Population lists and care gap reports - Outreach to patients overdue for screening - Track tobacco users and quit attempts - Monitor disparities by population and site	COMMON STRATEGIES - Screen all forms of tobacco use at intake - Advise, assess readiness, and assist - Counseling, medication, and quitline referral - Arrange follow-up after a quit attempt

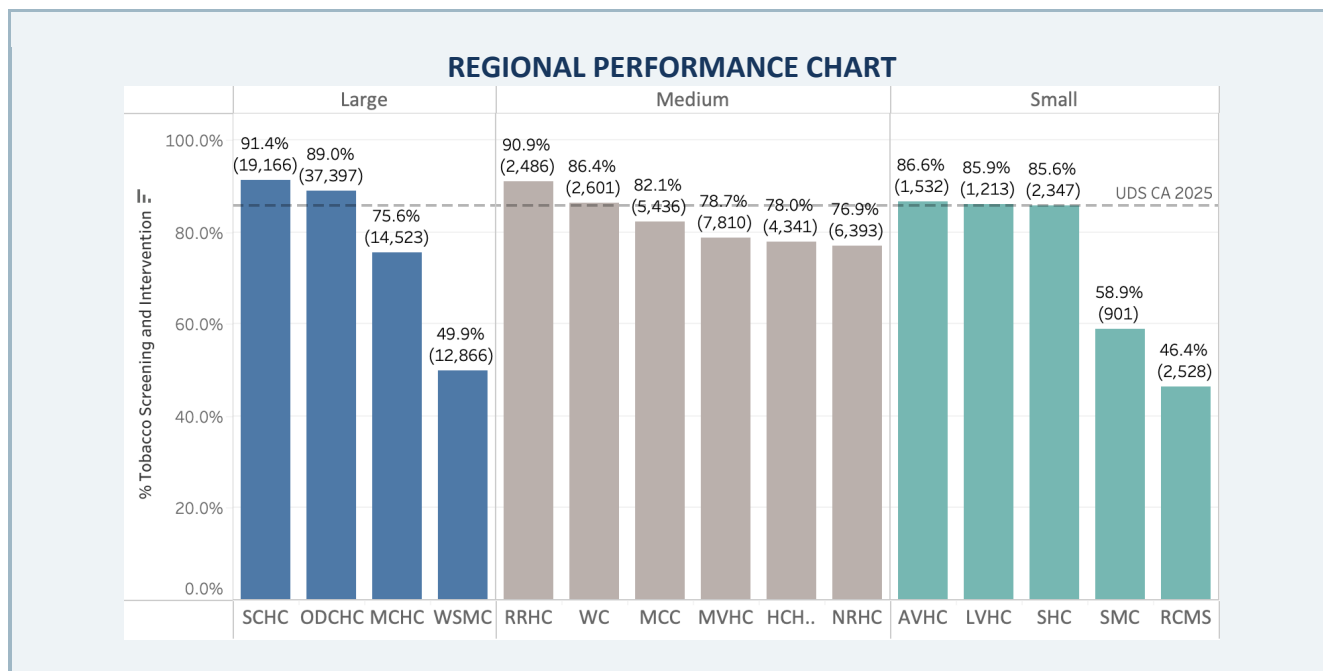
Strategic takeaway: Strong performance requires consistent screening for all forms of tobacco use and a documented cessation intervention for every patient identified as a tobacco user.

Rural Northern California Performance

Regional Insights

- Identifying tobacco users and tracking cessation counseling can be difficult when EHR configurations do not reliably connect screening results with interventions.
- Updated documentation tools and structured workflows can improve capture of counseling, medications, referrals, quit attempts, and follow-up.
- Regional health centers have successfully incorporated routine tobacco-use assessment and cessation intervention into primary care practice.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers?
- Are all forms of tobacco use—including vaping and smokeless tobacco—captured consistently?
- Do positive screens reliably lead to documented counseling, medication, referral, or follow-up?
- Should Tobacco Use Screening and Cessation be considered a quality improvement priority this year?

Quality Measure Definition (UDS)

Percentage of patients age 18 and older who were screened for all forms of tobacco use at least once within 24 months and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy.

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	Not applicable
California and U.S. UDS	CA UDS 2025: 85.6% US UDS 2025: 84.8%

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Adult BMI Assessment and Follow-up

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Obesity is associated with cardiovascular disease, type 2 diabetes, certain cancers, and other serious health conditions. Routine body mass index (BMI) assessment helps health centers identify adults who may benefit from additional evaluation and support.

