2018

Care Quality Summary
Santa Barbara County Public Health Department

2018-2019 Medical Quality Improvement Summary
Basic Health Measures
Data Fiscal Year 2018-2019
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The Santa Barbara County Public Health Department (SBCPHD) Primary Care and Family Health division (PCFH) is a Federally Qualified Health Center (FQHC) through the Health Resources & Services Administration (HRSA). Annually, the PCFH division must report on its clinical performance using measures defined in the Uniform Data System (UDS) which closely align with quality measures identified by the Centers for Medicare & Medicaid (CMS). The results of these annual reports are available on the HRSA website, and are compared to other FQHCs at both a state and national level. The SBCPHD PCFH division utilizes these measures, as well as the national averages and Healthy People 2020 recommendations, to assist in developing its annual performance improvement plan and goals.

The PCFH conducted its annual audit of quality measures during the first quarter of 2019. This report contains the results of our current reporting year which includes the time period from January 1, 2018 through December 31, 2018. Listed in the chart below are our results and also the PCFH goals for each measure and the national benchmarks. We have identified the numerator and denominator for each measure. Many of these indicators have been measured several years in a row, but some measures are new. We continue to audit new measures every year, as we identify areas where we would like to improve our care delivery. In the past, our audits were of a random sample of paper charts. We have converted to an Electronic Health Record (EHR) and now our audits are electronic and primarily include our entire patient population.
<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Patients Total</th>
<th>Percentage</th>
<th>Homeless Total</th>
<th>Percentage Homeless</th>
<th>Goal</th>
<th>HRSA 2017 National</th>
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<tbody>
<tr>
<td>HgA1c less than 9</td>
<td>2082</td>
<td>63.57%</td>
<td>0</td>
<td>0.00%</td>
<td>71.00%</td>
<td>67.05%</td>
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<td></td>
<td>3275</td>
<td></td>
<td>88</td>
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<tr>
<td>HTN with BP controlled(140/90 or less)</td>
<td>2773</td>
<td>55.52%</td>
<td>183</td>
<td>44.63%</td>
<td>70.00%</td>
<td>62.71%</td>
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<tr>
<td></td>
<td>4995</td>
<td></td>
<td>410</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Controller Medication for Persistent Asthma</td>
<td>304</td>
<td>78.76%</td>
<td>14</td>
<td>70.00%</td>
<td>85.00%</td>
<td>86.62%</td>
</tr>
<tr>
<td></td>
<td>386</td>
<td></td>
<td>20</td>
<td></td>
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<tr>
<td>Entry into Prenatal Care(first trimester)</td>
<td>828</td>
<td>62.60%</td>
<td>n/a</td>
<td>n/a</td>
<td>74.00%</td>
<td>73.97%</td>
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<tr>
<td></td>
<td>1313</td>
<td></td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Birth Weight(live births under 2500 grams. Lower % is better outcome)</td>
<td>63</td>
<td>10.31%</td>
<td>n/a</td>
<td>n/a</td>
<td>7.30%</td>
<td>8.03%</td>
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<tr>
<td></td>
<td>611</td>
<td></td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cervical Cancer Screening Documented in the Chart</td>
<td>4770</td>
<td>62.23%</td>
<td>130</td>
<td>30.00%</td>
<td>71.00%</td>
<td>55.67%</td>
</tr>
<tr>
<td></td>
<td>7665</td>
<td></td>
<td>433</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Tobacco Cessation Counseling for Patients with Tobacco Use</td>
<td>10408</td>
<td>90.18%</td>
<td>805</td>
<td>87.50%</td>
<td>95.00%</td>
<td>87.50%</td>
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<td></td>
<td>11542</td>
<td></td>
<td>920</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Counseling for BMI Out of Range adult</td>
<td>5404</td>
<td>41.74%</td>
<td>536</td>
<td>47.18%</td>
<td>60.00%</td>
<td>63.85%</td>
</tr>
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<td></td>
<td>12947</td>
<td></td>
<td>1136</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Counseling for BMI -Peds</td>
<td>2548</td>
<td>59.57%</td>
<td>11</td>
<td>28.95%</td>
<td>56.00%</td>
<td>65.85%</td>
</tr>
<tr>
<td></td>
<td>4277</td>
<td></td>
<td>38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood IZ by 2 Yrs</td>
<td>44</td>
<td>62.86%</td>
<td>2</td>
<td>100.00%</td>
<td>35.00%</td>
<td>40.24%</td>
</tr>
<tr>
<td></td>
<td>70(370)</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>2295</td>
<td>39.24%</td>
<td>140</td>
<td>21.91%</td>
<td>39.00%</td>
<td>55.67%</td>
</tr>
<tr>
<td></td>
<td>5484</td>
<td></td>
<td>639</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression Screening with intervention if screening is positive</td>
<td>6053</td>
<td>39.03%</td>
<td>496</td>
<td>51.56%</td>
<td>25%(internal goal 60%)</td>
<td>66.15%</td>
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<tr>
<td></td>
<td>15509</td>
<td></td>
<td>962</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mammogram(internal measure Q1&amp;2 FY1819)benchmark is HEDIS FQHC Nat'l ave</td>
<td>1159</td>
<td>48.01%</td>
<td>16</td>
<td>18.82%</td>
<td>59.00%</td>
<td>58.50%</td>
</tr>
<tr>
<td></td>
<td>2414</td>
<td></td>
<td>85</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>HIV Entry to Care</td>
<td>3</td>
<td>100.00%</td>
<td>n/a</td>
<td>n/a</td>
<td>100.00%</td>
<td>84.52%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ischemic Vascular Disease:Use of Asprin or another antiplatlet medication(IIV, Acute MI, CABG,PTCA procedure)</td>
<td>420</td>
<td>79.70%</td>
<td>44</td>
<td>78.57%</td>
<td>97.00%</td>
<td>79.27%</td>
</tr>
<tr>
<td></td>
<td>527</td>
<td></td>
<td>56</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronary Artery Disease(CAD) with lipid therapy</td>
<td>175</td>
<td>84.00%</td>
<td>21</td>
<td>72.41%</td>
<td>98.00%</td>
<td>80.72%</td>
</tr>
<tr>
<td></td>
<td>209</td>
<td></td>
<td>29</td>
<td></td>
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</tbody>
</table>
Stated Goals

