



primary care coalition
of Montgomery County, Maryland

Montgomery Cares Clinical Performance Measures

Fiscal Year
2013

December, 2013

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Executive Summary

Fiscal year 2013 marks the sixth 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 continue to demonstrate significant and continuous improvement.

- In FY 2013, Montgomery Cares performance met or exceeded HEDIS Medicaid benchmarks on annual measures of diabetes and hypertension care.

In the areas of cancer screening, Montgomery Cares clinics continue to demonstrate modest gains but remain well below HEDIS benchmarks.

- The Montgomery County Council awarded additional FY 2014 funding to support breast and colorectal cancer screening among the eligible population.

Medical Directors from Montgomery Cares participating clinics have recommended a revised set of measures to be tracked beginning January 1, 2014. Some changes to measure technical specifications will be made for the FY 2014 annual reporting period; the first reporting period in which all clinics will have transitioned to electronic medical records..

We gratefully acknowledge the physicians and staff of the twelve clinic organizations that participate in Montgomery Cares to serve Montgomery County's low income, 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 measurement and process improvement 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

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.

Between 2007 and 2009, PCC and Medical Directors from clinics participating in Montgomery Cares approved measure definitions and technical specifications in order to report and benchmark nationally endorsed measures of 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. Four Montgomery Cares clinics have adopted commercial electronic medical records (EMR). Community Clinic, Inc, Mary's Center for Maternal and Child Health, and Spanish Catholic Center have had EMRs for several years. Holy Cross Hospital Health Center Clinics transitioned to a commercial EMR in the late spring of 2013. The Primary Care Coalition led the roll-out of e-Clinical Works (commercial EMR) over five months (July through November 2013) in the remaining eight Montgomery Cares participating clinics.

Quarterly and annual measures are produced using data from CHLCare and from Holy Cross Hospital Health Center Clinics, Mary's Center and Spanish Catholic Center.

Care for Your Health and CCI are the only clinics not represented in this report. Care for Your Health (C4YH) joined the Montgomery Cares network in FY2012 and reports clinical data to Montgomery Cares, but requires additional time in operation to meet "look back" periods on many of these reported measures. We have therefore excluded C4YH results in this report. C4YH will be represented in the FY 2014 report. CCI does not report clinical data to Montgomery Cares.

Clinics Reporting FY 2008	Clinics Reporting FY 2009	Clinics Reporting FY 2010	Clinics Reporting FY 2011	Clinics Reporting FY 2012 and FY 2013
Holy Cross Clinic (DM only)	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	Mercy Clinic
Mobile Med	Mobile Med	Mobile Med	Mobile Med	Mobile Med
Muslim Community Center Medical Clinic (MCCMC)	MCCMC	MCCMC	MCCMC	MCCMC
Proyecto Salud	Proyecto Salud	Proyecto Salud	Proyecto Salud	Proyecto Salud
Spanish Catholic Center (SCC)	SCC	SCC	SCC	SCC
The People's Community Wellness Clinic (TPCWC)	TPCWC (mammo only)	TPCWC	TPCWC	TPCWC
		Chinese Culture and Community Services Center (Pan Asian)	Pan Asian	Pan Asian
		Mary's Center	Mary's Center	Mary's Center
		Mansfield Kaseman Clinic (CMR)		CMR
	Under One Roof	Under One Roof		Care for Your Health

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. Twelve clinical measures are presented in this annual report. Ten of these measures have been tracked over time in each of the six fiscal years since 2008. Some modest changes will be made to measure definitions and measure specifications in FY 2014 as a result of changes in expert recommendations and to better align with HEDIS technical specifications.

Results Reporting and Benchmarking

Where relevant public information is available, Montgomery Cares performance is benchmarked against HEDIS Medicaid HMO performance. HEDIS measure definitions are 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. NCQA-Accredited plans demonstrate higher quality than non-accredited plans. 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 benchmarks for Montgomery Cares comparisons.

PCC also reviews variation between clinics. Variation does not evaluate the clinical expertise of the providers, but rather the reliability of processes between clinics. 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.

The following pages highlight performance in fiscal years 2008-2013 for each relevant measure. This report demonstrates improvement each year in most clinical measures, with performance at or exceeding targets in diabetes and hypertension care.

