Connecting for Better Health

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UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

CALIFORNIA MEDICAL ASSOCIATION

EPT Learning Community Data Track

February 11, 13, 24, 2025

Welcome

While we're waiting, please:

Rename yourself

1

Click the Participants icon

2

Hover over your name & click Rename

3

Add your name, pronouns and organization's name

4

Click OK

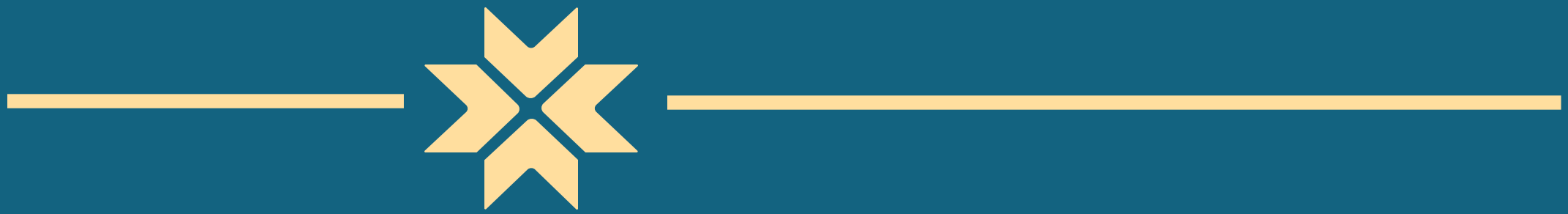
If you connected to the audio using your phone

- Find your participant ID; it should be in the top left of your Zoom window
- Once you find your participant ID, press: #number# (e.g., #24321#) to connect your audio and video
- The following message should briefly appear: "You are now using your audio for your meeting"

Learning Objectives

1. Learn key milestones components (e.g., data implementation plan, stratifying HEDIS-like measures for May 2025 submission)
2. Understand how HEDIS-like measures are calculated for EPT (e.g., numerator/denominator)
3. For Population of Focus HEDIS-like measures
   - Identify and leverage data sources to optimize data quality and performance
   - Explain the importance of stratifying data to look at disparities
4. Describe data collection best practices for Race, Ethnicity, Language (REAL) and Sexual Orientation and Gender Identity (SOGI)
5. Understand best practices for acquiring external data to support PHM workflows
   - The CA Data Exchange Framework and how it helps with data management
   - Data Sharing Agreement basics
   - Partners for data sharing, including QHIOs

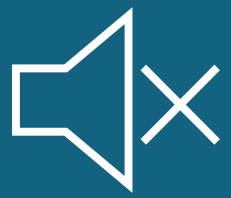
State of the State



Agenda

1. **Welcome**
2. **Reviewing our roadmap and connecting to the 'why'**
   Population Health Learning Center
3. **Measures introduction and Q&A**
   Population Health Learning Center, CMA Physician Services, Connecting for Better Health
4. **Break**
5. **Data exchanges**
   Connecting for Better Health
6. **Data stratification**
   UCSF Center for Excellence in Primary Care
7. **Next steps and closing**

Housekeeping Reminders



Mute

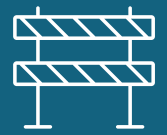
We will mute lines during the presentation to prevent background noise

Questions

Submit questions using the chat feature

Slides + Recording

Slides and recording will be posted PopHealth+



Tech Issues

Private chat Rachel Kochhar for assistance

Please chat in!

- Your name
- Role
- Organization
- One thing you are hoping to learn more about today

PHLC Presenters

Tammy Fisher, MPH
Chief Program Officer

Mary Deane, MPH
Director of Programs

Jess Liu, MPH, MS
Director, Analytics & Impact

Rachel Kochhar, MPH
Programs Associate

Jennifer Sayles, MD, MPH
Chief Executive

CEPC Presenters

Pat Mejia
Associate Director of Training

Meg Elliot
Trainer

Rachel Willard-Grace
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Connecting for Better Health Presenters

Timi Leslie
President

John Weir
Managing Director

Toria Thompson
Advisor

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Director

Stephanie Thornton
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CMA Physician Services Presenters

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Sr. Director, Physician Services

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Sr. Project Specialist

Graciela Garcia Arana
Practice Transformation Specialist

Amanda Main
Practice Transformation Specialist

Let’s keep it interactive!

Please turn cameras on. This will help us better engage with one another.

Use the chat liberally to ask questions and make comments. It would be great if we hear from everyone at least once!

Take care of yourself. Take breaks, stretch, and let us know if you need support.

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Reviewing the roadmap and connecting to the 'why'

Jennifer N. Sayles, MD, MPH Chief Executive

Mary Deane, Director of Programs

Population Health Learning Center

Executive Summary: November 2024 Deliverables Submission

87% of practices submitted at least one deliverable.

82 practices (41%) met the ≥ 70% target for patient continuity with provider.

120 practices (60%) met the ≤ 10-day third next available appointment target.

84 practices (42%) met the ≥ 90% empanelment target.

Practices earned ~$6.6M in directed payment for submission of the November deliverables.

What are you celebrating?

In the chat…

- What are you celebrating from the start of EPT?
- What are you seeing differently now through this work that you can no longer "un-see?"
- What milestones do you want to acknowledge?

Transformational Care Journey

Foundation & Readiness (Laying the Groundwork for Change)

- Empanelment Assessment
- Empanelment P&P
- Data Governance P&P
- Data Gap Assessment

Data-Driven Strategy & Planning (Identifying Needs & Setting Goals)

- Data Implementation Plan
- Stratified HEDIS Data on All Measures
- Disparity Reduction Plan

Care Model Enhancement (Optimizing Clinical & Outreach Strategies)

- Care Team Assessment
- Clinical Guidelines
- Outreach & Engagement
- Pre-Visit Planning
- Evidence Based Models of Care

Implementation & Data-Driven Adjustments (Turning Strategy into Action)

- BH Screen & Link
- SH Screen & Link
- VBP Assessment
- Data Progress Report

Measuring & Sustaining Change (Tracking Progress & Impact)

- KPI Report: Empanelment
- KPI Report: Continuity
- KPI Report: TNAA
- KPI Report: Disparity Reduction (1 disparity in 1 PoF measure)
- Assigned & Seen
- KPI Report: HEDIS Metrics (3x)
- PhmCAT (3x)

Looking Forward: 2025 EPT Overview

Jan - April 2025

- May Deliverables Templates Released (Feb)
- Data Integration and Stratification
- Using Data to Uncover Inequities

May 2025

Milestones

- Data Implementation Plan
- Stratified HEDIS-Like Measures
- KPIs: Empanelment, Continuity, TNAA
- Year 2 PhmCAT

Jun-Oct 2025

- Disparity Reduction Planning
- Clinical Guidelines
- Enhanced Outreach
- Care Team Optimization
- Pre-visit planning
- Remaining Deliverables Templates Released (June)

Nov 2025

Milestones

- Disparity Reduction Plan
- Care Team Assessment and Implementation
- Adopt Clinical Guidelines
- Implement Outreach and Engagement
- Implement Pre-Visit Planning
- Data Implementation Progress Report
- All Practice and MCP KPIs

Dec 2025

- BH & Social Needs Screening, Linkage
- VBP Readiness
- Milestone: Year 3 PhmCAT

Looking Forward: 2026 EPT Overview

Jan 2026 – April 2026

BH & Social Needs Screening, Linkage

VBP Readiness

May 2026

Milestones

Implement BH Screening and Linkage

Health Related Social Needs Screening and Linkage

Value Based Payment Assessment

All Practice and MCP KPIs

Year 3 PhmCAT

Jun – Oct 2026

QI and Sustainability

Nov 2026

Milestones

All Practice and MCP KPIs

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KPI Milestones

5 Milestones Tied to HEDIS-like Measures*

- Stratify HEDIS-like measures by race/ethnic and one additional criteria (1 milestone)
- Demonstrate improvement or reach target in 3 HEDIS-like measures (3 milestones total, each measure = 1 milestone)
- Demonstrate improvement in one disparity in one reported HEDIS-like measure (1 milestone)

**Practices are only required to report HEDIS-like measures for their selected population of focus.*

Population	HEDIS-like Measures
Pregnant People	Postpartum care (PPC) Timeliness of prenatal care (PPC) Postpartum depression screening (PDS-E)
Children/Youth	Child immunization status (CIS) Well child visits first 30 months (W30) Child and Adolescent Well-Care Visits (WCV) Depression screening (DSF)
Adult Preventive	Breast cancer screening (BCS) Cervical cancer screening (CCS) Colorectal cancer screening (COL) Depression screening (DSF)
Adult Chronic Care	Controlling high blood pressure (CBP) Glycemic status assessment (GSB) Depression screening (DSF)
Behavioral Health	Depression screening (DSF) Depression remission or response (DRR) Pharmacotherapy for Opioid Use Disorder (POD)

KPI Milestones (continued)

4 Milestones Tied to Administrative Measures

Empanelment Achievement	Continuity Achievement	TNAA Achievement	Assigned & Seen Improvement
Achieve target for the percent of patients who are assigned to a care team at the practice	Achieve target for patient-side continuity	Achieve target for average number of days to third next available routine appointment (TNAA)	Achieve improvement in assigned patients who had at least one primary care visit within a 12-month period

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What Are HEDIS® Measures And Why Do They Matter?

- HEDIS® measures are used to rate health plan quality for Medi-Cal, Medicare, Covered California and Commercial insurance.
- Medi-Cal now withholds money from all health plans with quality scores below the 50th percentile nationally for HEDIS® measures. Health plans can earn back money if they reduce disparities in these measures.
- For HEDIS measures to improve, practices must increase data capture and services provided to ALL health plan assigned patients.
- Health Plans are paying practices for higher quality scores on these measures and giving practices with higher scores more members.
- Therefore…**HEDIS® impacts practice revenue and membership.**

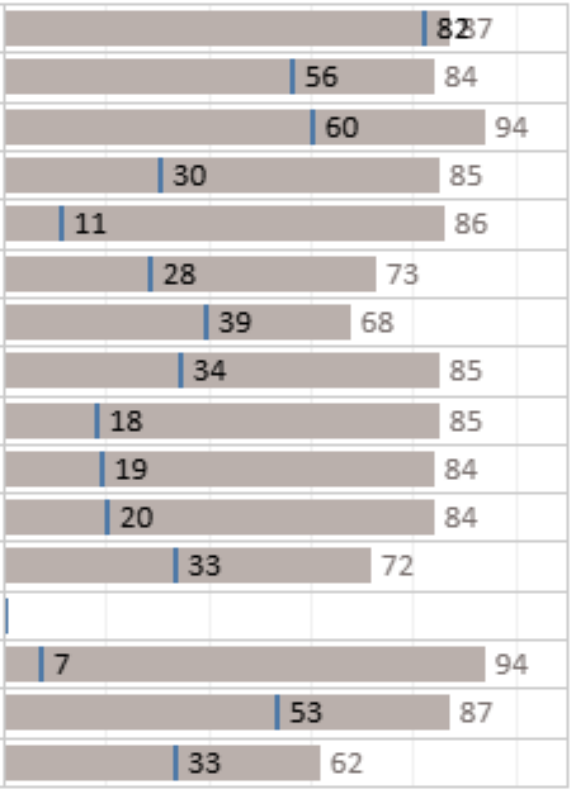
EPT Metrics: Improve Performance and Maximize Payment (1)

Small FQHC: Example P4P Scorecard

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Parent Organization (PO) Executive QIP Measure Summary

Measure	PO Score	50th Target	PO Partial Points NNT	PO Full Points NNT	PO QIP $ Earned	PO Remaining QIP $
ACS_ADMISSION	29.80	N/A	N/A	N/A	$0	$21,744
Asthma Medication Ratio	61.76	64.26	N/A	6	$8,531	$17,562
Avoidable ED/1000	10.44	N/A	N/A	N/A	$10,221	$11,523
★ Breast Cancer Screening	57.82	50.95	0	0	$26,093	$0
★ Cervical Cancer Screening	72.37	57.64	0	0	$26,093	$0
★ Child and Adolescent Well Care Visits	57.01	48.93	0	3	$37,326	$1,813
★ Childhood Immunization Status CIS 1(	7.50	34.79	N/A	13	$0	$26,093
★ Colorectal Cancer Screening	39.77	40.23	3	25	$17,211	$4,534
★ Controlling High Blood Pressure	69.35	59.85	0	0	$26,093	$0
★ Diabetes - HbA1C Good Control	76.43	60.10	0	0	$26,093	$0
Diabetes - Retinal Eye exam	63.69	51.09	0	0	$21,744	$0
Immunization for Adolescents IMA 2	25.81	35.04	0	9	$5,440	$20,653
Patient Experience	0.00	N/A	N/A	N/A	$0	$43,488
PCP Office Visits	3.78	N/A	N/A	N/A	$21,744	$0
RAR_READMISSION	0.91	N/A	N/A	N/A	$10,101	$11,643
★ Well Child First 15 Months	71.43	55.72	1	1	$18,182	$8,160



★ EPT KPI Measure

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EPT Metrics: Improve Performance and Maximize Payment (2)

Pediatric Practice – Example P4P Scorecard

Physician P4P Program - Physician Payment Report

January 1 - December 31, 2022

L.A. Care HEALTH PLAN

Medi-Cal PERFORMANCE SCORING — HEDIS Payment Measures (Higher rates are better)	HEDIS Hits	Eligible Population	2022 Rate	Incentive Scoring Threshold*	Incentive Scoring Benchmark**	Prior Year Rate	Attainment Score***	Improvement Score****	Incentive Score*****
Asthma Medication Ratio- Ages 5-64	11	12	91.67%	62.68%	91.33%	80.00%	10	9	10
★ Child and Adolescent Well-Care Visits†	1,343	2,100	63.95%	37.70%	70.36%	64.68%	8	0	8
★ Childhood Immunization Status - Combo 1 †	7	32	21.88%	17.65%	56.84%	30.23%	1	0	1
Chlamydia Screening in Women	38	57	66.67%	64.71%	86.69%	50.00%	1	4	4
Immunizations for Adolescents - Combo 2	106	170	62.35%	31.58%	64.48%	60.64%	9	4	9
Weight Assessment and Counseling for Nutrition and Physical Acti	1,219	1,388	87.82%	56.20%	91.81%	92.02%	8	0	8
★ Well-Child Visits in the First 15 months of Life	4	10	40.00%	32.14%	64.26%	44.44%	3	0	3
★ Well-Child Visits in the First 30 months of Life	29	44	65.91%	62.03%	87.44%	70.33%	2	0	2

† Double-Weighted Measure

Sum of Incentive Scores:	54
Count of Scored Measures x 10:	100
HEDIS PERFORMANCE SCORE:	54.00%

★ EPT KPI Measure

The Business Case for HEDIS / EPT KPI Metrics

Physician P4P Program - Physician Payment Report

January 1 - December 31, 2022

L.A. Care HEALTH PLAN

INCENTIVE PAYMENT CALCULATION

HEDIS Performance Score		Program Year Medi-Cal Membership		Member Points		Dollar Value / Member Point		INCENTIVE AMOUNT
54.00%	X	3,028	=	1,635	X	$48.76	=	$79,722.60

PEER GROUP COMPARISON

Your Performance Score (by Provider)		Your PMPM EQUIVALENT (by Provider)
54.00%		$2.19
0.00%	Solo and Small Group Physician Peer Group Minimum	$0.00
26.67%	Solo and Small Group Physician Peer Group Median	$1.00
98.33%	Solo and Small Group Physician Peer Group Maximum	$3.67
	Your Peer Group Percentile Ranking	90

Case Study: Children and Youth Population of Focus

2024 Performance

Practice A is a Pediatric Practice contracts with two Medi-Cal plans and is eligible for $1 million across both plans P4P Programs. In 2023, 150K was left on the table for 2 measures (Combo 10 and WC 3-6).

By participating in EPT Technical Assistance, Practice A was able to:

- Identify patients eligible for the two child measures and developed a gaps in care report for outreach.
- Activate the care team to proactively call parents when a gap in care was detected (not waiting until they came in).
- Use new sources of external data (e.g., CAIR, QHIO, health plan data) to capture what services the patient received outside their clinic.
- Improve EHR functionality to automatically drop codes for WCVs and vaccinations with certain smart phrases.
- Engage with health plans to reconcile the gaps in care reports.
- Work with plans to correct coding to get credit for 30 patients where the plan was missing immunization data.

2025 Performance

Results: Practice A met their goal for both measures:

- The additional **150K** earned helped support a new staff member on their care team
- 50 kids received the full immunization series
- 30 kids received WCVs including developmental screenings and anticipatory guidance for parents

May 2025 Deliverables

We will release templates and rubrics for these in February on our Milestones page

Category	Milestone	Available TA
PhmCAT	**Complete year 2 PhmCAT**	• PhmCAT Office Hours
Data to Enable Population Health Management	**Data implementation plan:** Develop implementation plan for addressing data and technology gaps and transforming practice operations to support development of KPIs. Plan must include steps for implementing these three strategies: 1. Identifying and outreaching to the assigned but unseen population 2. Using gaps in care reports that include practice and MCP data 3. Data exchange with 2 external partners, at least 1 of which is a Qualified Health Information Organization (QHIO) Note: Before completing this Milestone, the team needs to have submitted Milestone 4: Data governance and HEDIS reporting assessment	• May 2025 Deliverables Template Review Sessions • Data Implementation Office Hours • DxF Bootcamp • PoF User Groups • PopHealth+ Modules
Stratified HEDIS-like measures	**Stratify HEDIS-like measures:** Submit report that includes HEDIS-like measures applicable to selected population of focus stratified by race and ethnicity and at least one additional characteristic: primary spoken language, sexual orientation, gender identity, housing status, payer, or disability.	• May 2025 Deliverables Template Review Sessions • Data Implementation Office Hours • PoF User Groups • PopHealth+ Modules
Key Performance Indicators (KPIs)	**Submit KPI Updates:** Empanelment, Continuity, and Third Next Available Appointment Note: achievement/improvement must be sustained over two consecutive submissions or met in the final submission.	• PopHealth+ Modules • Access and Empanelment Office Hours

EPT Technical Assistance (TA): January – May 2025

Upcoming TA:

- **May 2025 Deliverables Template Review Sessions**
  - February 20 and March 7
  - These sessions will focus on reviewing the May deliverables templates and answering questions from practices
- **EPT Office Hours – Data Implementation**
  - Weekly starting February 26 @ 1:00 pm - 2:00 pm
  - These sessions will offer support for completing May data implementation deliverables
- **PhmCAT Support Sessions**
  - March 5, March 19, April 2
  - These sessions will answer questions related to completing the year 2 PhmCAT submission
- **Access Office Hours with Coleman Associates**
  - Twice a month starting February 27
  - These sessions will continue to provide support and address questions related to Access
- **DxF Bootcamp**
  - The DxF Bootcamp will provide California stakeholders step-by-step guidance to identify their organizations' priority data sharing use cases, existing assets, best practices for partner engagement, and technology resources to build a roadmap towards secure, real-time data exchange.
- **To Be Scheduled: PoF User Groups**
  - Each PoF will meet once a month with clinical SME and data SME

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EPT KPI Measures

Tammy Fisher, Chief Program Officer,
Population Health Learning Center

Toria Thompson, Advisor, BluePath Health

What data and how will it be used?