The PCFH division sets performance goals for each of the performance measures we monitor. Our goals are based on improving previous year’s achievements and are guided by HRSA (national averages for FQHCs), Healthcare Effectiveness Data Set (HEDIS) percentiles for the Medicaid and Medicare populations and the goals of the National Healthy People 2020 campaign.

Findings & Opportunities

FINDINGS:

- This past year the PCFH department was transitioning from one EHR to another. This impacted the results reported for 2018, but we have already seen much improvement in most of the measures for 2019.
- Nine of the fourteen measures improved overall from measurement years 2011 to 2018.
- Those were for: Diabetic Patients with A1c (blood sugar) controlled, Cervical Cancer Screening (PAPs), Colorectal Cancer Screening, Immunizations for Children 2 years old, Tobacco Cessation Counseling provided for patients who reported using tobacco, both adult and pediatric BMI assessment and nutritional and activity counseling and Depression Screening and intervention for patients over 12 years old.
- The most notable improvement was for colorectal cancer screening which jumped from 5% to 39% in the past three years.
- Rates of HbA1c control (<9.0%) in diabetic patients has made steady improvement, and is the focus of a performance improvement project, with HRSA, at several of the health centers this year.
- Rates of nutritional and activity counseling documented on all pediatric patients and adult patients with a BMI out of the normal range dropped from 2011 to 2014 with the implementation of our electronic health record, but have greatly improved in the past few years as a result of our quality improvement efforts.
- Breast Cancer Screenings have had a 21% improvement from last year as a result of our quality performance improvement plan.
- Cervical Cancer screening rates have remained fairly stable and below goal since 2010. The below goal Pap smear rates may be due to recent changes in the recommendations for the onset and frequency of Pap smear screening. We do consistently score well above the national average on this measure.
- The vaccination rate, which in previous years has been 80-90%, dropped to 33% in 2013-14 due to requirement changes in the numbers of vaccines and age changes in this
measure. Our pediatric care teams focused on this measure for quality improvement in 2017 and the result is 96% compliance. This reflects our efforts to complete all the recommended vaccinations on schedule.

