SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

AGENDA

TOPIC: **HCH/FH Program QI/QA Subcommittee**
DATE: September 11th, 2025
TIME: 12:30pm-2:00pm
PLACE: Half Moon Bay Library, 620 Correas Street, Half Moon Bay, CA 94019

Item	Time
1. Welcome	12:30 pm
2. Approve Meeting Minutes	12:35 pm
3. Program Updates	12:40 pm
4. Q3 2024- Performance Measures	1:10 pm
5. QI Annual Plan	1:30 pm
6. Looking ahead: 2025	1:55 pm
7. Adjourn	2:00 pm

FUTURE MEETING DATES: TBD

*Contact **Frank Trinh** ftrinh@smcgov.org **or Raven Nash** **rnash@smcgov.org** for additional information regarding the HCH/FH Program Quality Improvement/Quality Assurance Subcommittee.*

SAN MATEO COUNTY HEALTH
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HCH/FH Program QI/QA Subcommittee

Thursday April 10th, 2025; 12:30-2:00 PM at 500 County Center COB 3 (Manzanita Hall) Redwood City, CA 94063
Present: Suzanne Moore, Alejandra Alvarado, Jocelyn Vidales, Gabe Garcia, Janet Schmidt

ITEM	DISCUSSION/RECOMMENDATION	ACTION
	Meeting began at 12:38 PM	
Approve Meeting Minutes		Gabe approved, Suzanne second All committee members approved.

Program Updates	**Smart Watches Project**
	• HCH/FH is providing smart watch devices to homeless and farmworker patients
	• Homeless patients- working with LifeMoves to distribute watches to homeless individuals through case manager
	  ○ Primarily positive feedback- individuals grateful to participate, excited to learn about health, showing providers results
	  ○ Troubleshooting- watch band uncomfortable to sleep with, client responsiveness to follow-up surveys
	• Farmworker patients- recently began working with ALAS to distribute watches to farmworkers
	  ○ Collecting consent forms and initial survey responses, will be contacting clients to collect follow-up survey responses over the next couple of months
	• Next steps- thinking through how to use this data to create phase 2 of project or how to best utilize this data to make improvements in our program
	
	Library Expansion Project
	• HCH/FH is provided blood pressure cuffs to all San Mateo County Library (SMCL) locations
	• Currently working on promotional collaborations between SMCL and HCH/FH
	• Library- posted about collaboration on front page of their newsletter and website blog
	  ○ Link found here: Now Available: Blood Pressure Monitor Kits at the Library | San Mateo County Libraries
	• Contacting news outlets to promote project
	• HCH/FH- will be sharing collaboration in upcoming SMMC Heartbeat Newsletter
	  ○ Updating flyers for external partners
	
	AMI Phones Project	

	• Will be renewing this project for the 2025-2026 calendar hear (April to April)
	• Project will be concluded after April 2026
	• Out of 16 devices:
	  ○ 5 inactive for >100 days
	  ○ 2 inactive ~ 50 days
	  ○ 7 active within 24 hours
	• Notified 1 year in advance of project termination
	• Alternative phone plans will be provided to all clients	

Q3 2024 Performance Measures	**Early Entry into Prenatal Care** • Although early detection rates were high for the 2024 calendar year, several patients initiated prenatal care at SMMC during their second or third trimester. • As a result, the overall early screening percentage was lower compared to the previous year, despite an increase in first-trimester visits. **Cancer Screenings** • All three cancer screenings ended the 2024 calendar year with stable screening rates. • There was minimal fluctuation between Q3 and Q4, which may be attributed to the transition to EPIC. • Numerous trainings and meetings took place during this period, and the launch of EPIC introduced a learning curve. • While our program did not experience direct issues, we were aware of widespread troubleshooting efforts during the early weeks of the transition. • One example includes our ongoing collaboration with EPIC over the past year to emphasize the importance of accurate PEH/FW registration. We've been working to make this a hard stop in the system, which may have affected our reporting metrics. **Performance Measures** • Improvement was observed in both Depression Screening & Follow-Up and Diabetes A1c > 9% or Missing by the end of the calendar year. • Depression Screening & Follow-Up concluded at 34% for 2024, up from 31% the previous year.	
EPIC Implementation	**Transition** • Implementation of hard stops in EPIC for identifying Homeless and Farmworker patients • Ensuring data accuracy in preparation for early 2025 dashboards **Improvement Work** • Utilizing EPIC data to inform the 2025 Needs Assessment • Collaborating with other SMMC departments to understand their EPIC workflows and best practices • Improved efficiency in chart reviews for ongoing projects, such as the Cancer Screenings Project and Homeless Mortality Report	

	• Incorporating images of available dashboards for reference • The goal is to explore how to leverage this data to enhance program effectiveness. Previously, significant time was spent manually calculating these figures—now, there is an opportunity to redirect efforts toward strengthening partnerships and strategic planning **Community Resources** • Collaborating with the EPIC team to understand functionality and access to the Community Resources tab • Exploring the types of resources available and how they are shared with patients • Determining whether providers can attach resources to the After Visit Summary (AVS) • Evaluating similarities between the Community Resources tab and the former Provider Templates project • Investigating how providers access and utilize the Community Resources tab, and identifying opportunities to promote it • Potential to position this as Phase 2 of the original Provider Templates initiative • The feature was previously announced in *Heartbeat*; a similar promotional approach may be possible, or we may consult with EPIC about their promotional plans • Opportunity to tailor the tab to focus on PEH and FW populations, who frequently utilize these types of services	
Looking Ahead: 2025	• 2025 Needs Assessment (NA) will be taking place throughout this calendar year. HCH/FH currently reviewing what goals should be and selecting consultant. • Continue working with EPIC to improve data collection and resources for PEH/FW patients. • The next HCH/FH QI/QA Subcommittee meeting will likely be in June, subcommittee members will be notified closer to meeting date.	
Adjourn	Meeting adjourned at 1:36 PM	
Future meeting dates	**TBD**	