Practice Reporting

- Admin measures:
  - Empanelment, Continuity, and TNAA metrics, collected twice per year, used for practice level payments.
- HEDIS®-like measures: report twice per year for Population of Focus, not used for practice level payments.
- Disparity reduction KPI measure: report twice per year for at least one HEDIS®-like measure, used for payment.

MCP Reporting

- HEDIS-like measures: collect twice per year for all HEDIS like measures for Medi-Cal members, used for practice level payments.
- Assigned and Seen metric: used for practice payment calculation, measure specifications forthcoming.

Milestones available here: https://pophealthlearningcenter.org/wp-content/uploads/2025/01/EPT-Milestone-Submission-Timeline.pdf

Deep dive: HEDIS-like KPIs measures reporting

Purpose

Help practices assess and improve focus measures while collaborating with plans to enhance data quality and completeness.

Payment Criteria

Show improvement or meet targets in focus measures and improve at least one disparity identified in the reported measures.

Achievement must be sustained over two consecutive submissions or met in the final submission.

Population of Focus	HEDIS-like Measures
Pregnant People	Postpartum care (PPC) Timeliness of prenatal care (PPC) Postpartum depression screening (PDS-E)
Children/Youth	Child immunization status (CIS) Well child visits first 30 months (W30) Child and Adolescent Well-Care Visits (WCV) Depression screening (DSF)
Adult Preventive	Breast cancer screening (BCS) Cervical cancer screening (CCS) Colorectal cancer screening (COL) Depression screening (DSF)
Adult Chronic Care	Controlling high blood pressure (CBP) Glycemic status assessment (GSB) Depression screening (DSF)
Behavioral Health	Depression screening (DSF) Depression remission or response (DRR) Pharmacotherapy for Opioid Use Disorder (POD)

How are HEDIS® measures different from EPT “HEDIS-like” measures?

HEDIS® Measures

- Measures performance at the Managed Care Plan level.
- Uses continuous enrollment and allowable gaps in Health Plan enrollment.
- Uses anchor date (date patient must be enrolled with the plan to qualify for measure).
- Can be hybrid (sampling using chart data), ECDS or administrative (entire eligible population). Administrative measures rely mostly on claims type data.
- Include exclusions (criteria that removes a patient from the calculation of the measure) that are required or optional.
- Measurement year is the calendar year.

EPT “HEDIS-like” measures

- Measures performance at the practice level for all MCP assigned Medi-Cal patients.
- No continuous enrollment or gaps in enrollment.
- No anchor date is used, recommend using MCP assignment in the last month of the reporting period.
- Apply administrative measure specifications to all measures for the entire eligible population. Practices can use data from their EMR and other data systems to calculate measures.
- Exclusion criteria is optional.
- The measurement period is rolling 12 months: Jan-Dec 2024 for May 2025 submission, and Jul 2024-Jun 2025 for Nov 2025 submission.

Where can I find more information about the HEDIS measures?

Measure specifications

View measure specifications using the following resources

- **Partnership Health Plan QIP measure specifications (2024 measurement year):** https://qip.partnershiphp.org/qipdata/specs/2024%20PCP%20QIP%20Measure%20Specifications_Detailed%20Version_Final_2.2.24.pdf
- **IEHP 2025 Global Quality for P4P (for PCPs):** www.providerservices.iehp.org/content/dam/provider-services-rd/en/documents/providers/p4p--prop-56--gemt/global-quality-program/2025/20241114%20-%20FINAL%202025%20GQ%20P4P%20PCP%20Program%20Guide.pdf
- Reach out to your Medi-Cal Managed Care Plan to see if they have measure specifications to share!
- NCQA (Note: NCQA charges a fee for measure specifications): https://www.ncqa.org/hedis/measures/

Depression Screening and Follow-Up (DSF-E)

Percentage of people aged 12 and older who were screened for depression using a standard screening tool and, if positive, received follow-up care within 30 days.

	Measure	Pregnant	Adult Chronic	Adult Preventive	Children/ Youth	Behavioral
1	Depression screening - 12-17yo				x	
2	Depression screening - 18-64yo		x	x		
3	Depression screening - 65yo+		x	x		
4	Depression screening - Total					x
5	Follow-Up on Positive Screen - 12-17yo				x	
6	Follow-Up on Positive Screen - 18-64yo		x	x		
7	Follow-Up on Positive Screen - 65yo+		x	x		
8	Follow-Up on Positive Screen - Total					x

Depression Screening

Denominator (reported by age group)

People 12 years of age and older at the start of the measurement period

Numerator (reported by age group)

Those in the denominator who had a depression screening result using a standard screening tool for depression:

- Patient Health Questionnaire (PHQ-9, PHQ9M, PHQ-2)
  - DHCS recommended screening tool
- Beck Depression Inventory (BDI-II) adults only
- Beck Depression Inventory-Fast Screen (BDI-FS)
- Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)
- Edinburgh Postnatal Depression Scale (EPDS)
- PROMIS Depression
- Duke Anxiety-Depression Scale (DUKE-AD) adults only
- Geriatric Depression Scale-Short Form & Long Form (GDS) adults only
- My Mood Monitor (M-3) adults only
- Clinically Useful Depression Outcome Scale (CUDOS) adults only.

Standard Screening Tools

Instruments for adolecents (≤ 17 years)	Total score LOINC codes	Positive finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥ 10
Patient Health Questionnaire Modified for Teens (PHQ- 9M)®	89204-2	Total score ≥ 10
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥ 8
Center for Epidemiologic Studies Depression Scale — Revised (CESD-R)	89205-9	Total score ≥ 17
Edinburgh Postnatal Depression Scale (EPDS)	71354-5	Total score ≥ 10
PROMIS Depression	71965-8	Total score (T score) ≥ 60

1 Brief screening instrument. All other instruments are full-length.

2 Proprietary; may be cost or licensing requirement associated with use.

Instruments for adolecents (18+ years)	Total score LOINC codes	Positive finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥ 10
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥ 8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥ 20
Center for Epidemiologic Studies Depression Scale- Revised (CESD-R)	89205-9	Total score ≥ 17
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	90853-3	Total score ≥ 30
Geriatric Depression Scale Short Form (GDS)[1]	48545-8	Total score ≥ 5
Geriatric Depression Scale Long Form (GDS)	48544-1	Total score ≥ 10
Edinburgh Postnatal Depression Scale (EPDS)	48544-1	Total score ≥ 10
My Mood Monitor (M-3)®	71777-7	Total score ≥ 5
PROMIS Depression	71965-8	Total score (T score) ≥ 60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥ 31

Follow-Up on Positive Screen

Denominator

All patients from the Depression Screening Numerator (previous slide) with a positive depression result.

Numerator

Those in the denominator who had one of the following within 30 days:

- Outpatient, telephone or e-visit for follow-up for depression/behavioral health
- Depression case management encounter
- Behavioral health encounter (assessment, therapy, collaborative care, medication management)
- A diagnosis of encounter for exercise counseling
- Dispensed antidepressant medication
- Documentation of a negative full-length depression screening on the same day as a positive screen on a brief screening tool (i.e., a negative PHQ-9 as a follow-up to a positive PHQ-2).

General Guidelines for Data Capture: DSF-E

Where in the Clinical Process	What to Capture / Validate
Patient Intake / Registration	• Collect specific demographic data fields (race/ethnicity, gender, etc.) as well as information such as preferred language • Ensure / confirm Date of Birth • Confirm patient provider organization (PO) “enrollment” and attribution with Health Plan • Confirm and document payer/plan/product coverage
Initial Patient Assessment	• Include structured data field for overall standard assessment value/score • Include associated administration date • Include appropriate depression screening and/or standard assessment CPT code(s)
If positive, follow-up care is discussed with the patient and a plan made for next steps	• Include structured data field for documentation of a completed follow-up plan (this could be a binary Y/N or checkmark field or a more nuanced ‘drop down’ menu field with F/U plans) • Include appropriate depression and/or behavioral health diagnosis ICD code(s) • Include appropriate depression and/or behavioral health CPT code(s)
Follow-up Care	• Include appropriate depression and/or behavioral health diagnosis ICD code(s) • Include appropriate depression and/or behavioral health CPT code(s) • Include associated date of service • Define/classify antidepressant medications (and others as clinically defined by organization/ practice)

Data Sources to Optimize Data Capture and Performance

Within Your EHR

Create Custom Fields

- Most EHRs capture depression screening results only in unstructured clinical notes which presents challenges for reporting.
- Consider adding a structured data field within your Clinical Encounter/Visit Note to record each depression screening result (no need to record individual question scores)
- Once included as a discrete data element, use search and reporting functions to find patients with scores within the ranges for this measure.

Integrate with patient portals

- Enable patients to complete depression screenings through secure patient portals, increasing accessibility and potentially reducing stigma associated with screening.
- Ensure patient entered results are stored as discrete fields with your EHR for more automated reporting.

Data Sources to Optimize Data Capture and Performance

External Sources

Qualified Health Information Exchange (QHIO)

- Most QHIOs collect Care Summaries rather than individual assessments and screenings like depression screenings.
- Therefore, utilizing the portal of a QHIO will only yield results for this measure if depression screening results are contained within Care Summary Notes available within the QHIO.

Questions?

QUICK STRETCH

Measure Specifications

Breakouts

Breakout Instructions

There are three breakout groups:

1. Adults with Chronic Conditions/ Preventive Care Needs
2. Children and Youth
3. Pregnant People/People with Behavioral Health Needs

You should be automatically assigned to a breakout based on your selected **PoF**. If not, please stay in the main room and we will assign you.

Adults with Chronic Conditions & Preventive Care Needs Breakout

Introductions

Jessica Clark
Sr. Project Specialist

John Weir
Managing Director

Pat Mejia
Associate Director of Training

Mary Deane, MPH
Director of Programs

Let's get to know each other!
Chat in: Your name, organization, your PoF, and why your practice selected this PoF

What is You're *Why*?

- **Maria is overdue for several preventive screenings and chronic disease follow-ups.** She has multiple gaps in care across several HEDIS-like measures. Her last primary care visit was 14 months ago. Maria doesn't consider her own health care needs as much as she prioritizes her families needs first.
- **Her care team struggles with:**
  - Knowing if Maria has been seen anywhere else
  - Locating complete screening and lab data across different sources (MCP, IPA, QHIO, lab portals, or EHR)
  - Understanding where duplicate or missing data may exist
  - Contacting her effectively for scheduling
  - Addressing potential barriers (transportation, digital literacy, health literacy)

What are the KPIs?

Chronic

Measure and HEDIS® Abbreviation	Description
Controlling High Blood Pressure (CBP)	% of patients aged18 to 85 yrs with hypertension whose blood pressure was adequately controlled (139/89 or less)
Glycemic Status Assessment for Patients with DM >9% (GSD)	% of patients aged 18 to 75 yrs with diabetes whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was not under control (8.9% or less) .
Depression Screening and Follow-Up for Adolescents and Adults (DSF)	% of patients aged 12 and older who were screened for depression using a ***standard*** screening tool and, if positive, received follow-up care within 30 days.

Preventative

Measure and HEDIS® Abbreviation	Description
Colorectal Cancer Screening (COL)	The % of patients aged 45-75 yrs who had an ***appropriate*** screening for colorectal cancer.
Breast Cancer Screening (BCS)	% of patients aged 50 to 74 yrs who had at least one mammogram to screen for breast cancer ***in the past two years***.
Cervical Cancer Screening (CCS)	% of patients aged 21-64 yrs who had an ***appropriate*** screening for cervical cancer.

Content Check!

Chronic

Measure and HEDIS® Abbreviation
Controlling High Blood Pressure (CBP)
Glycemic Status Assessment for Patients with DM >9% (GSD)
Depression Screening and Follow-Up for Adolescents and Adults (DSF)

Preventative

Measure and HEDIS® Abbreviation
Colorectal Cancer Screening (COL)
Breast Cancer Screening (BCS)
Cervical Cancer Screening (CCS)

How familiar are you with this measure?

Please enter a 1, 2 or 3 in the Chat now that best characterizes your experience with your PoF's measures

1. We focus on these measures. I can tell you last years rates from memory. I can tell you all the things we have tried to improve them.
2. We track these measures. We are looking to learn more about them. We are just starting to work on improving our rates.
3. I recognize these measures. It hasn't been a focus for our practice.

Strategies for Improving Performance (CBP, GSD)

Where in the Clinical Process	Strategies and Best Practices (for many)
Patient Identification & Stratification: Who Needs Follow-Up?	• **Use care gap lists from health plans** to find patients with no recorded BP/A1c or GMI result. • **Use outcome coding to add a layer of detail** to your encounter as well as better capture outcome values like BP and HbA1c. (HINT: MCPs will accept this data and scrub patients off care gaps) • **Pull EHR reports** to flag patients with hypertension and their most recent BP or diabetes and the most recent A1c/GMI. • **Prioritize outreach** to those with high BP or A1c/GMI or no reading in the last 6 months.
Share Data With the Care Team: Who Can Help Close the Gap?	• **Train MAs** to check for missing BP readings and A1c/GMI **at every patient visit** (even if they come in for another reason). • **Use standing orders** so that patients with high BP get an automatic recheck during the visit. • **Stop chasing diabetic patients** and bring A1c testing in-house with point-of-care testing.
Engaging Patients Through Outreach & Education: How to Get BP/A1c Readings?	• **Make BP/A1c checks convenient.** Offer quick checks without a full visit (walk-in screenings). • **Leverage remote monitoring, telehealth, or digital machines.** If the patient has a BP cuff at home, **teach them how to report readings** via phone, patient portal, or text. • **Use culturally appropriate outreach.** Send reminders in the patient's preferred language and **explain why BP control matters** in simple terms.

Strategies for Improving Performance (DSF)

Where in the Clinical Process	Strategies and Best Practices (for many)
Patient Identification & Stratification: Who Needs Follow-Up?	• **Run EHR (or registry) reports for patients with upcoming visits** who haven't had a PHQ-9 or PHQ-2 in the last year • **Flag patients with risk factors in the EHR** (to prioritize screening & follow-up): chronic disease, pregnant/postpartum, adolescents • **Ensure follow-up planning is clearly documented** so care teams can act: If a **PHQ-9 score is 10+**, create an automatic referral flag or task for care coordination. If a patient declines a referral, **document an alternate follow-up plan** (e.g., PCP check-in, patient education, community resources).
Share Data With the Care Team: Who Can Help Close the Gap?	• Build depression screening into standard workflows: **Train MAs** to administer screenings **before the provider enters the room. Train them to verify that the PHQ-9 has been resulted by the provider after the visit.** • **Build a workflow** for how you look at and share data on how well your practice is screening patients.
Engaging Patients Through Outreach & Education	• **Schedule follow-ups before the patient leaves the visit** (even if it's just a PCP check-in). • **Phone-based or telehealth check-ins** can help engage patients who might struggle with in-person follow-ups.

Strategies for Improving Performance (BCS, CCS, COL)

Where in the Clinical Process	Strategies and Best Practices (for many)
Patient Identification & Stratification: Who Needs Follow-Up?	• **Flag high-priority patients for outreach:** Patients with chronic conditions (e.g., diabetes, obesity) may have higher cancer risks. • Or patients with long gaps in care or those overdue by **multiple years** should be prioritized for outreach. • **Document outside screenings to close gaps:** leverage data look-up or query through a QHIO. Document "patient stated last x was on y date" in their chart or health maintenance dashboard.
Share Data With the Care Team: Who Can Help Close the Gap?	• **Ensure all team members know which patients are due**: Use **EHR alerts** so MAs, nurses, and front desk staff can prompt patients about screenings. • **Integrate screening checks into standard visit workflows** (e.g., discuss screenings at annual visits, sick visits, and specialty visits).
Engaging Patients Through Outreach & Education	• **Make screenings more accessible:** Offer walk-in or same-day cervical cancer screenings when patients come for other visits. • **Distribute at-home FIT/FOBT kits** for colorectal screening to improve completion rates. • Partner with **mobile mammography units** for on-site screenings. • Use **culturally tailored messaging** to address screening hesitancy and barriers.

General Guidelines for Data Capture: CBP

Where in the Clinical Process	What to Capture / Validate
Patient Intake / Registration	• Collect specific demographic data fields (race/ethnicity, gender, etc.) as well as information such as preferred language • Ensure / confirm Date of Birth • Confirm patient provider organization (PO) “enrollment” and attribution with Health Plan • Confirm and document payer/plan/product coverage
At time of visit	• Ensure both Systolic and Diastolic values are recorded discretely in EHR. If multiple readings have been taken use the average readings per AMA guidelines. • Include / validate appropriate Hypertension diagnosis ICD code(s) – two diagnoses of HTN on different dates required • If not using EHR, include structured data field to indicate whether patient is eligible for this measure (i.e. they have two hypertension diagnoses in the current measure year). This could be a binary Y/N or checkmark field or a more nuanced ‘drop down’ menu field with F/U plans. • Include associated visit and diagnosis dates

General Guidelines for Data Capture: GSD

Where in the Clinical Process	What to Capture / Validate
Patient Intake / Registration	• Collect specific demographic data fields (race/ethnicity, gender, etc.) as well as information such as preferred language • Ensure / confirm Date of Birth • Confirm patient provider organization (PO) “enrollment” and attribution with Health Plan • Confirm and document payer/plan/product coverage
Pre-Visit	• Ensure prior lab results are available in Lab section of EHR • Where possible prior to visit, create electronic order with the EHR, for testing to be performed at a lab, allowing for results to be automatically returned to EHR, in time for visit.
At time of visit	• If testing at point of care, ensure HbA1c value or data supporting Glucose Management Indicator (GMI) is appropriately documented as discrete value and not embedded within notes ○ If using HbA1c, typically found in lab results section of the EHR, often within a dedicated area for point-of-care testing (POCT) • If GMI is being used as a continuous metric for individuals, ensuring up to date glucose readings are entered as specific data elements is critical. • Include / validate appropriate Diabetes diagnosis ICD code(s) • Include associated visit and diagnosis dates

Data Sources to Optimize Data Capture and Performance

External Sources

Qualified Health Information Organization (QHIO)

Most QHIOs collect Care Summaries from primary care providers that contain information such as HbA1c, Blood Pressure and diagnoses.

