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Improving Measure Outcomes Through Early Detection: Preventive Cancer Screenings

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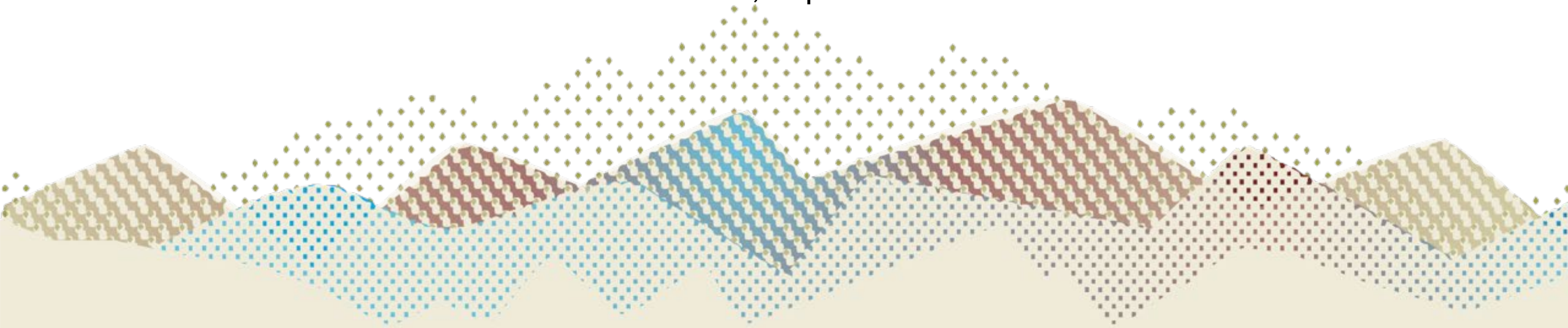

Learning Objectives

- Define the clinical background, technical specifications, and 2026 performance thresholds for the Provider Quality Incentive Program measures:
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Colorectal Cancer Screening
- Apply measure requirements to improve adherence and documentation practices in the delivery of recommended cancer screenings, including age-specific criteria, modality options, and follow-up protocols.

Learning Objectives

- Evaluate the prevalence, risk factors, and health inequities associated with breast, cervical, and colorectal cancers, especially disparities in screening access, diagnosis, and treatment outcomes.
- Implement strategies aimed at reducing barriers to care and increasing screening rates, including culturally-responsive education and evidence-based outreach models.

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Overview of Clinical Guidelines for Colorectal Cancer Screening

Fast Facts

- Colorectal cancer is a leading diagnosed new cancer in the U.S.
  - Fourth highest with an estimated 153k diagnoses annually.
  - More prevalent in males vs. females.
- Approximately 55,230 people will die from colorectal cancers in 2026 (U.S.).

Risk Factor Assessment

- No published guidelines.
- Look for familial risk factors over time.
- Begin assessing risk at 20 years and older (every 3 - 5 years).
- Opportunity to begin planting the seed for screening.

Screening Ages and Frequency for Average Risk

For average risk: adults ages 45 - 75 years old

Screening Method	Frequency
FOBT FIT*	Annually
FIT-DNA test*	Every 3 years
CT Colonography* Flexible Sigmoidoscopy*	Every 5 years
Colonoscopy	Every 10 years