In early FY 2014, Montgomery Cares led the adoption of e-Clinical Works, a certified commercial electronic medical record (EMR) to replace CHLCare in clinics that did not already have a commercial EMR. The availability of a commercial EMR is expected to better support recommended care and facilitate the efficient collection of clinical measure data. However we anticipate there may be a drop in FY 2014 reported indicators as Montgomery Cares and the participating clinics refine their utilization of the EMR, and establish consistent processes for utilization of clinical data support systems, data entry and data collection.

Results

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

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

In the areas of cancer screening, Montgomery Cares clinics continue to demonstrate modest gains but remain 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 Montgomery County Council awarded additional FY 2014 funding to support breast and colorectal cancer screening among the eligible population. The PCC has worked with providers, vendors and participating clinics to provide sufficient supplies of mammograms, fecal immunoassay testing (FIT) and colonoscopies to meet projected demand.

The table below summarizes Montgomery Cares' performance in fiscal years 2008-2013, comparing Montgomery Cares' results against the most recent HEDIS Medicaid benchmarks as published in NCQA State of Healthcare Quality 2013 (health plan performance in calendar year 2012).

Montgomery Cares Measures	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	Target Range HEDIS 2012 Medicaid (mean-90 th percentile)
* Diabetes: Annual A1c Testing	54%	74%	77%	83%	84%	84%	83-91%
* Diabetes: Annual LDL Testing	47%	65%	70%	77%	75%	78%	75-83%
* Diabetes: Good A1c Control (≤ 7)	26%	35%	37%	41%	42%	38%	34-43%
Diabetes: A1c Control (≤ 8)	NA	NA	NA	NA	NA	53%	46-59%
* Diabetes: Poor A1c Control (≥ 9% or no A1c testing)	57%	44%	37%	36%	42%	37%	45-31%
* Diabetes: LDL Control (≤ 100 mg/dL)	22%	32%	35%	38%	38%	39%	34-44%
* Diabetes BP Control (≤ 140/90)	70%	73%	73%	73%	72%	73%	59-75%
* Diabetes BP Control (≤ 130/80)	NA	NA	48%	49%	47%	48%	39-55% benchmarked HEDIS result for BP < 140/80
* Hypertension: BP Control (≤ 140/90)	52%	60%	65%	64%	62%	65%	56-70%
Breast Cancer Screening	12%	26%	29%	32%	34%	40%	52-63%
Cervical Cancer Screening	7%	15%	29%	39%	50%	53%	64-77%
Colorectal Cancer Screening	1%	2%	2%	3%	4%	8%	N/A

* Montgomery Cares meets or exceeds national Medicaid benchmarks in measures of chronic condition management.

*** Montgomery Cares Diabetes BP control results are shown for BP ≤ 130/80. Montgomery Cares has not previously calculated results for diabetes BP < 140/80 as adopted by NCQA. But Montgomery Cares Clinics exceeded benchmarks even against the more liberal HEDIS measure of diabetes BP < 140/80

The following pages provide information, primarily obtained from the National Committee on Quality Assurance's "State of Healthcare" 2012 and 2013, to describe the importance of improving quality of care in the areas of Diabetes, Hypertension and Cancer Screening. For each measure, the graphs indicate HEDIS Medicaid benchmarks, and the degree of variation between the highest and lowest performing Montgomery Cares clinic in each of the five reported years. The highest and lowest performing Montgomery Cares clinic may differ from year to year.

Diabetes

(from NCQA State of Healthcare Quality 2012 and 2013)

Diabetes is a group of diseases characterized by high blood sugar levels. Nearly 26 million Americans (8.3% of the population) have diabetes, the seventh leading cause of death in the U.S.¹

- Diabetes, especially when unmanaged, can cause serious health complications, including heart disease and stroke, hypertension, kidney failure,, lower-extremity amputation and blindness.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.
- These measures assesses whether patients are receiving guideline-recommended care to help manage their disease by achieving control levels of blood sugar, cholesterol and blood pressure.

Why Improvement in Diabetes Care is Important

(from NCQA State of Healthcare Quality 2012 and 2013)

On average, people with diagnosed diabetes spend twice as much on medical expenses than those without diabetes. Comprehensive diabetes control can prevent health complications and improve the quality of life for millions of Americans.¹ Studies have shown the following benefits of properly managing diabetes:

- Reducing A1c blood test results by 1 percentage point (e.g., from 8.0 percent to 7.0 percent) reduces the risk of microvascular complications (eye, kidney and nerve diseases) by as much as 40 percent.¹
- Blood pressure control reduces the risk of cardiovascular disease by as much as 50 percent and the risk of microvascular complications by 33 percent.¹
- Improved LDL cholesterol control can reduce cardiovascular complications by as much as 50 percent.¹

