Performance Improvement Team
presents:
Accelerated Learning Education Program

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

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April 12, 2022

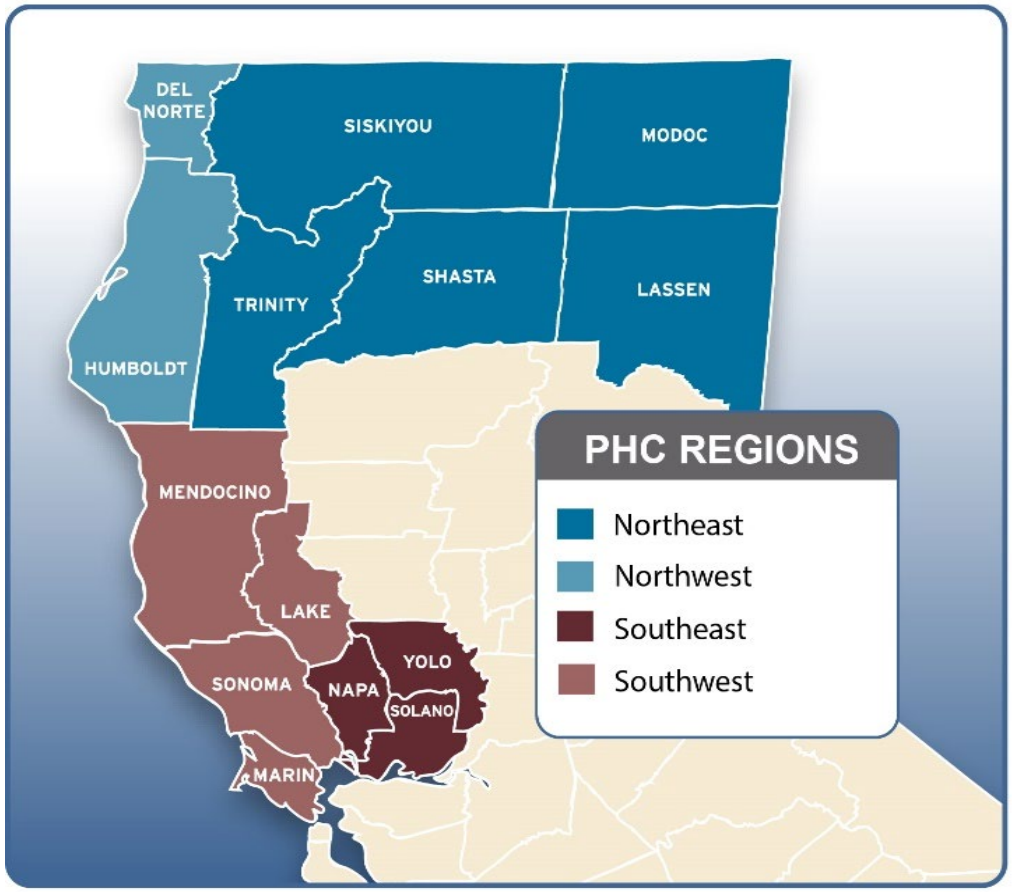
Objectives

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 work flows, interpersonal communication, member and staff education, outreach, and technical tips to improve early cancer detection screening services.

Partnership HealthPlan of California (PHC) Regions

FM



Mission

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

Vision

To be the most highly regarded managed care plan in California

Cervical Cancer Screening (CCS)

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Cervical Cancer Epidemiology

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- Leading cause of cancer deaths in women before routine Pap testing was implemented(1)
- Incidence rate in California 2012-2016 - 7.3 new cases per 100,000 persons per year(2)
  - Highest **incidence rate** is among Hispanic women - 8.8 new cases per 100,000 per year
- Mortality rate in California ~2.2 deaths per 100,000 persons per year
  - African-American women have the highest **mortality rate** - 3.0 deaths per 100,000 per year
- Six out of ten cases occurred in women with no history of a Pap test or no screening in the past five years(3)
- Overall Five-Year Relative Survival Rate in California = 68%

What Causes Cervical Cancer?

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

Risk Factors for Cervical Cancer

- Lack of Immunization
- Early onset sexual activity
  - 2x greater risk for onset before age 18 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

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

When to Stop Cervical Cancer Screening?

