County of Solano
Community Healthcare Board
Regular Meeting

June 17, 2020
12:00 pm-2:00 pm
275 Beck Avenue Fairfield, CA 94533
Room Location: Conference Call GoToMeeting
Call in #: 1-571-317-3112 **Access Code:** 293-069-869

AGENDA

1) CALL TO ORDER – 12:00 PM

a) Welcome
b) Roll Call

2) APPROVAL OF THE AGENDA

3) APPROVAL OF THE MAY 2020 MEETING MINUTES

4) PUBLIC COMMENT

This is the opportunity for the Public to address the Board on a matter not listed on the Agenda, but it must be within the subject matter jurisdiction of the Board. Please submit a Speaker Card before the first speaker is called and limit the comments to three (3) minutes.

5) PROJECT DIRECTOR/CHIEF EXECUTIVE OFFICER REPORT

a) COVID-19 Health Center Impact Update
b) HRSA Update
c) Project Roomkey Update

6) CO-APPLICANT AGREEMENT UPDATE BY DEPUTY COUNTY COUNSEL

7) OPERATIONS COMMITTEE UPDATES & REPORTS

a) QI/QA Update

8) UNFINISHED BUSINESS

a) None

9) ACTION ITEMS

a) FHS Budget

10) BOARD MEMBER COMMENTS

11) PARKING LOT

a) Health Center Marketing Campaign & Website Design
b) The IHI Quadruple Aim Initiative * Health Center Practices*

12) NEXT COMMUNITY HEALTH BOARD MEETING

Location: July 15, 2020
275 Beck Ave
Fairfield, CA 94533,
Start Time – 12:00 PM
Room: Conference Room 1

13) ADJOURN

The County of Solano Community Healthcare Board does not discriminate against persons with disabilities and is an accessible facility. If you wish to attend this meeting and you will require assistance to participate, please call Solano County Family Health Services at 707-784-2170 at least 24 hours in advance of the event to make reasonable arrangements to ensure accessibility to this meeting.

If you wish to address any item listed on the Agenda, or Closed Session, please submit a Speaker Card to the Board Clerk before the Board considers the specific item. Cards are available at the entrance to the Board chambers. Please limit your comments to three (3) minutes.

County Of Solano

Community Healthcare Board

REGULAR GOVERNING BOARD MEETING MINUTES
May 20, 2020
Telephone Conference Call

Members Present:
Ruth Forney, Miriam Johnson, Tracee Stacy, Gwen Piercy, Sandra Whaley, Gerald Hase, Michael Brown, Jim Jones, Anthony Lofton, Robert Wieda, Katrina Morrow

Members Absent:
Brandon Wirth

Staff Present:
Santos Vera, Dr. Bela Matyas, Gerry Huber, Alicia Jones, Sneha Innes, Jack Nasser, Noelle Soto, Dr. Michele Leary, Janine Harris, Amanda Meadows, Anna Mae Gonzales-Smith, Joann Parker, Yvonne Ezenwa, Cheryl Esters, Charlynn Askim

1) **CALL TO ORDER- 12:00 PM**
    a. Welcome
    b. Roll Call

2) **Approval Of The Agenda**

Move motion to approve May 20, 2020, Agenda with an amendment to move up action item 9a. Approval of the FHS Budget

Motion by Sandra Whaley seconded by Michael Brown
Discussion: None

Aye: Ruth Forney, Miriam Johnson, Tracee Stacy, Gwen Piercy, Sandra Whaley, Gerald Hase, Michael Brown, Jim Jones, Anthony Lofton, Robert Wieda, Katrina Morrow
Nay: None
Motion Carries

3) **Approval Of April 15, 2020, Meeting Minutes**

Move motion to approve April 15, 2020, Meeting Minutes
Motion by Miriam Johnson, seconded Jim Jones
Discussion: None

Aye: Ruth Forney, Miriam Johnson, Tracee Stacy, Gwen Piercy, Sandra Whaley, Gerald Hase, Michael Brown, Jim Jones, Anthony Lofton, Robert Wieda, Katrina Morrow
Nay: None
Motion Carries

4) Public Comment

None

5) PROJECT DIRECTOR/CHIEF EXECUTIVE OFFICER REPORT

a. COVID-19 Health Center Impact Update: Presented by Dr. Bela Matyas

  i. Countywide: 430 cases reported & 16 fatalities. Windsor Vallejo Care Center accounts for 30% of cases. Hospitals are in good standing with plenty of ICU beds and ventilators. Healthcare has seen a huge reduction in patient foot traffic, resulting in a negative finical impact. Hospitals all around are laying off employees. Slowly reopening, will not fully reopen for a while. Projecting $3-4 million in the red for revenue. Realignment money will be hit hard. Vacant positions will remain vacant, 20% vacancy rate to balance the budget. Trimming things not needed, trying to avoid layoffs, and initiating hiring freeze.

    1. Tracee Stacy suggested working as partners with the County's Board Of Supervisors (BOS) to recommend temporary layoffs to help with the budget. She was advised layoffs are implemented by the County's BOS at a county level and not by the Co-Applicant Healthcare Board.
    2. Gwen Piercy asked if providers can take patients over the phone for more revenue. Gwen was advised that "telehealth" is caring for patients over the phone. PPS rate is provided through Partnership Health Plan. Currently, there are 7 providers undertaking telehealth only & 4 hybrid providers doing face to face and telehealth.

b. HRSA Update: Presented by Santos Vera & Yvonne Ezenwa

  i. Refer to page 7 handout: *Solano County Family Health Services COVID-19 Grants & Awards*.

