



Fiscal Year
2021

Montgomery Cares Clinical Performance Measures

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Acknowledgements

The Montgomery Cares Medical Directors review and adopt clinical measures each fiscal year. Technical specifications are updated to reflect updates to HEDIS specifications as appropriate for relevant measures.

With deep appreciation, the PCC acknowledges the physicians and staff of the ten clinic organizations that participate in Montgomery Cares to serve Montgomery County's low-income, uninsured/uninsurable populations. **These clinical measures are only one reflection of their work and commitment to provide high quality healthcare to vulnerable county residents.** The PCC is grateful to the Montgomery County Council and Montgomery County Department of Health and Human Services for their oversight and financial support. Additionally, the Montgomery Cares program has benefitted from the expertise of many partners and funders.

Executive Summary

PCC and the Montgomery Cares participant clinics measure much more than the number of people receiving primary care services. For 14 years we have also been reporting on the quality of care those patients receive, and that focus has paid off. Emphasis on quality, guided by a robust clinical measure set, has resulted in consistent and sustained improvement in clinical quality over the past decade.

In FY 21, the continued effects of the global pandemic caused a significant disruption to health care operations. Clinics returned to in person visits but continued to face varying challenges of mask mandates and fluctuations in the COVID-19 positivity rate. Those uncertainties played a role in decreased scheduled appointments, along with increased missed appointments, and no shows. Patient reluctance to seek in-person care led to missed/delayed primary care visits and preventive screenings. Some of the FY 2021 quality measures reflect these pandemic-related delays. Nevertheless, the Montgomery Cares clinics continue to be resilient in ensuring patients receive high-quality care, despite unprecedented challenges brought about by a second year of the COVID-19 pandemic.

Disparities

For the 5th consecutive year, this report includes evaluations of disparities by race, gender, and ethnicity. Data for this evaluation is limited to the subset of six clinics that use a shared electronic medical record administered by PCC.¹ Statistically significant differences at $p \geq .99$ are reported.

Disparities exist in measures of diabetes, hypertension control, breast cancer, and cervical cancer, yet all of these measures neared or exceeded the HEDIS Medicaid benchmarks for all patient racial, ethnic, and gender categories. Some of these disparities are noted by measure category.

Chronic Conditions

Clinics maintain high performance in chronic condition management. The Montgomery Cares program meets or exceeds HEDIS benchmarks in diabetes and hypertension control.

- There were no race or gender disparities regarding blood pressure or diabetes screening.
- White patients had worse blood pressure control when compared with the Black/ African American and Asian population, without any gender disparities identified.
- Females outperformed males in diabetes control. Non-Hispanic/Latino outperform Hispanic/Latino patients in diabetes screening and control.
- Asian patients showed statistically higher rates of diabetes control than White patients ($Hgb A1c < 8$) and females were seen to have slightly better controlled diabetes than males.
- When looking at patients who had a $HgA1c$ greater than 9 or no $HgA1c$ test in the measurement period, White patients showed significantly poorer diabetes control than Black/African American or Asian patients.

Cancer Screening

Cancer Screening rates approach HEDIS benchmarks. Montgomery Cares clinics continue to improve colorectal cancer screening rates. There was a slight increase in breast and cervical cancer screening rates in FY 2021 which is back on target with pre-pandemic rates.

¹ Mansfield Kaseman Health Clinic, Mercy Health Clinic, Mobile Medical Care, Inc., Muslim Community Center Clinic, Pan Asian Volunteer Health Center, and Proyecto Salud.

Racial disparities persist in program-wide cancer screening rates (though many clinics may not demonstrate disparities within their own clinic population):

- Asian patients and Black/African American patients had lower breast and cervical cancer screening rates when compared with White patients, with Asian patients having the lowest breast and cervical cancer screening rates.
- White patients demonstrated higher colorectal cancer screening rates than Black/ African American patients for the first time.
- No gender disparities were noted. Currently, no HEDIS Medicaid benchmarks are available colorectal cancer screening.
- Hispanic/Latino outperformed non-Hispanic/Latino patients in measures of breast, cervical, and colorectal cancer screening.

Depression Screening

Montgomery Cares clinics routinely screen for depression. In this seventh year of reporting, annual depression screening remains high among MCares participants as a result of robust collaborative care models that integrate behavioral health and primary care. In FY 2021, 72% of active patients received depression screening within the previous twelve months.