- Depression Screening is our newest measure. We have worked hard on meeting our goal, and actually exceeded our expectations. We are focused on addressing behavioral wellness and are actively working to improve on the measure.

OPPORTUNITIES:

SBCPHD PCFH will continue to devote time and resources to improve the care we provide. In 2019, efforts have been made to provide more collaborative care and case management to patients we see for their primary care needs. The following are some of the changes we are implementing:

- Staff at the healthcare centers will case manage patients with HIV infection, Asthma and Diabetes. As part of the Patient Centered Medical Home (PCMH) model, patients with conditions which would benefit from more support will be identified for care planning and care management.
- SBCPHD PCFH will present regular reports at healthcare center meetings to remind staff of our goals and the importance of quality care.
- SBCPHD PCFH will assist providers and care teams to gather and review their own quality data regularly.
- SBCPHD PCFH will report quality data to its providers, patients and the public.
- SBCPHD PCFH will develop policies and procedures for improving care in areas with opportunities for improvement.
- SBCPHD PCFH will enhance the accessibility of Medical Quality Improvement reports to staff and providers to increase their participation in the Quality Improvement process.
- SBCPHD PCFH will remind providers of the current guidelines for breast and cervical cancer screening.
- SBCPHD PCFH has rolled out a new electronic medical record with improved capabilities for running reports on quality measures and providing the data to providers and health center staff in a timely manner.
Measure In-depth Review

The following offers a review of SBCPHD quality measures from 2018, and where possible includes data from previous years including 2013 through current year. The last four measurement periods have included a separate measurement of patients identified as experiencing homelessness. Our goals are the same for the entire population we serve; however, we have identified those experiencing homelessness as our most vulnerable patients, and as such look at their data separately to ensure that we are doing everything possible to provide for their health care needs.

Chronic Disease Care Results

Diabetes Care

Diabetes Care is measured by assessment of hemoglobin A1C control. Specifically, we measured the percentage of patients 18-75 years of age with diabetes (Type 1 & 2) who during the year 2018 had:

- Hemoglobin A1c levels < 9.0%

The percentage of patients with diabetes with good blood glucose control, those with an HbA1c <9%, had been declining in our system and in 2012 was 52% with a goal of 85%. At that point we adjusted our goal to a more realistic number (75% and then 71%) and with outreach, care management, group education visits and a collaborative diabetes clinics at several of our care centers we have increased our diabetic control figure to 64%. There was an issue with identifying the homeless patients in the EHR this past year. This has now been corrected. The following chart shows how these numbers have fluctuated over the past several years.

This year(2019) several of the PCFH locations are involved in a Diabetic quality improvement project with HRSA and are focused on patient and staff education, care management and alternative appointment types(group visits) to reduce the number of patients with Diabetes who hav an Alc of 9% or greater. We are also participating in a learning collaborative, hosted by the National Health Care for the Homeless Council, to specifically work on improved diabetic control for our patients experiencing homelessness.
According to American Diabetic Association the reduction of HbA1c below 9% has a substantially greater impact on complications than reductions at lower levels. Less than 8% is the safest control level across the population for nearly all patients with diabetes and the most net benefit can be gained by HbA1c levels reduced less than 8%

Cardiovascular disease is the leading cause of death for patients with diabetes. LDL can deposit in the walls of blood vessels, contributing to atherosclerosis (hardening of the arteries) and heart disease. People with Diabetes and high LDL cholesterol have a higher risk for cardiovascular disease than people who do not have Diabetes.

