



# Improving Measure Outcomes: Chronic Disease

## Controlling High Blood Pressure Colorectal Cancer Screening



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# Learning Objectives

- Define the clinical measure background, specifications, and performance threshold definitions for the 2025 Primary Care Provider Quality Improvement Program Specifications: *Controlling High Blood Pressure and Colorectal Cancer Screening* measures.
- Apply measure specification requirements, including those related to telehealth updates and remote blood pressure monitoring, to maximize adherence and measure performance.
- Evaluate the prevalence and risk factors for high blood pressure and colorectal cancer and associated health inequities prevalent in their diagnosis and treatment.
- Apply documentation requirements to maximize adherence and measure performance in the delivery of colorectal cancer screening.
- Identify best and promising practices including, successful clinical workflows, member and staff education, outreach, and technical tips to improve high blood pressure rates and improve timely screening for colorectal cancer.
- Examine disproportionate prevalence and/or rates of chronic disease and how culture and lifestyle factors (i.e., diet) of groups experiencing risk may contribute to ineffective management.



# Overview of Measures: QIP Specifications, Tools, and Resources





# Controlling High Blood Pressure



# Fast Facts

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## Prevalence

- Affects approximately 50M people in the U.S.
- Most common reason for office visits, although 50% of people with hypertension are not at adequate control of their blood pressure.

## Risk Factors

### Age

- Hypertension rates increase in older populations.

### Medical

- Medications

### Family History

- Individuals with one or two parents with hypertension carry twice the risk.

### Less Common Factors

- Kidney anatomy
- Genetic conditions

# Clinical Importance

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Hypertension can cause:

## Brain

- Stroke
- Dementia

## Arteries

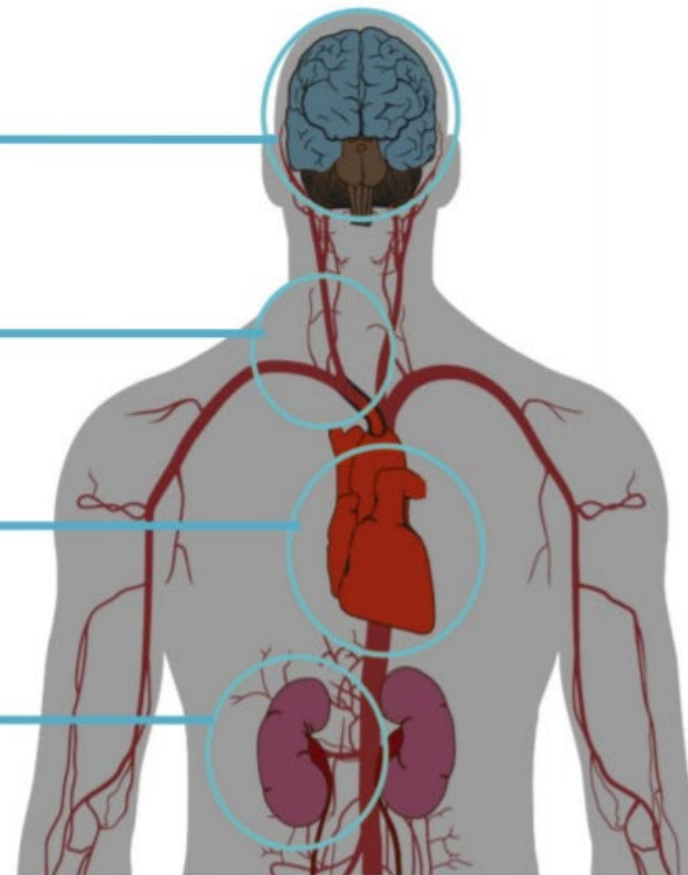
- Artery damage and narrowing
- Aneurysm
- Leg amputation

## Heart

- Coronary artery disease
- Heart attack
- Congestive heart failure

## Kidneys

- Kidney failure
- Kidney artery aneurysm



# Diagnosis

| Blood Pressure Levels   |  |  |  |
|---|--|--|--|
| <i>The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (2003 Guideline)<sup>2</sup></i> |  | <i>The American College of Cardiology/American Heart Association Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (2017 Guideline)<sup>1</sup></i> |  |
| Normal  | Systolic less than 120 mm Hg<br>Diastolic: less than 80 mm Hg                  | Normal   | Systolic less than 120 mm Hg<br>Diastolic: less than 80 mm Hg  |
| At risk (prehypertension)   | Systolic 120 – 139 mm Hg   | Elevated   | Systolic: 120–129 mm Hg<br>Diastolic: less than 80 mm Hg       |
| High Blood Pressure (hypertension)  | <b>S</b> ystolic: 140 mm Hg or higher<br><b>D</b> iastolic: 90 mm Hg or higher | High blood pressure (hypertension)   | Systolic: 130 mm Hg or higher<br>Diastolic: 80 mm Hg or higher |

# Hypertension Treatment: More than Medications

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## Lifestyle Changes for Prevention and Treatment

- Diet changes.
- Regular physical activity and exercise.
- Regular primary care provider (PCP) consults to address modifiable risk factors, early detection, and initiation of treatment.

## Home Self-Monitoring

- Self-monitoring empowers patients for self-management





# Evidence-Based Practices (EBP) in Self-Measured Blood Pressure Monitoring (SMBPM)

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## Combining SMBPM with additional supports

- Patient counseling (diet and exercise).
- Education sessions on hypertension management.
- Web-based support (electronic messaging, text reminders to measure BP, electronic requests for medication refills).

## Utilizing team-based care

- The team includes the PCP, RNs, pharmacists, dieticians, social workers, community health workers, and THE PATIENT.
- Shared responsibility for medication management, patient follow-up, adherence, and self-management support.

## Sharing EBP results

- During clinic visits, by telephone or electronically.



## Pharmacy academic detailing helps clinicians:

- Improve medication management.
- Improve quality measure performance.
- Achieve better clinical outcomes for their patients.

## Effective medication management:

- Requires clinicians and care team to have complete, accurate, and current data on the pharmacy claims.

## Partnership Pharmacy Academic Detailing:

- Partnership clinical staff are happy to provide prescribing data to Primary Care Provider practices to review care gaps in blood pressure medication prescribing.

# Health Disparities

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Blood pressure control rates have worsened in the U.S. over the last decade, with significantly lower rates of control among minority groups.