    1. One year to use the money awarded. High-level overview the money from the different grants and awards will be used to: maintain operations, staff salary & budgets allocated to staff, training & supplies.

      a. Mr. Huber has advised the following regarding testing within Solano County. Testing is available for community members, an average of about 300 people per day. High-risk clusters will be the focus. Moving forward with loosening shelter at home restrictions. Contact tracing for positive results will have follow up testing. Also, currently, antibody testing is not available.
      b. Tracee would like more involvement with the budget before submitting it to BOS. Mr. Huber has advised that the budget will need to be submitted as if COVID-19 never happened. Changes will happen in the budget throughout the summer. The final budget will be submitted around September. Suggested to the board to meet during the summer to discuss budgets.

c. Dentistry Update: Presented by Dr. Sneha Innes

  i. Tele dentistry is unable to bill out. Patients are being seen in the clinics. Treatments and exams are available. Opening one week at a time, morning is exams so no aerosol in the air and the afternoon treatments. Air purifiers throughout the clinics, on during the night, and ready for clean air in the morning. Limited who is seen, no one over the age of 85 years or health issues. Oral surgeries referral is given for referrals.

    1. Ruth Forney suggesting for teledentistry.

ACTION:
Santos Vera will investigate Teledentistry and report back to the board

d. Project Roomkey Initiative: Presented by Santos Vera
    i. A new initiative from CA Governor Newson. Ran across three cities: Vallejo, Vacaville, & Fairfield. Each city ran by its agency. FHS ask to participate to support Project Roomkey in Fairfield, dependent on provider availability. The award was given to Shelter Inc. Shelter Inc partnered with a local hotel to managing the homeless population during this crisis: managing chronic conditions of patients, assessments, and referrals. Dr. Leary is working on scheduling providers who have experience with the homeless. Possible collaboration with other FQHCs-with CMC, located in Dixon, & OLE Health, located in Fairfield.

6. CO-APPLICANT AGREEMENT UPDATE BY DEPUTY COUNTY COUNSEL

a. Presented by Joann Parker.
    i. A draft of the co-applicant agreement has been sent to the Executive Committee. Waiting on responses and will meet again in early June.

7. OPERATIONS COMMITTEE UPDATES & REPORTS

a. FHS Finance Update: Presented by Janie Harris
    i. Refer to page 8 within the agenda packet: *Solano County Health And Social Services: Family Health Services-Total Billable Encounters-March 16th - May 7th, 2020*
    ii. Face to Face encounters vs Telehealth encounter. Telehealth is reimbursed through the PPS rate. Charts are on a weekly bias-roughly 50/50 telehealth and face to face encounters.
    iii. Patient Survey: Presented by Jack Nasser
        1. Refer to pages 9-11 within the agenda packet: *Telehealth Patient Satisfaction Survey*
        2. Overall excellent to good feedback

b. Case Management Update: Presented by Noelle Soto
    i. Refer to pages 12 &13 within the agenda packet: *Family Health Services – Case Management*
    ii. The first page is an overview & goals of the case managers
    iii. Insufficient staffing has changed throughout the years
    iv. Collaborative with different agencies to work together

c. Board Self-Assessment Results: Presented by Yvonne Ezenwa
    i. Refer to pages 14 & 15 within the agenda packet: *Solano County Family Health Services-Community Healthcare Board Self-Assessment Results*
    ii. 50% responses, this not a HRSA requirement. Strictly internal information to find strengths and weaknesses.

8. UNFINISHED BUSINESS

a. None

9. **ACTION ITEMS**
    a. Approval of the FHS Budget

Move motion to approve the FHS budget with the understanding of leaving the FHS budget as a standing item due to changes.

Motion by Miriam Johnson seconded by Robert Wieda
Discussion: None

Aye: Ruth Forney, Miriam Johnson, Tracee Stacy, Gwen Piercy, Sandra Whaley, Gerald Hase, Michael Brown, Jim Jones, Anthony Lofton, Robert Wieda, Katrina Morrow
Nay: None
Motion Carries

10. BOARD MEMBER COMMENTS
    a. Robert Wieda mentioned he never received the Board Self-Assessment Survey
        i. He was advised this survey was emailed and mailed out within April's agenda packet
    b. Miriam Johnson stated she will need her agenda mailed and has inquired receiving a phone list for the board members
    c. Jim Jones inquired about the support group via telehealth. He was advised due to staffing issues this will have to be put on hold and relook at in the future.
    d. Jack Nasser & Toya Adams informed the board members they have been contacted by the Mayor's office. May is national nurses Month- presentation to take place at the 365 Tuolumne location

ACTION:
Review the list of board members who need the agenda packet mailed. - Ruth, Yvonne, & Amanda
Provide board members with a phone directory – Ruth, Yvonne, & Amanda

11. PARKING LOT
    a. Health Care Marketing Campaign & Website Design

12. NEXT COMMUNITY HEALTH BOARD MEETING

DATE: June 17, 2020
START TIME: 12:00pm
LOCATION: Telephone Conference Call
Dial: +1 (571) 317-3112
Access Code: 293-069-869

13. Adjourn

HANDOUTS:

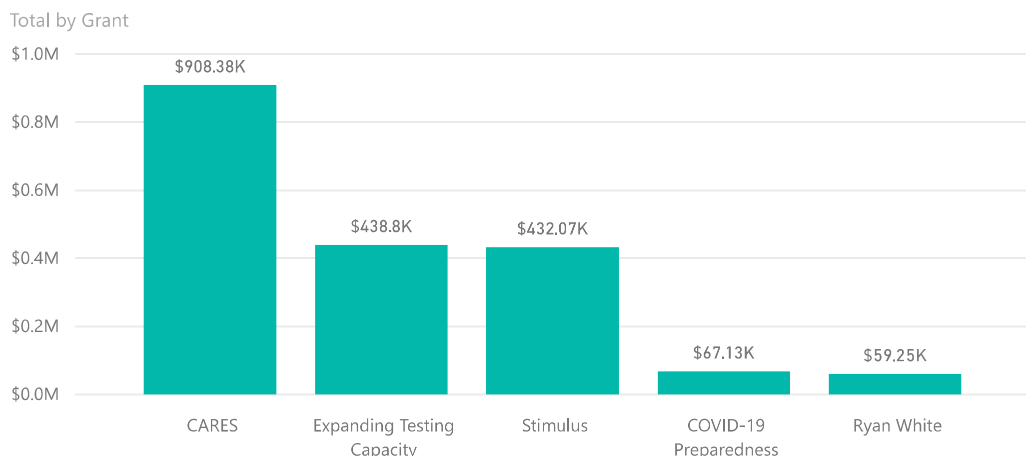
- Agenda
- April Meeting Minutes
- Solano County Family Health Services COVID-19 Grants & Awards