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- 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

PCP QIP Cervical Cancer Screening

Description:

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

Denominator:

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

PCP QIP 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 test performed within the last three years (screening 2022, 2021, or 2020)
- **Step 2**: Members age 30 - 64 who had Pap and human papillomavirus (HPV) co-testing within the last five years (2022, 2021, 2012, 2019, or 2018)
- **Step 3**: Members age 30 - 64 who had high-risk human papillomavirus (hrHPV) testing performed within the last five years (2022, 2021, 2020, 2019, or 2018)

Medical Record Documentation

- Members who do not have a cervix can be identified by the ICD 10 codes 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, 2021). Or, if only a year is known, use the last date of that year (e.g., December 31, 2021)
  - Do not leave this blank

Medical Record Documentation

- Pap findings to include date screening was performed **and** test results/findings.
- Biopsies are non-adherent documentation - they are diagnostic and therapeutic only.
- Check your lab results - ensure that it states that there was adequate cervical cells present and the test was completed.
- Check the minimal age at the date of testing; for example, a person 32 years of age in 2022 last record of HPV testing and results is in 2019 when person was 29 years of age. The HPV testing does not satisfy the criteria.

Cervical Cancer Screening Exclusions

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- 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

Breast cancer is the **most commonly** diagnosed cancer among women in California regardless of race/ethnicity

Second leading cause of cancer deaths among women in California:

- 121.5 new cases per 100,000 per women per year
  - Non-Hispanic white women have highest incidence rate - 139.5 new cases per 100,000 per women per year
- 19.8 deaths per 100,000 per women year
  - African-American women experienced the highest mortality rate - 31.1 deaths 100,000 per women per year[8]
- Mortality decreasing due to:
  - Better screening
  - Better treatments

Some Risk Factors for Breast Cancer

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

Lifestyle Risks and Breast Cancer

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

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

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

- Breast feeding
- Physical activity

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

Breast Cancer Screening Average Risk

Age based

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

Frequency

- Again - no consensus
- USPSTF - every 2 years

Roles of Clinical and Self-Breast Exams

Clinical Breast Exams (CBE)

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

Breast Self-Exams (BSE)

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

Take-home message:

Breast exams are not substitutes for mammograms!

PCP QIP Breast Cancer Screening

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

PCP QIP Breast Cancer Screening

Numerator:

Number of eligible population in the denominator with one or more mammograms on or between October 1, 2020, and December 31, 2022.

Mammography is the only eligible imaging counted as satisfying the numerator

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

Breast Cancer Screening Exclusions

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- Bilateral mastectomy, two unilateral mastectomies, unilateral mastectomy with a bilateral modifier

- MediCare 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 in Hospice or receiving Palliative Care during the measurement year (MY)

Colorectal Cancer Screening

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Epidemiology

Colon Cancer is Common:

- 3rd most common cancer (excluding skin cancers) in men and women
- U.S.
  - 145K cases per year, 2/3 of which are colon and 1/3 rectal
  - 59k deaths per year = ~ 8% of all cancer deaths
- Incidence and mortality are highest in non-Hispanic blacks, followed closely by American Indians and Alaska Natives and lowest in Asians/Pacific Islanders

Mortality:

- American Cancer Society - 53,200 deaths in 2020

Colon Cancer Pathophysiology

- 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 Programs

Factors to Include:

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

Assessing Risk

When to start identifying risk?

- Age 20 years and older at initial visit and every 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

Average Risk adults

45 year olds per USPSTF, AAFP

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

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

FDR >60 begin screening at 40

High-Risk Familial Colorectal Cancer Syndromes

Lynch Syndrome start at 20-25 years or 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

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

Choosing a Screening Test

- **FIT Testing - annually**

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

  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 - every 10 years**

  For **average or above average** risk individuals

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

- ***CT Colonography - every 5 years***

  Positive findings require follow up with colonoscopy

- ***Flexible Sigmoidoscopy - every 5 years***

  Positive findings require follow up with colonoscopy

PCP QIP 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 members 51 - 75 years of age by December 31 of the measurement year (MY)

PCP QIP 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

- 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 is information is not always provided as part of the record submissions.