Weight-related health risks are especially important in rural Northern California, where 43.0% of adults report a BMI of 27.5 or higher. Rural communities may also face limited access to affordable nutritious food, safe places for physical activity, and specialty weight-management services.

Documenting BMI and a follow-up plan when results fall outside normal parameters connects screening with action. Effective follow-up may include nutrition and physical-activity counseling, collaborative wellness planning, behavioral health support, referrals, and ongoing monitoring tailored to each patient.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
X HEDIS X QIP ✓ UDS ✓ PHMI	Primary Prevention	MODERATE

Adult BMI Assessment and Follow-up links preventive screening with documented care planning. Reliable performance depends on reaching the full eligible population, calculating BMI from current height and weight, and recording an appropriate follow-up plan whenever results are outside normal parameters.

Understanding the Improvement Strategy

PHMI	UDS
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which eligible adults lack a current BMI, and who still needs a documented follow-up plan?	Key question: At every eligible encounter, are BMI and an appropriate follow-up plan documented reliably?
COMMON STRATEGIES - Population lists and care gap reports - Outreach before planned visits - Track missing BMI and follow-up documentation - Monitor disparities by population and site	COMMON STRATEGIES - Capture current height and weight at intake - Use automated BMI calculation and reminders - Document counseling, referrals, or care plans - Reassess progress and update the plan

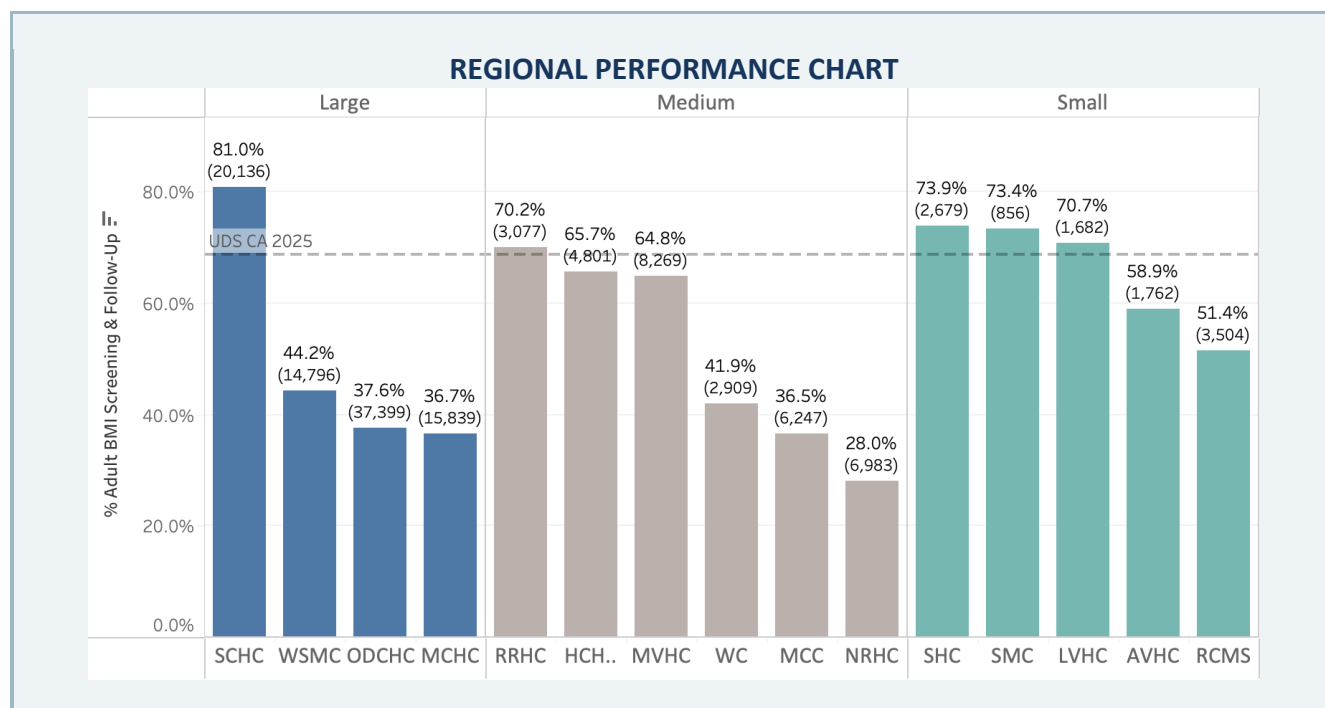
Strategic takeaway: Strong performance requires a current BMI for every eligible adult and a documented, patient-centered follow-up plan whenever the result is outside normal parameters.