- Black/AA groups having 10% lower control rates than non-Hispanic white counterparts
- Black/AA experience a 5x higher mortality rate from hypertension than white Americans
  - 30% higher risk of fatal stroke
  - 50% higher risk of CVD mortality
  - 4x higher risk of ESRD
- Blood pressure levels for Black/AA are significantly higher with an earlier age of onset

# U.S. Hypertension Race/Ethnicity Comparisons

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| Race/Ethnicity                  | Prevalence  | Awareness          | Treatment          | Control Rates         |
|---------------------------------|---|--------------------|--------------------|-----------------------|
| White<br>(reference population) | 31.4%   | 79.1%              | 67.3%              | 49.1%                 |
| Black/African-American          | 45.3%<br><b>Higher</b><br>(Black women > black men) | 79.7%<br>NSD       | 67.2%<br>NSD       | 39.2%<br><b>Lower</b> |
| Hispanic                        | 36.1% NSD   | 71.1% <b>Lower</b> | 60.5% <b>Lower</b> | 40% <b>Lower</b>      |
| Asian-American                  | 31.8% NSD   | 72.5% <b>Lower</b> | 58.8% <b>Lower</b> | 37.8% <b>Lower</b>    |

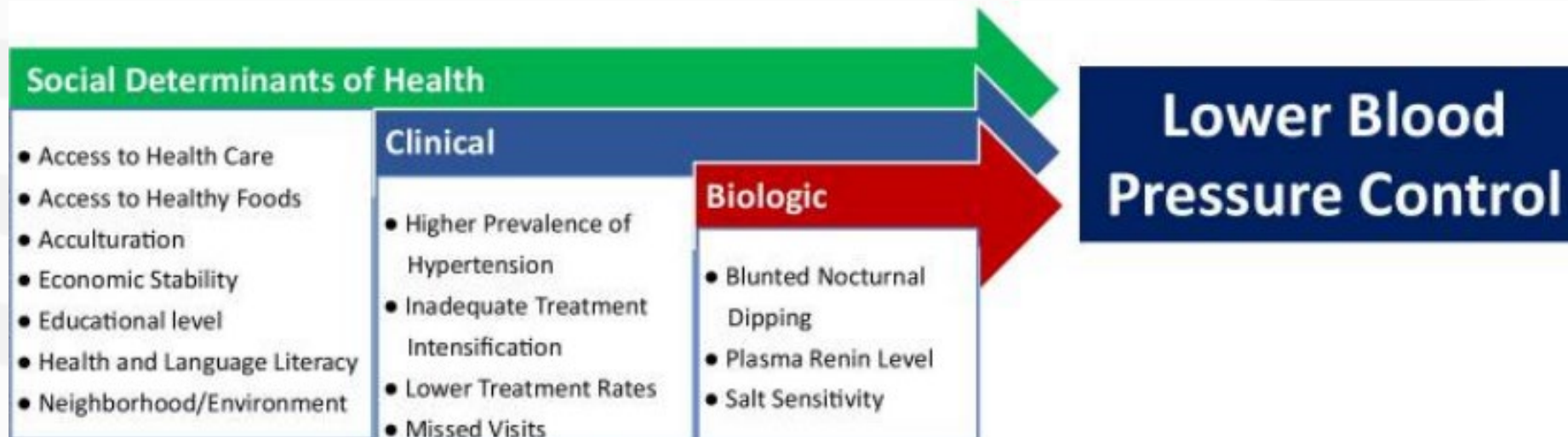
NSD= no significant difference

Data compiled from the National Health and Nutrition Examination Survey (NHANES), 2013-2018, n=28,061

Reference: <https://www.ahajournals.org/doi/full/10.1161/HYPERTENSIONAHA.121.17570>



# Contributing Factors to Disparities



SDoH are the main contributing factors, compounded by clinical factors and barriers to hypertension management including inadequate treatment due to biologic factors.

Reference: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9838393/>

# Potential Drivers of Disparities

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- Factors can differ among racial and ethnic groups.
- Access to healthy food options impact inequities in management and control.
- Limited healthcare access
  - Poor control seen in those without a PCP visit > one year.
- Dietary patterns by race and ethnicity.



# Colorectal Cancer Screening



# Fast Facts

RM

- Colorectal cancer is a leading diagnosed new cancer in the U.S.
  - 4<sup>th</sup> highest with an estimated 153k diagnoses annually.
  - More prevalent in males vs. females.
- Approximately **53,010** people will die from colorectal cancers in **2024** (U.S.).

## Risk Factor Assessment

- No published guidelines.
- Look for familial risk factors over time.
- Begin assessing risk at 20 years and older (every 3 - 5 years).
- Opportunity to begin planting the seed for screening.





# Screening Ages and Frequency for Average Risk

RM

**For average risk:** adults ages 45 - 75 years old

| Screening Method                            | Frequency      |
|---|----------------|
| FOBT<br>FIT*                                | Annually       |
| FIT-DNA test*                               | Every 3 years  |
| CT Colonography*<br>Flexible Sigmoidoscopy* | Every 5 years  |
| Colonoscopy                                 | Every 10 years |

\*Positive findings require follow-up with a colonoscopy

# Health Disparities

- Colorectal cancer incidence and deaths are highest in the U.S. for AIAN and Black/African Americans.
- Black/African Americans in the U.S. have the lowest 5-year survival rate of all ethnicities, despite stage at diagnosis. They are also more likely to be diagnosed at later-stage disease (when metastatic or unresectable).
- Screening is lowest among Asian Americans (50%), individuals with less than a high school education (48%), and recent immigrants (29%).

# Potential Drivers of Disparities for Colorectal Cancer Screening (CRC)

RM

Among racially diverse populations with less than a high school education, low income, no health insurance, and no regular health care provider. Other barriers to colon cancer screening are fatalism, religious beliefs, lack of self-worth, sexually related concerns, history of sexual abuse, past negative experiences with screening, and suspicion that a physician may be motivated to recommend the procedure for financial gain.

Knowledge, perceptions, and beliefs about CRC screening and an individual's cultural, social, and physical environments influence the decision to undergo preventive screening.

#### References:

[https://www.cdc.gov/pcd/issues/2015/14\\_0586.htm#:~:text=Among%20racially%20diverse%20populations%20with,abuse%2C%20past%20negative%20experiences%20with](https://www.cdc.gov/pcd/issues/2015/14_0586.htm#:~:text=Among%20racially%20diverse%20populations%20with,abuse%2C%20past%20negative%20experiences%20with)  
Jones RM, Devers KJ, Kuzel AJ, Woolf SH. Patient-reported barriers to colorectal cancer screening: a mixed-methods analysis. *Am J Prev Med* 2010;38(5):508–16.  
Stacy R, Torrence WA, Mitchell CR. Perceptions of knowledge, beliefs, and barriers to colorectal cancer screening. *J Cancer Educ* 2008;23(4):238–40.  
DiClemente RJ, Salazar LF, Crosby RA. *Health behavior theory for public health: principles, foundations, and applications*. Burlington (MA): Jones and Bartlett Learning; 2013.



# Overview QIP Specifications, Tools, and Resources



# Measure Specification – Controlling High Blood Pressure

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## Measure Description

The percentage of members 18 - 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

**Denominator:** Members 18 - 85 years of age by December 31, 2024, who had at least two visits on different dates of service on or between 1/1/2025-6/30/2025 with a diagnosis of hypertension.

**Numerator:** The number of members whose most recent blood pressure (BP) taken during an outpatient visit, a nonacute inpatient encounter, or remote monitoring event was <140/90 mm Hg during the measurement year.

More detailed information can be found in the  
[PCP 2025 Measurement Specifications Manual](#)



## Eligible Readings Include:

- Outpatient visits, telephone visits, virtual check-ins, or remote monitoring taken by **any digital device**
- Multiple readings for a single date: use the lowest systolic and diastolic BP
  - Example: BP readings on 5/30/23 were 140/**80**, 138/90 and **130**/87
  - Use 130/87

# Unit of Service Measure – Academic Detailing

## ***New Measure: Academic Detailing HEDIS Measure: Controlling High Blood Pressure***

### **Description:**

Measure to incentivize sites for hosting a two-part academic detailing with Partnership's Pharmacy team/Medical Director.

### **Program Goal:**

Share Medi-Cal Rx prescription drug data with our provider organization's clinical leaders and quality improvement leaders to drive measure performance improvement as well as clinical outcomes.

