



primary care coalition
of Montgomery County, Maryland

Montgomery Cares Clinical Performance Measures

Fiscal Year
2011

March 2012

Table of Contents

Executive Summary..... 2

Background..... 3

History of Clinical Measures in Montgomery Cares..... 3

Results Reporting and Benchmarking..... 4

Condition Specific Results

 Diabetes..... 7

 Hypertension..... 10

 Breast Cancer..... 11

 Cervical Cancer 12

 Colon Cancer..... 13

Measure Definition (Appendix 1)..... 14

References..... 16

Executive Summary

Fiscal year 2011 marks the fourth year that the Primary Care Coalition has published selected annual measures of clinical performance among clinics participating in Montgomery Cares.

For chronic care, Montgomery Cares clinics have demonstrated significant and continuous improvement in annual measures.

- In FY 2011, Montgomery Cares performance met or exceeded HEDIS Medicaid benchmarks on annual measures of diabetes and hypertension care.

For preventive care, Montgomery Cares clinics have demonstrated modest gains in annual measures of cancer screening, but are performing well below HEDIS benchmarks.

- The Primary Care Coalition and Montgomery Cares participating clinics continue to seek sufficient and reliable supplies of mammography and colonoscopy services, while also continuing to test process improvements to improve cancer screening rates.

Improvements reflect wide-ranging process changes, including the adoption of evidence-based practices, office practice redesign, collaborative interprofessional practice, and technology-enabled care. The Primary Care Coalition is actively evaluating commercial Electronic Medical Records to replace CHLCare in order to better support recommended care, facilitate the efficient collection of clinical measure data, and better position clinics to serve a larger population of vulnerable Montgomery County residents.

We gratefully acknowledge the physicians and staff of the eleven clinic organizations that participate in Montgomery Cares to serve Montgomery County's low income and uninsured populations. These clinical measures reflect their work and commitment. The PCC is very appreciative of the Montgomery County Council and Montgomery County Department of Health and Human Services for their oversight and support. We have benefitted from the expertise of many partners, including the University of Maryland School of Pharmacy and the Institute for Healthcare Improvement. Much of the work that has driven these improvements over time has been supported by generous grant funding. The Primary Care Coalition thanks our funders, including the following, who have made this work possible.

Adventist HealthCare
Agency for Healthcare Research and Quality
American Breast Cancer Foundation
Bank of America
CareFirst BlueCross BlueShield
Consumer Health Foundation
Communities IMPACT Diabetes Center/Centers for Disease Control and Prevention
Maryland Department of Health and Mental Hygiene
Meyer Foundation
Susan G. Komen for the Cure

Background

In the past year, the Primary Care Coalition (PCC) Board approved a Strategic Plan that envisions all Montgomery County residents having an opportunity to live healthy lives, and defines the PCC mission to be the catalyst for the development and coordination of a community-based health care system that strives for universal access and health equity for underserved residents. Quality is at the heart of everything we do. The Institute of Medicine defines quality healthcare as care that is safe, timely, effective, efficient, accessible, equitable and patient-centered.

The Primary Care Coalition (PCC) and clinics participating in the Montgomery Cares (MC) Program remain committed to improving the quality of healthcare provided to low income, uninsured residents of Montgomery County. Montgomery Cares Medical Directors meet quarterly to discuss quality-related issues including clinical process and outcome measures, best practices, and common challenges. Invited guests share expertise and resources. These meetings help to maintain and support clinic focus on quality improvement and guideline-concordant care, and identify opportunities for collaboration and technical assistance. In addition to quality improvement activities, Montgomery Cares performs on-site Quality Assurance (QA) Reviews, and produces clinic-specific and aggregate reports. Clinics utilize this information to improve their services and performance.

The History of Clinical Measures in Montgomery Cares

The Primary Care Coalition has collected clinical data from participating Montgomery Cares Clinics to inform quality improvement efforts since 2003. Originally, data was collected from a CVDems Diabetes Registry, utilized by five clinics, and funded through a federal grant from the Health Resources and Services Administration (HRSA). Over time, additional clinics began entering data into the CVDems Diabetes Registry. Reporting capabilities were limited, but PCC presented available information to Medical Directors on an annual basis.

In 2007, PCC and Medical Directors from clinics participating in Montgomery Cares approved measure definitions and technical specifications in order to report nationally endorsed measures of diabetes care. Funding from two CareFirst Blue Cross Blue Shield grants enabled PCC to develop syntax and technology for data capture in CHLCare, a shared electronic record available free of charge to Montgomery Cares participating clinics. Effective July 1, 2007, PCC officially converted from CVDems to CHLCare, a more robust and flexible system that could better capture clinical and demographic information, and support clinical operations, contractual reporting requirements and quality improvement efforts. The conversion to CHLCare required clinics to revise workflow in order to assure timely and accurate data entry and reporting in CHLCare. The performance metrics in this report are a reflection of clinical processes of care provided in the clinics, as well as a reflection of data entry practices in each clinic.

