# Improving Measure Outcomes:
## Chronic Disease

### Controlling High Blood Pressure
### Colorectal Cancer Screening


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# Learning Objectives

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- 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.

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

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# Controlling High Blood Pressure

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# 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

MK

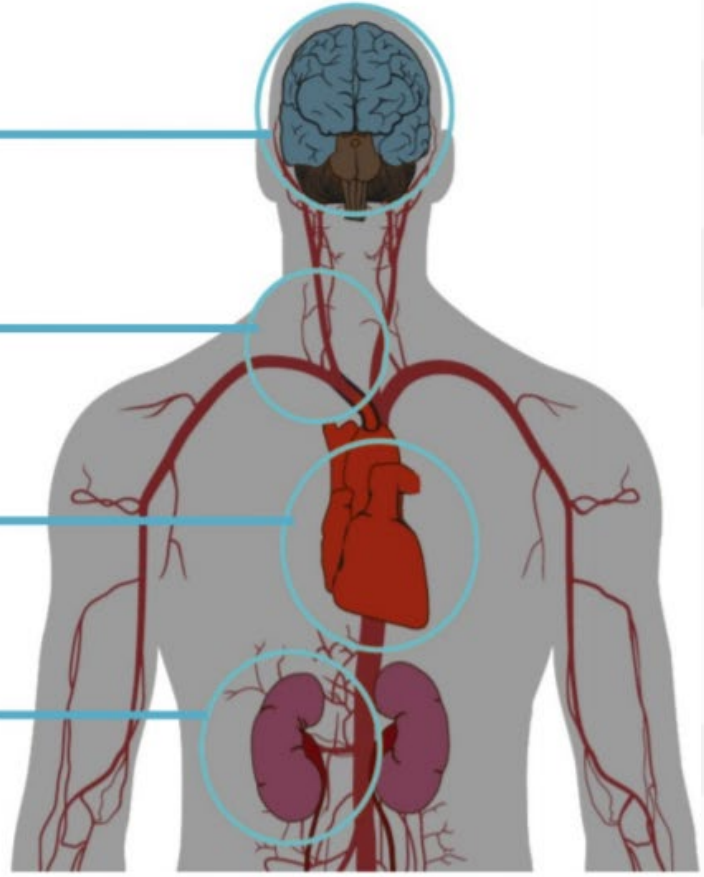
## Hypertension can cause:

**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



*cdc.gov/globalhealth/healthprotection*

# Diagnosis

MK

| Blood Pressure Levels | | | |
|---|---|---|---|
| *The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (2003 Guideline)*[2] | | *The American College of Cardiology/American Heart Association Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (2017 Guideline)*[1] | |
| 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) | Systolic: 140 mm Hg or higher<br>Diastolic: 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

MK

## 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)

MK

## 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.

# Academic Detailing in Controlling High Blood Pressure

MK

## 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

MK

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

MK

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

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

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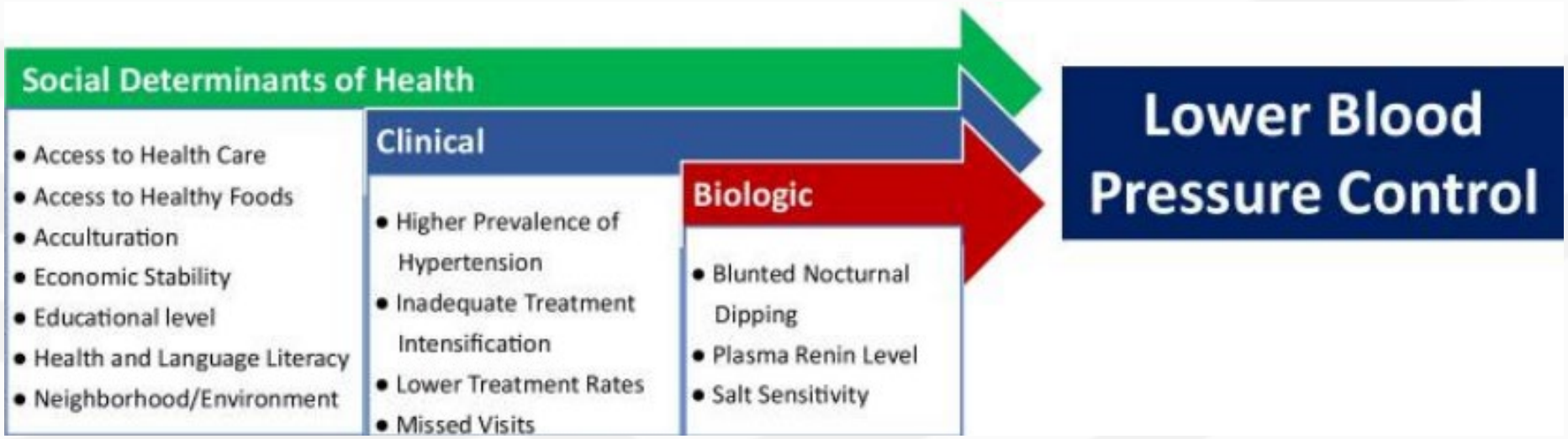


SDoH are the main contributing factors, compounded by clinical factors and barriers to hypertension management including inadequate treatment due to biologic factors.