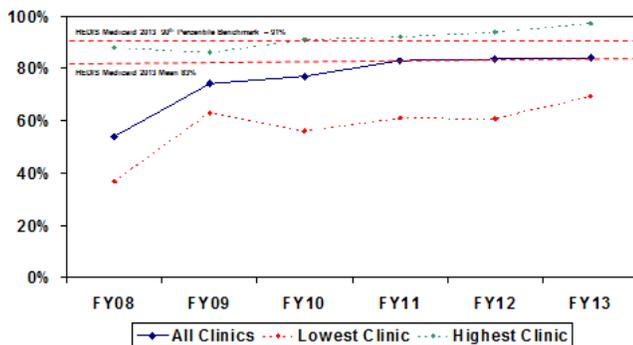
In the following graphs, the PCC presents five measures related to Diabetes care:

Diabetes Process Measures	Diabetes Outcome Measures
Annual A1c Test	Poor A1c Control
Annual LDL Cholesterol Test	Good LDL Control
	Blood Pressure Control

Measure Definitions
<p>Annual A1c 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 A1c Control Percent of eligible patients with most recent A1c level >9.0%. If no A1c 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>
<p>BP Control Percent of eligible patients with most recent BP measurement ≤ 140/90</p>

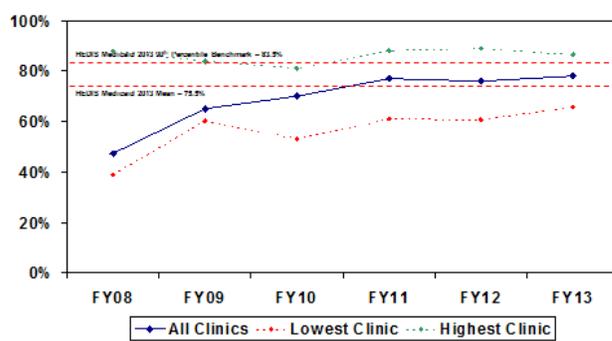
Diabetes Clinical Performance

Diabetes measurement patients with at least 1 HgA1c test



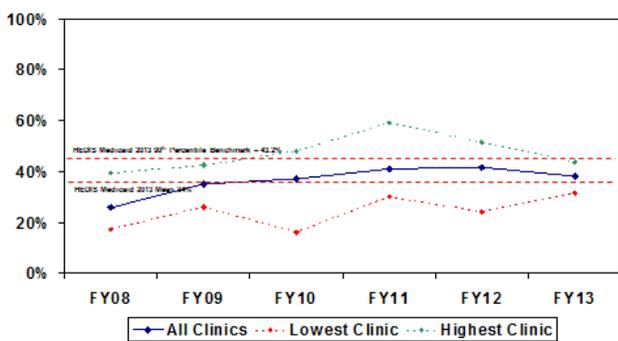
Includes patients who had a blood test for Hemoglobin A1c within one year of their most recent encounter. (Data not reported from CCI)

Diabetes measurement patients with at least 1 LDL test



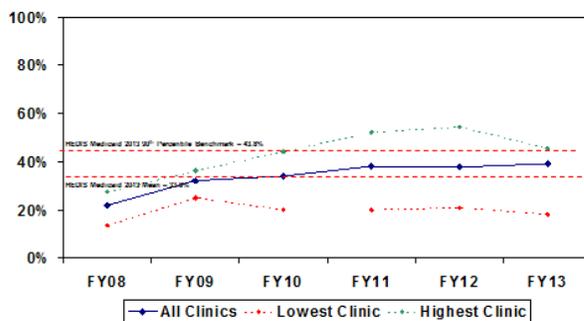
Includes patients who had an LDL cholesterol test within one year of their most recent encounter. (Data not reported from CCI)

Diabetes measurement patients with good control of HgA1c



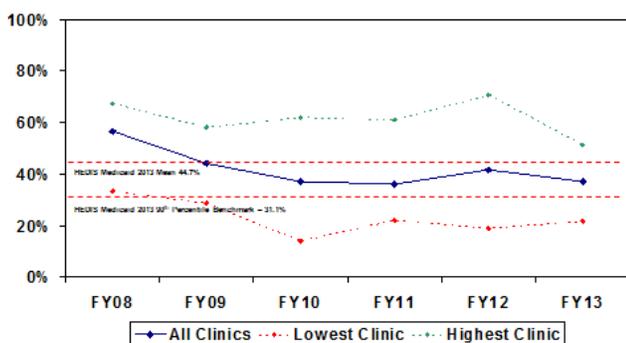
Includes patients who had a Hemoglobin A1c test result ≤ 7 . (Data not reported from CCI)