In July, 2008, PCC produced clinical diabetes measure results from CHLCare for the first time, and began presenting quarterly results to the Medical Directors for their review and consideration. In 2008 and 2009, PCC and clinic Medical Directors added measures to evaluate clinical performance related to hypertension and wellness/preventive care, and refined the quarterly reporting of each.

Most, but not all Montgomery Cares participating clinics report clinical data for quality measures. A list of reporting clinics for each fiscal year is provided below. The "Under One Roof" clinic closed in fiscal year 2011 and is not represented in this year's report. Seven clinics utilize CHLCare; six of those reported clinical data for measures in FY 2011; the Mansfield Kaseman Clinic did not. Four clinic organizations utilize registries or commercial electronic medical records (EMR). Holy Cross Clinic reports data for Diabetes measures from their CVDems Registry. Mary's Center and Spanish Catholic Center report data from their commercial EMR. Community Clinic, Inc. utilizes a commercial EMR, but does not report clinical measures data to Montgomery Cares.

Clinics Reporting FY 2008	Clinics Reporting FY 2009	Clinics Reporting FY 2010	Clinics Reporting FY 2011
Holy Cross Clinic (DM only)	Holy Cross Clinic (DM only)	Holy Cross Clinic (DM only)	Holy Cross Clinic (DM only)
Mercy Clinic	Mercy Clinic	Mercy Clinic	Mercy Clinic
Mobile Med	Mobile Med	Mobile Med	Mobile Med
Muslim Community Center Medical Clinic	Muslim Community Center Medical Clinic	Muslim Community Center Medical Clinic	Muslim Community Center Medical Clinic
Proyecto Salud	Proyecto Salud	Proyecto Salud	Proyecto Salud
Spanish Catholic Center	Spanish Catholic Center	Spanish Catholic Center	Spanish Catholic Center
The People's Community Wellness Clinic	The People's Community Wellness Clinic (mammo only)	The People's Community Wellness Clinic	The People's Community Wellness Clinic
		Chinese Culture and Community Services Center (Pan Asian)	Chinese Culture and Community Services Center (Pan Asian)
		Mary's Center	Mary's Center
		Mansfield Kaseman Clinic (CMR)	
	Under One Roof	Under One Roof	

Current Measures

The PCC and clinic Medical Directors have selected measures for reporting based on several criteria, including:

- Existence of nationally endorsed measure specifications;
- Evidence that improvement in the measures correlates with improved patient outcomes;
- Sufficient prevalence of condition in the Montgomery Cares population;
- HEDIS Medicaid results available to serve as meaningful benchmarks and performance targets where possible.

Montgomery Cares tracks 18 measures of chronic, preventive and wellness care on a quarterly basis. Nine clinical measures are presented in the annual report. This report provides information on clinical performance in each of the four fiscal years since 2008, reflecting the time period after Montgomery Cares converted to CHLCare.

Results Reporting and Benchmarking

The PCC reviewed performance in selected clinical measures reported by HEDIS for the Medicaid population, and by HRSA for Federally Qualified Health Centers in Maryland and nationally. While the technical specifications for the HEDIS, HRSA and Montgomery Cares measures differ from one another in some respects, results from both HEDIS and HRSA are comparable, and they serve as reasonable benchmarks for Montgomery Cares performance. Where relevant public information is available, Montgomery Cares performance is benchmarked against the HEDIS Medicaid performance, since annual HEDIS results are more timely and publicly available than HRSA results. HEDIS measure definition is typically similar, but not identical to Montgomery Cares measure definitions (Appendix I). Only 25% of Medicaid beneficiaries are enrolled in a HEDIS-reporting plan according to the National Committee for Quality Assurance. These Medicaid plans typically have more sophisticated infrastructure, more financial resources, and more specialty care access than Montgomery Cares participating clinics. Still, HEDIS Medicaid has been selected by PCC and participating Medical Directors as the most relevant public benchmark for Montgomery Cares comparisons.

Research indicates that health plans that publicly report clinical quality indicators outperform plans that do not. Montgomery Cares has set a goal that clinics perform at levels higher than the average for HEDIS Medicaid on measures for which Montgomery Cares and HEDIS produce comparable measures. Montgomery Cares performance is benchmarked against average and 90th percentile HEDIS Medicaid performance.

PCC also reviews variation between clinics. Variation does not evaluate the clinical expertise of the providers, but rather the reliability of the process. Reduced variation signals improved reliability in planned care and/or data entry processes. In the following graphs, changes in the “lowest” and “highest” clinic results do not necessarily reflect performance in a single clinic; the “highest” and “lowest” performing clinics are not necessarily the same clinics year to year.