*Positive findings require follow-up with a colonoscopy

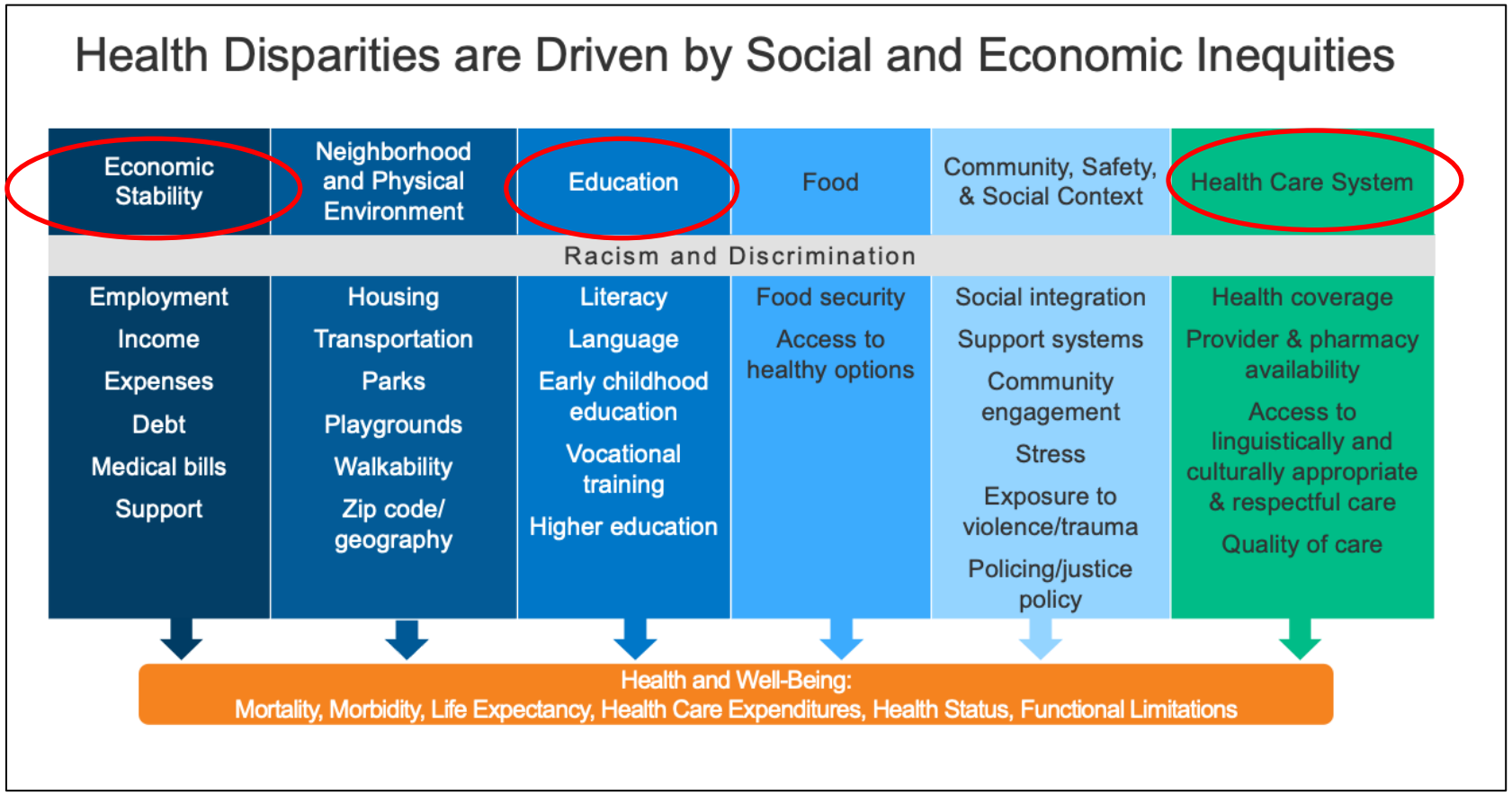
Health Disparities

- Colorectal cancer incidence and deaths are highest in the U.S. for Native American and Black populations.

- Black populations in the U.S. have the lowest five-year survival rate of all ethnicities, despite stage at diagnosis. They are also more likely to be diagnosed at later-stage disease (when metastatic or unresectable).

- Screening is lowest among Asian Americans (50%), individuals with less than a high school education (48%), and recent immigrants (29%).

Drivers of Disparities



Source: Kaiser Family Foundation

Potential Drivers of Disparities for Colorectal Cancer Screening (CRC)

- Among racially diverse populations with less than a high school education, low income, no health insurance, and no regular health care provider. Other barriers to colon cancer screening are fatalism, religious beliefs, lack of self-worth, sexually-related concerns, history of sexual abuse, past negative experiences with screening, and suspicion that a physician may be motivated to recommend the procedure for financial gain.
- Knowledge, perceptions, and beliefs about CRC screening and an individual's cultural, social, and physical environments influence the decision to undergo preventive screening.

References:
https://www.cdc.gov/pcd/issues/2015/14_0586.htm#:~:text=Among%20racially%20diverse%20populations%20with,abuse%2C%20past%20negative%20experiences%20with Jones RM, Devers KJ, Kuzel AJ, Woolf SH. Patient-reported barriers to colorectal cancer screening: a mixed-methods analysis. Am J Prev Med 2010;38(5):508–16. Stacy R, Torrence WA, Mitchell CR. Perceptions of knowledge, beliefs, and barriers to colorectal cancer screening. J Cancer Educ 2008;23(4):238–40. DiClemente RJ, Salazar LF, Crosby RA. Health behavior theory for public health: principles, foundations, and applications. Burlington (MA): Jones and Bartlett Learning; 2013.

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Overview of Clinical Guidelines for Breast Cancer Screening

Terminology

Notes on terminology:

- Throughout this presentation, we will use the term “Assigned Female at Birth” rather than “female” or “woman.”
- We do this to respect and normalize the experiences of transgender and gender diverse individuals.

Epidemiology

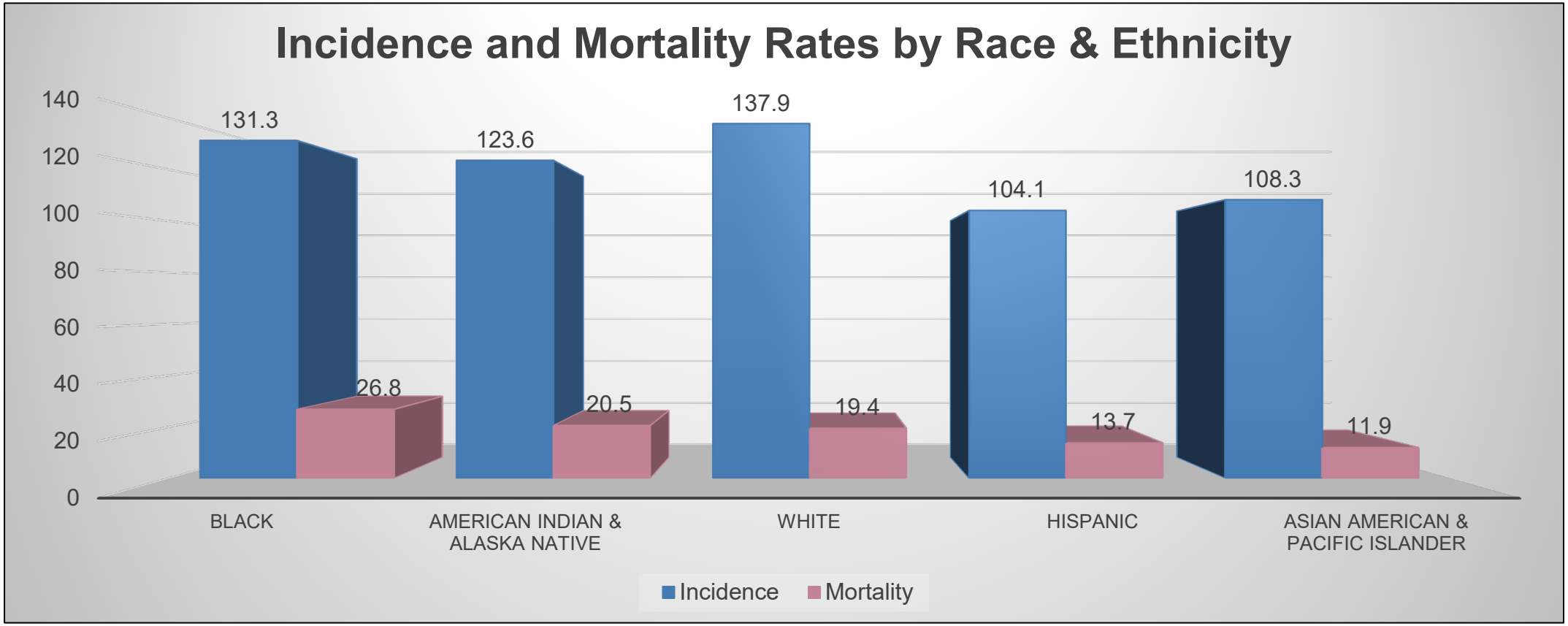
- Approximately one in eight persons assigned female at birth (13.1%) living in the U.S. will be diagnosed with invasive breast cancer, and one in 43 persons assigned female at birth (2.3%) will die from the disease.
- In 2025, an estimated 42,170 persons assigned female at birth in the U.S. died from breast cancer.
- From data of the decade 2012 – 2021, the incidence of breast cancer increased by 1% each year overall.
    - By 1.4% in those aged <50 years.
    - By 0.7% in those aged ≥50 years.

