

LESSONS FROM THE FIELD: STATE- AND
PRACTICE-LEVEL POLICIES TO FOSTER
HIGH PERFORMANCE IN CERVICAL CANCER
SCREENING IN FEDERALLY QUALIFIED HEALTH
CENTERS

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- **Colorado:** Colorado Department of Health Care Policy and Financing, Colorado Community Health Network, Clínica Family Health Services, and High Plains Community Health Center;
- **Maine:** Maine Primary Care Association, Pines Health Services, and St. Croix Regional Family Health Care Center;
- **Maryland:** Maryland Department of Health and Mental Hygiene, Mid-Atlantic Association of Community Health Centers, Chase Brexton Health Services, and Three Lower Counties Community Services, Inc.;
- **New York:** New York State Department of Health, Community Health Care Association of New York State, Care for the Homeless, and Charles B. Wang Community Health Center;
- **Texas:** Texas Health and Human Services Commission, Texas Association of Community Health Centers, El Centro de Corazón, and North Texas Area Community Health Centers, Inc.;
- **Vermont:** Department of Vermont Health Access, Bi-State Primary Care Association, Springfield Medical Care Systems, Inc., and NE Washington County Health Center; and
- **Virginia:** Virginia Department of Medical Assistance Services, Virginia Community Healthcare Association, Alexandria Neighborhood Health Services, and HealthWorks for Northern Virginia.

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EXECUTIVE SUMMARY

States can make important strides in eradicating deaths due to cervical cancer among women through the development of policies and partnerships that promote cervical cancer screening. With support from the Health Resources and Services Administration (HRSA), the National Academy for State Health Policy (NASHP) conducted research to elucidate state policies and programs that promote high performance in cervical cancer screening. Through a review of state programs and interviews with Medicaid departments, primary care associations, and federally qualified health centers (FQHCs) in seven states—Colorado, Maine, Maryland, New York, Texas, Vermont, and Virginia—this paper summarizes promising state policies that support cervical cancer screening, as well as innovative policies at the practice level, mostly facilitated through state policy.

Over the past few years, there have been several significant national and federal policies resulting in many new initiatives that improve cervical cancer screening and in the process, take steps to become or exemplify a patient centered medical home (PCMH). The PCMH model provides a useful framework to describe the changes made to improve cervical cancer screening rates. This paper describes six categories of promising practices and policies among high-performing states and FQHCs:

- Emphasis on quality through performance measurement;
- Comprehensive and coordinated care through support for patient navigation;
- Patient-centered care through messaging and informational materials;
- Accessibility through transportation assistance;
- Payment and financing to insure or screen more women; and
- Health information technology implementation.

Through interviews about best practices in cervical cancer screening, several key lessons and considerations emerged:

- Broad state delivery reform efforts support improvement in cervical cancer screening;
- Primary care associations can be a great resource to states for providing technical assistance and disseminating information to providers about improvement initiatives;
- High-performing FQHCs and states blend and leverage multiple funding opportunities—at the federal, state and local levels—to foster improvement;
- High-performing states and FQHCs value data and track provider performance;
- High-performing FQHCs engage *all* practice staff—not just providers—in quality improvement; and
- Screening is only the first step in affecting the process of care for cervical cancer.

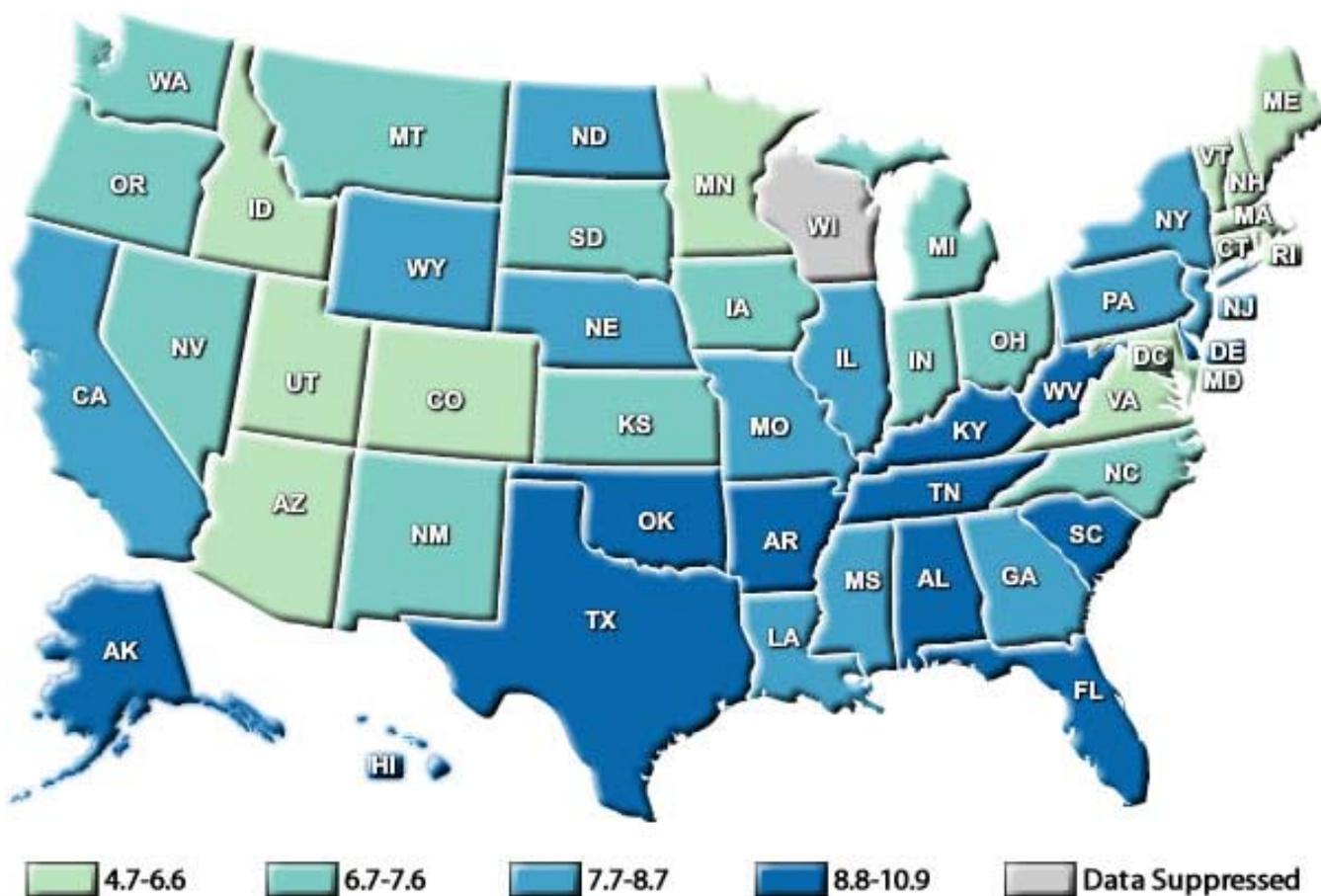
Experience and examples from Colorado, Maine, Maryland, New York, Texas, Vermont, and Virginia show how state policies and programs can reward, require or facilitate performance measurement, the delivery of comprehensive, coordinated, and patient-centered care, and access to care. These efforts assist practices in becoming PCMHs and complement health center-level processes to improve cervical cancer screening.

 INTRODUCTION

States can make important strides in eradicating deaths due to cervical cancer among women through the development of policies and partnerships that promote cervical cancer screening. Cervical cancer screening, which means checking a woman's cervix for cancer before there are signs or symptoms of the disease through a Papanicolaou test¹ (or smear), is strongly correlated with decreased cervical cancer incidence and mortality.² Approximately 50 percent of cervical cancer diagnoses in the United States are among women who have never been screened; an additional 10 percent of cancer diagnoses are among women who have not been screened within five years.³

Women who are members of racial or ethnic minority groups, have low socio-economic status, and/or lack health insurance, and access to regular sources of health care experience significantly higher risk of cervical cancer incidence due to lower rates of screening.⁴ Since women in these underserved populations tend to seek care through safety net providers, such as federally qualified health centers (FQHCs), a

Map 1. Cervical Cancer Incidence Rate by State, 2009



*Rates are per 100,000 and are age-adjusted to the 2000 U.S. standard population.

Source: U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999–2009 Incidence and Mortality Web-based Report*. Atlanta (GA): Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; 2013. Map available at: <http://www.cdc.gov/cancer/cervical/statistics/state.htm>.

concerted approach between states and safety net providers is needed to develop policies that emphasize the importance of cervical cancer screening.