Process improvement efforts have resulted in significant and sustained improvements in most measures in terms of both absolute performance, and reduced variation between clinics.

The following pages highlight performance in fiscal years 2008-2011 for each relevant measure. This report demonstrates improvement each year in most clinical measures, with performance at or exceeding target in diabetes and hypertension care.

Improvements have been demonstrated as a result of multiple factors:

- Clinics are increasingly developing and utilizing clinical practice guidelines.
- Clinical measures continue to be reviewed and discussed quarterly by Medical Directors representing MC-participating clinics. This has helped to reinforce clinic focus on QI and clinical outcomes.
- Review of quarterly performance identified access problems for particular services. PCC and individual clinics responded by identifying new sources of care, and revised processes of care to facilitate more effective and efficient referrals.
- Over the past several years, six clinics have embarked on office practice redesign, focusing on care team development, streamlining processes and optimizing utilization of staff to more reliably provide planned and evidence-based, “recommended” care.
- Two clinics have formally adopted a patient-centered medical home model.
- Clinics that utilize CHLCare have continued to increase their utilization of CHLCare for data entry, and have increasingly utilized the CHLCare “Visit Planner” to identify care needs at the time of a visit to facilitate recommended care for individual patients.
- PCC has improved CHLCare functionality to support more focused and efficient utilization of visit planners, care management functions, and other features.
- Patient navigation and care management services have been introduced in many clinics.
- PCC led a re-evaluation of diabetes self-management education in FY 2010. Diabetes educators from participating clinics evaluated the current group class curriculum and shared best practices from literature reviews and from one another. Clinics have increasingly utilized bilingual educational materials intended for low literacy populations.
- PCC led several educational sessions on Motivational Interviewing for providers and diabetes educators to increase their effectiveness in supporting patient self-management.
- Two clinics added grant-funded medication therapy management (MTM) in cooperation with the University of Maryland School of Pharmacy. Clinical pharmacists meet individually with patients to review and reinforce medications, and recommend changes in drug, dose or regimen to primary providers.
- The Pharmacy and Therapeutics Committee continues to review and update formularies to provide meaningful pharmaceutical support to Montgomery Cares participating clinics. Point of Service generic medications and diabetes supplies are provided to participating clinics, supplemented by brand name and other medications obtained through Pharmacy Assistance Programs and retail pharmacies.

- PCC provides consultation and technical assistance to clinics with funding from grants and MCDHHS. A shared Yahoo! Group was established in FY 2011 to provide ready access to documents and internet links relevant to quality assurance and quality improvement.

Challenges remain. In particular, availability of specialists and procedures such as screening mammography and colonoscopy services continue to be insufficient to meet demand. Montgomery Cares is actively evaluating commercial EMRs to replace CHLCare in order to better support recommended care and facilitate the efficient collection of clinical measure data.

Results

For chronic care, Montgomery Cares (MC) clinics have demonstrated significant and continuous improvement in annual measures.

- In FY 2011, MC performance met or exceeded HEDIS Medicaid benchmarks on annual measures of diabetes and hypertension care.

For preventive care, Montgomery Cares clinics have demonstrated modest gains in annual measures of cancer screening, but are performing well below HEDIS benchmarks.

- A 2010 federal US study¹ found low cancer screening rates among minorities and the uninsured. Montgomery Cares performance is well below even those national rates.
- The Primary Care Coalition and Montgomery Cares participating clinics continue to seek sufficient and reliable supplies of mammography and colonoscopy services, while also continuing to test process improvements.

The table below summarizes Montgomery Cares' performance in fiscal years 2008-2011, comparing Montgomery Cares' results against the most recent HEDIS 2011 Medicaid benchmarks.

Measure	FY 08	FY 09	FY 10	FY 11	Target Range (mean-90 th percentile)
* Diabetes: Annual HgA1c Testing	54%	74%	77%	83%	82-91%
* Diabetes: Annual LDL Testing	47%	65%	70%	77%	75-84%
* Diabetes: Good HgA1c Control (≤ 7)	26%	35%	37%	41%	35-44%
* Diabetes: Poor HgA1c Control ($\geq 9\%$)	57%	44%	37%	36%	44-29% (Note: Lower numbers demonstrate improvement)
* Diabetes: LDL Control (≤ 100 mcg/dL)	22%	32%	35%	38%	35-46%
* Hypertension: BP Control ($\leq 140/90$)	52%	60%	65%	64%	56-68%
Breast Cancer Screening	12%	26%	29%	32%	51-63%
Cervical Cancer Screening	7%	15%	29%	39%	67-79%
Colorectal Cancer Screening	1%	2%	2%	3%	N/A

*achieving target

The following pages provide information, obtained from the National Committee on Quality Assurance's "State of Healthcare" 2009, 2010 and 2011 reports to describe the importance of improving quality of care in the areas of Diabetes, Hypertension and Cancer Screening. Additionally, PCC has provided the definition of each measure, and performance metrics for each of the four reported fiscal years. For each measure, the graph indicates HEDIS Medicaid benchmarks, and the degree of variation between the highest and lowest performing Montgomery Cares clinic.