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

# Potential Drivers of Disparities

MK

- 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

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# Fast Facts

RM

- Colorectal cancer is a leading diagnosed new cancer in the U.S.
  - 4th 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

RM

- 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
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

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# Measure Specification – Controlling High Blood Pressure

TT

## 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

# Measure Specification – Controlling High Blood Pressure

TT

## Eligible Readings Include:

- Outpatient visits, telephone visits, virtual check-ins, or remote monitoring taken by **any digital device**

- Multiple readings for a singe 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

TT

## *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

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# 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

TT

## New 2025 Targets:

Partnership is now using NCQA MediCaid standards:

- Partial Points set at the 50th percentile
- Full Points are set at 75th percentile

More detailed information can be found in the
PCP 2025 Measurement Specifications Manual

# Screening Methods and Measure Criteria

TT

| 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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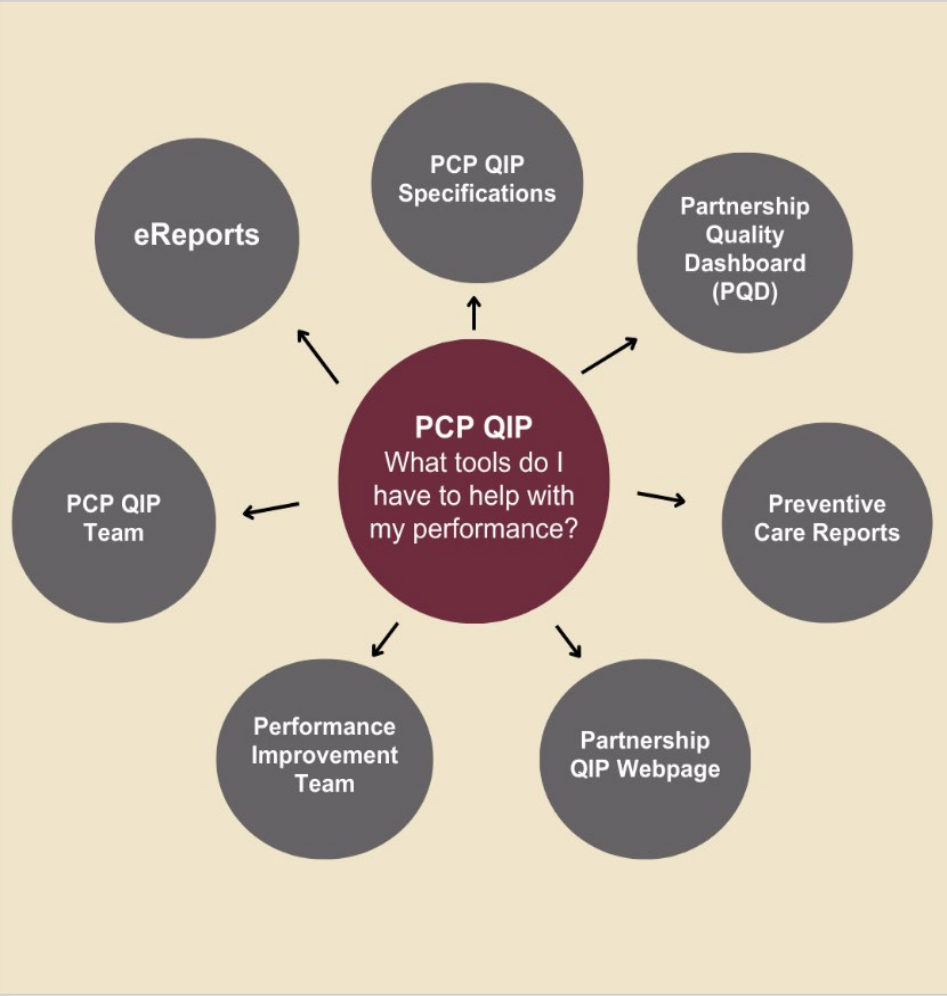
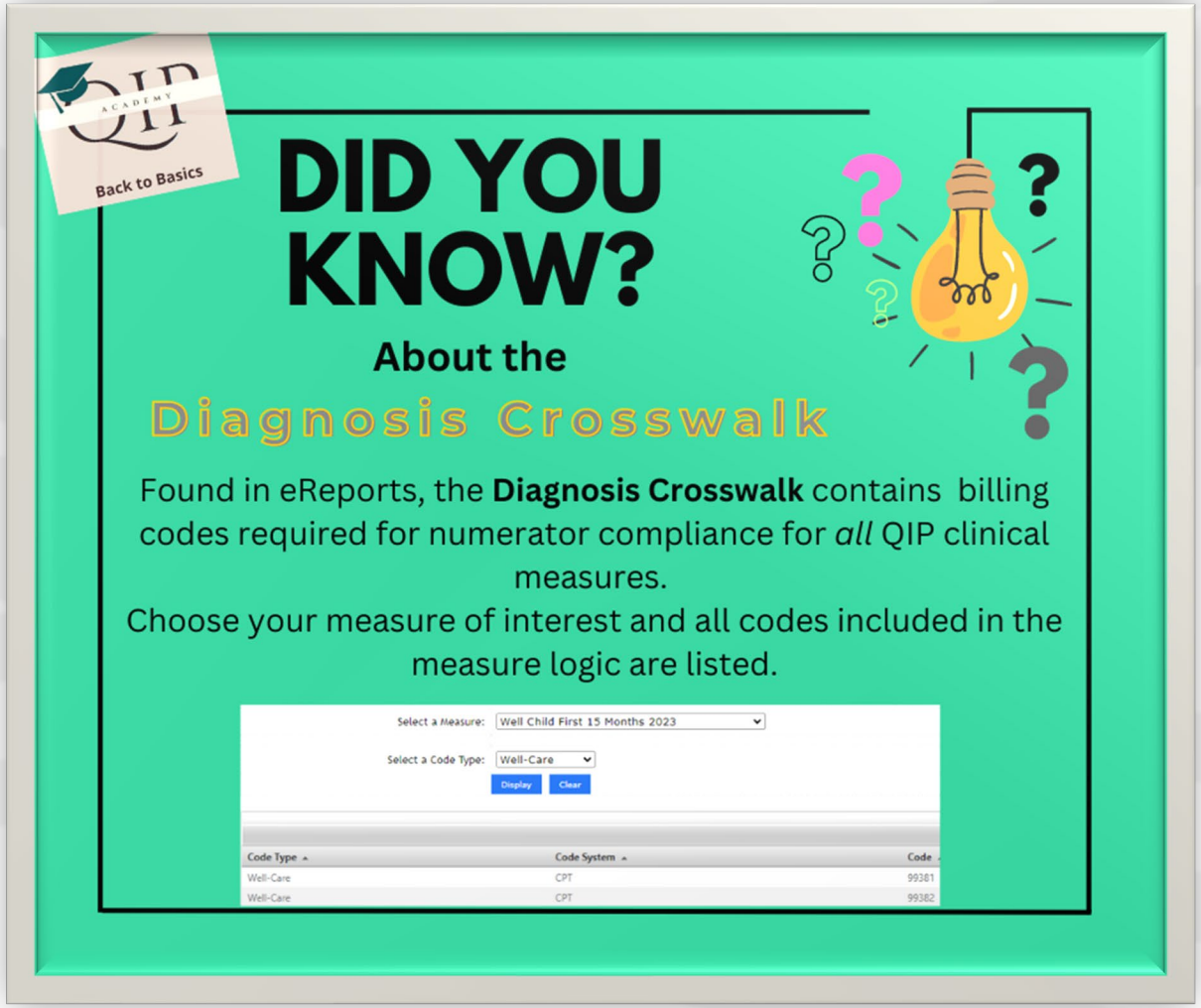



