PRIMARY CARE COALITION OF MONTGOMERY COUNTY, MD.
Center for Health Improvement

Montgomery Cares Clinical Performance Measures

Fiscal Year
2009

2/22/2010

Table of Contents

Executive Summary

Background

The Primary Care Coalition (PCC) and clinics participating in the Montgomery Cares (MC) Program are committed to improving the quality of healthcare provided to low income, uninsured residents of Montgomery County. PCC's approach to Quality is multi-faceted. Montgomery Cares performs annual on-site Quality Assurance Reviews, and produces clinic-specific and aggregate reports. QA Reviews include Administrative, Financial and Clinical Standards. PCC is in its third year of leading "Office Practice Redesign" among several MC-participating clinics. Office Practice Redesign facilitates a structured and data-driven approach to improving appointment access, clinic efficiency, and the delivery of evidence-based preventive and chronic care. Montgomery Cares Medical Directors meet quarterly to discuss quality-related issues including clinical process and outcome measures, best practices, and common challenges. These meetings help to maintain clinic focus on quality improvement and guideline-concordant care.

The Primary Care Coalition has convened quarterly Quality Health Improvement Committee (QHIC)/Medical Directors' meetings and collected clinical data from participating Montgomery Cares Clinics to inform quality improvement (QI) efforts since 2003. QI staff and clinical measures activities, including QHIC/Medical Director meetings, measures development, data collection and data analysis have been primarily grant funded, through federal and private organizations.

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. Effective July 1, 2007 (the beginning of fiscal year 2008), PCC officially converted from CVDems to CHLCare, a more robust and flexible system that could capture clinical and demographic information, and support clinical operations as well as 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 care provided in the clinics, as well as a reflection of data entry practices in each clinic. The conversion to CHLCare occurred at the beginning of fiscal year 2008.

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. In 2008 and 2009, PCC, in consultation with the Medical Directors, added measures in addition to diabetes, to evaluate clinical performance related to hypertension and preventive care, and refined the quarterly reporting of each. This report documents performance on seven of these clinical measures in fiscal years 2008 and 2009, since the conversion to CHLCare.

Current Measures

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

- Existence of nationally endorsed measure specifications;

- Evidence that improvement in the measures correlates with improved clinical outcomes;
- Sufficient prevalence of condition in the Montgomery Cares population;
- Healthcare Effectiveness Data and Information Set (HEDIS) Medicaid results available to serve as meaningful benchmarks and performance targets where possible.

Montgomery Cares has set a goal that clinics perform in the 50th-90th percentile for HEDIS Medicaid on measures for which Montgomery Cares and HEDIS Medicaid produce comparable measures.

The following pages highlight performance in FY 2008 and FY 2009 for each relevant measure. This report demonstrates significant improvement between fiscal years 2008 and 2009 in most clinical measures, with performance at or approaching target in diabetes and hypertension care.

The table below summarizes Montgomery Cares' performance in fiscal years 2008 and 2009, and compares Montgomery Cares' results against HEDIS 2009 Medicaid benchmarks.

Measure	**Target**	**FY 08**	**FY 09**	**Number of Clinics with Improvement FY '08 to '09**
Diabetes: Annual HgA1c Testing	79%-89%	54%	74%	5 of 6 reporting both years
Diabetes: Annual LDL Testing	73%-81%	47%	65%	5 of 6 reporting both years
***Diabetes: Poor HgA1c Control (≥ 9%)**	31%-48% (Note: Lower numbers demonstrate improvement)	57%	44%	5 of 6 reporting both years
Diabetes: LDL Control (≤ 100 mcg/dL)	N/A	22%	32%	4 of 6 reporting both years
***Hypertension: BP Control (≤ 140/90)**	56%-66%	52%	60%	4 of 5 reporting both years
Breast Cancer Screening	54%-65%	12%	26%	5 of 6 reporting both years
Colorectal Cancer Screening	N/A	1%	2%	4 of 5 reporting both years

***achieving target**

Demonstrated Improvement
In general, improvements have been demonstrated as a result of several factors:

- Clinical measures are reviewed and discussed quarterly by Medical Directors representing MC-participating clinics. This has helped to maintain clinic focus on QI and clinical outcomes.

- Review of quarterly performance identified access problems for particular services. Where possible, PCC and individual clinics responded by identifying new sources of care. Some gaps in access still remain.
- Some clinics have embarked on office practice redesign, including care team development, streamlining processes and optimizing utilization of staff to more reliably provide planned and evidence-based, "recommended" care.
- Clinics that utilize CHLCare have increased utilization of CHLCare for data entry, and have increasingly utilized the CHLCare "Visit Planner" to identify care needs at the time of a visit and facilitate recommended care for individual patients.