Diabetes measurement patients with LDL ≤ 100



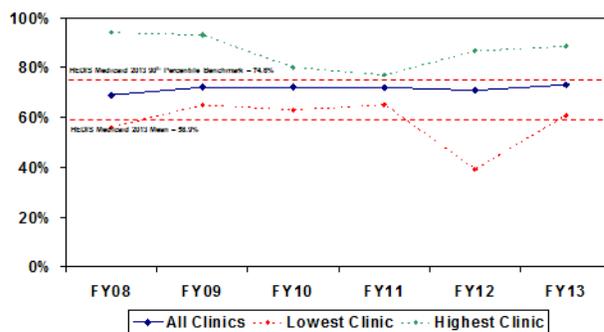
Includes patients who had an LDL cholesterol test within a year prior to their most recent encounter and whose most recent LDL cholesterol test had a result ≤ 100 . (Data not reported from CCI)

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)

Diabetes measurement patients with blood pressure $\leq 140/90$



Includes patients who a blood pressure measurement $\leq 140/90$ at their most recent encounter. (Data not reported from CCI)

Hypertension (High Blood Pressure)

(from NCQA State of Healthcare Quality 2012 and 2013)

Approximately 1 in 3 Americans have been diagnosed with high blood pressure², but fewer than 50% of Americans with high blood pressure have their condition under control³. High blood pressure is a condition caused by the increased force of blood flow against artery walls, by constriction of arteries or by an increase in the amount of blood pumped by the heart. Also known as hypertension, high blood pressure increases the risk of heart disease, stroke, heart attack, congestive heart failure and kidney disease.^{1,2} Stage 1 high blood pressure begins at 140/90 mm Hg.³ Hypertension can be minimized by incorporating behavioral changes, such as decreasing sodium intake and increasing exercise.^{4,5}

Why Improvement in Hypertension Care is Important

(from NCQA State of Healthcare Quality 2012 and 2013)

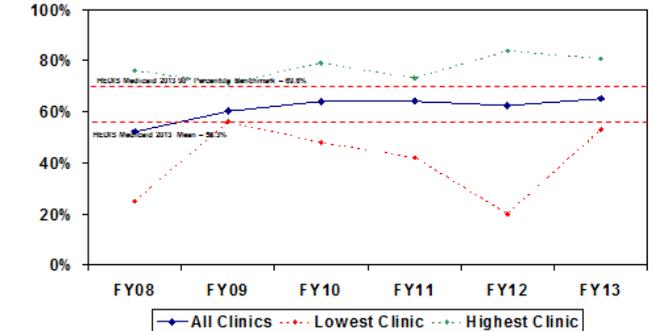
Hypertension can lead to serious cardiovascular health conditions. Life expectancy for people with hypertension is approximately 5 years shorter than for people with normal blood pressure⁶. Incorporating healthy lifestyle behaviors and taking medications to reduce blood pressure can provide health benefits and can lead to improved longevity.

Measure Definition

Hypertension BP Control

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

Hypertension - patients with blood pressure \leq 140/90



Includes patients whose last recorded blood pressure less than or equal to 140/90 (Data not reported from CCI and Holy Cross clinics)

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.S.¹ 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 costly².

PCC is reporting three cancer screening results:

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

Breast Cancer

Other than skin cancer, breast cancer is the most commonly diagnosed cancer among women in the United States². It is the second leading cause of cancer deaths in women³. In the U.S., a woman has about a 12% risk of developing breast cancer in her life time³.

Cervical Cancer

In the United States, more than 12,000 women will be diagnosed with cervical cancer each year, and over 4,000 will die of the disease^{4,5}. Regular screening is critical to detecting precancerous cellular changes before they lead to cervical cancer^{6,7}.

Colorectal Cancer

Colorectal cancer is currently the second leading cause of cancer death in the United States.

