

Performance Improvement Team
presents:
Accelerated Learning Education Program



Early Cancer Detection: Cervical, Breast, and Colorectal Cancer Screening

Marshall Kubota, MD
Regional Medical Director - Southwest Region

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April 27, 2021

Webinar Instructions

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

Figure 1

You can switch your audio connection by clicking on the three dot ellipsis icon found at the bottom of your screen.

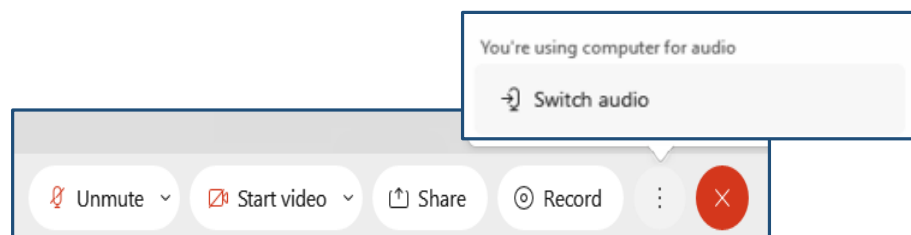
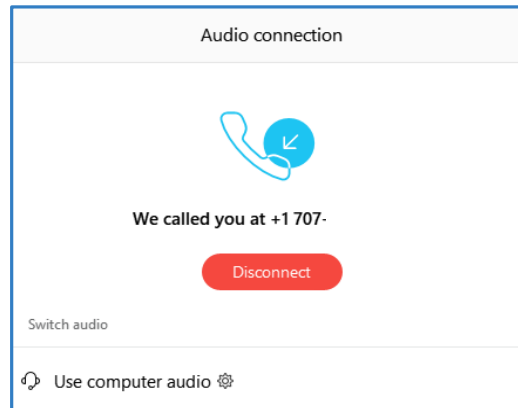


Figure 2

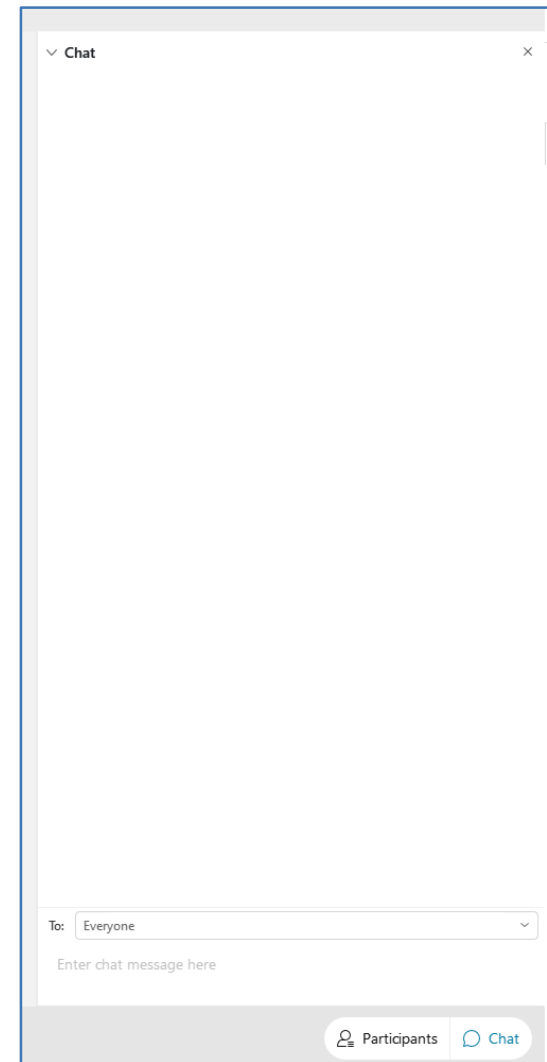
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Webinar Instructions

Figure 1

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- Please take a moment and open your chat box by clicking the chat icon found at the bottom right-hand corner of your screen and as shown in **Figure 1**.
- If you have any questions, please type your questions into the chat box, and they will be answered throughout the presentation.
- Be sure to select “**Everyone**” when sending a message.