Colorectal Cancer Screening Exclusions

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- History of colorectal cancer
- History of a total colectomy
- In hospice or receiving palliative care during the measurement year
- Medicare members 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)

Summary of 2022 PCP QIP

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	70.67%	64.78%	7 / 5	12.5 / 9	12 / 9
✓	✓		Comprehensive Diabetic Care - HbA1c Control		18 - 75 YRS	61.63%	56.81%	7 / 5	12.5 / 9	--
✓	✓		Controlling High Blood Pressure		18 - 85 YRS	62.53%	55.35%	7 / 5	12.5 / 9	--
✓		✓	Immunization for Adolescents - Combination 2		13 YRS	43.55%	36.74%	7 / 5	--	12 / 9
✓	✓		Breast Cancer Screening	PREVENTATIVE SCREENING	50 - 74 YRS	58.70%	53.93%	7 / 5	12.5 / 9	--
✓	✓		Cervical Cancer Screening		21 - 64 YRS	63.66%	59.12%	7 / 5	12.5 / 9	--
✓		✓	Childhood Immunization Status - Combination 10		2 YRS	45.50%	38.20%	7 / 5	--	12 / 9
✓	✓		Colorectal Cancer Screening		51 - 75 YRS	TBD		6 / 5	12.5 / 9	--
		✓	Counseling for Nutrition for Children/Adolescents		3 - 17 YRS	76.64%	70.11%	--	--	12 / 9
		✓	Counseling for Physical Activity for Children /Adolescents		3 - 17 YRS	72.81%	66.18%	--	--	12 / 9
✓		✓	Child and Adolescent Well Care Visit	UTILIZATION	3 - 17 YRS	53.83%	45.31%	10 / 8	--	12.5 / 9
✓		✓	Well Child Visits in the First 15 Months of Life		15 MONTHS	61.25%	54.92%	10 / 8	--	12.5 / 9

Voices from the Field

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

Beth Dadko, MPH
Population Health Manager
Santa Rosa Community Health

Santa Rosa COMMUNITY HEALTH

About Santa Rosa Community Health

- FQHC in Sonoma County
- We see 1 in 4 people in Santa Rosa
- 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

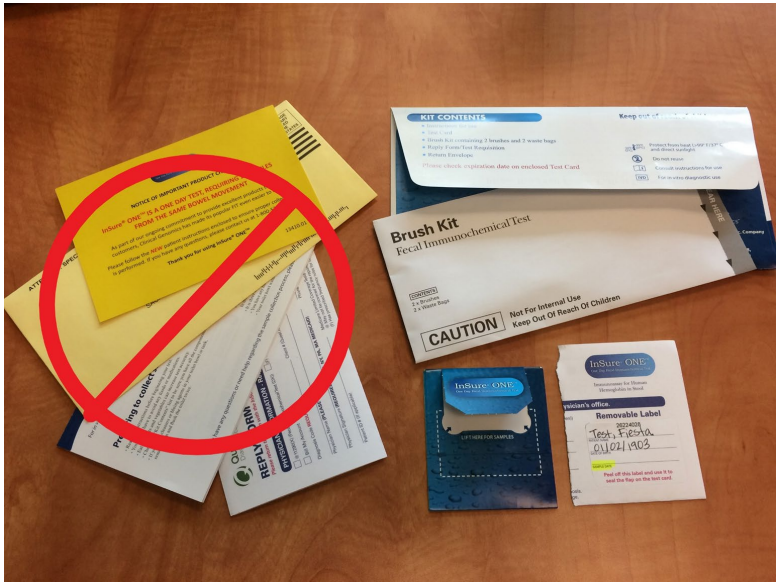
Overall Culture of Quality

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

CRC Successful Strategies



- Centralized Mailing with text follow-up

Mammo Successful Strategies

- 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 ordered but not completed
- Pair with National Prev. Health Months to use educational materials

Mammo Successful Strategies

- Partner with a Mobile Mammogram Van


a single image can save your life.
get your mammogram!
alinea
STOP
ALTO
Your health is important to us!
If you have a fever, cough, or shortness of breath:


bubly
AHA

Cervical Cancer Screening 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
- ROI to get records from outside (like Planned Parenthood)
- HPV Only Workflow

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

PHC Best and Promising Practices

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.
- ✓ Schedule cancer screening 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.
- ✓ Establish standard practice to include hrHPV testing, with or without cytology, for members 30 - 64 years of age.