Background

Since 1993, the Primary Care Coalition of Montgomery County, Maryland (PCC) has administered a variety of programs designed to increase access to health care and improve the quality of care in the Montgomery County safety net. Montgomery Cares is a public-private partnership designed to provide health care to low-income, uninsured adults in Montgomery County. The Montgomery Cares system currently includes 10 independent safety-net primary care organizations, six hospitals, the Montgomery County Department of Health and Human Services, and the PCC, as well as community-based providers and organizations. Participating health care providers share a common mission to provide high-quality, efficient, accessible, equitable, and outcome-focused health services to culturally diverse community members who are uninsured or underinsured. Montgomery Cares patients are low-income adults who are not eligible for any state or federal health care programs.

FY 2021 Patient Population

In FY 21, Montgomery Cares served more than 19,500 individuals, providing more than 53,000 primary care encounters, a 20% decrease in unduplicated patients and a 15% decrease in encounters from FY20. Project Access—the PCC operated specialty care network—provided more than 1,900 specialty care appointments.

Two-thirds of patients identified as Latino/Hispanic (up from 55% in FY20); 62% identified as female (up from 59% in FY20). Of the 41 different languages spoken, 79% of patients report Spanish as their primary language. The vast majority (78%) of patients are between 30 and 64 years of age, and 66% report incomes below the Federal Poverty Level.

Quality

Medical Directors from Montgomery Cares participating clinics meet quarterly to discuss quality issues, including clinical process and outcome measures, best practices, and common challenges relevant to the patient population. Invited guests share expertise and resources. These meetings help to maintain clinic focus on quality improvement and guideline-concordant care. Together, participating clinics identify opportunities for collaboration and spread successful practices. The PCC leads grant-funded quality improvement projects that provide additional opportunities for staff from multiple clinics to work together. In addition to quality improvement activities, Montgomery Cares performs on-site Quality Assurance (QA) Reviews.

Measurement is essential to improving quality. Since 2007, the PCC and Medical Directors from clinics participating in Montgomery Cares have reviewed, revised, and approved the Montgomery Cares clinical measures. PCC's data team produces quarterly and annual results using data from the PCC shared instance of eClinicalWorks (eCW - electronic medical record used by six participating organizations) and from data provided by Mary's Center, Catholic Charities Medical Clinic, and Holy Cross Health Centers.

Current Measures

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

- Existence of nationally endorsed measure specifications
- Evidence that improvement in the measure correlates with improved patient outcomes

- Sufficient prevalence of the population or condition in the Montgomery Cares population
- HEDIS Medicaid results available to serve as meaningful benchmarks and performance targets where possible

In FY 2021, Montgomery Cares tracked and reported 17 measures of chronic care and prevention on a quarterly basis, including diabetes, hypertension, cancer screening and depression screening. Eight clinical measures are presented in this public annual report.

Results Reporting and Benchmarking

Nationally endorsed measures and technical specifications were used to report and benchmark Montgomery Cares (MCares) performance against publicly reported measures of care. While recognizing that we did not share identical technical specifications due to differences in enrollment and claims data limitations, PCC and Montgomery Cares Medical Directors selected HEDIS Medicaid as the most relevant public benchmarks for Montgomery Cares comparisons.

Health plans that report HEDIS measures to NCQA have historically demonstrated higher quality than non-reporting plans. Medicaid plans against which Montgomery Cares benchmarks performance typically have more sophisticated infrastructure, more financial resources, and more specialty care access than Montgomery Cares participating clinics.

In addition to absolute performance, PCC also reviews variation between clinics. Displaying variation is a way to assess the reliability of processes between clinics, and to identify areas of best practice. In the following graphs, the “highest” or “lowest” performing clinics are not necessarily the same clinics year to year.

Condition Specific Results

Depression Screening

In the seventh year of reporting, rates of annual depression screening among MCares dropped below the 75% target, to 72%. FY 21 was the first time in four years in which depression screening rates did not exceed 90%; this can be attributed to the COVID 19 pandemic and fewer visits to the MCares clinics overall.

Diabetes Control

Diabetes is a group of diseases characterized by high blood sugar levels. Diabetes is associated with serious,

life-threatening complications, and is the 8th leading cause of death in the U.S. as of 2020.¹

Diabetes affected 11.3% of Americans—or 37.3 million people—in 2019, according to the American Diabetes Association, including:

- 7.4% of non-Hispanic whites
- 9.5% of Asian Americans
- 11.8% of Hispanics
- 12.1% of non-Hispanic blacks
- 14.5% of American Indians/Alaskan Natives²

Among the Montgomery Cares population, nearly 5,200 patients (26.30% of patients seen in FY 2021) had a diagnosis of diabetes, up 10% from FY 2020.