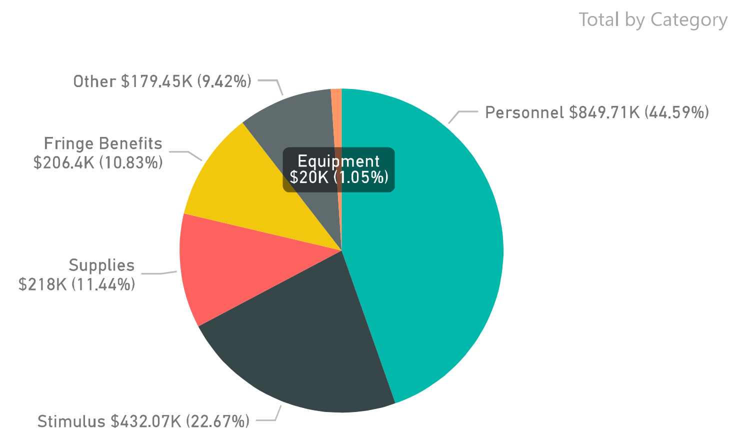
- Solano County Health And Social Services: Family Health Services-Total Billable Encounters-March 16th - May 7th, 2020
- Telehealth Patient Satisfaction Survey
- Family Health Services – Case Management
- Solano County Family Health Services- Community Healthcare Board Self-Assessment Results
- County Of Solano: Requested: Div 7580 - Family Health Services-For The Fiscal Year 20/21

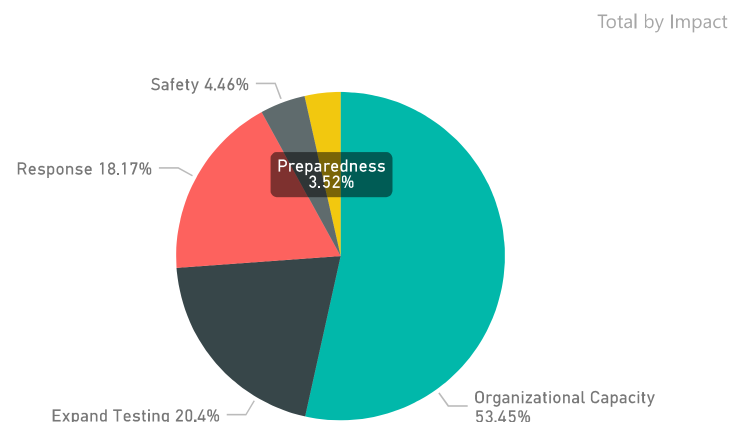
Solano County Family Health Services

COVID-19 GRANTS & AWARDS

$1.91M







CATEGORIES

Personnel: Staff performing COVID-19 preparedness activities, telehealth, contact tracing, outreach, and testing

Stimulus: Lost revenue or operational expenses

Supplies: PPE and hardware such as laptops, tablets, headsets, and pagers

Other: Patient education/outreach, transportation for clients with barriers, storage units

Community Healthcare Board Clinical Quality Improvement Report
Solano County Family Health Services
Month: May 2020

TABLE OF CONTENTS

The below information reflects critical components related to Risk Management & Quality Improvement activities for Family Health Services:

I. Clinical Quality

I. CLINICAL QUALITY

Terms Defined

Quality Improvement Program (QIP)- financial incentive program from Partnership HealthPlan of California to primary care providers for meeting specific performance thresholds.

Uniform Data System (UDS)- standardized reporting system for Health Resources & Services Administration (HRSA) health center grantees.

Focus on Partnership QIP Measures

In response to the extenuating circumstances the COVID-19 pandemic has placed on the healthcare delivery system, Partnership HealthPlan has modified their QIP measure set for 2020.

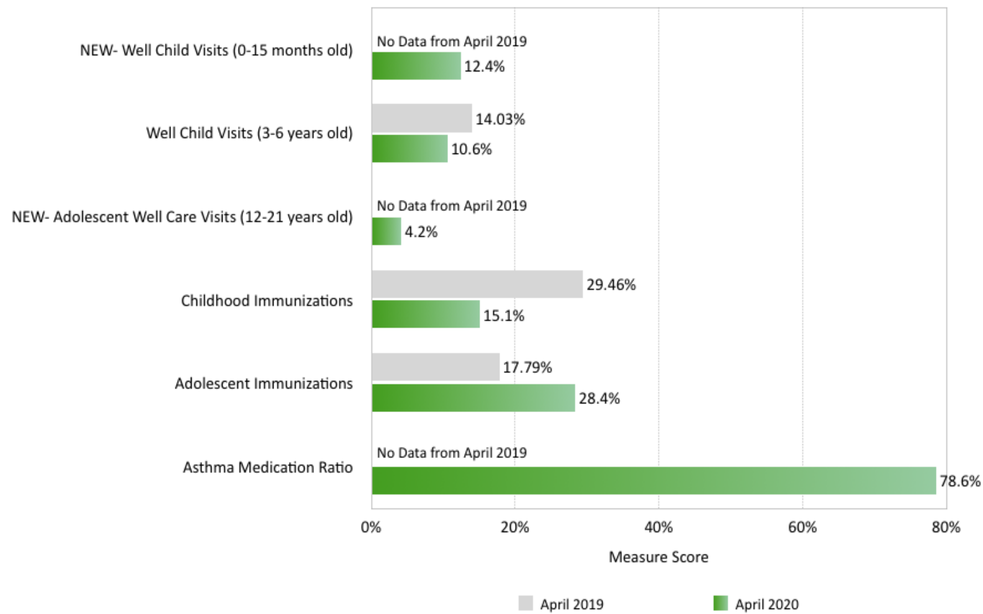
The new focused measurement list for 2020 will include:

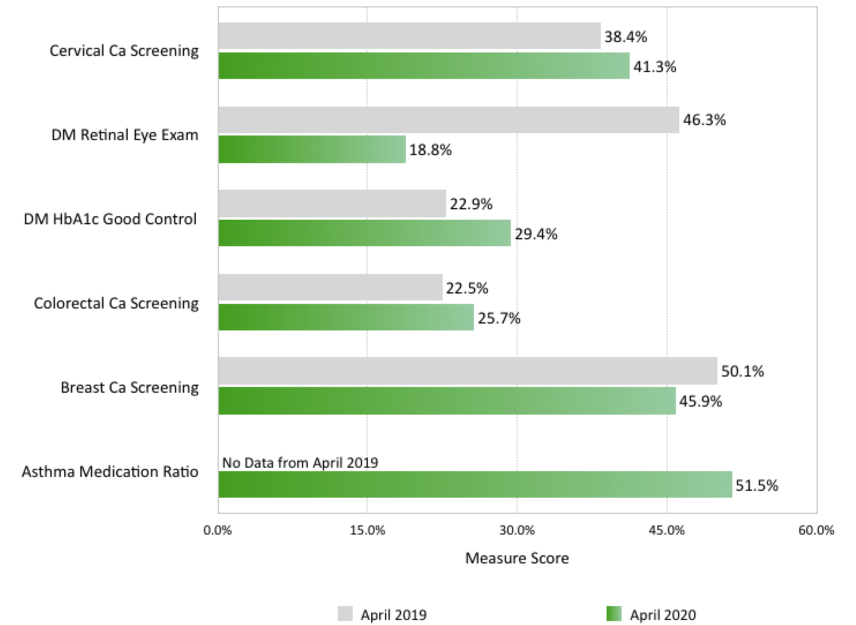
1. Diabetes A1c Good Control
2. Controlling High Blood Pressure
3. Colorectal Cancer Screening
4. Asthma Medication Ratio
5. Well Child Visits First 15 Months of Life
6. Childhood Immunizations-Combo 10

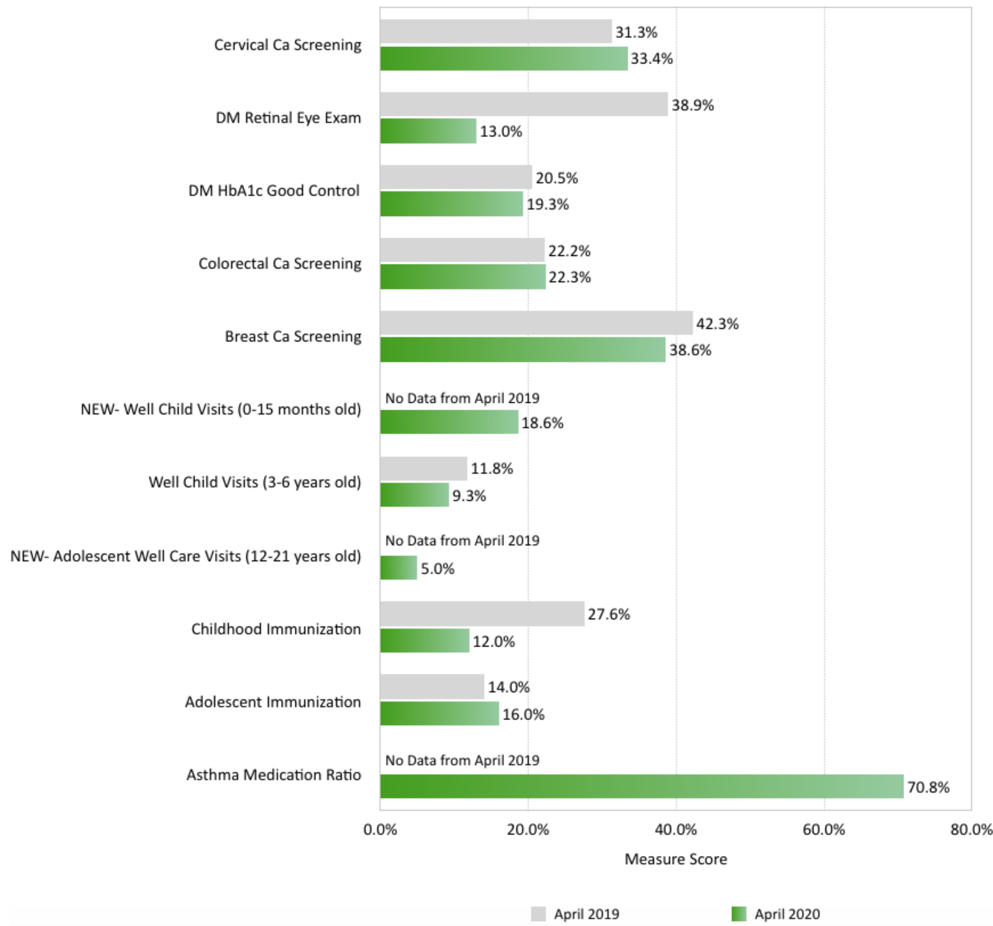
These measures have been removed:

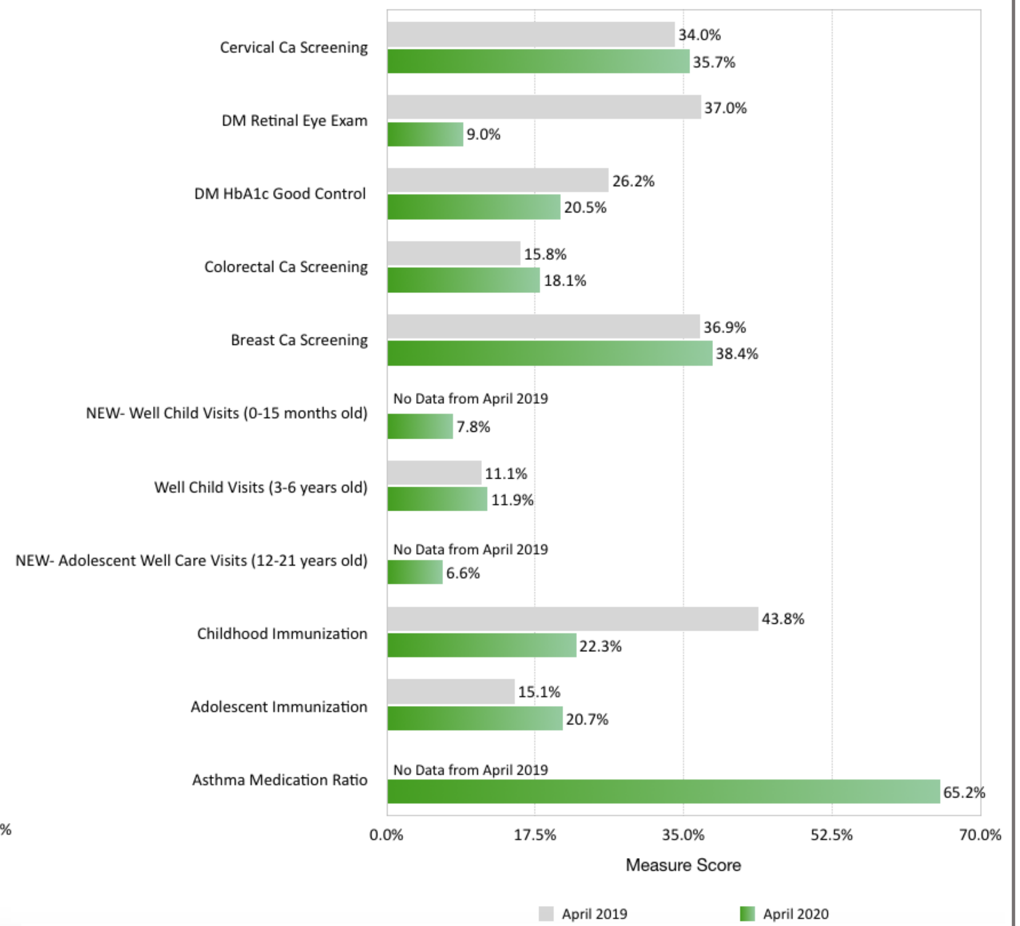
1. Diabetes Eye Exam
2. Cervical Cancer Screening
3. Breast Cancer Screening
4. Well Child Visits 3-6 years of age
5. Adolescent Well Care Visits 12-21 years of age
6. Adolescent Immunizations

Family Health Services continues to be committed to improve patient care and clinical outcomes for all measures in accordance with the 2020-2021 Solano County Family Health Services Quality Assurance/Quality Improvement Plan. The following graphs show the current QIP score for all measures in comparison to the score for the same timeframe in 2019 for each clinic site.






Vacaville Clinic
Cervical Ca Screening
31.3%
33.4%
DM Retinal Eye Exam
38.9%
13.0%
DM HbA1c Good Control
20.5%
19.3%
Colorectal Ca Screening
22.2%
22.3%
Breast Ca Screening
42.3%
38.6%
NEW- Well Child Visits (0-15 months old)
No Data from April 2019
18.6%
Well Child Visits (3-6 years old)
11.8%
9.3%
NEW- Adolescent Well Care Visits (12-21 years old)
No Data from April 2019
5.0%
Childhood Immunization
27.6%
12.0%
Adolescent Immunization
14.0%
16.0%
Asthma Medication Ratio
No Data from April 2019
70.8%
0.0%
20.0%
40.0%
60.0%
80.0%
Measure Score
April 2019
April 2020


Vallejo Clinic
Cervical Ca Screening
34.0%
35.7%
DM Retinal Eye Exam
37.0%
9.0%
DM HbA1c Good Control
26.2%
20.5%
Colorectal Ca Screening
15.8%
18.1%
Breast Ca Screening
36.9%
38.4%
NEW- Well Child Visits (0-15 months old)
No Data from April 2019
7.8%
Well Child Visits (3-6 years old)
11.1%
11.9%
NEW- Adolescent Well Care Visits (12-21 years old)
No Data from April 2019
6.6%
Childhood Immunization
43.8%
22.3%
Adolescent Immunization
15.1%
20.7%
Asthma Medication Ratio
No Data from April 2019
65.2%
0.0%
17.5%
35.0%
52.5%
70.0%
Measure Score
April 2019
April 2020

2020 Core Quality Improvement Measures

Adult Clinical Measure	Measure Description	FHS Measure Goal	UDS National Average	FHS 2019 UDS	Partnership Plan-wide Average	FHS 2019 QIP	Prior Quarter Results	Current Results
Comprehensive Diabetes Management	A1c Control: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) less than or equal to 9.0 percent during the measurement period. (UDS reports poor control HbA1c > 9.0 percent or no test)	Good Control Goal: 60.77% Poor Control Goal: 25.24%	32.79% (Poor Control)	27.3%	69.02% (Good Control)	Fairfield: 47.9% Vallejo: 48.4% Vacaville: 43.9%	N/A	Good Control FF: 29.4% VJO: 20.5% VV: 19.3% Poor Control (pending)
	Medical Attention for Nephropathy: Percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	50%					N/A	(pending)
	Foot Exam: Percentage of patients 18-75 years of age with diabetes who received a foot exam during the measurement year.	50%					N/A	(pending)
	Retinal Eye Exam: Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam in the measurement year or a negative retinal or dilated eye exam in the year prior to the measurement year.	69.53%			63.63%	Fairfield: 57.5% Vallejo: 44.8% Vacaville: 55.7%	N/A	FF: 18.8% VJO: 9% VV: 13%

