# Improving Measure Outcomes:
## Perinatal Care and Chlamydia Screening


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# Learning Objectives

- Define the clinical background, specifications, and performance threshold definitions of the 2025 Primary Care Provider Quality Improvement Program Specifications: Chlamydia screening measure and 2025 Perinatal Quality Improvement Program Specifications: Timely Prenatal and Postpartum Care screening measures.
- Apply measure specification requirements to maximize adherence and measure performance for Chlamydia Screening in Women and Timely Prenatal and Postpartum Care.
- Evaluate the prevalence and risk factors for chlamydia and associated health inequities prevalent in their diagnosis and treatment.

# Learning Objectives

- Identify barriers for timely prenatal and postpartum care and discuss best practices for implementing effective care practices.
- Identify best and promising practices including access to care, successful clinical workflows, member and staff education, outreach, addressing social context which influence treatment decisions, referrals to local community resources, disproportionate prevalence and/or rates for maternal health and technical tips to improve women's sexual and reproductive health.

# Overview of Measure(s)

# Timely Prenatal and Postpartum Care

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# Purpose of Prenatal and Post-Partum Care

- Prenatal and postpartum care aims to support healthy outcomes for pregnant person and infants.
- Prioritizes screening for and management of complications including but not limited to:
  - Cardiovascular
  - Infections
  - Psychosocial factors
  - Normal development of fetus
- Not all practices offer prenatal care. Primary care provider practices are an important link for timely prenatal care and for providing services after pregnancy as well as infant care.

# Recommendations for Perinatal Care

## Prenatal Visits

- First visit in first trimester
- Identify behavioral health and substance use disorders
- Screening for high-risk medical conditions
- Breast feeding & family planning discussions
- Vaccinations: TDAP, Influenza and COVID19 and RSV
- Develop relationship with patient

## Post-Partum Visits

- Two visits: first within 3 weeks and follow up by 12 weeks
- Screening for post partum depression
- Lactation support
- Implement family planning
- Address conditions or risks identified in pregnancy
- Connection to healthcare systems

# Visit Components

## Prenatal Visit Components

- <14 weeks gestation

Documentation to include:

- Pregnancy diagnosis
- Estimated due date & gestational age in weeks
- Weight (lbs.) and blood pressure
- One of the following:
  - Auscultation for fetal heart tone
  - Measurement of fundus height
  - Pelvic Exam
  - Ultrasound
- Assessment of Medical and Social History, including:
  - History of Gestational Diabetes
  - Use of drugs, alcohol, or tobacco during this pregnancy
  - C-Section prior to this pregnancy
  - Issues with previous pregnancy
- Depression Screening

## Post-Partum Visit Components

Two visits recommended post partum:

- <21 Days after delivery
- Between 22 – 84 days after delivery

Documentation to include:

- Weight and blood pressure
- Depression screening and follow up as indicated by results
- Lactation education/support
- Family planning discussion
- Examination of abdomen/breast as needed

# Perinatal Mood Disorders: Bad for Mom and Bad for Baby

## Maternal Impacts

**Pregnancy Effects**

- Preterm delivery
- Small for gestational age
- Low birth weight infant

**Post-Partum Effects**

- Negatively impacts parenting and interactions with infant/children

## Infant /Child Impacts

- Early cessation of breastfeeding
- Fewer preventative visits
- Fewer vaccinations
- Increased behavioral and cognitive issues
- Increased risk for psychiatric disease

# Screening for Mood Disorder Diagnosis

## Highly Predictive Factors

- Personal history
- Current symptoms but not meeting criteria
- Current intimate partner abuse
- Low socio-economic status
- Single or teen parent

## Additional Associated Factors

- History of physical or sexual abuse
- Medical complications to pregnancy
- Family history of depression
- Poor social/financial support
- Current stressful life
- Unplanned/undesired pregnancy

# Interventions to Stem Impact of Perinatal Depression and Risk for Depression

## Moderate Depression

Behavioral Health Therapy and Supportive Services:

- Cognitive behavioral or interpersonal therapy
- Refer to Partnership Growing Together program
- Consider Partnership Care Coordination
  *Refer to Carelon (Beacon) Perinatal Services phone number: (855) 765-9703*

## Severe Depression

Medication Management and Behavioral Therapy:

- SSRI and SSNRI safe and effective
- Reassess every 1-2 weeks after starting Rx, titrate if no change after 4-6 weeks
- Treat at least 6 months
  *Refer to: Carelon (Beacon) Perinatal Services, Partnership Care Coordination and Growing Together Programs*

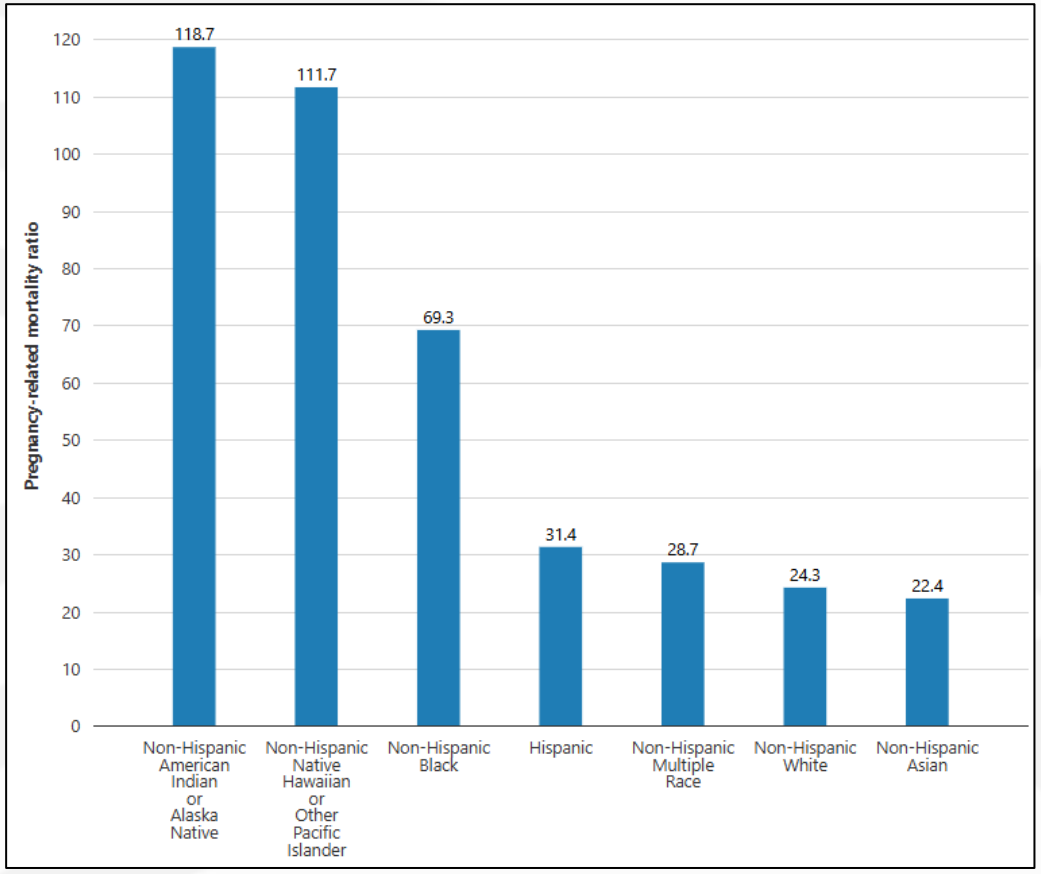
# Maternal and Infant Health Disparities

- Disparities exist for preterm labor and birth, pregnancy-related deaths, stillbirth, low birthweight, gestational diabetes, and other clinical conditions, which impact overall health for women and infants.
- Increased barriers to abortion services for people of color widens existing disparities in maternal and infant health.
- Black and American Indian/Alaska Natives (AI/AN) persons have higher rates of pregnancy-related death compared to white women.
- Black and AI/AN infants have twice the rate of infant mortality than white, Hispanic, and non-Hispanic infants.
- AIAN infants are 2.7 times more likely than to die from accidental deaths before the age of one year, and 50% more likely to die from complications related to low birthweight when compared to non-Hispanic white infants.