With support from the Health Resources and Services Administration (HRSA), the National Academy for State Health Policy (NASHP) conducted research to elucidate state policies and programs that promote high performance in cervical cancer screening. Cervical cancer incidence varies by state (See Map 1, previous page); and states develop unique strategies to meet the needs of their constituents. Through a review of state programs and interviews with Medicaid departments, primary care associations, and FQHCs in seven states—Colorado, Maine, Maryland, New York, Texas, Vermont, and Virginia—this paper summarizes promising state policies that support cervical cancer screening, as well as innovative policies at the practice level, mostly facilitated through state policy. Many of the FQHCs interviewed for this report provide examples of a strong practice culture that may be replicated and nurtured in other primary care practices through policymaking at the state level.

FEDERAL, NATIONAL, AND STATE POLICIES THAT SUPPORT CERVICAL CANCER SCREENING

Over the past few years, there have been several significant national and federal policies that target cervical cancer screening. It is important to note that during this time, there also have been significant increases in federal and state policies that require primary care practices to transform into patient-centered medical homes. This perfect storm of policy activity has resulted in many new initiatives that improve cervical cancer screening and in the process, exemplify steps taken on the quality improvement journey to becoming a patient-centered medical home (PCMH).

- **Screening Guidelines:** In 2012, the U.S. Preventive Services Task Force, the American College of Obstetricians and Gynecologists, and a partnership among the American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology all independently released new screening guidelines. These guidelines reduce the frequency of screening across all age groups; women ages 21–29 are recommended to have a Papanicolaou (Pap) test, one of the screening methods for cervical cancer, every three years. According to the American Cancer Society and the American College of Obstetricians and Gynecologists, it is strongly preferred that women ages 30–65 receive a concurrent Pap test and human papillomavirus (HPV) test every five years, although screening with only a Pap test every three years is also considered acceptable.⁵ The U.S. Preventative Services Task Force recommends either co-testing every five years with Pap and HPV tests, or testing every three years with a Pap test for women ages 30–65.⁶
- **Affordable Care Act (ACA):** The ACA underscores the importance of prevention by expanding coverage for preventive services including cervical cancer screening. Section 2713 of the ACA requires new health plans to cover cervical cancer screening without a patient co-payment. Although this requirement does not apply to state Medicaid programs, the ACA (Section 4106) includes a federal matching incentive for states to provide preventive services (including cervical cancer screening) to Medicaid patients without a co-payment. The ACA covers cervical cancer screening at intervals that adhere to the most recent national screening guidelines (above).

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- **HRSA Cervical Cancer Screening Indicator:** FQHCs report information to HRSA about their operation and performance—including for cervical cancer screening—through the agency’s Uniform Data System (UDS). The cervical cancer screening rate, one of 14 clinical quality indicators reported by FQHCs, was chosen as a performance measure because it is indicative of the value of care delivered by health centers.⁷ This measure is currently being updated, effective in 2014, to align with the new aforementioned screening guidelines. HRSA has set its health center cervical cancer screening goal at 93 percent to align with Healthy People 2020.⁸
 - **Patient-Centered Medical Home (PCMH):** The PCMH, as defined by the Agency for Healthcare Research and Quality (AHRQ), is an enhanced model of primary care organization with the following core functions of health care:⁹ comprehensive care; patient-centeredness; coordinated care; accessibility; and emphasis on quality and safety. PCMH transformation promotes a practice culture steeped in quality improvement activity, including performance measurement, provider education, and population health management.
 - **State:** Twenty-nine states support payments for medical homes in one or more initiatives.¹⁰ FQHCs are key participants in many state PCMH initiatives, including in Maine, Maryland, New York, and Vermont.
 - **HRSA:** HRSA shares a commitment to the PCMH model; HRSA’s Bureau of Primary Health Care funds the *Patient-Centered Medical/Health Home Initiative*, which provides support for its health center grantees to gain patient-centered medical home recognition via organizations such as the National Committee for Quality Assurance (NCQA).¹¹ This initiative currently supports more than 950 FQHCs and nearly a quarter of health centers have achieved PCMH recognition thus far. Last fall HRSA announced a supplemental funding opportunity to improve cervical cancer screening by supporting health centers in achieving PCMH recognition; the initiative currently supports 811 FQHCs, including 13 interviewed for this research.¹²

In complement to the HRSA PCMH funding opportunity described above, this report distills promising state and health center practices that support high performance in cervical cancer screening within the context of the medical home.

PROMISING PRACTICES AND POLICIES AMONG HIGH-PERFORMERS

NASHP, in consultation with HRSA, identified and interviewed representatives from states, primary care associations (PCAs), and FQHCs with high performance in cervical cancer screening to identify promising practices for replication. The PCMH model provides a useful framework to describe the changes made to improve cervical cancer screening rates. (See Appendix A for selection criteria and process). The following sections describe six categories of promising practices and policies among high-performing states and FQHCs:

- Emphasis on quality;
- Comprehensive and coordinated care;
- Patient-centered care;
- Accessibility;
- Payment and financing; and
- Health information technology implementation.

EMPHASIS ON QUALITY THROUGH PERFORMANCE MEASUREMENT

States increasingly are pursuing strategies such as medical homes, accountable care initiatives, and value-based purchasing to reform the health care delivery system within Medicaid and for other purchasers. Some state delivery reform initiatives explicitly support high performance in cervical cancer screening among FQHCs and other primary care providers or managed care organizations (MCOs) through PCMH measures. More commonly, states include a cervical cancer screening measure in provider incentive programs, value-based purchasing initiatives or as part of Medicaid managed care. Below are sample state and PCA performance measurement activities related to cervical cancer screening.

- Cervical cancer screening is one of seven preventive care clinical quality measures for **Maine's** PCMH Pilot.¹³ The pilot established a goal of 70 percent or better screening rate for the measure.
- Since 1999, **Maryland's** Medicaid managed care program, HealthChoice, has had a value-based purchasing program in place. Through the program, the state's Department of Health and Mental Hygiene offers financial incentives and disincentives based on MCO performance on specific measures, including for the past few years, the Healthcare Effectiveness Data and Information Set (HEDIS) cervical cancer screening measure. In 2010, this measure was defined as the percent of women ages 21–64 (continuously enrolled during reporting year) that received at least one Pap test during the last three years, consistent with U.S. Preventive Services Task Force recommendation at that time. For 2010, health plans whose performance was 77 percent or greater on the measure were eligible to receive an incentive payment; plans whose performance was 68 percent or below were eligible to have a disincentive payment collected.¹⁴
- **New York** requires its managed care plans to report their performance on a series of measures and then publishes the information, creating an incentive for plans to ensure that their contracted providers are providing high-quality care. The Department of Health publishes an annual Managed Care Plan Performance Report¹⁵ with information from the state's Quality Assurance Reporting Requirements (QARR), which have been in place since 1994 to monitor plan performance. The QARR measures include the Healthcare Effectiveness Data and Information Set (HEDIS) cervical

HEALTH CENTER SPOTLIGHTS: QUALITY IMPROVEMENT AT THE PRACTICE-LEVEL

State-level initiatives support and complement performance measurement at the health center level. All of the high-performing FQHCs identified in this project have made critical organization-wide investments in quality improvement. Interviewees from multiple health centers praised the improvements in screening rates due to putting in place processes, such as peer chart reviews, to monitor performance. Some health centers have developed specialized tools to measure and raise provider awareness of performance on measures such as cervical cancer screening.

- **North Texas Area Community Health Center** implemented an internal data dashboard with performance measures and clinical Uniform Data System (UDS) and HEDIS metrics to track its overall quality and performance. Providers discuss each metric on the dashboard at monthly Compliance Performance Improvement (CPI) Committee Meetings. When the center implemented the dashboard in 2011, cervical cancer screening performance was poor. In response, the CPI Committee identified a provider champion and conducted peer reviews every one to two months with mid-level and supervising providers until they started seeing improvement.
- **Charles B. Wang Community Health Center** in New York City formed a cervical cancer screening committee to identify and address barriers that patients or providers may face when accessing or linking patients to screening services. Cervical cancer screening rates are monitored monthly and data are shared with section chiefs in the internal medicine and women's health departments. Additionally, the center conducts provider peer chart reviews quarterly and provides performance-based quality bonuses.

cancer screening measure. New York also has a Pay for Performance Quality Incentive in place for its Medicaid managed care plans. Health plans with "superior performance" can receive up to an additional 2.5 percent (per member per month) to plan premiums from the Department of Health.¹⁶ Cervical cancer screening is one of the Quality Incentive measures.^{17,18}

- **Virginia's** Department of Medical Assistance Services is working to standardize MCO performance measurement by contractually requiring MCOs to be accredited by the National Committee for Quality Assurance (NCQA). In order to obtain and maintain that accreditation, MCOs report HEDIS measures to NCQA, including the cervical cancer screening metric.

States can support FQHCs as they undergo the PCMH transformation process. Many states have chosen to partner with their PCAs to provide practice coaching and on-site assistance as health centers prepare to undergo medical home recognition.