CME Credit

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

The AAFP has reviewed Accelerated Learning Education Program, and deemed it acceptable for AAFP credit. Term of approval is from 04/13/2021 to 04/13/2022. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Credit approval includes the following session(s): 1.50 In-Person, Live (could include online) AAFP Prescribed Credit(s) - Early Cancer Detection (Cervical, Breast, and Colorectal Screening)

Provider approved by the California Board of Registered Nursing, Provider #CEP16728 for 1.50 hours.

Performance Improvement Team
presents:
Accelerated Learning Education Program



Early Cancer Detection: Cervical, Breast, and Colorectal Cancer Screening

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Objectives

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

- Understand the clinical background, specifications, and performance threshold definitions of the *Cervical, Breast, and Colorectal Cancer Screening* measures.
- Apply documentation requirements to maximize adherence and measure performance in the delivery of cervical, breast, and colorectal cancer screening services.
- Identify best and promising practices that can be used to address clinical process, interpersonal communication, education, outreach, and technical barriers to improve early cancer detection screening services.

California Cancer Registry

MK

Age-Adjusted Invasive Cancer Incidence Rates in California

Breast, Female, 2015 - 2017

By County

Age-Adjusted to the 2000 U.S. Standard Population

California Rate: 121.41 / per 100,000

83.74 - 113.01

114.64 - 119.99

120.32 - 128.29

128.30 - 158.68

Risk Population
less than 20000



Age-Adjusted Cancer Mortality Rates in California

Breast, Female, 2015 - 2017

By County

Age-Adjusted to the 2000 U.S. Standard Population

California Rate: 19.11 / per 100,000

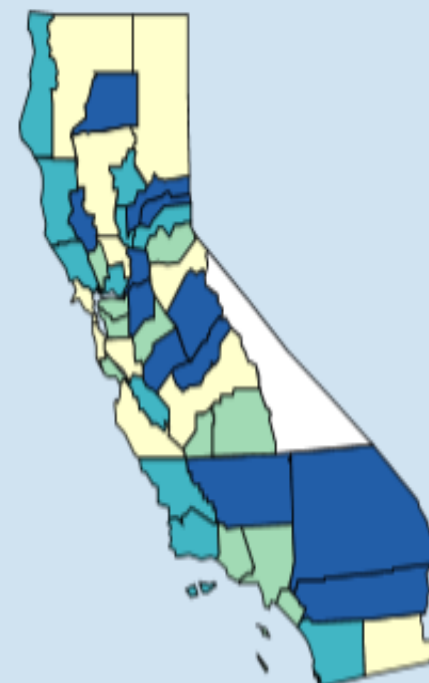
12.10 - 16.95

17.10 - 18.98

19.02 - 20.88

21.07 - 28.02

Risk Population
less than 20000



Cervical Cancer Screening (CCS)

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Cervical Cancer Epidemiology

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

What Causes Cervical Cancer?

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

Risk Factors for Cervical Cancer

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

Cervical Cancer Screening

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- Looking for precancerous cells and cancer cells
- Two tests:
 - Papanicolaou or “Pap” test (cytology testing)
 - High-risk human papillomavirus (hrHPV) testing
- Goal: Find changes in the earliest stages when treatment and cure possible

Word about Chlamydia Screening

MK

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

It occurs most often among adolescent and young adult females.

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

When to Stop Cervical Cancer Screening?

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

Cervical Cancer Screening

Description:

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

Denominator:

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

Cervical Cancer Screening

Numerator:

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

Step 1: Members age 24 - 64 who had Pap performed within the last three years (screening 2021, 2020, or 2019)

Step 2: Members age 30 - 64 who had Pap and human papillomavirus (HPV) co-testing within the last five years (2021, 2020, 2019, 2018 or 2017)

Step 3: Members age 30 - 64 who had high-risk human papillomavirus (hrHPV) testing performed within the last five years (2021, 2020, 2019, 2018 or 2017)