### **Thresholds**

A \$2,500 bonus for scheduling & hosting academic detailing meetings with at least one Medical Director, one Pharmacist (where applicable) & QI team/Partnership pharmacist/medical director present.

More detailed information can be found in the  
[PCP 2025 Measurement Specifications Manual](#)

# Measure Specification – Colorectal Cancer Screening

TT

## Measure Description

The percentage of members 46 - 75 years of age who had appropriate screening for colorectal cancer.

**Denominator:** Number of continuously enrolled members 46 - 75 years of age by December 31 of the measurement year (MY).

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

More detailed information can be found in the  
[PCP 2025 Measurement Specifications Manual](#)





# New Screening Benchmark Targets Colorectal Cancer Screening

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## New 2025 Targets:

Partnership is now using NCQA MediCaid standards:

- Partial Points set at the 50<sup>th</sup> percentile
- Full Points are set at 75<sup>th</sup> percentile

More detailed information can be found in the  
[PCP 2025 Measurement Specifications Manual](#)



# Screening Methods and Measure Criteria

| Screening Method                          | Frequency                               |
|---|---|
| FOBT or FIT                               | During the measurement year (MY)        |
| FIT-DNA test                              | During the MY or two years prior to MY  |
| CT Colonography or Flexible Sigmoidoscopy | During the MY or four years prior to MY |
| Colonoscopy                               | During the MY or nine years prior to MY |

## Documentation

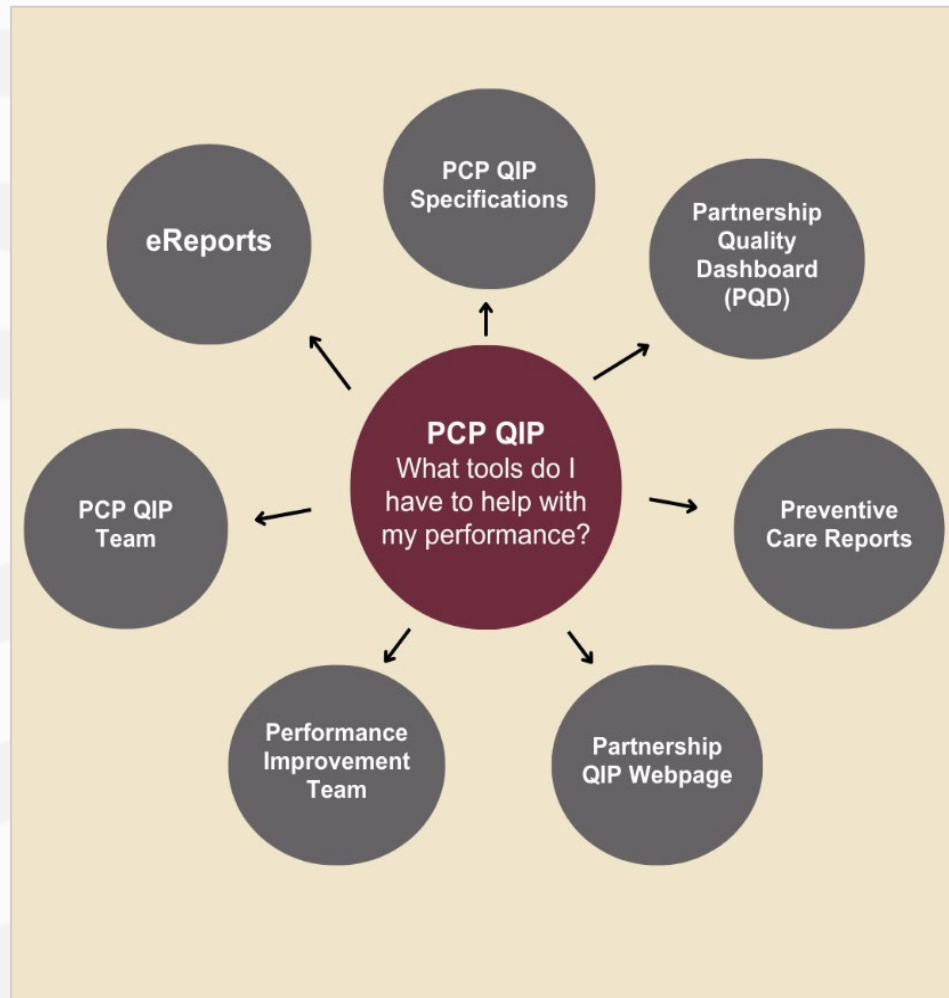
Include date of screening, type of screening, and result.

\*This type of information is included in health history forms, however, not always provided as part of the record submissions.

**Note:** Codes to identify the tests can be found on the Diagnosis Crosswalk in [eReports](#)

# Quality Incentive Program (QIP) Tools

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## PCP QIP Tool Links:

- [PCP QIP Webpage](#) > Click the link: *'Learn More about the 2025 PCP QIP'*
- [eReports](#) >
  - **Diagnosis Crosswalk**
  - **Disparity Analysis Dashboard**
  - **"Help" Section** >
    - **PQD User Guide**
    - **Preventive Care Reports User Guide**

# eReports: Diagnosis Crosswalk Coding Questions

- Home
- My QIP Scores
- QIP Measure Report
- QIP Member Report
- Member Search
- Upload QIP Data
- Weekly Count Report
- My eAdmins
- eAdmin
- Diagnosis Crosswalk**
- QIP Specification Manual
- Templates
- Partnership Quality Dashboard
- Preventive Care Reports



## DID YOU KNOW?

About the

## Diagnosis Crosswalk



Found in eReports, the **Diagnosis Crosswalk** contains billing codes required for numerator compliance for *all* QIP clinical measures.

Choose your measure of interest and all codes included in the measure logic are listed.

Select a Measure:

Select a Code Type:

| Code Type | Code System | Code  |
|-----------|-------------|-------|
| Well-Care | CPT         | 99381 |
| Well-Care | CPT         | 99382 |

# Disparity Analysis Dashboard

**Purpose:** To promote the ease of identification of PCP QIP measure performance across race/ethnicity groups within various levels of geographic stratification. The dashboard also offers the ability to filter by denominator size for selected geographic and race/ethnicity group stratification.

**Filters and Breakouts to Modify the Table Display**

Refresh Date: Apr 24 | Measure Name: (All) | Provider Name: (All) | Race/Ethnicity Group: (All) | Denominator Size: (All)