Diabetes

Diabetes is a group of diseases characterized by high blood sugar levels. It is one of the leading causes of death and disability in the US. Much of the burden of illness and cost of treatment is due to potentially preventable long-term complications of diabetes, including heart disease, stroke, blindness, limb amputations and nervous system and kidney disease^{1,2}.

Long-standing, nationally endorsed measures exist to measure the *process* of Diabetes care (eg. Are patients receiving recommended care) and the *outcomes* of care (eg. Is the diabetes well controlled?). These were the first set of measures adopted by PCC.

In this report, the PCC presents the following four measures related to Diabetes care:

Diabetes Process Measures	Diabetes Outcome Measures
Annual HgA1c Test	Poor HgA1c Control
Annual LDL Cholesterol Test	Good LDL Control

Why Improvement in Diabetes Care is Important

Almost 26 million Americans (8.3%) are diabetic, and an additional 79 million are prediabetic³. Compared to non-Hispanic white adults, the risk of diabetes is 66% higher among Hispanics, and 77% higher among non-Hispanic blacks³. Average medical costs are 2-3 times higher for patients with diabetes than expected costs in the absence of diabetes³. In 2007, the estimated cost of diabetes to the US economy was \$174 billion. \$116 billion was attributed to medical care, and another \$58 billion was lost through disability, missed work days, and premature mortality³.

Evidence to support improvement in diabetes care is irrefutable. For people with diabetes, the risk of death is twice that of people without diabetes². Even modest improvements in outcomes are meaningful. Blood pressure control reduces the risk of cardiovascular disease among people with

diabetes by 33-50%. Controlling LDL cholesterol can decrease cardiovascular risk by 20-50% For every 1 percentage point improvement in glucose control, microvascular complications (eye, kidney and nerve disease) are reduced by 40%².

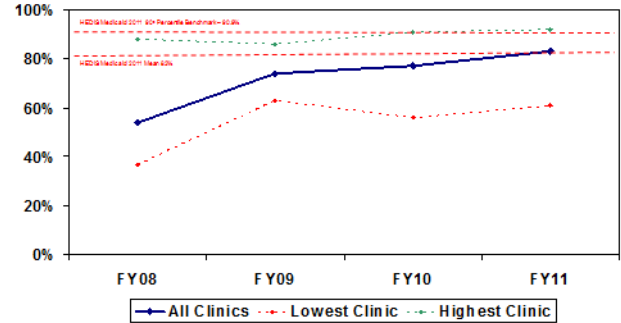
Measure Definitions
<p>Annual HgA1c Test Percent of eligible patients who had at least one A1c test(s) during the measurement year</p>
<p>Annual LDL Cholesterol Test Percentage of eligible patients who had at least one LDL cholesterol test during the measurement year</p>
<p>Poor HgA1c Control Percent of eligible patients with most recent HgA1c level >9.0%. If no HgA1c test was performed during the measurement year, result is considered to be in poor control (Note: Lower rates are better for this measure).</p>
<p>Good LDL Control Percent of eligible patients with most recent LDL cholesterol level ≤ 100 mg/dl.</p>

Interpretation of FY 2008-2011 Results

For both process measures (annual HgA1c and annual LDL cholesterol testing), Montgomery Cares performance improved in each of the four fiscal years tracked, and is at target. High performing clinics maintained performance at or near HEDIS Medicaid 90th percentile.

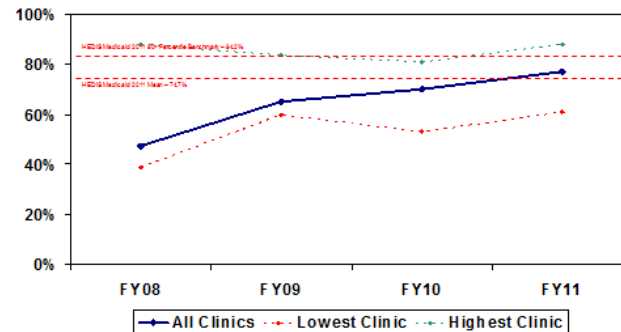
Montgomery Cares clinics have been tracking and reporting measures of Diabetes Care since 2003. In fiscal years '08 and '09, clinics made significant improvements in data entry (entering relevant data into CHLCare), and in clinic workflow. These improvements have been maintained through fiscal year 2011. Three clinics utilized a web-based laboratory order entry system and the PCC developed a new laboratory module which enables these lab results to auto-populate CHLCare, obviating the need for manual laboratory data entry for those clinics. Additionally, PCC designed a CHLCare "Visit Planner" that auto-populates patient level data for providers and care teams to review prior to the clinic encounter. The "Visit Planner" provides, dates and results of Diabetes testing, and serves as an alert or reminder to the care team when recommended care is due. Three reporting clinics in FY 2011 utilized electronic registries or commercial electronic medical records with similar functionality. Clinics have expanded the role of non-provider members of the care team to help assure that recommended care is provided.