**Persistent Asthma Patients on Controller Medications**

This measure quantifies the percentage of patients with the diagnosis of persistent asthma during the measurement period who were given a controller medication such as an inhaled corticosteroid or Singulair. This measure was added to our audits in 2011. Our Providers and Healthcare teams have worked to develop Asthma Action Plans(care plans) that are in the EHR and can be tailored to the unique needs of the individual patient. Addressing asthma is one of our performance improvement measures for 2019 and we have already seen an impact on our outcome.
Our audit found that 79% of the time our patients with persistent asthma were given a prescription for a controller medication. Our goal for this measure is 85%. Our compliance percentage increased in 2019 by over 5% already; in large part because the healthcare teams are working on the care planning process. This year the audit represents all patients in this measure. Prior audits were done on a sample of charts only.

**Nutrition and Activity Counseling for Pediatric Patients**

This measure quantifies the percentage of patients between 3 (by the end of the measurement year) and 17 years of age who have their Body Mass Index (BMI) measured at least once during the reporting year, and who were given counseling on nutrition and activity. This measure was added in 2011. The last few years our audit of this measure was conducted using the reporting functions in our EHR. In previous years, our audits were done manually, using a patient sample. Using the EHR has allowed us to audit our entire universe of patients, rather than just a small percentage for each provider. This also means that if the counseling components were not entered in a way that our program can detect it, the results may not have been captured in our audit.
In 2011, when we audited manually, we met this measure 31% of the time. When we started auditing with the electronic health record, we dropped to 3% and last year we rose up to 63%, and now, with the new EHR system we are at 60%. At the end of 2018, we discovered we were having an issue in the new system identifying patients who were homeless. We have addressed this and should see improvement in 2019 on this. Our prior audits found that the counseling was not documented in a way that was recognized by our reporting system electronically. Our EHR training team has worked with providers in documenting this measure in a manner that can be captured electronically, and we believe that by addressing this in our new system we will continue to see improved results.

**Adult BMI Measurement and Counseling for those with a BMI Out of Normal Range**

This measure quantifies the percentage of patients over 18 years of age who have their BMI (body mass index) measured at least once during the reporting year and who were
offered counseling if their BMI was out of the normal range. Our audit showed that for patients with a BMI out of the normal range counseling was offered 42% of the time. Our goal for this measure is 60%.

SBCPHD has defined a BMI out of the normal range using World Health Organization (WHO) guidelines as a BMI less than 18.5 or greater than or equal to 25 for patients under the age of 65. For patients 65 and older, out of the normal range is defined as a BMI less than 22 and greater than or equal to 27.

**Counseling for Adults with BMI Out of Range**

![Counseling for Adults with BMI Out of Range](image)

*Centers for Disease Control currently reports that up to 39.8% of adult Americans are obese. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, some of the leading causes of preventable death.*

**Controlling High Blood Pressure (HTN)**

This measure quantifies the percentage of patients 18-85 years of age who have a diagnosis of hypertension (HTN) and whose last documented blood pressure was adequately controlled (<140/90). SBCPHD noticed a dip in blood pressure control in patients who are homeless as we transitioned to our new medical record, while we saw an overall increase in compliance of 5%. This measure was identified to be on our performance improvement plan for 2019.
Some of our Health Care Centers are recognized as Patient Centered Medical Homes, and patients with HTN are being case managed by our medical support staff at those centers. By focusing extra support on patients with HTN, we hope to help them achieve and maintain healthy blood pressure levels.

Untreated or inadequately treated high blood pressure can lead to stroke, heart disease, renal failure, and other medical problems. Nearly half of adults in the United States (45.6%) have high blood pressure (AHA). The condition itself usually has no symptoms.

**Tobacco Cessation Counseling**

This was a new measure starting in 2011 and our 2011 audit found that we offered tobacco cessation counseling to our smoking patients 47% of the time. By the 2015-2016 audits we had increased this to 75%, and then it started to dip for several years. This has been largely attributed to long standing patients who are known by their health care team to be non-smokers not having this question addressed and updated each year. We had a goal to offer cessation counseling 78% of the time. We have been striving to reach our goal by working with our health care team to document their counseling efforts in the EHR and working with our tobacco cessation outreach coordinator to develop a program for patients who need this service. Also, as part of a Patient Centered Medical Home, our patients who are identified as
tobacco users are being case managed by our medical team and receive a care plan at least once a year. This year our audit showed we were screening and offering cessation services 92% of the time. We have increased our goal to 93%!