Challenges

Challenges remain. Availability of specialists and procedures such as screening mammography and colonoscopy services continues to be insufficient to meet demand. Economic issues have strained many clinics; increasing patient demand for free or reduced cost care has occurred in the face of declining availability of volunteer physicians and staff. The stress of increasing patient demand reveals opportunities to improve systems for patient flow, documentation, and data entry.

Next Steps

The PCC and Medical Directors have committed to the following actions in order to improve performance over time and reduce variation in performance between clinics:

- Identify opportunities to increase access to specialty and procedural care;
- Conduct chart concordance reviews as appropriate to support improvement in data entry into CHLCare;
- Continue to share best practices in Medical Directors' quarterly meetings, and track progress on a quarterly basis;
- Expand support for office practice redesign to improve clinic access, efficiency and planned care;
- Continue to work with clinics that utilize non-CHLCare systems (Mary's Center, CCI and Holy Cross Clinic) to obtain electronic data necessary for more complete Montgomery Cares reporting;
- Work with TPCWC to re-institute data entry into CHLCare;
- Determine how best to evaluate for health disparities within the current measure set.

Acknowledgement

Special thanks to the leadership, providers and staff of Montgomery Cares-participating clinics. It is their tireless effort and commitment to high quality care for the County's low income, uninsured residents that have made these improvements possible. And to CareFirst BlueCross BlueShield, who provided the generous funding that supported PCC staffing and health information technology changes reflected in this report.

Background

The non-profit Primary Care Coalition of Montgomery County, MD, Inc. (PCC), established in 1993, administers county-wide public private collaborations delivering primary and preventive health care to low-income, uninsured, and ethnically diverse county residents. Among its responsibilities, PCC manages the "Montgomery Cares" (MC) program for adults. Two-thirds of the adults served by Montgomery Cares are Hispanic; the remaining third include Korean, Chinese, South Asian, Caucasian, African American and continental African populations. While 50% of MC participants are employed, over 80% of families earn less than $25,000 per year. PCC contracts with 12 independent non-profit safety-net clinics, to provide direct patient care services. Additionally, the PCC offers clinics a shared electronic record (CHLCare), point of service prescription medicine, access to specialty care, behavioral health services, and technical assistance.

The PCC is committed to improving the quality of healthcare provided to low income, uninsured residents of Montgomery County. In order to do that, it is essential that providers and organizations that work with PCC understand and share our commitment to quality and process improvement. PCC's approach to Quality is multi-faceted. Montgomery Cares performs annual on-site Quality Assurance (QA) Reviews, and produces clinic-specific and aggregate reports. QA Reviews include Administrative, Financial and Clinical Standards. PCC is in its third year of leading "Office Practice Redesign" among several MC-participating clinics. Office Practice Redesign facilitates a structured and data-driven approach to improving appointment access, in-clinic cycle time, and the delivery of evidence-based preventive and chronic care. PCC has convened quarterly Quality Health Improvement Committee (QHIC)/Medical Directors' meetings and collected clinical data from participating Montgomery Cares Clinics to inform quality improvement (QI) efforts since 2003. Quarterly Medical Director discussions of clinical process and outcome measures maintains clinic focus on quality improvement and guideline-concordant care. Medical Directors share best practices and identify common challenges. The PCC works regularly with MC-participating clinics in areas of Quality Assurance and Quality Improvement.

Quality Assurance and Quality Improvement

Quality Assurance is a "snapshot in time" to evaluate clinic performance. In 2009, the PCC launched formal on-site Quality Assurance reviews to assess clinic performance in areas of administrative, financial and clinical performance, to identify opportunities for improvement, and to provide technical assistance where needed. "Quality Improvement" is a dynamic process, that relies on measurement to track the effects of various changes and interventions that are designed and implemented to improve adherence to evidence-based care. Ongoing quarterly Quality Health Improvement Committee meetings provide an opportunity for Medical Directors from each Montgomery Cares-participating clinic to meet with colleagues, review performance indicators, learn together and share best practices for process improvement. The PCC also supports inter-clinic collaboration to improve quality in focused areas such as office practice redesign and breast health process improvement. This combination of Quality Assurance and Quality Improvement has provided an important foundation on which our improvement efforts are based.