Rural Northern California Performance

Regional Insights

- All eligible adult encounters—including acute-care visits—contribute to the measure, making reliable intake and documentation workflows essential across visit types.
- Automated reminders and structured EHR fields can improve capture of height, weight, calculated BMI, and the related follow-up plan.
- Regional performance varies considerably, suggesting opportunities to learn from higher-performing health centers and strengthen consistent counseling and follow-up workflows.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers?
- Are height, weight, and BMI documented reliably across all eligible visit types?
- When BMI is outside normal parameters, is an appropriate follow-up plan consistently documented?
- Should Adult BMI Assessment and Follow-up be considered a quality improvement priority this year?

Quality Measure Definition (UDS)

Percentage of patients age 18 and older with a documented BMI during the most recent visit or within the preceding 12 months and, when BMI is outside normal parameters, a documented follow-up plan.

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	Not applicable
California and U.S. UDS	CA UDS 2025: 68.8% US UDS 2025: 70.0%

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Child and Adolescent Well-Care Visits

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Regular well-care visits support children's physical, mental, developmental, and social health. They provide opportunities for timely immunizations, developmental and behavioral screening, anticipatory guidance, identification of learning concerns, and connection to services before needs become more complex.

These visits are especially important in rural Northern California, where families may experience transportation barriers, workforce shortages, poverty, lack of insurance, and limited access to pediatric services. Adverse childhood experiences can also have lasting effects on health, making trusted, ongoing relationships with care teams particularly valuable.

Improving well-care visit completion requires both population-level outreach and reliable access to comprehensive visits. Health centers can use reminders and recall, flexible scheduling, team-based care, community partnerships, and support for transportation and other social needs to help families complete recommended care.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS ✓ QIP UDS ✓ PHMI	Primary Prevention	MODERATE

Child and Adolescent Well-Care Visits is aligned across managed-care quality programs and population health priorities. Strong performance depends on identifying assigned members who have not completed a visit, reducing access barriers, and ensuring visits deliver comprehensive, age-appropriate preventive care.

Understanding the Improvement Strategy

HEDIS	QIP
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which assigned children and adolescents have not completed a well-care visit during the measurement year?	Key question: Are we making comprehensive well-care visits accessible and completing all age-appropriate preventive services?
COMMON STRATEGIES • Member lists and care gap reports • Reminder, recall, and portal outreach • Segment outreach by age, site, and barrier • Track scheduled, missed, and completed visits	COMMON STRATEGIES • Reserve access for preventive visits • Use pre-visit planning and team-based care • Deliver screenings and anticipatory guidance • Address transportation and social needs

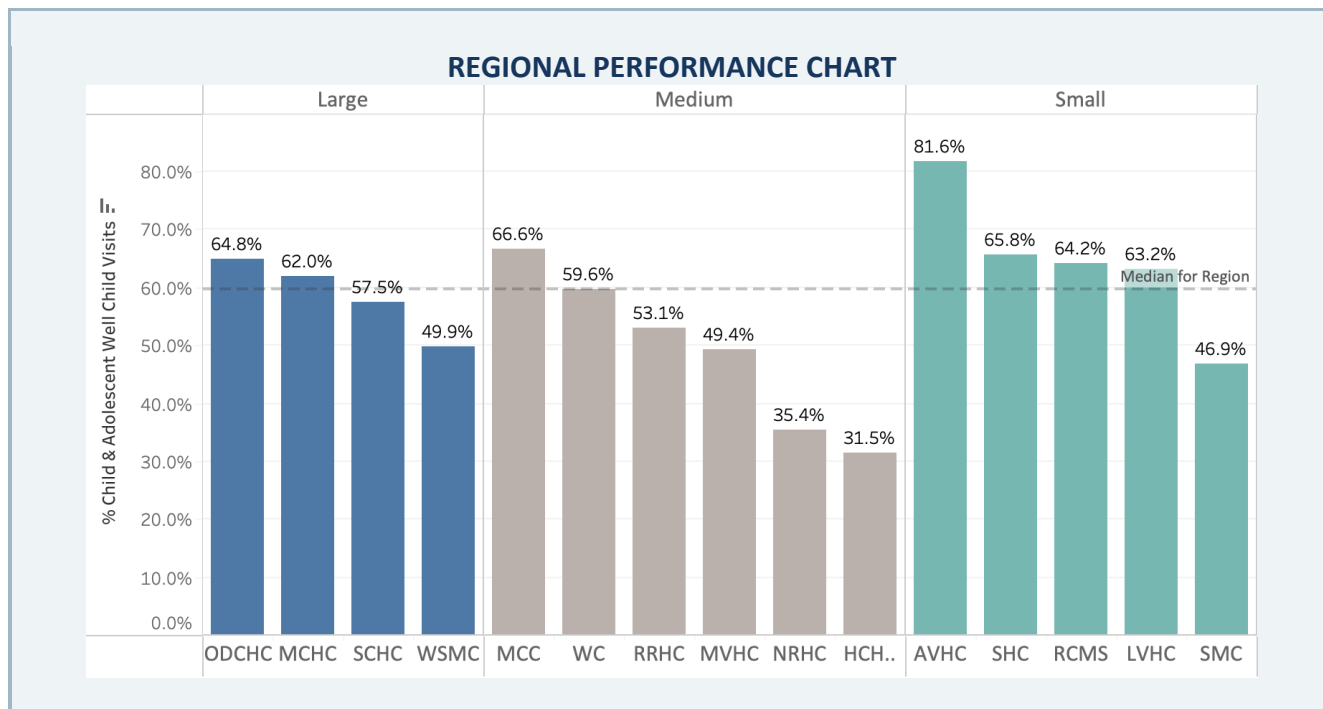
Strategic takeaway: Strong performance requires proactive outreach to every child and adolescent due for care and reliable delivery of a comprehensive, age-appropriate well-care visit.