National Cancer Institute: Surveillance, Epidemiology, and End Results Program
https://seer.cancer.gov/statfacts/html/breast.html

Risk and Protective Factors

Risk Factors	Protective Factors
Being a person assigned female at birth	Early in life pregnancy
Personal or genetic history of breast cancer	Breastfeeding / chestfeeding
Dense breast tissue	Getting regular exercise
Reproductive history resulting in greater exposure to estrogen	-
Taking hormone therapy for symptoms of menopause	-
Previous treatment using radiation therapy	-
Obesity	-
Alcohol use	-

Breast Cancer
United States, 2017 – 2021



Data source: North American Association of Central Cancer Registries, 2024
Rate per 100,000, age-adjusted to the 2000 US standard population. Incidence is adjusted for delays when possible.

Breast Cancer Disparities Summary

	Up-to-date Mammography (%)	Incidence of Breast Cancer (rate per 100,000)	Mortality Due to Breast Cancer (rate per 100,000)
White	65%	137.9 **(highest)**	19.4
Black / African American	69% **(highest)**	131.3	26.8 **(highest)**
Hispanic	60%	104.1 **(lowest)**	13.7
Asian / Pacific Islander	56%	108.3	11.9 **(lowest)**
American Indian / Alaskan Native	47% **(lowest)**	123.6	20.5

Breast Cancer Disparities

- Black individuals assigned female at birth are more likely to die from breast cancer than any other race.
- Breast cancer is the leading cause of cancer death for Black individuals assigned female at birth.
- Disparity in overall cancer mortality between Black and White populations has narrowed by half during the last two decades – *except* in breast cancer.
- Among Partnership members, Native American individuals assigned female at birth have the lowest rates of breast cancer screening.

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Overview of Clinical Guidelines for Cervical Cancer Screening

What Causes Cervical Cancer

Infection with Human Papillomavirus (HPV)

>85% of individuals will get an HPV infection in their lifetime

Most of the time, the immune system eliminates the virus

HPV is found in 99.7% of cervical cancers

Cervical Cancer Risk Factors

- Exposure to HPV / lack of immunization
- Early onset of sexual activity
  - Two times greater risk when sexually active prior to 18 versus delaying sexual activity until after age 21
- Multiple sexual partners / high-risk sexual partners
- History of sexually transmitted infections (STIs)
- History of vulvar or vaginal cancer
- Immunosuppression (e.g., HIV)
- Low socioeconomic status
- Use of oral contraceptives
- Genetics? Uncertain