Diabetes measurement patients with at least 1 HgA1c test



Includes patients who had a blood test for Hemoglobin A1c within one year of their most recent encounter. (Data not reported from CCI and Mansfield Kaseman clinics)

Diabetes measurement patients with at least 1 LDL test



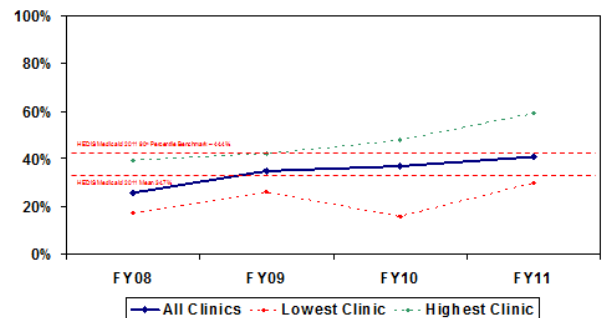
Includes patients who had an LDL cholesterol test within one year of their most recent encounter. (Data not reported from CCI and Mansfield Kaseman clinics)

In fiscal years 2009 and 2010, the PCC led a re-evaluation of diabetes self-management education with Montgomery Cares participating clinics. Diabetes educators from many of the clinics met regularly to evaluate the current group class curriculum and share best practices from literature reviews and from one another. Clinics increasingly utilize bilingual educational materials intended for low literacy populations. PCC led several educational sessions on Motivational Interviewing for providers and diabetes educators. Two clinics added a grant-funded medication therapy management (MTM) service in cooperation with the University of Maryland School of Pharmacy. Increasing utilization of clinical practice guidelines, and availability of point of service medications and diabetes supplies also contribute to improving clinical outcomes.

Measures of diabetes control (HgA1c and LDL Cholesterol) continue to demonstrate improvement in each reported year, and Montgomery Cares performance is at target for all three reported measures of diabetes control: good HgA1c and LDL cholesterol, and poor HgA1c control. High performing clinics exceed 90th percentile HEDIS Medicaid results.

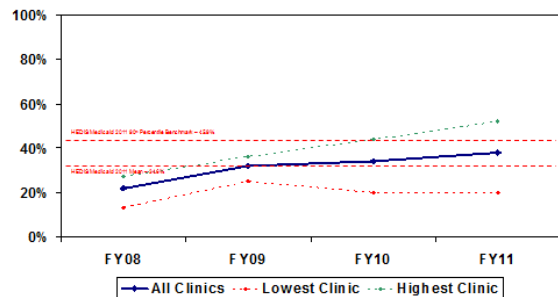
Because Montgomery Cares wants to reduce the number of patients in poor control, DECREASING percentages represent improvement on the measure “Poor Control of HgA1c”.

Diabetes measurement patients with good control of HgA1c



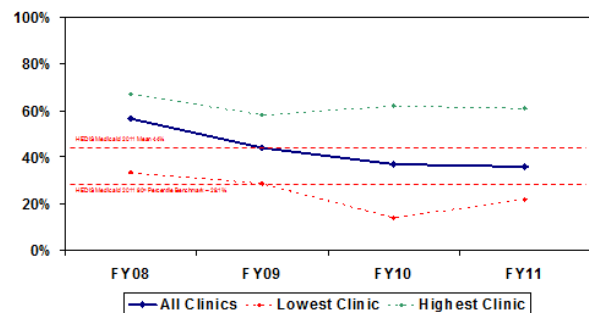
Includes patients who had a Hemoglobin A1c test result ≤ 7 . (Data not reported from CCI and Mansfield Kaseman clinics)

Diabetes measurement patients with LDL ≤ 100



Includes patients who had an LDL cholesterol test within a year prior to their most recent encounter and whose most recent LDL cholesterol test had a result ≤ 100 . (Data not reported from CCI and Mansfield Kaseman clinics)

Diabetes measurement patients with poor control of HgA1c



Includes patients who had a Hemoglobin A1c test result ≥ 9 or who had no test for HgA1c within one year prior to their most recent encounter. (Data not reported from CCI and Mansfield Kaseman clinics)

Hypertension (High Blood Pressure)

Why Improvement in Hypertension Care is Important

Approximately 76.4 million people in the United States (33.55%) have high blood pressure. The prevalence of hypertension in blacks in the United States is among the highest in the world, and it is increasing⁴.