Rural Northern California Performance

Regional Insights

- Transportation remains a significant barrier for rural and frontier families seeking preventive services.
- Workforce shortages, increased demand, and closures of private practices can limit timely access to well-care appointments.
- Regional variation suggests opportunities to strengthen recall systems, expand scheduling options, and learn from health centers achieving higher visit completion.

2025 REGIONAL PERFORMANCE



Performance Reflection

- How does our performance compare with regional peers and the QIP partial-points threshold?
- Which assigned children and adolescents have not completed a well-care visit this year?
- What transportation, scheduling, or workforce barriers are contributing to missed visits?
- Should Child and Adolescent Well-Care Visits be considered a quality improvement priority this year?

Quality Measure Definition (QIP)

Percentage of assigned members ages 3–17 who had at least one comprehensive well-care visit with a primary care practitioner or an obstetrics/gynecology practitioner during the measurement year.

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	75th percentile nationally for Medicaid health plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.
California and U.S. UDS	Not applicable

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.

Well-Child Visits in the First 30 Months

STRATEGIC MEASURE PROFILE

Why This Measure Matters

Well-child visits during infancy and early childhood provide the foundation for healthy growth and development. Frequent visits create opportunities for immunizations, developmental and behavioral screening, growth monitoring, laboratory testing, safety guidance, and early response to family concerns.

Visits at 18 and 24 months are particularly important for developmental screening, including autism-spectrum disorder screening. Regular contact also helps families build trusted relationships with care teams and receive age-appropriate guidance on feeding, sleep, behavior, safety, and healthy routines.

Completing the recommended visit sequence can be difficult for rural families facing transportation barriers, workforce shortages, limited appointment availability, and changes in insurance or newborn enrollment. Reliable tracking, early scheduling, reminder and recall systems, and family-centered access strategies are central to improvement.

Measure Alignment

MEASUREMENT SYSTEMS	CLINICAL PORTFOLIO	ALIGNMENT LEVEL
✓ HEDIS ✓ QIP X UDS ✓ PHMI	Well Child Checks	MODERATE

Well-Child Visits in the First 30 Months aligns managed-care quality priorities with early-childhood prevention. The measure includes two age-specific rates, requiring health centers to track infants through the first 15 months and sustain visit completion from 15 through 30 months.