Medical Record Documentation

- Members who do not have a cervix can be identified by the ICD 10 code Z90.710 and Z90.712 and the date or approximation of the date of the acquired absence of cervix
- Documentation for eReports includes:
 - Entry of the date that is as defined as the date of surgery (operative report); OR
 - Identify a close date, could be month and year - use the last date of the month (e.g., May 31, 2020). Or, if only a year is known, use the last date of that year (e.g., 12/31/2020)

Medical Record Documentation

MK

- Pap findings to include date screening was performed **and** test results/findings.
- Biopsies are non-adherent documentation - they are diagnostic and therapeutic only.
- Check your lab results - ensure that it states that there was adequate cervical cells present and the test was completed.
- Check the minimal age at the date of testing; for example, a person 32 years of age in 2020 last record of HPV testing and results is in 2017 when person was 29 years of age. The HPV testing does not satisfy the criteria.

Cervical Cancer Screening Exclusions^{MK}

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

Breast Cancer Screening

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Breast Cancer Epidemiology

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

Second most common cause of cancer deaths in women:

- 260,000 cases per year
- 40,000 deaths per year⁽⁸⁾
- Mortality decreasing due to
 - Better screening
 - Better treatments

Some Risk Factors for Breast Cancer

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- Increasing age
- Race: White > Black
- Weight and body fat – pre- vs. post-menopause
- Tall stature
- Estrogen levels
- Dense breast tissue
- Higher bone density
- Early menarche/late menopause
- Infertility/Nulliparity/Advanced age at first pregnancy
- Personal history of breast cancer
- Family history of breast cancer

Lifestyle Risks and Breast Cancer

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

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

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

- Breast feeding
- Physical activity

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

Breast Cancer Screening

MK

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

Breast Cancer Screening Average Risk

Age based

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

Frequency

- Again – no consensus
- USPSTF – every 2 years

Roles of Clinical and Self-Breast Exams

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Clinical Breast Exams (CBE)

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

Breast Self-Exams (BSE)

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

Take-home message:

Breast exams are not substitutes for mammograms!

Breast Cancer Screening

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Description:

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

Denominator:

Number of continuously enrolled eligible population 52 - 74 years of age as of the end of the MY

Breast Cancer Screening

Numerator:

Number of eligible population in the denominator with one or more mammograms on or between October 1, 2019, and December 31, 2021

Documentation

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

Breast Cancer Screening Exclusions

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

Colorectal Cancer Screening

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Colon Cancer is Common

- 3rd most common cancer in males and 2nd most common in women
- U.S.: 145K cases per year, 2/3 of which are colon and 1/3 rectal and 59k deaths per year ~ 8% of all cancer deaths

Mortality:

- American Cancer Society - 52,980 deaths expected in 2021

What is Colon Cancer?

- Most human CRCs arise from adenomas (adenomatous polyps) that become dysplastic
- Early carcinomas are frequently seen within large adenomatous polyps, and areas of adenomatous change can often be found surrounding human CRCs
- Adenomas/polyps and carcinomas are found in the large bowel, and adenomas are observed 10 to 15 years prior to the onset of cancer in both sporadic and familial cases
- The ability to reduce the incidence of CRC through removal of polyps has been shown in controlled trials in humans

EARLY detection is key to preventing advanced disease

Colorectal Cancer Screening

Factors to Consider:

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

Assessing Risk

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When to start identifying risk?

- Age 20 years and older at initial visit and every 3 - 5 years
- Identifies familial risk factors that may be revealed over time
- No published guidelines

Assessing risk: All “no” answers = average risk

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

Starting Screening

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Average Risk adults

50 year olds per USPSTF, AAFP

45 year old African American – Multi Society Task Force on Colorectal Cancer

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

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

FDR >60 begin screening at 40

High–Risk Familial Colorectal Cancer Syndromes

Lynch Syndrome start at 20-25 years or 2-5 years prior to earliest CRC dx in family

Inflammatory Bowel Disease

8 years after dx of IBD or proctitis

Cystic Fibrosis ~ if IBD present follow IBD recommendations

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

When to STOP Screening

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- 75 years as long as life expectancy is 10 years +
- 76 - 85 years - individualize decision based on patient preference, prior tests, comorbidities
- Shorten life expectancy of (<5-10 years) may not benefit from screening