- **Maryland** partners with its PCA, the Mid-Atlantic Association of Community Health Centers, to provide a PCMH readiness assessment, host webinars, and offer health coaching for FQHCs.
- The Blueprint for Health in **Vermont**, the state's multi-payer chronic care prevention and management program,¹⁹ contracts with a PCA staff member to provide on-site assistance with continuous quality improvement including practice transformation, workflow redesign, and specifically the NCQA patient-centered medical home recognition process.

According to interviewees, training on new guidelines and screening protocols must take place at all organizational levels in order for implementation to be successful. Front desk staff, medical assistants, and

care coordinators in FQHCs must understand the screening guidelines so they can bring women into the health center at appropriate intervals; and providers must subscribe to newly implemented policies and processes. One way that states can help raise awareness about screening guidelines is by incorporating them into their Medicaid program guidance.

- The **Texas** Department of State Health Services updated its Family Planning Program policy manual to reflect 2012 national cervical cancer screening guidelines, underscoring the importance of screening at recommended intervals.²⁰

STATE SPOTLIGHT: VERMONT

FQHCs are active in Vermont's Blueprint for Health a coordinated system of PCMHs supported by multi-disciplinary community health teams (CHTs) who collectively manage care, exchange information, and report on populations using a shared health information technology infrastructure. In 2012, FQHCs served a full quarter of Blueprint patients.* FQHCs are able to leverage the resources available to them through their participation in the Blueprint for Health to improve women's access to comprehensive services that includes preventive cervical cancer screening and coordinated follow-up for patients with positive Pap tests. Local CHTs are also able to connect patients to health and social services.

- **NE Washington County Health Center** has a CHT nurse on site to assist other staff with panel management. Staff review patient records prior to their appointments to make sure that they are up to date on all preventive screenings, and flag any necessary tests in the electronic medical record (EMR). The CHT nurse specifically runs reports from the Blueprint registry (DocSite) to manage who is due for their Pap test and who has had a positive screening, then follows up with these patients.
- **Springfield Medical Care Systems, Inc.**, located in a rural health service area, is working on a project with their local CHT to organize existing resources to address transportation issues for women in the community.

*Department of Vermont Health Access, *Vermont Blueprint for Health: 2012 Annual Report* (Williston, VT: Department of Vermont Health Access, 2013).

COMPREHENSIVE AND COORDINATED CARE

Comprehensive and coordinated care is a hallmark of the PCMH. State agencies and PCAs may complement delivery reform initiatives such as PCMHs by providing additional resources and tools that help providers and FQHCs deliver comprehensive and coordinated care. For example, Maryland, Maine, and Vermont support FQHCs in providing coordinated care by helping patients navigate the health care system to access timely cervical cancer screening, referral, and follow-up.

- **Maryland's** Department of Health and Mental Hygiene (DHMH) leveraged and tailored two grants—a Centers for Disease Control and Prevention (CDC) colorectal cancer control grant and a patient care coordination demonstration project grant—to support health centers in providing patient navigation and improving data collection and quality related to cervical, breast, and colorectal cancer screening, referral, and follow-up. After an analysis of current cancer screening practices, the state decided to focus the grant opportunity on FQHCs to support improvement in cervical, breast, and colorectal cancer screening and, as an added benefit, to help FQHCs that did not yet qualify for PCMH or other incentives to make changes to better position themselves for future incentives. Beginning in 2011, three FQHCs received funding through the federal grants

(administered by the state) to improve quality for cancer screening—all funding recipients selected patient navigation as one component of their improvement strategy. The department has offered annual patient navigation training to the funded clinics as well as ongoing technical assistance and networking opportunities among the clinics (and opened up the training to other FQHCs and health departments). All sites used funds to hire new staff or support existing staff to serve as patient navigators; one site used some of its funds to hire a consultant to help implement patient navigation into clinical workflow to support screening and follow-up. Funds also supported information technology staff to make changes to electronic medical record (EMR) systems to create provider reminders and provider assessment and feedback reports.

- The **Maine Primary Care Association** has been a key partner in supporting the Patient Navigation Project Pilot, an initiative sponsored by the Maine Center for Disease Control and Prevention and initiated by the Maine Breast and Cervical Health Program.²¹ The project aims to improve comprehensive cervical (and breast) cancer screening, referral, and follow-up care for eligible women, particularly follow-up for health center patients. The PCA’s clinical quality improvement team offers training and technical assistance via an online forum for members, and in-person and web-based meetings or conference calls among health centers, all to allow peer-to-peer learning and information exchange among health centers. The Maine Primary Care Association recently began a “top performers” webinar series to highlight best practices; the first topic to be covered is patient navigation to improve breast and cervical cancer screening.

HEALTH CENTER SPOTLIGHTS: CARE COORDINATION TO ENHANCE TIMELY SCREENING AND FOLLOW-UP

Health centers sometimes add additional staff or adapt roles of current staff to provide care coordination. Throughout interviews, it became apparent that health centers need to have protocols in place for screening as well as the provision of follow-up care. Interviewees expressed that often patients do not complete follow-up treatment because they are unable to navigate the health system outside of the health center. Care coordinators or patient navigators help guide women through the screening and treatment process, and even connect them to social services. Case managers will either set up an appointment for the woman to have a colposcopy—a procedure done after an abnormal Pap test that examines the cervix for abnormal cells—in-house or assist with the referral to an external gynecology practice or hospital.

- **Chase Brexton Health Services**, a large health center in Maryland, utilizes both case managers and patient navigators. Nurses, functioning like case managers, are tasked with conducting patient assessments, care planning, referrals, and connecting patients to community and social service resources. As a recipient of one of the grants from the Maryland Department of Health and Mental Health, Chase Brexton was able to fund a patient navigator who focuses exclusively on cervical and colorectal screening. She dedicates herself to tracking and bringing in women when they are due for screening and making sure women with abnormal Pap tests are receiving the necessary follow-up treatment.
- **Charles B. Wang Community Health Center**, which serves a predominantly Asian population—almost half of which has limited English proficiency—saw an opportunity to provide more intensive case management for women with abnormal screening results. Staff sought out funding from a family foundation to hire a full-time patient navigator to assist uninsured and insured women with abnormal screening results. The navigator, upon request, will accompany patients to the hospital for follow-up, assist with registration, ensure that she understands the appointment, and even will help her apply for subsidized care if needed.

PATIENT-CENTERED CARE

Patient-centered care that reflects a patient's personal circumstances and values is a core medical home attribute. State agencies may complement efforts to provide patient-centered educational materials by providing messaging and/or informational materials.

- Earlier this year, **New York's** Department of Health funded a digital campaign promoting new cervical cancer screening guidelines. The campaign utilized web banner advertisements and a campaign page on the Department's website targeted to English-speaking women ages 30 and older in regions that have low rates of cervical cancer screening and high mortality rates. The campaign also included posts to the Department's Twitter and Facebook pages. The Department also compiles educational materials in a cancer service program resource guide, which is sent out to statewide partners twice a year.²²
- **Vermont's** Department of Health develops handouts about cervical cancer screening, which health centers, such as Springfield Medical Services, Inc., distribute along with national materials produced by entities such as the Agency for Healthcare Research and Quality.

HEALTH CENTER SPOTLIGHTS: PATIENT-CENTERED CARE THROUGH COMMUNITY ENGAGEMENT

FQHC providers and staff engage patients and women living within their communities through education and outreach. Interviewees frequently referenced patient engagement as one of their largest hurdles to increasing screening rates. All of the health centers interviewed provide some form of patient education; activities range from distributing pamphlets to newsletters to offering nutrition and fitness classes on site. The most common form of outreach is attendance at community health fairs. Health fairs offer staff the platform to provide women with educational materials and publicize available services.

- **Pines Health Services** in Maine partners with the local school system to talk to middle and high school health classes about topics including cervical cancer screening. They have found it beneficial to start educating girls at a young age, and they are able to educate female teachers and staff to be proactive about screening.
- **El Centro de Corazón** in Texas partners with a business in their community, General Electric, each year to host a Women and Girls Expo where they offer educational seminars and vouchers for discounted cervical cancer screening services.
- **Care for the Homeless** in New York also engages with the community, but has found better results from offering women incentives for screening. It has offered women transit passes and pocketbooks if they come into the clinic for cervical cancer screening.

ACCESSIBILITY

Patients are likely to engage in their own health care and utilize medical home services when they are readily accessible. States can support this goal by providing transportation assistance benefits and emphasizing the importance of accessibility within state PCMH initiatives.

- In **Maryland**, Medicaid beneficiaries are eligible for transportation services to and from appointments for Medicaid-covered services if they have no other means of accessing their medical care.²³ Transportation services are operated through the state's local health departments. Three Lower Counties Community Services, an FQHC in rural Maryland, provides tokens to

patients to use on a transit service to come to the health center; FQHC staff estimate that on average, patients need to travel 25 miles to get to the health center.