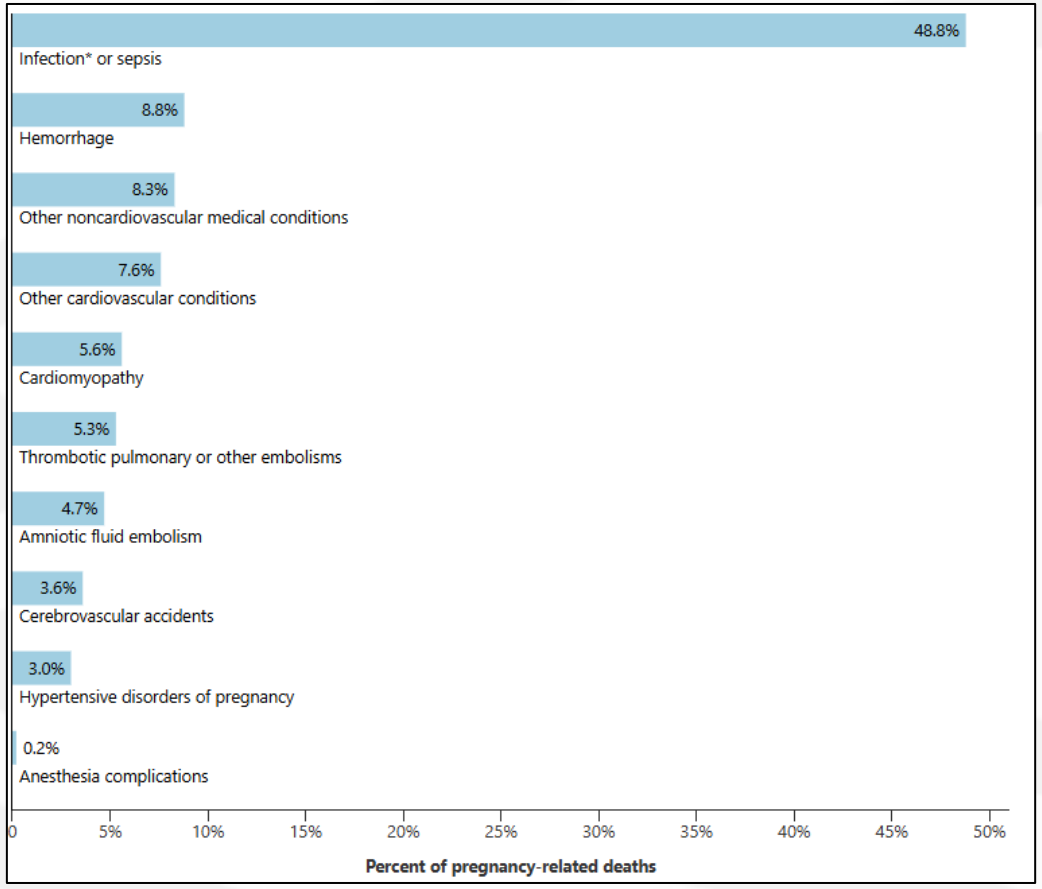
Source: National Center for Health Statistic Data Brief No. 489, December 2023 https://www.cdc.gov/nchs/data/databriefs/db489.pdf

# Disparities in Maternal Mortality

## Pregnancy-related Mortality Ratio by Race-ethnicity: 2017 - 2021




## Causes of Pregnancy-related Deaths: 2017 - 2021




Considerable racial-ethnic disparities in pregnancy-related mortality exist, and these disparities increased during 2020 and 2021.

# Partnership Timely Prenatal Care Disparities 2023

## Healthcare Effectiveness Data and Information Set (HEDIS®) Data

| NE | NW | SE | SW |
|---|---|---|---|
| 85.30 | 79.00 | 88.75 | 93.71 |

**NW**

| | |
|---|---|
| American Indian/Alaska Native | 62.50 |
| Asian/Pacific Islander | 87.50 |
| Black | 33.33 |
| Hispanic | 87.23 |
| Other/unknown | 77.27 |
| White | 80.00 |

**NE**

| | |
|---|---|
| American Indian/Alaska Native | 75.00 |
| Asian/Pacific Islander | 77.78 |
| Black | 75.00 |
| Hispanic | 84.48 |
| Other/unknown | 88.89 |
| White | 86.26 |

| | |
|---|---|
| 90th% | 91.07 |
| 75th% | 88.33 |
| 50th% | 84.23 |
| 25th% | 79.63 |
| below 25th% | |

**SW**

| | |
|---|---|
| American Indian/Alaska Native | 50.00 |
| Asian/Pacific Islander | 100.00 |
| Black | 100.00 |
| Hispanic | 95.00 |
| Other/unknown | 97.44 |
| White | 89.66 |

**SE**

| | |
|---|---|
| American Indian/Alaska Native | -- |
| Asian/Pacific Islander | 94.12 |
| Black | 88.00 |
| Hispanic | 89.43 |
| Other/unknown | 87.18 |
| White | 86.11 |

# Partnership Postpartum Care Disparities 2023

## Healthcare Effectiveness Data and Information Set (HEDIS®) Data

| NE | NW | SE | SW |
|---|---|---|---|
| 81.36 | 82.19 | 87.50 | 93.71 |

### NW

| | |
|---|---|
| American Indian/Alaska Native | 75.00 |
| Asian/Pacific Islander | 75.00 |
| Black | 100.00 |
| Hispanic | 87.23 |
| Other/unknown | 81.82 |
| White | 81.74 |

### NE

| | |
|---|---|
| American Indian/Alaska Native | 50.00 |
| Asian/Pacific Islander | 77.78 |
| Black | 100.00 |
| Hispanic | 86.21 |
| Other/unknown | 94.44 |
| White | 79.67 |

| | |
|---|---|
| 90th% | 84.59 |
| 75th% | 82 |
| 50th% | 78.1 |
| 25th% | 73.97 |
| below 25th% | |

### SW

| | |
|---|---|
| American Indian/Alaska Native | 75.00 |
| Asian/Pacific Islander | 100.00 |
| Black | 100.00 |
| Hispanic | 98.75 |
| Other/unknown | 92.31 |
| White | 82.76 |

### SE

| | |
|---|---|
| American Indian/Alaska Native | -- |
| Asian/Pacific Islander | 94.12 |
| Black | 88.00 |
| Hispanic | 90.24 |
| Other/unknown | 79.49 |
| White | 83.33 |

# Overview of Measure(s)
# Chlamydia Screening

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# Chlamydia Screening Purpose

- Chlamydia is among the most common sexually transmitted infections in the United States.
- Chlamydial infections in women are usually asymptomatic.
- Chlamydial infections may lead to pelvic inflammatory disease (PID) and its associated complications, such as ectopic pregnancy, infertility, and chronic pelvic pain.
- Newborns of pregnant persons with untreated infection may develop neonatal chlamydial complications.
- Chlamydia screening has been demonstrated to reduce PID rates among women.
- The primary focus of chlamydia screening should be to detect and treat chlamydia, prevent complications, and test and treat their partners.