Process and Outcome Measures

Performance reporting is key to quality improvement. "Process measures" assess how well *systems* of care are performing to reliably provide evidence-based chronic and preventive care. Process measures answer the question, "are you doing the right things?" For example, process measures include screening rates for immunizations, cancer screening, and routine diabetic testing. "Outcome measures" asses the *health status* of Montgomery Cares patients. They answer the question, "how is the health of your population?" For example, outcome measures include how well we are controlling chronic conditions such as hypertension and diabetes. Medical Directors from Montgomery Cares-participating clinics meet quarterly to review clinical metrics and discuss areas of common concern relating to Quality Assurance and Quality Improvement. By tracking these measures over time, PCC and participating clinics are able to assess the impact of their efforts to improve the quality of care delivered to this vulnerable population.

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 Administation (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. A CareFirst grant funded a majority of the QI Manager salary, and partially funded a Data Manager, who creates and utilizes reporting functionality in CHLCare for clinical measure development and a host of other administrative data support. Effective July 1, 2007, PCC officially converted from CVDems to CHLCare, a more robust and flexible system that could capture clinical and demographic information, and support clinical operations as well as 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 care provided in the clinics, as well as a reflection of data entry practices in each clinic. The conversion to CHLCare occurred at the beginning of the fiscal year. Most, but not all MC-participating clinics, converted to CHLCare. Clinics varied in their ability to identify diabetic patients and enter timely and accurate data during the conversion period. As a result, some FY 2008 individual clinic results may be affected by initial data entry challenges.

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 comment. In 2008 and 2009, PCC, in consultation with the Medical Directors, added measures in

addition to diabetes, to evaluate clinical performance related to hypertension and preventive care, and refined the quarterly reporting of each.

Seven clinics reported FY 2008 data, and eight clinics reported FY 2009 data to PCC for inclusion in quarterly and annual reporting for some or all measures. Seven of the eight clinics have CHLCare available in their clinics. The People's Community Wellness Clinic (TPCWC) entered CHLCare data in FY 2008, but has not entered data in 2009. PCC does, however, have mammography data available from TPCWC. This report, therefore, includes TPCWC data for all measures in FY 2008, and for mammography screening only in FY 2009. Not all clinics utilize CHLCare; three clinics utilize registries or commercial electronic medical records. Holy Cross Clinic reports data for Diabetes measures from their CVDems Registry. PCC is working with Holy Cross Clinic to explore options for reporting on a more complete measure set, beyond diabetes alone. Mary's Center and Community Clinic, Inc. also utilize data systems different than CHLCare. PCC has not had access to comparable data from those clinics, and they are therefore not included in the clinical measures from FY 08 or 09. PCC is working with Mary's Center and Community Clinic, Inc. to develop a data-sharing infrastructure for future reporting of data from those clinics.

Clinics Reporting FY 2008	**Clinics Reporting FY 2009**
Holy Cross Clinic (DM only)	Holy Cross Clinic (DM only)
Mercy Clinic	Mercy Clinic
Mobile Med	Mobile Med
Muslim Community Center Medical Clinic	Muslim Community Center Medical Clinic
Proyecto Salud	Proyecto Salud
Spanish Catholic Center	Spanish Catholic Center
The People's Community Wellness Clinic	The People's Community Wellness Clinic (mammo only)
	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 clinical outcomes;
- Sufficient prevalence of condition in the Montgomery Cares population;
- HEDIS Medicaid results available to serve as meaningful benchmarks and performance targets where possible.

This report provides information on clinical performance in fiscal years 2008 and 2009, reflecting the time period after Montgomery Cares converted to CHLCare.

Results Reporting and Benchmarking

The PCC has reviewed performance in selected clinical measures that are 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 2009 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). Utilizing HEDIS Medicaid benchmarks sets a relatively high standard for Montgomery Cares. 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 and more financial resources 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. The National Committee for Quality Assurance, in their report, "The State of Health Care Quality 2009" asserts that if all health plans in the U.S. performed at the same level as the top 10 percent (90th percentile) of reporting Plans, between 49,400 and 115,300 deaths would be prevented, and billions of dollars in healthcare spending would be averted.

Montgomery Cares has set a goal that clinics perform in the 50th-90th percentile for HEDIS Medicaid. Goals of 100% are generally considered not achievable due to issues that are not accounted for in the measures (eg. "recommended care" may not be appropriate due to individual patient circumstances), and as increasing numbers of new patients present for care, clinics may have less time to impact control measures in any given measurement period. PCC also reviews variation between clinics. Variation does not evaluate the clinical expertise of the provider, but rather the reliability of the process. Reduced variation signals improved reliability in planned care and/or data entry processes.