Approximately 69% of people who have a first heart attack, 77% of those who have a first stroke, and 74% of those who have heart failure have high blood pressure⁴.

Despite available effective treatment options, studies show that over half of Americans with hypertension go untreated or undertreated.⁵

In clinical trials, treatment for hypertension has been associated with a 35 to 40 percent reduction in stroke incidence, 20 to 25 percent reduction in heart attack and a more than 50 percent reduction in heart failure⁶.

In 2007, the associated direct and indirect medical costs in the US attributable to hypertension were estimated to be \$43.5 billion⁴.

Measure Definition

Hypertension BP Control

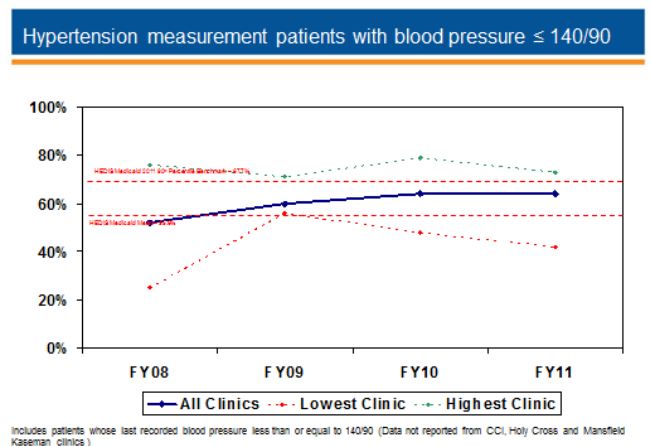
Percent of eligible hypertensive patients with most recent recorded blood pressure measurement \leq 140/90

Interpretation of FY 2008-2011 Results

Montgomery Cares clinics continue to improve blood pressure control among hypertensive patients, with most clinics exceeding HEDIS Medicaid 90th percentile performance.

Montgomery Care clinics began tracking and reporting data for hypertension control during fiscal year 2008. Prior to that time, some clinics did not routinely enter BP data into CHLCare. Fiscal year 2009 was the first complete year in which hypertension measures were reported.

Changes in performance between 2008 and 2009 may be largely reflective of improved data entry. Increasing utilization of clinical practice guidelines, and availability of medications also contribute to improving clinical outcomes. Nearly all reporting clinics performed at HEDIS Medicaid's 90th percentile for hypertension control in fiscal years 2010 and 2011.



Cancer

Cancer Screening

The purpose of performing screening exams on otherwise healthy and asymptomatic patients is to identify conditions that carry a high risk of morbidity or mortality, but for which effective treatments are available if caught early. Clear disparities in care exist among minorities and the uninsured in the U.S¹. Authors Of the Centers for Disease Control and Prevention’s “Cancer Screening in the U.S. 2010” note that financial barriers and access to health care account for some of the disparities in cancer screening, but education levels, age, and length of residence in the U.S. for some immigrant subgroups also have an effect.

Lack of health insurance and other barriers prevent many Americans from receiving optimal health care. Uninsured patients and ethnic minorities are substantially more likely to be diagnosed at later stages, when treatment can be more extensive and costly⁷.

PCC is reporting three cancer screening results:

Cancer Screening Process Measures
Breast Cancer Screening
Cervical Cancer Screening
Colorectal Cancer Screening

Why Improvement in Breast Cancer Screening (Mammography) is Important

Breast cancer accounts for 1 in 4 new cancer diagnoses, and is one of the most common types of cancer among American women. It is the second leading cause of cancer death in women (after lung cancer).

Treatment for breast cancer detected in its earliest, pre-invasive stage costs significantly less than treatment for breast cancer detected in more advanced stages. A mammogram can detect 80-90 percent of breast cancers in women without symptoms⁷.

According to the “Cancer Screening in the U.S. 2010” survey by the Centers for Disease Control

and Prevention, 36.2% of women with no health insurance or those relying on hospital emergency departments for medical attention received mammograms, as compared to 75.4% of women with regular access to health care.

Measure Definition

Breast Cancer Screening

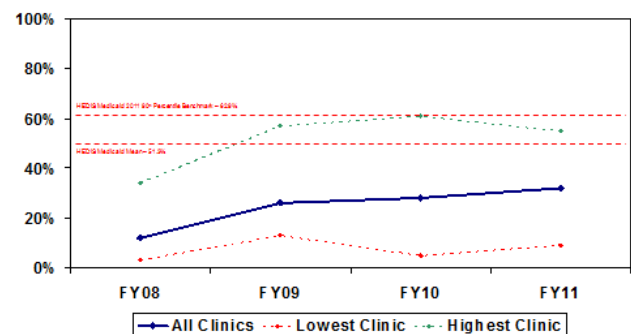
Percent of eligible women ≥ 40 years of age with a documented mammogram in the past two years.