Choosing a Screening Test

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- **FIT Testing – annually**

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

Positive findings require follow up with colonoscopy

- **FIT/DNA – every 3 years**

Cologuard every 3 years for **average risk**

Positive findings require follow up with colonoscopy

- **Colonoscopy**

For **average or above average** risk individuals

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

- **Computed tomography (CT) Colonography**

Every 5 years

Colorectal Cancer Screening

Description:

Percentage of members 51 - 75 years of age who were screened for colorectal cancer according to evidence-based guidelines

Denominator:

Number of continuously enrolled Medi-Cal members 51 - 75 years of age by December 31 of the measurement year (MY)

Colorectal Cancer Screening

Numerator:

Percentage of members 51 - 75 years of age who had one or more screenings for colorectal cancer

Any of the following meet the criteria:

- FOBT or FIT (during measurement year [MY])
- Flexible sigmoidoscopy (during MY or 4 years prior)
- Colonoscopy (during MY or 9 years prior to MY)
- CT Colonography (during MY or 4 years prior to MY)
- FIT-DNA test/ Cologuard (during MY or 2 years prior to MY)

Medical Record Documentation

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

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

Colorectal Cancer Screening Exclusions

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- Have or have had colorectal cancer
- Have had a total colectomy
- In hospice or receiving palliative care during the measurement year
- Age 66 years and older with frailty and advanced illness

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

Primary Care Provider Quality Improvement Program (PCP QIP)

2021 PCP QIP Clinical Measures

JD

CLINICAL DOMAIN										
PRACTICE TYPE			MEASURE	MEASURE CATEGORY	AGE RANGE	TARGETS		FULL / PARTIAL POINTS		
FAMILY	INTERNAL	PEDS				FULL	PARTIAL	FAMILY	INTERNAL	PEDS
✓	✓	✓	Asthma Medication Ratio	CHRONIC DISEASE MGMT.	5 - 64 YRS	68.52%	63.58%	7 / 5	12.5 / 9	12 / 9
✓	✓		Comprehensive Diabetic Care - HbA1c Control		18 - 75 YRS	55.96%	50.97%	7 / 5	12.5 / 9	--
✓	✓		Controlling High Blood Pressure		18 - 85 YRS	66.91%	61.04%	7 / 5	12.5 / 9	--
✓		✓	Immunization for Adolescents - Combination 2		13 YRS	40.39%	34.43%	7 / 5	--	12 / 9
✓	✓		Breast Cancer Screening		50 - 74 YRS	63.98%	58.67%	7 / 5	12.5 / 9	--
✓	✓		Cervical Cancer Screening		21 - 64 YRS	66.49%	60.65%	7 / 5	12.5 / 9	--
✓		✓	Childhood Immunization Status - Combination 10	PREVENTATIVE SCREENING	2 YRS	42.02%	34.79%	7 / 5	--	12 / 9
✓	✓		Colorectal Cancer Screening		51 - 75 YRS	41.84%	32.24%	6 / 5	12.5 / 9	--
		✓	Counseling for Nutrition for Children/Adolescents		3 - 17 YRS	70.92%		--	--	12 / --
		✓	Counseling for Physical Activity for Children /Adolescents		3 - 17 YRS	64.96%		--	--	12 / --
✓		✓	Child and Adolescent Well Care Visit	UTILIZATION	3 - 17 YRS	TBD		10 / --	--	15 / --
✓		✓	Well Child Visits in the First 15 Months of Life		15 MONTHS	69.83%	65.83%	10 / 8	--	12.5 / 9

Cervical Cancer Screening

PCP QIP 2021

JD

<u>PCP QIP</u> <u>2021</u>	Practice Type	Total Points	Threshold	Percentile
Full Points	Family	7 Points	66.49%	75 th
	Internal Medicine	12.5 Points		
Partial Points	Family	5 Points	60.65%	50 th
	Internal Medicine	9 Points		

Breast Cancer Screening

PCP QIP 2021

<u>PCP QIP</u> <u>2021</u>	Practice Type	Total Points	Threshold	Percentile
Full Points	Family	7 Points	63.98%	75 th
	Internal Medicine	12.5 Points		
Partial Points	Family	5 Points	58.67%	50 th
	Internal Medicine	9 Points		