Despite rapidly increasing numbers of patients receiving care in participating clinics, and many new patients with diabetes or hypertension between FY 2008 and FY 2009, 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 FY 2008 and FY 2009 for each relevant measure. This report demonstrates significant improvement between fiscal years 2008 and 2009 in most clinical measures, with performance at or approaching target in diabetes and hypertension care.

In general, improvements have been demonstrated as a result of several factors:

- Clinical measures are reviewed and discussed quarterly by Medical Directors representing MC-participating clinics. This has helped to maintain clinic focus on QI and clinical outcomes.

- Review of quarterly performance identified access problems for particular services. Where possible, PCC and individual clinics responded by identifying new sources of care. Some gaps in access remain, and will be highlighted where appropriate.
- Some clinics have embarked on office practice redesign and care team development, streamlining processes and optimizing utilization of staff to more reliably provide planned and evidence-based, "recommended" care.
- Clinics have increased utilization of CHLCare for data entry, and have increasingly utilized the CHLCare "Visit Planner" to identify care needs at the time of a visit, and facilitate recommended care for individual patients.

Challenges remain. Availability of specialists and procedures such as screening mammography and colonoscopy services continues to be insufficient to meet demand. Economic issues have strained many clinics; increasing patient demand for free or reduced cost care has occurred in the face of declining availability of volunteer physicians and staff. The stress of increasing patient demand reveals opportunities to improve systems for patient flow, documentation, and data entry.

The table below summarizes Montgomery Cares' performance in fiscal years 2008 and 2009, and compares Montgomery Cares' results against HEDIS 2009 Medicaid benchmarks.

Measure	**Target**	**FY 08**	**FY 09**	**Number of Clinics with Improvement FY '08 to '09**
Diabetes: Annual HgA1c Testing	79%-89%	54%	74%	5 of 6 reporting both years
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***achieving target**

Next Steps

The PCC and Medical Directors have committed to the following actions in order to improve performance over time and reduce variation in performance between clinics:

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- Work with TPCWC to re-institute data entry into CHLCare;
- Determine how best to evaluate for health disparities within the current measure set.

The following pages provide information, obtained from the National Committee on Quality Assurance's "State of Healthcare 2009", 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 in fiscal years 2008 and 2009. For each measure, the graph indicates the degree of variation between the highest and lowest performing clinic, and HEDIS Medicaid benchmarks where available.

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.[1] Much of the burden of illness and cost of treatment is due to potentially avoidable long-term complications of diabetes, including heart disease, stroke, blindness, and kidney disease[2]. Timely and appropriate screening and treatment is essential to avoid complications and reduce the burden and cost of diabetes.

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

Evidence to support improvement in diabetes care is irrefutable. According to the National Committee on Quality Assurance[3], people with diabetes are 2-4 times more likely than others to die as a result of heart disease[4], and diabetes accounts for almost 45% of new cases of kidney failure[5]. Diabetic retinal eye disease is a leading cause of blindness[1]. And the medical costs for diabetics are more than double the medical costs of others[6]. Even modest improvements in outcomes are meaningful. Every 10 millimeters of mercury reduction in systolic blood pressure in diabetics results in a 12 percent reduction in diabetic complications. Improved cholesterol can reduce cardiovascular complications of diabetes by 20 to 50 percent[5]. And patients with diabetes who maintain near-normal HgA1c levels gain, on average, an extra five years of life, eight years of eye sight, and six years of freedom from kidney disease[7].

Measure Definition
Annual HgA1c Test Percent of eligible patients who had at least one A1c test(s) during the measurement year
Annual LDL Cholesterol Test Percentage of eligible patients who had at least one LDL cholesterol test during the measurement year
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).
Good LDL Control Percent of eligible patients with most recent LDL cholesterol level ≤ 100 mg/dl.