Best and Promising Practices

- ✓ 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.
- ✓ Consider using an equity approach to increase screening rates for targeted communities. Explore possible barriers that may impact screening services.

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.
- ✓ Your clinical recommendation is the most influential factor in whether a person decides to get screened (Colorectal screening). Patients are 90% more likely to get a screening when they reported a physician recommendation.

Best and Promising Practices

Communication/Education:

- ✓ Educate patients that cervical cancer screening is a covered preventive service.
- ✓ 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).
- ✓ Ensure information is person-centered.
- ✓ Collaborate with community agencies for outreach.

Best and Promising Practices

Strengthen Internal Operating Practices*:*

- ✓ Submit timely claims and encounter data within 90 days of service.
- ✓ Use complete and accurate codes to capture clinical services completed.
- ✓ Document why the member is excluded (e.g., total abdominal or vaginal hysterectomy).
- ✓ Document results of most recent Pap screening and the date screening was performed.
- ✓ Compare EHR or lab requisition forms with codes to ensure lab order is in alignment with measure.

Questions

Upcoming Trainings/Events

Accelerated Learning Education Program

The Accelerated Learning webinars are designed to enhance learning on a subgroup of measures that are part of our Primary Care Provider Pay for Performance Program (PCP QIP). ***CME/CE credits are available for each session.***

- **June 7** - Pediatric Health: A Cluster of Services for 0 - 2 Years Old
  Noon - 1:15 p.m.
  https://partnershiphp.webex.com/partnershiphp/onstage/g.php?MTID=ee95300db3c18dfdda9a41334f0bdf024

- **July 12** - Pediatric Health: Child and Adolescent Well-Care Visits (3-17 years), Screenings, and Immunizations for Adolescents
  Noon - 1:15 p.m.
  https://partnershiphp.webex.com/partnershiphp/onstage/g.php?MTID=e4434d3313a539874d58c1d1bc4f55b3a

Update on Childhood Lead Poisoning Prevention

Update on childhood lead poisoning prevention: counseling, screening, and management for children potentially exposed to lead.

- **April 20 - Noon - 1:30 p.m.**
  https://partnershiphp.webex.com/partnershiphp/j.php?RGID=r28b9fe3b69ff9538c77f3e80c8bbf6ac

Virtual ABCs of Quality Improvement

Eureka | Fairfield | Redding | Santa Rosa | *(800) 863-4155* | *www.partnershiphp.org*

This virtual training consists of five sessions via webinar.
The following topics will be covered:

- What is quality improvement?
- Introduction to the Model for Improvement
- Setting project goals and measures
- How to use data to measure quality and to drive improvement
- Methods for developing change ideas that lead to improvement
- Testing changes with the Plan-Do-Study-Act (PDSA) cycle

These courses are FREE. All webinars are scheduled noon to 1 p.m. on the dates below.

Wednesday, May 18

Introduction to Quality and Goal Setting

Registration:
https://partnershiphp.webex.com/partnershiphp/onstage/g.php?MTID=ecbf5bb810bdd1117187b4b70c69d5a0f

Wednesday, May 25

Using Data for Quality Improvement

Registration:
https://partnershiphp.webex.com/partnershiphp/onstage/g.php?MTID=e135d1743ac519d40ccda446b1414da12

Wednesday, June 1

How Do We Know That a Change is an Improvement?

Registration:
https://partnershiphp.webex.com/partnershiphp/onstage/g.php?MTID=eec87427342a230b6f29c8f9a8cba03d1

Wednesday, June 8

What Changes Can We Make That Will Result in Improvement?

Registration:
https://partnershiphp.webex.com/partnershiphp/onstage/g.php?MTID=e3695fb4a43b2d55e59d5efe63e544434

Wednesday, June 22

Testing Change Ideas – Plan-Do-Study-Act (PDSA)

Registration:
https://partnershiphp.webex.com/partnershiphp/onstage/g.php?MTID=e459c17cc3c77be8193ba864c405f40fb

**Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.*

***Application for CE credit has been filed with the California Board of Registered Nursing, Provider Number CEP16728. Determination of credit is pending.*

Questions: Email improvementacademy@partnershiphp.org

Quality Improvement Trainings

On-Demand Courses

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

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

PHC Resources

QI/Performance Team:

ImprovementAcademy@partnershiphp.org

Quality Improvement Program: QIP@partnershiphp.org

2022 PCP QIP Webpage:

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

QI Monthly Newsletters:

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

FM

A Quick Guide to Starting Your Quality Improvement Projects

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

Contact Us

FM

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Evaluation

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

References

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National Committee on Quality Assurance (NCQA) HEDIS® Measurement Year 2021 and Measurement Year 2022 Vol 2 Technical Specifications for Health Plans. HEDIS® is a registered trademark of NCQA.