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Q3 2025 SUBCOM MEE

BY ALEJAND
THURSDAY SEPT

5 QI/QA
MMITTEE
TING

RA ALVARADO
EMBER 11TH, 2025

AGENDA

Approve Meeting Minutes

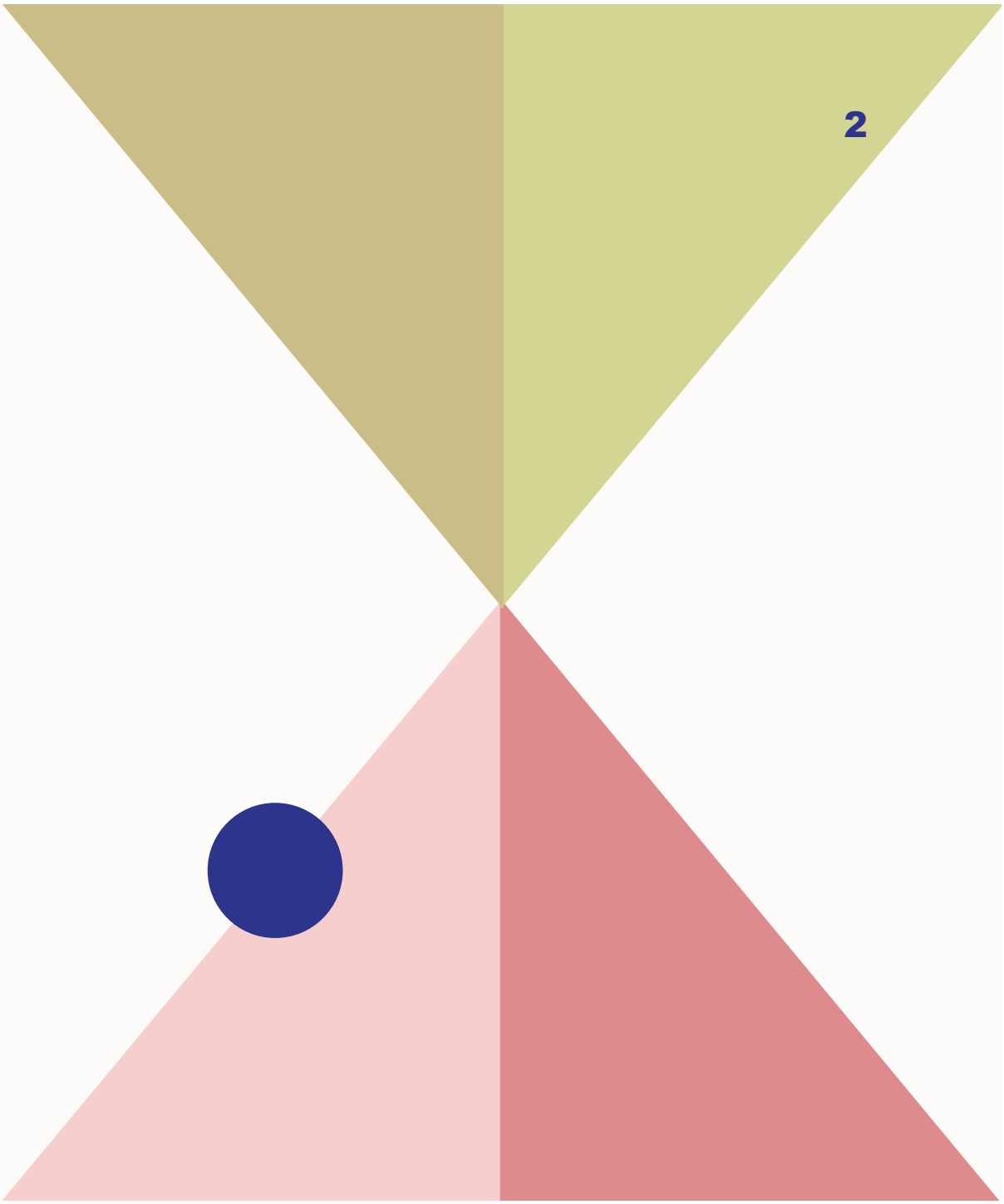
Program Updates

Performance Measures

QI/QA Plan

Self- Administered Pap Tests

Looking Ahead: 2025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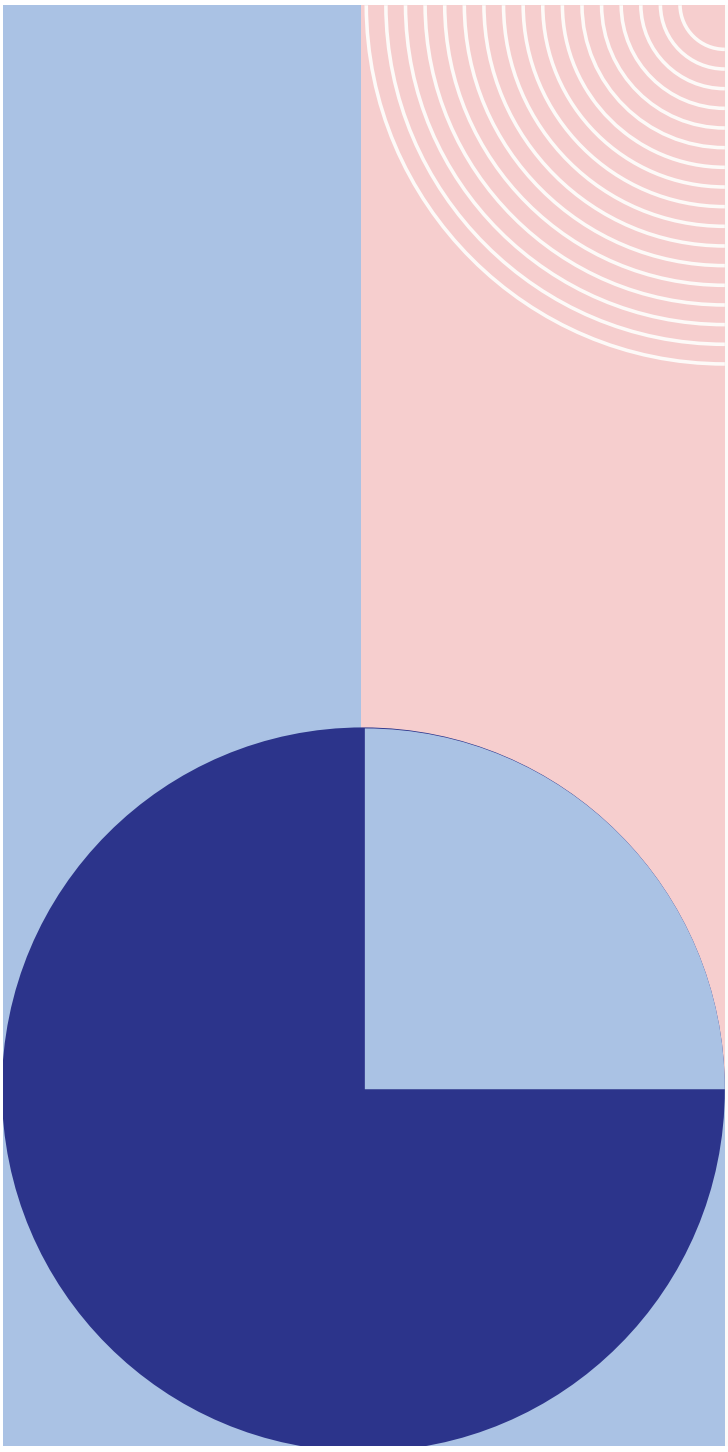


APP
MEI

PROVE Q1 2025
ETING MINUTES

PROGRAM UPDATES

Homeless Mortality Report

- Public Health Epidemiology- hold with data analysis
  - HSA doing quality checks on HMIS data
  - Completed- waiting for them to provide updated
- Updated report outline, will be sharing with HCH/F

AMI Phones Project

- Inactive users beyond 180 days will be deactivated in
  - Currently 6/16 phone lines active (used within 24
- All phone lines will be terminated in April 2026