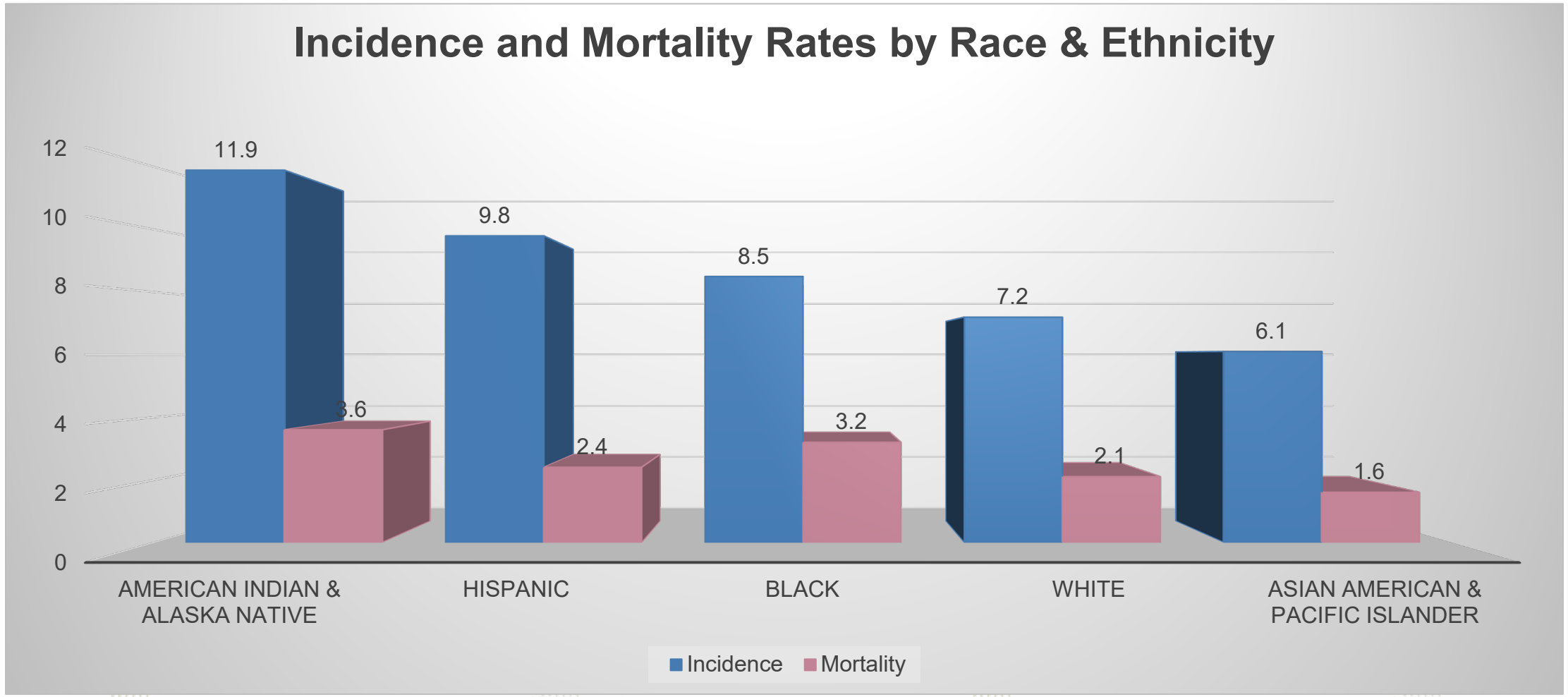
Cervical Cancer Screening

- **Goal:**
  - Find high risk HPV virus or changes in cells in the earliest stages possible to increase chances of successful treatment.
  - Looking for precancerous cells, cancer cells, or high-risk HPV.

- **Two tests:**
  - Papanicolaou or “Pap” test (cytology testing).
  - High-risk human papillomavirus (hrHPV) testing.

    - Current USPSTF recommendation: Begin at age 21

Cervical Cancer
United States 2017 – 2021



Cervical Cancer Disparities Summary

	Up-to-date Pap/HPV test 2020-2021 (%)	Incidence of Cervical Cancer (per 100,000)	Mortality Due to Cervical Cancer (per 100,000)
White	80% **(highest)**	7.2	2.1
Black / African American	76%	8.5	3.2
Hispanic	69%	9.8	2.4
Asian / Pacific Islander	64% **(lowest)**	6.1 **(lowest)**	1.6 **(lowest)**
American Indian / Alaskan Native	68%	11.9 **(highest)**	3.6 **(highest)**

Cervical Cancer Disparities

- Among Partnership members, Native American individuals assigned female at birth had the lowest rates of cervical cancer screening in 2023.
- Nationally, Native American individuals assigned female at birth had the highest rate of new cervical cancer diagnosis, and the highest rate of cervical cancer mortality.
- Cervical cancer is seen as entirely preventable given the HPV vaccine and testing availability. Lack of screening is seen as a weakness in the health care system infrastructure.

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Overview of Measures

Breast Cancer Screening

Cervical Cancer Screening

Colorectal Cancer Screening

Quality Improvement Program (QIP) Measure
Breast Cancer Screening

Core Measure: Breast Cancer Screening (40 - 74 years old)

Description: The percentage of continuously enrolled Medi-Cal members 40 - 74 years of age were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.

Denominator: The number of continuously enrolled assigned members assigned female at birth 42 – 74 years of age as of December 31 of the measurement year (Date of birth between January 1, 1952, and December 31, 1984). For full details, please review QIP specifications manual via eReports.

Numerator: The number of members from the eligible population in the denominator with one or more mammograms any time on or between October 1, 2024, and December 31, 2026

QIP Measure
Cervical Cancer Screening

Description: The percentage of continuously enrolled members 21 - 64 years of age who were recommended for routine cervical cancer screening.

Denominator: The number of continuously enrolled members 24 - 64 years of age as of December 31 of the measurement year (Date of birth between January 1, 1962, and December 31, 2002).

Numerator: The number of assigned members in the eligible population who were appropriately screened according to evidence-based guidelines.

Note: *Codes to Identify Cervical Cancer Screening and hrHPV Test can be found on the Diagnosis Crosswalk in eReports. eReports uploads for this measure are allowed March 1, 2026, through January 31, 2027.*

PCP QIP Cervical Cancer Screening MY2026

Measure Description: The percentage of continuously enrolled members 21 – 64 years of age who were recommended for routine cervical cancer screening using any of the following criteria:

- Women age 21 – 64 years of age who had cervical cytology performed within the last three (3) years.
- **Women 30 – 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.**
- Women 30 – 64 years of age who had cervical cytology / high-risk human papillomavirus (hrHPV) co-testing within the last five years.
    - **hrHPV self-collect is accepted for cervical cancer screening compliance**

PCP QIP MY2025 CCS (update for 2026)
Full point target 90th Percentile 67.46%
Partial point target 75th Percentile 61.56%

Cervical Cancer Screenings in Transgender Individuals

- **Transgender females** (born males but currently with gender identity of female):
  - Member with Sex assigned at birth (LOINC code 76689-9) of male (LOINC code LA2-8) at any time in patient's history.