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- 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
- California Cancer Registry Fact Sheets- https://www.ccrcal.org/retrieve-data/data-for-the-public/cancer-fact-sheets/

Primary Care Provider Quality Improvement Program (PCP QIP)

Cervical Cancer Screening PCP QIP 2022

PCP QIP 2022	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Internal Medicine	7 Points 12.5 Points	63.66%	75th
Partial Points	Family Internal Medicine	5 Points 9 Points	59.12%	50th

Breast Cancer Screening PCP QIP 2022

PCP QIP 2022	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Internal Medicine	7 Points 12.5 Points	58.70%	75th
Partial Points	Family Internal Medicine	5 Points 9 Points	53.93%	50th

Colorectal Cancer Screening PCP QIP 2022

PCP QIP 2022	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Internal Medicine	6 Points 12.5 Points	TBD	50th
Partial Points	Family Internal Medicine	5 Points 9 Points	TBD	25th

Summary of 2022 QIP

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	70.67%	64.78%	7 / 5	12.5 / 9	12 / 9
✓	✓		Comprehensive Diabetic Care - HbA1c Control		18 - 75 YRS	61.63%	56.81%	7 / 5	12.5 / 9	--
✓	✓		Controlling High Blood Pressure		18 - 85 YRS	62.53%	55.35%	7 / 5	12.5 / 9	--
✓		✓	Immunization for Adolescents - Combination 2	PREVENTATIVE SCREENING	13 YRS	43.55%	36.74%	7 / 5	--	12 / 9
✓	✓		Breast Cancer Screening		50 - 74 YRS	58.70%	53.93%	7 / 5	12.5 / 9	--
✓	✓		Cervical Cancer Screening		21 - 64 YRS	63.66%	59.12%	7 / 5	12.5 / 9	--
✓		✓	Childhood Immunization Status - Combination 10		2 YRS	45.50%	38.20%	7 / 5	--	12 / 9
✓	✓		Colorectal Cancer Screening		51 - 75 YRS	TBD		6 / 5	12.5 / 9	--
		✓	Counseling for Nutrition for Children/Adolescents		3 - 17 YRS	76.64%	70.11%	--	--	12 / 9
		✓	Counseling for Physical Activity for Children /Adolescents		3 - 17 YRS	72.81%	66.18%	--	--	12 / 9
✓		✓	Child and Adolescent Well Care Visit	UTILIZATION	3 - 17 YRS	53.83%	45.31%	10 / 8	--	12.5 / 9
✓		✓	Well Child Visits in the First 15 Months of Life		15 MONTHS	61.25%	54.92%	10 / 8	--	12.5 / 9

Summary of 2022 QIP

PRACTICE TYPE			NON-CLINICAL				FULL / PARTIAL POINTS		
FAMILY	INTERNAL	PEDS					FAMILY	INTERNAL	PEDS
ACCESS AND OPERATIONS									
✓	✓	✓	Ambulatory Care Sensitive Admissions		FULL POINT TARGET TBD (60th Percentile)	PARTIAL POINT TARGET TBD (70th Percentile)	5 / 4	5 / 4	--
			Risk Adjusted Readmission Rate		FULL POINT TARGET TBD	PARTIAL POINT TARGET TBD	5 / 4	5 / 4	--
APPROPRIATE USE OF RESOURCES									
✓	✓	✓	Avoidable ED Visits		FULL POINT TARGET TBD (60th Percentile)	PARTIAL POINT TARGET TBD (70th Percentile)	5 / 4	5 / 4	5 / 4
PATIENT EXPERIENCE									
✓	✓	✓	Patient Experience	**CAHPS**	**ACCESS**	**COMMUNICATIONS**	10 / 8	10 / 8	10 / 8
					FULL POINTS 50TH Percentile 47.62%	FULL POINTS 50TH Percentile 75.17%			
					PARTIAL POINTS 25TH Percentile 43.17%	PARTIAL POINTS 25TH Percentile 70.97%			
				SURVEY OPTION	**FULL POINTS**	**PARTIAL POINTS**	10 / 8	10 / 8	10 / 8
					PARTS 1 AND 2	PARTS 1 OR 2			