Interpretation of FY 2008-2011 Results

Montgomery Cares has reported breast cancer screening performance since FY 2008. Through Susan G. Komen grant funding and in cooperation with local hospitals and private radiologists, several Montgomery Cares clinics implemented patient navigation, care management, and “rapid referral processes” with significant improvement in referral and screening rates. The PCC has also worked with the Maryland Women’s Cancer Control Program.

The currently available supply of screening mammograms for low-income women remains too low to meet MC demand. In FY 2011, with the help of additional Susan G. Komen Foundation funding and hospital community benefit support, the pilot model was spread to a small number of MC-participating clinics. Those clinics are at or near HEDIS Medicaid averages, but the program as a whole remains far below HEDIS benchmarks and only slightly higher than the CDC survey results of women with no regular access to care.

Breast Cancer Screening (≥ 40)



Includes patients who had a mammogram within 2 years prior to their most recent encounter (Data not reported from CCL, Holy Cross and Mansfield Kaseman clinics)

Why Improvement in Cervical Cancer Screening is Important

Cervical cancer is nearly 100 percent preventable, yet it is the second most common cancer among women worldwide.⁷

For women in whom pre-cancerous lesions were detected through Pap tests, the likelihood of survival is nearly 100 percent with appropriate evaluation, treatment and follow-up.⁷

Cervical cancer incidence and mortality rates have decreased 67% over the past three decades, primarily attributable to the Pap test which detects cervical cancer and precancerous lesions.⁷ All women are at risk for cervical cancer and women with the lowest levels of education tend to have fewer screenings in their lifetime.⁸ In 2008, the prevalence of recent Pap test use was lowest among older women, women with no health insurance, and recent immigrants.⁷ According to "Cancer Screening in the U.S. 2010" survey by the Centers for Disease Control and Prevention, 64.9% of women with no health insurance or those relying on hospital emergency departments for medical attention were tested for cervical cancer, as compared to 86.4% of women with regular access to health care. Between 60-80% of women with advanced cervical cancer have not had a Pap test in the past five years.⁷

Measure Definition

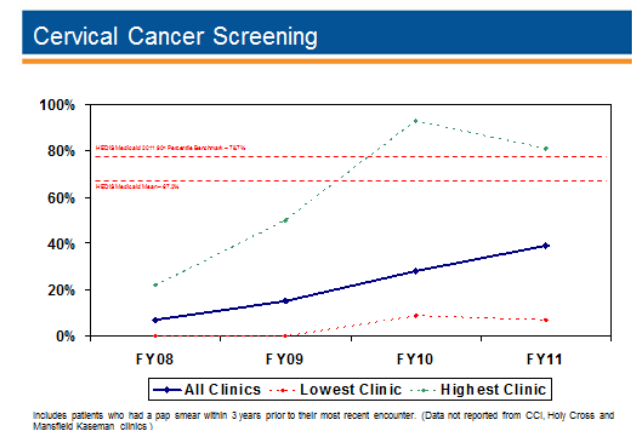
Cervical Cancer Screening

Percent of eligible women between 21 and 65 years of age with a documented pap smear in the past two years.

Interpretation of FY 2008-2011 Results

Cervical cancer screening rates among Montgomery Cares participating clinics has improved significantly since FY 2008 as a result of improved data entry, increased attention to preventive care and clinical practice guidelines, and increasing recruitment of providers who perform routine gynecologic exams as part of normal physical exams or dedicated well woman visits. Still, very significant opportunity for

improvement remains. Montgomery Cares documented cervical cancer screening (39%) is far below national averages of self-reported women without health insurance (65%), and below HEDIS Medicaid benchmarks (67% average).



Why Improvement in Colorectal Cancer Screening is Important

Colorectal cancer is the third most common cancer in men and women⁷. Symptoms are not common in colorectal cancer until the disease has progressed. Effective screening methods are available, and can identify polyps whose removal can prevent more than 90 percent of colorectal cancers. Yet approximately half of American adults do not receive colorectal cancer screening.

Place of birth, ethnicity, education, health coverage, smoking, gender and body mass index all have been shown to affect prevalence of colorectal cancer.⁹ According to “Cancer Screening in the U.S. 2010” survey by the Centers for Disease Control and Prevention, Hispanics were the least likely to report regular screenings (46.5%). The percentage for non-Hispanics overall was 59.9%.