You can do a manual search in a QHIO to see if your patients have been seen in another care setting where their blood pressure is being monitored and/or a Hypertension diagnosis is indicated.

General Guidelines for Data Capture: COL, BCS, CCS

Where in the Clinical Process	What to Capture / Validate
Patient Intake / Registration	• Collect specific demographic data fields (race/ethnicity, gender, etc.) as well as information such as preferred language • Ensure / confirm Date of Birth • Confirm patient provider organization (PO) “enrollment” and attribution with Health Plan • Confirm and document payer/plan/product coverage
At time of visit	• Review prior lab results and procedure codes to determine whether allowable services were completed within timeframes indicated by this measure and for the age of the patient. ○ If not using an EHR, Include structured data field to indicate whether patient is eligible for this measure based on completion of measurement requirements. This could be a binary Y/N or checkmark field or a more nuanced ‘drop down’ menu field with F/U plans • If screening not confirmed, order appropriate test from within EHR so results will be automatically delivered when complete. • Include associated visit date

Discussion

- Which of these measures has been the most challenging to meet in your practice, and why?
- Have you identified any successful strategies for improving compliance with these measures? If so, what has worked well?
- What data gaps or missing data are you experiencing?
- What external data sources (outside of EMR) are you receiving for these measures?
- Is your EMR optimized to capture these measures? What changes have you made?
- How are you monitoring these measures?
- What workflows have you put in place to better capture data or monitor these measures?

Adults with Preventive Care Needs Breakout

What are the KPIs?

Measure and HEDIS® Abbreviation	Description
Controlling High Blood Pressure (CBP)	Percentage of patients, aged18 to 85 yrs, with hypertension whose blood pressure was adequately controlled (<140/90 mm Hg)
Glycemic Status Assessment for Patients with DM >9% (GSD)	Percentage of 18- to 75-year-old people with diabetes whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was not under control (>9.0%) .
Depression Screening and Follow-Up for Adolescents and Adults (DSF)	Percentage of people aged 12 and older who were screened for depression using a standard screening tool and, if positive, received follow-up care within 30 days.

Controlling Blood Pressure (CBP)

Percentage of 18- to 85-year-old people with hypertension whose blood pressure was adequately controlled (<140/90 mm Hg)

Measure	Pregnant	Adult Chronic	Adult Preventive	Children/ Youth	Behavioral
Controlling High Blood Pressure		X			

Controlling High Blood Pressure (CBP)

Denominator

18- to 85-year-old people with hypertension as of the end of the measurement period.

Numerator

Those in the denominator whose most recent BP reading was adequately controlled (<140/90 mm Hg). Controlled BP reading must occur on or after the date of the second HTN diagnosis.

Blood pressure is not adequately controlled if:

- Systolic blood pressure is >140 mm Hg
- Diastolic blood pressure is >90 mm Hg
- No blood pressure is recorded
- Either the systolic or diastolic value is missing

Documentation must include:

- Two diagnoses of HTN
- Most recent systolic BP is <140mm Hg AND diastolic BP is <90 mm Hg.
- If multiple BP measurements occur on the same date or noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. BP can be taken by any staff member or the PCP.
- Patient documented BP in the chart counts if patient used a digital device.

Controlling Blood Pressure - Strategies for Improving Performance

Strategies to Improve HEDIS Measure for Controlling Blood Pressure

Optimizing Blood Pressure Measurement & Documentation

- Ensure Proper BP Measurement Techniques: Train staff on using correct cuff sizes, patient positioning, and rest periods before measurement. The American Heart Association recommends two readings, one minute apart.
- Standardize BP Workflow in the EHR: Implement a structured process for BP measurement and repeat checks when readings are high. Use BP alerts, templates, or smart phrases to improve documentation accuracy.
- Leverage Standing Orders & Protocols: Enable medical assistants or nurses to take repeat BP readings if the first is high before the patient sees the provider.

Identifying & Managing Undiagnosed Hypertensive Patients

- Use EHR Data to Find At-Risk Patients: Run reports to identify patients with multiple elevated BP readings who lack a hypertension diagnosis. Flag them for provider review.
- Follow Up on Elevated Readings: Create outreach workflows to follow up on patients with high BP readings in past visits who weren't diagnosed or treated.
- Engage High-Risk Patients in Monitoring Programs: Provide home BP monitors and track readings via patient portals or remote monitoring programs.

Improve BP Control & Patient Engagement

- Start BP Treatment Early & Adjust Quickly: Encourage providers to follow clinical guidelines for medication adjustments when BP remains uncontrolled.
- Use Team-Based Care: Engage nurses, care coordinators, or community health workers in BP coaching, medication adherence, and lifestyle modifications.
- Improve Medication Adherence: Use 90-day prescriptions, mail-order pharmacies, and medication synchronization to reduce missed doses.
- Leverage Technology for Follow-Ups: Use text reminders, patient portals, or calls to track BP readings and medication adherence.

Glycemic Status Assessment for Patients with DM >9% (GSD)

The percentage of patients18–75 years of age with diabetes whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was not under control (>9.0%) .

Measure	Pregnant	Adult Chronic	Adult Preventive	Children/ Youth	Behavioral
Glycemic Status Assessment for Patients With Diabetes Poor Control (> 9%)		X			

Glycemic Status Assessment for Patients with DM >9% (GSD)

This is an inverse measure, meaning that a lower rate indicates higher performance

Denominator

18- to 75-year-old people with diabetes as of the end of the measurement period.

Numerator

Those in the denominator whose most recent glycemic status assessment (HbA1c or GMI), taken during the measurement period and after the diagnosis, was:

- Inadequately controlled (>9%)
- Missing a result (i.e., there is a date the test was conducted with no result).
- Glycemic status assessment was not done during the measurement period.
- If there are multiple glycemic status assessments on the same date, use the lowest result.

Documentation in medical record or lab result must include a note indicating the date when the glycemic assessment was performed and result or finding during the measurement year

Glycemic Status Assessment for Patients with DM >9% (GSD)

Strategies to Improve HEDIS Measure for Glycemic Status Assessment for Patients with DM >9%

Workflow Optimization for Timely A1c Testing & Follow-up

- Standing Orders for A1c Testing: Empower MAs and nurses to order A1c tests per protocol to reduce missed opportunities.
- Point-of-Care A1c Testing: Implement in-clinic A1c testing to reduce no-shows for lab work and allow real-time treatment adjustments.
- Pre-Visit Planning: Use morning huddles to flag high-risk diabetes patients due for testing or medication changes.
- Embedded Best Practices in EHR:
  - Alerts for overdue A1c tests.
  - Automated risk stratification (e.g., flag patients with last A1c >9%).
  - Standardized templates for diabetes visits that prompt providers to escalate treatment if A1c remains high.

Treatment Intensification & Medication Adherence

- Standardized Treatment Protocols: Ensure practices follow ADA guidelines for stepped therapy based on A1c levels.
- Care Manager Interventions:
  - Medication reconciliation to address polypharmacy and non-adherence.
  - Direct outreach for patients missing refills (via pharmacy data or payer claims).

Glycemic Status Assessment for Patients with DM >9% (GSD)

Strategies to Improve HEDIS Measure for DM >9%

Addressing Social Determinants of Health (SDOH)

- Screen for Barriers in Every Visit: Use brief SDOH screening tools to assess food insecurity, transportation barriers, and health literacy.
- Partnerships with Community Resources:
  - Link patients to community health workers.
  - Collaborate with local food pantries or ride-share programs.

Patient Engagement & Self-Management

- Group Visits & Diabetes Self-Management Programs:
  - Offer virtual or in-person diabetes education with dieticians or care coordinators.
  - Use billable diabetes education codes.
- Text Message, Reminders: Automated reminders for A1c tests and medication refills improve adherence.
- Remote Patient Monitoring (RPM): For high-risk patients, provide connected glucometers with real-time monitoring and coaching.

Pay-for-Performance & Provider Incentives

- Tie Performance to Value-Based Payments: Use payer incentives or shared savings models to drive provider engagement.
- Provider Scorecards & Dashboards: Show A1c control rates by provider and compare against practice benchmarks.

Glycemic Status Assessment for Patients with DM >9% (GSD)

Strategies to Improve HEDIS Measure for Glycemic Status Assessment for Patients with DM >9%

Key Continuous Glucose Monitoring Tips

Identify high-risk patients for CGM use

- Prioritize **patients with persistently high A1c (>9%)** who may struggle with self-monitoring or medication adherence.
- Use **EHR reports** to flag uncontrolled diabetics for CGM eligibility.

Leverage Time-in-Range (TIR) for better monitoring

- A1c is a 2–3-month average, but **CGM's Time-in-Range (TIR)** gives **daily** feedback on glucose trends.
- A TIR goal of **>70% (70-180 mg/dL)** is associated with an **A1c of ~7%**, helping to prevent patients from staying in the >9% category.

Adjust treatment faster to prevent persistent high A1c

- CGM alerts can **trigger medication adjustments** between A1c tests, reducing sustained hyperglycemia.
- Providers can use **CGM data instead of waiting 3 months for A1c trends.**

Key Continuous Glucose Monitoring Tips Continued

Enhance patient engagement & self-management

- Educate patients on **using CGM to identify high-carb meals, stress, or missed meds** impacting glucose.
- Reinforce **lifestyle changes in real-time** using CGM trend reports.

Improve HEDIS Performance by Reducing A1c >9% Rates

- Patients who lower A1c <9% move out of the "poor control" category, **improving HEDIS scores.**
- Regular CGM check-ins **support care plans that keep A1c below 9% consistently.**

Adults with Chronic Care Needs Breakout

What are the KPIs for Adults with Preventive Care Needs?

Measure and HEDIS® Abbreviation	Description
Colorectal Cancer Screening (COL)	The percentage of patients 45-75 years of age who had an appropriate screening for colorectal cancer.
Breast Cancer Screening (BCS)	Percentage of people 50 to 74 years of age who had at least one mammogram to screen for breast cancer in the past two years.
Cervical Cancer Screening (CCS)	The percentage of women 21-64 years of age who were screened for cervical cancer

Colorectal Cancer Screening (COL)

Percentage of 45- to 75-year-old people who were screened for colorectal cancer at the recommended interval.

Measure	Pregnant	Adult Chronic	Adult Preventive	Children /Youth	Behavioral
Colorectal Cancer Screening			X		

Colorectal Cancer Screening (COL)

Numerator

People 45–75 years as of the end of the measurement period.

Denominator

Those in the denominator who had one or more screenings for colorectal cancer including date and result:

- Fecal occult blood test (within the year)
- Stool DNA (sDNA) with FIT test (within past three years)
- Flexible sigmoidoscopy (within past five years)
- CT colonography (within past five years)
- Colonoscopy (within the past 10 years)

Documentation must include:

Need date and type of colorectal cancer screening(s) performed. A result is not required if the documentation is clearly part of the "medical history" section of the medical record. If it is not clear, results or findings need to be provided to show screening was performed and not just ordered. Forms of documentation accepted:

- Member-reported colorectal cancer screening documented in the medical history (e.g., member reports normal colonoscopy in 2015)
- Pathology report indicating the type of screening and screening date
- FOBT, depending on the number of samples and type of test: guaiac (gFOBT) or immunochemical (FIT)

Refer to Plan specifications for details.

Colorectal Cancer Screening (COL) - Strategies for Improving Performance

Awareness or understanding of screening importance

Educate & Normalize Screening: Use simple, culturally relevant messaging through phone calls, texts, and printed materials to emphasize non-invasive options like FIT/FOBT.

Fear or discomfort with colonoscopy

Offer At-Home Test Kits (FIT/FOBT): Provide kits during office visits or mail to patients with clear instructions and return envelopes.

Transportation or financial challenges

Leverage Community Resources: Partner with organizations to provide transportation, financial assistance, or navigation support for colonoscopy referrals.

Language and literacy barriers

Use Bilingual and Low-Literacy Materials: Ensure patient outreach materials are available in multiple languages

Colorectal Cancer Screening (COL) - Strategies for Improving Performance

Standardized workflows for recommending screenings

- Standing Orders & Pre-Visit Planning: Implement standing orders for FIT/FOBT; ensure staff flag patients due for screening before their visit.
- Team-Based Approach: Train MAs and nurses to discuss screening options and distribute kits, reducing the burden on providers.
- Leverage EHR Alerts: Set up best-practice alerts (BPAs) to remind providers when a patient is overdue for screening

Data visibility and tracking

- Optimize EHR Reports & Dashboards: Ensure practices have a way to track screening rates and identify patients due for outreach.
- Automate Reminders for Patients: Implement text, call, or patient portal reminders to return FIT/FOBT kits or schedule a colonoscopy.

Optimize FIT/FOBT return rates

Follow Up on FIT/FOBT Non-Returns – Assign a staff member to call patients who haven't returned kits within two weeks.

Documentation and coding

Train staff on proper coding to ensure screenings are captured correctly.

Breast Cancer Screening (BCS)

Percentage of people 50 to 74 years of age who had at least one mammogram to screen for breast cancer in the past two years.

Measure	Pregnant	Adult Chronic	Adult Preventive	Children/ Youth	Behavioral
Breast Cancer Screening			X		

Breast Cancer Screening (BCS)

Numerator

Those in the denominator who had one or more mammograms any time in the 27 months prior to, and including the last day of, the measurement period.

Denominator

The percentage of patients 52–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.

Documentation indicating a mammogram was completed and the date it was performed.

- Patient reported mammogram is acceptable. Document date in the history or preventive service section of the medical record.
- If the exact date of the last mammogram is unclear, do not use terms like “approximate” or “about” in your documentation. Instead, record the month and year, or just the year.

Breast Cancer Screening (BCS) - Strategies for Improving Performance

Address Awareness & Misinformation	• Use patient-friendly materials in multiple languages explaining the importance of mammograms. • Train staff to discuss screening benefits in culturally appropriate ways. • Share survivor stories in newsletters or social media to encourage screening.
Improve Access & Reduce Appointment Barriers	• Mobile mammography: Partner with payers, hospitals or mobile units to bring screening to the community. • Weekend/evening screenings: Offer flexible hours at partner radiology centers. • Walk-in or same-day scheduling: Coordinate with radiology centers for expedited appointments. • Transportation assistance: Provide rides through community partnerships, health plans, or Uber Health.
Reduce Fear & Anxiety	• Offer “mammogram walkthrough” videos to show the process and alleviate fears. • Have female staff address concerns about discomfort or radiation exposure. • Use a trusted CHW or patient navigator for outreach and support

Breast Cancer Screening (BCS) - Strategies for Improving Performance

Provider & Staff Strategies

Embed Screening in Routine Visits	• Standing orders for MAs to schedule mammograms during office visits. • Use Well-Woman Visits and Annual Wellness Visits (AWVs) as triggers to order mammograms.
Improve Provider Buy-in & Communication	• Share provider-level HEDIS performance data to create friendly competition. • Implement a reminder system (EHR pop-ups) for PCPs to discuss screenings at visits. • Use scripts for front desk staff & MAs: “You’re due for a mammogram—let’s schedule that now.”
Address Specialist & Radiology Gaps	• Ensure preferred imaging centers have fast appointment availability for patients. • Work with payers and IPAs to expand in-network radiology centers near patient homes.

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Breast Cancer Screening (BCS) - Strategies for Improving Performance

Workflow & Data Improvement

Optimize EHR & Data Capture	• Use HEDIS gap reports from payers and supplement with EHR lists for outreach. • Train staff on correct documentation and mapping CPT codes for screenings. • Implement automated reminders (texts, calls, portal alerts) for overdue screenings.
Implement Outreach & Follow-Ups	• Pre-visit planning: Call patients before visits and offer mammogram scheduling. • Post-visit tracking: Assign staff to follow up with patients who missed screenings. • Leverage payers: Many health plans offer member incentive programs (gift cards, wellness points).
Close Gaps with Alternative Data Sources	• Accept claims from outside screenings (e.g., patients who got mammograms elsewhere). • Use payer portals to check for completed mammograms not in EHR. • Work with radiology partners to get monthly screening completion reports.

Breast Cancer Screening (BCS) - Strategies for Improving Performance

Payer Specific Strategies

- Ensure dual-eligible and Medicaid patients receive no-cost screenings (verify coverage).
- Medicare AWVs: Incorporate mammogram discussions into every AWV visit.
- Use CHWs or case managers for outreach & navigation

Cervical Cancer Screening (CCS)

The percentage of patients 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer.

Measure	Pregnant	Adult Chronic	Adult Preventive	Children/ Youth	Behavioral
Cervical Cancer Screening			X		

Cervical Cancer Screening (CCS)

Denominator

People 21–64 years of age by the end of the measurement period who were recommended for routine cervical cancer screening.

Numerator

Those in the denominator who had one or more screenings for cervical cancer, including date and result:

- Members 21–64 years of age by the end of the measurement period who had cervical cytology performed within the last 3 years
- Members 30–64 years of age by the end of the measurement period who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Members 30–64 years of age by the end of the measurement period who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology was performed
- Lab result or findings

Note: Do not count biopsies because they are diagnostic and therapeutic only and are not for primary cervical cancer screening. Evidence of hrHPV testing within the last 5 years also captures patients who had co-testing.