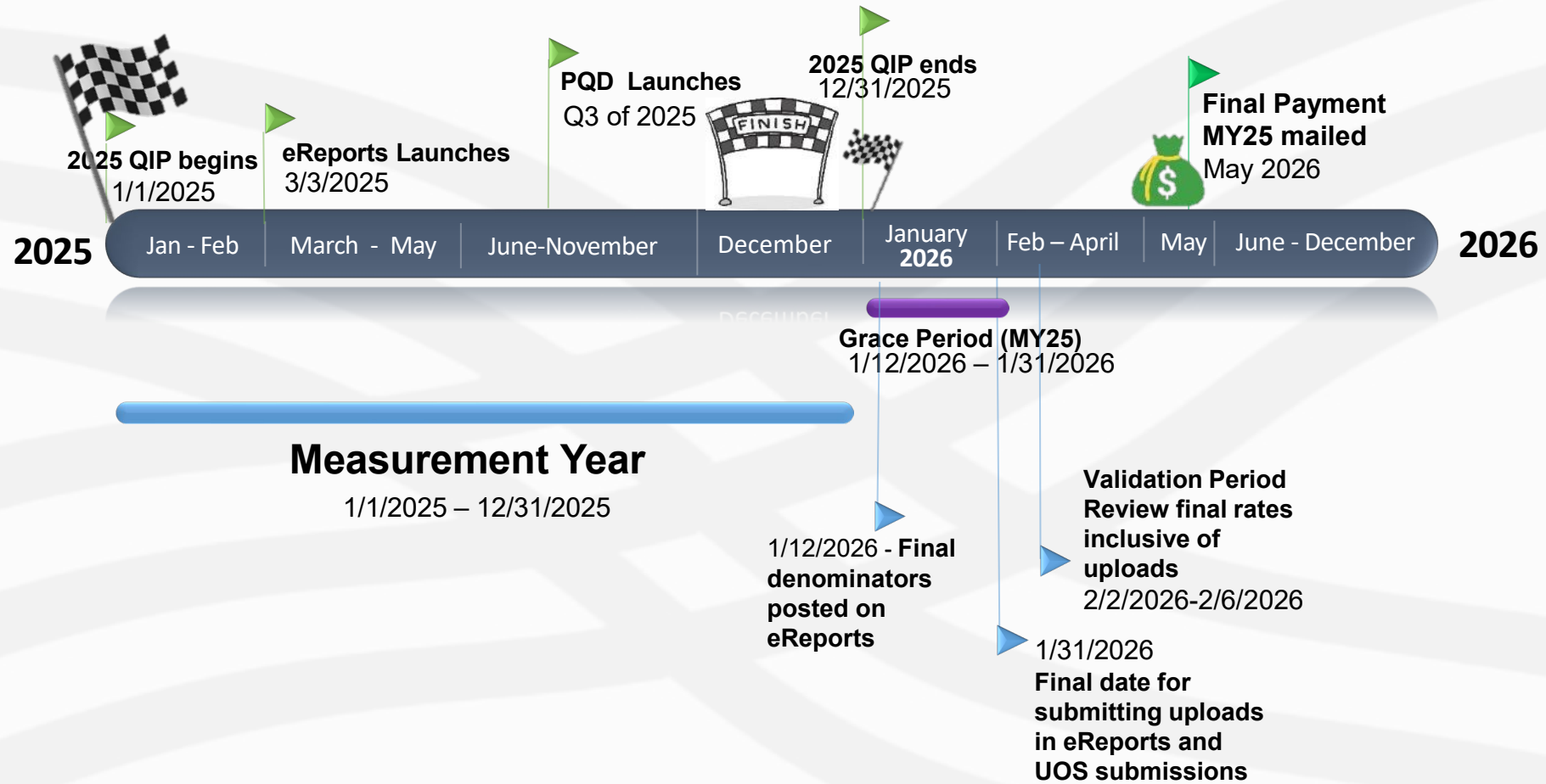
Geo Breakout 1: None | Geo Breakout 2: None

**EXAMPLE**

| Measure Name                          | Geo Breakout 1 | Geo Breakout 2 | ASIAN/PAC ISLANDER | BLACK | EAST ASIAN | HISPANIC | NATIVE AMERICAN | OTHER | SOUTH ASIAN | SOUTHEAS ASIAN | UNKNOWN | WHITE |
|---------------------------------------|----------------|----------------|--------------------|-------|------------|----------|-----------------|-------|-------------|----------------|---------|-------|
| Breast Cancer Screening               | None           | None           | 33.33              | 33.64 | 48.96      | 58.74    | 25.00           | 40.24 | 49.39       | 42.14          | 46.81   | 37.50 |
| Cervical Cancer Screening             | None           | None           | 39.58              | 44.44 | 34.75      | 45.84    | 34.04           | 46.74 | 50.35       | 42.09          | 42.45   | 39.15 |
| Child and Adolescent Well Care Visits | None           | None           | 7.58               | 12.17 | 8.11       | 16.09    | 11.76           | 12.10 | 11.40       | 16.06          | 13.32   | 11.83 |
| Childhood Immunization Status CIS 10  | None           | None           | 37.50              | 12.60 |            | 34.51    |                 | 22.86 | 0.00        | 37.50          | 25.82   | 17.33 |
| Colorectal Cancer Screening           | None           | None           | 24.71              | 23.66 | 32.43      | 31.36    | 27.50           | 31.02 | 31.36       | 34.60          | 30.41   | 27.91 |
| Controlling High Blood Pressure       | None           | None           | 6.90               | 7.14  | 0.00       | 7.62     | 0.00            | 8.75  | 7.81        | 4.61           | 4.46    | 10.60 |
| Diabetes - HbA1C Good Control         | None           | None           | 26.42              | 14.00 | 37.50      | 19.08    | 0.00            | 22.62 | 13.43       | 26.73          | 15.20   | 23.54 |
| Diabetes - Retinal Eye exam           | None           | None           | 26.42              | 24.00 | 37.50      | 21.19    | 14.29           | 21.43 | 26.87       | 38.61          | 21.57   | 20.90 |
| Immunization for Adolescents IMA 2    | None           | None           | 14.29              | 19.35 | 80.00      | 51.93    | 80.00           | 23.40 | 77.78       | 33.33          | 26.09   | 16.28 |
| Lead Screening in Children            | None           | None           | 33.33              | 69.23 |            | 33.44    |                 | 70.37 | 80.00       | 50.00          | 78.11   | 74.51 |
| Well Child First 15 Months            | None           | None           | 0.00               | 16.67 |            | 16.61    |                 | 16.67 | 42.86       | 0.00           | 17.14   | 17.65 |



# PCP QIP Timeline



# Putting Quality Into Practice



# Measure Best Practices

**PARTNERSHIP HEALTHPLAN of CALIFORNIA**  
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CLAIMS  
PHARMACY  
QUALITY IMPROVEMENT

- ECM QIP
- PCP QIP
- Hospital QIP
- LTC QIP
- Palliative Care QIP
- Perinatal QIP
- HEDIS
- Managing Pain Safely
- Partnership Improvement Academy

## MEASURE BEST PRACTICES

The 2025 Measure Best Practices documents are resources for the Primary Care Provider Quality Improvement Program (PCP QIP) measure set, which aligns closely with the Managed Care Accountability Set (MCAS) measures for which Partnership HealthPlan of California is held accountable by the Department of Health Care Services (DHCS). Each Measure Best Practice document includes Partnership tools and resources, guidelines to facilitate optimal member care, opportunities for patient education, outreach, and equity, data and coding resources, and helpful links to improve measure performance.

- Breast Cancer Screening
- Cervical Cancer Screening
- Child & Adolescent Well Care
- Childhood Immunizations Status
- Colorectal Cancer Screening ★
- Controlling Blood Pressure ★

### 2025 Best Practices Colorectal Cancer Screening

**Partnership Tools, Programs, and Promising Practices:**

- Partnership partners with Exact Sciences, a colorectal cancer screening vendor, to support **bulk ordering of Cologuard (FIT-DNA) screening kits** for direct shipment to members/patients. Provider organizations must have at least 100 members/patients due for colon cancer screening who are interested.