Adult Clinical Measure	Measure Description	FHS Measure Goal	UDS National Average	FHS 2019 UDS	Partnership Plan-wide Average	FHS 2019 QIP	Prior Quarter Results	Current Results
Hypertension Management	Controlling High Blood Pressure: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period.	72.26%	63.26%	68.4%	69.71%	Fairfield: 51.8% Vallejo: 54.4% Vacaville: 52.3%	N/A	FF: 1.6% VJO: 0.2% VV: 2.8%
Cardiovascular Disease Management	Statin Therapy: Percentage of patients 21 years of age and older at high risk for cardiovascular event who were prescribed statin therapy during the measurement period.	83%	80.63%	75.7%			N/A	(pending)
	Ischemic Vascular Disease (IVD): Percentage of patients 18 years of age and older diagnosed with acute myocardial infarction, or had a coronary artery bypass graft, or percutaneous coronary interventions in the 12 months prior to the measurement year or who had an active diagnosis of IVD during the measurement period and who had documentation of aspirin/antiplatelet during the measurement period.	83%	80.86%	82.4%			N/A	(pending)

Adult Clinical Measure	Measure Description	FHS Measure Goal	UDS National Average	FHS 2019 UDS	Partnership Plan-wide Average	FHS 2019 QIP	Prior Quarter Results	Current Results
HIV	Screening: Percentage of patients 15-65 years of age tested for HIV at least once ever.	50%	*(New measure)*	*(New measure)*			N/A	(pending)
	Newly Diagnosed Linkage to Care: Percentage of patients newly diagnosed with HIV between October 1 of the prior year through September 30 of the current measurement year and who were seen for follow-up treatment within 30 days of diagnosis.	100%	85.55%	100%			N/A	(pending)
Preventative Health Screenings	Cervical Cancer Screening: Percentage of women 21-64 years of age with one medical visit during the measurement period who were screened for cervical cancer using either of the following criteria: • Women age 21-64 who had cervical cytology performed every 3 years. • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	72.02%	55.95%	28.5%	61.36%	Fairfield: 41.9% Vallejo: 37.5% Vacaville: 34.7%	N/A	FF: 41.3% VJO: 35.7% VV: 33.4% UDS: (pending)
	Breast Cancer Screening: 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 (October 1, 2018-December 31, 2020)	69.23%	*(New measure)*	*(New measure)*	59.12%	Fairfield: 57.9% Vallejo: 45.5% Vacaville: 51.5%	N/A	FF: 45.9% VJO: 38.4% VV: 38.6% UDS: (pending)

Adult Clinical Measure	Measure Description	FHS Measure Goal	UDS National Average	FHS 2019 UDS	Partnership Plan-wide Average	FHS 2019 QIP	Prior Quarter Results	Current Results
Preventative Health Screenings (continued)	Colorectal Cancer Screening: Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer as defined by any one of the following criteria: • Fecal occult blood test (FOBT) during the measurement period. • Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA) during the measurement period or the 2 years prior to the measurement period. • Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period. • Computerized tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period. • Colonoscopy during the measurement period or the 9 years prior to the measurement period.	61.7%	44.11%	18.8%	42.19%	Fairfield: 28.3% Vallejo: 21% Vacaville: 26%	N/A	FF: 25.7% VJO: 18.1% VV: 22.3% UDS: (pending)

Adult Clinical Measure	Measure Description	FHS Measure Goal	UDS National Average	IS 2019 UDS	Partnership Plan-wide Average	FHS 2019 QIP	Prior Quarter Results	Current Results
Preventative Health Screenings (continued)	Adult Screening for Body Mass Index (BMI): Percentage of patients aged 18 years and older with at least one medical visit during the measurement period with BMI documented during the most recent visit or within the previous 12 months to that visit and when the BMI is outside of normal parameters, a follow-up plan is documented.	34%	70.15%	33.2%			N/A	(pending)
	Tobacco Use Screening and Cessation Intervention: Percentage of patients 18 years of age and older with at least two medical visits or at least one preventive medical visit during the measurement period who were screened for tobacco use at least once within 24 months and who received cessation counseling intervention if defined as a tobacco user.	79.7%	88.09%	74.7%			N/A	(pending)

Adult & Pediatric Clinical Measure	Measure Description	FHS Measure Goal	UDS National Average	FHS 2019 UDS	Partnership Plan-wide Average	FHS 2019 QIP	Prior Quarter Results	Current Results
Asthma Management	Asthma Medication Ratio: The percentage of patients 5-64 years of age with at least four outpatient visits (or at least one emergency department visit, at least one inpatient encounter, or four asthma medication dispensing events) with a diagnosis of persistent asthma who have a medication ratio greater than or equal to 0.5 during the measurement year. The medication ratio is calculated as follows: Units of controller medications ÷ Units of total asthma medications.	71.62%			57.86%	Fairfield: 44% Vallejo: 53.9% Vacaville: 66.7% Peds: 51.6%	N/A	FF: 51.5% VJO: 65.2% VV: 70.8% Peds: 78.6
Depression Screening	Depression Screening: Percentage of patients aged 12 years and older screened for depression on 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 the positive screen.	13.6%	70.57%	5.8%			N/A	(pending)

