

*Quality Report-Calendar Year 2016*

In March this year, CHC submitted its report to the Health Resources and Services Administration (HRSA) through the Universal Data System (UDS). Final acceptance of the report is pending, per HRSA's deadline of March 31, 2017. Data collection relied heavily on electronic systems, and was supplemented where necessary by reviewing patient records. The data team identified opportunities for improvement in collecting data in the future. As an example, the electronic health record (EHR) does not reliably capture immunization records; the team is seeking access to reports directly from the immunization registry to ensure accurate reporting.

Ventura County Federally Qualified Health Centers (FQHCs) served approximately 107,000 individuals in Ventura County in 2016, including about 13,000 who were homeless. The team noted opportunities to better collect certain demographic information, especially Federal Poverty Level, sexual orientation, and gender identity.

Adults 18 to 64 years old make up the majority of our homeless population, and tend to prefer English for receiving services. Most of our homeless population receive Medicaid (Medi-Cal), and fall in the Federal Poverty Level (FPL) of 101-150% FPL.

For the homeless, obesity/unhealthy weight was the top diagnosis category, followed by hypertension and diabetes. Analysis reveals that the rates of all three top diagnoses are much higher than in the universal population; for hypertension and diabetes, they are almost double the rates of the entire population served. The top services for the homeless were immunizations, influenza vaccinations, and HIV tests.

Our universal population (everyone, including homeless individuals), comprises more children than the homeless population, and slightly more females. More of the overall population has Medicare and private health coverage, and of those who reported their socioeconomic status, the majority were again 101-150% of the FPL. More non-English speakers, agricultural workers, and school-based patients comprise the universal population, and the top diagnoses for all were the same as for the homeless: obesity/unhealthy weight, hypertension, and diabetes.

Analysis of clinical quality was limited by several factors: 2016 being the first year reporting on the universal population; difficulty reporting on specific demographics within the population (e.g. homeless only); and accuracy and consistency within electronic records. Nonetheless, the data collected were validated by the team to ensure the most accurate representation of patient conditions, services rendered, and health outcomes.

CHC showed improvement and sustained results in several aspects of care in 2016. 87% of our patients were able access prenatal care in the first trimester of pregnancy, and we continued to see our patients deliver healthy babies above the HRSA national average\*. Implementation of a tobacco screening and cessation program in 2015 continued to improve our ability to screen and counsel patients to quit using tobacco, and in 2016, we climbed above the national HRSA average to 88.5% of our patients screened and counseled. CHC also performed above the HRSA average in providing appropriate asthma treatment, cholesterol treatment for coronary artery disease, aspirin therapy for heart attack/stroke, controlling hemoglobin A1c3 in diabetic patients, and linking newly diagnosed HIV patients to care.

Data did not reveal any health disparities for cultural/ethnic minorities and vulnerable populations, and overall patients' outcomes were better than the national average with blood pressure control as an exception. Challenges were experienced in collecting accurate data on screening for colorectal cancer, cervical cancer, and depression. The team has begun using UDS data to identify if the problems lie primarily in the electronic system and data collection methods, in the actual delivery of care, or both. In some cases, work has already begun to increase the number of these screenings. For colorectal cancer, CHC will soon be able to offer Fecal immunochemical testing (FIT) at the point of care instead of sending samples to an outside lab. CHC is recruiting seven (7) new behavioral health clinicians to increase the number and quality of standardized depression screenings and follow up for all patients.