### 2025 Best Practices Controlling High Blood Pressure

**Partnership Tools, Programs, and Promising Practices:**

- Partnership's Pharmacy Department offers **Academic Detailing** analysis of Controlling Blood Pressure measure performance and opportunities for improvement based on prescribing and pharmacy fill data. Please contact the Pharmacy Department at [RxConsult@PartnershipHP.org](mailto:RxConsult@PartnershipHP.org) if you would like to request Academic Detailing for your practice.
- Attend or view Partnership's [Improving Measure Outcomes training](#) on *Chronic Disease Management*.

[Link to Measure Best Practices](#)





# Quality Improvement Partnership Improvement Academy Landing Page

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PROVIDER RELATIONS  
CLAIMS  
PHARMACY  
QUALITY IMPROVEMENT

- ECM QIP
- PCP QIP
- Hospital QIP
- LTC QIP
- Palliative Care QIP
- Perinatal QIP
- HEDIS
- Managing Pain Safely
- Partnership Improvement Academy
- Member Safety and Quality Assurance
- Potential Quality Issues

HEALTH SERVICES  
STRATEGIC INITIATIVES  
COVID VACCINE INCENTIVE PROGRAM  
HIPAA/EDI PUBLICATIONS  
PHC PRIMARY CARE BLOG  
WORKFORCE DEVELOPMENT

## PARTNERSHIP IMPROVEMENT ACADEMY

Improvement requires change and change can be hard! We launched the Partnership Improvement Academy in 2014 to create a space for clinicians, administrators, and staff to gain quality improvement expertise from industry leaders and peers.

We provide training and technical assistance opportunities designed to help you practice optimize population health, enhance the patient experience, promote provider and care team satisfaction, and foster a culture of continuous quality improvement.

### Contact Us

Email: [ImprovementAcademy@partnershiphp.org](mailto:ImprovementAcademy@partnershiphp.org)

### Programs

ABCs of Quality Improvement  
Lead Testing Initiative

### Events

ABCs of Quality Improvement  
March 25, 2025 - Redding

Improving Measure Outcomes Webinar Series  
February - April  
[Click Here for Details](#)

### Webinars

Partnership HealthPlan of California provides resources and webinars to help our providers improve performance across a variety of clinical, operational and patient experience metrics.

[Click Here for On Demand Courses](#)

### Resources

2025 Best Practices - Resources for the PCP QIP Measure Set

Best Practices in EMR Configuration:

- Best Practices
- Presentation

Cologuard Resource:

- Cologuard Bulk Order Information Document

[Link to Partnership Improvement Academy](#)

## Short-term strategies/easy wins

- Take blood pressures at every visit, multiple times if out of normal range.
- Provide blood pressure clinics with MAs.
- Create EMR alerts and flags for patients with hypertension.
- Work your gap lists to outreach; follow-up on no-shows.
- Upload data beginning in October.
- Confirm health information, medication management, and next steps for those who screen high.
- Re-assess blood pressure every three months if target is achieved.

## Long-term strategies

- Use a remote monitoring blood-pressure cuff program.
- Offer tele-health for management visits as appropriate.
- Collaborate with multidisciplinary teams for management (RN, RD, and Pharmacy).
- Enroll in Chronic Case Management.
- Reinforce patient education with diet, smoking cessation, physical activity, and medication management.
- Promoting Academic Detailing around blood pressure management

## Short-term strategies/easy wins

- For average risk patients, offer options for screenings. The best screening is the one your patients will complete!
- Provide patient education and send them home with a kit.
- Create standing orders for the care team to implement.
- Create EMR alerts and flags for patients.
- Work your gap lists to outreach and offer to ship kits to patients; follow-up on no-shows.
- Create scripts to simplify messages around colorectal screening.
- Promote ePrompts for pre-visiting plans and/or front line staff

## Long-term strategies

- Train staff in talking points and motivational interviewing techniques to build capacity to answer patient questions during outreach calls.
- Repeat reminders – patients need multiple chances to perform this screening.
- Streamline referral workflows to ensure timely appointments.

## Strategies with a health equity focus

- Address transportation barriers.
- Continue to educate about preventative services and dispel myths.
- Review measure adherence rates by race, ethnicity, location (zip code) and preferred language to address potential barriers.
- Consider how member information is presented.
- Partner with community organizations that share your goals.
- Address access issues.

# Care Gap Identification by Staff

Best practice for pre-visit and/or check-in processes is to identify needed care gaps within the PCP QIP. This can be done two ways:

- **eReports > Member Search**

- Provide staff involved in these processes with access to eReports. They can conduct a member search and will display the care gaps from the PCP QIP.
- Access to eReports can be given by your organization's designated eAdmin.

- **Provider Online Services > ePrompts**

- Ensure staff involved with insurance verification knows about and utilizes ePrompts within the Provider Online Services.
- Access to Provider Online Services is provided by your Provider Relations Representative.
- Not all PCP QIP Clinical Measures transmit to ePrompts.

# Additional Resources

- Need to reach the PCP QIP Team? [QIP@PartnershipHP.org](mailto:QIP@PartnershipHP.org)
  - eReports access.
  - Measure specification questions.
- Need a resource for improving performance? Reach out to the Performance Improvement Team: [ImprovementAcademy@partnershiphp.org](mailto:ImprovementAcademy@partnershiphp.org)
  - Coaching, measure best practices, sounding board, project planning guidance, facilitation.
- Link to [PCP QIP Webinars Page](#): 2025 Kick-Off Webinar recordings are now available for PCP QIP and eReports.



# Anderson Valley Health Center

Boonville, CA

Anderson Valley  
HEALTH CENTER



## Who We Are and Serve:

- Non-Profit FQHC
- Recognized as a Patient Centered Medical Home
- Primary Care, Urgent Care, Behavioral Health, Dental, and Acupuncture
- Outreach and Enrollment, Case Management
- ~2,600 patients, 1/3 being PHC
- ~30% Monolingual Spanish-speaking
- ~500 Migrant/Seasonal Farmworkers

Our QI Team: about 1.5 FTE

Our Care Coordination Team:  
about 2.5 FTE

- Outreach mostly by calls,  
some texting and letters



# Hypertension Care Coordination

**QI Staff does outreach to patients due for visits.  
Care Coordination Team takes referrals for  
patients with elevated BPs in office.**



# HOME BP MONITORING AND CARE COORDINATION

- **Remote Patient monitoring – Gojji Pharmacy**
- **Home monitoring patient instruction:**
  - **Setting the monitor up, using the memory function**
  - **Proper use of the monitor.**
- **Between visit check ins:**
  - **2-3 week check in by phone for home BPs, medication adherence, side effects or symptoms.**
  - **Communication to PCP for any potential medication adjustments.**