## PCP QIP Tool Links:

- 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



# Disparity Analysis Dashboard

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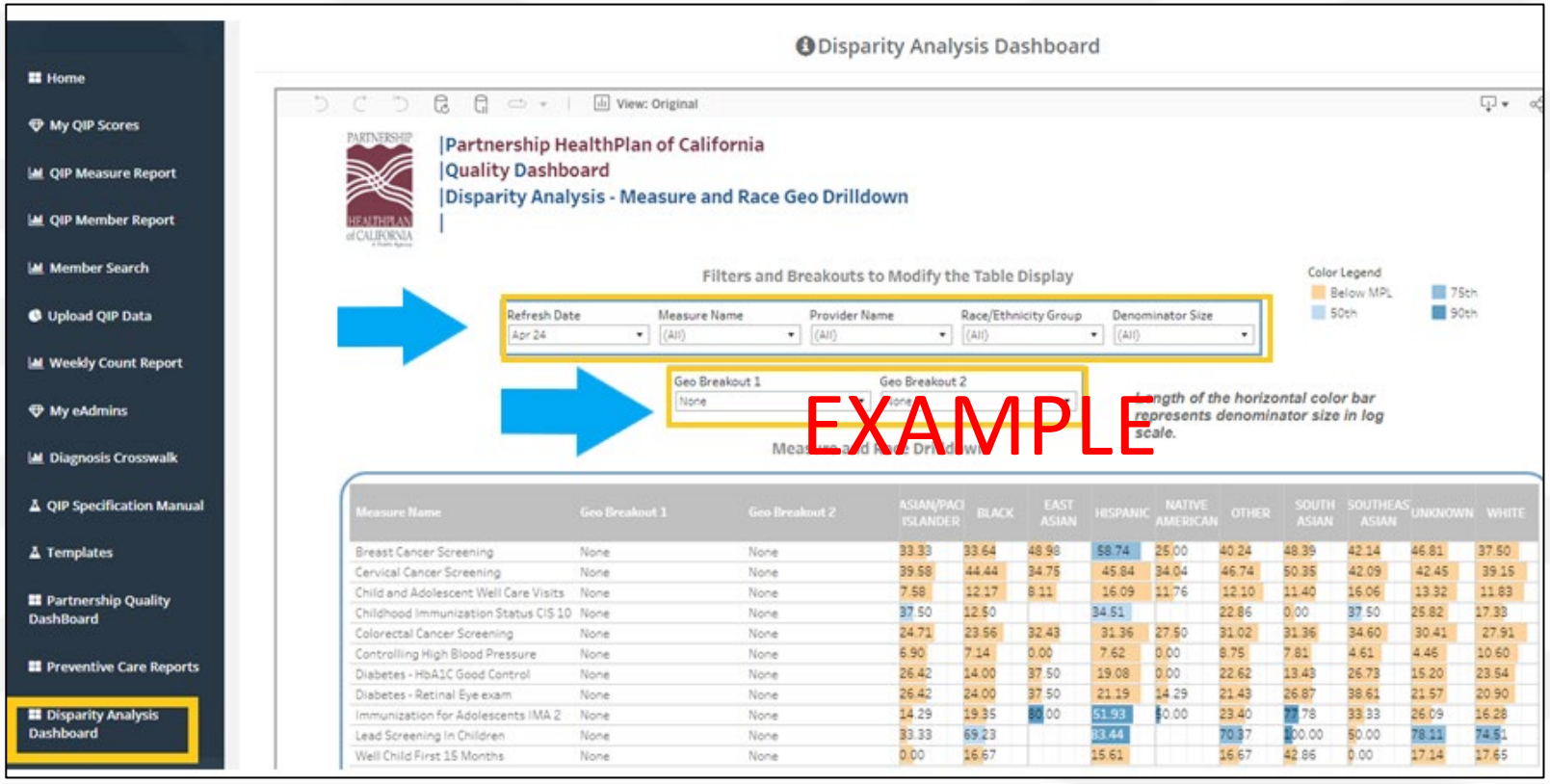
**Purpose:** To promote the ease of identification of PCP QIP measure performance across race/ethnicity groups within various levels of geographic stratification. The dashboard also offers the ability to filter by denominator size for selected geographic and race/ethnicity group stratification.