- **Transgender males or gender non-conforming** (born females but currently with gender identity of male):
  - Should be screened for cervical cancer if the cervix is still intact but will not be part of the official denominator for this measure due to system constraints.

Note: *Additional exclusions can be found in eReports and should be reviewed with clinical team, incorporated into flags and documentation.*

New Screening Benchmark Targets
Colorectal Cancer Screening

New 2026 Targets:

- Partnership is now using NCQA Medicaid standards:
    - Partial Points set at the 75th percentile
    - Full Points are set at 90th percentile

More detailed information can be found in the
PCP 2026 Measurement Specifications Manual

Screening Methods and Measure Criteria

Screening Method	Frequency
FOBT or FIT	During the measurement year (MY)
FIT-DNA test	During the MY or two years prior to MY
CT Colonography or Flexible Sigmoidoscopy	During the MY or four years prior to MY
Colonoscopy	During the MY or nine years prior to MY

Documentation

Include date of screening, type of screening, and result.

*This type of information is included in health history forms, however, not always provided as part of the record submissions.

Note: Codes to identify the tests can be found on the Diagnosis Crosswalk in eReports

Quality Improvement Program (QIP) Tools and Resources

Landing Page

Frequently Asked Questions

QIP Dashboard

Primary Care Provider (PCP) Quality Improvement Program

PCP QUALITY INCENTIVE PROGRAM

The Primary Care Provider Quality Incentive Program (PCP QIP), designed in collaboration with Partnership HealthPlan of California providers, offers substantial financial incentives, data resources, and technical assistance to primary care providers who serve our members so that significant improvements can be made in the following areas:

- Preventive Screening
- Pediatric Access
- Hospital Utilization
- Primary Care Utilization
- Chronic Disease Management
- Patient Experience

Contact Us

Email: QIP@partnershiphp.org (please allow two business days for a response)
Fax: (707) 863-4316

PCP QIP Overview

To help orient our providers to the PCP QIP year, we have provided measurement set documents, a code list, and other useful tools and resources.

Learn More about the 2026 PCP QIP

Equity Adjustment - PCP QIP Payment Methodology

Webinars

PCP QIP Webinars

Upcoming Webinars and Trainings

On Demand Courses

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Quality Incentive Program (QIP) Tools

Tools and Resources

- 2026 PCP Measure Specification Manual
- PQD User Guide
- PCP QIP Webpage
- eReports

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Putting Quality Into Practice

Measure Best Practices

MEASURE BEST PRACTICES

The Measure Best Practices documents are resources for the Primary Care Provider Quality Improvement Program (PCP QIP) measure set, which aligns closely with the Managed Care Accountability Set (MCAS) measures for which Partnership HealthPlan of California is held accountable by the Department of Health Care Services (DHCS). Each Measure Best Practice document is updated annually and includes Partnership tools and resources, guidelines to facilitate optimal member care, opportunities for patient education, outreach, and equity, data and coding resources, and helpful links to improve measure performance.

- Breast Cancer Screening ★
- Cervical Cancer Screening ★
- Child & Adolescent Well Care
- Childhood Immunizations Status
- Chlamydia Screening
- Colorectal Cancer Screening ★
- Controlling Blood Pressure
- Comprehensive Diabetes Care: HbA1c - Good Control
- Comprehensive Diabetes Care: Retinal Eye Exam
- Dental Flouride Varnish
- Immunizations for Adolescents
- Lead Screening for Children
- Well Child Visits 0-30 Months

Performance Improvement

2026 Best Practices

Breast Cancer Screening

Partnership Tools, Programs, and Promising Practices:

- Partnership contracts with a **mobile mammography** vendor to sponsor events for provider offices located in imaging center deserts, areas with delayed access to appointments at local imaging centers, or counties with breast cancer screening rates far below DHCS's Minimum Performance Level (MPL). Please contact Mobilemammography@partnershiphp.org if you are interested in learning more.
- Attend or view Partnership's **Improving Measure Outcomes training** on *Preventive Cancer Screening-Improving Outcomes Through Early Detection*.
- Members can access transportation for non-emergency medical services for assistance in traveling to and from appointments. This is particularly helpful for imaging center appointments which cannot be completed at the PCP office. Members can access services by calling **Partnership Transportation Services** at **(866) 828-2303**, Monday – Friday, 7 a.m. – 7 p.m.

Patient Care:

- Establish a practice commitment to cancer screening.
- Utilize "flag" alerts in the EMR / EHR system that each care staff can use to identify and communicate to patients who are due for their screening services at every patient encounter.
- Conduct chart scrubbing prior to the visit to determine if mammogram is due.
- Ensure the list of mammography / imaging facilities is accurate and up to date and train clinical teams on locating the most accessible facility for every member.
- Work with the mammography / imaging facility to collaborate on the active pursuit of patients who have been referred yet have not completed their screening or who are a no-show for mammography appointment.

Measure Best Practices: Short-Term Strategies

- For average risk patients, offer options for screenings. The best screening is the one your patients will complete!
- Provide patient education.
- Create standing orders for the care team to implement.
- Create EMR alerts and flags for patients.
- Work your gap lists to outreach and follow-up on no-shows.
- Promote ePrompts for pre-visiting plans and / or front-line staff.