Summary of 2022 QIP

UNIT-OF-SERVICE				
PRACTICE TYPE			MEASURE	CRITERIA
FAMILY	INTERNAL	PEDS		
✓	✓		Advance Care Planning Attestations	Minimum 1/1000th (0.01%) of the sites assigned monthly membership 18 years and older for: • $100 per Attestation, maximum payment $10,000. • $100 per Advance Directive/POLST, maximum payment $10,000
		✓	Extended Office Hours	Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification).
✓	✓	✓	PCMH Certification	$1,000 yearly for achieving or maintaining PCMH accreditation.
			Peer-led Self-Management Support Groups (both new and existing)	$1,000 per group (Maximum of 10 groups per parent organization).
✓	✓	✓	Health Information Exchange	One time $3000 incentive for signing on with a local or regional health information exchange; Annual $1500 incentive for showing continued participation with a local or regional health information exchange. The incentive is available once per parent organization.
			Initial Health Assessment	$2,000 per parent organization for submitting all required parts of improvement plan regardless of visit volume.
✓	✓	✓	Health Equity	$2000 per parent organization for submission of proposed plan to adopt internal best practices supporting a Health Equity initiative.
			Tobacco Screening	$5.00 per tobacco use screening or counseling of members 11- 21 years of age after 3% threshold of assigned members screened.
✓		✓	Blood Lead Screening	Tier 1-3, $1000, $3000, $5000 per parent organization for the number of children between 24 to 72 months who had capillary or venous lead blood test for lead poisoning.
			Dental Varnish	$1,000 per parent organization for submission of proposed plan to implement fluoride varnish application in the medical office.

2022 eReports Upload Schedule

CLINICAL MEASUREMENT SET:	
Cervical Cancer Screening Childhood Immunization Status - Combo 10 Counseling for Nutrition Counseling for Children/Adolescents Counseling for Physical Activity for Children/Adolescents Comprehensive Diabetes Care - Retinal Eye Exams Colorectal Cancer Screening Immunizations for Adolescents - Combination 2	MAR 01, 2022 - JAN 31, 2023
Comprehensive Diabetes Care - HbA1c Control (A1c) Controlling High Blood Pressure Well-Child Visits in the First 15 Months of Life	OCT 01, 2022 - JAN 31, 2023
Breast Cancer Screening Child and Adolescent Well Care Visits	JAN 10, 2023 - JAN 31, 2023
*Asthma Medication Ratio	N/A *

** Asthma Medication Ratio – Data is captured through claims and pharmacy data only. Uploads are not accepted for this measure.*

Claims Companion

CLINICAL DOMAIN						
PRACTICE TYPE			MEASURE	CODING	NUMERATOR CODING RULES	NUMERATOR COMPLIANCE
FAMILY	INTERNAL	PEDS				
✓	✓	✓	Asthma Medication Ratio	REFERENCE MEASURE(S) CODE-SET IN eREPORTS DIAGNOSIS CROSSWALK	REFERENCE DETAILED SPECIFICATIONS - IN eREPORTS	CLAIMS & PHARMACY DATA ONLY NO eREPORTS UPLOAD AVAILABLE
✓	✓		Comprehensive Diabetic Care - HbA1c Control			eREPORTS UPLOAD - ADHERE TO UPLOAD SCHEDULE
✓	✓		Controlling High Blood Pressure			
✓		✓	Immunization for Adolescents - Combination 2			
✓	✓		Breast Cancer Screening			
✓	✓		Cervical Cancer Screening			
✓		✓	Childhood Immunization Status - Combination 10			
✓	✓		Colorectal Cancer Screening			
		✓	Counseling for Nutrition for Children/Adolescents			
		✓	Counseling for Physical Activity for Children Adolescents			
✓		✓	Child and Adolescent Well Care Visit			
✓		✓	Well Child Visits in the First 15 Months of Life		ADHERE TO 14-DAY RULE (IN-BETWEEN DATES OF SERVICE)	