Measure Definition

Colorectal Cancer Screening

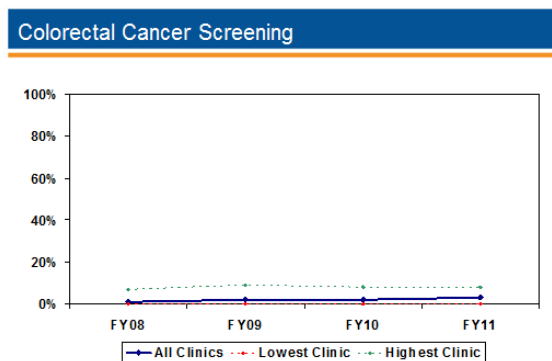
Percent of eligible adults who had appropriate screening for colorectal cancer including fecal occult blood test X3 in the measurement year, or flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year or, double contrast barium enema during the measurement year or the four years prior to the measurement year or, colonoscopy during the measurement year or the nine years prior to the measurement year.

Interpretation of FY 2008-2011 Results

Colorectal cancer screening was reported for the first time in fiscal year 2009, though results for 2008 have been calculated for purposes of this report. The extremely low results are a function of limited testing, poor data entry of fecal occult blood testing, and severely limited access to recommended procedures (colonoscopies and flexible sigmoidoscopies) for low-income

uninsured County residents. There are significant challenges to improving screening rates. Some clinics that utilize fecal occult blood testing began to address work-flow issues in FY 2011 that impeded attempts to document testing in CHLCare. In FY 2011, the PCC was awarded grant funding from the Maryland Department of Health and Human Services to develop systems similar to the successful breast cancer screening approach, to streamline workflow processes in one clinic site. Some clinics are considering more specific (but also more costly) alternatives to fecal occult blood tests. Availability of colonoscopy and other procedural services for low income county residents is far less than needed to meet evidence-based care recommendations. The PCC continues to work with the state and others in the county to identify available screening and diagnostic colonoscopy services and to explore clinically acceptable screening alternatives.

Relevant HEDIS Medicaid benchmarks are not available for comparison.



Includes patients who had a colonoscopy within 10 years, a flexible sigmoidoscopy or double contrast barium enema within 5 years, or a FOBT within 1 year of their most recent encounter. (Data not reported from CCL, Holy Cross and Mansfield Kaseman clinics)

Appendix I: Annual Clinical Quality Measures Primary Care Coalition of Montgomery County

Measure Name	HEDIS 2010 Denominator	Montgomery Cares Denominator	Montgomery Cares Numerator
<i>Diabetes Measures</i>			
Hemoglobin A1c (HgA1c) Testing	Patients aged 18-75 with diabetes	Patients aged 18 or older with a diagnosis of diabetes who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who had at least one HgA1c test within one year prior to their most recent encounter
Good control of HgA1c	Patients aged 18-75 with diabetes	Patients aged 18 or older with a diagnosis of diabetes who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who had at least one HgA1c test within one year prior to their most recent encounter and whose last HgA1c test was $\leq 7\%$
Poor control of HgA1c ($\geq 9\%$)	Patients aged 18-75 with diabetes	Patients aged 18 or older with a diagnosis of diabetes who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who did not have at least one HgA1c test within one year prior to their most recent encounter or whose last HgA1c test was $\geq 9\%$
LDL Cholesterol Testing	Patients aged 18-75 with diabetes	Patients aged 18 or older with a diagnosis of diabetes who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who had at least one LDL cholesterol test within one year prior to their most recent encounter
Good Control LDL cholesterol (≤ 100 mg/dL)	Patients aged 18-75 with diabetes	Patients aged 18 or older with a diagnosis of diabetes who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who had at least one LDL cholesterol test within one year prior to their most recent encounter and whose last LDL cholesterol was ≤ 130 mg/dL

<i>Hypertension Measures</i>			
Blood pressure control (BP ≤140/90)	Patients 18-85 with hypertension	Patients aged 18 or older with a diagnosis of hypertension who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients whose most recent blood pressure was ≤140/90
<i>Preventative Measures – Cancer Screening</i>			
Breast Cancer Screening	40-69 years old	Women aged 40 or older who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who received a mammogram within two years prior to their most recent encounter
Cervical Cancer Screening	21-64 years old	Women aged 21 to 64 who had two face-to-face encounters with different dates of service – one visit during the measurement period and the other visit in the measurement period or within two year prior to the end of the measurement period.	Denominator patients who received cervical cancer screening in the past three years.
Colorectal Cancer Screening	50-80 years old No Medicaid Benchmark	Patients aged 50 or older who had two face-to-face encounters with different dates of service - one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period	Denominator patients who received one of the following tests: <ul style="list-style-type: none"> • Colonoscopy within ten years prior to their most recent encounter • Flexible sigmoidoscopy within five years prior to their most recent encounter • Double contrast barium enema within five years prior to their most recent encounter • Fecal occult blood test within one year prior to their most recent encounter

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