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Data Sources to Optimize Data Capture and Performance

External Sources: Particularly for colorectal screenings which can span many years, it can be helpful to utilize external sources to find past services.

Qualified Health Information Organization (QHIO)

Most QHIOs have been collecting data from participant organizations for a decade or more. Therefore, if a patient was seen in a setting other than your clinic and received a screening for any of these measures, indication of the date, location and type of screening can be easily found by manually querying using the QHIO portal. Furthermore, most QHIOs allow you to download a PDF of the encounter which can sometimes be ingested into your EHR in an "external" or "foreign" documentation repository.

CommonWell / Carequality

Some EHRs have an integration with Carequality or CommonWell enabling you to search practices in your area to see if your patient was seen there and, if so, view the Care Summary from the practice. Sometimes these care summaries contain results from labs and other procedures which can help you to close this measure when the patient sought care outside of your practice.

Cervical Cancer Screening (CCS)

Strategies for Improving CCS HEDIS Performance

Patient Outreach & Engagement

- Proactive Patient Communication
  - Use automated calls, texts, and patient portal messages to remind eligible patients about screenings.
  - Send letters or postcards to patients who haven't completed screening.
  - Train front desk staff to mention cervical cancer screening during check-ins for unrelated visits.
- Address Patient Barriers
  - Educate patients on the importance of screening through culturally appropriate materials.
  - Offer flexible scheduling, including evening and weekend hours.
  - Implement standing orders for medical assistants to initiate screening discussions during visits.
- Leverage Community Partnerships: Partner with local organizations, churches, and community groups to educate and encourage screenings.

Provider & Staff Engagement

- Standing Orders & Workflow Optimization
  - Allow nurses and medical assistants to place screening orders based on protocols.
  - Develop scripts for MAs and front desk staff to discuss screening importance.
- Provider Alerts & Reminders
  - Set up EHR prompts to notify providers when a patient is due or overdue for a screening.
  - Use gap reports in morning huddles to highlight patients needing screening.
- Incentivize Performance
  - Consider provider-level incentives for improved screening rates.
  - Celebrate improvements in screening completion within the team.

Cervical Cancer Screening (CCS) - Strategies for Improving Performance

Proactive Patient Communication

- Use automated calls, texts, and patient portal messages to remind eligible patients about screenings.
- Send letters or postcards to patients who haven't completed their screening.
- Train front desk staff to mention cervical cancer screening during check-ins for unrelated visits.

Address Patient Barriers

- Educate patients on the importance of screening through culturally appropriate materials.
- Offer flexible scheduling, including evening and weekend hours.
- Implement standing orders for medical assistants to initiate screening discussions during visits.

Leverage Community Partners

- Partner with local organizations, churches, and community groups to educate and encourage screenings.

Patient Outreach & Engagement

Cervical Cancer Screening (CCS) - Strategies for Improving Performance

Standing Orders & Workflow Optimization

- Allow nurses and medical assistants to place screening orders based on protocols.
- Develop scripts for MAs and front desk staff to discuss screening importance.

Provider Alerts & Reminders

- Set up EHR prompts to notify providers when a patient is due or overdue for a screening.
- Use gap reports in morning huddles to highlight patients needing screening.

Incentivize Performance

- Consider provider-level incentives for improved screening rates.
- Celebrate improvements in screening completion within the team.

Provider & Staff Engagement

Cervical Cancer Screening (CCS) - Strategies for Improving Performance

Standardized Documentation & Coding

- Ensure correct use of CPT, LOINC, and ICD-10 codes to capture completed screenings.
- Implement structured data fields in the EHR to track screenings efficiently.

Close Data Gaps

- Check payer portals for screenings completed outside your system.
- Use a Qualified Health Information Exchange (QHIO) to retrieve outside screening results.

Optimize Reporting

- Run monthly reports to identify and reach out to patients overdue for screenings.
- Use registries to track screenings and follow up with patients needing care.

EHR Optimization & Data Accuracy

Cervical Cancer Screening (CCS) - Strategies for Improving Performance

Self-Sampling for HPV Testing

- Consider offering at-home HPV test kits for patients reluctant to come in.
- Partner with labs that support self-sampling and ensure proper follow-up.

Co-Testing Opportunities

- Perform screenings during other preventive visits, like annual wellness exams.
- If a patient refuses a Pap smear, offer HPV testing as an alternative per guidelines.

Alternative Screening Approaches

Children and Youth Breakout

Introductions

Jennifer Sayles, MD, MPH
Pop Health Learning Center

Paul Norton
BluePath

Christina Andersen
BluePath

Rachel Willard-Grace
UCSF Center for Excellence in Primary Care

Jess Liu, MPH, MS
Pop Health Learning Center

Chat in: Your name, organization, and why your practice selected this PoF

Welcome to the Children & Youth Measure Breakout

Please type your **name, role, and organization** in the **chat** along with 1 thing you want to learn today

What are the EPT KPIs for Children and Youth?

Measure and HEDIS® Abbreviation	Description
Child Immunization Status (CIS) – Combo 10	Percentage of two-year-old children who have received the 10 recommended vaccines.
Well Child Visits in First 30 Months of Life (W30)	Percentage of children who have had six or more well child visits in their first 15 months of life, and two or more well child visits between 15 and 30 months of life.
Child and Adolescent Well-Care Visits (WCV)	Percentage of patients 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Childhood Immunization Status - Combo 10

How familiar are you with this measure?

Please enter a **1, 2 or 3 in the Chat** to best characterizes your experience with Combo 10

1. I am so sick of this measure. I can tell you our last years rate from memory. I can tell you all the things we have tried to improve it.
2. We track this measure. We are looking to learn more about it. We are just starting to tackle improving our rate.
3. I know this measure. It hasn't been a focus for our practice.

Child Immunization Status – Combo 10

Denominator

Children who turned 2 during the measurement year.

Numerator

Those in the denominator who have received the 10 recommended vaccines:

- 4 DTAP (diphtheria, tetanus, acellular pertussis)
- 3 IPV (polio)
- 1 MMR (measles, mumps, rubella)
- 3 HIB (haemophilus influenza type B)
- 3 HEP B (hepatitis B)
- 1 VZV (chicken pox)
- 4 PCV (pneumococcal conjugate)
- 1 HEP A (hepatitis A)
- 2 or 3 RV (rotavirus—2 Rotarix; 3 Rota Teq)
- 2 Influenza (flu)

Evidence obtained from the medical record counts where the antigen was rendered from one of the following:

A note indicating the name of the specific antigen and the date of the immunization

A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered

If an immunization is not given, documentation for that immunization must include:

- Allergic reaction to the vaccine or other contraindication
- History of illness (measles, mumps, rubella, chicken pox, hepatitis A, hepatitis B)

Parent refusal does not meet compliance for any vaccines.

Discussion: Data Challenges with Combo10

What are the biggest pain points you have with DATA related to this measure?

- What data gaps or missing data are you experiencing?
- What external data sources (outside of EMR) are you receiving for this measure?
- Is your EMR optimized to capture this measure? What changes have you made?
- How are you monitoring this measure?
- What workflows have you put in place to better capture data or monitor this measure?

Child Immunization Status – Combo 10 - Strategies for Improving Performance

Optimize Data Capture & Reporting

- For EHR-integrated practices: Ensure the immunization module is correctly mapping to the registry and HEDIS data extracts. Some EHRs may require customization to pull Combo 10 data accurately.
- For manually tracking practices: Encourage consistent and complete documentation in the chart, and ensure vaccines administered elsewhere (e.g., pharmacies, health departments) are documented.
- Conduct regular data audits to identify missing or incorrectly documented vaccines. Check against CAIR for accuracy.

Implement Standing Orders & Workflow Support

- Recommend standing orders for immunizations so that nurses and MAs can administer vaccines without direct provider approval each time. This reduces missed opportunities.
- Leverage every visit for vaccination, even if the patient is seen for a sick visit. Provide a protocol for screening and offering catch-up vaccines.
- If standing orders are not in place, work with providers to develop a streamlined process for approving immunizations during visits.

Well Child Visit in First 30 month of Life (W30)

How familiar are you with this measure?

Please enter a 1, 2 or 3 in the Chat now that best characterizes your experience with W30

1. We focus on this measure. I can tell you our last years rate from memory. I can tell you all the things we have tried to improve it.
2. We track this measure. We are looking to learn more about it. We are just starting to work on improving our rate.
3. I know this measure. It hasn't been a focus for our practice.

Well Child Visits in the First 15 Months of Life (W30)

Denominator

Children who turned 15 months old during the measurement year

Numerator

Those in the denominator who had at least 6 well child visits in the last 15 months.

Does not include telehealth visits, or sick visits (unless converted to well).

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Components of a well child visit:

- Health history
- Physical exam
- Assessment of physical development
- Assessment of mental development
- Anticipatory guidance related to preventive health

Well Child Visits between 15 and 30 Months of Life (W30)

Denominator

Children who turned 30 months old during the measurement year

Numerator

Those in the denominator who had at least 2 well child visits in the last 15 months.

Does not include telehealth visits, or sick visits (unless converted to well)

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Components of a well child visit:

- Health history
- Physical exam
- Assessment of physical development
- Assessment of mental development
- Anticipatory guidance related to preventive health

Discussion: Data Challenges with W30

What are the biggest challenges you have with DATA related to this measure? Is one part (0-15mo or 15-30mo) more difficult?

- What data gaps or missing data are you experiencing?
- What external data sources (outside of EMR) are you receiving for this measure?
- Is your EMR optimized to capture this measure? What changes have you made?
- How are you monitoring this measure?
- What workflows have you put in place to better capture data or monitor this measure?

Well Child Visits between 0 and 30 Months of Life (W30) -

Strategies for Improving Performance

Billing & Documentation Education	• HEDIS-Compliant Coding: Ensure practices are using the correct CPT and ICD-10 codes for Well-Child Visits and that the encounter meets all numerator criteria. • Billing & EHR Optimization: Teach billers and providers to properly link well-child services in claims submission.
Data & Reporting (If Available)	• Run Missed Visit Reports: Encourage practices to use their EHR or billing system to identify children overdue for visits and conduct targeted outreach. • Monitor Denials & Rejections: Ensure claims aren't being incorrectly denied due to documentation errors.

Peer Sharing – Redwood Learning Community

Staff Scheduling Guidelines

PEDIATRIC WELL CHILD CHECK SCHEDULING GUIDELINES

WCC:	SCHEDULE WHEN CHILD IS:
NEWBORN	
3-5 DAYS	3d-5d
1 MO WCC	14d-30d
2 MO WCC	1mo-3mo 31d
4 MO WCC	4mo-5mo 31d
6 MO WCC	6mo-8mo 31d
9 MO WCC	9mo-11mo 31d
12 MO WCC	12mo-14mo 31d
15 MO WCC	15mo-17mo 31d
18 MO WCC	18mo-22mo 31d
2 YEAR/24 MO WCC	23mo-2yr 4mo
2.5 YEAR/30 MO WCC	2yr 5mo-2yr 10mo
3 YR WCC	2yr 11mo – 3yr 10mo
4 YR WCC	3yr 11mo-4yr 10mo
5 YR WCC	4yr 11mo-5yr 6mo
5.5YR-20YR WCC	**See below**

* **Kids 5.5yrs-21yrs**: Well Child Check should be done based on their age and provider's discretion. There should be a minimum interval of 6 months between WCC's for any patient over 2 years old.

- Guideline: Any child 5.5 years or older, can be seen **up to 4 months before their birthday** to have the WCC done that corresponds with the **age they will be at that birthday**.

  Example: A child seen at age 6 yrs 9 months **could** have a 7 year WCC. Which WCC is completed is at the provider's discretion.

** **Kindergarten visit** has to be done when child is 4 yrs 3 months or older

- WCC is scheduled when a "Sports Physical", "School Physical" or "Izzy update" are requested.

Care Team should discuss at huddle which WCC to be done in appointment and note in appointment's General Notes to assist the front desk in giving patient the correct paperwork.

Child and Adolescent Well Care Visits (WCV)

How familiar are you with this measure?

Please enter a 1, 2 or 3 in the Chat now that best characterizes your experience with WCV

1. We focus on this measure. I can tell you our last years rate from memory. I can tell you all the things we have tried to improve it.
2. We track this measure. We are looking to learn more about it. We are just starting to work on improving our rate.
3. I know this measure. It hasn't been a focus for our practice.

Well Child Visits (WCV)

Denominator (reported by age group)

Children who are 3 to 21 years of age at the end of the measurement period

Numerator (reported by age group)

Those in the denominator who had at least one well visit with a primary care practitioner or an OB/GYN practitioner during the measurement year

The well-child visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the child.

Components of a well child visit:

- Health history
- Physical exam
- Assessment of physical development
- Assessment of mental development
- Anticipatory guidance related to preventive health

Preventive services may be rendered on visits other than WCVs. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, such as OB/GYN visits, but services that are specific to an acute or chronic condition do not count toward the measure.

Discussion: Data Challenges with WCV

What are the biggest challenges you have with DATA related to this measure?

- What data gaps or missing data are you experiencing?
- What external data sources (outside of EMR) are you receiving for this measure?
- Is your EMR optimized to capture this measure? What changes have you made?
- How are you monitoring this measure?
- What workflows have you put in place to better capture data or monitor this measure?

Data Sources to Optimize Data Capture for WCV

Within Your EHR:

- **Well-Child Visit Tracking:** Many EHR systems have dedicated sections or modules for tracking well-child visits. Look for a specific tab or menu option related to "well-child care," "preventive care," or "developmental screenings."
- **Templates:** Some EHR systems utilize age-specific templates for well-child visits. Ensure that your templates contain the required components to close this measure.
- **Encounter Codes:** Utilize the EHR's search or reporting functions to locate encounters based on the specific WCV codes (e.g., "well-child visit," "developmental screening," or "immunization").

External Sources:

- **Health Information Exchange (HIE)*:** Since a visit by any PCP can count toward this measure, you can do a manual search in an HIE that serves your area to see whether the child was seen at another location and received this service during the measurement year.
- **Carequality / CommonWell:** Some EHRs have an integration with Carequality or CommonWell enabling you to search practices in your area to see if your patient was seen there and, if so, view the Care Summary from the practice.

*Includes QHIO

Data Sources to Optimize Data Capture and Performance

- Immunization Registries*:
  - CAIR2:
    - a web-based portal to look up immunization history by patient
    - automated query and retrieval of immunization history directly into your EHR
    - reminder/recall reporting feature which can be used to generate a list of patients for this measure that are overdue for vaccinations.
  - RIDE/Healthy Futures: For practices in Alpine, Amador, Calaveras, Mariposa, Merced, San Joaquin, Stanislaus, and Tuolumne counties
    - a web-based portal to look up immunization history by patient
    - Ability to run HEDIS reports and list of patients due for immunizations based on ACIP guidelines
- EHR Diagnosis Reporting: Run reports on patients < 2 years old who have exclusion DX codes
- Health Information Exchanges (HIE): Some HIEs may also be connected to the immunization registries and have a consolidated list of immunizations and/or DX information available via their portals.

* As of 1/1/2023 all California providers are required to enter immunizations they administer as well as Race and Ethnicity into an immunization registry.

Well Child Visits (WCV)

Definition: Percentage of patients 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Measure	Pregnant	Adult Chronic	Adult Preventive	Children/ Youth	Behavioral
1 well child visit between 3 and 21 years of age: 3-11yo				x	
1 well child visit between 3 and 21 years of age: 12-17yo				x	
1 well child visit between 3 and 21 years of age: 18-21yo				x	
1 well child visit between 3 and 21 years of age: Total				x	

Child Immunization Status – Combo 10 - Strategies for Improving Performance

Use Reminder & Recall Systems

- Automated reminders: For EHR-based practices, set up automated calls, texts, or portal messages reminding parents about upcoming or overdue vaccines.
- Manual outreach: For practices without automation, front desk staff can generate call lists for outreach.
- Use CAIR to run recall reports and contact families with overdue vaccines.

Improve Parental Engagement & Education

- Train staff on how to address vaccine hesitancy with culturally competent, evidence-based communication.
- Offer education materials at well-child visits explaining the importance of completing all vaccines by age 2.
- Use provider endorsements—parents are more likely to vaccinate when the provider strongly recommends it.

Leverage Community Partnerships & External Resources

- Work with WIC programs, childcare centers, and local health departments to reinforce immunization messaging.
- Identify alternate vaccine locations (pharmacies, public health clinics) and ensure proper documentation of vaccines given outside the practice.

Strategies for Improving Performance - Child Measures

Where in the Clinical Process	**Strategies and Best Practices** (for many)
Patient Engagement	• Train staff on vaccine hesitancy using culturally competent, evidence-based communication. • Use provider-led encouragement, as strong provider recommendations increase vaccine uptake. • Pre-visit planning: Identify patients due for WCVs or vaccines during other visits and schedule accordingly.
Scheduling	• Offer evening/weekend hours to accommodate working families. • Allow walk-in or same-day appointments to reduce missed visits due to scheduling conflicts. • Schedule future well-child visits before families leave the clinic.
At Time of Visit	• Implement standing orders to allow nurses and MAs to administer vaccines without provider approval. • Use EHR alerts to flag overdue Well-Child Visits (WCVs) and vaccines at check-in. • Encourage bundled appointments, scheduling WCVs alongside other services like immunizations and screenings.
Community Partnerships	• Collaborate with WIC programs, childcare centers, Head Start, and local health departments to reinforce immunization messaging. • Identify and document vaccines administered at pharmacies and public health clinics. • Engage CHWs to reach high-risk families.

General Guidelines for Data Capture – Child Measures

Where in the Clinical Process	What to Capture / Validate
Patient Intake / Registration	• Collect and verify race/ethnicity, gender, preferred language, and DOB for accurate patient identification. • Confirm patient provider organization enrollment and attribution with the health plan. • Ensure payer/plan/product coverage is correctly documented.
At Time of Visit	• Use EHR templates that include all required components for well-child care and preventive visits. • Ensure vaccines are properly coded with CPT codes and recorded in discrete EHR fields (not just notes).
Immunization Registries & Tracking	• CAIR2 & RIDE/Healthy Futures: Use web-based portals to retrieve immunization history, generate recall lists, and automate immunization data entry into EHR. • HIE Integration: Check Health Information Exchanges (HIE) for consolidated immunization records and well-child visit documentation.