HEALTH CENTER SPOTLIGHTS: INCREASING ACCESSIBILITY

Patients are more likely to engage in their own health care and utilize medical home services when they are readily accessible. Health centers employ a number of strategies to accommodate patients' need to access timely care, including increasing the number and type of providers that can provide comprehensive care, extending night and weekend hours, and providing transportation.

- **NE Washington County Health Center** in rural Vermont contracts with a local transit association to bring patients to the health center three times per week; staff actively work to make sure that women who need to utilize this service can access appointments on those days.
- **Alexandria Neighborhood Health Services** in Virginia operates a walk-in screening clinic, staffed by a family nurse practitioner.

PAYMENT AND FINANCING

State-administered funding is an incredibly valuable incentive to facilitate PCMH transformation and quality improvement. Many of the high-performing health centers interviewed take advantage of other federal and private funding opportunities, including the aforementioned HRSA Bureau of Primary Health Care *Patient-Centered Medical/Health Home Initiative*. Although funding for state-supported programs is limited and varies depending on state budgets, financial assistance for screening and follow-up care helps providers serve individuals who might not otherwise seek out or consent to receiving the services. States help finance cervical cancer screening through presumptive eligibility and/or participation in the Centers for Disease Control and Prevention (CDC)'s National Breast and Cervical Cancer Early Detection Program, and through special state-specific programs that offer financial assistance to patients.

The National Breast and Cervical Cancer Early Detection Program provides low-income, uninsured and underinsured women access to Pap tests, HPV tests, follow-up testing for abnormal tests, and referrals to treatment if needed.²⁴ All states participate and have chosen to also provide women diagnosed with cancer through the program access to care through Medicaid providers, including FQHCs. FQHCs contract with state breast and cervical cancer programs to provide services to eligible women through the program. FQHC participation varies by state; for example in Maine, all FQHCs participate.

High-performing states also are pursuing other means of financing to promote cervical cancer screening.

- In **Colorado**, presumptive eligibility is available for women who have been diagnosed with cervical (or breast) cancer. After a woman has been diagnosed, she can receive treatment before her Breast and Cervical Cancer Program Medicaid application is processed.²⁵
- The **New York** State Cancer Services Program provides funding to conduct cervical and other cancer screenings for uninsured or underinsured individuals who meet income, age, and residency requirements.²⁶ Through this program, the Charles B. Wang Community Health Center in Manhattan has been able to screen approximately 1,000 uninsured women annually.

- In **Vermont**, a Bi-State Primary Care Association staff member is contracted with Vermont Ladies First, a screening program run through the state's Department of Health. The program pays for various preventive tests, including Pap tests, for eligible women. The contracted PCA staff member provides screening outreach and support for three of the state's FQHCs, along with two other non-FQHC member organizations.

IMPLEMENTATION OF HEALTH INFORMATION TECHNOLOGY

Finally, health information technology innovations—from electronic medical record (EMR) systems and patient registries to electronic data exchange—are an integral part of the infrastructure underlying state medical homes and quality improvement initiatives in health centers.

EMR systems have the ability to generate provider reminders at varying intervals based on the specific screening guidelines. Providers and staff are able to look at a patient's electronic chart prior to the visit to see which preventive tests she needs. Some state Medicaid agencies (e.g., Maine, Vermont, and New York) require practices to achieve NCQA PCMH recognition, which at higher levels necessitates health information technology such as EMRs. State agencies and health centers expressed the difficulties of exchanging screening data, particularly when women receive services outside of their local FQHCs; however, FQHCs with well-established systems have found EMRs to be an invaluable tool. All 14 of the high-performing health centers interviewed have implemented EMR systems, and are currently receiving CMS Meaningful Use incentives—incentive payments to eligible providers for meeting a certain set of implementation and utilization standards in their electronic health record systems.²⁷ Specific examples of state policies supporting health information technology adoption and implementation are below.

- The Community Health Care Association of **New York State** (CHCANYS) has partnered with the state's health department and Quality Improvement Organization to develop a cancer screening registry, funded through a CDC grant. Ultimately 47 health centers will interface with CHCANYS's statewide data warehouse, the Center for Primary Care Informatics, to provide daily cancer screening, follow-up, and treatment data.
- The **Texas** Health and Human Services Commission is currently developing and implementing a portable patient record, which will be accessible through patients' Medicaid identification cards. The record will track various performance metrics, including cervical cancer screening, with the ultimate goal of improving population health management. Plans are in place to implement this for all Medicaid beneficiaries.
- **Vermont's** Blueprint for Health mandated that FQHCs report into the clinical registry (DocSite) that supports population management.²⁸ **NE Washington County Health Center** uses DocSite to pull reports to identify women who need to be screened as well as to identify gaps in care.

Most EMR systems have educational resources that can be printed and distributed to patients, sometimes in multiple languages. FQHCs take advantage of these features to help ensure care is patient-centered and culturally and linguistically appropriate.

LESSONS LEARNED AND KEY CONSIDERATIONS

Through interviews with representatives from state agencies, PCAs, and FQHCs about best practices in cervical cancer screening, several key lessons and considerations emerged:

- **Broad state delivery reform efforts support improvement in cervical cancer screening.** Several interviewees noted that the growing emphasis on (and support for) quality improvement in their states has given FQHCs additional tools and momentum to identify gaps in care, prioritize areas for improvement, and implement improvement strategies. In more than one case, an FQHC identified cervical cancer screening as an area for improvement as part of an ongoing, consistent attention to quality improvement. In short, an explicit focus on cervical cancer screening within statewide improvement efforts helps, but is not necessary for improvement.
- **PCAs can be a great resource to states for providing technical assistance and disseminating information to providers about improvement initiatives.** Using their networks and provider contacts, PCAs share information and updates about state PCMH, accountable care or other initiatives and opportunities available to FQHCs to improve quality of care. They also provide FQHCs with learning opportunities to complement and reinforce PCMH initiatives, and ensure that FQHCs are aware of cervical cancer screening-specific guidelines and information.
- **High-performing FQHCs and states blend and leverage multiple funding opportunities—at the federal, state, and local levels—to foster improvement.** FQHCs and states seek out any and all opportunities to support providers in delivering high-quality cervical cancer screening and care, from tailoring federal grants, taking advantage of state programs to provide services to more uninsured or underinsured women, and pursuing small local grants to ensure follow-up care is culturally competent.
- **High-performing states and FQHCs value data and track provider performance.** Using peer review processes, regular performance feedback and health information technology, such as registries, FQHCs create a “culture” of quality improvement where the identification of gaps in care and improvement strategies is accepted and reinforced as a continuous way of life. Similarly, several interviewed states expect or require MCOs to track and report their performance on measures such as cervical cancer screening.
- **High-performing FQHCs engage all practice staff—not just providers—in quality improvement.** Interviewees consistently emphasized the importance of bringing quality improvement and medical personnel together to ensure common understanding and commitment to improvement. Interviewees noted the role front office staff play in quality improvement and the importance of keeping staff informed about screening recommendations and eligibility guidelines for state-specific programs.
- **Screening is only the first step in affecting the process of care for cervical cancer.** Multiple FQHC interviewees noted that strengthening follow-up processes and access to care after an abnormal Pap test are just as important as improving protocols and clinical workflows for screening. Several FQHCs identified opportunities to strengthen screening processes only after reviewing medical records and reasons why women failed to receive timely follow-up care. States might consider measuring and tracking receipt of follow-up care to support FQHCs and providers in improving the entire cervical cancer care process.

CONCLUSION

The array of federal, national, and state policies targeting cervical cancer screening and promoting primary care practice transformation into PCMHs has created a unique opportunity to improve cervical cancer screening. Experience and examples from Colorado, Maine, Maryland, New York, Texas, Vermont, and Virginia show how state policies and programs can reward, require or facilitate performance measurement, the delivery of comprehensive, coordinated, and patient-centered care, and access to care. These efforts assist practices in becoming PCMHs and complement health center-level processes to improve cervical cancer screening. High-performing FQHCs in these states demonstrate how to adopt a range of practices to best leverage state policies and reform initiatives. Given the new opportunities afforded by the ACA, PCAs and FQHCs are important resources for states to ensure high-quality care, including for cervical cancer screening, among newly covered and vulnerable individuals. Selected policies and practices by state Medicaid and health agencies, PCAs, and FQHCs in high-performing states offer examples for adoption by others to ensure high-quality preventive care for women.

APPENDICES

 APPENDIX A: METHODOLOGY

To identify best state and health center practices in cervical cancer screening, NASHP conducted interviews with state, FQHC, and primary care association (PCA) representatives in seven states, and spoke with several key experts. Clinical experts from organizations²⁹ such as the American Cancer Society provided background on cervical cancer screening and some of the barriers to meeting performance targets. To identify states with clusters of high-performing health centers in cervical cancer screening, HRSA provided NASHP with Uniform Data System (UDS) data collected from 2009–2011 on the cervical cancer screening measure. Using this data, NASHP, in consultation with HRSA, selected seven states with clusters of high-performing FQHCs in cervical cancer screening based on the following UDS criteria (see Table 1):

- The state demonstrated a *consistent increase* in average yearly screening rate over the three years of data;
- The state had an average yearly screening rate of more than 50 percent in 2011; and
- The state had a cluster of more than 20 percent of its FQHCs in the top adjusted quartile (as defined by HRSA) of 2011 cervical cancer screening rates.