SERVING HEALDSBURG AND WINSOR COMMUNITIES  
SONOMA COUNTY

MEDICAL  
DENTAL  
COMPREHENSIVE WELLNESS CENTER

LISA WARD, MD, MSPH, MS  
REGIONAL MEDICAL DIRECTOR

PARTNERSHIP HEALTH PLAN OF  
CALIFORNIA

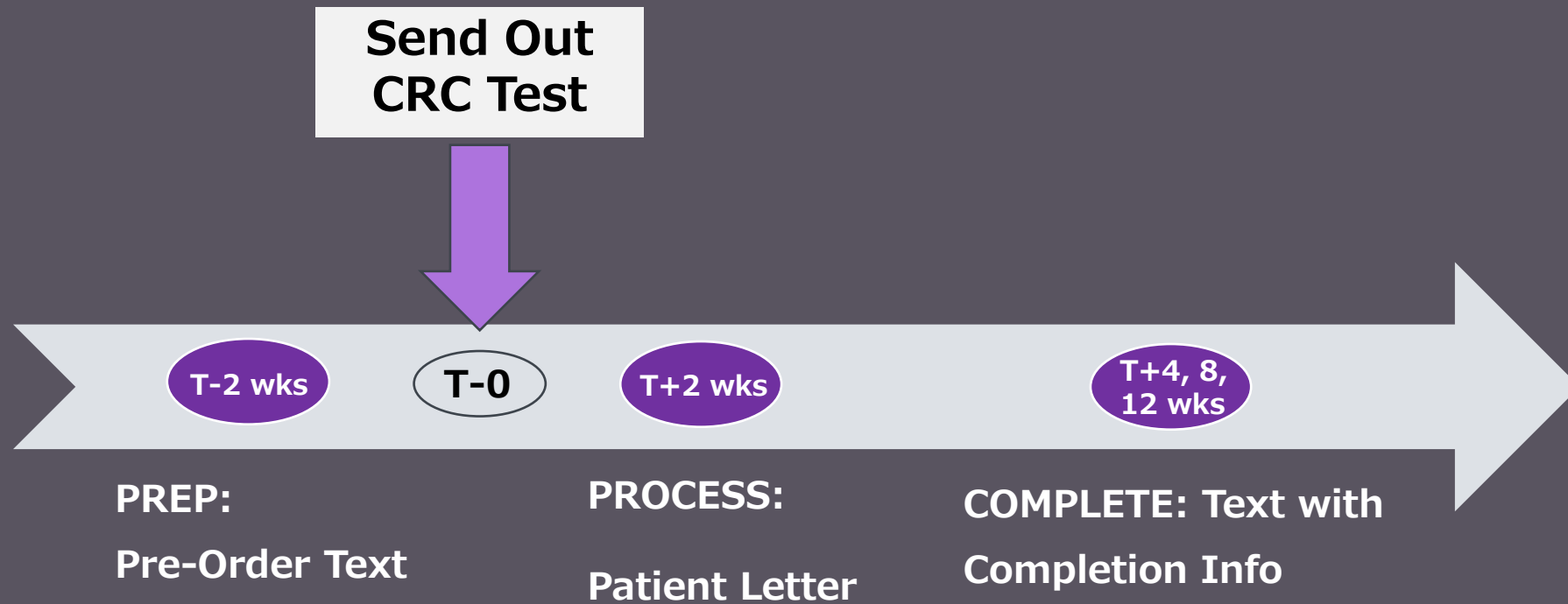
# **COLORECTAL CANCER SCREENING: BULK ORDERING IN EPIC**



## EHR AS A TOOL

- Population Health or Data Analysts creates the list of patients with a screening care gap
- Gap List goes to EHR Team
- EHR “Bulk Orders” submitted
- Cologuard test sent to homes
- Results go to PCPs

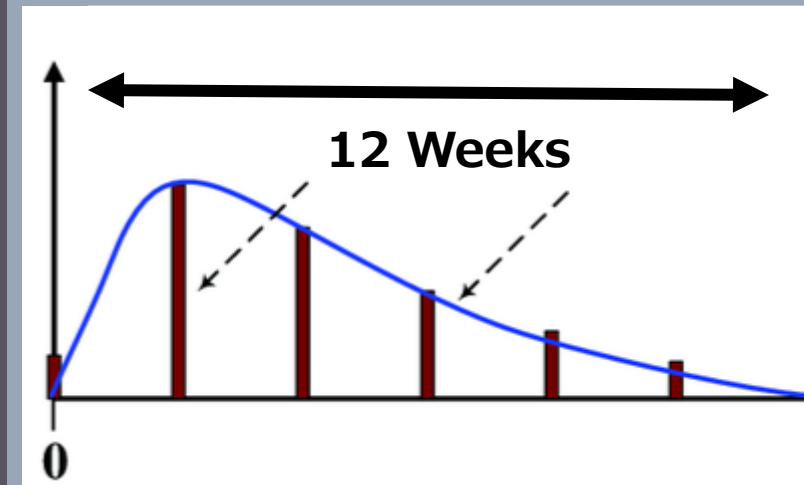
# TIMELINE FOR OUTREACH





# Return of Screening Tests

- Return Rate ~15%
- Options for Return of Tests:
  1. Return to Clinic
  2. Send back via UPS
  3. UPS pick up by calling to schedule pick up
- PCPs get results → MAs send result letter



# Project Learnings

- Get EHR support early, it's a LONG road
- Communicate with patients in a way they trust
- Get provider AND MA buy in; train both groups
- Plan in detail how patients can return tests
- Create standard language for text messages, letters, results letters



**DOs**

- No surprises for patients; HIGH confusion
- Must account for gap in digital literacy
- Must adjust communication to language and grade level

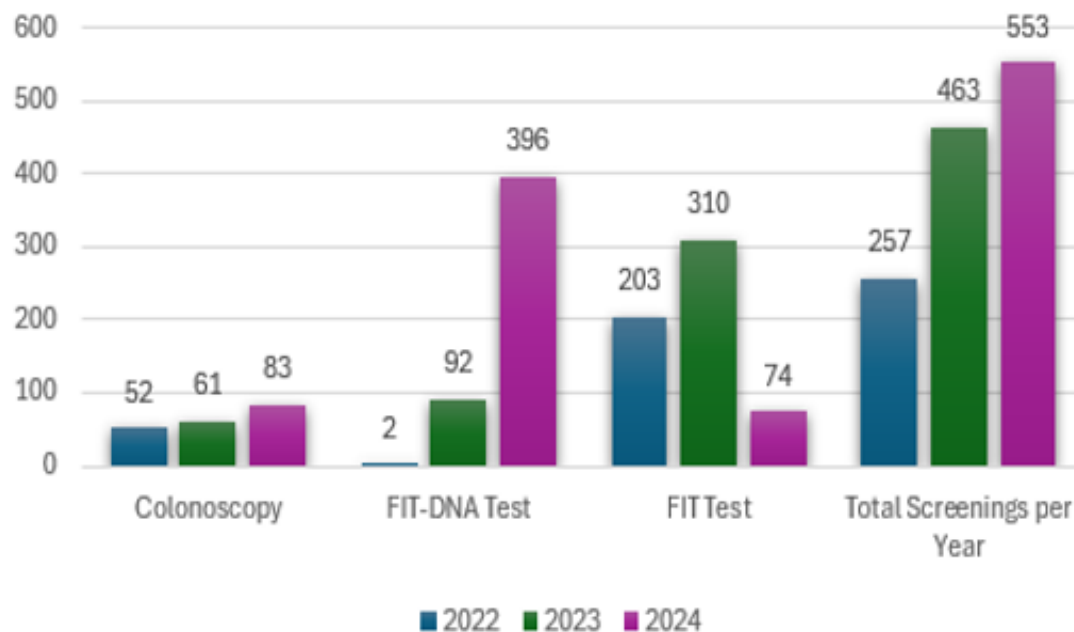


**DON'Ts**

# Breakdown of screenings by type and overall measure rates Year-over-Year

| Colorectal Cancer Screening 2022-2024 |                        |             |              |          |                           |
|---------------------------------------|------------------------|-------------|--------------|----------|---------------------------|
| Year                                  | Final CRC Measure Rate | Colonoscopy | FIT-DNA Test | FIT Test | Total Screenings per Year |
| 2022                                  | 35.54%                 | 52          | 2            | 203      | 257                       |
| 2023                                  | 34.81%                 | 61          | 92           | 310      | 463                       |
| 2024                                  | 43.85%                 | 83          | 396          | 74       | 553                       |

Colorectal Cancer Screenings 2022-2024



## Results:

- Overall the Colorectal Cancer Screening measure rates improved from 2022 to 2024 with FIT-DNA screenings increasing and FIT screenings decreasing.