The American Diabetes Association has called out the disproportionate impact of diabetes among minority populations,³ calling it “an urgent health problem in the Latino community” and “one of the most serious health problems that the African American community faces today.”⁴

- **African American community.** Diagnosed diabetes rates are 60% higher among African American adults (13%) than non-Hispanic white adults.⁵ African American death rates from the disease are 200% higher.⁵
- **Latino and Hispanic community.** Diagnosed diabetes rates among Hispanic/Latino adults are 70% higher than non-Hispanic white American adults.⁶ Hispanic/Latino death rates from the disease are 30% higher.⁶

Type 2 diabetes prevention strategies include eating nutritious foods and staying active while staying away from tobacco products and extra body weight.⁷ (Type 2 diabetes accounts for the vast majority of diagnoses, making these preventive strategies especially important.) Complications of diabetes can be severe, including blindness and cardiovascular damage.⁷ These complications affect both quality and length of life, with diabetes implicated in 5% more early deaths globally in 2016 than in 2000.⁷ Regular medical care—along with diet and exercise—can help manage the disease to avoid long-term complications.⁷

In the following graphs, the PCC presents four measures related to Diabetes care.

Process Measure Definition: Annual A1c Test

Percent of eligible patients who had at least one A1c test during the measurement year.

Outcome Measure Definition: A1c Control

Percent of eligible patients with most recent A1c level <8.0%.

Outcome Measure Definition: 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 in poor control (*Note: Lower are better for this measure*).

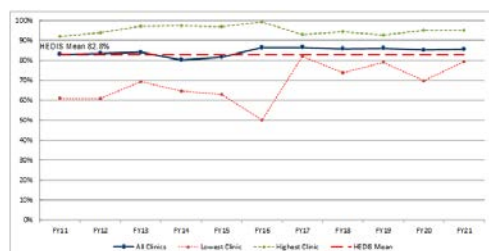
Outcome Measure Definition: BP Control

Percent of eligible patients with most recent BP measurement < 140/90.

Diabetes Clinical Performance

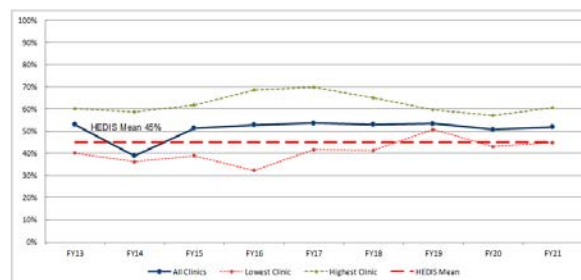
Clinics continue to meet or exceed HEDIS Medicaid benchmarks. A1c control measures continue to meet or exceed HEDIS Medicaid benchmarks. Diabetes blood pressure control exceeds HEDIS Medicaid benchmarks by 6%.

Diabetes Annual HgA1c testing



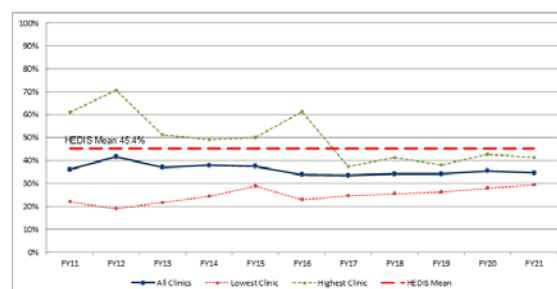
Includes patients who had a blood test for Hemoglobin A1c within one year of their most recent encounter (Data not reported from HCHC clinic)

Diabetes HgA1c Control < 8



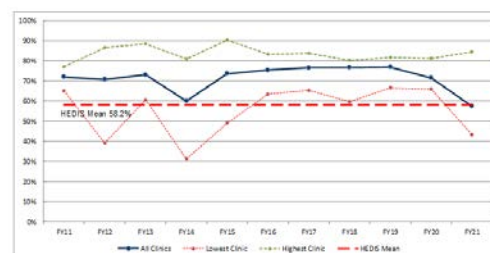
Includes patients who had a Hemoglobin A1c test result < 8. (Data not reported from HCHC clinic)

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 HCHC clinic)

Diabetes Blood Pressure Control



Includes patients who a blood pressure measurement < 140/90 at their most recent encounter.

Hypertension (High Blood Pressure) Control

Hypertension is caused by the increased force of blood flow against artery walls.⁸ The condition is common, affecting an estimated 47% of American adults in 2019.⁸

It is also serious, decreasing life expectancy at 50 by roughly five years compared to patients without hypertension in a 2005 study.⁹ Heart disease and stroke risks are higher for patients with hypertension—a major concern since these conditions caused nearly 30% of American deaths in 2018 and 2019.^{8,10}

Measure Definition: Hypertension BP Control

Percent of eligible hypertensive patients with most recent recorded blood pressure measurement of

- 140/90 for patients ages 18-59
- 140-90 for patients ages 60-85 with diabetes
- 150/90 for patients ages 60-85 without diabetes