Measure Best Practices: Long-Term Strategies

- Establish a practice commitment to cancer screening.
- Consider a variety of service options – after-hours and same-day appointments, weekend cervical and/or breast cancer screenings.
- Train entire clinical team on breast, cervical, and colorectal cancer education, cultural competency for targeted communities, and motivational interviewing techniques
- Create scripts that all staff can use to simplify a message that encourages cancer screenings.

Measure Best Practices: Health Equity Focus

- Consider using an equity approach to increase screening rates for targeted communities. By looking at cancer screening rates by race, ethnicity, location (i.e., zip code), and preferred language, it is possible to identify barriers that affect specific communities, and plan interventions to address these barriers.
- Review measure adherence rates by race, ethnicity, location (zip code) and preferred language to address potential barriers.
- Address access issues such as transportation barriers.
- Consider how member information is presented.
- Partner with community organizations that share your goals.

Cologuard by Exact Sciences
Care-Gap Orders

Partnership collaborates with Exact Sciences, the maker of Cologuard, to expand access to colorectal cancer screenings.

Through this collaboration, provider sites with eligible members can place Care-Gap orders (formerly known as bulk orders) for Cologuard kits. Each patient will be enrolled in Exact Sciences' patient navigation program which provides follow-up and support throughout the screening process.

More information, including how to place Care-Gap orders, scan the QR code to visit our Cologuard Bulk Orders webpage.

For more information on submitting an order reach out to Exact Sciences at phc@exactsciences.com

Mobile Mammography Program

Partnership HealthPlan of California is offering a unique sponsorship opportunity by bringing mobile mammography services to your organization.

Program Eligibility:

- Provider sites below the 75th percentile benchmark
- Provider sites with an imaging center in rural locations *(Patient's travel to imaging center is long or difficult)*
- Provider sites with lack of access at nearby imaging centers
- Provider sites with Partnership care gaps to support event *(An event day requires at least 25 completed screenings)*

For more information, email us at
mobilemammography@partnershiphp.org

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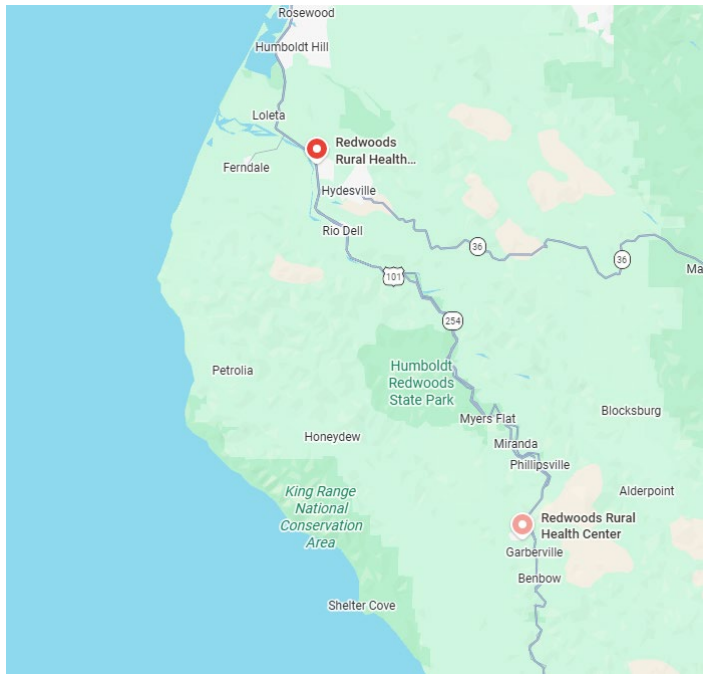
Voices of the Field

Redwoods Rural Health Center

Background

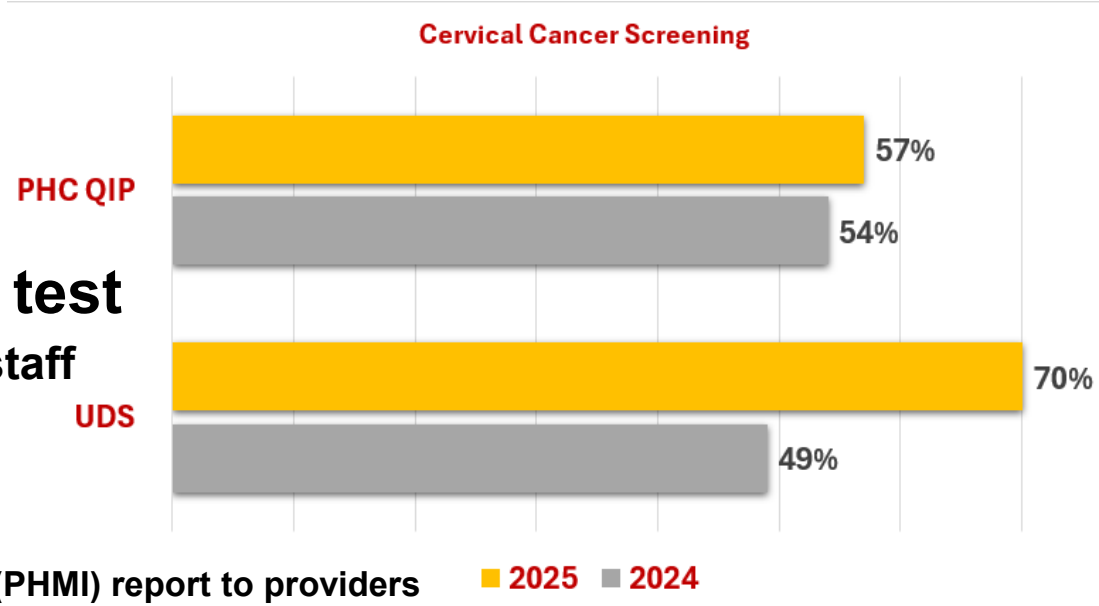
- **Small**
  - 6961 patients (UDS 2025)
    - ~ 3600 Primary Care
    - ~ 4300 Dental
  - 55% Partnership or Medi-Cal
- **Rural**
  - Southern Humboldt – off-grid
  - Barriers: access, transportation, increasingly challenging economy
- **Staff turnover**
  - PCPs – (cycle of 9 short-term contracts between mid-2023-2025)
  - Medical Assistants
  - Executive leadership
- **EHR switch**