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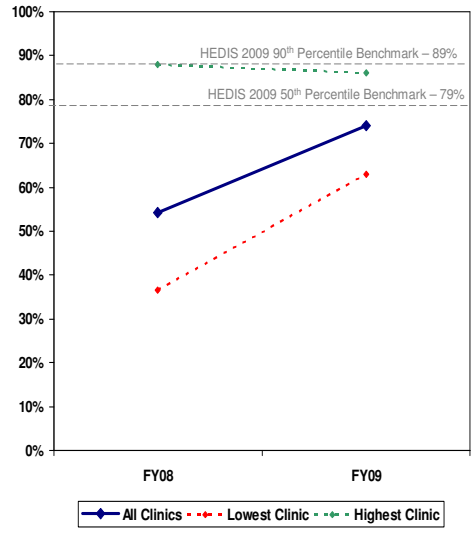
Interpretation of FY '08-09 Results

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. Three clinics utilize a web-based laboratory order entry system; during FY 2009, the PCC developed a new laboratory module, and included the ability for results to automatically be included in CHLCare, obviating the need for manual laboratory data entry for those clinics. Additionally, PCC designed a "Visit Planner", that auto-populates patient level data for providers to review prior to the clinic encounter. The "Visit Planner" provides important information to the provider or care team, highlighting dates and results of Diabetes testing, and serving as an alert or reminder to the care team when recommended care is due. Clinics have expanded the role of non-provider members of the care team to help assure that recommended care is provided. Some clinics have established a policy to print the Visit Planner for any Diabetic patient presenting for care; some utilize the Medical Assistant to review the Visit Planner, and initiate screening and orders for lab work on behalf of the provider.

For both process measures, patients receiving tests for HgA1C and tests for LDL cholesterol, performance improved between 2008 and 2009. High performing clinics maintained performance near HEDIS 90th percentile, and lower performing clinics improved significantly. Variation between clinics was thus reduced, and total Montgomery Cares performance is approaching target.

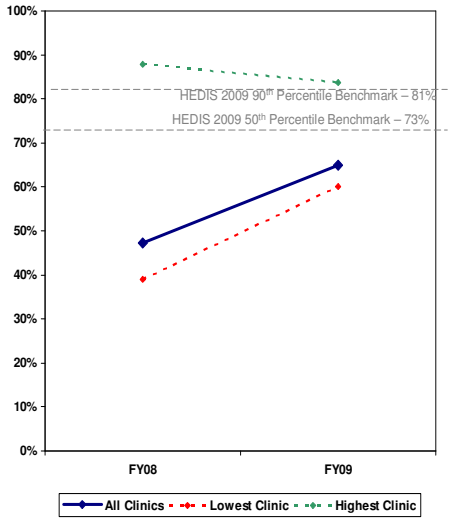
Diabetes measurement patients with at least 1 HgA1c test



	FY08	FY09
All Clinics	54%	74%
Lowest Clinic	37%	63%
Highest Clinic	88%	86%

Includes patients who had a blood test for Hemoglobin A1c within one year of their most recent encounter

Diabetes measurement patients with at least 1 LDL test



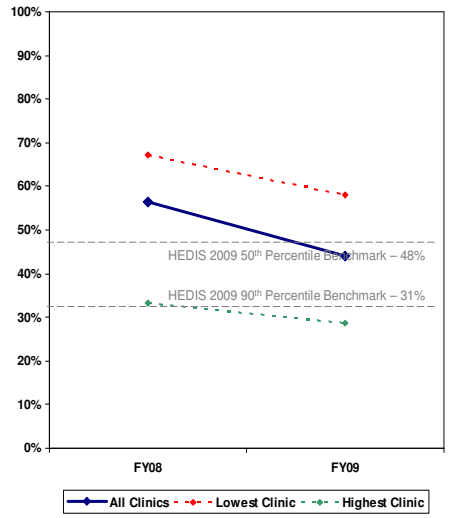
	FY08	FY09
All Clinics	47%	65%
Lowest Clinic	39%	60%
Highest Clinic	88%	84%

Includes patients who had an LDL cholesterol test within one year of their most recent encounter

Measures of poor Hemoglobin A1c (HgA1c) control also demonstrate significant improvement. On this measure, DECREASING percentages represent improvement, since poor control is reflected in higher HgA1c numbers. In this measure, both higher and lower performing clinics improved performance between 2008 and 2009.

Montgomery Cares performance is at target for this measure.