Smart Watches Project

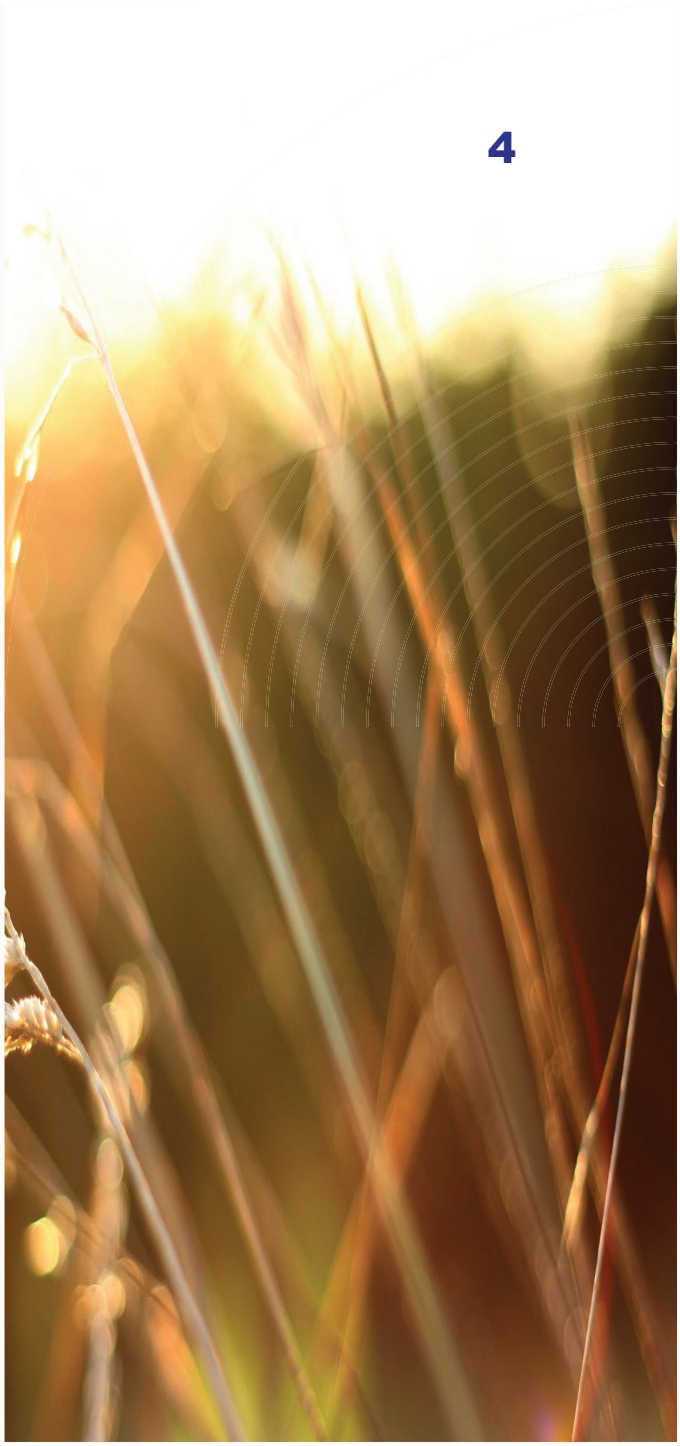
- LifeMoves continuing to send consent forms and sur
- ALAS has sent all consents, Start Up surveys, and Fol
  - In the process or reviewing feedback and determ

s for past couple of months

l dataset
H soon for feedback

September
4 hrs)

rveys
low Up surveys
ining next steps



Q2 PERFORMAN

EPIC Implementation/Transition

- Q1 quarterly reports were received- working on data validation for r
  - # of PEH/FW on the reports
  - Adding visit location and visit date columns
  - Clinic registration- EPIC language and PSA registration
  - Language change from FW dependents in eCW/EPIC

November Update

- This will remove all non PEH/FW patients from our UDS dashboar
- Depression Screening & Follow-Up measure should be updated
- Validate update changes before next UDS submission

Santa Clara County & Contra Costa County contact

- Reached out to learn more about their EPIC implementation proces
- Come present at future HCH/FH board meeting