# PCP QIP Timeline

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**Grace Period (MY25)**
1/12/2026 – 1/31/2026

**Measurement Year**
1/1/2025 – 12/31/2025

1/12/2026 - **Final denominators posted on eReports**

**Validation Period**
**Review final rates inclusive of uploads**
2/2/2026-2/6/2026

1/31/2026
**Final date for submitting uploads in eReports and UOS submissions**

# Putting Quality Into Practice

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# Measure Best Practices

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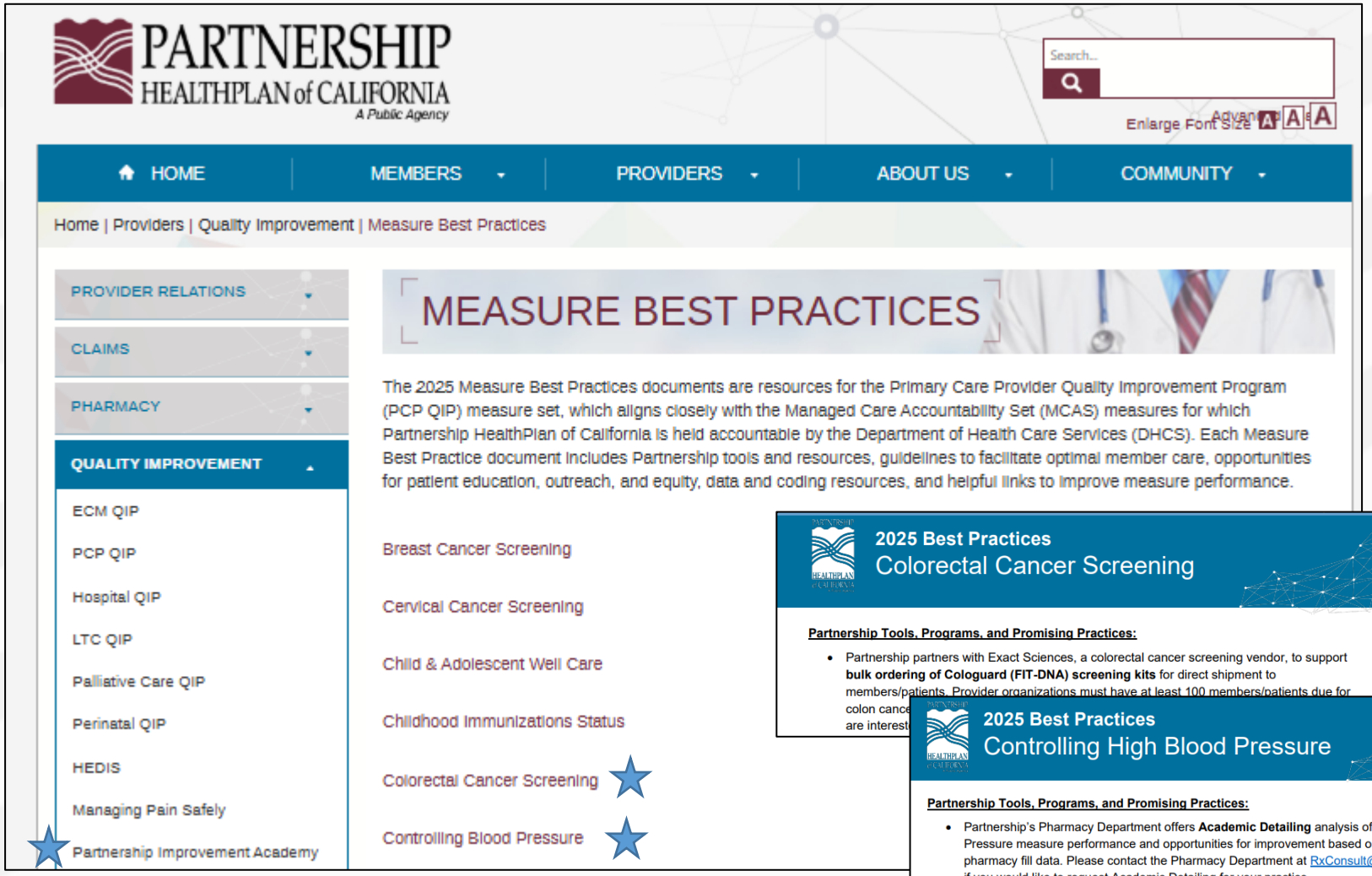








**Link to Measure Best Practices**

# Quality Improvement
# Partnership Improvement Academy Landing Page

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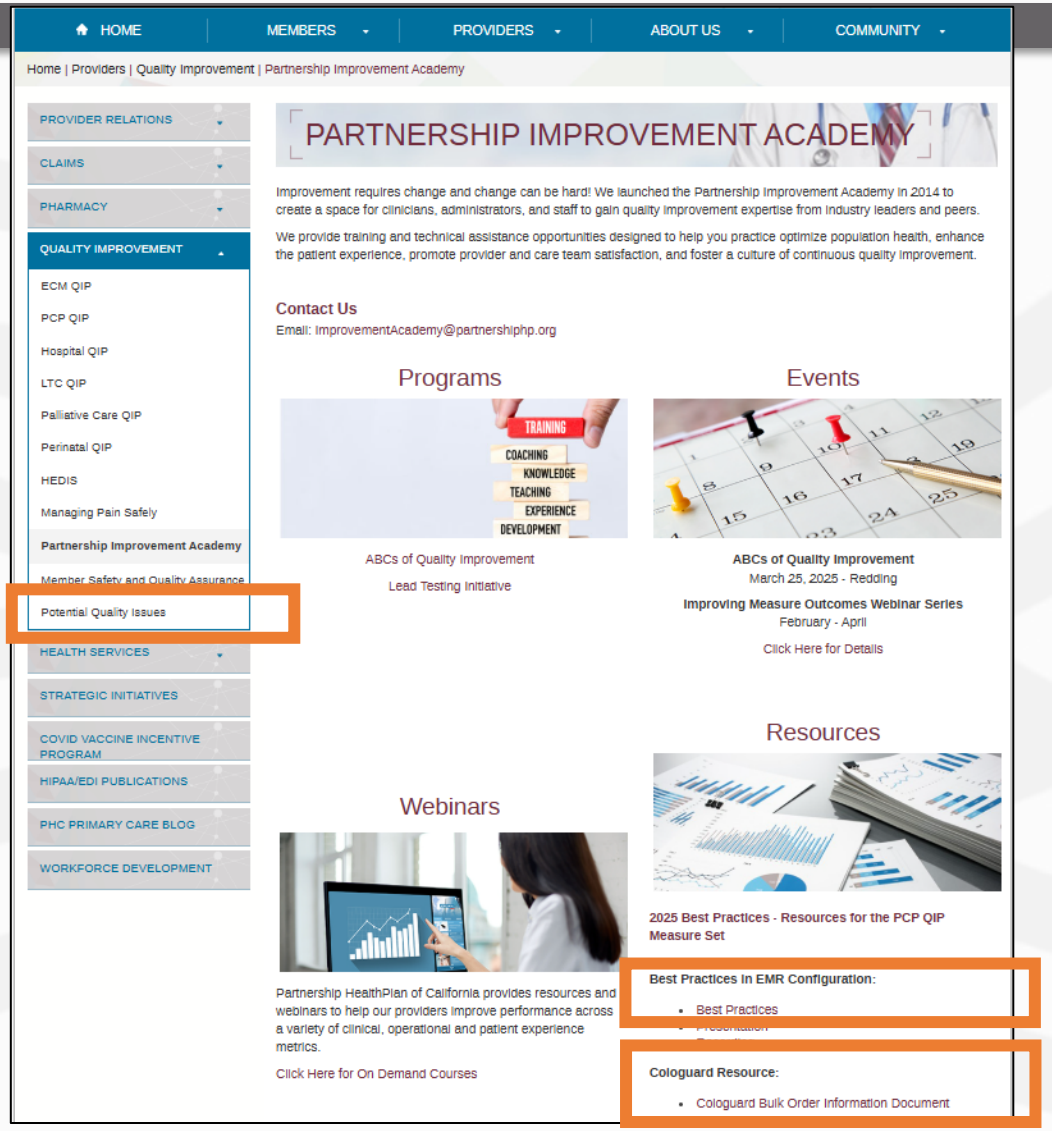