Colorectal Cancer Screening

PCP QIP 2021

JD

<u>PCP QIP</u> <u>2021</u>	Practice Type	Total Points	Threshold	Percentile
Full Points	Family	6 Points	41.84%	50 th
	Internal Medicine	12.5 Points		
Partial Points	Family	5 Points	32.24%	25 th
	Internal Medicine	9 Points		

Questions

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Best and Promising Practices

Seize every opportunity:

Establish a practice commitment to cancer screening!

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

Best and Promising Practices

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- ✓ Actively pursue missed appointments with letters and reminder calls.
Designate staff member (s) to outreach.
 - Reminder calls by staff tend to be more effective than robo-calls.
 - Reminder calls made later in the day or early evening may result in more contacts.
 - Reminder or due letters that are personalized/signed by clinician make a positive impact.
- ✓ Breast Cancer Screening: Collaborate with the referral mammography imaging center/facility - meet with imaging managers.

Best and Promising Practices

Increase Access:

- ✓ Consider a variety of service options and choices - after hours and same day appointments, weekend cervical and/or breast cancer screening day(s).
- ✓ Depending on location, consider mobile mammography services.
- ✓ Cervical Cancer Screening: Be proactive - contact members before their 21st birthday to let them know its recommended to have regular CCS when they reach 21 years.
- ✓ Explore possible barriers that may impact screening services, such as access to care, cultural diversity, anxiety, embarrassment. Offer choices of gender and spoken language of provider.

Best and Promising Practices

Increase Access:

- ✓ Use of standing orders for internal staff to implement and educate members/patients.
- ✓ Hand FIT kit out at end of visit, coupled with brief health coaching.
- ✓ Mail FIT kit to patients who are due (and do not need to be seen for another reason).
- ✓ For average-risk members/patients, offer options to screening.
Emphasize personal choice - studies have shown this can increase screening.

Best and Promising Practices

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Communication/Education:

- ✓ Staff should use approved tailored targeted education; can be done by MAs – should not be a one-time occurrence.
- ✓ Conduct outreach efforts that rely on several communication/touch points. Combined with physician recommendations, these can have a significant cumulative effect .
- ✓ Use already existing media (videos, printed materials, posters, newsletters).
- ✓ Reminder systems for patients - place last test sticker on health card.
- ✓ Ensure information is consistent, member/patient preference, plain and person-centered, language and culturally appropriate, and delivered in traditional and electronic applications (based on patient's preference).
- ✓ Collaborate with community agencies for outreach.

Best and Promising Practices

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Strengthen Internal Operating Practices:

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

Voices from the Field

FM



Voices from the Field

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Beth Dadko, MPH
Lead Population Health Specialist
Santa Rosa Community Health



Colorectal, Breast, and Cervical Cancer Screening: Tips from an FQHC

Beth Dadko, MPH
Lead Population Health Specialist
Santa Rosa Community Health





About Santa Rosa Community Health

- FQHC in Sonoma County
- We see 1 in 4 people in Santa Rosa
- 40,000 pts/year
- 8 campuses
- Services: Primary care, Pediatrics, Dental, IDD, MH/BH, CPSP, MAT, Campus for Homeless, CAM, Residencies (MD & NP), COVID Testing Site, COVID IZ Dist, Care Coordination, IOPCM, Transitions

Overall Culture of Quality



- Quality Liaisons for Each Site
- Site Quality Committees
- Huddle with Data Analytics Tool
- Continuous Data Sharing
- Education and Training
- Designated Patient Outreach Staff
- Engaged Leadership- Clinical and Operations

CRC Successful Strategies



- Mail FIT Kit during Telehealth Visits
- Develop text messages with link to instructional video
- Incentives for Returning FITs
- FIT Return Clinic/appointment to return
- Follow up on FIT Kits Ordered, but not received
- Centralized Mailing with text follow-up