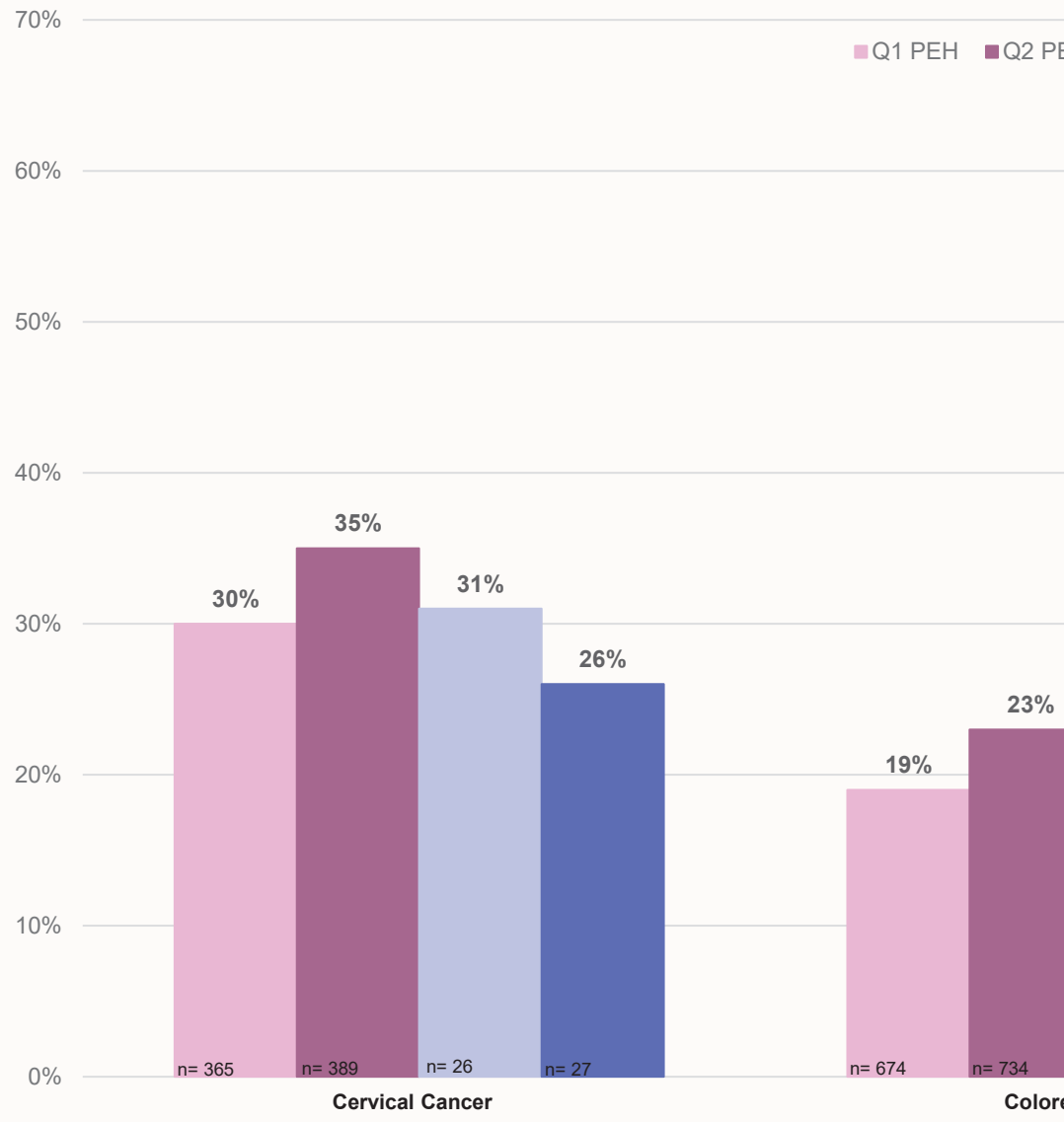
NCE MEASURES

eports

d

ss, adapting to transition, and collaboration with EPIC analysts

CANCER SC


70%
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50%
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30%
20%
10%
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Q1 PEH
Q2 PE
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35%
31%
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n= 26
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n= 674
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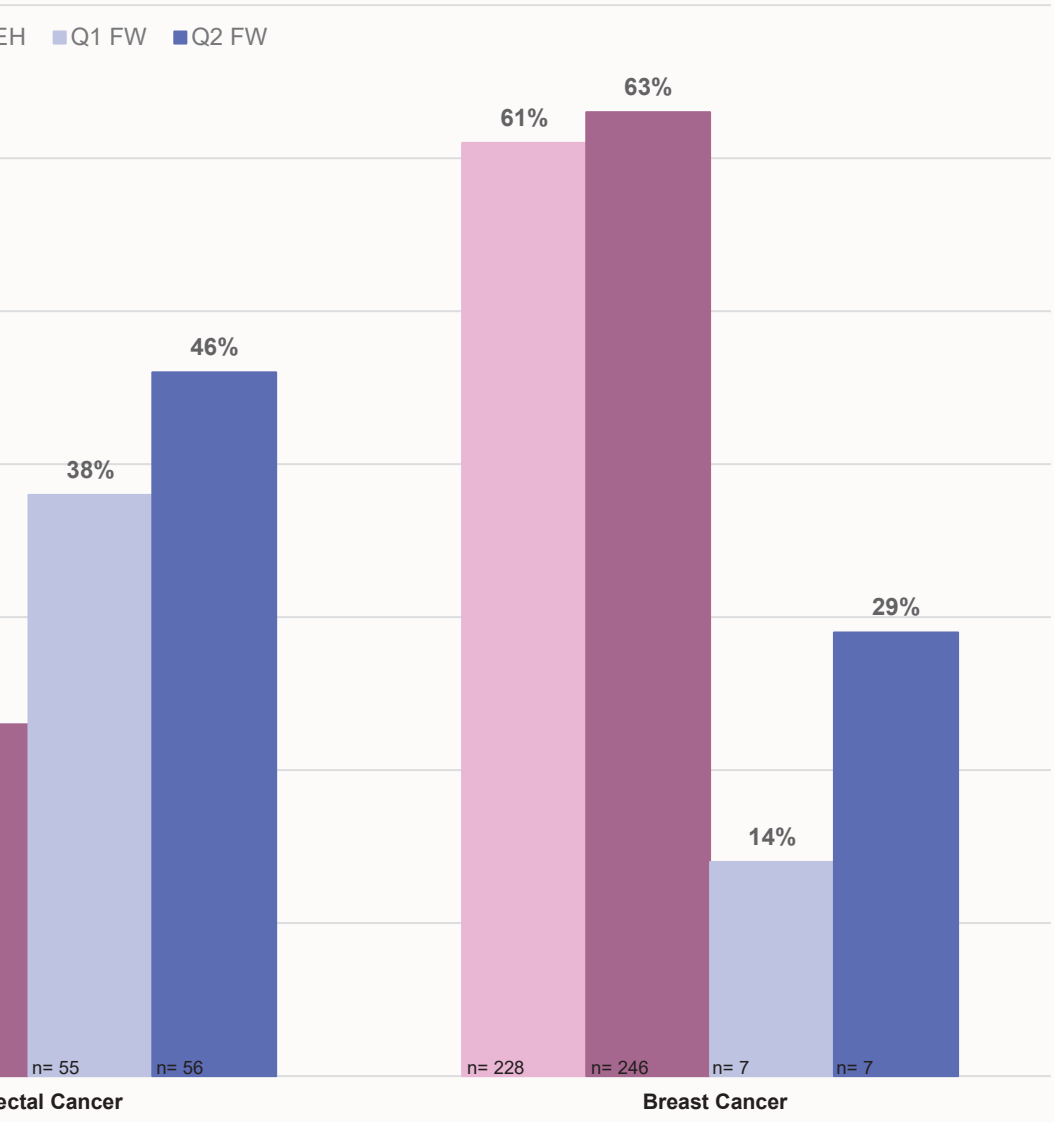
Cervical Cancer
Colore