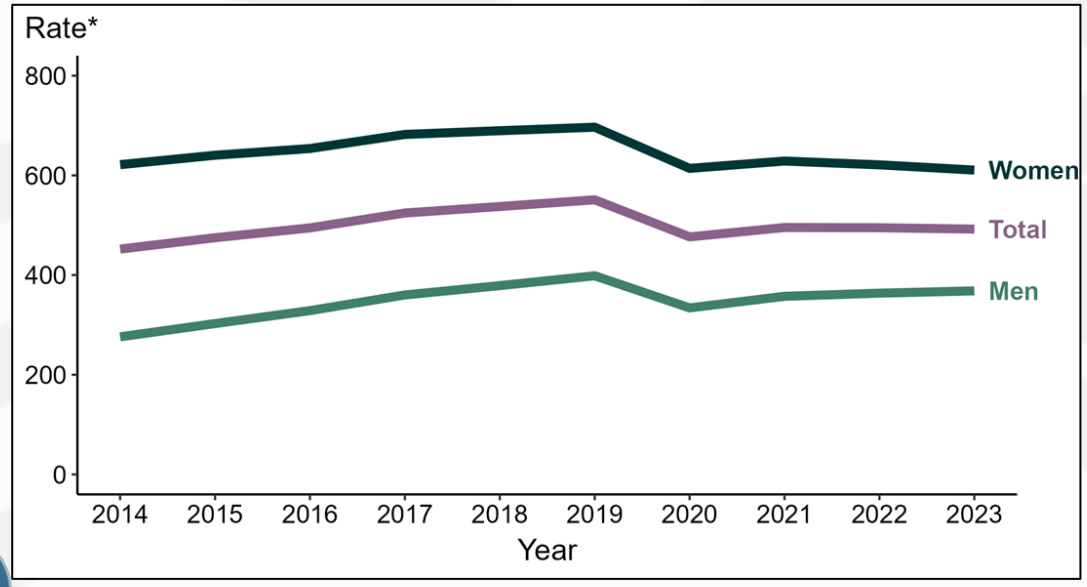
# United States Preventive Services Taskforce (USPSTF) and Center for Disease Control (CDC) Recommendations for Chlamydia Screening

- The USPSTF and CDC recommend screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection every year.
- This recommendation applies to asymptomatic, sexually active adolescents and adults, including pregnant persons.
- Age and sex is a strong predictor of risk: highest infection rates in women
  - Ages 15 to 24 years
  - Women 25 years or older are at increased risk if they have a new sex partner, more than 1 sex partner, a sex partner with concurrent partners, or a sex partner who has an STI; practice inconsistent condom use when not in a mutually monogamous relationship; or have a previous or coexisting STI.

# Chlamydia Rates and Impact

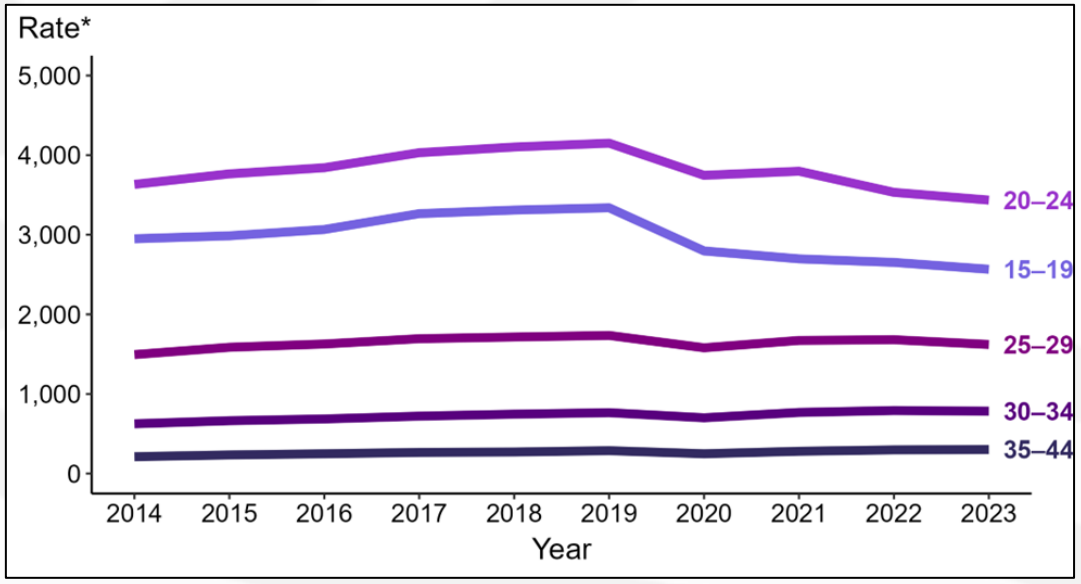
- In the United States the rate of chlamydia infection among women was nearly double the rate among men.
- Rates of reported chlamydia remain highest among adolescents and young adults and in 2023, 55.8% of all cases of chlamydia were reported among persons aged 15 - 24 years.

**Chlamydia Rates of Reported Cases by Sex and Year United States, 2014–2023**




* Per 100,000

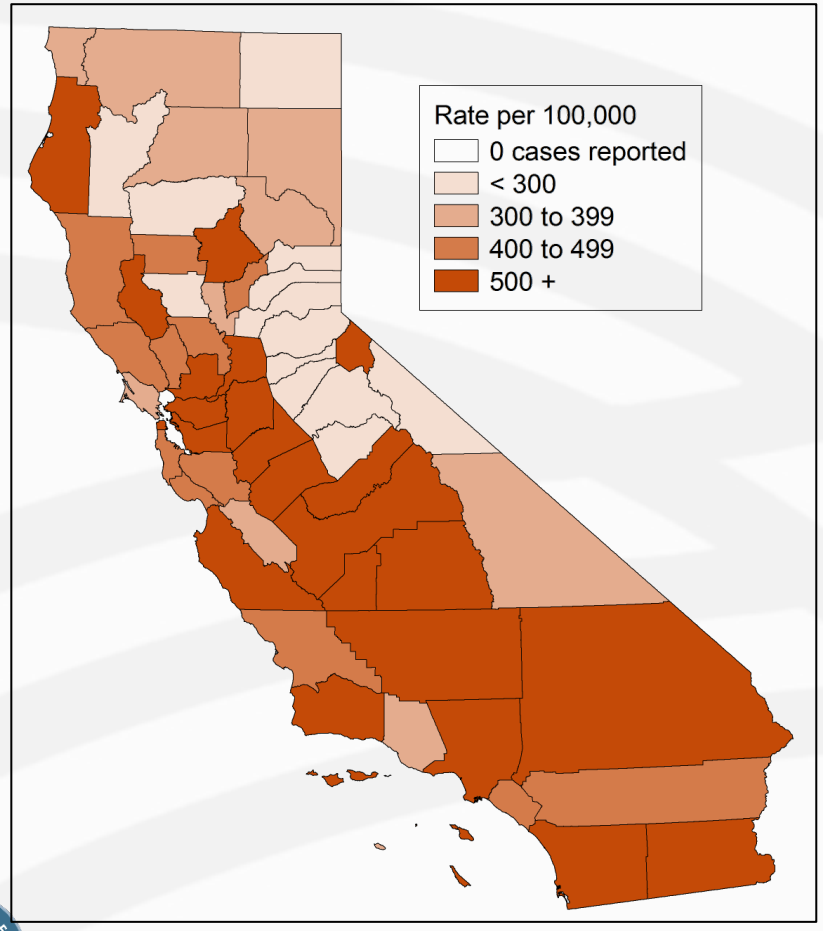
**Chlamydia Rates of Reported Cases Among Women Aged 15–44 Years by Age Group and Year United States, 2014–2023**