Treatment recommendations vary depending on the stage of hypertension. Lifestyle changes alone may be used to control Stage 1 hypertension—when readings average 130-139/80-89 mm Hg—while medication is likely to be added for patients with average readings at or above 140/90 mm Hg.¹¹ There are two stages of hypertension.¹¹

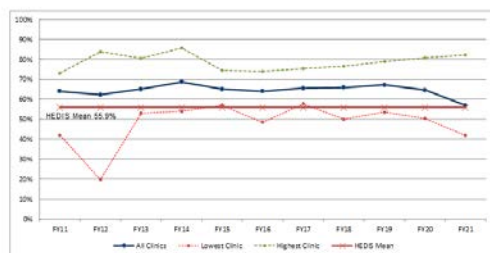
In FY 21, nearly 5,500 (27.87%) of Montgomery Cares patients had a diagnosis of hypertension which is a 3% decrease compared to last year.

A 2017 article by the American College of Cardiology/American Heart Association noted that non-Hispanic blacks had the highest rates of hypertension. While they had the highest rates of hypertension that should have been treatable, they also had the highest rates of hypertension that remained uncontrolled, despite a treatment regimen.¹²

Hypertension Clinical Performance

Montgomery Cares continues to demonstrate excellent control of hypertension. Although disparities continue to be demonstrated by race, gender and ethnicity, BP control continues to exceed HEDIS benchmarks for White, Black, and Asian patients, as well as for males, females, Hispanics and non-Hispanics.

Hypertension Control



Includes patients with targeted BP: Age 18-59 or 60-85 with Diabetes < 140/90. Age 60-85 without Diabetes < 150/90

Cancer Screening

The purpose of performing screening exams on otherwise healthy and asymptomatic patients is to identify conditions for which early treatment can avoid significant sickness and death. Clear disparities in care exist among minorities and the uninsured in the U.S., driven not only by patient-related disadvantages like limited health care coverage and health literacy but by resource pressures on the practices serving many of these patients.¹³

PCC reports results for three cancer screening measures:

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening

Disparities by race are demonstrated in all three Montgomery Cares cancer screening measures, though disparities differ by type of cancer, and many clinics do not demonstrate any disparities within their own clinic population.

Breast Cancer

Breast cancer accounted for 30% of cancer diagnoses among U.S. women in 2019 and 15% of cancer deaths—making it the most frequently diagnosed and second-most deadly cancer.¹⁴ A combination of factors make breast cancer more deadly for black women than white women, including lower screening rates and treatment quality, higher obesity rates, and higher rates of more aggressive cancer sub-types.¹⁵

Measure Definition: Breast Cancer Screening

Percent of eligible women 50-74 years of age with a documented mammogram in the past two years.

Breast Cancer Screening Clinical Performance

Montgomery Cares participating clinics have made great strides in approaching HEDIS Medicaid benchmarks.

However, there were significant differences in breast cancer screening by race. White women had the highest screening rates, Asian women the lowest breast cancer screening rates. The rate of screening among white women (64.38%) exceeds HEDIS Medicaid target of 59%, while the screening rate in Black women was

54.27% (which increased from last year) and in Asian women was 47.14% (a decrease from last year).

Measure Definition: Colorectal Cancer Screening

Percent of eligible adults 51-75 years of age who had appropriate screening for colorectal cancer (includes fecal occult blood test X3 or fecal immunoassay in the past year, or flexible sigmoidoscopy in the past 5 years or colonoscopy in the past 10 years).

In 2021, approximately 5.5% of MCares mammograms were found to have potential abnormalities. Mammography quality guidelines suggest recall rates should be less than 10%; one study found that these rates trended lower at community screening sites (6.9%) than at hospitals (8.6%).¹⁶

Measure Definition: Cervical Cancer Screening

Percent of eligible women

- Age 24–64 who had cervical cytology performed during the measurement period or the two years prior to the end of the measurement period.
- Age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the end of the measurement period and who were 30 years or older on the date of both tests.

Cervical Cancer

Cervical cancer testing not only detects early-stage cancer but also precancerous lesions, when treatment can almost guarantee survival.¹⁷ However, certain races and ethnicities are associated with screening disparities, as is a lack of health insurance.¹⁷

Black and Hispanic women face higher rates of cervical cancer diagnosis and death than non-Hispanic white women (8.8, 9.6, and 7.2/100,000 respectively for diagnosis and 3.1, 2.5, and 2/100,000 for death between 2014 and 2018),^{18,19} and they are more likely to experience treatment delays.¹⁹

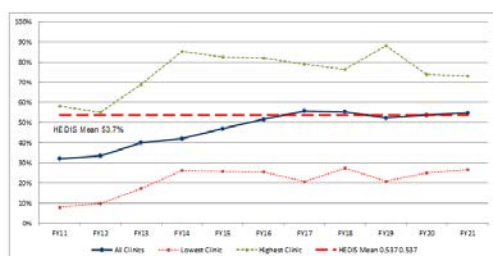
Cervical Cancer Screening Clinical Performance

The Montgomery Cares program has significantly improved cervical cancer screening rates, demonstrating stable performance in recent years and surpassing the HEDIS benchmark for FY21 (60% for MCares, 56.80% for HEDIS).