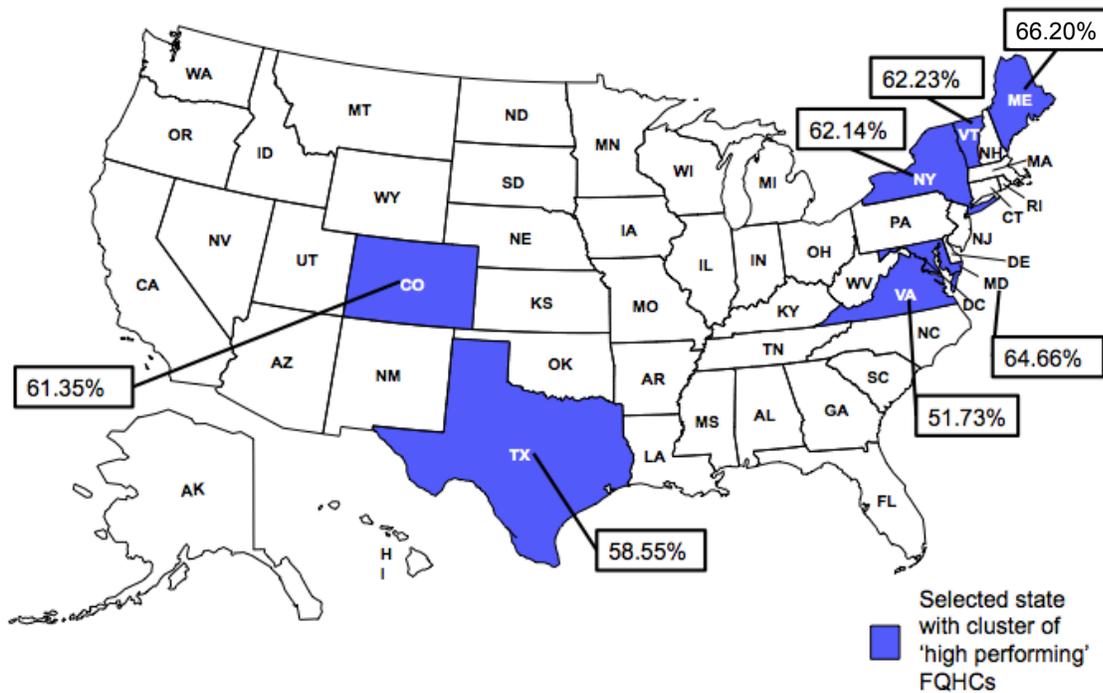
Table 1. UDS Cervical Cancer Screening Rates For Each Selected High-Performing State, 2009-2011

State	2009	2010	2011	Percent Increase from 2009-2011	Number of FQHCs in State (as of 2011)	Percent of total FQHCs in 1st Quartile ³⁰ in 2011
Colorado	58.49%	60.49%	61.35%	4.89%	15	33%
Maine	62.47%	62.73%	66.20%	5.97%	18	56%
Maryland	56.09%	61.56%	64.66%	15.28%	16	25%
New York	60.59%	61.63%	62.14%	2.56%	51	29%
Texas	55.10%	57.37%	58.55%	6.25%	64	28%
Vermont	54.29%	60.06%	62.23%	14.63%	8	75%
Virginia	44.61%	48.94%	51.73%	15.96%	25	20%

HRSA and NASHP then selected two high-performing FQHCs from each high-performing state, 14 in total, for interviews, using a process of elimination to identify high-performing FQHCs, defined as those with consistent improvement in cervical cancer screening rates and in the top adjusted quartile of health centers in 2011 for cervical cancer screening. Health centers with either of the following characteristics were eliminated from consideration for this particular project:

- A decrease in screening rates from 2009-2010 *and* 2010-2011 and/or
- Less than a 10 percent increase or greater than 100 percent increase in screening in any of the selected years.³¹

Map 2. Selected High-Performing States with Corresponding 2011 Screening Rates



NASHP and HRSA decided that an increase in screening rates of 10 percent or less could be attributable to random variation rather than practice-level transformation; conversely, increases of more than 100 percent in screening could be due to errors in reporting. If further elimination was required in selected states, other health center characteristics—size and geographic location—were considered to ensure a mix of small, large, urban, and rural FQHCs. Small health centers had a total of less than 10,000 patients, while large centers had greater than 10,000. Health centers self-report their urban or rural status yearly to HRSA based on the geographic location of the majority of their patient population. It was important to HRSA and NASHP that selected health centers include a fairly balanced representation of these categories in order to elucidate the broadest base of best practices.

For each selected state, NASHP conducted up to four interviews: two with representatives from state-level entities, typically the state Medicaid agency and the PCA, and two with selected high performing health centers (one urban and one rural, when possible) in the state. The Medicaid and PCA interviews were intended to garner information on state-facilitated grants, quality improvement initiatives, and policy levers that supported improvements in cervical cancer screening. These two interview protocols³² explored a range of topics: statewide demographics, grant programs, patient and provider resources, Medicaid reimbursement strategies, PCMH delivery system reform, and health information technology initiatives. The two FQHC interview protocols³³ varied depending on urban or rural geographic location, but still focused on similar topics: PCMH and quality improvement initiatives, health center staffing and screening policies, patient and provider educational resources, community outreach, health information technology, and reimbursement and financing strategies.

Table 2. UDS Cervical Cancer Screening Rates For Each Selected High-Performing Health Center, 2009-2011

Federally Qualified Health Center	State	2009	2010	2011	Percent Increase from 2009-2011	Quartile Ranking (2011) ³⁴	Geographic location ³⁵	Size ³⁶
Clinica Family Health Services	CO	81.78%	82.87%	83.82%	2.50%	1	Urban	Large
High Plains Community Health Center	CO	70.90%	80.50%	79.46%	12.06%	1	Rural	Small
Pines Health Services	ME	80.00%	75.71%	94.29%	17.86%	1	Rural	Large
St. Croix Regional Family Health Center	ME	62.86%	68.57%	72.86%	15.91%	1	Rural	Small
Chase Brexton Health Services	MD	48.00%	55.70%	84.89%	76.86%	1	Urban	Large
Three Lower Counties Community Services, Inc.	MD	81.43%	81.43%	74.29%	-8.77%	1	Rural	Large
Care For The Homeless	NY	34.29%	42.86%	64.29%	87.50%	1	Urban	Small
Charles B. Wang Community Health Center, Inc.	NY	76.88%	86.47%	86.66%	12.72%	1	Urban	Large
El Centro De Corazón	TX	72.24%	74.29%	74.23%	2.76%	1	Urban	Small
North Texas Area Community Health Center, Inc.	TX	47.14%	85.71%	85.71%	81.82%	1	Urban	Small
NE Washington County Community Health, Inc.	VT	67.14%	71.43%	70.00%	4.26%	1	Rural	Small
Springfield Medical Care Systems, Inc.	VT	55.71%	85.71%	85.71%	53.85%	1	Rural	Large
Alexandria Neighborhood Health Services, Inc.	VA	75.71%	70.00%	72.86%	-3.77%	1	Urban	Large
HealthWorks for Northern Virginia	VA	57.05%	63.40%	67.52%	18.35%	1	Urban	Small

APPENDIX B: INTERVIEW PROTOCOLS

MEDICAID PROTOCOL

Background

In collaboration with the federal Health Resources and Services Administration (HRSA), the National Academy for State Health Policy is researching federally qualified health center (FQHC) practices and state policies in seven states that have a high number of FQHCs that perform well in cervical cancer screening. UDS data was used to identify seven high-performing states. These include Colorado, Maine, Maryland, New York, Texas, Vermont, and Virginia. Through interviews with state Medicaid policymakers, FQHC staff, and state primary care associations, we hope to elucidate common practice-level and state-level policies that may contribute to their high performance. Information from the interviews will be used to develop several products through which NASHP will identify and disseminate promising practices for replication. These products will include a white paper and accompanying webinar, highlighting promising practice-level and state-level policies, for a broad state policy maker audience, as well as a short issue brief and accompanying webinar targeted toward health center audiences.

About The Interview

Thank you for agreeing to speak with NASHP to help inform this study. The purpose of this interview is to gather information about relevant state Medicaid policies or practices that may be affecting cervical cancer screening rates in your state. NASHP staff will conduct the interview. Summary notes from this call may be shared with our colleagues at HRSA. If at any point you would like to go “off the record” please let us know and we will ensure that portion of the conversation is not in the summary given to HRSA. We will also make sure that any such information is de-identified if included in our final materials. Interviewees will be given the opportunity to review and comment on any written products for this project prior to their finalization.