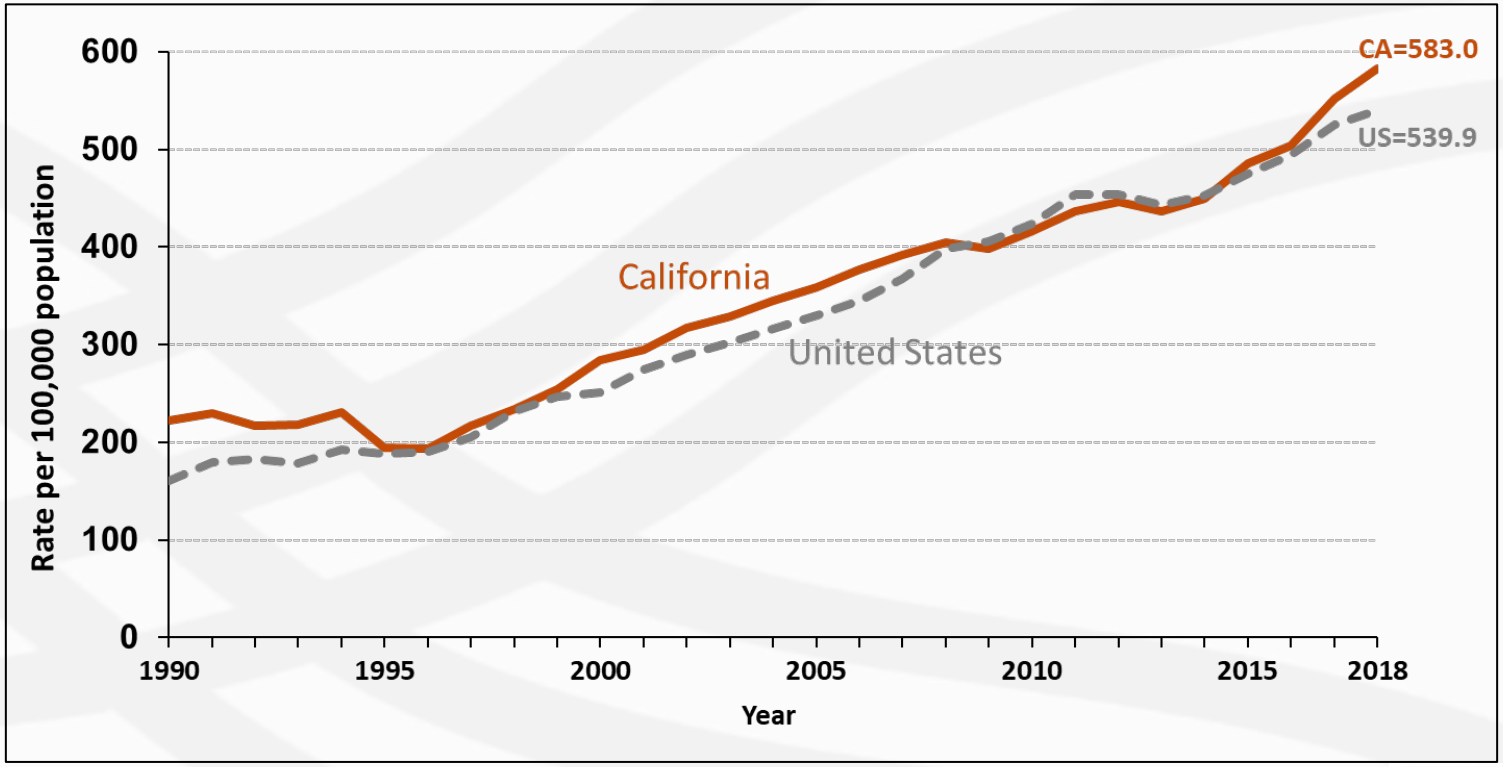

* Per 100,000

# Chlamydia Rates and Impact

## Chlamydia, Incidence Rates by County, California, 2018



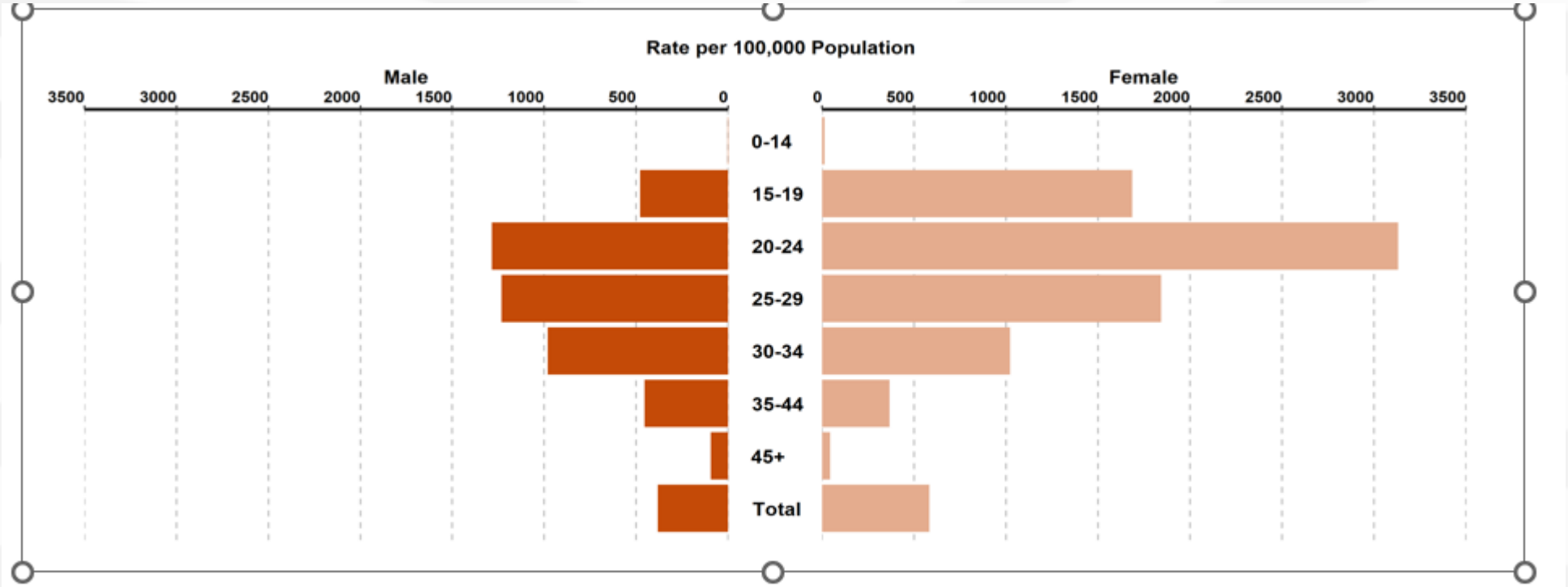

## Chlamydia, California Versus United States Incidence Rates, 1990 - 2018




Source: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx

# Chlamydia Rates by Age and Sex

## Chlamydia, Incidence Rates by Age Group (in years) and Gender, California, 2021




Age was "Not Specified" for 0.09% of female cases and 0.11% of male cases in 2021.
Screening guidelines recommend routine screening for specific populations, therefore higher rates of reported cases may in part reflect the targeted nature of screening programs.