Pediatric Clinical Measure	Measure Description	FHS Measure Goal	UDS National Average	FHS 2019 UDS	Partnership Plan-wide Average	FHS 2019 QIP	Prior Quarter Results	Current Results
Routine Physical Exams	Infants First 15 Months of Life: The percentage of patients who turn 15 months of age during the measurement year who had 6 or more Well Child visits during their first 15 months of life. Documentation must include evidence of all of the following: • A health history • A physical developmental history • A mental developmental history • A physical exam • Health education/anticipatory guidance.	72.87%			*(New measure)*	*(New measure)*	N/A	VJO: 7.8% VV: 18.6% Peds: 12.4%
	Children 3-6 Years of Age: The percentage of patients 3–6 years of age who had one or more Well-Child visits with a PCP during the measurement year. Documentation must include evidence of all of the following: • A health history • A physical developmental history • A mental developmental history • A physical exam • Health education/anticipatory guidance.	83.85%			75.23%	Vallejo: 42.4% Vacaville: 43.9% Peds: 55%	N/A	VJO: 11.9% VV: 9.3% Peds: 10.6%

Pediatric Clinical Measure	Measure Description	FHS Measure Goal	UDS National Average	FHS 2019 UDS	Partnership Plan-wide Average	FHS 2019 QIP	Prior Quarter Results	Current Results
Routine Physical Exams (continued)	Adolescents 12-21 Years of Age: The percentage of adolescents 12 to 21 years of age who had at least one comprehensive well-care visit. Documentation must include evidence of all of the following: • A health history • A physical developmental history • A mental developmental history • A physical exam • Health education/anticipatory guidance.	54.26%			*(New measure)*	*(New measure)*	N/A	VJO: 6.6% VV: 5% Peds: 4.2%
Preventative Health Screenings and Immunizations	Childhood Immunizations: Combo-10: Percentage of children 2 years of age with one medical visit during the measurement period who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three Hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one Hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	34.79%	39.44%	25.7%	62.45% (Combo-3)	Combo-3: Vallejo: 46.7% Vacaville: 36.4% Peds: 41.3%	N/A	VJO: 22.3% VV: 12% Peds: 15.1%
	Adolescent Immunizations: Percentage of children 13 years of age who had at least one meningococcal vaccine between 11th and 13th birthdays, at least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) between 10th and 13th birthdays, and at least two human papillomavirus (HPV) between 9th and 13th birthdays.	40.39%			38.24%	Vallejo: 20.3% Vacaville: 30.5% Peds: 34.6%	N/A	VJO: 20.7% VV: 16% Peds: 28.4%

Pediatric Clinical Measure	Measure Description	FHS Measure Goal	UDS National Average	FHS 2019 UDS	Partnership Plan-wide Average	FHS 2019 QIP	Prior Quarter Results	Current Results
Preventative Health Screenings and Immunizations (continued)	Child/Adolescent Weight Assessment and Counseling: Percentage of patients 3–17 years of age who had a medical visit and who had documented height, weight, and body mass index (BMI) percentile and counseling for nutrition and physical activity during the measurement period.	50%	69.16%	49.9%			N/A	(pending)
Dental Sealant	Dental Sealant: Percentage of children aged 6-9 years, who had a dental visit and had an oral assessment or comprehensive or periodic oral evaluation visit and are at moderate to high risk for caries in the calendar year and received a sealant on a permanent first molar tooth during the calendar year.	85%	52.8%	82.4%			N/A	(pending)

PERFORMANCE IMPROVEMENT

Diabetes: HbA1c Control

Goal: By October 2020, reduce the proportion of persons with Diabetes with a HbA1c value greater than 9% by 5%.

Problem: Persons with uncontrolled Diabetes with HbA1c value greater than 9% are at greater risk for complications including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death.

Initiative: By the end of Quarter 1 (January 16, 2020), clinics will implement workflow to identify persons with Diabetes prior to scheduled appointments and the Medical Assistant (MA)/Nurse will pre-order point-of-care HbA1c testing.

Process: Staff will look at next day appointments to identifying patients with Diabetes. Staff will document if the patient needs HbA1c testing on the Pre-Visit Planning template. Point-of-care test will be pre-ordered for patients whose last HbA1c testing was > 3 months prior or have not had a HbA1c test completed during the calendar year. Dr. Leary will discuss the workflow with Providers during staff meeting on December 19.

Results: Provider training completed in December 2019. Clinics have started pre-visit planning with pre-order of point-of-care HbA1c test. Quarter 1 year lookback showed improvement of the measure score of 27.3% in comparison to 30.24% at baseline.

Initiative #2: By the end of Quarter 2 (April 16, 2020), expand the implementation of pre-visit planning for persons with Diabetes across all clinic sites.

Process: QI staff will train Provider-Medical Assistant teams in the Vacaville clinic site on the Pre-Visit Planning template process. Once the roll-out of the initiative is complete in Vacaville, QI staff will train Provider-Medical Assistant teams in the Vallejo clinic site.

Results: In February 2020, QI staff trained Vacaville teams and implemented the process. Unfortunately, prior to training and implementation at the remaining clinic site, Solano County had the first confirmed community acquired case of COVID-19 which shifted significant attention to COVID-19 preparedness activities across all clinic sites. Due to the higher risk for severe illness from COVID-19, follow up visits for persons with Diabetes were converted to virtual visits when possible in order to minimize potential exposure to the virus in our community. Due to the reduction in face-to-face encounters, routine HbA1c testing has been impacted thereby affecting the opportunity for continued improvement of this measure during this timeframe.

Diabetes: HbA1c Control (continued)

Results (continued):

Despite these extreme challenges, in Quarter 2 we have been able to maintain parity with Quarter 1 look-back results. Pre-visit planning will continue for both face-to-face and telemedicine encounters. For patients not seen in the clinic or able to attain tests at a laboratory facility, the pre-visit planning will serve as a placeholder for pending non-emergent/urgent labs and diagnostic studies to be completed once the County's Shelter at Home Health Order has been lifted.