CREENINGS


EH
Q1 FW
Q2 FW
46%
38%
61%
63%
29%
14%
n= 55
n= 56
n= 228
n= 246
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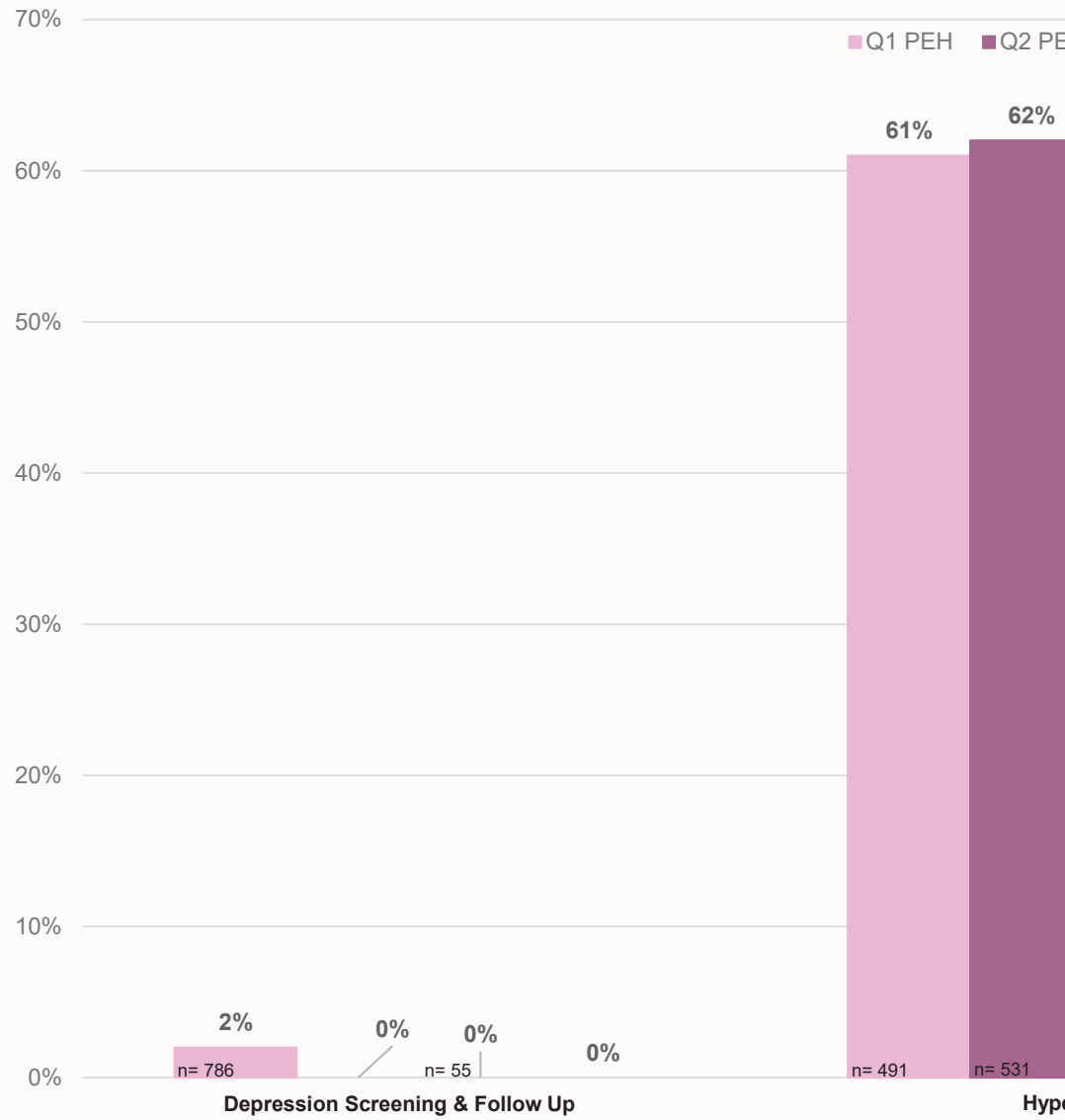
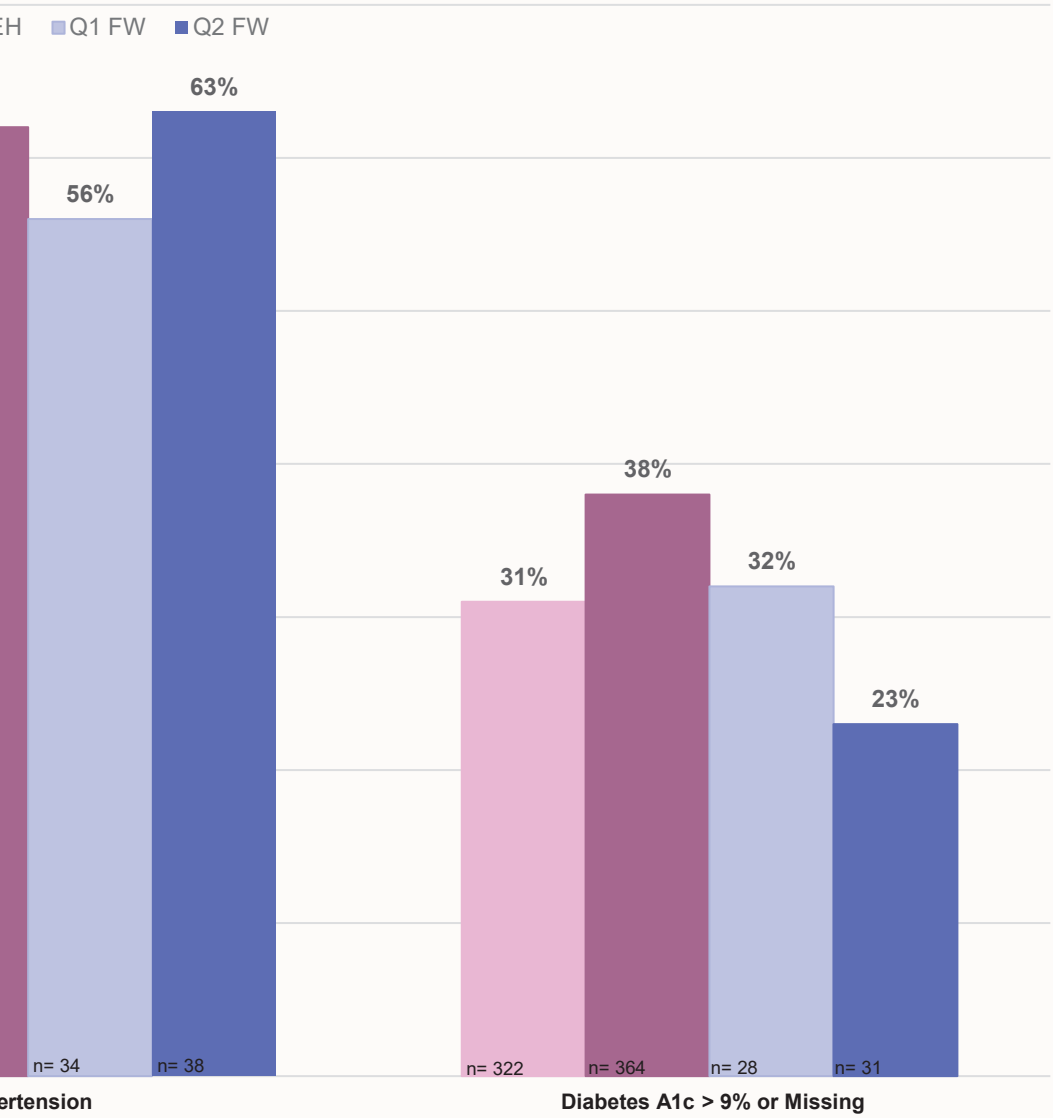
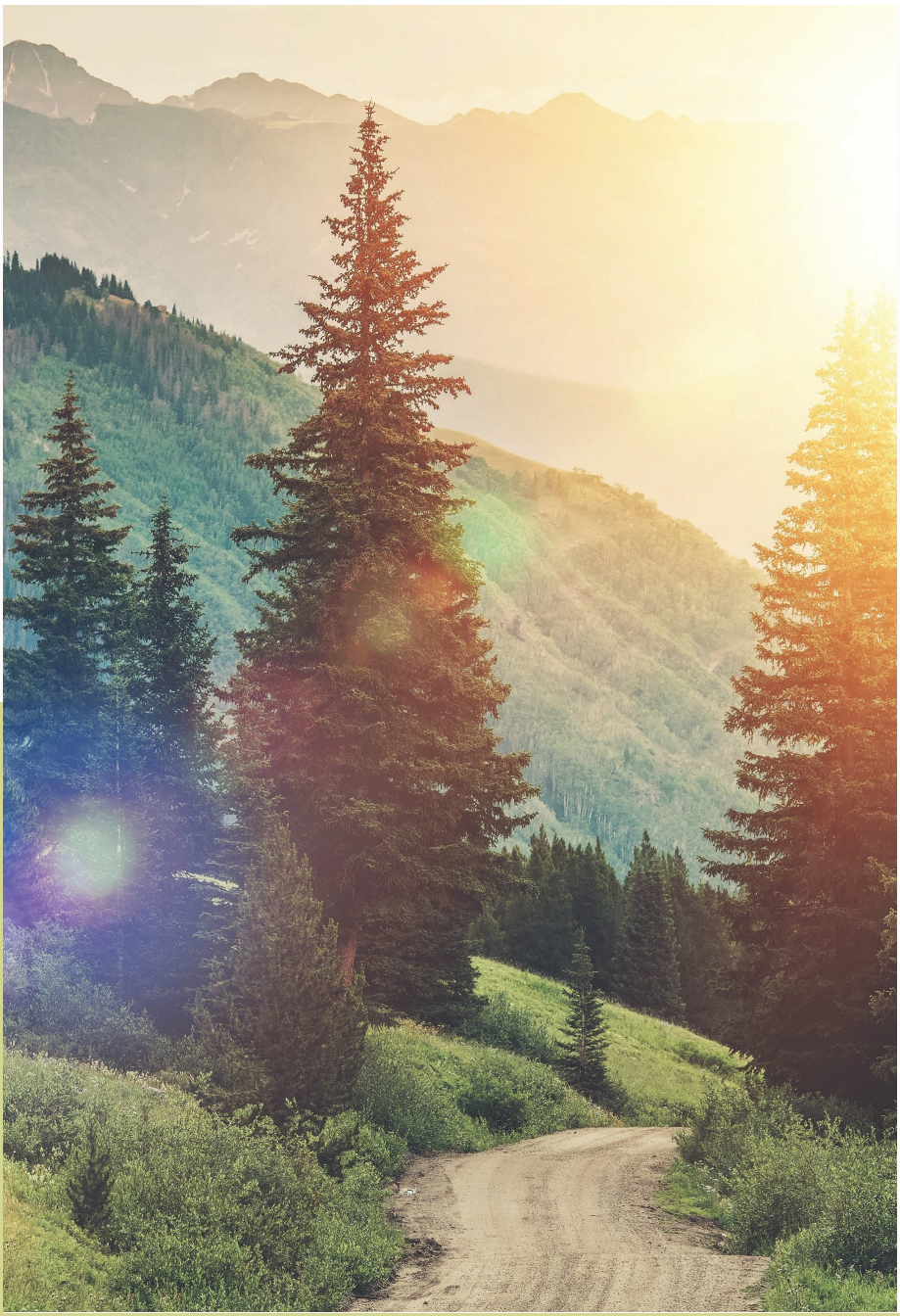
ectal Cancer
Breast Cancer