[Link to Partnership Improvement Academy]

# Measure Best Practices: Controlling Blood Pressure

TT

## 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.

# Measure Best Practices: Controlling Blood Pressure

TT

## 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

# Measure Best Practices: Colorectal Screening

TT

## 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

# Measure Best Practices: Colorectal Screening

TT

## 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.

# Measure Best Practices



## 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

TT

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



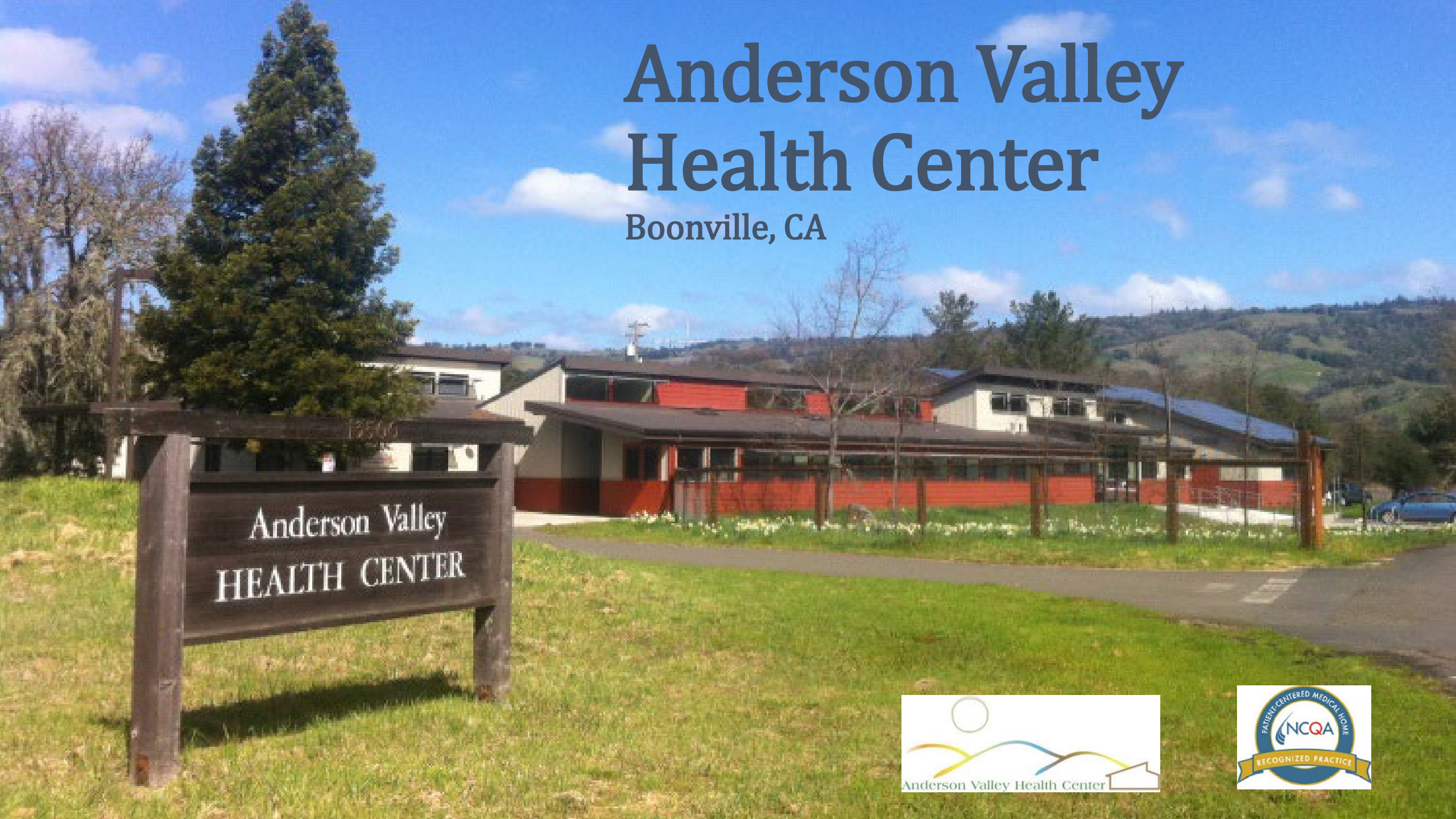
- Need to reach the PCP QIP Team? QIP@PartnershipHP.org
  - eReports access.
  - Measure specification questions.