PCC reports highest cervical cancer screening among White women, and lowest among Asian women. Cervical cancer screening rates among white women (66.39%) exceed HEDIS Medicaid benchmarks (56.80%), but cervical cancer screening among Black women (42.86%) and Asian women (38.03%) are far below benchmarks. However, screening among Black women is up from FY20.

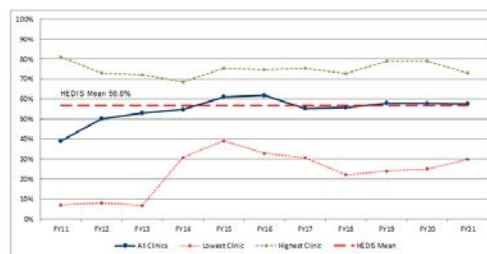
For cervical cancer, the rate of abnormal results found in 2021 among Montgomery Cares' patients was 9.14%. Nationally, the rate is approximately 5%.²⁰

Breast Cancer Screening (Age 50-74)



Includes patients who had a mammogram within 2 years. (Data not reported from Holy Cross clinic)

Cervical Cancer Screening



Includes patients who had a pap smear within 3 years, or patients >30 years of age with co-tested pap and HPV within 5 years. (Data not reported from Holy Cross clinic)

Colorectal Cancer

Affecting both men and women, colorectal cancer (cancer of the colon and rectum) accounted for an estimated 8% of all 2019 cancer diagnoses and 8% of all cancer deaths, surpassed only by breast, lung, and prostate cancer in diagnoses and only by lung cancer in

deaths.¹⁴ African Americans face disproportionately high rates of colorectal cancer diagnosis and death.²¹

As with cervical cancer screening, colorectal cancer screening can detect both early and developing disease—polyps that can be removed while still precancerous.²² New colorectal cancer diagnoses have been declining overall because of improvements for the older adults most at risk, but the 2012-2016 period saw an uptick in new cases among Americans 63 and under.²¹

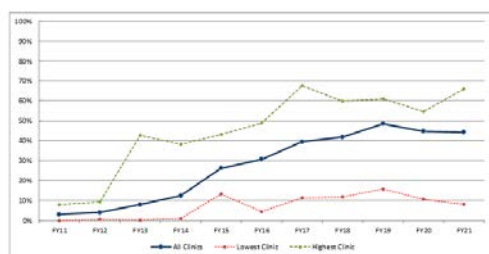
Colorectal Cancer Screening Clinical Performance

Montgomery Cares participating clinics have seen improvements in their colorectal cancer screening rates year after year, except for a slight decline in FY 20 and FY 21. The decline is likely attributable to pandemic-related disruptions in preventative services, but there are no relevant HEDIS Medicaid benchmarks available for comparison.

MCares reported statistically similar colorectal cancer screening rates among Black v White, Black v Asian and Asian v White patients. In FY 21, MCares White patients had the highest reported screening rate (44.76%) which is different in past years when Black/ African Americans typically had the highest screening rates. Black/ African Americans followed at 41.91% and Asians 37.06%. No gender disparities were identified.

In 2021, the reported rate of abnormal results found among Montgomery Cares patients (5.70%) was a little more than half the expected rate of 7% to 8% that has been generally found in large studies.²³ This may be due to the fact that patients at higher-than-normal risk are referred to a state funded programs for colonoscopy screenings (Cancer Crusade), and positive findings may not be documented in an easily identifiable way.

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. (Data not reported from Holy Cross clinic)