Diabetes measurement patients with poor control of HgA1c



	FY08	FY09
All Clinics	57%	44%
Lowest Clinic	67%	58%
Highest Clinic	33%	29%

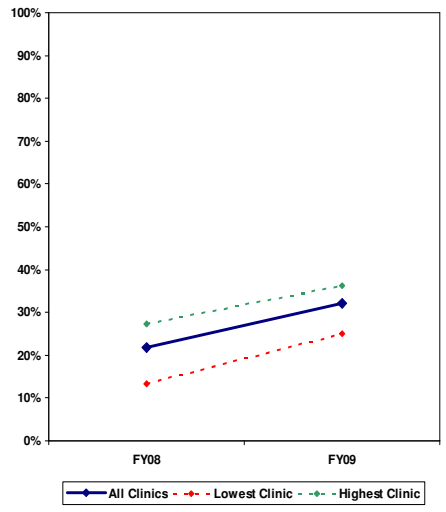
Includes patients who had a Hemoglobin A1c test result ≥9 or who had no test for HgA1c within one year prior to their most recent encounter

NOTE: Decreasing percentages indicate IMPROVED performance

Measures of good LDL cholesterol control also demonstrate improvement since 2008.

HEDIS benchmarks are not available for this measure.

Diabetes measurement patients with LDL ≤100



	FY08	FY09
All Clinics	22%	32%
Lowest Clinic	13%	25%
Highest Clinic	27%	36%

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

Hypertension

Why Improvement in Hypertension Care is Important

The National Committee on Quality Assurance[2] reports that one out of every 3 Americans currently has hypertension, or high blood pressure[8] and over 90 percent of middle-aged and elderly Americans will be affected by it at some point in their lives.[9] Despite available effective treatment options, studies show that over half of Americans with hypertension go untreated or undertreated.[10]

People with hypertension have twice the • lifetime risk of stroke compared to those without hypertension.[11] Nearly one-third of adults with high blood • pressure are unaware of their condition, thus increasing the risk of associated complications and diseases.[10]

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 failure.[12]

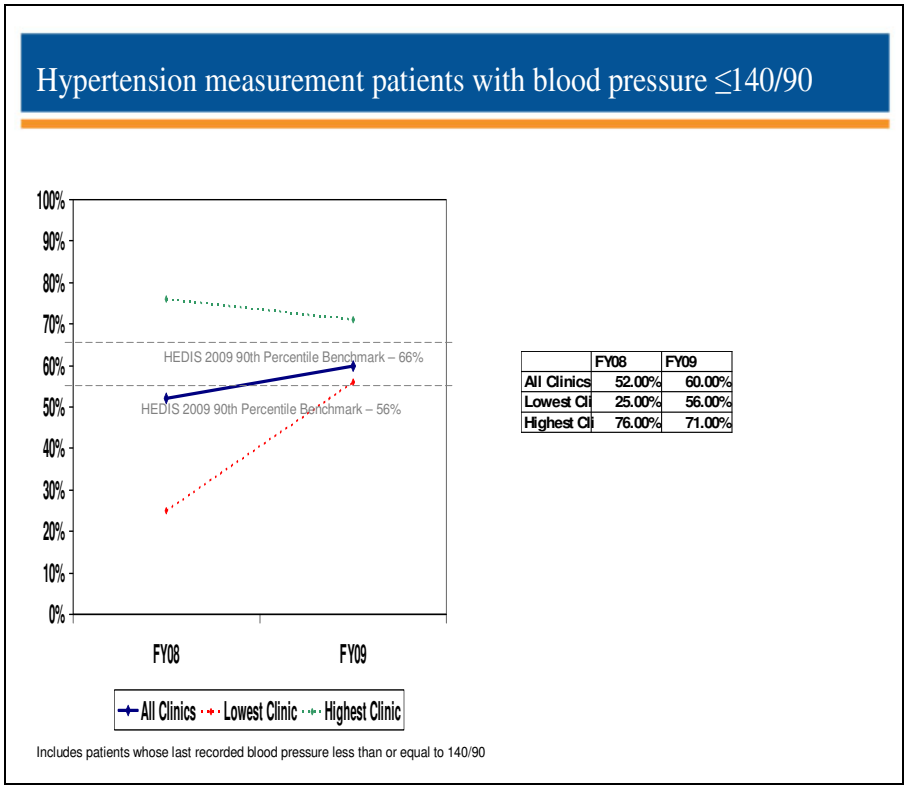
Measure Definition

Hypertension BP Control
Percent of eligible hypertensive patients with most recent recorded blood pressure measurement ≤ 140/90

Interpretation of FY '08-09 Results

Montgomery Cares 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 is the first complete year in which hypertension measures have been reported. Changes in performance between 2008 and 2009 may be largely reflective of improved data entry. With blood pressure entered into CHLCare, clinics are able to track blood pressure over time with the CHLCare Visit Planner.

All clinics met or exceeded HEDIS benchmarks for hypertension control in FY 2009.