Prepared by CDPH STD Control

# Partnership Chlamydia Screening Disparities 2023

## Healthcare Effectiveness Data and Information Set (HEDIS®) Data

**Risks associated with chlamydia are age and sexual practice based and NOT race, and ethnicity based.**

| NE | NW | SE | SW |
|---|---|---|---|
| 49.23 | 51.77 | 59.02 | 57.39 |

### NW

| | |
|---|---|
| American Indian/Alaska Native | 47.83 |
| Asian/Pacific Islander | 48.94 |
| Black | 57.14 |
| Hispanic | 59.05 |
| Other/unknown | 53.41 |
| White | 49.57 |

### NE

| | |
|---|---|
| American Indian/Alaska Native | 44.63 |
| Asian/Pacific Islander | 50.00 |
| Black | 45.00 |
| Hispanic | 48.67 |
| Other/unknown | 49.40 |
| White | 49.76 |

| | |
|---|---|
| 90th% | 67.39 |
| 75th% | 62.9 |
| 50th% | 56.04 |
| 25th% | 49.65 |
| below 25th% | |

### SW

| | |
|---|---|
| American Indian/Alaska Native | 55.70 |
| Asian/Pacific Islander | 50.81 |
| Black | 70.71 |
| Hispanic | 59.50 |
| Other/unknown | 56.63 |
| White | 52.77 |

### SE

| | |
|---|---|
| American Indian/Alaska Native | 50.00 |
| Asian/Pacific Islander | 58.25 |
| Black | 68.10 |
| Hispanic | 57.46 |
| Other/unknown | 62.47 |
| White | 55.61 |

# Perinatal Quality Incentive Program and HEDIS®

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# Perinatal Quality Improvement Program (PQIP)

**What is it?**

- The Perinatal Quality Improvement Program (PQIP) is a value-based program that offers financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP practitioners that provide quality and timely prenatal and postpartum care to Partnership members.

**Why does Partnership offer financial incentives?**

- Financial incentives offer enhanced reimbursement which encourages practices to provide high quality care and build systems that support this care.

**Measures**

- The PQIP is developed and designed with primary care providers (PCP) and OB/GYN providers in mind who drive measurable health outcomes through a concise and meaningful measurement set focused on the following measures:
  - Timely Prenatal and Post Partum Care
    - Includes depression screening
  - Vaccinations in Pregnancy: TDaP and Influenza
  - Electronic Clinical Data System (ECDS)

Perinatal Quality Improvement Program Detailed Specifications 2024-2025

# Measure Specification - Timely Prenatal Care

## Measure Description

Timely prenatal care services are rendered to pregnant Partnership members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization.

**Measurement Period:** July 1, 2024, to June 30, 2025

**Documentation to include:**

- Comprehensive physical exam
- Assessment of complete medical and social history including
  - History of Gestational Diabetes
  - Use of drugs, alcohol or tobacco during pregnancy
  - C-section prior to the pregnancy
  - Issues with previous pregnancy
- Depression screening using validated tool and score reported

# Measure Specification - Timely Postpartum Care

## Measure Description

Two timely postpartum care services rendered to Partnership members with one occurring within 21 days after delivery and the other occurring between 22 and 84 days after delivery.

**Measurement Period:** April 8, 2024, to April 7, 2025 (index period by which women with live births are identified)

**Documentation to include:**

- Date of delivery and live birth confirmation
- A complete postpartum visit with notations
- Depression screening
- Provider attestation of lactation evaluation and discussion of family planning

# Putting Quality Into Practice
# Perinatal Care

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# Perinatal Best and Promising Practices
## Timely Prenatal Care

### Timely Prenatal Care

- Prenatal care visit to an OB/GYN or other perinatal care practitioner or primary care provider (if appropriate) in first trimester less than 14 weeks gestation
- For non-perinatal practices, connect pregnant patients to perinatal care providers
- Train all reception / front office staff in “pregnancy dating” based on last menstrual period to schedule in first trimester. Use pregnancy calculators to aid office staff when scheduling
- Offer Partnership sponsored patient incentives such as Prenatal Growing Together Program to engage patients early in a timely first prenatal visit
- Effective documentation of EDD and date of visit, physical exam, FHT auscultation, ultrasound, fundal height OR pelvic examination
- Complete depression screening-tool and score

# Perinatal Best and Promising Practices
## Timely Prenatal Care

### Timely Prenatal Care

- Correct use of pregnancy surveillance codes
- Refer all pregnant patients to Partnership Health Perinatal Services Program for case management and system navigation.
- For PCP practices who conduct pregnancy tests consider outreach and follow up with patients who had positive test to connect to next stage of care.
- Consider a variety of appointment options: after hours, same day appointments, and weekends, telehealth allowed for ONE post partum visit.
- During pregnancy, inform patients of the importance of two post-partum visits.

# Perinatal Best and Promising Practices
## Prenatal Immunization Status

### Prenatal Immunization Status

- Discuss Vaccination throughout pregnancy and identify reasons for hesitancy
- Educate patients that vaccines protect them **and** their baby
- Discuss with patients the significant benefits for the baby of vaccination during pregnancy
- Young infants carry the highest risk of complications. Infants cannot be fully vaccinated until after 6 months of age

### TDaP

- Administered within 30 weeks before delivery date
- Vaccinate with TDaP in second trimester if you are concerned about timely and regular visits from the patient

### Influenza

- Administered within 40 weeks of delivery date
- All pregnancies are affected by at least one flu season

# Perinatal Best and Promising Practices
## Postpartum

### Postpartum

- Refer all pregnant patients to Partnership Health Perinatal Services Program for case management and system navigation
- During pregnancy, inform patients of the importance of two post-partum visits
- Schedule first visit prior to discharge from hospital
- First visit occurring within 21 days after delivery
- Second visit occurring between 22 and 84 days after delivery
- Schedule second visit at the time of the first visit
- Second visit is recommended by ACOG to **ALL** patients in postpartum period
- Consider use of telehealth for one of the visits
- Offer Partnership sponsored patient incentives such as Prenatal Growing Together Program and as needed to Partnership Care Coordination

# Primary Care Provider Quality Improvement Program and Measure Focus

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# Primary Care Plan
# Quality Improvement Program

## PCP QUALITY IMPROVEMENT PROGRAM

The Primary Care Provider Quality Improvement Program (PCP QIP), designed in collaboration with Partnership HealthPlan of California providers, offers substantial financial incentives, data resources, and technical assistance to primary care providers who serve our capitated Medi-Cal members so that significant improvements can be made in the following areas:

- Prevention and Screening
- Chronic Disease Management
- Appropriate Use of Resources
- Primary Care Access and Operations
- Patient Experience

**Contact Us**

Email: QIP@partnershiphp.org (please allow two business days for a response)
Fax: (707) 863-4316

### PCP QIP Overview

To help orient our providers to the PCP QIP year, we have provided measurement set documents, a code list, and other useful tools and resources.