Self-collection HPV swab

Cervical Cancer Screening

- **Previous PDSA**
  - Well Woman Exams – up to 30% no-show rate
  - Adding pap to scheduled visits – 60% consented
    - In reach vs outreach
- **Partnership webinar re: self-collection HPV test**
  - Garner team support - Clinical leadership & support staff
  - Training (Partnership materials)
    - Eligibility criteria & demonstration w/support staff
    - Updated Standing Orders
    - Emails, huddles, Population Health Management Initiative (PHMI) report to providers
  - Pap-a-palooza event – advertising, buzz
  - Daily "paportunities" report to MAs
  - Focus on trauma-informed practices

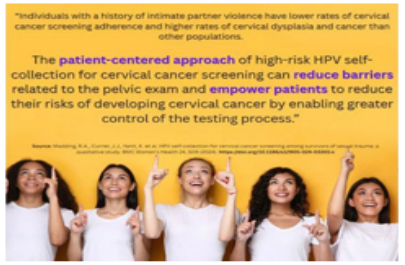


Quality Improvement Storyboard

Quality Improvement Storyboard:
Redwoods Rural Health Center - HPV Self-Collect Pilot

Background
Redwoods Rural Health Center attended a Partnership HealthPlan of California's webinar regarding HPV self-swabs and then relayed the key information to stakeholders at the clinic. Based on their previous Plan-Do-Study-Act (PDSA) cycle, offering self-swabs to eligible patients during visits had strong potential to improve their quality measure.

Implementation
The first step was staff education and support. Staff began learning about the self-swab test, including eligibility criteria and clinical considerations. The lab manager provided a hands-on demonstration during a morning huddle. This helped build confidence and ensured staff felt prepared to support patients. Staff also revisited their previously successful PDSA cycle. Communication between staff and patients emphasized the patient-centered benefits of self-collection and kept self-swab messaging visible and consistent through multiple channels. The consistent communication allowed Partnership to maintain current information like key facts, instructions, and care-gap opportunities, ensuring the self-swabs remained active and front-of-mind for staff, especially at a 2025 cervical cancer screening event. Additional information about the event can be found here.



Pictured above: Board post example.

Addressing Barriers
Initially, Quest Lab only provided five HPV self-swab test kits. Partnership connected with Quest to allow a larger one-time order for Redwoods Rural, which helped get the "Pap-A-Palooza" event scheduled. Because of the connection with Quest, there is no longer a limit to ordering HPV self-swab test kits. Early in the pilot, it was discovered that the electronic health record software (Epic) was automatically assigning a five-year re-testing window to all completed self-swabs, regardless of clinical findings. Redwoods Rural worked to modify the back-end logic so appropriate re-testing intervals populated for most result types. One-year re-tests still require manual adjustment by medical assistants or providers, but the bulk of the issue has been resolved.

Training and Support for Clinical Staff
Medical assistants received hands-on training for the HPV self-swab test and providers received email training and communication. Instructions and education provided by Partnership were utilized and posted in clinic restrooms.

Patient Selection
Eligibility criteria were reviewed with all clinical staff and were based on the patient's prior screening history. During rooming, medical assistants checked the electronic medical records for previous Pap or HPV results. To ensure clinical accuracy, medical assistants confirmed eligibility with the provider during the patient hand-off. Medical assistants then introduced the HPV self-swab option, explained the purpose of the test, and provided step-by-step instructions for the self-collection process. The workflow allowed them to incorporate the HPV self-swab test option seamlessly into existing visits while maintaining provider oversight and prioritizing patient comfort.

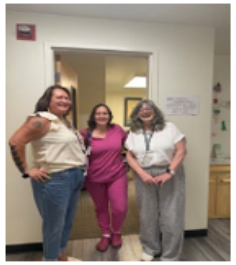
Education Materials
Redwoods Rural shared Partnership education materials, created flyers, talking points, and shared a HPV self-collection guide handout.