Appendix I: Montgomery Cares Clinical Measures by Fiscal Year

Measure	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	Target: Average Medicaid HMO Performance NCQA "State of Healthcare Quality 2021"
Diabetes: Annual A1c Testing	54%	74%	77%	83%	84%	84%	80%	82%	86%	87%	86%	86%	85%	88%	82.80%
Diabetes: A1c Control (<8)	N/A	N/A	N/A	N/A	N/A	53%	39%	51%	53%	53%	53%	53%	51%	56%	45.00%
Diabetes: Poor A1c Control	57%	44%	37%	36%	42%	37%	38%	37%	34%	33%	34%	34%	35%	35%	45.4% (lower values are better)
Hypertension: BP Control	52%	60%	65%	64%	62%	65%	69%	65%	64%	66%	66%	67%	65%	62%	55.90%
Breast Cancer Screening >50 years old	N/A	N/A	29%	32%	33%	40%	42%	47%	51%	56%	55%	52%	54%	59%	53.70%
Cervical Cancer Screening	7%	15%	29%	39%	50%	53%	55%	61%	62%	55%	56%	58%	58%	60%	56.80%
Colorectal Cancer Screening	1%	2%	2%	3%	4%	8%	12%	26%	31%	39%	42%	48%	45%	44%	N/A for Medicaid
Annual Depression Screening (selected clinics)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	63%	74%	85%	95%	92%	90%	72%	N/A HEDIS

Appendix II: Statistically Significant Differences by Race, Ethnicity, Gender (p-value ≥ 0.99)

Hypertension Control FY 21 HEDIS Medicaid Mean = 55.90%

Sum of Total Patients				vs white	vs black	vs asian
	Denominator	Numerator	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	11	7	0.636363636			
Asian	225	139	0.617777778	0.662708	0.548602	
Black or African American	506	315	0.622529644	0.728516		0.548602
Native Hawaiian or Other Pacific Islander	3	2	0.666666667			
Other Race	530	329	0.620754717			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	46	30	0.652173913			
White	209	125	0.598086124		0.728516	0.662708
All Races	1530	947	0.618954248			

Sum of Total Patients				vs non hispanic
	Denominator	Numerator	Percentage	
Hispanic or Latino	703	429	0.610241821	0.717929347
Not Hispanic or Latino	810	506	0.624691358	
Refused to Report	17	12	0.705882353	
Unknown	0	0	#DIV/0!	
All Ethnicities	1530	947	0.618954248	

Sum of Total Patients				vs male
	Denominator	Numerator	Percentage	
female	978	632	0.646216769	0.99815112
male	552	315	0.570652174	
Unknown	0	0	#DIV/0!	
All Gender	1530	947	0.618954248	

Diabetes Screening FY 21 HEDIS Medicaid Mean =82.80%

Sum of Total Patients				vs white	vs black	vs asian
	Denominator	Numerator	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	6	5	0.833333333			
Asian	259	233	0.8996139	0.575261663	0.967819639	
Black or African American	472	403	0.853813559	0.947213236		0.967819639
Native Hawaiian or Other Pacific Islander	4	3	0.75			
Other Race	648	566	0.87345679			
Unknown	0	0				
Unreported/Refused to Report	54	48	0.888888889			
White	256	229	0.89453125		0.947213236	0.575261663
All Races	1699	1487	0.875220718			

Sum of Total Patients				vs non hispanic
	Denominator	Numerator	Percentage	
Hispanic or Latino	866	764	0.88221709	0.748442284
Not Hispanic or Latino	817	712	0.871481028	
Refused to Report	16	11	0.6875	
Unknown	0	0	#DIV/0!	
All Ethnicities	1699	1487	0.875220718	

Sum of Total Patients				vs male
	Denominator	Numerator	Percentage	
female	979	862	0.880490296	0.776856695
male	720	625	0.868055556	
Unknown	0	0	#DIV/0!	
All Gender	1699	1487	0.875220718	

Diabetes A1c Control <8 FY 21 HEDIS Medicaid Mean = 45.00%

Sum of Total Patients				vs white	vs black	vs asian
	Denominator	Numerator	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	6	2	0.333333333			
Asian	259	166	0.640926641	0.972146	0.888545	
Black or African American	472	281	0.595338983	0.830775		0.888545
Native Hawaiian or Other Pacific Islander	4	1	0.25			
Other Race	648	333	0.513888889			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	54	28	0.518518519			
White	256	143	0.55859375		0.830775	0.972146
All Races	1699	954	0.561506769			

Sum of Total Patients				vs non hispanic
	Denominator	Numerator	Percentage	
Hispanic or Latino	866	455	0.525404157	0.999138246
Not Hispanic or Latino	817	491	0.600979192	
Refused to Report	16	8	0.5	
Unknown	0	0	#DIV/0!	
All Ethnicities	1699	954	0.561506769	

Sum of Total Patients				vs male
	Denominator	Numerator	Percentage	
female	979	582	0.594484168	0.999301731
male	720	372	0.516666667	
Unknown	0	0	#DIV/0!	
All Gender	1699	954	0.561506769	

Diabetes Poor Control A1c >9 (or no test) FY 20 HEDIS Medicaid Mean =45.4% (lower is better on A1c>9)