PERFORMANCE M



EASURES (*CONT.*)





2
A

025 QI PLAN
AMENDMENTS

CLINICAL UPDATES

Table 6A Services Render

- Column 1: number
- Column 2: number

New Table 6A additions

- Tobacco Use Cessat
  visits where tobacco
- Medications for opi
  1+ visits where MO
- Alzheimer's disease
  visits/patients where

QUALITY MEASURES

ed- updating clinic codes

of visits

of patients

ion Pharmacotherapies: number of visits/patients with 1+
o cessation was provided

ioid use disorder (MOUD): number of visits/patients with
UD services were provided

and related dementias (ADRD) screening: number of
e ADRD screening is provided

CLINICAL UPDATES

- Tables 6B and 7 were u

Depression Screening &

- New guidance: scre
- Previously: screen f

Diabetes: Glycemic Statu

- Language change

Breast Cancer Screening, Pressure, Diabetes: Glyce

- Previously: 2 outpa
- Exclusion criteria u

QUALITY MEASURES (*CONT.*)

pdated to align with the latest CMS CQMs

Follow Up

en *all* patients for depression

or new cases of depression in patients

s Assessment Greater than 9%

Colorectal Cancer Screening, Controlling High Blood
mic Status Assessment Greater than 9%

tient encounters with advanced illness

pdated- advanced illness *diagnosis* revision

CLINICAL UPDATES

Initiation and Engageme

- New measure adde
- **Denominator:** Pati measurement perio visit between Janua
- **Numerator 1:** initi
  - Includes either within 14 days
  - A patient must considered for

QUALITY MEASURES *(CONT.)*

nt of Substance Use Disorder Treatment

d to CQMs

ents 13 years of age and older as of the start of the
d who were diagnosed with a new SUD episode during a
ry 1 and November 14 of the measurement period

ation of treatment

r an intervention or medication for the treatment of SUD
of the new SUD episode.

t first meet the criteria for Numerator 1 (Initiation) to be
Numerator 2 (Engagement).

CLINICAL UPDATES

- **Numerator 2:** Enga initiation
  - 1. A long-actin 34 days after th
  - 2. One of the fo treatment thro
    - a) two eng
    - b) two eng
    - c) one eng event.

QUALITY MEASURES *(CONT.)*

agement in ongoing SUD treatment within 34 days of

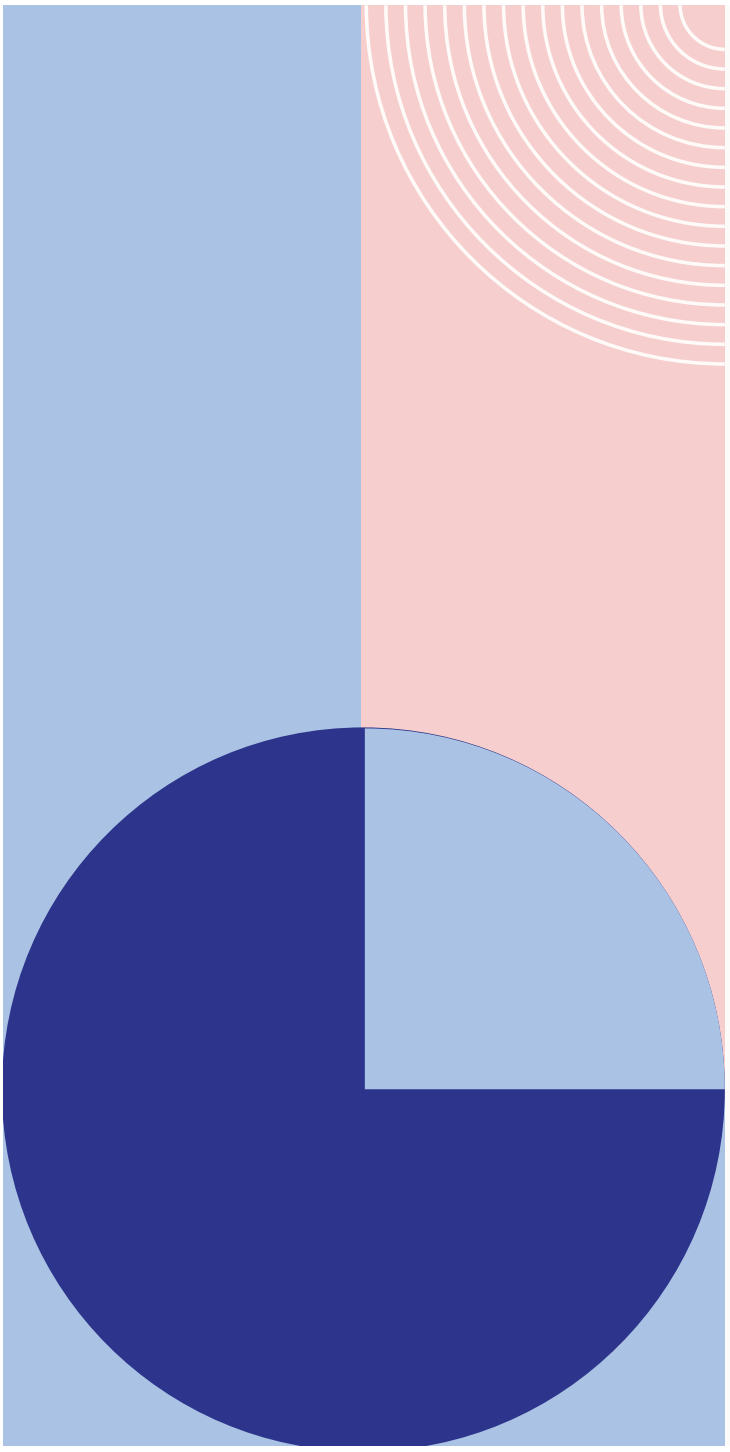
g SUD medication on the day after the initiation through
ne initiation of treatment.

ollowing options on the day after the initiation of
ugh 34 days after the initiation of treatment:

gagement visits

gagement medication treatment events

gagement visit and one engagement medication treatment



SELF-A
TESTS

- Where wo
- Who woul
- Barriers
- Realistic ti
- Next steps

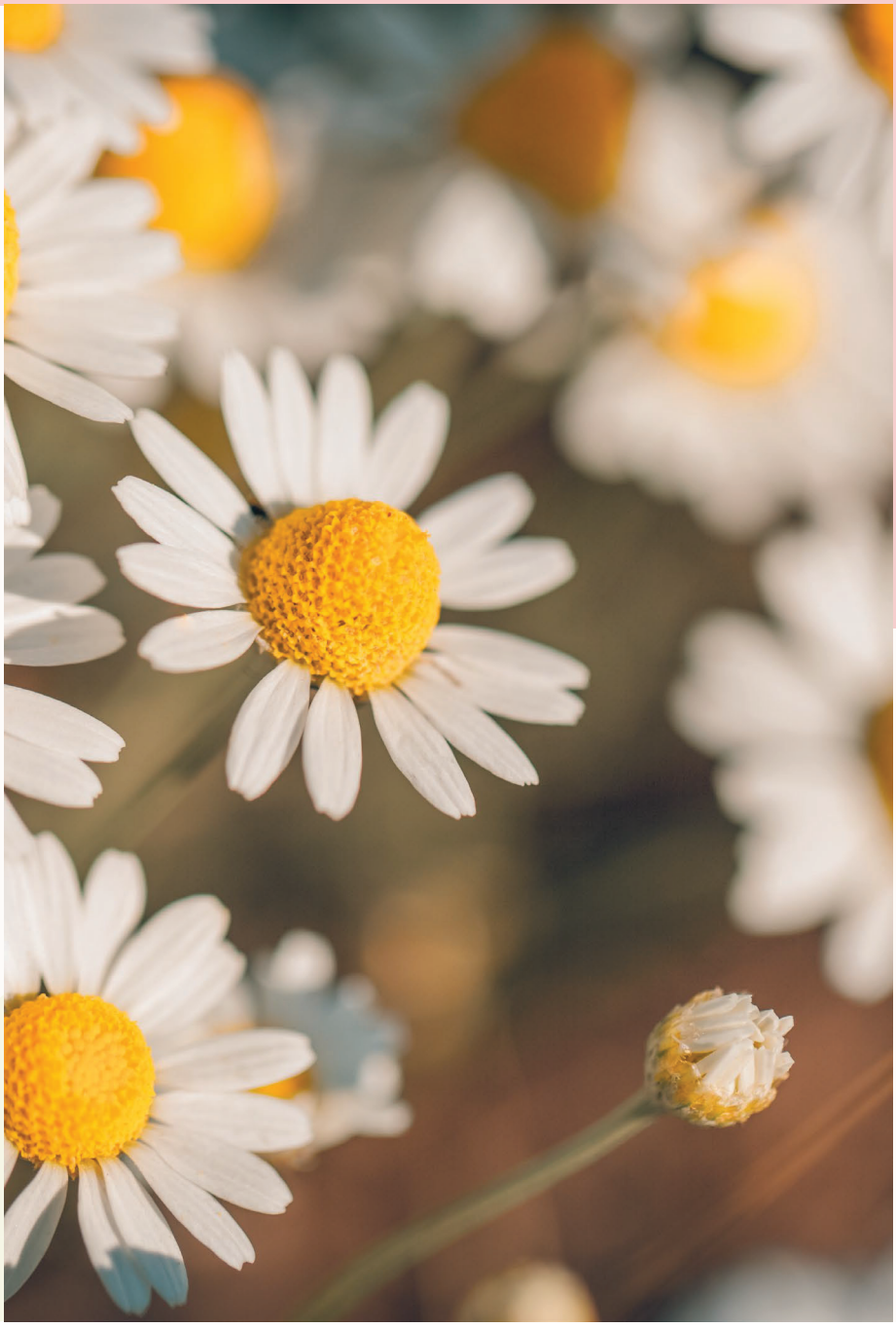
ADMINISTERED PAP

uld we pilot this? PHPP?
ld we need to involve? (ex. Labs)

imeline for implementation

LOOKING AHEAD: 2025

- Review EPIC progress with quarterly reports
  - Q3 cumulative YTD data for quality metrics
  - November update with EPIC
- Needs Assessment 2025-2026
  - Obtaining data reports for consultant
- Next Meeting: November



THANK YOU!

From the HCH/FH Team

SAN MATEO COUNTY HEALTH

SAN MATEO MEDICAL CENTER

HCH/FH PROGRAM QI/QA SUBCOMMITTEE ANNUAL PLAN AMENDMENT

TERM: October 2025 – September 2026

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Quality Improvement Mission Statement

The purpose of the Health Care for the Homeless/Farmworker Health (HCH/FH) Program Quality Improvement (QI) Plan is to evaluate and ensure the effectiveness of health care provided to homeless and farmworker patients and families, meet or exceed clinical performance objectives, and provide the highest levels of patient satisfaction.

Meeting Schedule and Calendar

The QI/QA Subcommittee meets at least quarterly, with a minimum of four meetings per year, unless otherwise stated.

EVENT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT
HCH/FH QI/QA Subcommittee Meetings			X			X			X			X
Approval of QI Plan Amendment by HCH/FH Program Co-Applicant Board	X											X
Patient Satisfaction Survey Data			Review available reports				Review available reports				Review available reports	
UDS Report			X	X	Submit report	Final Report						
Evaluation of Selected CQMs	Review Q3 data			Review annual Data			Review Q1 data			Review Q2 data		
QI Annual Plan Amendments									X			X
Strategic Plan/ Needs Assessment			X			X			X			X
Data Available	Q3 data refreshed			Q4 data refreshed			Q1 data refreshed			Q2 data refreshed		
Homeless Mortality Report	X	X	X	X	X	X	X	X	X	X	X	X
Cancer Screenings Project	Review available data	X	X	X	X	Create dashboard	X	X	X	X	X	X

2024-25 Performance

- 330 program performance data have been released for calendar year 2022. The adjusted quartile is an ordering of health centers' clinical performance compared to other health centers on the clinical quality measures (CQMs) that are reported to the UDS annually.
- Clinical performance for each measure is ranked from quartile 1 (highest 25% of reporting health centers) to quartile 4 (lowest 25% of reporting health centers).
- Our program changed quartile rankings for the following metrics:

Metric	2023 Adjusted Quartile Ranking	2024 Adjusted Quartile Ranking	Positive/Negative Change
Early Entry into Prenatal Care (1st Trimester)	**3**	**3**	**Sustained performance**
Cervical Cancer Screening	**3**	**3**	**Sustained performance**
Adult BMI and Follow Up	**3**	**3**	**Sustained performance**
Diabetes A1c > 9% or missing	**2**	**3**	**Positive**

2024-25 QI Annual Plan Goals

The following goals were selected to align with the quality improvement efforts of the San Mateo Medical Center. The Adjusted Quartile Ranking measures the priority performance measures on a national level, placing it's ranking in the 1st (to 25th percentile) to 4th (lowest 25th percentile) quartile, indicating the amount of improvement from the previous year to this year. Cancer screenings were selected as a result of the 2019 HCH/FH Needs Assessment, which indicated disparities in the number of screenings performed for colorectal and breast cancer for both people experiencing homelessness and farmworkers, as well as incidence of cancer in the homeless patient population. Cervical cancer screening and diabetes remain SMMC priorities and have been decreasing since 2017, indicating a need for improvement. Trimester Entry into Care (1st Trimester) saw a vast improvement in 2019 due to data validation and will be monitored in 2023-2024 to ensure this measure maintains upward progress. Depression Screening and Follow-up remains a challenging measure for quality improvement and relies heavily on SMMC roll-out of depression screening procedures in outpatient clinics.

In 2021, Hypertension was added as a measure of focus due to significant decrease in performance during the COVID-19 pandemic. Lastly, Adult BMI Screening & Follow-up will be removed in 2024 in order to align with SMMC's reporting; SMMC has removed or de-prioritized this measure in their Primary Care Quality Report and QIP reporting in 2024.

QI Measures of Focus	2024 PEH	2024 FW	HCH/FH Goals	2024 CA 330 Programs	2024 Adjusted Quartile Ranking	2024 SMMC Annual Performance (QIP)
Screening and Preventive Care						
Cervical Cancer Screening	35%	39%	79%	60%	3	64%
Colorectal Cancer Screening	43%	56%	68%	43%	1	59%
Breast Cancer Screening	55%	76%	80%	57%	1	66%
Depression Screening and Follow-up	33%	35%	45%	70%	4	63%
Chronic Disease Management						
Hypertension	63%	59%	66%	66%	2	67%
Diabetes A1c >9% or missing	38%	29%	12%	29%	3	33%
Maternal Health						
Early Entry into Prenatal Care	64%		81%	76%	3	89%

*Data from UDS Report of corresponding year

*Ranking (from 1 to 4) of health center clinical performance compared to other health centers nationally, one is the highest.