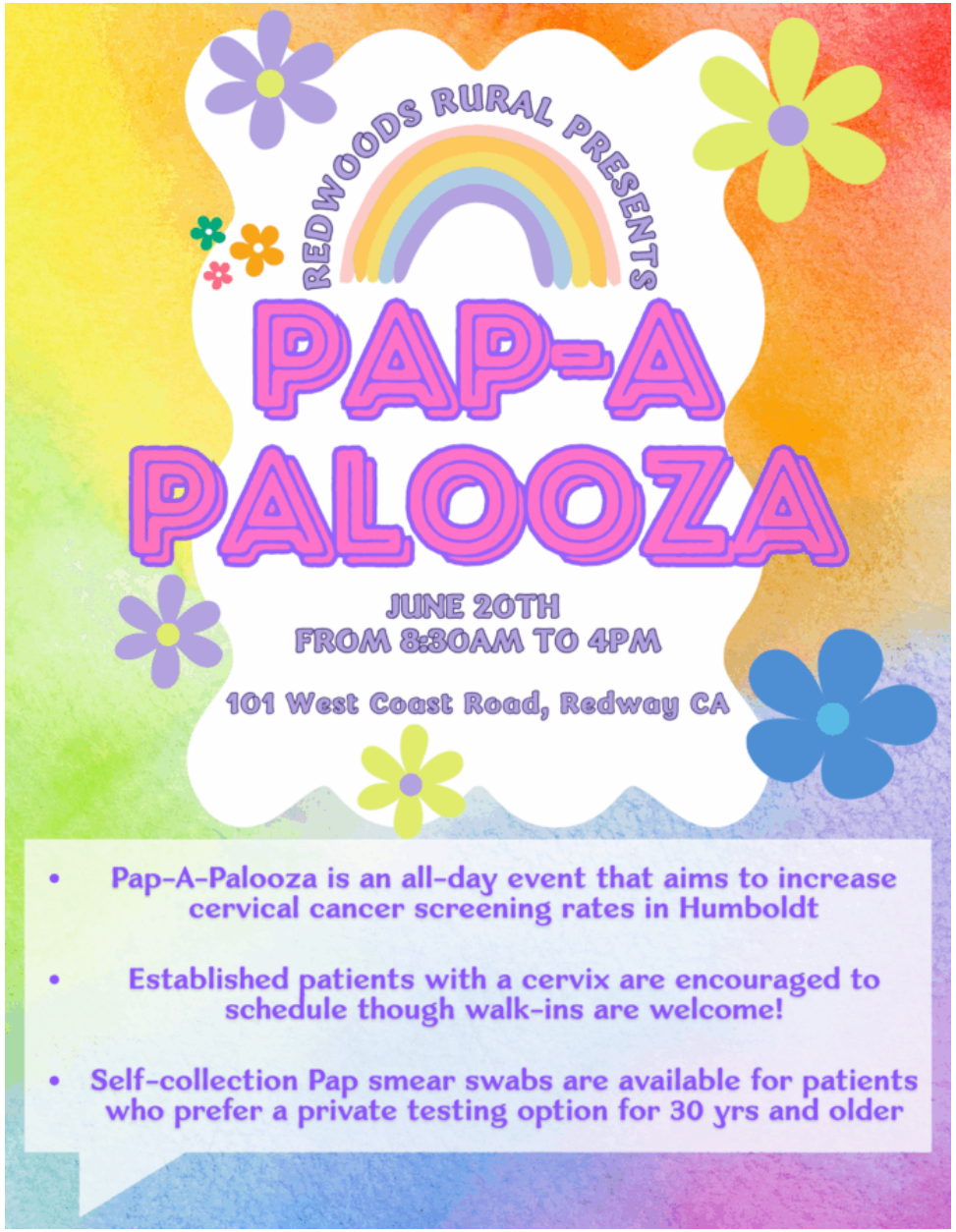
Engaging with Patients
Medical assistants would review the chart and screen patient history to gauge if patients were eligible for the HPV self-swab test. They would then offer the HPV self-swab test as a way to complete the cervical cancer screening before patients leave the appointment.

Results and Follow-up Care
All HPV self-swab test results are automatically routed to each patient's primary care provider where next steps are determined based on the patient's results. To date, they have had a small number of positive self-swab results, with nine positive tests. The overall cervical cancer screening abnormal result rate is small, at 13% for 2025.

In addition to the provider workflow, there is an internal risk-management review process. All positive cervical cancer screening results, including those from self-collection, are reviewed to ensure timely follow-up, correct documentation, and follow-up of care. This additional layer of oversight helps ensure that no abnormal result is missed and that patients receive appropriate and timely follow-up care.

Pictures from Redwoods Rural Health Center




REDWOODS RURAL PRESENTS
PAP-A PALOOZA
JUNE 20TH
FROM 8:30AM TO 4PM
101 West Coast Road, Redway CA
• Pap-A-Palooza is an all-day event that aims to increase cervical cancer screening rates in Humboldt
• Established patients with a cervix are encouraged to schedule though walk-ins are welcome!
• Self-collection Pap smear swabs are available for patients who prefer a private testing option for 30 yrs and older

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Upcoming Trainings

Improving Measure Outcomes Webinar Series

The Improving Measure Outcomes learning series is designed to help quality improvement teams turn knowledge into action. These sessions focus on Partnership's Primary Care and Perinatal Provider Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, advance health equity, and improve clinical outcomes.

2026 Webinar Schedule

All webinars are held from noon to 1 p.m.

March 25, 2026 - Managing Chronic Disease: Strategies for Blood Pressure and Diabetes Control
April 8, 2026 - Sexual and Reproductive Health
April 22, 2026 - Improving Perinatal Outcomes

**Continuing education credits available.*

For details and registration, visit Improvement Academy's event page
Questions? Email improvementacademy@partnershiphp.org

ABCs of Quality Improvement

an in-person training designed to introduce participants to key Quality Improvement (QI) methodologies, with a specific focus on the Model for Improvement – a widely used framework for driving measurable change in health care settings

Thursday, May 14, 2026

8 a.m. – 4 p.m.

Auburn

Course topics include:

- *Basic Principles of Quality Improvement*
- *Introduction to the Model for Improvement*
- *Creating an Aim Statement*
- *Using Data to Measure and Drive Improvement*
- *Developing Change Ideas*
- *Testing Changes with the Plan-Do-Study-Act Cycle*

**CME / CEs available*.

REGISTER HERE

Email questions to improvementacademy@partnershiphp.org

Evaluation

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