	Baseline Data 10/2019	Quarter 1 Year Lookback (1/2019-1/2020)	Quarter 2 Year Lookback (4/2019-4/2020)
Percentage of Persons with Diabetes with a HbA1c value greater than 9% (includes persons without a HbA1c test done)	612/2024 = 30.24%	595/2181 = 27.3%	621/2280 = 27.24%

Nutrition and Physical Activity Counseling

Goal 1: By October 2020, increase by 5% the number of children and adolescents who receive nutrition and physical activity counseling to restrict the risk of developing uncontrolled diabetes.

Problem: Childhood obesity rate is on the rise and has both immediate and long-term effects on health and well-being. Establishing health nutrition and physical activity habits at a younger age can prevent future health complications.

Initiative: By the end of Quarter 1 (January 16, 2020), Family Health Services clinics will implement standardized workflow for documenting nutrition and physical activity counseling.

Process: Review established workflow for review of BMI and documentation of both nutrition and physical activity counseling at least annually for children and adolescents 3-17 years of age with staff during meeting on December 19.

Result: Documentation workflow reviewed with staff in December 2019. Year lookback for quarter 1 reporting shows an improvement of documentation of BMI, nutrition and physical activity counseling in children and adolescents of 50.1% in comparison to 44% at baseline.

Nutrition and Physical Activity Counseling (continued)

Initiative #2: By the end of Quarter 2 (April 16, 2020), FHS will review workflow for documentation of nutrition and physical activity counseling and reduce the gap from missed counseling opportunities. Additionally, FHS will utilize QI reports to recall and schedule pediatric patients who are due for their well child exams.

Process: FHS completed documentation review with staff. QI staff generated lists of pediatric patients by age which were used to recall patients who had not had or were due for their well child exams. The process was underway for 2 months when FHS modified its recall and appointment scheduling process due to the COVID-19 pandemic. In accordance with the recommendation from the American Academy of Pediatrics, priority was placed on well child care exams for those needing immunization(s) in order to reduce the risk exposure to other children and adults with potential disease.

Result: The one year look-back at the end of Quarter 2 continued to show improvement of rate for nutrition and physical activity counseling in comparison to baseline and Quarter 1. This is a reflection of the one year quality improvement efforts around this measure which initially started in March 2019.

	Baseline Data 10/2019	Quarter 1 Year Lookback (1/2019-1/2020)	Quarter 2 Year Lookback (4/2019-4/2020)
Percentage of children and adolescents with documented BMI, nutrition and physical activity counseling	1770/4018 = 44%	2308/4608 = 50.1%	2735/4842 = 56.5%

Disparities in Rate of Diabetes

Goal: By October 2020, reduce by 1% the disparities gap between racial and ethnic groups with the highest and lowest rates of diabetes. Baseline data shows highest prevalence rate of Diabetes in persons who identify as Hispanic/Latino ethnicity and Asian race and lowest rate in those who identify as Hispanic/Latino ethnicity and Black/African American race (27.59% and 10.06% respectively).

Problem: The prevalence of Diabetes has increased rapidly since the 1990s. Additionally, disparities in the prevalence of Diabetes exist between racial and ethnic groups. One of the overarching goals of Healthy People 2020 is to achieve health equity and eliminate disparities. Interventions designed to delay or prevent diabetes target diabetes-related lifestyle factors such as obesity, physical inactivity, and poor dietary habits.

Initiative: By the end of Quarter 1 (January 16, 2020), initiate quality improvement pre-visit plan. Calculate and follow incidence of developing diabetes in this high-risk group.

Disparities in Rate of Diabetes (continued)

Process: IT staff generated list of persons 18-75 years of age, seen in the clinic after January 1, 2018, at highest risk of developing Diabetes (defined as diagnosis of obesity, impaired fasting glucose, pre-diabetes, or gestational diabetes). Staff shall utilize this list to schedule follow-up appointment for assessment and development of care plan.

Result: Pre-visit planning template reviewed with staff in December 2019. Staff began scrubbing charts of patients at high risk of developing Diabetes. Patients who had missed follow-up appointments/labs or had not been seen in >6 months were called to re-establish care with PCP.

Initiative #2: By the end of Quarter 2 (April 16, 2020), continue to expand the use of pre-visit care plans initiated for patients at high risk for developing Diabetes

Process: QI staff continued to complete care plans for patients at risk. However in March, clinic efforts shifted to COVID-19 preparedness activities. Our cohort of patients with a high risk for developing Diabetes also frequently met the criteria of high risk for serious illness with COVID-19 as defined by the Centers for Disease Control and Prevention. In response to the California Department of Public Health Self-Isolation for Older Adults and Those Who Have Elevated Risk and the Solano County Shelter at Home Health Order, non-urgent face-to-face appointments for patients in high risk for severe illness were initially placed on hold. Once telemedicine services were initiated and scaled up, non-urgent visits were reviewed and converted to virtual visits whenever possible

Result: The one year look-back at the end of Quarter 2 showed an increase in the overall prevalence rate for the two racial and ethnic groups that are being followed for this measure. However, FHS continued to show improvement in the disparity gap between these two groups with the highest and lowest rates of Diabetes (Hispanic/Latino Asian and Hispanic/Latino Black/African American respectively).

Race & Ethnicity	Total Persons 18-75 years of age	Total Persons 18-75 years of age with Diabetes	Prevalence Rate of Diabetes (Baseline Data 10/2019)	Prevalence Rate of Diabetes Quarter 1 Year Lookback (1/2019-1/2020)	Prevalence Rate of Diabetes Quarter 2 Year Lookback (4/2019-4/2020)
Hispanic/Latino Asian	50	12	27.59%	22.86%	24%
Hispanic/Latino Black/African American	445	54	10.06%	9.36%	12.13%