Well Child Visits between 0 and 30 Months of Life (W30) - Strategies for Improving Performance

Patient Outreach & Engagement

- Automated Reminders: Encourage practices to implement text, call, and email reminders for upcoming and overdue visits. Medi-Cal patients often have high phone turnover, so multiple outreach methods help.
- Front Desk Scripts for Well-Child Scheduling: Train front desk staff to proactively schedule W30 visits whenever parents call for other issues (e.g., sick visits, vaccine questions).
- Provider-Driven Messaging: Ensure providers discuss the importance of Well-Child Visits during all patient interactions, even unrelated visits.

Scheduling & Workflow Adjustments

- Standing Order for Future Appointments: At every completed Well-Child Visit, schedule the next one before the family leaves.
- Expanded Hours: If accessible, evening or weekend slots may increase compliance.
- Walk-In or Same-Day Appointments: Some parents delay visits due to scheduling conflicts—allowing walk-ins helps.

General Guidelines for Data Capture: W30 & WCV

Where in the Clinical Process	What to Capture / Validate
Patient Intake / Registration	• Collect specific demographic data fields (race/ethnicity, gender, etc.) as well as information such as preferred language • Ensure / confirm Date of Birth • Confirm patient provider organization (PO) “enrollment” and attribution with Health Plan • Confirm and document payer/plan/product coverage
At time of visit	• Ensure template being used to record visit has all required segments for the measure • Include appropriate CPT code(s) for administration of "well-child care," "preventive care," or "developmental screenings." • Ensure date of service is appropriately recorded

Well Child Visits (WCV) - Strategies for Improving Performance

Proactive Patient & Family Engagement

- Automated Outreach & Reminders
  - Use text messages, phone calls, and patient portal messages to remind families about WCVs.
  - Implement automated recall systems to schedule visits before the due date.
- Provider-Led Encouragement
  - Train clinicians and staff to educate parents/guardians about the importance of WCVs during sick visits.
  - Have providers give a "personalized nudge" to parents when they come in for other visits.
- School & Community Partnerships
  - Partner with local schools, Head Start programs, and daycare centers to promote WCVs.
  - Work with community health workers (CHWs) to conduct outreach for high-risk or hard-to-reach families.

Scheduling & Workflow Optimization

- Pre-Visit Planning & Bundled Appointments
  - Identify patients due for WCVs during check-in for other visits (e.g., sick visits, vaccine visits, sports physicals).
  - Schedule WCVs at the same time as other necessary services, like vaccinations or behavioral health screenings.
- Flexible & Extended Hours
  - Offer evening or weekend WCV slots for working parents.
  - Implement walk-in or same-day availability for WCVs.
- Standing Orders & EHR Alerts
  - Use standing orders to allow nurses or MAs to schedule WCVs proactively.
  - Set up EHR alerts to flag patients due for WCVs when they check in for other services.

Well Child Visits (WCV) - Strategies for Improving Performance

Payer Collaboration & Quality Improvement Initiatives

- Data Sharing & Gaps in Care Reports
  - Leverage payer-provided member lists to conduct targeted outreach.
  - Work with payers to obtain "gaps in care" lists and integrate them into scheduling workflows.
  - Use claims and encounter data reconciliation to ensure all completed WCVs are accurately captured.
- Incentives & Patient Engagement
  - Advocate for patient incentives (e.g., gift cards, diapers, transportation support).
  - Promote incentive opportunities for providers based on improved WCV rates.

Data Tracking & Performance Monitoring

- Regular Internal Reporting
  - Track WCV completion rates by provider, age group, and payer to identify trends.
  - Use EHR reports or population health tools to monitor outreach effectiveness.
- Chart Audits & Documentation Reviews
  - Conduct periodic audits to ensure WCV components are correctly documented to meet HEDIS specifications.
  - Train providers on proper CPT codes and visit documentation to avoid missed encounters in HEDIS reporting.

Pregnant People and Adults with Behavioral Health Needs Breakout

Welcome & Introductions

Tammy Fisher, MPH
Chief Program Officer

Meg Elliot
Trainer

Toria Thompson
Advisor

Jeff Nguyen, MHA
Sr. Director, Physician Services

Let's get to know each other!
Chat in: Your name, organization, your PoF and why your practice selected this PoF

pop health LEARNING CENTER

What are the KPIs?

Pregnant People

Measure and HEDIS® Abbreviation	Description
Prenatal and Postpartum Care (PPC) - Postpartum Care	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
Postpartum Depression Screening and Follow-up (PDS-E)	Percentage of deliveries in which patients were screened for clinical depression using a standardized instrument during the postpartum period and, if positive, received follow-up care within 30 days.

Adults with Behavioral Health Needs

Measure and HEDIS® Abbreviation	Description
Depression Remission or Response for Adolescents and Adults (DRR)	Percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score.
Pharmacotherapy for Opioid Use Disorder (POD)	Percentage of opioid use disorder (OUD) pharmacotherapy treatment events among members age 16 and older that continue for at least 180 days (6 months).

Prenatal Care

How familiar are you with this measure?

Please enter a **1, 2 or 3 in the Chat** to best characterizes your experience with Prenatal Care

1. I am so sick of this measure. I can tell you our last years rate from memory. I can tell you all the things we have tried to improve it.
2. We track this measure. We are looking to learn more about it. We are just starting to tackle improving our rate.
3. I know this measure. It hasn't been a focus for our practice.

Postpartum Care

How familiar are you with this measure?

Please enter a **1, 2 or 3 in the Chat** to best characterizes your experience with Postpartum Care

1. I am so sick of this measure. I can tell you our last years rate from memory. I can tell you all the things we have tried to improve it.
2. We track this measure. We are looking to learn more about it. We are just starting to tackle improving our rate.
3. I know this measure. It hasn't been a focus for our practice.

Timeliness of Prenatal Care

Denominator

Live birth or deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include deliveries that occur in any setting.

Numerator

Those in the denominator who had a prenatal visit with an OB/GYN or other prenatal care provider, or PCP (with a diagnosis of pregnancy) within the required timeframe (first trimester/280–176 days prior to delivery). Prenatal visit must include at least one of the following :

- When documenting a prenatal visit, include diagnosis of pregnancy, last menstrual period or estimated date of delivery
- Basic physical obstetrical examination
- Evidence that a prenatal care procedure was performed.

Include prenatal care such as prenatal risk assessment, complete obstetrical history, fetal heart tone and screening tests.

Postpartum Care

Denominator

Live births or deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include deliveries that occur in any setting.

Numerator

Those in the denominator who have a postpartum visit between 7 and 84 days after delivery, with an OB/GYN or other prenatal care clinician or PCP in an outpatient setting. Postpartum visit must include at least one of the following:

- Pelvic exam.
- Evaluation of breasts, weight, blood pressure and abdomen.
- Notation of breastfeeding, postpartum care, postpartum care check or six-week check.
- Preprinted postpartum care form with information from visit documented.
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders.
- Glucose screening for members with gestational diabetes
- Documentation of infant care or breastfeeding; resumption of intercourse, birth spacing or family planning; sleep/fatigue; resumption of physical activity; and attainment of healthy weight.

Discussion: Data Challenges with Prenatal and Postpartum care

What are the biggest pain points you have with DATA related to this measure?

- What data gaps or missing data are you experiencing?
- What external data sources (outside of EMR) are you receiving for these measures?
- Is your EMR optimized to capture these measures? What changes have you made?
- How are you monitoring these measures?
- What workflows have you put in place to better capture data or monitor these measures?

General Guidelines for Data Capture

Where in the Clinical Process	What to Capture / Validate
Patient Intake / Registration	• Collect demographic data (race/ethnicity, gender, preferred language) to support equity-focused care. • Confirm patient DOB for accurate measure alignment. • Verify health plan attribution and provider organization enrollment to ensure patients are counted under the correct provider.
At time of Visit	• Ensure EHR templates include all necessary fields for measure closure (e.g., assessment scores, ICD/CPT codes, provider type). • Use structured data fields to capture screening outcomes, follow-up plans, and standard assessment values. • Ensure services are linked to appropriate provider types and coded correctly.
Follow-Up & Outcome Tracking	• Document structured follow-up care plans (binary Y/N or dropdown with specific options). • Track prescribed antidepressants and pharmacotherapy for behavioral health measures. • Ensure gestational diabetes screenings and diagnoses are correctly recorded in pregnancy-related care.

General Guidelines for Data Capture: PPC

Where in the Clinical Process	What to Capture / Validate
Patient Intake / Registration	• Collect specific demographic data fields (race/ethnicity, gender, etc.) as well as information such as preferred language • Ensure / confirm Date of Birth • Confirm patient provider organization (PO) “enrollment” and attribution with Health Plan • Confirm date of enrollment since prenatal visit measure keys off this date when member is enrolled during measure year • Confirm and document payer/plan/product coverage
At time of Prenatal Visit	• Ensure template being used to record visit has all documentation options for closing the measure • Ensure provider is either an OB/GYN or other prenatal care clinician OR PCP • Ensure patient has appropriate ICD code(s) indicating pregnancy • Ensure date of service is appropriately recorded
At time of Postpartum Visit	• Ensure template being used to record visit has all documentation options for closing the measure • Ensure provider is either an OB/GYN or other prenatal care clinician OR PCP (in outpatient setting) • If doing a screening, include appropriate CPT code(s) for administration of this assessment • If doing glucose screening, ensure diagnosis for gestational diabetes is recorded • Ensure date of service is appropriately recorded

Data Sources to Optimize Data Capture and Performance

Notification of a Hospital Delivery:

Hospitals are required by federal health and safety standards called Conditions of Participation (CoPs) to electronically send real-time notifications admissions, discharges and transfers to the patient's primary care and other health care team members.

Part of an ADT message includes the patient's diagnosis which, for pregnant people giving birth, will contain an ICD code indicating a birth.

These messages can be electronically received into most EHR systems from hospitals or Health Information Exchanges.

Discussion: What strategies have enhanced your practice's performance in Prenatal and Postpartum care?

What is your practice doing to improve these measures?

- Scheduling and access?
- Patient outreach?
- Reducing disparities?
- Strengthening care coordination?

Strategies for Improving Performance

Where in the Clinical Process	**Strategies and Best Practices** (for many)
Streamline Patient Outreach	• Text, Call, and Portal Reminders: Automated messages for appointment scheduling and follow-ups. • Leverage Health Plans: Collaborate with Medi-Cal managed care coordinators for outreach. • Community Partnerships: Work with WIC, home visiting programs, and mental health organizations for patient referrals.
Improve Scheduling & Access	• Same-Day & Walk-In Appointments and Same-Day Specialist Referrals. • Standing Orders for Postpartum Visits: Schedule postpartum visits before hospital discharge. • Scheduling Alerts in EHR: Require confirmation of follow-up appointments scheduling.
Strengthen Care Coordination	• Case Manager & CHW Support: Assign team members to track high-risk patients and follow up. • Warm Handoffs: Ensure seamless transitions between OB/GYNs, PCPs, and behavioral health providers. • Telehealth Follow-Ups: Offer virtual visits to improve accessibility.

Postpartum Depression Screening and Follow-up (PDS-E)

How familiar are you with this measure?

Please enter a **1, 2 or 3 in the Chat** to best characterizes your experience with Postpartum depression screening and follow-up?

1. I am so sick of this measure. I can tell you our last years rate from memory. I can tell you all the things we have tried to improve it.
2. We track this measure. We are looking to learn more about it. We are just starting to tackle improving our rate.
3. I know this measure. It hasn't been a focus for our practice.

Postpartum Depression Screening

Denominator

Live birth deliveries on or between September 8 of the year prior to the measurement year and September 7 of the measurement year. Include deliveries that occur in any setting.

Numerator

Those in the denominator who had a depression screening result using a standard screening tool for depression, within 7-84 days following delivery:

- Patient Health Questionnaire (PHQ-9, PHQ9M, PHQ-2)
- Beck Depression Inventory (BDI-II) adults only
- Beck Depression Inventory-Fast Screen (BDI-FS)
- Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)
- Edinburgh Postnatal Depression Scale (EPDS)
- PROMIS Depression
- Duke Anxiety-Depression Scale (DUKE-AD) adults only
- Geriatric Depression Scale—Short Form and Long Form (GDS) adults only
- My Mood Monitor (M-3) adults only
- Clinically Useful Depression Outcome Scale (CUDOS) adults only.

Follow-Up on Positive Screen

Denominator

All patients from the Postpartum Depression Screening Numerator (previous slide) with a positive depression result.

Numerator

Those in the denominator who had one of the following within 30 days:

- Outpatient, telephone or e-visit for follow-up for depression/behavioral health
- Depression case management encounter
- Behavioral health encounter (assessment, therapy, collaborative care, medication management)
- A diagnosis of encounter for exercise counseling
- Dispensed antidepressant medication
- Documentation of a negative full-length depression screening on the same day as a positive screen on a brief screening tool (i.e., a negative PHQ-9 as a follow-up to a positive PHQ-2).

Discussion: Data Challenges with Postpartum Depression Screening and Follow-up?

What are the biggest pain points you have with DATA related to this measure?

- What data gaps or missing data are you experiencing?
- What external data sources (outside of EMR) are you receiving for this measure?
- Is your EMR optimized to capture this measure? What changes have you made?
- How are you monitoring this measure?
- What workflows have you put in place to better capture data or monitor this measure?

General Guidelines for Data Capture: POS-E

Where in the Clinical Process	What to Capture / Validate
Patient Intake / Registration	• Collect specific demographic data fields (race/ethnicity, gender, etc.) as well as information such as preferred language • Ensure / confirm Date of Birth • Confirm patient provider organization (PO) “enrollment” and attribution with Health Plan • Confirm and document payer/plan/product coverage
Initial Patient Assessment	• Include structured data field for overall standard assessment value/score • Include associated administration date • Include appropriate depression screening and/or standard assessment CPT code(s)
If positive, follow-up care is discussed with the patient and a plan made for next steps	• Include structured data field for documentation of a completed follow-up plan (this could be a binary Y/N or checkmark field or a more nuanced ‘drop down’ menu field with F/U plans) • Include appropriate depression and/or behavioral health diagnosis ICD code(s) • Include appropriate depression and/or behavioral health CPT code(s)
Follow-Up Care	• Include appropriate depression and/or behavioral health diagnosis ICD code(s) • Include appropriate depression and/or behavioral health CPT code(s) • Include associated date of service • Define/classify antidepressant medications (and others as clinically defined by organization/ practice)

Data Sources to Optimize Data Capture and Performance

Within Your EHR:

Create Custom Fields:

- Most EHR systems capture depression screening results only in unstructured clinical notes which presents challenges for reporting.
- Consider adding a structured data field within your Clinical Encounter/Visit Note to record each depression screening result (no need to record individual question scores)
- Once included as a discrete data element, use your EHRs search and reporting functions to find patients with scores within the ranges needed to report on this measure.

Integrate with Patient Portals:

- Enable patients to complete depression screenings through secure patient portals, increasing accessibility and potentially reducing stigma associated with screening.
- Ensure patient entered results are stored as discrete fields with your EHR for more automated reporting.

Data Sources to Optimize Data Capture and Performance

External Sources

Qualified Health Information Organization (QHIO)

Most QHIOs collect Care Summaries rather than individual assessments and screenings like depression screenings. Therefore, utilizing the portal of a QHIO will only yield results for this measure if depression screening results are contained within Care Summary Notes available within the QHIO.

Behavioral Health Treatment Organizations

- Another source of Depression Screening results are Behavioral Health organizations where your patients may also be receiving services. Since most BH organizations also provide substance use treatment, they typically hold all their records to stricter 42 CFR Part 2 data sharing requirements.
- Therefore, obtaining depression screening results from these organizations would likely require a special consent from the patient. Also, most data aggregators, such as QHIOs, do not have the capability to segment 42 CFR Part 2 data and therefore do not accept Care Summary and other documentation from these facilities.

Discussion: What strategies have enhanced your practice's performance in Postpartum Depression Screening and Follow-up?

What is your practice doing to improve this measure?

- Scheduling and access?
- Screening and response workflows?
- Partnerships with community providers and organizations?
- Patient outreach?
- Reducing disparities?

Postpartum Depression Screening - Strategies for Improving Performance

Screening Not Consistently Conducted During Postpartum Visits	• Embed Screening into Standard Workflow: Set an automatic alert or template in the EHR for postpartum visits (6-week visit) requiring PHQ-9 completion. • Front-Desk/MA Involvement: Have medical assistants (MAs) or nurses administer the PHQ-9 before the provider enters the room. • Use Standing Orders: Allow MAs to conduct screening without provider approval to streamline workflow.
Standardized Documentation	• Ensure PHQ-9 scores are recorded in structured fields, not just in progress notes. • Train providers and staff on correct CPT, ICD-10, and HCPCS codes for both screening (96127) and follow-up interventions. • EHR Smart Forms & Templates: Set up structured data fields to capture screenings and follow-up in a way that maps to HEDIS reporting.
Low Patient Engagement & Follow-Up Completion	• Same-Day Behavioral Health Referral: If depression is identified, schedule a behavioral health visit before the patient leaves the clinic. • Telehealth Follow-Ups: Offer phone or video check-ins to make follow-up more accessible. • Care Coordination Support: Assign a case manager or CHW to follow up with high-risk patients to ensure follow-up is completed. • Warm Handoffs: If the clinic has behavioral health providers, introduce the patient immediately during the visit.

Postpartum Depression Screening - Strategies for Improving Performance

Provider Awareness & Training	• Conduct brief trainings on measure requirements and best practices for postpartum depression management. • Embed guidelines into EHRs to prompt providers on when and how to screen, document, and refer. • Facilitate provider-to-provider learning sessions on handling postpartum depression effectively.
Behavioral Health Integration	• Partner with community mental health providers and ensure warm handoffs are done. • If possible, implement a behavioral health integration model where a psychiatric consultant is available to support primary care providers. • Leverage Medi-Cal managed care plans care coordination support for mental health

Pregnant People Appendix

What are the KPIs for Pregnant People?

Measure and HEDIS® Abbreviation	Description
Prenatal and Postpartum Care (PPC) - Postpartum Care	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
Postpartum Depression Screening and Follow-up (PDS-E)	Percentage of deliveries in which patients were screened for clinical depression using a standardized instrument during the postpartum period and, if positive, received follow-up care within 30 days.