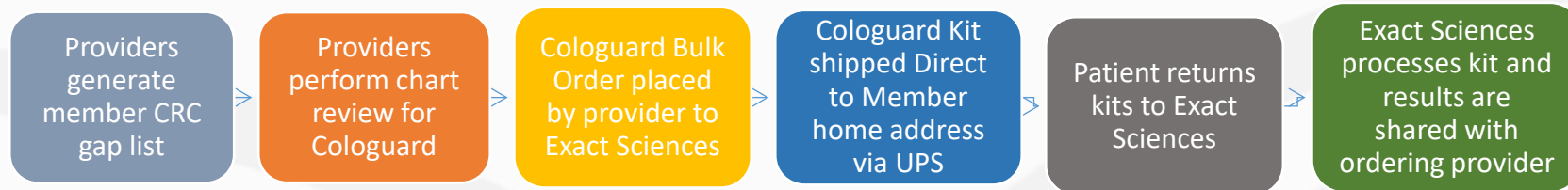
# QUESTIONS?

Lisa Ward, MD, MsPH, MS  
Regional Medical Director  
Santa Rosa Region  
[lward@partnershiphp.org](mailto:lward@partnershiphp.org)

# Quality Improvement Programs and Resources



# Cologuard Bulk Order Program



Ability to capture patients not seen annually

Exact Sciences sends co-branded letter to members one week prior to kit shipment

Exact Sciences Patient Navigation Program and Lifeline offers multiple patient touchpoints in first 60 days of kit shipment

Exact Sciences offers provider portal for Cologuard results via EpiCare

Positive results are prioritized with direct provider communication

- For further information, please contact:
  - Chandler Ackerman: [cackerman@partnershiphp.org](mailto:cackerman@partnershiphp.org)
  - Exact Sciences: [phc@exactsciences.com](mailto:phc@exactsciences.com)

# Partnership's Electronic Blood Pressure Cuff Program

- All Partnership members can get equipment from Partnership (ages 6 and older).
- Contact your provider to see if you are eligible to receive medical equipment, your PCP will reach out to Partnership and request the equipment you need.
- Equipment to be delivered within 5 - 7 days of the provider's request, urgent delivery is available upon request.



# How to Submit Requests

- Providers can submit requests to Partnership as follows:
  - Send request form via secure email to [request@partnershiphp.org](mailto:request@partnershiphp.org)
  - Secure fax to (707) 420-7855
- The request form and guidelines are available through Partnership's Provider Relations section of the website. [Partnership website](#)
- Contact [request@partnershiphp.org](mailto:request@partnershiphp.org) with any questions.

**MEDICAL EQUIPMENT DISTRIBUTION SERVICES REQUEST FORM**

**SECTION 1: EQUIPMENT REQUEST**

**Instructions:**

1. Download and save this form to your PC.
2. Select the type of medical equipment needed and mark the appropriate reasons for request.
3. Complete the member and provider information section.
4. Submit this form to [request@partnershiphp.org](mailto:request@partnershiphp.org) or fax the form to (707) 420-7855.

Please note that Urgent Delivery is available for certain requests. All other items are shipped via Routine Delivery. Certified U.S. Mail (in 2-3 days).

**Member Information:**

Member Name:  (First Name)  
PHC Member ID# / CIN:   
Member DOB:  (Follow-up and decline)  
Member Email:   
Member Language Preference:  English  Other, please specify:

**Important Note:** If the device site address and indicate "Attention" to Number and Street Name (No PO Boxes)

Attn To:

**General Guidelines:**

- Members must go through:
- If the patient has questions, instructions with the form.
- If the PCP suspects an equipment request, an email to [partnership@partnershiphp.org](mailto:partnership@partnershiphp.org) not reach out directly to PHC.
- Set expectations on how to interpret the numbers (i.e. Establish regular virtual of the data they are collecting of such visits would be ideal)

I acknowledge that I have read and understand the above information.

Select One:  PHC  Other

Provider Name:   
Office Name:   
Office Contact:

Requestor/Provider Email:  Phone:  Fax:

Date of Request:

**Equipment Request Sections:**

- Nebulizer by Cardinal Health**  
I confirm that the patient has been diagnosed with the following (select all that apply):
  - COVID: Home Treatment, confirmed or suspected to follow for decompensation
  - Asthma
  - Chronic Obstructive Pulmonary Disease
  - Cystic Fibrosis
  - Bronchopulmonary Dysplasia
  - Bronchiectasis
- Vicks Warm Steam Vapo**  
I confirm that the patient has been diagnosed with the following (select all that apply):
  - COVID: Home Treatment
  - Nasal congestion due to upper respiratory infection
  - Sinusitis
  - Other - please note on form:
- Vicks Mini Cool Mist Humidifier**  
I confirm that the patient has been diagnosed with the following (select all that apply):
  - COVID: Home Treatment
  - Croup
  - Pharyngitis
  - Other - please note on form:
- Care Line Instant Digital Thermometer**  
I confirm that the patient has been diagnosed with the following (select all that apply):
  - COVID: Home Treatment, confirmed or suspected to follow for decompensation
  - Elevated risk of contracting or spreading COVID
  - At risk for severe COVID (co-morbidity or other conditions)
  - Occupational exposure to general public
  - Individuals living in congregate living settings
  - Oncology patients on Chemotherapy
  - Immunocompromised
- Vive Digital Scale, Model # DMD1002**  
I confirm that the patient has been diagnosed with the following (select all that apply):
  - Obesity (BMI greater than or equal to 30)
  - Congestive Heart Failure (CHF)
  - Chronic Kidney Disease
  - Other - please note on form:
- GreaterGoods Smart Baby Scale, Model # GGS1001**  
I confirm that the patient is under 2 years of age (select all that apply):
  - Underweight infant
  - Failure to thrive
  - Unexplained (Abnormal) weight loss
  - Low Birth Weight
  - Risk of poor weight gain
  - Other - please note on form:
- Fingertip Pulse Oximeter, Model #F021 or Contact Pulse Oximeter, Model #MS001**  
I confirm that the patient is age 3 and older and has been diagnosed with the following (select all that apply):
  - COVID: Home Treatment, Confirmed or Suspected to Follow For Decompensation (Urgent Delivery - Next Day)
  - Chronic Lung Or Heart Conditions To Assist Office Visits
  - Patient is On Home Oxygen Therapy Home Mechanical Ventilation
  - Recurrent Pulmonary Embolism
  - Acute/Chronic Lung Disease
  - Incurable Lung Disease
  - Other - please note below:
- Vivo Precision Blood Pressure Monitor, Model #DMD1001 with Adult Medium Size Cuff**  
(Arm circumference 27-34 cm) I confirm that the patient is age 6 or older and has been diagnosed with the following (select all that apply):
  - COVID: Home Treatment, confirmed or suspected to follow for decompensation
  - Chronic Heart conditions to assist office visits
  - Hypertension, includes pregnancy induced hypertension
  - Pre-eclampsia/History of Eclampsia
  - Diabetes mellitus (any type)
  - Coronary Artery Disease/Peripheral Vascular Disease
  - History of Stroke
  - Atrial Fibrillation
  - Congestive Heart Failure (CHF)
  - End Stage Renal Disease (ESRD)
  - Pregnancy (for duration of COVID emergency)
  - Other - please note on form:
- Alternative Equipment needed:**
  - Talking BP Monitor (For low vision member)
  - Small (Arm circumference 16-24 cm)
  - Large (Arm circumference 35-44 cm)
  - Extra-Large (Arm circumference 42-48 cm)