Learn More about the 2025 PCP QIP

Equity Adjustment - PCP QIP Payment Methodology

### Webinars

PCP QIP webinars

Upcoming Webinars and Trainings

On Demand Courses

# Quality Incentive Program Tools


## Tools and Resources

- 2025 PCP Measure Specification Manual
- PQD User Guide
- Preventive Care Reports User Guide
- PCP QIP Webpage
- eReports

# Partnership Quality Dashboard
# QIP Stoplight Report

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

Home | QIP Stoplight | Provider | MeasurePerformance | Scorecard | DrillDown_Clinical | Drilldown_NonClinical | FS1 | FS2 | FS3

Partnership HealthPlan of California
Quality Dashboard
Home

- PQD is an online platform that integrates many sources of quality performance data to enable PCPs and PHC staff to prioritize, inform and evaluate quality improvement efforts.
- QIP data is updated monthly on the 10th in PQD.
- Please reach out to PQD team (PQD@partnershiphp.org) for any questions.

MENU

Status ESTIMATED

Refresh Date Dec-23

Parent Organization (PO) Executive QIP Measure Summary

## QIP Stoplight

Refresh Date: December 2023

Target/Benchmark Filter: PCP QIP Full Points target

Gap Size & Dollars Remaining

< 10 From Target | < 30 From Target | > 30 From Target | Target Met

| Measure | Total Org Gap | Total Org Num | Total Org Denom | < 10 From Target | < 30 From Target | > 30 From Target | Target Met |
|---|---|---|---|---|---|---|---|
| Asthma Medication Ratio | 3 | 248 | 356 | 2<br>$9,949 | 1<br>$4,764 | 0<br>$0 | 0<br>$0 |
| Breast Cancer Screening | 57 | 694 | 1,311 | 4<br>$4,975 | 0<br>$0 | 48<br>$160,209 | 5<br>$5,056 |
| Cervical Cancer Screening | 297 | 3,129 | 5,783 | 4<br>$29,847 | 0<br>$0 | 210<br>$160,209 | 83<br>$30,338 |
| Child and Adolescent Well Care Visits | 989 | 4,824 | 10,346 | 41<br>$9,949 | 0<br>$0 | 824<br>$240,314 | 124<br>$45,507 |

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# Coding Questions

QIP ACADEMY

Back to Basics

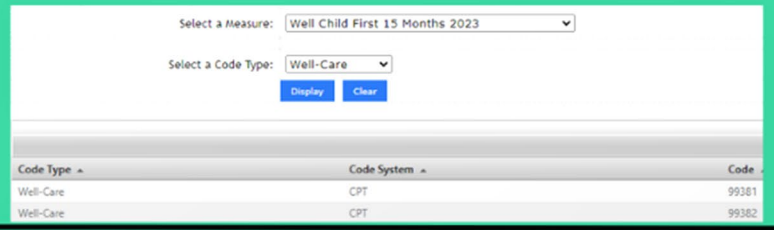
## DID YOU KNOW?

### 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.

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# PCP QIP Measure Specifications - Chlamydia Screening

NEW!

MY2025 PCP QIP Pediatric Measure: Chlamydia Screening (16 - 20 yo)

MY2025 PCP QIP Family Medicine *Monitoring Measure*: Chlamydia Screening (16 - 24 yo)

MY2025 PCP QIP Internal Medicine *Monitoring Measure*: Chlamydia Screening (21 - 24 yo)

## Measure Description (Pediatric)

The percentage of patients 16 - 20 years of age for whom screening is indicated and who had at least one test for chlamydia during the measurement year

## Denominator

The number of continuously enrolled assigned members for whom screening is indicated 16-20 years of age as of December 31 of the measurement year

## Numerator

The number of members from the eligible population in the denominator with at least one (1) test for chlamydia during the measurement year

## Exclusions

Member with male sex assigned at birth or male at any time in the patient's history

# Putting Quality Into Practice
# Chlamydia Screening

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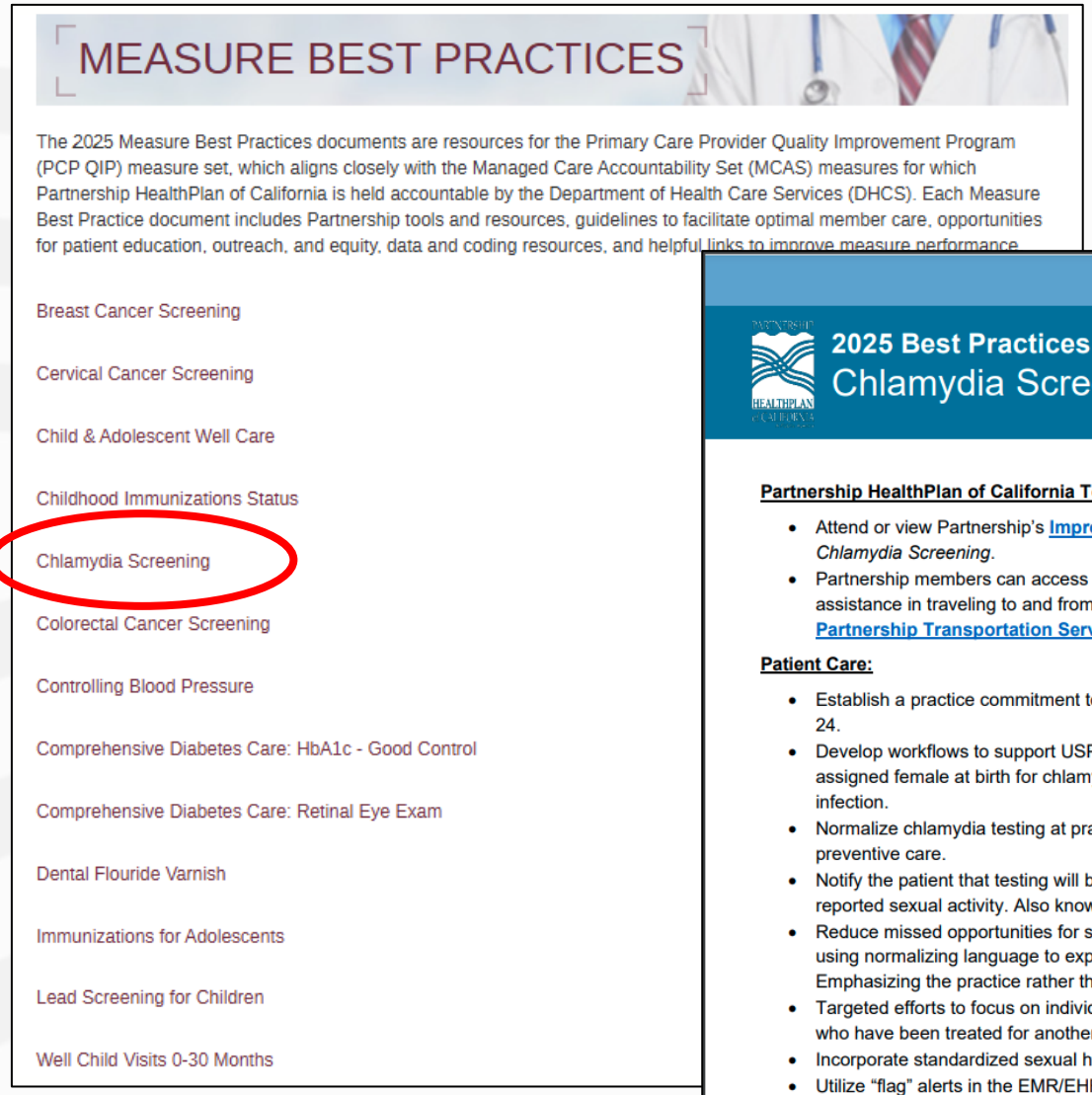
# Measure Best Practices