	FY08	FY09
All Clinics	52.00%	60.00%
Lowest Cl	25.00%	56.00%
Highest Cl	76.00%	71.00%

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. PCC is reporting two cancer screening results:

Cancer Screening Process Measures
Breast Cancer Screening
Colorectal Cancer Screening

Why Improvement in Breast Cancer Screening (Mammography) is Important

The National Committee on Quality Assurance[2] reports that breast cancer accounts for 1 in 4 cancer diagnoses, and is one of the most common types of cancer among American women. Treatment for breast cancer detected in its earliest, pre-invasive stage costs significantly less than treatment for breast cancer detected in more advanced stages. Mammography screening for women ages 50 to 69 can reduce breast cancer mortality by up to 35 percent through early detection.
A mammogram can detect about 85 percent of breast cancers in women without symptoms.[3]

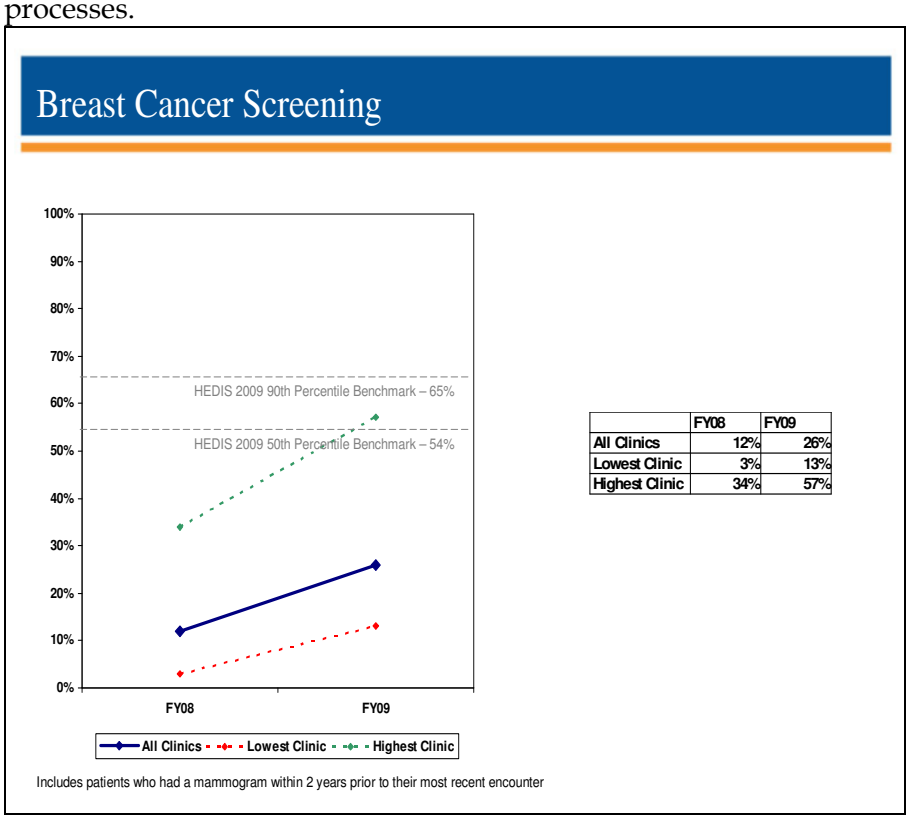
Measure Definition

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

Interpretation of FY '08-09 Results

Breast cancer screening has been reported since FY 2008. Through Susan G. Komen grant funding, three MC clinics have participated in patient navigation and care management, with significant improvement in referral and screening rates. The PCC worked with the Women's Cancer Control Program to improve timeliness of referrals, and has created partnerships between clinics and hospital radiology providers to better meet the demand from the three pilot clinics for routine breast cancer screening. The available supply of screening mammography for low-income women remains too low to meet MC demand. With the help of additional Susan G. Komen Foundation funding and hospital community benefit support, the model developed with the three pilot clinics will be spread to all MC-participating clinics, to increase the supply of available mammograms, and streamline referral and care management processes.

The three clinics participating in the grant funded process improvement for mammography have demonstrated significant improvement since 2008, and are performing at or near target. Other clinics have made smaller improvement since 2008, largely as a result of better data entry, but with little improvement in availability of mammography, or significant process improvement. During FY 2010, PCC has begun working with other Montgomery Cares participating clinics and all County hospitals to increase the availability of mammography and improve workflow processes.