Prenatal and Postpartum Care (PPC)

Percentage of deliveries in which women had a prenatal care visit in the first trimester, and percentage of people with a postpartum visit within seven to 84 days after delivery

Measure	Pregnant	Adult Chronic	Adult Preventive	Children/ Youth	Behavioral
Postpartum Care	x				
Timeliness of Prenatal Care	x				

Postpartum Care

Denominator

Live births or deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include deliveries that occur in any setting.

Numerator

Those in the denominator who have a postpartum visit between 7 and 84 days after delivery, with an OB/GYN or other prenatal care clinician or PCP in an outpatient setting. Postpartum visit must include at least one of the following:

- Pelvic exam.
- Evaluation of breasts, weight, blood pressure and abdomen.
- Notation of breastfeeding, postpartum care, postpartum care check or six-week check.
- Preprinted postpartum care form with information from visit documented.
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders.
- Glucose screening for members with gestational diabetes
- Documentation of infant care or breastfeeding; resumption of intercourse, birth spacing or family planning; sleep/fatigue; resumption of physical activity; and attainment of healthy weight.

Timeliness of Prenatal Care

Denominator

Live birth or deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include deliveries that occur in any setting.

Numerator

Those in the denominator who had a prenatal visit with an OB/GYN or other prenatal care provider, or PCP (with a diagnosis of pregnancy) within the required timeframe (first trimester/280–176 days prior to delivery). Prenatal visit must include at least one of the following :

- When documenting a prenatal visit, include diagnosis of pregnancy, last menstrual period or estimated date of delivery
- Basic physical obstetrical examination
- Evidence that a prenatal care procedure was performed.

Include prenatal care such as prenatal risk assessment, complete obstetrical history, fetal heart tone and screening tests.

Prenatal and Postpartum Care (PPC) - Strategies for Improving Performance

Patient Engagement & Scheduling	• Automate Outreach & Reminders – Implement text, call, and portal reminders for prenatal and postpartum visits. • Same-Day & Walk-In Appointments – Offer walk-in prenatal visits and flexible scheduling, especially for postpartum care, which is often missed. • Leverage Community Health Workers (CHWs) & Case Managers – Assign CHWs or case managers to conduct outreach and track patients who need care. Contact your payer about CHW referrals. • Integrate Scheduling with OB/GYNs & Hospitals – Ensure warm handoffs from hospitals/birth centers to schedule postpartum visits before discharge.
Provider Awareness & Workflow Standardization	• Quick HEDIS Education for Providers – Develop short, simple guides for OB/GYNs, midwives, and PCPs on required visit timeframes and documentation tips. • Prenatal Visit as an EMR Alert – Add a required field in the EHR scheduling system prompting staff to confirm if a prenatal appointment has been scheduled. • Standing Orders for Postpartum Visits – Implement standing orders for postpartum visits at delivery discharge to schedule before the patient leaves the hospital. • Leverage Non-Physician Providers – Train nurses, midwives, and lactation consultants to perform components of postpartum visits to increase compliance.

Prenatal and Postpartum Care (PPC) - Strategies for Improving Performance

Documentation & Coding Accuracy	• Standardized Templates in the EHR – Create a prenatal and postpartum visit template with required fields to ensure proper documentation. • Leverage Z Codes & CPT Codes Correctly – Ensure the right ICD-10 and CPT codes are used • Conduct Regular Chart Audits – Identify gaps in documentation and retrain staff as needed. • Use EHR Smart Phrases or Macros – Standardize documentation with built-in EHR macros or text shortcuts for HEDIS-compliant visit notes.
Health Plan & Community Partnerships to Support Patient Engagement	• Leverage Health Plans for Outreach – Many Medi-Cal managed care plans have care coordinators who can help schedule visits and provide outreach. • Coordinate with WIC Programs & Community Groups – WIC programs often interact with pregnant patients before their first prenatal visit and can encourage early care. • Integrate with Home Visiting Programs – Partner with local Maternal Home Visiting Programs to assist high-risk patients.
Data Tracking & Reporting Improvements - Potential Barrier: Gaps in tracking patients due for visits lead to missed opportunities	• Create a Prenatal/Postpartum Patient Registry – Track patients due for visits using an EHR report or dashboard to identify gaps in care. • Monthly HEDIS Performance Reports – Review clinic-wide PPC measure reports and flag missing patients. • Train Front Desk & Care Coordinators – Ensure staff know which patients should be scheduled when they call for other services.

Postpartum Depression Screening and Follow-Up (PDS-E)

Percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period and, if positive, received follow-up care within 30 days.

Measure	Pregnant	Adult Chronic	Adult Preventive	Children/ Youth	Behavioral
Postpartum Depression Screening	x				
Follow-Up on Positive Screen	x				

Adults with Behavioral Health Needs Breakout

What are the KPIs for Adults with Behavioral Health Needs?

Measure and HEDIS® Abbreviation	Description
Depression Remission or Response for Adolescents and Adults (DRR)	Percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score.
Pharmacotherapy for Opioid Use Disorder (POD)	Percentage of opioid use disorder (OUD) pharmacotherapy treatment events among members age 16 and older that continue for at least 180 days (6 months).

Depression Remission or Response for Adolescents and Adults

How familiar are you with this measure?

Please enter a **1, 2 or 3 in the Chat** to best characterizes your experience with Depression Remission or Response for Adolescents and Adults

1. I am so sick of this measure. I can tell you our last years rate from memory. I can tell you all the things we have tried to improve it.
2. We track this measure. We are looking to learn more about it. We are just starting to tackle improving our rate.
3. I know this measure. It hasn't been a focus for our practice.

Pharmacotherapy for Opioid Use Disorder

How familiar are you with this measure?

Please enter a **1, 2 or 3 in the Chat** to best characterizes your experience with Pharmacotherapy for Opioid Use Disorder

1. I am so sick of this measure. I can tell you our last years rate from memory. I can tell you all the things we have tried to improve it.
2. We track this measure. We are looking to learn more about it. We are just starting to tackle improving our rate.
3. I know this measure. It hasn't been a focus for our practice.

Depression Remission or Response (DRR-E)

Denominator	People 12 years and older with a diagnosis of depression, and an elevated PHQ-9 score, from May 1 of the year prior to the measurement period through December 31 of the measurement period
Follow-Up Numerator	Those in the denominator who had a follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score.
Remission Numerator	Those in the denominator who achieved remission within 4–8 months after the initial elevated PHQ-9 score, as measured by a score of <5 on the most recent PHQ-9 in the response period.
Response Numerator	Those in the denominator who showed response within 4–8 months after the initial elevated PHQ-9 score, as measured by a 50% reduction in the response period from the initial elevated PHQ-9 score.

Discussion: Data Challenges with Depression Remission and Response

What are the biggest pain points you have with DATA related to this measure?

- What data gaps or missing data are you experiencing?
- What external data sources (outside of EMR) are you receiving for these measures?
- Is your EMR optimized to capture these measures? What changes have you made?
- How are you monitoring these measures?
- What workflows have you put in place to better capture data or monitor these measures?

General Guidelines for Data Capture: DRR-E

Where in the Clinical Process	What to Capture / Validate
Patient Intake / Registration	• Collect specific demographic data fields (race/ethnicity, gender, etc.) as well as information such as preferred language • Ensure / confirm Date of Birth • Confirm patient provider organization (PO) “enrollment” and attribution with Health Plan • Confirm and document payer/plan/product coverage
Patient Assessment	• Include structured data field for overall PHQ-9 score • Include associated administration date • Include appropriate depression screening and/or standard assessment CPT code(s)
If positive, follow-up care is discussed with the patient and a plan made for next steps	• Include structured data field for documentation of a completed follow-up plan (this could be a binary Y/N or checkmark field or a more nuanced ‘drop down’ menu field with F/U plans) • Include appropriate depression and/or behavioral health diagnosis ICD code(s) • Include appropriate depression and/or behavioral health CPT code(s)
Follow-Up Care	• Include appropriate depression and/or behavioral health diagnosis ICD code(s) • Include appropriate depression and/or behavioral health CPT code(s) • Include associated date of service • Define/classify antidepressant medications (and others as clinically defined by organization/ practice)

Data Sources to Optimize Data Capture and Performance

Within Your EHR

Create Customer Fields:

- Most EHR systems capture PHQ-9 score only in unstructured clinical notes which presents challenges for reporting.
- Consider adding a structured data field within your Clinical Encounter/Visit Note to record each PHQ-9 total score (no need to record individual question scores)
- Once included as a discrete data element, use your EHRs search and reporting functions to find patients with scores within the ranges needed to report on this measure.

Integrate with Patient Portals:

- Enable patients to complete depression screenings through secure patient portals, increasing accessibility and potentially reducing stigma associated with screening.
- Ensure patient entered results are stored as discrete fields with your EHR for more automated reporting.

External Sources

Qualified Health Information Organization (QHIO)

- Most QHIOs collect Care Summaries rather than individual assessments and screenings like the PHQ-9. Therefore, utilizing the portal of a QHIO will only yield results for this measure if PHQ-9 results are contained within Care Summary Notes available within the QHIO.

Discussion: What strategies have enhanced your practice's performance in depression remission or response?

What is your practice doing to improve this measure?

- Access to care?
- Patient engagement and retention in care?
- Enhancing follow-up and coordination of care?
- Partnerships with community providers and organizations?

DRRE- Strategies for Improving Performance

Optimize Depression Screening & Diagnosis

- Standardize PHQ-9 (adults) and PHQ-9M (adolescents, 12-17).
  - Ensure PHQ-9 are completed at every visit for patients with a prior depression diagnosis
  - Embed PHQ-9 prompts into EHR workflows for primary care, behavioral health, and care management teams.
- Improve Documentation and & Coding Accuracy
  - Use the correct ICD-10 diagnosis codes for major depression to trigger HEDIS measure tracking.
  - Ensure PHQ-9 scores are documented in structured fields (not just notes) for easier reporting.
- Engage Patients in Self-Reporting
  - Provide PHQ-9 surveys via patient portals or pre-visit check-ins to increase response rate.
  - Offer alternative formats (paper, digital, telephone follow-ups) for accessibility.

Enhance Follow-up & Care Coordination

- Develop Systematic Follow-up Processes
  - Implement EHR alerts & care gap reports to flag patients due for follow-up PHQ-9s at 4-8 months.
  - Assign care coordinators or behavioral health specialists to track and engage patients.
- Use Multi-Channel Outreach
  - Use text, email, phone calls, and portal reminders to encourage follow-up appointments and PHQ-9 completion.
  - Work with care managers for high-risk patients needing extra engagement.
- Leverage Collaborative Care Models
  - Strengthen primary care & behavioral health integration through warm hand-offs and shared care plans.

DRRE- Strategies for Improving Performance

Improve Treatment Engagement & Patient Retention	• Personalized Treatment Plans & Shared Decision-Making: Educate patients on depression treatment options (therapy, medication, lifestyle changes).
	• Expand Access to Behavioral Health
	  • Use telehealth visits for follow-ups to increase access, especially for adolescents.
	  • Co-locate behavioral health providers in primary care when possible.
	• Address Social Drivers of Health (SDOH): Screen for barriers (transportation, cost, stigma) and provide community resources & peer support referrals.

Maximize Date Capture & Reporting Accuracy	• EHR Optimization for HEDIS Tracking
	  • Configure EHR templates to auto-populate PHQ-9 scores into structured fields.
	  • Train staff to correctly document PHQ-9 scores, remission (<5), or response (50% reduction).
	• Audit & Close Gaps in Data Reporting
	  • Run monthly reports on depression remission response rates.
	  • Identify patients missing PHQ-9 documentation at follow-up and re-engage them.

Provider & Staff Education	• Offer workflow training to simplify depression management • Behavioral Health Integration Best Practices

Pharmacotherapy for Opioid Use Disorder (POD)

Numerator

People 16 years of age and older with an active diagnosis of Opioid Use Disorder (OUD), between July 1 of the year prior to the measurement year and June 30 of the measurement year.

Denominator

Those in the denominator who had pharmacotherapy for at least 180 days, without a gap in treatment of 8 or more consecutive days.

Opioid Use Disorder Treatment Medications include:

- Naltrexone (oral)
- Naltrexone (injectable)
- Buprenorphine (sublingual tablet)
- Buprenorphine (injection)
- Buprenorphine (implant)
- Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)
- Methadone (oral)

Discussion: Data Challenges with Pharmacotherapy for Opioid Use Disorder

What are the biggest pain points you have with DATA related to this measure?

- What data gaps or missing data are you experiencing?
- What external data sources (outside of EMR) are you receiving for these measures?
- Is your EMR optimized to capture these measures? What changes have you made?
- How are you monitoring these measures?
- What workflows have you put in place to better capture data or monitor these measures?

General Guidelines for Data Capture: POD

Where in the Clinical Process	What to Capture / Validate
Patient Intake / Registration	• Collect specific demographic data fields (race/ethnicity, gender, etc.) as well as information such as preferred language • Ensure / confirm Date of Birth • Confirm patient provider organization (PO) “enrollment” and attribution with Health Plan • Confirm and document payer/plan/product coverage
At time of visit	• Include / validate appropriate OUD diagnosis ICD code(s), if applicable • Validate appropriate OUD medication has been prescribed • Include associated visit and diagnosis dates

Data Sources to Optimize Data Capture and Performance

Within Your EHR:

- This measure relies not only on a specific set of medications being prescribed but also evidence of no more than an 8-day gap in medication adherence.
- Many EHRs have direct connections with SureScripts where actual fill data is available so providers can track whether medications are being filled at regular intervals which would indicate medication adherence.

External Sources:

- If you EHR is not directly connected to SureScripts, or another service that providers pharmacy fill data, some Health Information Exchanges provide this information within their portals.

Discussion: What strategies have enhanced your practice's performance in Pharmacotherapy for Opioid Use Disorder?

What is your practice doing to improve this measure?

- Scheduling and access?
- Medication initiation and continuation?
- Provider and staff training?
- Partnerships with community providers and organizations?
- Patient outreach?
- Reducing disparities?

Pharmacotherapy for Opioid Use Disorder (POD) - Strategies for Improving Performance

Strengthen Medication Initiation & Continuation Support

- Leverage telehealth for initiation & follow-up to reduce barriers to in-person visits.
- Ensure quick access to medications by working with pharmacies.
- Implement structured follow-up plans for continuity (e.g., 7-day follow-ups, reminder calls, automated refills).

Improve EHR Documentation & Coding

- Ensure that pharmacotherapy for OUD is properly documented in structured fields (not just free text).
- Train billing teams on proper CPT/HCPCS coding for buprenorphine, methadone, and naltrexone to improve measure capture.
- Conduct chart reviews to identify missed documentation opportunities.

Pharmacotherapy for Opioid Use Disorder (POD) - Strategies for Improving Performance

Identify and Address Provider Barriers

- Conduct a quick provider survey or focus group to assess barriers to prescribing (e.g., comfort level, time constraints, patient engagement challenges).
- Provide technical assistance on buprenorphine prescribing for non-waivered clinicians (as the X-waiver requirement has been eliminated).
- Offer EHR-based clinical decision support (CDS) to prompt OUD medication discussions when patients have opioid use disorder (OUD) diagnoses.

Optimize Patient Identification & Engagement

- Use claims & EHR data to flag eligible patients with an OUD diagnosis who have not received pharmacotherapy.
- Implement proactive outreach via care coordinators or behavioral health staff to engage patients in treatment.
- Address stigma and misperceptions by training front-line staff on motivational interviewing techniques.

BH Appendix

Pharmacotherapy for Opioid Use Disorder (POD)

Percentage of opioid use disorder (OUD) pharmacotherapy treatment events among members age 16 and older that continue for at least 180 days (6 months).

Measure	Pregnant	Adult Chronic	Adult Preventive	Children/ Youth	Behavioral
Pharmacotherapy for Opioid Use Disorder					X

Depression Remission or Response (DRR-E)

Percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score.

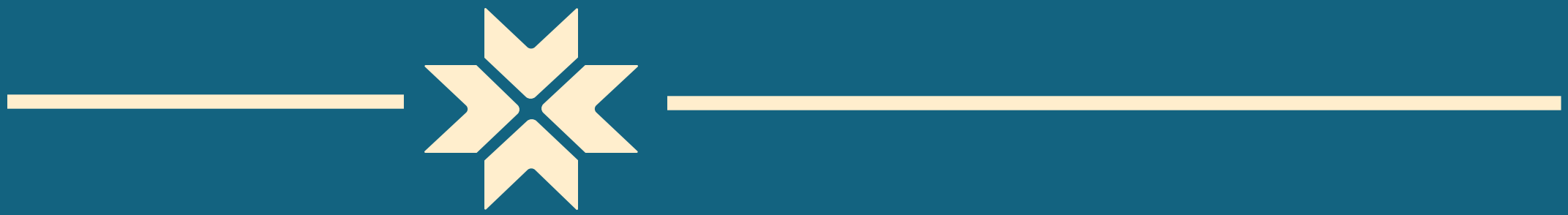
Measure	Pregnant	Adult Chronic	Adult Preventive	Children/ Youth	Behavioral
Depression Follow-Up					x
Depression Remission					x
Depression Response					x

Pharmacotherapy for Opioid Use Disorder (POD) - Strategies for Improving Performance

Leverage Payer Partnerships

- Collaborate with payers to receive patient-level data on measure performance.
- Advocate for quality incentives or P4P programs that reward improved POD performance.
- Explore plan or IPA case management resources to help engage members in treatment adherence.

Debrief and Q&A



Debrief

- What were the biggest takeaways from your group's discussion?
- What bright spots rose to the top?
- What remaining questions or challenges need further support?

Deeper training in the HEDIS-like KPIs

May 2025 Deliverables Template Review Sessions

February 20 and March 7

These sessions will focus on reviewing the May deliverables templates and answering questions from practices

EPT Office Hours – Data Implementation

Weekly starting February 26 @ 1:00 pm - 2:00 pm

These sessions will offer support for completing May data implementation deliverables

PhmCAT Support Sessions

March 5, March 19, April 2

These sessions will answer questions related to completing the year 2 PhmCAT submission

Access Office Hours with Coleman Associates

Twice a month starting February 27

These sessions will continue to provide support and address questions related to Access KPIs

To Be Scheduled: PoF User Groups

Each PoF will meet once a month with clinical SME and data SME

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Breaktime!