Sum of Total Patients				vs white	vs black	vs asian
	Denominator	Numerator	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	6	1	0.166666667			
Asian	259	33	0.127413127	0.998516	0.762008	
Black or African American	472	69	0.146186441	0.995462		0.762008
Native Hawaiian or Other Pacific Islander	4	2	0.5			
Other Race	648	144	0.222222222			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	54	11	0.203703704			
White	256	58	0.2265625		0.995462	0.998516
All Races	1699	318	0.187168923			

Sum of Total Patients				vs non hispanic
	Denominator	Numerator	Percentage	
Hispanic or Latino	866	192	0.221709007	0.999893129
Not Hispanic or Latino	817	124	0.151774786	
Refused to Report	16	2	0.125	
Unknown	0	0	#DIV/0!	
All Ethnicities	1699	318	0.187168923	

Sum of Total Patients				vs male
	Denominator	Numerator	Percentage	
female	979	170	0.173646578	0.950665652
male	720	148	0.205555556	
Unknown	0	0	#DIV/0!	
All Gender	1699	318	0.187168923	

Breast Cancer Screening (Female 50-74 yo) FY 19 HEDIS Medicaid Mean =58.4%

Sum of Total Patients				vs white	vs black	vs asian
	Denominator	Numerator	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	9	8	0.888888889			
Asian	297	140	0.471380471	0.999997	0.982582	
Black or African American	820	445	0.542682927	0.999542		0.982582
Native Hawaiian or Other Pacific Islander	4	3	0.75			
Other Race	785	511	0.650955414			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	63	37	0.587301587			
White	365	235	0.643835616		0.999542	0.999997
All Races	2343	1379	0.588561673			

Sum of Total Patients				
	Denominator	Numerator	Percentage	vs non hispanic
Hispanic or Latino	1104	737	0.667572464	1
Not Hispanic or Latino	1225	634	0.51755102	
Refused to Report	14	8	0.571428571	
Unknown	0	0	#DIV/0!	
All Ethnicities	2343	1379	0.588561673	

Sum of Total Patients				
	Denominator	Numerator	Percentage	vs male
female	2343	1379	0.588561673	#DIV/0!
male	0	0	#DIV/0!	
Unknown	0	0	#DIV/0!	
All Gender	2343	1379	0.588561673	

Cervical Cancer Screening (Females 24-64 yo) FY 20 HEDIS Medicaid Mean = 56.80%

Sum of Total Patients				vs white	vs black	vs asian
	Denominator	Numerator	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	13	9	0.692307692			
Asian	305	116	0.380327869	1	0.930406	
Black or African American	840	360	0.428571429	1		0.930406
Native Hawaiian or Other Pacific Islander	6	4	0.666666667			
Other Race	2124	1438	0.677024482			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	114	57	0.5			
White	958	636	0.66388309		1	1
All Races	4360	2620	0.600917431			

Sum of Total Patients				vs non hispanic
	Denominator	Numerator	Percentage	
Hispanic or Latino	3023	2040	0.674826331	1
Not Hispanic or Latino	1316	567	0.430851064	
Refused to Report	21	13	0.619047619	
Unknown	0	0	#DIV/0!	
All Ethnicities	4360	2620	0.600917431	

Sum of Total Patients				vs male
	Denominator	Numerator	Percentage	
female	4360	2620	0.600917431	#DIV/0!
male	0	0	#DIV/0!	
Unknown	0	0	#DIV/0!	
All Gender	4360	2620	0.600917431	

Colorectal Cancer Screening (Ages 50-75 yo) No HEDIS Medicaid benchmark available

Sum of Total Patients				vs white	vs black	vs asian
	Denominator	Numerator	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	15	4	0.266666667			
Asian	510	189	0.370588235	0.994946	0.96929	
Black or African American	1131	474	0.419098143	0.867409		0.96929
Native Hawaiian or Other Pacific Islander	5	2	0.4			
Other Race	1147	572	0.498692241			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	101	43	0.425742574			
White	563	252	0.447602131		0.867409	0.994946
All Races	3472	1536	0.442396313			

Sum of Total Patients				
	Denominator	Numerator	Percentage	vs non hispanic
Hispanic or Latino	1620	796	0.491358025	0.999999981
Not Hispanic or Latino	1827	728	0.398467433	
Refused to Report	25	12	0.48	
Unknown	0	0	#DIV/0!	
All Ethnicities	3472	1536	0.442396313	

Sum of Total Patients				
	Denominator	Numerator	Percentage	vs male
female	2248	990	0.440391459	0.626356419
male	1224	546	0.446078431	
Unknown	0	0	#DIV/0!	
All Gender	3472	1536	0.442396313	

Appendix III: Annual Clinical Quality Measures (Measure Definition)