![Patients Counseled to Quit](image)

Tobacco use is responsible for about one in every five deaths (1,300 deaths per day) in the United States each year. Overall mortality among smokers is about three times higher than that among people who never smoked. Diseases that are related to smoking include cancer, heart disease, vascular disease and lung disease.

**Breast Cancer Screening- Mammography**

This measure quantifies the percentage of SBCPHD primary care patients who are women 50 to 74 years of age and had at least one visit in the measurement year and have had a screening mammography completed within 2 years. The percentage of women who completed mammograms had declined to 26% during the 2013-14 audit period and this was thought to largely be due to the implementation of the electronic health record and documentation issues using this new system. This measure became one that the SBCPHD focused on for performance improvement. The SBCPHD has set a goal of 59% (based on national averages) for completion of mammograms. The results in 2018 after transition to a new EHR system showed a dip again in our results. The Quality team and the Health Center Care teams worked with the EHR department to identify issues with documentation. Many of our HCC
teams also began proactive outreach to patients due or overdue for screening services. We have seen an 8% increase in compliance since the start of 2019.

Breast cancer is the second-leading cause of cancer death among women in the United States. One in eight (12%) of women in the U.S. will be diagnosed with breast cancer in their lifetime. Widespread uses of screening, along with treatment advances in recent years, have been credited with significant reductions in breast cancer mortality. The US Preventive Services Task Force recommends screening mammography every two years for women aged 50 to 74 years.

**Cervical Cancer Screening**

This measure quantifies the percentage of female patients 21-64 years of age who received a pap smear at least once in the past 3 years. The percentage of women who have received pap smears was 62% this measurement period. The SBCPHD has set a goal of 64%. The national average for this measure at FQHCs is 55.95%. As demonstrated in the graph below, our cervical cancer screening rates have been slowly improving over the past several years. As part of our Patient Centered Medical Home tasks, we are case managing preventive care and giving our patients annual reminders when they are due for preventive services. We hope to see continued improvement in our cervical cancer screening rates next year. We have also identified this measure as part of our yearly quality improvement plan, focusing on those women experiencing homelessness.
This measure quantifies the percentage of patients at 2 years of age who have completed their recommended immunizations (IZ). These immunizations are Polio (3), TDAP (4), Hepatitis B (3), HIB (3), MMR (1), Varicella (1), Prevnar (4), Hepatitis A (1), Rotavirus (2-3), and Flu (2).

After the SBCPHD compliance rates dipped in the 2014-15 measurement period, one of our pediatricians organized a quality improvement team at one of the SBCPHD health care centers to work on improving this measure. The team was able to create a workflow (that was shared with the other centers) to address a child’s immunization needs at every visit. The goal was re-set for this measure using national averages (39.4%) and also taking into consideration of the addition of 3 vaccine requirements. We are proud to have greatly exceeded those benchmarks and goals, and will continue to strive to provide the best preventive care for our patients.
Colorectal Cancer Screening

This measure quantifies the percentage of patients over the age of 50 who have had colorectal cancer screening either with annual fecal occult blood tests, flexible sigmoidoscopy every five years, or a colonoscopy every 10 years. In the first measurement year, 2012-13, we were screening and documenting on 3% of our patients. Then we rose to 5% in 2013-2014. This year we were at 39%. The SBCPHD had set our goal at 39% for this measure, this year we have exceeded that goal, and have increased it to 44%.
We have made tremendous progress, and anticipate even better results on our next audit. Similar to mammography, results of the colorectal cancer screening must be entered manually into the flow sheet in the patient’s e-chart. The EHR team has worked with staff on capturing the results in a measurable way. This year we have seen much higher numbers of patients being screened and having the screening documented correctly. Through ongoing training in documenting in the electronic record, and improved indexing of colonoscopy results, we anticipate continued improvement on this measure.