Medicaid profile

1. What is your role at the [Fill in exact name of Medicaid agency]?
2. Roughly how many individuals are currently enrolled in your Medicaid program?
 - a. Approximately what percent are adult women, ages 21-29? Ages 30-64?
 - b. What are typical eligibility requirements for adult women in your Medicaid program?
 - c. Has your state adopted the option to include women with breast or cervical cancer diagnosed as part of the CDC NBCCEDP program as part of your presumptive eligibility categories?

[If so]

- i. Are any FQHCs in your state designated as providers who can determine eligibility and enroll individuals under presumptive eligibility?

Delivery system, payment reform, and/or quality improvement

3. Medical Homes
 - a. Does your state formally recognize medical homes?
 - i. How does your state recognize or certify medical homes? (e.g., NCQA standards, state-based definition)

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- ii. Does your Medicaid program provide incentive payments to providers who meet medical home standards?
4. Medicaid Managed Care
- a. Does your Medicaid program contract with managed care organizations (MCOs)?
 - i. Approximately what percent of Medicaid recipients are covered by a MCO? Adult women, ages 21 -29? Adult women ages 30-64?
 - b. Does your Medicaid program operate a Primary Care Case Management Program (PCCM)?
 - i. Approximately what percent of Medicaid recipients participate in PCCM?
 - ii. Do you provide incentive payments to primary care providers who manage primary care through a PCCM?
 - c. Is participation in Medicaid managed care (MMC) mandatory for any specific Medicaid enrollees?
 - d. Does your Medicaid program leverage MMC to drive any specific quality improvement goals?
 - e. Does your Medicaid program use the HEDIS cervical cancer screening measure? If so, how?
5. Are there other standards or criteria that are required by Medicaid that encourage quality improvement efforts in your state?
6. Which providers can be reimbursed by Medicaid to perform cervical cancer screening in your state?

Cervical cancer screening

- 7. When did your state adopt the option to offer women access to cervical cancer screening through the National Breast and Cervical Cancer Early Detection Program?
- 8. Does your state have any other programs meant to encourage cervical cancer screening among women? Please describe.
 - a. Who is the target audience for this program?
 - b. How long has this program been in place?
 - c. How many women does this program serve?
 - d. Are there any specific eligibility requirements to participate in this program?
 - e. How does Medicaid interact with this program?
 - f. Does the state partner with any private or national programs to offer this program?
- 9. Does your state have any guidelines or requirements to promote referrals or enrollment into cervical cancer screening and treatment programs?

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10. Does Medicaid contract with any agencies or providers explicitly to deliver cervical cancer screening and treatment services?
 - a. Approximately how many?
 - b. Do you know what percentage are FQHCs?
 11. Does your Medicaid program provide any educational programming or resources *for providers* specifically focused on cervical cancer screening, since 2009? Such educational opportunities may include webinars, newsletters, and online tools made available through your state's public health department, or other sources.
 - a. Are these resources aimed toward any specific providers?
 - b. How does your state promote or distribute these resources?
 - c. Are you aware of any other state programs outside of the Medicaid department that provide similar education programming or resources?
 12. Does your Medicaid program provide any educational programming or resources *for patients* specifically focused on cervical cancer screening, since 2009? Such educational opportunities may include webinars, newsletters, and online tools made available through your state's public health department, or other sources.
 - a. Are these resources aimed toward any specific consumers?
 - b. How does your state promote or distribute these resources?
 13. Have there been any major Medicaid policy changes related to cervical cancer screening or prevention from 2009–2011?
 - a. Are there any Medicaid policies in place to prevent over screening?
 - b. Has your state's fiscal climate and/or state budget resulted in a shift in Medicaid policy focus? If so, how? (e.g., perhaps toward treatment and away from preventive services, such as cervical cancer screening)?
 14. Have there been any other (non-Medicaid) major policy changes related to cervical cancer screening or prevention from 2009–2011?

Reporting and the role of health IT

15. Does your state require reporting for any performance measures relevant to cervical cancer screening or treatment such as data related to preventive care?
 - a. Do you have a sense of your state's overall trends in cervical cancer screening for Medicaid eligibles?
 - b. Have you identified specific vulnerable populations or gaps in care related to cervical cancer screening?
16. Does your Medicaid program track cervical cancer screening rates? If so, how? (e.g., claims, EHR, CDC data, etc).

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17. Does your Medicaid program employ or promote the use of various kinds of health information technology, such as electronic databases or disease registries, to document cervical cancer screening?
 - a. Can or does your state use this data to generate reports on specific populations?
 - b. Does your state publically distribute these reports?

FQHCs

18. Reimbursement rates
 - a. Do you use a Prospective Payment System (PPS), an alternative payment method (APM), or both to pay FQHCs?
 - b. Does the Medicaid program offer any incentives or support for FQHC providers to adopt health information technology? (e.g., adjust FQHC reimbursement rates based on implementation of electronic health records)
 - c. Generally, what is included in the scope of services for FQHCs? Does your PPS or APM specifically cover services provided by care managers or care coordinators?
 - d. Are there any characteristics of Medicaid provider reimbursement methodology that especially support preventive services, particularly as it may relate to cervical cancer screening?
19. FQHCs in your state have been identified as having high or rising rates of cervical cancer screening between 2009–2011. Are there any processes or policies in Medicaid that contribute to this high screening performance?
20. Does your Medicaid program collaborate with FQHCs on any statewide initiatives?

Conclusion

21. We understand that through the US Department of Health and Human Services, the goal for Healthy People 2020 is to have 93% of eligible women screened for cervical cancer.
 - a. From your perspective as a Medicaid leader, what are the major barriers to achieving this goal?
 - b. What are best practices or policies we may not have covered earlier in this interview that will aid in attaining this goal?

PRIMARY CARE ASSOCIATION PROTOCOL

FQHC/PCA profile

1. What is your role at your organization?
2. How many years have you served in that role?
3. We understand there are XX FQHCs in your state. Roughly how many patients do they serve?
 - a. Approximately what proportion of your FQHC consumers are Medicaid enrollees? Medicare? Privately insured? Uninsured? Other?
 - b. About what proportion of patients at FQHCs in your state are female, ages 21-29? Ages 30-64?
4. Please describe the general characteristics of the FQHCs in your state:
 - Urban vs. rural;
 - 330 FQHCs vs. Look-Alikes?
 - Community demographics (race/ethnicity/languages);
 - Size of practice;
 - How many have been designated as an FQHC since 2008?

Cervical cancer screening

5. What proportion of your FQHCs offer gynecological services including cervical cancer screenings?
6. Please describe the ability of FQHCs providers to arrange for referrals or access to gynecologists for FQHC patients.
7. What proportion of your FQHCs are contracted providers under your state's breast and cervical cancer early detection program?
8. Do you know of any state or local programs meant to encourage cervical cancer screening among women, such as a state chapter of the National Cervical Cancer Coalition? Please describe.
 - a. Who is the target audience for this program?
 - b. How long has this program been in place?
 - c. Does your PCA promote these programs?
 - d. How do your FQHCs leverage these programs?
9. Are there any public-private partnerships, such as those between FQHCs and local hospitals or foundations, that provide grants or funding for cervical cancer screening in your state?
10. Does your state or your PCA provide any educational programming or services or technical resources *for providers* specifically focused on cervical cancer screening, since 2009? Such educational programs and services may include webinars, newsletters, practice coaching, online tools made available through your state's public health department, or other sources. Technical resources may include practice or provider-level data reports and analytics.
 - a. Are these resources aimed toward any specific providers?
 - b. How do you promote or distribute these resources?

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11. Has your PCA provided any educational programming or resources *for patients* specifically focused on cervical cancer screening, since 2009? Such educational opportunities may include webinars, newsletters, and online tools made available through your state’s public health department, or other sources.
 - a. Are these resources aimed toward any specific consumers?
 - b. How does your PCA promote or distribute these resources?
 12. Has your PCA provide any educational resources to providers, other FQHC staff, or patients about overscreening for cervical cancer in the past 5-6 years? If so, please describe.
 13. NASHP identified that your state has clusters of FQHCs with high or rising rates of cervical cancer screening between 2009–2011.
 - a. What factors do you think most contribute to high performance at the following levels:
 - i. Practice-level factors?
 - ii. FQHC system-level factors?
 - iii. State-level factors?
 - iv. Other?
 14. Do you know of any FQHCs in your state that have championed improving cervical cancer screening practices?
 - a. Have you learned of any best practices from these or other FQHCs related to improving cervical cancer screening or generally promoting preventive services?