Mammo Successful Strategies



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

Pap Successful Strategies



- Take advantage of “pap-portunities”
- Phrasing “I’ve done 5 of these this week, if you haven’t prepped it’s not a big deal. Let’s just get it done so you don’t have to come back”
- Fully stocked rooms w/ setup diagrams
- Resident Pap Clinic
- Partner w/ PCP who DOES do paps
- Homelessness- pair with shower clinic & fem hygiene gift bag
- ROI to get records from outside (like Planned Parenthood)

Overall Successful Strategies



- Care Gaps/Alerts- will be due in 3 months
- Texts/emails/robocalls to remind patients (save valuable staff time since patients often don't answer phone)
- Give PCPs Panel Management time to review lists
- Show data - # of positives or cases prevented
- Highlight patient stories – patients are our families
- Individual data- start with clinic, then team, then provider
- Review labs that appear not done but might be

Questions





Upcoming Trainings / Events



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Accelerated Learning Education Program

These learning sessions will cover Partnership HealthPlan of California's Primary Care Provider Quality Incentive Program measures. Registration is now open for the AL, ABC's and all

April 13 - Well-Child Visits and Immunizations (0 - 2 years) (*Recorded*)

April 27 - Early Cancer Detection (Cervical, Breast, and Colorectal Screening) (*Recorded*)

May 11 - Controlling High Blood Pressure

May 25 - Diabetes Management HbA1C Good Control

July 14 - Improving Asthma Care and the Asthma Medication Ratio

July 27 - Child and Adolescent Well-Care Visits (3 - 17 years)

**All sessions are from noon to 1 p.m. except today's session*

ABCS of Quality Improvement

This training consists of five sessions and the following topics will be covered:

June 02 - The Model for Improvement and Creating an Aim Statement

June 09 - Using Data for Quality

June 16 - Understanding the Role of Measurement in Quality Improvement

June 23 - Tips for Developing Change Ideas for Improvement

June 30 - Testing and Implementing Changes via the Plan-Do-Study-Act Cycle

**All sessions are from noon to 1 p.m.*

The Role of Leadership in Quality Improvement Efforts

September 23 - Petaluma Health Center - Interview with Top Performing Leaders

October 5 - Community Medical Center - Interview with Top Performing Leaders



Upcoming Trainings / Events



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PCP QIP HIGH Performers: How'd They Do That?

All webinars are from Noon to 1 p.m.

Webinar 1: Sonoma Valley Community Health

Date: Thursday, May 6, 2021

Webinar 2: NorthBay Healthcare

Date: Tuesday, May 18, 2021

Webinar 3: Santa Rosa Community Health

Date: Thursday, May 27, 2021

PQD Launch May 13, 2021

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

PHC QI Resources

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QI/Performance Team:

ImprovementAcademy@partnershiphp.org

Quality Improvement Program: QIP@partnershiphp.org

2021 PCP QIP Webpage:

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

QI Monthly Newsletters:

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

Measure Highlights:

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

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

Resources

Member mammography landing

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

PHC QI Resources

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A Quick Guide to Starting Your Quality Improvement Projects

<http://www.partnershipphp.org/Providers/Quality/Pages/PIAcademyLandingPage.aspx>



Contact Us

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References

References:

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

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

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

References

References:

- Centers for Disease Control and Prevention. *Increasing Colorectal Cancer Screening: An Action Guide for Working with Health Systems*. Atlanta: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2013.
- https://www.cdc.gov/cancer/colorectal/basic_info/screening/tests.htm
- Patient and Physician Reminders to Promote Colorectal Cancer Screening: A Randomized Controlled Trial. *Arch Intern Med*. 2009 Feb 23; 169(4): 364-71. doi: 10.1001/archinternmed.2008.564
- <http://www.ncbi.nlm.nih.gov/pubmed/22493463>
- <https://www.uspreventiveservicestaskforce.org/Tools/ConsumerInfo/Index/information-for-consumers> (use the consumer topic search)

Evaluations

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

Evaluation

<input checked="" type="checkbox"/>	OUTSTANDING
<input type="checkbox"/>	Excellent
<input type="checkbox"/>	Very Good
<input type="checkbox"/>	Average
<input type="checkbox"/>	Below Average