## 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

Chlamydia Screening

Colorectal Cancer Screening

Controlling Blood Pressure

Comprehensive Diabetes Care: HbA1c - Good Control

Comprehensive Diabetes Care: Retinal Eye Exam

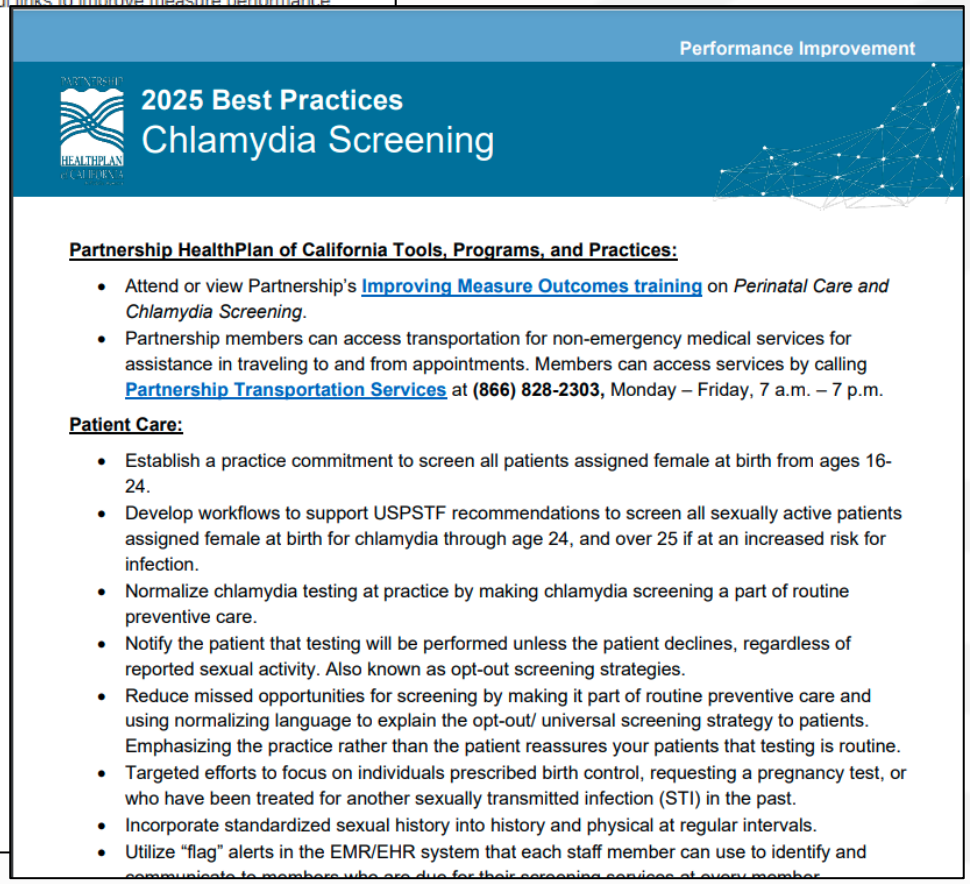
Dental Flouride Varnish

Immunizations for Adolescents

Lead Screening for Children

Well Child Visits 0-30 Months

**2025 Best Practices Chlamydia Screening**



Performance Improvement

**2025 Best Practices**
Chlamydia Screening

**Partnership HealthPlan of California Tools, Programs, and Practices:**

- Attend or view Partnership's Improving Measure Outcomes training on *Perinatal Care and Chlamydia Screening*.
- Partnership members can access transportation for non-emergency medical services for assistance in traveling to and from appointments. Members can access services by calling Partnership Transportation Services at **(866) 828-2303,** Monday – Friday, 7 a.m. – 7 p.m.

**Patient Care:**

- Establish a practice commitment to screen all patients assigned female at birth from ages 16-24.
- Develop workflows to support USPSTF recommendations to screen all sexually active patients assigned female at birth for chlamydia through age 24, and over 25 if at an increased risk for infection.
- Normalize chlamydia testing at practice by making chlamydia screening a part of routine preventive care.
- Notify the patient that testing will be performed unless the patient declines, regardless of reported sexual activity. Also known as opt-out screening strategies.
- Reduce missed opportunities for screening by making it part of routine preventive care and using normalizing language to explain the opt-out/ universal screening strategy to patients. Emphasizing the practice rather than the patient reassures your patients that testing is routine.
- Targeted efforts to focus on individuals prescribed birth control, requesting a pregnancy test, or who have been treated for another sexually transmitted infection (STI) in the past.
- Incorporate standardized sexual history into history and physical at regular intervals.
- Utilize "flag" alerts in the EMR/EHR system that each staff member can use to identify and

# Measure Best Practices

- Develop workflows to support USPSTF and CDC recommendations to screen all sexually active patients assigned female at birth for chlamydia through age 24, and over 25 if at an increased risk for infection.
- Universal screening/opt out screening: establish a practice commitment to screen all patients assigned female at birth from ages 16 – 24.
- Targeted efforts to focus on individuals prescribed birth control, requesting a pregnancy test, or who have been treated for another sexually transmitted infection (STI) in the past.
- Consider screening individuals who received a pregnancy test in the emergency room or urgent/immediate care setting, or who present with urinary tract infections.

# Measure Best Practices

- STI screening is considered by Medi-Cal as a sensitive service and therefore parental/legal guardian consent is not required for patients who are 12 years and older.
- Meet with teens and young adults separately from their parents/caregivers to allow open and honest conversation.
- Reduce missed opportunities for screening by making it part of routine preventive care and using normalizing language to explain the opt-out/ universal screening strategy to patients. Emphasizing the practice rather than the patient reassures your patients that testing is routine.
- Train entire clinical team on sexual health education, cultural competency for targeted communities, and motivational interviewing techniques.
- Standardized care staff communication using scripts for taking sexual history and reviewing the recommendations for screening.

# Measure Best Practices

- Consider a variety of service options and choices - after hours and same day appointments, weekends, teen back-to-school events, well-child visits, vaccine visits, sick/acute visits for non STI related concerns.
- Pair with National Health Preventive Months (e.g. April - STI awareness month), to utilize existing educational materials.
- Use standardized templates in the EMR/EHR system to guide providers and staff through the visit to ensure all components were met and documented.
- Incorporate standardized sexual history into history and physical at regular intervals.
- Schedule future visits while the patient is waiting to be seen by the provider or before they leave the office.
- Educate patients on sexually transmitted infections including signs, symptoms, treatment, and prevention.
- Share local resources for sexual/reproductive care for adolescent patients.
- Encourage patients to complete chlamydia screening during current appointment.
- Collect urine during intake.

# CHLAMYDIA SCREENING AT CCOLE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Caring for Napa, Solano & Yolo Counties

# Locations

## CCOLE CLINICS - YOLO COUNTY

*Napa/Solano Counties coming soon

Safe Care Clinic Program offers free and confidential (private) sexual and reproductive health services to individuals ages 12+.