Primary Care Coalition of Montgomery County

CHRONIC CONDITION MANAGEMENT	Measure Name	Denominator	Numerator
	<i>Diabetes Measures</i>		
	Hemoglobin A1c (HgA1c) Testing	Patients aged 18-75 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 the end of the measurement period.
	Poor Control of HgA1c	Patients aged 18-75 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 the end of the measurement period or who's last HgA1c test was > 9%.
	Control of Hga1c	Patients aged 18-75 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 the end of the measurement period and who's last HgA1c test was < 8%.
	Retinal Eye Exams	Patients aged 18-75 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 received a retinal eye exam from an ophthalmologist or optometrist within one year prior to the end of the measurement period.
	Foot Exams	Patients aged 18-75 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 received at least one LEAP or diabetic/sensory foot exam during the measurement period or within one year prior to the end of the measurement period.
	Diabetes Blood Pressure Control (<140/90)	Patients aged 18-75 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 whose blood pressure at their last encounter was <140/90.
	<i>Hypertension Measures</i>		
	Blood Pressure Measurement	Patients aged 18-85 with a diagnosis of hypertension who had two face-to-face encounters* with different dates of service—one during the measurement period and the other in the measurement period or within two years prior to the end of the measurement period.	Denominator patients who had a blood pressure measurement taken at their last encounter
	Blood Pressure Control	Patients aged 18-85 with a diagnosis of hypertension who had two face-to-face encounters* with different dates of service - one visit during the measurement period and	Of the denominator patients: <ul style="list-style-type: none"> • Adults 18–59 years of age whose blood pressure was <140/90 mm Hg.

		the other visit in the measurement period or within two years prior to the end of the measurement period.	<ul style="list-style-type: none"> Adults 60–85 years of age, with a diagnosis of diabetes, whose blood pressure was <140/90 mm Hg. Adults 60–85 years of age, without a diagnosis of diabetes, whose blood pressure was <150/90 mm Hg.
WELLNESS AND PREVENTIVE CARE	<i>Cancer Screening</i>		
	Breast Cancer Screening 40+ years	Women aged 40-74 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 the end of the reporting period.
	Breast Cancer Screening 50+ years	Women aged 50 to 74 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 the end of the reporting period.
	Cervical Cancer Screening	Women aged 24-64 as of the end of the measurement period 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.	<p>Of the denominator patients:</p> <ul style="list-style-type: none"> Women aged 24–64 who had cervical cytology performed during the measurement period or the two years prior to the end of the measurement period. Women aged 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the end of the measurement period and who were 30 years or older on the date of both tests.
	Colorectal Cancer Screening	Men and women aged 51-75 as of the end of the measurement period 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.	<p>Denominator patients who received one of the following tests:</p> <ul style="list-style-type: none"> Colonoscopy during the measurement period or within 10 years of the end of the measurement period. Flexible sigmoidoscopy during the measurement period or within 5 years of the end of the measurement period. Fecal occult blood or FIT test within 12 months of the end of the measurement period.
BEHAVIORAL	Primary Care Visit Depression Screening	Completed primary care visit (PCV) encounters during the measurement period.	Denominator encounters with a documented PHQ-9 or PHQ-2.

*Encounters include face-to-face visits as well as telehealth visits

	Active Patient Depression Screening	Patients as of the end of the measurement period who had two face-to-face encounters* (PCV or SCV) 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 documented PHQ2 or PHQ9 at any type of visit in the 15 months prior to the end of the measurement period.
	Behavioral Health Follow Up After Positive Depression Screen	Patients as of the end of the measurement period who had two face-to-face encounters* (PCV or SCV) 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>And</i> have a completed PCV visit in the three months prior to the beginning of the measurement period with a positive PHQ screen (PHQ>9 OR PHQ-2>0).	Denominator patients who receive any BH visit (excluding phone visits) within two months of the positive PHQ screen.
	Depression Symptom Reduction Percentage of patients with clinically significant symptoms of depression with a demonstrated decrease in depression symptoms within six months of initial Behavioral Health evaluation (2 measures: Most recent score and best score)	Patients as of the end of the measurement period who had two face-to-face encounters* (PCV or SCV) 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. AND who have Behavioral Health evaluation (CPT Code 90791 or 90792) in the six months prior to the beginning of the measurement period with a PHQ ≥10. <u>This is the baseline score.</u> AND at least one additional PHQ9 score at any type of visit before the end of the measurement period.	Denominator patients whose: Measure 1: Most recent PHQ-9 score at any visit in the measurement period is <i>either</i> ≤9 OR a decrease of ≥50% from the <i>baseline score</i> . Measure 2: Lowest recorded PHQ-9 score at any visit after the baseline score is <i>either</i> ≤9 OR a decrease of ≥ 50% from the <i>baseline score</i> .

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