**Depression Screening and intervention if screening is positive**

The primary care and family health division (PCFH) of the SBCPHD has, over the past several years, been focused on providing a medical home to our primary care patients. The goal is to work with the patient to address all of their health care needs, either by providing needed care or working with other divisions of the SBCPHD, or community partners to ensure needed services are obtained.

This measure is a wonderful example of that partnership, as the SBCPHD PCFH division has worked with the Community Health division, the department of Behavioral Wellness and community organizations such as our local homeless shelters to ensure that all of our patients age 12 and over are screened at least annually with a standardized screening tool for...
depression. If the screening is positive, indicating moderate to severe depression, the primary care provider addresses the management of the depression with the patient, and if needed makes a plan for treatment, follow up, or a referral to a behavioral health partner. Our health care centers (HCCs) have been working toward integrating behavioral health with primary care and now have behavioral health providers at the HCC.

When we first started assessing this measure, we had set our goal at 10% for intervention of a positive screening. We exceeded that goal, and last year moved the goal up to 25%. This year we have increased our goal to 60% for this measure and additionally will look to have at least 75% of all patients 12 and over screened for depression at least annually.

We feel we have significant room for improvement on these measures, and therefore formed a corrective action plan around this service.

Positive Depression Screening with Intervention

![Graph showing the percentage of positive depression screenings with intervention from 2014-15 to 2018. The goal is 60% intervention. The graph shows an increase from 14% in 2014-15 to 60% in 2018.]
Studies have suggested that despite the high prevalence and substantial impact of depression, detection and treatment in the primary care setting has been suboptimal. Studies have shown that usual care by primary care physicians fails to recognize 30 percent to 50 percent of depressed patients. Because patients in whom depression goes unrecognized cannot be appropriately treated, systematic screening has been advocated as a means of improving detection, treatment, and outcomes of depression.

HIV diagnosis and follow up care

This measure quantifies the percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 90 days of diagnosis. This is usually a very small number of patients, as most of our HIV diagnosed patients are referred to our health care centers after diagnosis at a community partner (Pacific Pride, Planned Parenthood, Santa Barbara Neighborhood clinics). The probability of HIV related complications and transmission of disease are reduced, if patients found to be HIV positive are seen for follow-up care within 90 days of the initial HIV diagnosis. The SBCPHD has set a goal of 100% for this measure, and we reached that goal of 100%.
Conclusions and Recommendations

Effective and successful interventions to reduce the onset and support the management of illnesses and chronic disease are crucial for the SBCPHD’s patient population. Monitoring of clinical quality measures demonstrates the efficacy of the care we provide and is useful for identifying areas of success and opportunities for improvement.

As we move forward with respect to the findings in this 2018 summary, we have great hopes to improve future care by collaborating with our providers and patients. We are dedicated to our mutual goals of promoting wellness and providing the highest quality of care for Santa Barbara County residents.

Future goals include:
- Develop a Patient Centered Medical Home care approach at all of our Health Care Centers.
- Expand the use of provider teams to address the management of chronic disease.
- Facilitate patient access to care by fully integrating our electronic health record system into our medical practice and by offering patients access to the health centers via a patient portal.
- Utilize our electronic health record for case management of preventive and chronic disease care.
- Focus care management at the Health Care Centers to address the care needs of patients with Chronic Diseases like Diabetes and Asthma as well as to coordinate preventive health services such as cervical and breast cancer screening and annual preventive health assessments.
- Continue to support our Medical Practices Committee and its participation in program development, improvement and evaluation.

Thank You

The Santa Barbara County Public Health Department, Quality Improvement Division, would like to thank all the staff that participated in the data gathering process required to complete our reporting.
References

American Diabetes Association “Complications”
http://www.cdc.gov/obesity/data/adult.html.  Page last reviewed: August 13, 2018

World Health Organization BMI Classification.

United States Preventive Task Force Website
Current as of: May 2019

Centers for Disease Control and Prevention “Tobacco-Related Mortality”
Page last updated: January 17, 2018

Agency for Healthcare Research and Quality: Screening for Depression in Adults
https://www.ahrq.gov/professionals/clinicians-providers/resources/depression/depsum1.html
Content last reviewed April 2013.