* Healthy People 2030 used for the following target goals: Cervical Cancer Screening, Colorectal Cancer Screening, Breast Can cer Screening, Diabetes A1c > 9% or missing, Early Entry into Prenatal Care

1. **Standardize a reporting pathway between gathering and analyzing data and presenting the data to the system to execute change.**
    a. Build reporting pathway to Health Plan of San Mateo to ensure clinical data of vulnerable populations are included in future programs and planning.
    b. Create data communication pathway between service agencies and HCH/FH program to exchange information on number of clients experiencing homelessness or farmworkers served.
        i. Share changes in population total with county leaders.
2. **Cervical Cancer Screening**
    a. Goal: Percentage of women 21*–64 years of age who were screened for cervical cancer using either of the following criteria:

• Women age 21–64 who had cervical cytology performed within the last 3 years

• Women age 30–64 who had human papillomavirus (HPV) testing performed within the last 5 years

b. Criteria

i. Numerator: Women with one or more screenings for cervical cancer using either of the following criteria:

1. Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women 24–64 years of age by the end of the measurement period.
2. Cervical HPV testing performed during the measurement period or the 4 years prior to the measurement period for women who are 30 years or older at the time of the test.

ii. Denominator: Women 24 through 64 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria

c. Analyze current challenges in getting patients screening for cervical cancer across SMMC and County Health. Implement evidence-based intervention to improve clinical performance.

3. Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)

a. Goal: Reduce the percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

b. Criteria

i. Numerator: Patients whose most recent HbA1c level during the measurement year was greater than 9.0%, or was missing, or was not performed during the measurement period

ii. Denominator: Patients 18 to 75 years of age by the end of the measurement period with a countable visit during the measurement period

4. Early Entry into Prenatal Care [Monitor Only]

a. Goal: Improve the percentage of prenatal care patients who entered prenatal care during their first trimester during the measurement year.

b. Criteria

i. Numerator: Patients who began prenatal care at the health center or with a referral provider, or who began care with another prenatal provider, during their first trimester

ii. Denominator: Patients seen for prenatal care during the measurement year.

iii. Trimester of entry based on last menstrual period

5. Depression Screening and Follow-up

a. Goal: Improve the Percentage of patients aged 12 years and older screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying visit

b. Criteria

i. Numerator: 1) Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and screened negative for depression. 2) Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and if screened positive for depression, a follow-up plan is documented on the date of or up to two days after the date of the qualifying visit.

ii. Denominator: Patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period, as specified in the measure criteria.

6. Colorectal Cancer Screening

a. Goal: Improve the percentage of adults 45–75 years of age who had appropriate screening for colorectal cancer in the measurement year.

b. Criteria

i. Numerator: Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

1. Fecal occult blood test (FOBT) during the measurement period
2. Stool deoxyribonucleic acid (DNA) (sDNA) with fecal immunochemical test (FIT)- during the measurement period or the 2 years prior to the measurement period
3. Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period
4. Computerized tomography (CT) colonography during the measurement

period or the 4 years prior to the measurement period

5. Colonoscopy during the measurement period or the 9 years prior to the measurement period

ii. Denominator: Patients 46 through 75 years of age by the end of the measurement period with a countable visit during the measurement period.

7. **Breast Cancer Screening**

   a. Goal: Improve the percentage of women 50–74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.

   b. Criteria:

      i. Numerator: Women with one or more mammograms anytime on or between October 1 two years prior to the measurement period.

      ii. Denominator: Women 52 through 74 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria

8. **Monitor and Review: SMMC Patient Satisfaction**

   The Clinical Services Coordinator will monitor and review patient satisfaction performance received by the San Mateo Medical Center to ensure quality of care. The Clinical Services Coordinator will provide updates to the QI Committee.

9. **Develop Baseline for Homeless Death Data with Public Health, Policy and Planning (PHPP) Epidemiology**

   The Clinical Services Coordinator and Planning and Implementation Coordinator will work with PHPP Epidemiology to validate current death data collected for persons experiencing homelessness in San Mateo County. Collaborate to improve data collection following validation.

10. **Develop Baseline for Cancer Screenings Data with Population Health**

    The Clinical Services Coordinator and Planning and Medical Director will work with Population Health to evaluate health disparities among cancer screenings and prevalence data collected for people experiencing homelessness and farmworkers in San Mateo County. Collaborate to improve data collection following validation.

APPENDIX

QI/QA Committee Structure

The role of QI Committee members is to:

Provide leadership and recommendations for:

- Ongoing assessment, monitoring and improvement of services including primary care
- Patient and staff education, continuity of care
- Patient satisfaction
- Support services

Information systems integrity and accountability- **The role of the Medical Director** is to:

- Oversee and guide of QI/QA activities and clinical services coordinator
- Prepare and present the HCH/FH QI quarterly report to the HCH/FH CAB
- Report out to various QI and Hospital Groups working with homeless and farmworker patients
- Represent QI/QA and HCH/FH Program interests

Information systems integrity and accountability- **The role of the HCH/FH Clinical Liaison** is to:

- Advice and guide the HCH/FH Program and its QI/QA activities and Clinical Services Coordinator with the perspective of primary care providers with a particular focus on the brick & mortar clinic sites
- Report out HCH/FH updates to various QI, hospital groups and SMMC providers
- Represent QI/QA and HCH/FH program interests
- Liaison between HCH/FH program and County health clinics

With support from the HCH/FH Program staff, **the role of the Clinical Services Coordinator** is to:

- Prepare agenda and meeting material
- Present previous meeting minutes for approval
- Review of status of UDS quality of care and health disparities clinical measures
- Review of HCH and FH utilization trends
- Review of areas of concern/problem reports
- Follow-up on previously identified problems/opportunities for improvement

- Work with SMMC and other stakeholders to meet identified goals

QI/QA Process

The HCH/FH QI Plan will be carried out in accordance with SMMC policy by:

- Establishing broad performance improvement goals and priorities that are aligned with the mission, vision, values and goals of SMMC
- Developing and utilizing specific mechanisms for the identification, adoption and reporting of performance improvement projects
- Monitoring organization performance through appropriate data collection, aggregation and analysis
- Providing information regarding performance improvement activities and education to the HCH/FH CAB, SMMC Hospital Board, SMMC Quality Improvement Committee (QIC), program employees, outpatient clinics and program contractors.
- PDSA (Plan-Do-Study-Act) Models will be used to plan action for CQM goals.

Reporting Channels

A concerted effort is being undertaken during the 2020-2021 year to standardize reporting pathways for both gathering and analyzing data as well as presenting the data to SMMC or County Health to execute change.

- The HCH/FH QI Plan will be submitted by the HCH/FH QI/QA Committee to the HCH/FH Co-Applicant Board (CAB).
- Quarterly reports of performance improvement activities will be provided to the HCH/FH CAB with annual reports provided to the SMMC Hospital Board.
- Recommendations and actions involving SMMC clinics will be communicated by the HCH/FH QI Committee to the SMMC QIC and Primary Care QI Group as appropriate.
- Recommendations and actions involving program contractors will be communicated by the HCH/FH QI Committee to the Program Coordinator as appropriate.