Salud Clinic

Hansen Family Health Center

Vida Family Health Center


Davis Community Clinic


South Napa Campus


safe care clinic

CommuniCare+OLE

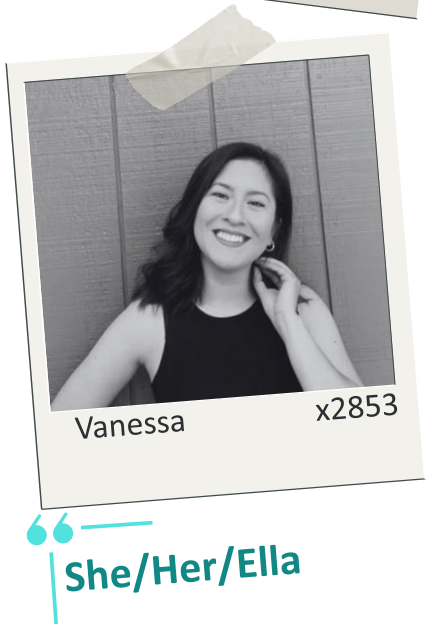
Caring for Napa, Solano & Yolo Counties

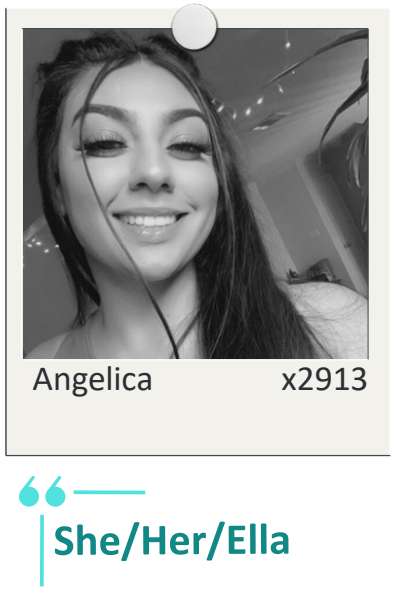
# Srh Team


She/They
Diane
x3116


He/Him/El
Jesus
x3328


She/Her/Ella
Karolina
x2837


Vanessa
x2853
She/Her/Ella


Angelica
x2913
She/Her/Ella


Ann
x2925
She/Her

# Office Visits

## HEALTH COACH FLIPPED VISITS + WHOS

- Health coaches are…
- Their training includes…
- They offer the following services…
- Workflows include offering STI testing to all patients regardless of reason for visit.


safe care clinic

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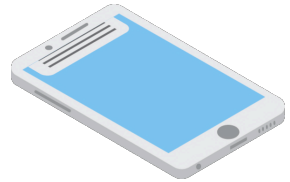
# Reducing Barriers

## BY...

- Online + phone call scheduling
- Walk in appointments
- Outreach during schools lunch time
- Presentations to youth and community members
- Reaching community members where they are located (mobile medicine)



safe care clinic

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# Coming Soon

## TO CCOLE SITES

- Health Coach expansion to Solano/Napa Counties
- Explore CT/GC POCT
- Stock DoxyPEP

safe care clinic

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Caring for Napa, Solano & Yolo Counties

# THANK YOU!

Any Questions?

# Upcoming Trainings
# Save the Dates

## Improving Measure Outcomes Webinar Series: 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**:

- 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

# Partnership Growing Together and Care Coordination

## Growing Together Program (GTP)

- Focus: Health education and access to services for all members
- Prenatal and postpartum outreach from Partnership to members
- Refer ALL pregnant, postpartum members, and members/families < 5 years old

Phone: (855) 798-8764
Monday – Friday  8 a.m. – 5 p.m.
PopHealthOutreach@partnershiphp.org

ACCREDITED NCQA HEALTH PLAN

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

# The Growing Together Program

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

## The Growing Together Program

Our Growing Together Program supports members during and after pregnancy, and children from birth up to age 3. This program is offered to Partnership members at no cost. Learn how the Growing Together Program can help you.

### The Growing Together Program features:

**The Prenatal Program – earn up to $50 in gift cards!**
This program encourages early prenatal care. Members will receive a $25 gift card for getting their flu vaccine while pregnant, and another $25 gift card for getting their Tdap vaccine between 27 weeks and delivery. Call us to join as soon as you know you are pregnant.

You will also get:

- A welcome call upon referral
- Up to 3 check-in phone calls throughout the program
- Information about doula benefits
- Support for prenatal visits
- Referrals to care coordination
- Health education

**The Postpartum Program – earn up to $100 in gift cards!**
This program encourages postpartum and well-baby visits. Members will receive a $50 gift card for each of their 2 postpartum exams ($100 total) between 7 to 84 days after delivery.

You will also get:

- A welcome call upon having your new baby
- Up to 2 check-in calls throughout the program
- Help to enroll your baby into Medi-Cal
- Support for postpartum and well-baby visits
- Referrals to care coordination
- Health education





**The Healthy Baby Program – earn up to $200 dollars in gift cards!**
This program encourages well-baby visits. Parents or caregivers will receive a $25 gift card each for taking their baby to the following visits:

- 2 well-child visits before 3 months
- 2 well-child visits before 9 months
- 2 well-child visits between 9-15 months
- 2 well-child visits between 15-30 months

Parents or caregivers can receive an extra $100 in gift cards if their baby receives all required vaccines, including 2 flu shots, by 24 months of age. A vaccine record must be submitted to Partnership's Population Health Department. Call us to enroll your baby as soon as they get Partnership.

You will also get:

- A welcome call
- Referrals to care coordination
- Check-in calls at 3, 7, 14, 22, 26, and 30 months
- Support for well-baby visits and the recommended screenings and vaccines

To learn more or sign up for the Growing Together Program, call us at **(855) 798-8764**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call the California Relay Service at **(800) 735-2929** or **711**. You can also email us at PopHealthOutreach@partnershiphp.org.

*This notice does not change your Partnership benefits or keep you from getting the care you need.*



ACCREDITED NCQA HEALTH PLAN

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

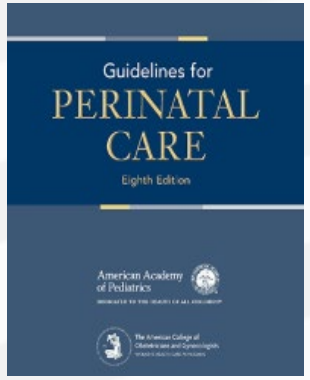
# Partnership Growing Together and Care Coordination

## Partnership Care Coordination

- Health care guides and nurse case managers offer care management for high-risk members and families
- Refer patients with care coordination needs, such as issues with transportation, high-risk conditions, or other psycho-social or medical concerns.
- To contact the Care Coordination Department: **(800) 809-1350**

# Reference Materials

- Guidelines for Perinatal Care –8th Edition by the American College Obstetricians & Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), September 2017
- California Department of Public Health CPSP Program https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx
- American Diabetes Association Management of Diabetes in Pregnancy: Standards of Care in Diabetes – 2024 (January 2024)



# Additional Resources

Need to reach the PCP QIP Team? QIP@partnershiphp.org

- eReports access
- Measure specification questions

Interested in coaching resources for improving measure performance?
Reach out to the Performance Improvement Team: pit@partnershiphp.org

- Coaching, measure best practices, sounding board, project planning guidance, facilitation

Partnership Quality Dashboard (PQD) User Guide

Link to PCP QIP Webinars Page: 2025 Kick-Off Webinar recordings are now available for PCP QIP and eReports

# Contact Us

Colleen Townsend MD, Regional Medical Director:

ctownsend@partnershiphp.org

Performance Improvement Team:

pit@partnershiphp.org

# Evaluation

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