Reimbursement rates

15. Does your state use a Prospective Payment System (PPS), an alternative payment method (APM), or both to pay FQHCs?
16. Does your state’s PPS or APM specifically cover services provided by care managers or care coordinators?
17. Are there any characteristics of your FQHC reimbursement method either through Medicaid or Medicaid plan payments that especially support preventive services, particularly related to cervical cancer screening?

Delivery system, payment reform, and/or quality improvement

18. How many FQHCs in your state are formally certified or recognized medical homes, either through state-based or national (ex. NCQA or other) standards?
 - a. How many FQHCs in your state are participating in HRSA’s Bureau of Primary Health Care Patient-Centered Medical/Health Home Initiative?
19. Can you describe other programs or policies in your state that support FQHCs promotion of high functioning primary care, such as learning collaboratives, public or private grants, in the past 5–6 years?

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20. Do you know of any types of incentive payments available to your FQHCs or that they receive to promote coordinated care?
 - a. Do many of your FQHCs receive these payments?
 - b. What are the greatest barriers to FQHCs that prevent them from adopting enhanced delivery system or coordinated care models? Where are there opportunities to better promote this?
 21. Describe the level of health information technology adoption and use across your state's FQHCs.
 - a. What proportion of your FQHCs have and use electronic health records (EHR)?
 - i. How many of your FQHCs have qualified for Meaningful Use incentives?
 - ii. Does your state, health plans, commercial payers, or others provide any incentives or support for providers to adopt EHRs or other health information technology?
 - b. Are your FQHCs connected to state or local data registries (ex. cancer screening registries)?
 - c. Does your PCA and/or any FQHCs in your state participate in a FQHC Controlled Network (HCCN)?
 - d. Can you describe what performance measures including data related to preventive care FQHCs are tracking and reporting?

Conclusion

22. We understand that through the US Department of Health and Human Services, the goal for Healthy People 2020 is to have 93% of eligible women screened for cervical cancer.
 - a. From your perspective as a PCA leader, what are the major barriers to achieving this goal?
 - b. What are best practices or policies we may not have covered earlier in this interview that will aid in attaining this goal?
23. Is there anything else we did not discuss about cervical cancer screening in your state that you would like to share?

RURAL FEDERALLY QUALIFIED HEALTH CENTER PROTOCOL

1. We understand that you are the [job title] at [health center], how long have you worked here?
2. Please describe the geographic region that your health center serves.
 - a. Are there other providers that care for Medicaid populations located nearby?
 - b. Are there many primary care providers in your region?
 - c. How accessible is inpatient care for your patients?
 - d. How accessible is specialty care, particularly OB-GYN physicians, either within or outside of your health center?
3. We understand that your health center sees approximately XX patients per year:
 - a. Please describe the population served by your health center (racial/ethnic diversity, age, literacy, and primary languages spoken)?
 - b. Please describe your payer mix.
 - c. Are there any unique or special populations your health center serves (homeless, migrant, uninsured)?
 - d. How far do patients need to travel to access care at your health center? Does your health center provide any services to help mitigate these issues?
 - e. Does your rural location make it more or less likely that your patients will seek out routine care from other providers rather than return to your center and experience continuity of care?
4. Please describe your staff.
 - a. How many physicians work in this health center?
 - b. Mid-levels: Nurse practitioners/physician assistants?
 - c. Registered nurses?
 - d. Medical assistants?
 - e. Who is tasked with care management or care coordination? Please describe their primary responsibilities.
 - i. Given your rural location, describe how your health center undertakes care coordination/management.
 - f. Does the [small/large] size of your rural-based health center play a role in your ability to achieve high screening rates? Please describe.
5. Has your health center provided any educational opportunities for providers specifically focused on cervical cancer screening, since 2009? Such educational opportunities may include learning collaboratives, practice coaching, webinars, and online tools made available through the CDC's National Breast and Cervical Cancer Early Detection Program, your state's public health department, or other source.

[If so]

 - a. Were these educational opportunities available and/or completed health center-wide?

[If not]

- b. Does your geographic location create barriers for your staff in accessing educational or training opportunities when they are made available (i.e. limited internet access, ability to travel to non-local training events)? How do you and your providers overcome these barriers?

Quality improvement

6. Has your health center been qualified as a patient-centered medical home?

[If so]

- a. What year did you become qualified as a medical home?
- b. Which qualification standards do you follow?
 - i. NCQA PCMH 2011 standards? What level are you?
 - ii. Other national standards -- Which one?
 - iii. State medical home standards?
- c. Do you receive payments from that are aligned with your achievement of either national or state-based medical home standards from Medicaid, Medicare, or Commercial payers?

[If not]

- d. Do you have any plans to undergo the process of becoming a designated patient-centered medical home, either by state, NCQA or other standards? Does your rural location [and, if a small health center, size] create challenges for qualification?
7. Please describe other performance metrics or quality improvement activities required by Medicaid, Medicaid plans, or other payers in your state that your health center participates in.
 8. Are there additional payments (i.e. performance-based payments) from public or private payers for achieving cervical cancer screening targets?
 9. Does your health center receive additional sources of funding, such as from a federal program, state public health, non-governmental organization, etc., that improve your ability to screen for cervical cancer? Please describe.
 10. Since or after 2009, has your health center participated in any quality improvement projects focused on women's health?
 11. Does your rural location [and, if a small health center, size] affect your ability to engage in robust quality improvement activities? If so, how does your center work to overcome any challenges?
 12. Is there a physician or staff "champion" that leads quality improvement projects at your health centers?
 - a. Has this person undertaken policy changes to increase your health center's cervical cancer screening rates?
 13. If yes to either #11 or 12, what years has your health center received these payments or additional funding sources? How does your health center use these additional?

Role of health information technology

14. Does your health center have an Electronic Medical Record [EMR]?

[If so]

- a. How does your staff use the data available through your EMR?
 - i. Can/ do you currently use it to generate reports on specific populations, specifically with regard to cervical cancer screening rates?
 - ii. Have you been able to use it to identify gaps in care for women?
 - iii. Does your rural location affect your ability to exchange electronic information with other providers outside of your health center?
 - iv. Do you use it to record patient's cervical cancer screening results?
 - v. Do you use it to generate reminders for physicians and patients? Specifically related to cervical cancer screening or follow-up?
 - vi. Does your health center participate in any of CMS Meaningful Use incentives?

[If not]

b. Are there any challenges in implementing an EMR in your center because of the rural location?

15. Does your health center employ other kinds of methods, such as electronic databases or disease registries, to document, track and/or report cervical cancer screening for your current patients? For other target groups who may not yet be current health center patients?

[If so]

- a. How do you record and follow up on patients' screening results when they come from another provider or source, such as the local health department?

16. Please describe any reminders that your patients receive when annual visits are due.

Health center policies

17. Does your health center use a standardized screening protocol(s) for cervical cancer? Please describe.

- a. How does your office identify which women need to receive a Pap test each year?
- b. Which providers in the health center conduct the Pap tests?
- c. Are your patients notified when they are due for screening? If so, how?

18. We understand that in 2011 your health center screened XX% of eligible women ages 21–64 for cervical cancer. How does your health center report its cervical cancer screening data to HRSA, via universal or random sampling (as defined by the Bureau of Primary Health Care)?

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19. For the first time in 2012, the American Cancer Society, the American College of Obstetricians and Gynecologists, and the US Preventative Task Force agree on the screening guidelines. Barring extenuating medical circumstances, it is now strongly recommended that women, ages 21–29, receive a Pap test every 3 years. For women over the age of 30, it is recommended that those who test negative for both HPV and their Pap test be screened every 5 years.
 - a. Has your health center made any adjustments based on these new recommendations?
 - b. Do you have policies in place to prevent over-screening?
 20. What, if any, follow-up protocols does your health center have in place for women who receive abnormal results from their Pap test?
 - a. How are patients notified?
 - b. Are you able to do follow-up tests and/or procedures, such as colposcopies? If you are not able to perform such tests, how far do your patients have to travel for further follow-up?
 21. Please describe the cervical cancer screening education offered to your patients.
 - a. Who primarily educates your patients about cervical cancer screening?
 - b. Do you provide your patients with cervical cancer screening educational materials or is information provided verbally?
 - i. If materials are provided, does your center develop these itself or do you access them from elsewhere?
 - ii. How, if at all, are these materials tailored to your health center's population?
 22. Has your rural location been a factor in your ability to engage in community outreach to encourage women to get screened? Please describe.
 23. Have there been any policy changes at the federal (e.g., HRSA) or state level that you believe contributed to the increase [X% change] in cervical cancer screening rates in your health center from 2009–2011?
 - a. Are there any other health center practices, processes or policies that contribute to your high screening rate?
 24. Of all of the strategies that we discussed, which do you think is most important to contributing to your health center's success as a high-performer in cervical cancer screening?