- Need a resource for improving performance? Reach out to the Performance Improvement Team: 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

PATIENT-CENTERED MEDICAL HOME
NCQA
RECOGNIZED PRACTICE

# 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.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MEDICAL
DENTAL
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LISA WARD, MD, MsPH, MS
REGIONAL MEDICAL DIRECTOR

PARTNERSHIP HEALTH PLAN OF CALIFORNIA

# COLORECTAL CANCER SCREENING: BULK ORDERING IN EPIC

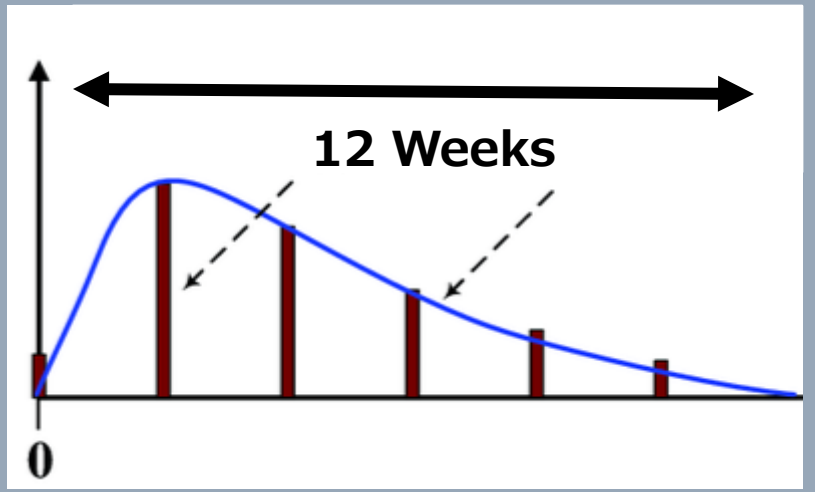

# EHR AS A TOOL

- 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



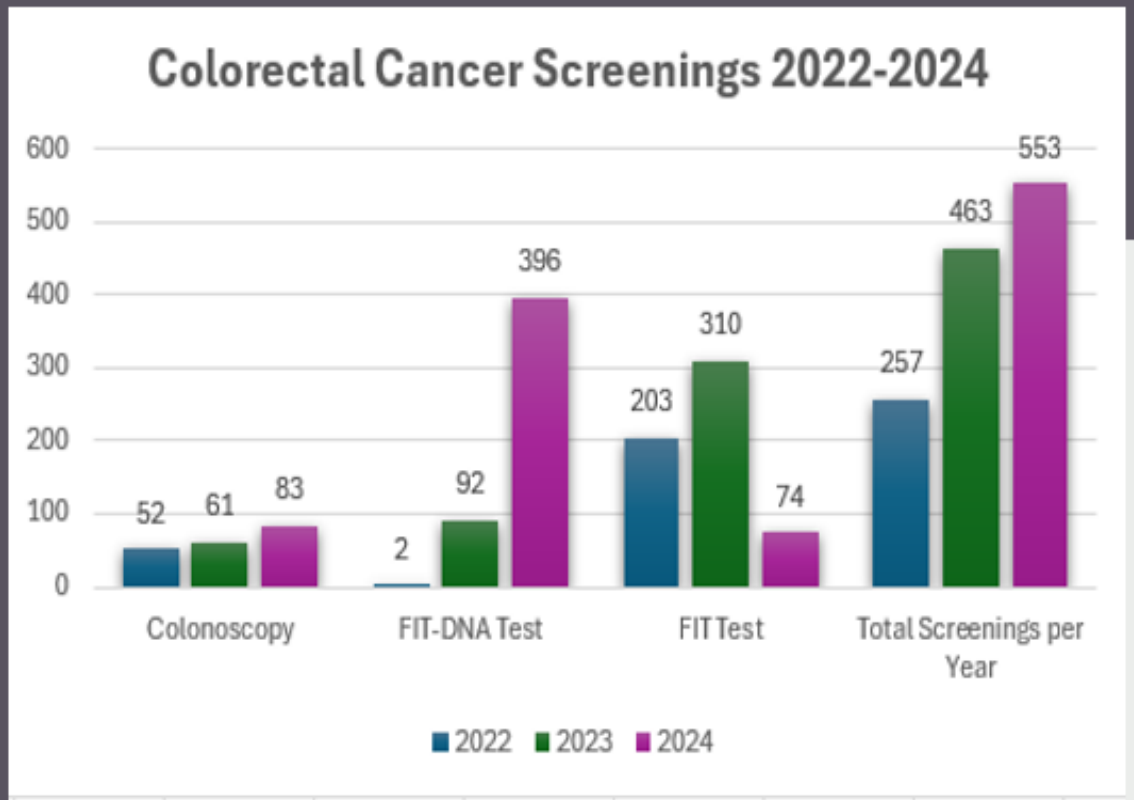
# Project Learnings

- 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


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

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

| Colorectral 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 |




## Results:

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

# QUESTIONS?

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Regional Medical Director

Santa Rosa Region

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# Quality Improvement Programs and Resources

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# 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
  - Exact Sciences: phc@exactsciences.com