Next up, Data Exchange!

Please return at: 11:20

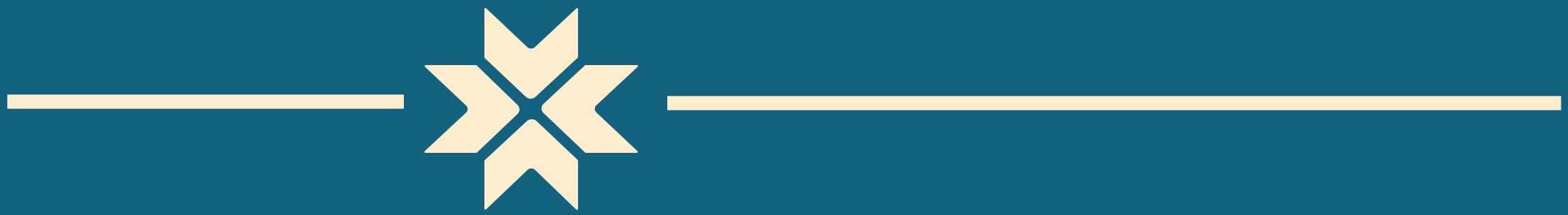
Data Exchange

Stephanie Thornton, Director

Toria Thompson, Advisor

Connecting for Better Health

Quick Poll!



The Vision for Data Exchange in California

Once implemented across California, the Data Exchange Framework (DxF) will create new connections and efficiencies between health and social services providers, improving whole-person care.

The DxF is California's first-ever statewide Data Sharing Agreement (DSA) that requires the secure and appropriate exchange of health and human services information to enable providers to work together and improve an individual's health and wellbeing.

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About the California DxF

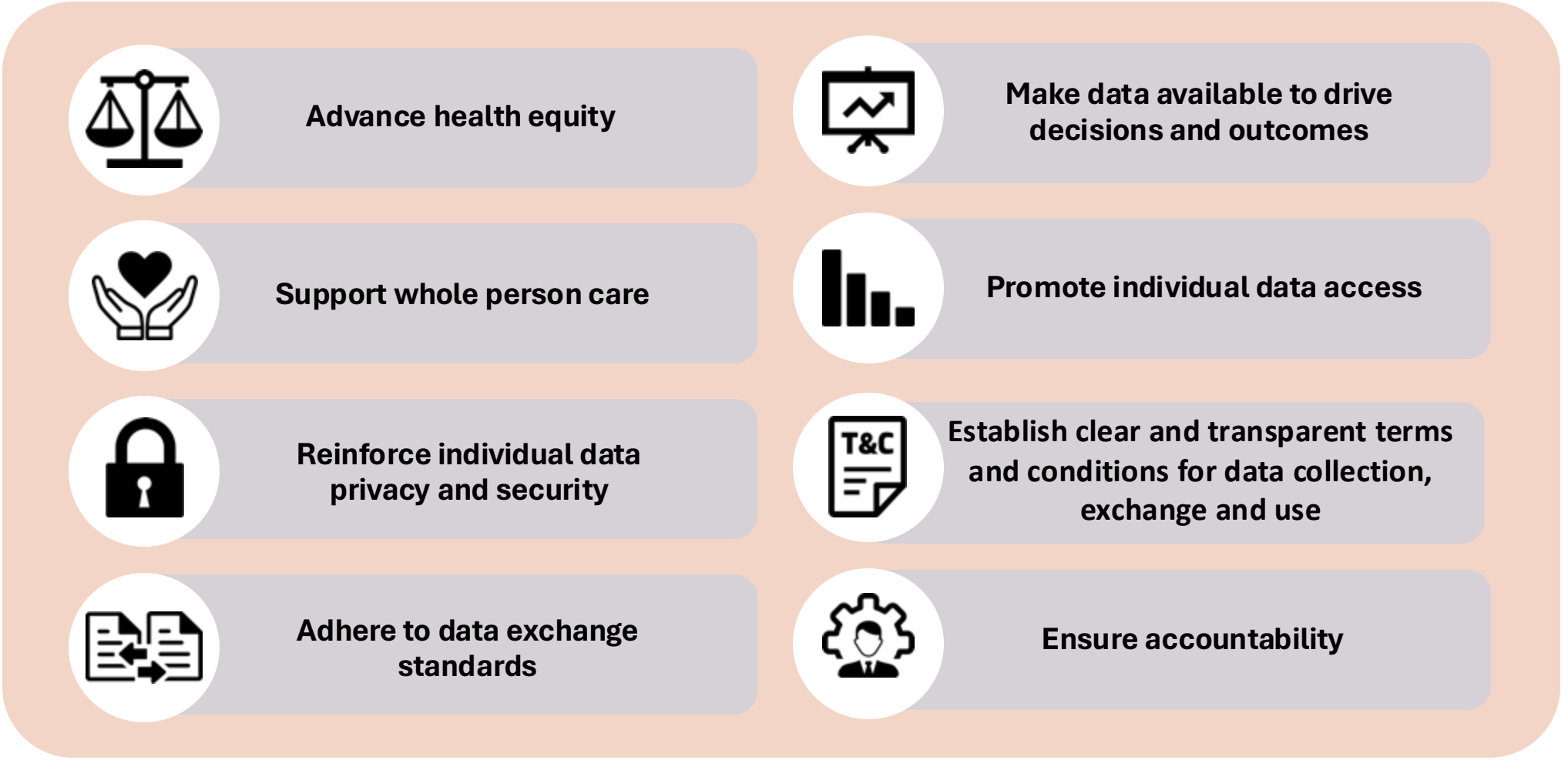
What the DxF is

- The DxF provides the **rules of the road** to bring existing stand alone health systems, providers, and social services together
- The DxF is a **technology-agnostic** collection of organizations that are required to share health information using national standards and a common set of policies
- The DxF includes a **strategy for unique, secure digital identities** capable of supporting master patient indices (details TBD)
- **Signing the DSA is the first step of the DxF implementation process**

What the DxF *isn't*

- The DxF is **not a technology system for a single repository of data**

DxF Principles



For more information on DxF principles, please refer to the following: Data Exchange Framework Guiding Principles

Supporting the Whole Person

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What is the Data Sharing Agreement (DSA)?

AB 133 required the establishment of a single data sharing agreement and a common set of policies and procedures that govern and require the exchange of health information.

DxF Data Sharing Agreement (DSA)

A legal agreement that a broad spectrum of health organizations are required to execute by January 31, 2023

- ❑ Streamlined document that focuses on the key legal requirements

Policies & Procedures (P&Ps)

Rules and guidance to support "on the ground" implementation

- ❑ Detailed implementation requirements
- ❑ Will evolve and be refined over time through a participatory governance process involving stakeholders

The DSA & P&Ps were developed to align with an build upon existing state and federal data exchange laws, regulations, and initiatives where possible (e.g., HIPAA, TEFCA, CalDURSA).

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DxF Participants & What Data Will Be Shared

Who are the Participants

- **Mandatory signatories**, which are mostly **health services organizations**
- **Non-mandatory signatories**, such as **community-based organizations, county agencies, and technology companies**

What is Health and Social Services Information (HSSI)?

- "…any and all **individually identifiable information** received, stored, processed, generated, used, transferred, disclosed, made accessible, or shared pursuant to the DSA **including but not limited to**:

(a) **data elements** as set forth **in the applicable Policy and Procedure**

(b) **information related to the provision of health care services**, including but not limited to PHI; and

(c) **information related to the provision of social services**. HSSI may include PHI, PII, and digital identities"

PHI = Protected Health Information, PII = Personally Identifiable Information
For more information on DxF Terms, please refer to the following: Data Exchange Framework Glossary of Defined Terms

When Organizations Need to Start Sharing Information

The following were ***required to sign the DSA*** by January 31, 2023, and are ***required to begin exchanging*** information or provide access by

January 31, 2024

- General acute care hospitals
- Acute psychiatric hospitals (100+ beds)
- Physician organizations (e.g., Independent Practice Associations that exchange health information) and medical groups (with 25+ physicians)
- Skilled nursing facilities that currently maintain electronic records or electronic health information
- Health care service plans and disability insurers
- Clinical laboratories regulated by CDPH

The following were ***required to sign the DSA*** by January 31, 2023, and are ***required to begin exchanging*** information or provide access by

January 31, 2026

- Physician organizations (e.g., Independent Practice Associations that exchange health information) and medical groups with <25 physicians and any nonprofit clinic with <10 health care providers

The following are **not *required to sign the DSA***, but if they do, are ***required to begin exchanging*** information or provide access by

January 31, 2026

- Governmental organizations
- Social services organizations (including Community-Based Organizations)

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Policies and Procedures (P&Ps)

P&P Topic	P&P Link
Breach Notification	OPP-3
Permitted, Required, and Prohibited Purposes	OPP-4
Requirement to Exchange HSSI	OPP-5
Privacy and Security Safeguards	OPP-6
Individual Access Services	OPP-7
Data Elements to Be Exchanged	OPP-8
Technical Requirements for Exchange	OPP-9
California Information Blocking Prohibitions	OPP-10
Qualified Health Information Organization	OPP-11
Real-Time Exchange	OPP-12
Participant Directory	OPP-14
Fees	OPP-15

What is a Qualified Health Information Exchange?

A QHIO is a **DxF designated intermediary** that meets the requirements for secure data exchange and other criteria

These intermediaries **offer services and functions** to help DxF Participants share HSSI and meet their DSA requirements.

DxF Participants **may choose to use a QHIO** or **another intermediary** to meet some or all of their DSA requirements.

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What is a QHIO?

9 organizations designated as QHIOs can assist Participants in meeting their DxF obligations:

- Manifest MedEx
- San Diego Health Connect
- SacValley MedShare
- Cozeva
- LongHealth
- Serving Communities Health Information Organization (SCHIO)
- Health Gorilla
- Los Angeles Network for Enhanced Services (LANES)
- Orange County Partners in Health (OCPH)

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QHIOs at a Glance – Types of Data Exchanged

	Types of Data Exchanged						
Name of QHIO	**Behavioral Health**	**Claims**	**Clinical**	**Emergency Medical Services**	**Public Health Reporting**	**Social Services**	**Other Types of Data**
Cozeva – Applied Research Works, Inc.		X	X	X	X	X	
Health Gorilla	X	X	X	X	X		
Long Health			X		X	X	
Los Angeles Network for Enhanced Services (LANES)	X	X	X		X	X	X
Manifest Medex	X	X	X	X	X		
Orange County Partners in Health – HIE			X				
Sac Valley MedShare	X	X	X	X	X	X	
San Diego Health Connect	X	X	X	X	X	X	X
Serving Communities Health Information Organization (SCHIO)	X		X	X	X	X	X

Access the "QHIOs at a Glance" resource here.

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Data Supported by QHIOs

- Behavioral Health
- Claims
- Clinical
- Closed-Loop Referral Services
- "Data on quality care gaps, risk adjustment gaps, and healthcare efficiency metrics"
- Direct Messaging
- Eligibility files
- Emergency Medical Services
- Mental Health
- Orders and Results
- POLST forms and data
- Public Health Reporting
- Social Services
- Substance Use Disorder

Each QHIO offers different types of data exchange opportunities for organizations that exchange data with them. Your organization should examine which QHIO can serve your data sharing needs best.

DxF Participant Directory

The **Participant Directory enables DxF Participants to indicate their choices** for intermediaries or data exchange technologies they have selected to exchange information

All DSA signatories must make selections in the Participant Directory as obligated by the Participant Directory P&P

CENTER FOR DATA INSIGHTS AND INNOVATION

The **Center for Data Insights and Innovation (CDII) maintains** an updated DSA Signatory List publicly available on their webpage that includes fields that lists Participants' methods of exchange.

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DxF Participant Directory

DxF Participant Directory
QUICK START GUIDE

Framing

Think of the Participant Directory like an old-school telephone book. If a human cannot find your organization or facility by name lookup, neither they nor the technology they use will know how to exchange with you. If your business name is "CA's Health Care System" but the facilities where you maintain HSSI are called "CA's Best Hospital", "CA's Best SNF", "CA's Best Health Plan Coastal", "CA's Best Health Plan of the Sierras", DxF Participants will not be able to find any "Best" organization to engage in DxF exchange of Health and Social Services Information (HSSI).

The Participant Directory is how an Organization indicates to other DxF Participants which of their facilities intend to exchange HSSI under the DxF.

LEGEND

PRIMARY ORGANIZATION

SUBORDINATE ORGANIZATION

PARTICIPANT DIRECTORY SUBORDINATE ORGANIZATION

DATA EXCHANGE FRAMEWORK CalHHS

DSA Signing Portal and Participant Directory Components

- Primary Organization ("Primary Org")
- Subordinate Organization in DSA ("Sub Org")
- Participant Directory Subordinate Organization, a Subordinate that is not listed on the DSA ("PD Sub")
- Option to elect to delay until January 31, 2026
- Three choices of exchange:
  - Request for Information
  - Information Delivery
  - For hospitals, EDs, QHIOs, SNFs (optional), and Intermediaries that serve these types of Participants, How to Receive Requests for Notification of ADT events

First Steps

1. Log into the DSA Signing Portal
2. Account Status must say "DSA Document Signed" in order to launch the Participant Directory, see Steps 4 & 5 in Participant Directory How To Guide
3. Review Organization(s), see Step 6 in How To Guide to determine which scenario to follow on page 2

See Page 2 for the workflow on different scenarios

Learn more at dxf.chhs.ca.gov
Contact us at dxf@chhs.ca.gov

- **Reference the DxF Participant Directory Quick Start Guide here.**
- **Watch the DxF Participant Directory Walkthrough Webinar here.**

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QUICK STRETCH

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Data Stratification

Pat Mejia, Associate Director of Training

Rachel Willard-Grace, Director

University of California Center of Excellence in Primary Care

Learning Objectives

1. Explain the importance of stratifying data to look at disparities in your population of focus (PoF) HEDIS-like measures.

2. Describe the best practices and tools for collecting accurate data on Race, Ethnicity, Language (REAL), and Sexual Orientation and Gender Identity (SOGI).

Case study

During a meeting at Neighborhood Clinic, Selena brings up plans to start stratifying their Depression Screening and Follow-up by patient characteristics.

One of the physicians asks, "Why bother spending your time doing that, shouldn't we just try to improve care for everyone in the clinic overall?"

- Why is it valuable to stratify our quality metrics by patient characteristics?

Why Stratify?

Stratifying data by patient characteristics allows a practice to:

Understand the current state of a patient population

Inform targeted performance improvements in access, continuity, preventive care and care management

Identify and respond to inequities in care

Monitor improvements over time

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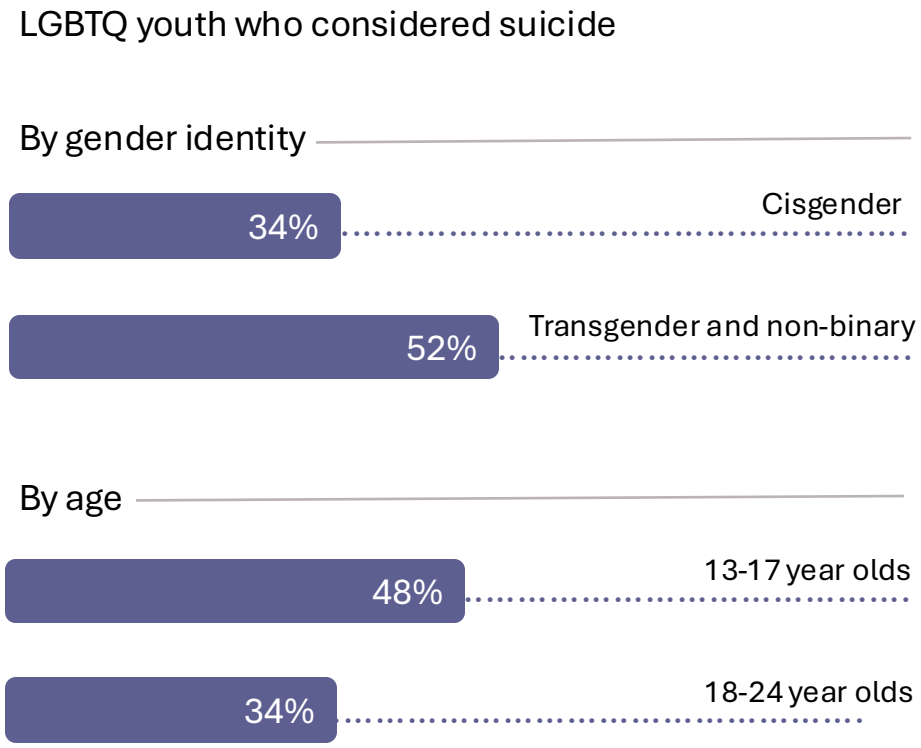
May 2025 Deliverables

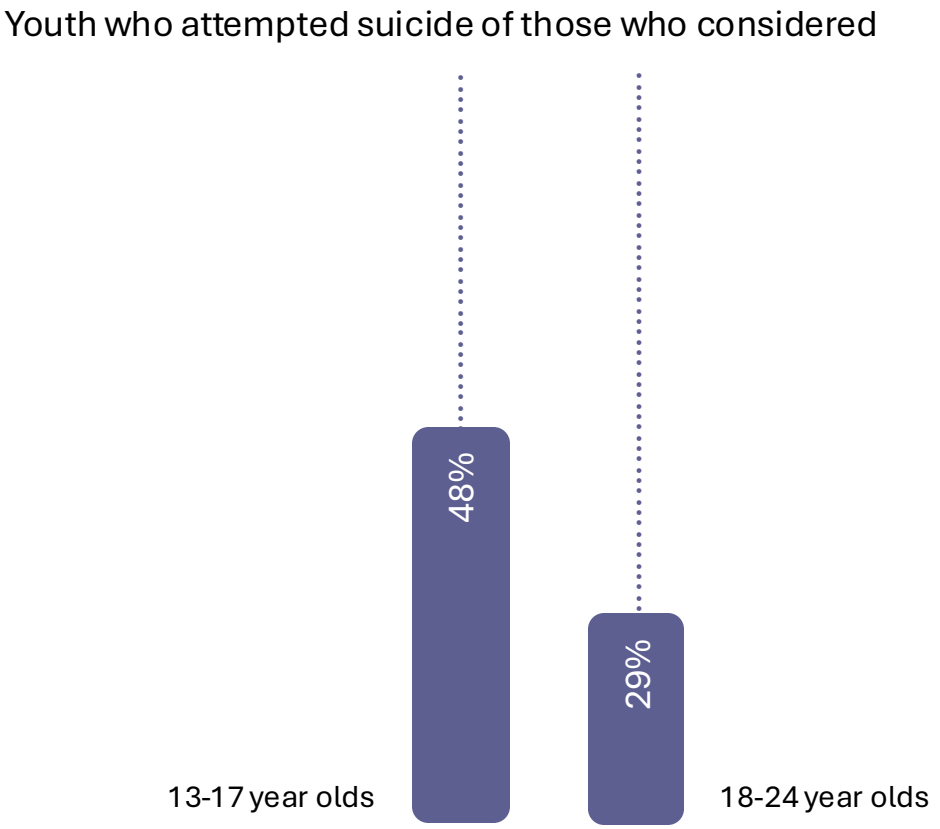
We will release templates and rubrics for these in February on our Milestones page

Category	Milestone	Deliverable
PhmCAT	**Complete year 2 PhmCAT**	Assessment
Data to Enable Population Health Management	**Data implementation plan:** Develop implementation plan for addressing data and technology gaps and transforming practice operations to support development of KPIs. Plan must include steps for implementing these three strategies: 1. Identifying and outreaching to the assigned but unseen population 2. Using gaps in care reports that include practice and MCP data 3. Data exchange with 2 external partners, at least 1 of which is a Qualified Health Information Organization (QHIO) Note: Before completing this Milestone, the team needs to have submitted Milestone 4: Data governance and HEDIS reporting assessment	Implementation Plan
Stratified HEDIS-like measures	**Stratify HEDIS-like measures:** Submit report that includes HEDIS-like measures applicable to selected population of focus stratified by race and ethnicity and at least one additional characteristic: primary spoken language, sexual orientation, gender identity, housing status, payer, or disability.	Stratified HEDIS-like measures
Key Performance Indicators (KPI)	**Submit KPI Updates:** Empanelment, Continuity, and Third Next Available Appointment Note: achievement/improvement must be sustained over two consecutive submissions or met in the final submission.	KPI Report

Why Stratify?