Understanding the Improvement Strategy

HEDIS	QIP
POPULATION HEALTH PERSPECTIVE	CARE DELIVERY PERSPECTIVE
Key question: Which infants and toddlers are off track for the required visit sequence through 30 months?	Key question: Are we scheduling, completing, and documenting every age-appropriate visit reliably?
COMMON STRATEGIES - Age-based member lists and care gap reports - Newborn enrollment and attribution follow-up - Schedule the next visit before checkout - Track missed visits and outreach outcomes	COMMON STRATEGIES - Use pre-visit planning and visit bundles - Reserve access for frequent infant visits - Deliver screenings, vaccines, and guidance - Address transportation and social needs

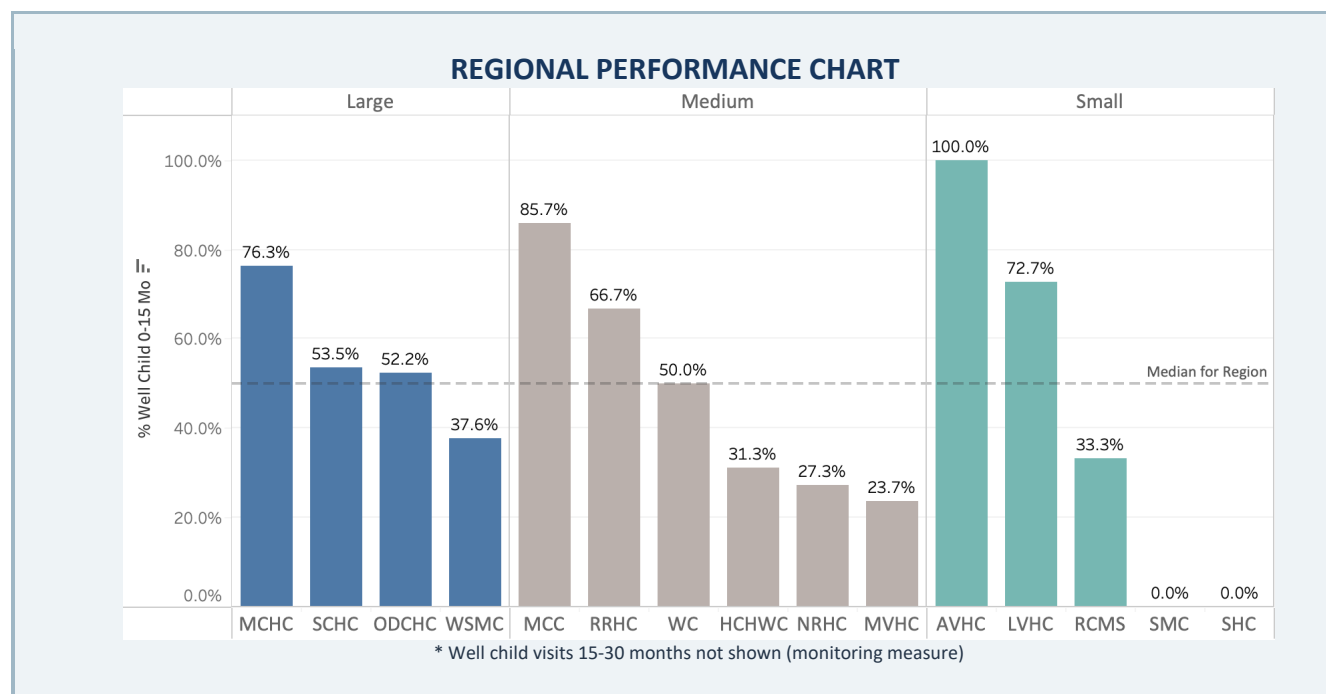
Strategic takeaway: Strong performance requires early enrollment, proactive scheduling, and reliable completion of the full age-appropriate well-child visit sequence.

Rural Northern California Performance

Regional Insights

- Linking Medi-Cal records for birthing people and newborns can affect member attribution, claims continuity, and accurate measurement.
- Workforce shortages, increased demand, and closures of private practices can limit access to frequent well-child appointments.
- Because the measure includes two age-specific rates, care teams need longitudinal tracking and outreach that continue through 30 months.

2025 REGIONAL PERFORMANCE



Performance Reflection

- Which infants and toddlers are missing visits in the recommended sequence?
- Are newborn enrollment, attribution, and record-linking issues creating apparent care gaps?
- Do scheduling and recall workflows begin early enough to complete all required visits?
- Should Well-Child Visits in the First 30 Months be considered a quality improvement priority this year?

Quality Measure Definition (QIP)

Two rates: (1) children turning 15 months with six or more well-child visits in their first 15 months; and (2) children turning 30 months with two or more visits from 15 months and one day through 30 months.

National and State Quality Benchmarks

BENCHMARK	REFERENCE VALUE / INTERPRETATION
QIP partial-points threshold	75th percentile nationally for Medicaid health plans, as reported by NCQA HEDIS in the year prior to the QIP measurement year.
California and U.S. UDS	Not applicable

Use this profile to connect measure alignment, regional performance, and improvement strategy during annual quality planning.