# Partnership's Electronic Blood Pressure Cuff Program

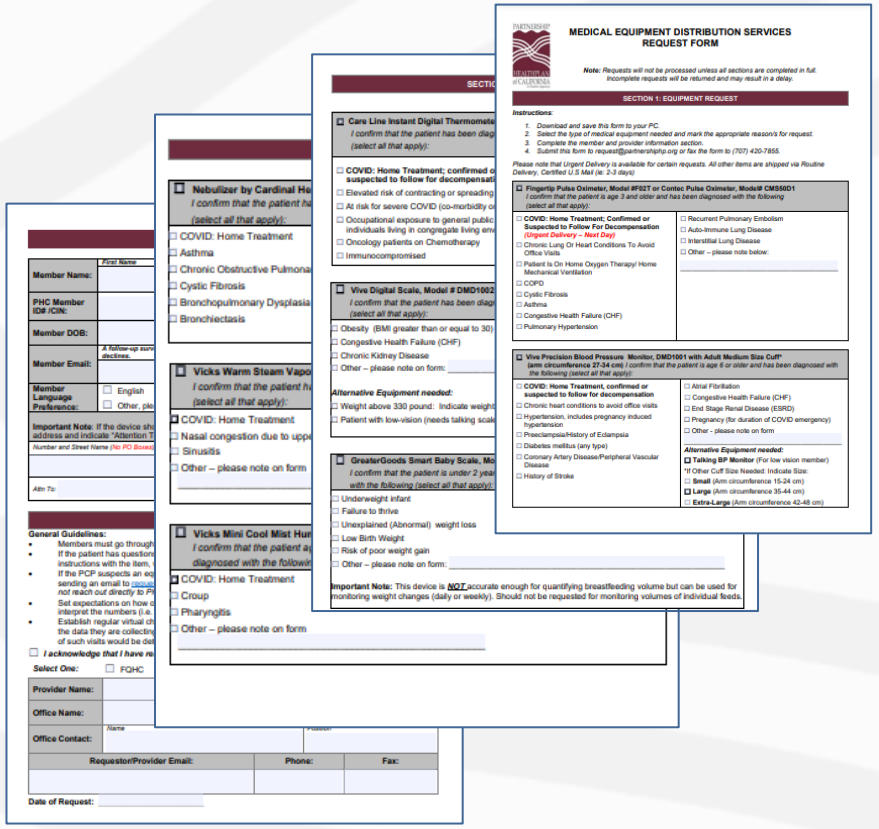
- All Partnership members can get equipment from Partnership (ages 6 and older).
- Contact your provider to see if you are eligible to receive medical equipment, your PCP will reach out to Partnership and request the equipment you need.
- Equipment to be delivered within 5 - 7 days of the provider's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

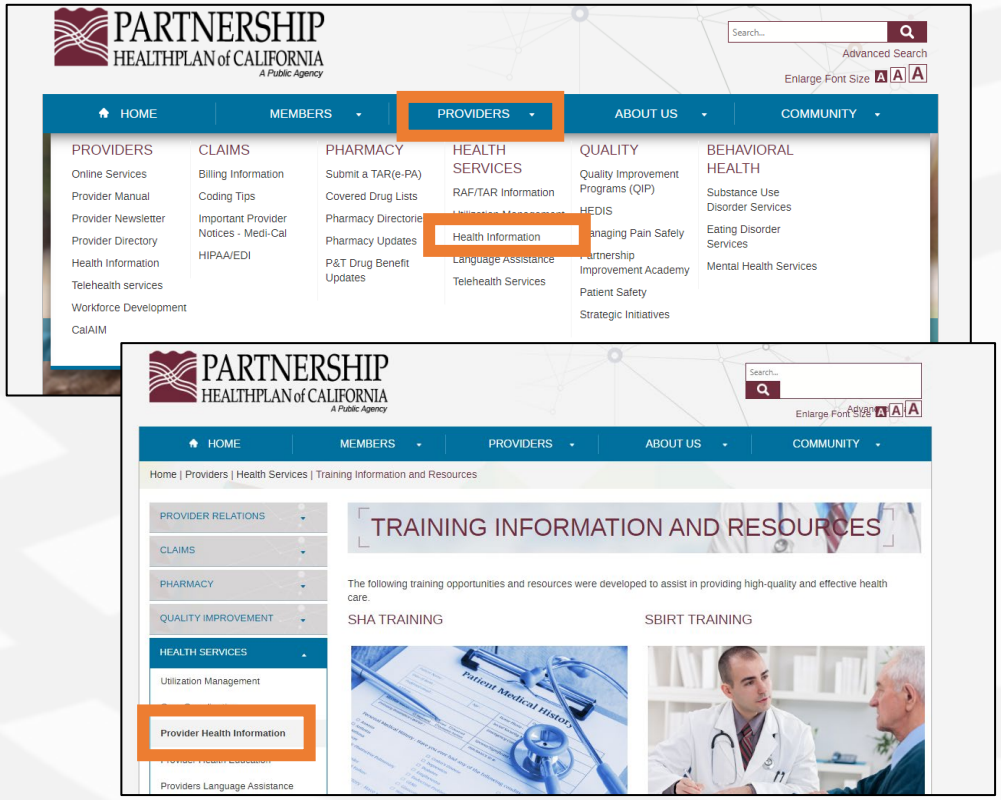


# Partnership's Health Education Materials

[Provider Health Education Materials]