40% of LGBTQ respondents seriously considered attempting suicide in the last twelve months. **More than half** of transgender and nonbinary youth have considered suicide.





https://www.thetrevorproject.org/survey-2020/?section=Suicide-Mental-Health

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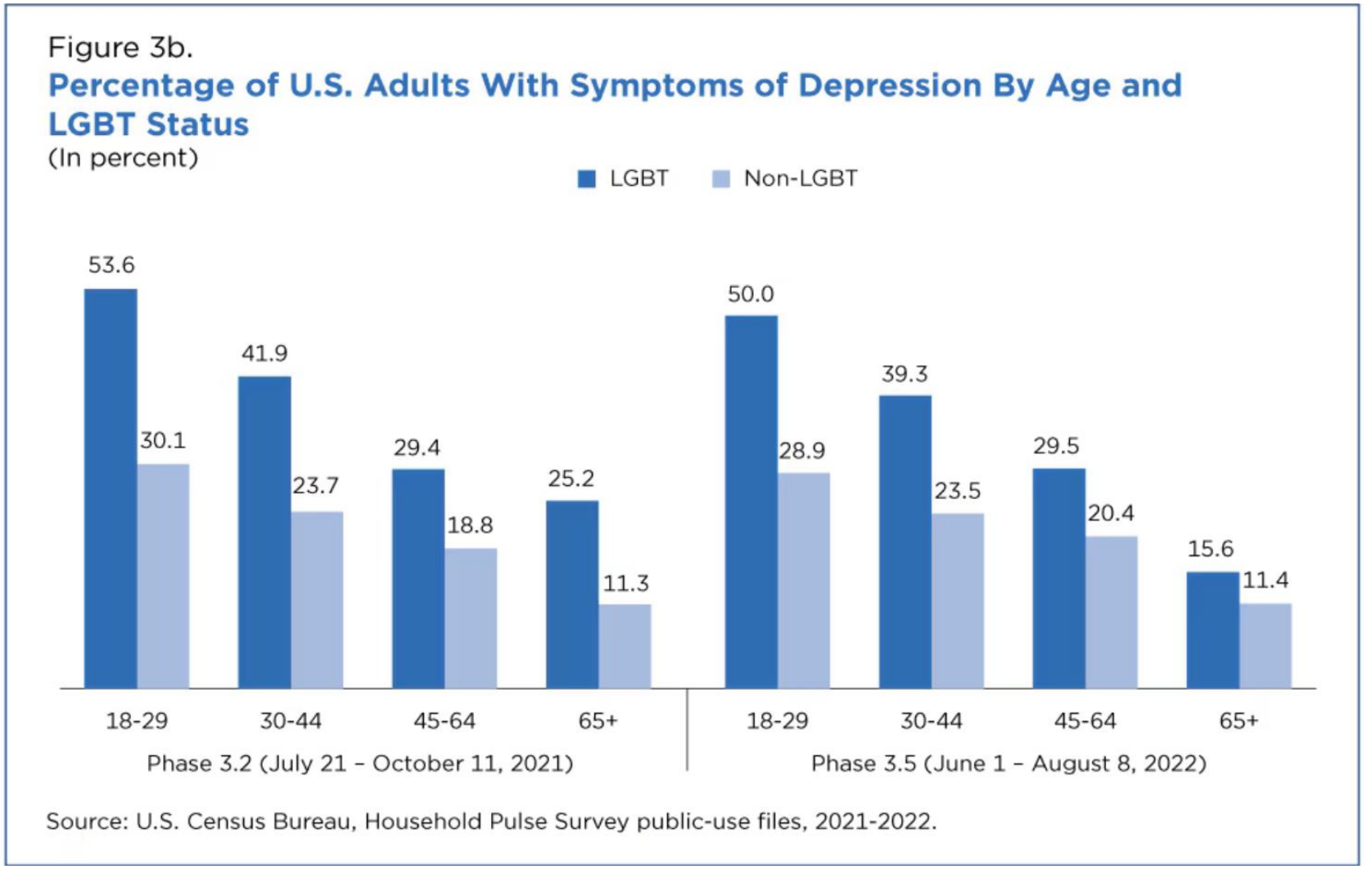
Why stratify?

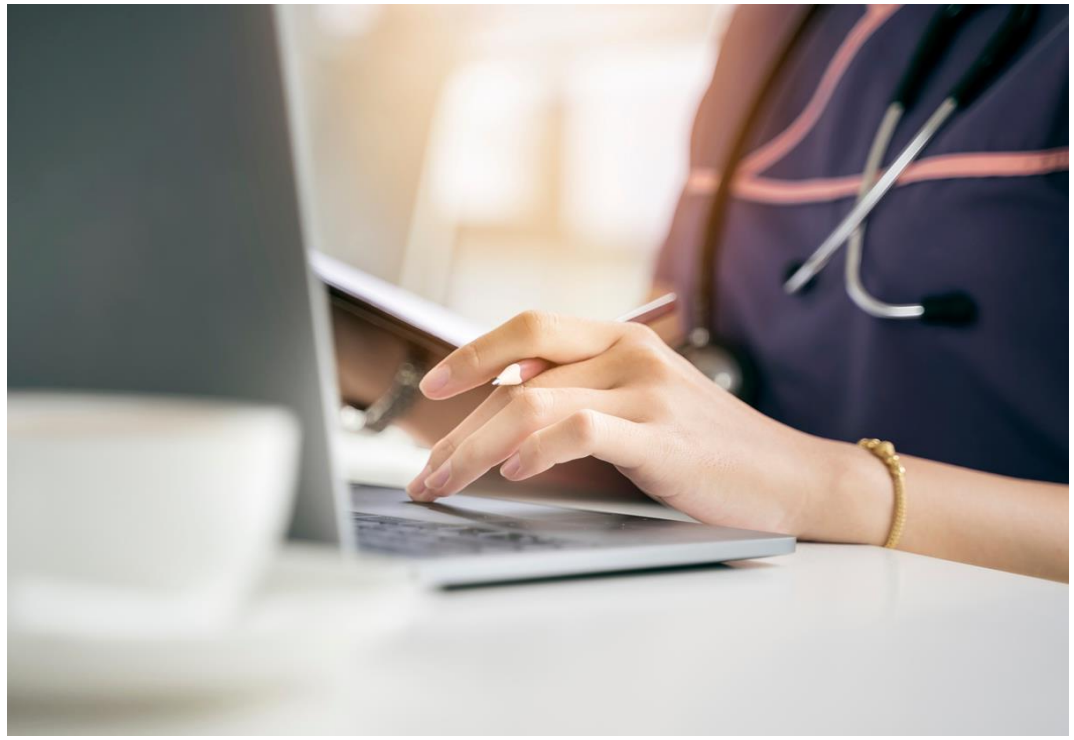


https://www.census.gov/library/stories/2022/12/lgbt-adults-report-anxiety-depression-at-all-ages.html

Case Study

Selena knows there are a lot of differences in access to care for depression. She is trying to think about how she should stratify the data to understand who isn't getting care.

- What are some of the characteristics that may separate groups that are getting depression screening compared to those who are not?



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What do we stratify by to understand inequities?

- Age
- Sexual Orientation
- Gender Identity

SOGI

- Race/ethnicity
- Language

REAL

- Disability
- Education
- Insurance status
- Neighborhood
- Rurality
- Other SDOH: employment, housing, economic stability

Poll

Which of these characteristics do you routinely ask patients about at your practice in order to understand health inequities? (select all that apply)

- Race/ethnicity
- Preferred language
- Sexual orientation
- Gender identity
- Disability
- Housing status
- Other: please share in the chat

Case study

Selena has heard that there are a lot of health disparities for LGBTQ+ patients. She wants to look at Neighborhood Clinic's data to see if that's true for them as well. This is what she sees when she looks at depression screening and follow up (DSF).

By sexual orientation

- Straight/heterosexual: 6%
- Gay/Lesbian: 27%
- Bisexual: 83%
- Other: 3%

By gender identity

- Male: 8%
- Female: 8%
- Gender fluid/non-binary: 40%
- Transgender: 100%

- What stands out to you about this data?
- What do you want to examine next?

Case study

Wait a second… you take a closer look at the raw data on DSF by sexual orientation, and this is what you see…

	Numerator	Denominator	Proportion
Straight/heterosexual	161	2,684	6%
Gay/lesbian	45	168	27%
Bisexual	15	18	83%
Other	56	1,856	3%
No sexual orientation reported	364	3,285	11%
Overall	**641**	**8,011**	**8%**

- What do you notice?
- What do you think might be going on?

Case study

And here's what you see when you look at depression screening and follow up by gender identity…

	Numerator	Denominator	Proportion
Male	339	4,239	8%
Female	293	3,744	8%
Gender fluid/non-binary	2	5	40%
Transgender	3	3	100%
No gender identity listed	4	20	20%
Overall	**641**	**8,011**	**8%**

- What do you notice?
- What do you think might be going on?

Case study

Determined to capture better SOGI data, Selena adds it to the all-staff meeting agenda.

Front office staff look really uncomfortable with the discussion. Finally, one person speaks up….

> "I don't feel comfortable asking personal questions about sexual orientation and gender identity. I mean, patients are going be like, 'What does that have to do with my arthritis?'"

Another says…

> "Yeah, and they're going to look at me funny if I ask them about their gender. Like, can't you tell I'm a man?"

- What would you say next?

Best practice tips

- Be transparent about why you're asking about REAL/SOGI
- Respect the patient's privacy
- Ask the patient directly
- Do not answer for the patient
- Share response options if the person is unsure
- Do not add response options from other sources (i.e. health plan)
- Practice until asking these questions feel comfortable for you

How do we support our care teams in gathering accurate information?

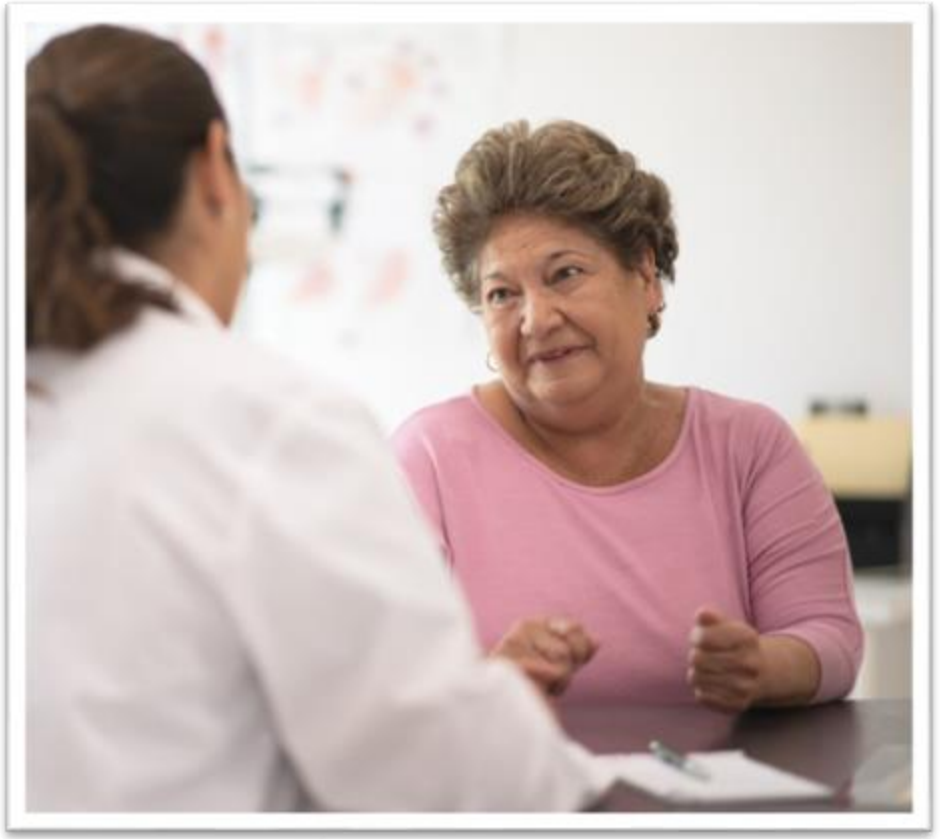
1. Offer multiple ways for patients to provide information
2. Provide a script for staff and providers
3. Offer opportunities for practice and feedback
4. Develop FAQs and practice answering them

Offer multiple ways for patients to provide information

This may include:

- Paper forms
- Online forms
- Being asked the questions in an exam room

Allow patients to choose the method that feels most comfortable for them.



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Provide a script for staff and providers

How might you introduce REAL and SOGI questions?

"We ask all of our patients about their sexual orientation and gender identity so that we can provide everyone with the best care possible."

Offer opportunities for practice and feedback

Create dedicated time for team members to practice with one another.

Examples of feedback may include:

- Don’t apologize for asking the questions.
- Allow the person to answer for themselves – don’t suggest answers

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Practice answering FAQs from patients

- Develop a list of frequently asked questions
- Ask staff and providers to share common questions they hear from patients
- Ask staff and providers to share questions they find challenging to answer
- Provide opportunities for practice

Case study

Overall, staff are feeling more comfortable with asking SOGI questions. However, one of your MAs pulls you aside to ask you a question.

“I had a patient ask me today if I could change her gender identity from Transgender female to Female. I think that she’s afraid of someone finding out that she’s transgender. Should I do what she asks?”

- How might you respond to this staff member?
- What are the important principles to consider?

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Small group practice

25 mins

Part 1: Develop a practice script (5 mins)

Take five minutes to develop a script to support staff in asking a question that may be challenging for them. This could be related to SOGI, disability, race/ethnicity, language, etc.

Be sure to include the following:

- In one sentence, explain why you are asking the question.
- What specific question will you ask?
- What are three questions or reactions you think you may get from patients? How might you respond?

Part 2: Put your script into practice! (20 mins)

Identify two volunteers. One person will play the **team member**. Another person will play the **patient**. Everyone else will **observe** and provide feedback.

- **Team member:** Using your script, take up to five minutes to practice asking your question.
- **Patient:** Bring some real-life experience to the scenario.
- **Observers:** Remember to support one another by providing feedback!
- Switch roles to give as many people the opportunity to practice as time allows.

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Debrief

- What worked well?
- What was challenging?
- Now that you've had a chance to test it out, how might you adjust your script?

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Resources

National LGBTQIA+ Health Education Center

- Ready, Set, Go! Guidelines and Tips For Collecting Patient Data on Sexual Orientation and Gender Identity (SOGI) – 2022 Update

The Trevor Project

- https://www.thetrevorproject.org/survey-2020/?section=Suicide-Mental-Health

Need Help?

- Contact the Learning Center…
  - General questions - Info@pophealthlc.org
  - PopHealth+ (eLearning Hub) - elearning@pophealthlc.org

EPT Technical Assistance (TA): January – May 2025

Upcoming TA:

- **May 2025 Deliverables Template Review Sessions**
  - February 20 and March 7
  - These sessions will focus on reviewing the May deliverables templates and answering questions from practices
- **EPT Office Hours – Data Implementation**
  - Weekly starting February 26 @ 1:00 pm - 2:00 pm
  - These sessions will offer support for completing May data implementation deliverables
- **PhmCAT Support Sessions**
  - March 5, March 19, April 2
  - These sessions will answer questions related to completing the year 2 PhmCAT submission
- **Access Office Hours with Coleman Associates**
  - Twice a month starting February 27
  - These sessions will continue to provide support and address questions related to Access
- **DxF Bootcamp**
  - The DxF Bootcamp will provide California stakeholders step-by-step guidance to identify their organizations' priority data sharing use cases, existing assets, best practices for partner engagement, and technology resources to build a roadmap towards secure, real-time data exchange.
- **To Be Scheduled: PoF User Groups**
  - Each PoF will meet once a month with clinical SME and data SME

Take a few minutes to complete a feedback survey

https://form.jotform.com/250227821575154

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