# Partnership's Health Education Materials

## Provider Health Education Materials


Member materials:

- Contact [CLHE@PartnershipHP.org](mailto:CLHE@PartnershipHP.org) to access more health education topics

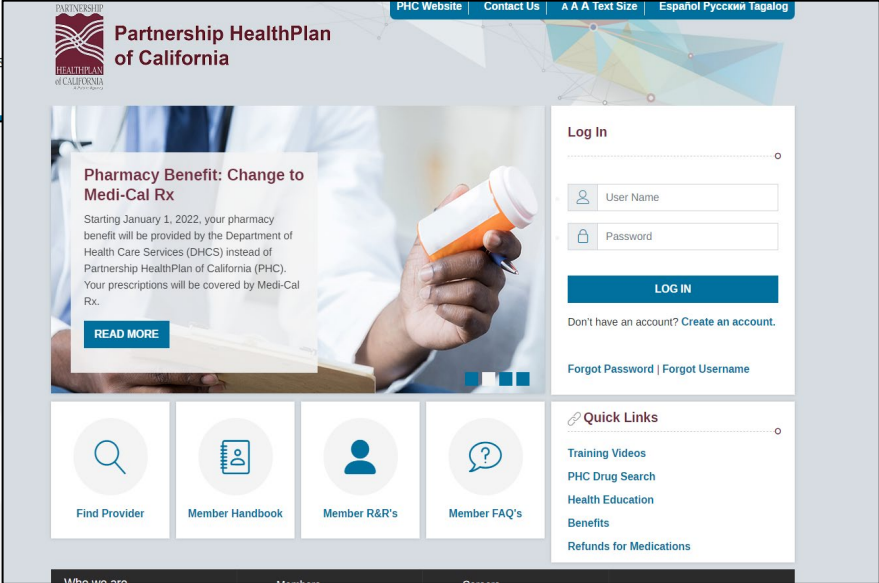


# Healthy Living Tool

- Members can access the healthy living tool through the member portal.
- Members can call Population Health at **(855) 798-8764** if they need help.



The screenshot shows the top navigation bar of the Partnership HealthPlan of California website. The 'MEMBERS' menu item is highlighted with an orange box. Below it, a dropdown menu is visible, with the 'Member Portal' link also highlighted with an orange box. Other links in the dropdown include 'About Member Services', 'Find a Provider', 'Benefits', 'Member Handbooks', and 'Grievances and Appeals'. The main navigation bar also includes 'HOME', 'PROVIDERS', and 'ABOUT US'. At the top right, there are links for 'Miembros', 'Участники', 'Miyembro', 'Member Portal', 'Language Assistance', and 'Provider Online'.



The screenshot shows the login page for the Partnership HealthPlan of California. The page features a 'Log In' section with fields for 'User Name' and 'Password', and a 'LOG IN' button. Below the login fields, there are links for 'Forgot Password' and 'Forgot Username'. A 'Quick Links' section is also visible, containing links for 'Training Videos', 'PHC Drug Search', 'Health Education', 'Benefits', and 'Refunds for Medications'. At the bottom of the page, there are four icons representing 'Find Provider', 'Member Handbook', 'Member R&R's', and 'Member FAQ's'. A banner at the top of the page reads 'Pharmacy Benefit: Change to Medi-Cal Rx' and includes a 'READ MORE' button.

# ePrompts Access and FAQs

**What are ePrompts?** ePrompts will allow providers to access members' clinical preventive screenings and remind them when the screenings are due while supporting HEDIS Improvement Goals.

**What measures are available for ePrompts?**

There are six measures available: Cervical Cancer Screening, Colorectal Cancer Screening, Breast Cancer Screening, Diabetes – Retinal Eye Exam, Diabetes – HbA1c, and Child and Adolescent Well-Care Visits.

**How do I check the status of a member's preventative screenings?** Log into the Online Provider Portal, search a member, click on ePrompts tab on eEligibility screen, and the member's preventive screenings will display if applicable.

**Member Details**

Member Name: [REDACTED] CIN: [REDACTED] Date of Birth: [REDACTED]  
Gender: [REDACTED] Member Address: [REDACTED]  
PCP Details: [REDACTED] PCP Address: [REDACTED]

**ePrompts**

| Measure Name                       | Current Status | Response                        |
|------------------------------------|----------------|---------------------------------|
| Colorectal Cancer Screening 2024   | Completed      |                                 |
| Diabetes - HbA1C Good Control 2024 | Completed      |                                 |
| Diabetes - Retinal Eye exam 2024   | Due Now        | <a href="#">Complete Report</a> |

# Upcoming Trainings

## Save the Dates

### Improving Measure Outcomes Webinar Series: March - April 2025

The *Improving Measure Outcomes Webinar Series* allows Quality Improvement teams to make knowledge actionable, improving quality service and clinical outcomes around specific measures of care.

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

These learning sessions will cover Partnership's Primary Care Provider Quality Incentive Program measures. Content will focus on direct application on best practices including eliminating health disparities with examples from quality improvement teams who are doing the work.

Planned sessions include:

- March 26, 2025 - Perinatal Care and Chlamydia Screening
- April 9, 2025 - Breast and Cervical Cancer Screenings
- April 23, 2025 - Diabetes Control

*\*Sessions offered during the lunch hour and approximately 60 minutes in length. CME/CEs will be offered for live attendance.*

[http://www.partnershiphp.org/Providers/Quality/Pages/Quality\\_Events.aspx](http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx)

Questions: [improvementacademy@partnershiphp.org](mailto:improvementacademy@partnershiphp.org)



# ABCs of Quality Improvement

The ABCs of Quality Improvement is an in-person training designed to teach you the basic principles of quality improvement:

- Introduction to Quality Improvement and the Model for Improvement
- Learn how to create an Aim Statement (project goal)
- Learn how to use data to measure quality and drive improvement
- Tips for developing change ideas for improvement
- Testing changes via the Plan-Do-Study-Act cycle

**Date:** Tuesday, March 25, 2025

**Time:** 8:30 a.m. – 4:30 p.m.

**Location:** The McConnell Foundation  
800 Shasta View Dr, Redding

*Registration and light breakfast from 8:30 – 9 a.m.*

*Lunch will be provided.*

\*The AAFP has reviewed ABCs of Quality Improvement (QI) and deemed it acceptable for AAFP credit. Term of approval is from 11/07/2024 to 11/07/2025. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session ABCs of Quality Improvement (QI) is approved for 5.50 Live AAFP Prescribed credits. \*\*Provider approved by the California Board of Registered Nursing, Provider Number CEP16728, for 5.50 contact hours.

**Registration is  
FREE**



**Scan me**



Email questions to [improvementacademy@partnershiphp.org](mailto:improvementacademy@partnershiphp.org)



# Contact Us

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# Evaluation

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