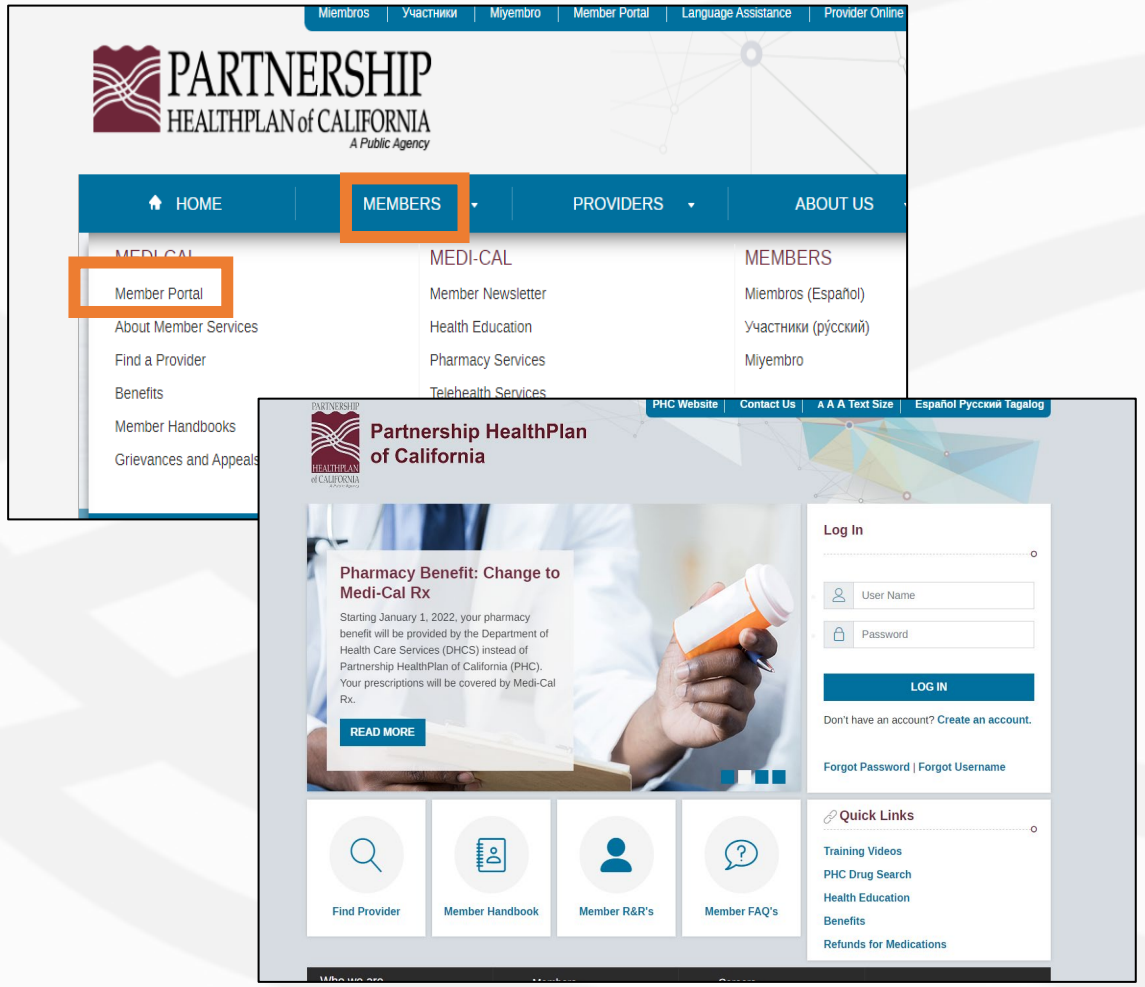
Member materials:

- Contact 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.

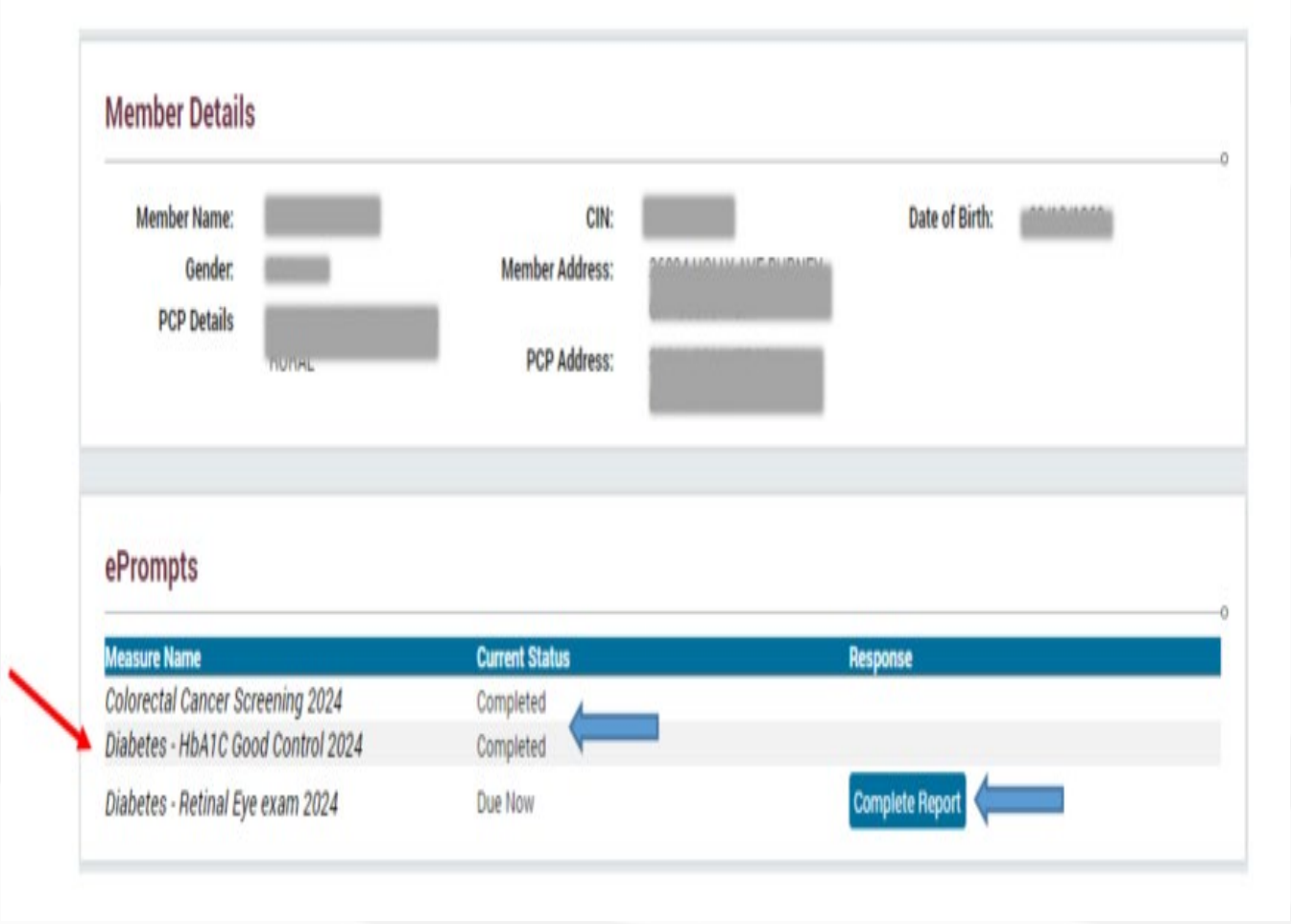


# ePrompts Access and FAQS

**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.



# 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

Questions: 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

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# Evaluation

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