Barriers

25. We understand that through the US Department of Health and Human Services, the goal for Healthy People 2020 is to have 93% of eligible women screened for cervical cancer. From a your perspective as a provider, what are the major barriers to achieving that goal?
 - a. At the state policy level?
 - b. At the practice level?
 - c. At the patient level?
 - d. From your perspective, what strategies could be implemented in a health center to help address those barriers?

26. As many women who have had the HPV vaccine become of screening age, do you feel this will affect screening protocols in the future?
27. As a rural-based health center, what lessons can you share with other health centers in rural locations to help them achieve higher screening rates in cervical cancer screening?
28. Is there anything else that we haven't covered that would be important for our team to know regarding cervical cancer screening or your health center's performance?

URBAN FEDERALLY QUALIFIED HEALTH CENTER PROTOCOL

1. What is your role(s) in this health center?
2. How long have you practiced here?
3. Please describe your staff.
 - a. How many physicians work in this health center?
 - b. Mid-levels: Nurse practitioners/physician assistants? Registered nurses? Medical assistants?
 - c. Do you employ any care managers or coordinators? Please describe their primary responsibilities. If not, who is tasked with care management or care coordination.
 - d. Is there a physician or staff “champion” that leads quality improvement projects at your health centers?
 - i. Has this person undertaken policy changes to increase your health center’s cervical cancer screening rates?
 - e. Do you work with any community health workers to engage women in the community to get screened for cervical cancer?
 - f. Does the size of your health center play a role in its ability to achieve high screening rates?
4. Roughly how many patients does your health center serve per year?
 - a. Can you describe the population served by this health center (e.g., homeless, migrant, uninsured, racial/ethnic diversity, literacy and primary languages)?
 - b. Is your health center population fairly representative of the population in the neighborhoods surrounding the center?
 - c. Would you describe your patient base as stable, or do you experience frequent turnover of patients?
 - d. Approximately what percent of your patients are covered by Medicaid? Private insurance? Uninsured? Other?
 - e. Does your staff receive any special training or education to address cultural, ethnic, or other needs of your health center population?
 - f. How accessible is specialty care for your patients, particularly OB-GYN physicians either within or outside of your health center?
 - g. Do your patients often seek care at other health centers in your urban area, and if so, how do you ensure continuity and coordination with other providers?

5. Has your health center been qualified as a patient-centered medical home?

[If so]

- a. What year did you become qualified as a medical home?
- b. Which qualification standards do you follow?
 - i. NCQA PCMH 2011 standards? What level are you?
 - ii. Other national standards -- Which one?
 - iii. State medical home standards?
- c. Do you receive payments from any public or private payers that are aligned with your achievement of either national or state-based medical home standards from Medicaid, Medicare, or commercial payers?

[If not]

- d. Do you have any plans to undergo the process of becoming a designated patient-centered medical home, either by state, NCQA or other standards? Does your center face any challenges in meeting these qualifications?
6. Please describe other performance metrics or quality improvement activities your health center participates in as required by Medicaid, Medicaid plans, or other payers in your state.
7. Has your health center provided any educational opportunities for providers specifically focused on cervical cancer screening, since 2009? Such educational opportunities may include learning collaboratives, practice coaching, webinars, and online tools made available through the CDC's National Breast and Cervical Cancer Early Detection Program, your state's public health department, or other source.
- [If so]*
- a. Were these educational opportunities available and/or completed health center-wide?
 - b. Do you feel that available educational resources and tools adequately reflect the needs of your provider or patient populations (e.g., cultural or linguistic needs)?
8. Are there additional payments (e.g., performance-based payments) from public or private payers for achieving cervical cancer screening targets?
9. Does your health center receive additional sources of funding, such as from a federal program, state public health, non-governmental organization, etc., that improve your ability to screen for cervical cancer? Please describe.
10. If yes to either #8 or 9, what years has your health center received these payments or additional funding sources? How does your health center use these additional funds?
11. Has your health center participated in any quality improvement projects focused on women's health?

Health center policies

12. We understand that in 2011 your health center screened XX% of eligible women ages 21–64 for cervical cancer.
 - a. How does your health center report its cervical cancer screening data to HRSA, via universal or random sampling (as defined by the Bureau of Primary Health Care)?
 - b. Does your health center use a standardized screening protocol(s)? Please describe.
 - c. How does your office identify which women need to receive a Pap test each year?
 - d. Which providers in the health center conduct the Pap tests?
 - e. Are your patients notified when they are due for screening? If so, how?
13. For the first time in 2012, the American Cancer Society, the American College of Obstetricians and Gynecologists, and the U.S. Preventative Task Force agree on the screening guidelines. Barring extenuating medical circumstances, it is now strongly recommended that women, ages 21–29, receive a Pap test every 3 years. For women over the age of 30, it is recommended that those who test negative for both HPV and their Pap test be screened every 5 years.
 - a. Has your health center made any adjustments based on these new recommendations?
 - b. Do you have policies in place to prevent over-screening?
14. What, if any, follow-up protocols does your health center have in place for women who receive abnormal results from their Pap test?
 - a. How are patients notified?
 - b. Are you able to do follow-up tests and/or procedures, such as colposcopies?
15. Please describe the cervical cancer screening education offered to your patients.
 - a. Do they promote health literacy and cultural competency?
 - b. Are they offered in languages other than English?
 - c. If materials are provided, does your center develop these itself or do you access them from elsewhere?
 - d. How else do you tailor these materials to your health center's population (if at all)?
 - e. Who primarily educates your patients about cervical cancer screening?
16. Does your health center engage in community outreach to encourage women to get screened? Methods may include “screening days,” mass transit passes or reimbursement for travel to the clinic, culturally appropriate educational materials, etc.
 - a. Does your health center engage the uninsured women in this community? If so, how?
 - b. What other community groups or events do you partner with, if any, to conduct outreach to your populations?

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17. Have there been any policy changes at the federal (e.g., HRSA) or state level that you believe contributed to the increase [X% change] in cervical cancer screening rates in your health center from 2009–2011?
 - a. Are there any other health center practices, processes or policies that contribute to your high screening rate?
 18. Are there any other health center practices, processes or policies that contribute to your high screening rate?
 - a. Have there been any major policy changes that you can attribute to your increase/decrease [X% change] in cervical cancer screening rates from 2009–2011?

Payment

19. Is your health center eligible for any additional payments (e.g., performance-based payments) from public or private payers for achieving cervical cancer screening targets?

[If so]

 - a. What years has your health center participated in these payments?
 - b. What does your health center use they additional payments for?
20. Does your health center receive additional sources of funding, such as from a federal program, state public health, non-governmental organization, etc., that improve your ability to screen for cervical cancer?

Role of health information technology

21. Does your health center have an Electronic Medical Record [EMR]? When was it implemented? How satisfied are you with your EMR to date?
 - a. How does your staff use the data available through EMRs?
 - i. Do you currently use it to generate reports on specific populations?
 - ii. Do you use it to look at cervical cancer screening rates in your health center's panel? Have you been able to use it to identify gaps in care (particularly for women)?
 - b. Does you health center participate in any of the CMS Meaningful use incentives?
 - c. Do you use the EMR to exchange information with other providers outside of your health center?
 - d. Does your health center face any barriers in exchanging information with other providers outside of the health center?
 - e. Do you use it to generate cervical cancer screening reminders for physicians and patients?

22. Has your health center employed various kinds of health information technology (HIT), such as electronic databases or disease registries, to document, track and/or report cervical cancer screening?

[If so]

a. How do you record and follow up on patient's screening results when they come from another provider or source, such as the local health department?

[If not]

b. How do you record and report your patients' screening results?

23. Please describe any reminders that your patients receive when annual visits are due.

Barriers

24. We understand that through the US Department of Health and Human Services, the goal for Healthy People 2020 is to have 93% of eligible women screened for cervical cancer. From your perspective as a provider, what are the major barriers to achieving that goal?

a. At the state policy level?

b. At the practice level?

c. At the patient level?

d. From your perspective, what strategies could be implemented in a health center to help address those barriers?

25. As many women who have had the HPV vaccine become of screening age, how do you feel this will affect screening rates among vaccinated women or impact screening recommendations in the future?

26. Of all of the strategies that we discussed, which do you think is most important to contributing to your health center's success as a high-performer in cervical cancer screening?

27. Are there any lessons learned that you would like to share with other health centers working towards becoming high-performers?

a. Lessons particularly for other health centers in urban settings?

28. Is there anything else that we haven't covered that would be important for our team to know regarding cervical cancer screening or your health center's performance?

ENDNOTES

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31 Yearly percent change categories include: percent change from 2009-2010, percent change from 2010-2011, percent change from 2009-2011, and average percent change from 2009-2011.

32 See Appendix B for full Medicaid and Primary Care Association protocols.

33 See Appendix B for full Urban Federally Qualified Health Center and Rural Federally Qualified Health Center protocols.

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36 Small health centers had a total of less than 10,000 patients, while large had greater than 10,000 patients per year.