	FY08	FY09
All Clinics	12%	26%
Lowest Clinic	3%	13%
Highest Clinic	34%	57%

Why Improvement in Colorectal Cancer Screening is Important

Symptoms are not common in colorectal cancer until the disease has progressed. When colorectal cancer is treated at its earliest stage, five-year survival rate is more than 90 percent.[16] But once symptoms occur, the patient's chance of survival decreases. [17]

The National Committee on Quality Assurance[2] reports that nationally, screening rates for colorectal cancer lag behind other cancer screening rates, even though research shows that screening with fecal occult blood testing, sigmoidoscopy, or colonoscopy effectively detects early-stage cancer and polyps. Place of birth, ethnicity, education, health coverage, smoking, gender and body mass index all have been shown to affect prevalence of colorectal cancer.[18]

Measure Definition

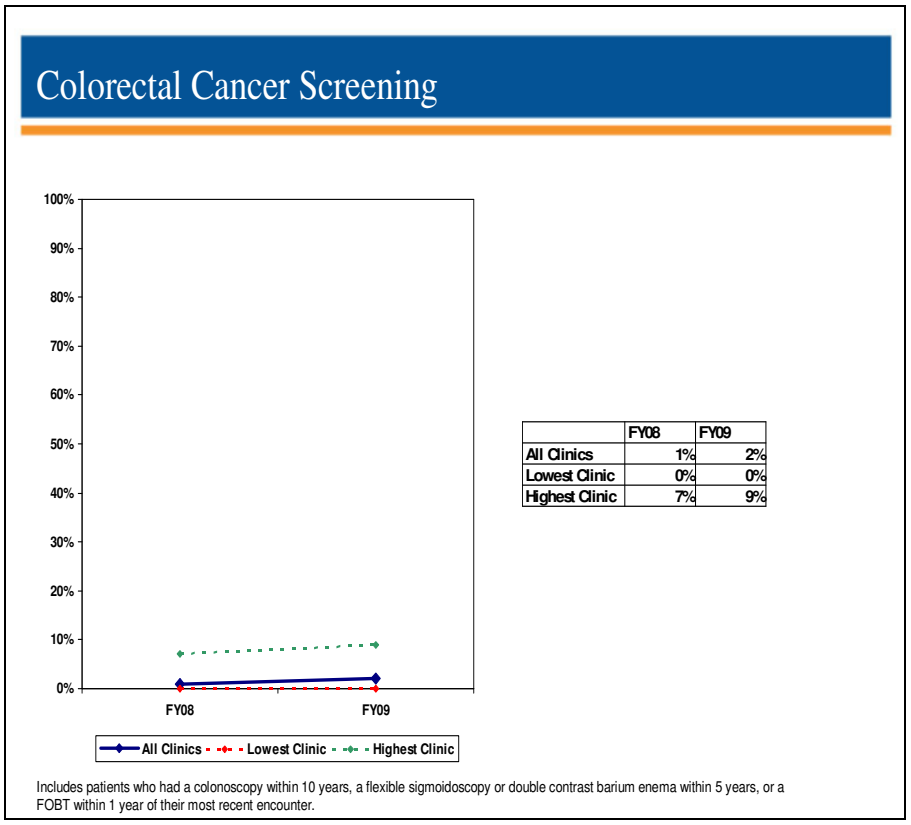
Colorectal Cancer Screening

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 '08-09 Results

Colorectal cancer screening is being 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 poor data entry of fecal occult blood testing, and severely limited access to screening colonoscopies and flexible sigmoidoscopies for low-income uninsured County residents. There are significant challenges to improve the screening rate. Clinics are beginning to address work-flow issues that, to date, have impeded attempts to record fecal occult blood testing in CHLCare. Availability of colonoscopy services for low income county residents is far less than needed to meet clinical guidelines. The PCC, through grant funding, is developing systems similar to the successful breast cancer screening approach, to streamline workflow processes. The PCC continues to work to identify available screening colonoscopy services.

Relevant HEDIS benchmarks are not available for comparison.



	FY08	FY09
All Clinics	1%	2%
Lowest Clinic	0%	0%
Highest Clinic	7%	9%

Appendix I: Annual Clinical Quality Measures January 2010
Primary Care Coalition of Montgomery County

Measure Name	HEDIS 2009 Denominator	Montgomery Cares Denominator	Montgomery Cares Numerator
Diabetes Measures			
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
Poor control of HgA1c (≥ 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 ≥ 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 No Medicaid Benchmark	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
Hypertension Measures			
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

Preventative Measures – Cancer Screening			
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
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: • 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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