Alameda County Health Care for the Homeless Commission
Clinical Quality Committee
April 20, 2020

Review of ACHCH Program Areas and Measures

A. Program Areas

1. Primary Care (contracted)
2. Dental and Optometry (contracted)
3. Street Health Outreach (directly provided and contracted, coordinated with other provider organizations)
4. Shelter Health (directly provided and contracted, coordinated with other provider organizations)
5. Recuperative/Respite Care (new programmatic area, contracted)

B. **Clinical Quality Measures** (note the measures below are primarily clinical in focus and for the purposes of this meeting do not include many ACHCH structure and process measures)

Measurement Area	Current ACHCH Measures, Comments
Covid-19	Comments: New work is focused on: 1. Outreach. 2. Linkage to Testing Sites. 3. Case Tracking. 4. Referrals to Isolation and Quarantine Housing as it is available. HRSA surveys FQHCs weekly (see attached CA summary).
HIV	Current measures include: **Follow-up:** Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 90 days of diagnosis. **Clinical outcome:** % of patients screened positive for HIV who achieve viral suppression.

	Comments: The above are HRSA-selected measures. HRSA updated the follow-up measure to reflect a shorter period, 30 days. Additional focus this year for ACHCH: • **Outreach:** Engage new and existing patients in HIV prevention services, identifying those at risk for HIV using validated screening tools. • **HIV Testing:** Increase the number of new and existing patients tested for HIV. 2a. **PrEP Prescriptions:** For persons who test negative, provide HIV prevention education, and prescribe and support the use of clinically indicated PrEP. 2b. **Linkage to Treatment:** For persons who test positive, link them to HIV treatment.
Hepatitis C	Current measures include: • **Follow-up:** Percentage of patients newly diagnosed with Hepatitis C who were seen for follow-up treatment within 90 days of diagnosis. • **Clinical outcome:** % of patient diagnosed with Hep C who were cured. Comments: These measures have been included in HealthPAC contracts and are familiar to contracted FQHCs.
Hypertension	Current measures include: **Clinical outcome:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period. Comments: This is a HRSA-selected measure (NCQA).
Diabetes	Current measures include: **Clinical outcome:** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. Comments: HRSA required measure (NCQA).

Dental	Comments: Due to Covid-19, contracted dental services provided by On-Site Dental are suspended. On-site Dental services are suspended. AHCHC is consulting with Dr. Amanzadeh on dental strategy. ACHCH does not track the HRSA-selected measure which is focused on dental sealants for children.
Mental Health	Comments: • Contracted FQHCs provide integrated behavioral health services with medical care. • ACHCH providers serve as consulting psychiatrists, in addition to holding caseloads of patients with serious and persistent mental illness. • Due to Covid-19, behavioral health visits are provided via telehealth; patients are responding positively and no-shows are down. ACHCH does not track the HRSA-selected measure which is focused on depression screening.
Substance Use Disorder (SUD)	Comments Additional measures are being considered to reflect the work ACHCH staff and contractors are doing: • Screening for Alcohol (use of Audit-C) • Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, and (2) if identified to be a tobacco user received cessation counseling intervention • Medication Assisted Treatment for opioid addiction (buprenorphine).
Case Management - Primary Care	Current measures include: • # clients with linkage to a primary care medical home
Case Management - Housing	Current measures include: Completion of a housing status assessment for every client.
Patient Experience	Current measures include: • % who indicate they would refer friends/family to the Trust clinic. • % improvement in net promoter score.

HRSA PERFORMANCE MEASURES SAC 2020-2022					
Measure		**2018 numbers**	**2019 Target**	**2021 SAC Target**	**Contrib/Restrict Factors/ Notes**
Access to Prenatal Care	Percentage of prenatal care patients who entered treatment during their first trimester	70%	70%	80%	FINHA
Birthweight	Percentage of patients born to health center patients whose birthweight was below normal (less than 2500 grams)	5%	6%	5%	FINHA
Childhood Immunization	Percentage of children with their 3rd birthday during the measurement year or January 1st of the following year who are fully immunized before their 3rd birthday.	20%	80%	75%	AHS Epic reporting connecting to State IZ database in 2020
Cervical Cancer Screening	Percentage of women 21-64 years of age who received one or more tests to screen for cervical cancer	61%	65%	65%	increased Street Health services will lower #'s
Adolescent Weight Assessment and Counseling	Percentage of patients aged 3 until 17 who had evidence of BMI percentile documentation AND who had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year	57%	95%	80%	Epic improvement at AHS will improve
Adult Weight Screening and Follow-up	Percentage of patients aged 18 and older who had documentation of a calculated BMI during the most recent visit or within the six months prior to that visit and if the most recent BMI is outside parameters, a follow-up plan is documented	34%	70%	70%	influenced by Street Health numbers, Epic
Tobacco Use Screening and Cessation	Percentage of patients age 18 years and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user	94%	90%	95%	increased Street Health services may lower #'s, but critical
Use of appropriate medications for asthma	Percentage of patients 5–64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period	94%	80%	95%	
Cholesterol Treatment (Lipid Therapy for Coronary Artery Disease (CAD)	Percentage of patients aged 18 years and older with a diagnosis of Coronary Artery Disease (CAD) who were prescribed a lipid-lowering therapy	99%	95%	95%	

Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy	Percentage of patients aged 18 years and older who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) in the prior year OR who had a diagnosis of ischemic vascular disease during the measurement year who had documentation of use of aspirin or another antithrombotic	97%	90%	95%	
Colorectal Cancer Screening	Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer	57%	65%	65%	increased Street Health services will lower #'s
HIV Linkage to Care	Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis	100%	95%	100%	
Depression Screening and Follow-up	Percentage of patients aged 12 and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	56%	90%	80%	increased Street Health services may lower #'s, but critical
Dental Sealants	Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the reporting period		50%	90%	
Hypertension	Percentage of patients 18 to 85 years of age with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 at the time of the last reading	74%	75%	80%	increased Street Health services may lower #'s, but critical
Diabetes	Percentage of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1c (HbA1c) was greater than or equal to 9% at the time of the last reading in the measurement year	36%	30%	30%	Focus of cross Health Center Quality activities
Additional: Ensure Access to comprehensive oral health services for homeless persons treated in portable care settings	By 2019 increase access to comprehensive oral health examinations, dental services and supportservices to at least 30% of homeless patients receiving medical services on ACHCH portable medical care (mobile medical clinic and Street Medicine).	36%	30%	30%	How to track access to Dental homes

Financial Viability / Costs						
Total Cost Per Patient	ACHCHP is expecting our average cost per patient to be increased for the next 2 years to $1,600. Our program strategy is to perform increasingly costly work with chronically homeless patients with complex comorbidity.	$ 1,839	$ 1,600	$	1,800	
Medical Cost Per Medical Visit	Maintaining average medical cost/visit to under $350 during the length of the Project Period	$ 412	$ 350	$	400	
Health Center Program Grant Cost Per Patient	Limit the total 330 grant funding per patient to less than $360.	$ 386	$ 360	$	360	
Change in Net Assets to Expense Ratio	N/A					
Working Capital to Monthly Expense Ratio	N/A					
Long-Term Debt to Equity Ratio	N/A					
Additional Measure: Provider Productivity	Utilization of licensed providers, including physicians, nurse practitioners, licensed mental health providers, dentists, optometrists, and ophthalmologists.	1403	1800		1500	
Additional Measure Program Income to Grant	By the end of 2018, the total of HCH program non-federal income over the total of HRSA 330 (h) grant is 3:1	$ 2.0	$ 3.0	$	2.4	$ -

California Health Center COVID-19 Survey Summary Report

Latest data from April 10, 2020

Number of Health Center respondents = 140 (78% of all Health Centers)

Data represents information provided by health centers from a single, specified reporting date. Summary information across report dates is not comparable due to differences in which health centers responded for a given report date.

Patient Testing

Metrics	Value
Health Centers with COVID-19 Testing Capacity	85.71%
Health Centers with COVID-19 Drive-Up/Walk Up Testing Capacity	52.86%
Patients Tested for COVID-19	11,611
Patients Tested Positive for COVID-19	799

Operations and Staff

Metrics	Value
Health Center Weekly Visits Compared to Pre-COVID 19 Weekly Visits	54.18%
Health Center Sites Temporarily Closed	250
Staff Tested Positive for COVID-19	49
Health Center Staff Unable to Work (due to site/service closure, exposure, family/home obligations, lack of PPE, etc.)	16.93%
Average Percent of Health Center Visits Conducted Virtually	64.29%
Health Centers with an adequate supply of Personal Protective Equipment (PPE) for the next week (Types of PPE)	
– Surgical Masks	77.14%
– N95/PPR Masks	81.43%
– Gowns	77.14%
– Gloves	90.71%

Metrics	Value
– Face Masks/Goggles	72.86%

Date Last Reviewed: April 2020

Quick Links

- HRSA.gov
- Find Funding
- BPHC Career Opportunities
- Annual Health Center Data
- Health Center Program Policies
- Primary Health Care Digest Archives

En Español Share

Find a Health Center

Enter a City name, ZIP Code, (such as "20002"), address, State name, or place name.

Near

Enter a location

HRSA Powered by data.hrsa.gov

Contact Us

- Subscribe to weekly BPHC updates
- HRSA News & Events
- Key BPHC Staff
- Health Center Program Support or call 877-464-4772. 7 a.m. to 8 p.m. ET, Monday - Friday (except federal holidays)

Language Assistance Available

Español	繁體中文	Tiếng Việt	한국어
Tagalog	Русский	العربية	Kreyòl Ayisyen
Français	Polski	Português	Italiano
Deutsch	日本語	فارسی	English