Why Improvement in Breast Cancer Screening (Mammography) is Important

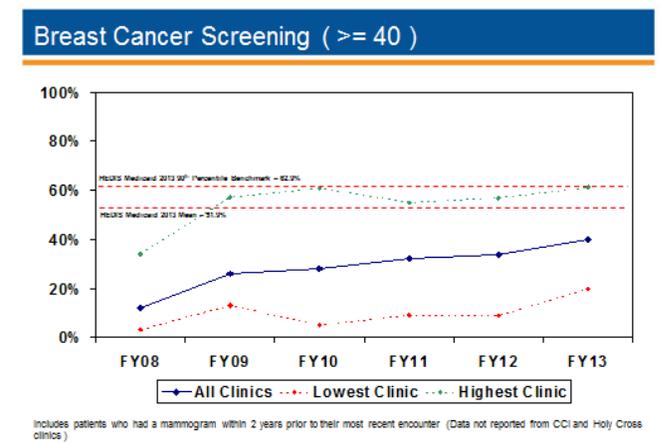
(from NCQA State of Healthcare Quality 2012 and 2013)

About 85% of breast cancers occur in women with no family history of the disease. Screening mammography is especially valuable to these women, often detecting breast cancer at an early stage when treatment is less costly, more effective and a cure is more likely¹.

Measure Definition

Breast Cancer Screening

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



Why Improvement in Cervical Cancer Screening is Important

(from NCQA State of Healthcare Quality 2012 and 2013)

For women in whom precancerous lesions were detected through Pap tests, the likelihood of survival is nearly 100% with appropriate care⁶. Approximately 50% of newly diagnosed invasive cervical cancers in the U.S. are in women who have never had a Pap test, and an additional 10% are in women who have not had a Pap test in the past 5 years⁶. In 2010, the prevalence of Pap test use was lowest among older women, women with no health insurance, and recent immigrants.⁸

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.

Why Improvement in Colorectal Cancer Screening is Important

(from NCQA State of Healthcare Quality 2012 and 2013)

Colorectal cancer screening in asymptomatic adults between 50 and 75 years of age can catch dangerous polyps before they become cancerous, or can detect colorectal cancer in its early stages, when treatment is most effective.

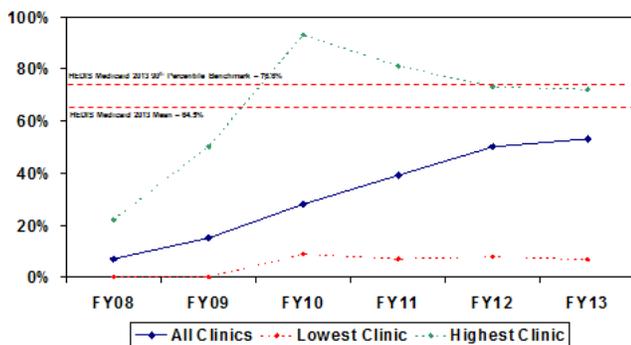
Measure Definition

Colorectal Cancer Screening

Percent of eligible adults who had appropriate screening for colorectal cancer including fecal occult blood test X3 or fecal immunoassay in the measurement year, or flexible sigmoidoscopy 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.

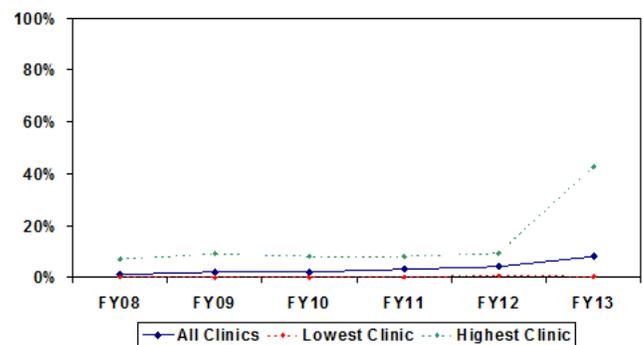
Relevant HEDIS Medicaid benchmarks are not available for comparison.

Cervical Cancer Screening



Includes patients who had a pap smear within 3 years prior to their most recent encounter. (Data not reported from CCI and Holy Cross clinics)

Colorectal Cancer Screening



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 CCI and Holy Cross clinics)

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

Measure Name	HEDIS 2012 Denominator	Montgomery Cares Denominator	Montgomery Cares Numerator
<i>Diabetes Measures</i>			
Hemoglobin A1c 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 A1c test within one year prior to their most recent encounter
Good control of A1c	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 A1c test was $\leq 7\%$
Poor control of A1c ($\geq 9\%$)	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 A1c test within one year prior to their most recent encounter or whose last A1c 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
Diabetes Blood Pressure	Patients aged	Patients aged 18 or older with a diagnosis of diabetes who had two	Denominator patients whose most recent blood pressure was $\leq 140/90$

Control	18-75 with diabetes	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	
<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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