

# Montgomery Cares Clinical Quality Measures Report Fiscal Year 2023

May 28, 2024

**Authors:**

Veronica X. Vela, DrPH, MEng, Senior Director of Healthcare Access

Sara Woods, MHA, Director of Clinical Transformation

Sophy Yang, MS, Data Analyst



# Table of Contents

Acknowledgements .....	3
Executive Summary.....	4
Purpose.....	4
About Montgomery Cares .....	4
Quality Indicators.....	4
Network Performance Indicator Results.....	6
General .....	10
White Patient Population .....	10
Black/African American Patient Population.....	10
Asian Patient Population .....	11
Hispanic/Latino Patient Population .....	11
Sex .....	11
Appendices .....	14
Appendix A: FY23 Providers in the Montgomery Cares Network.....	14
Appendix B: Race/Ethnicity/Sex Performance by Indicator Over Time .....	15

## Acknowledgements

The Primary Care Coalition would like to acknowledge our funders and partners, which include the Montgomery County Department of Health and Human Services, the Montgomery County Executive Office and Council, participating health centers within the Montgomery Cares network, and our many funders that make this work possible. We appreciate your support in caring for some of our county's most vulnerable residents.

## Executive Summary

The Primary Care Coalition, in collaboration with the Quality Health Improvement Committee, monitors a variety of performance indicators to ensure high-quality service provision in the Montgomery Cares program for the uninsured/uninsurable of Montgomery County, Maryland. Eight indicators are publicly reported on an annual basis, pertaining to hypertension, diabetes control, and cancer and depression screenings.

Fiscal Year 2023 showed many findings worth celebrating. The all-clinic average was above the network's HEDIS benchmarks (where available) in nearly all categories, including hypertension control, diabetes screening and control, and breast cancer screening. When analyzed by race, ethnicity, and sex, all categories outperformed the HEDIS Medicaid HMO average in hypertension control, uncontrolled diabetes, and breast cancer screening. There were marked improvements in colorectal cancer tests and hypertension control, both overall and across analyzed demographic groups. Monitoring trends over time is advisable for hypertension and diabetes testing and control, as well as HbA1c testing in Hispanic/Latino and male populations. There continues to be a need for improvement in cervical cancer testing rates as well as retinal exam rates for diabetic patients.

## Purpose

This report highlights how the Montgomery Cares network of ten health centers performs on eight healthcare quality indicators. The purpose of this document is to compare the network's performance with the average Medicaid performance nationwide. The report documents findings from FY2023, covering July 1, 2022 to June 30, 2023.

These findings present the Montgomery Cares network performance on each indicator, and includes a disparity analysis, investigating performance on each indicator by race, ethnicity, and sex.

## About Montgomery Cares

The Montgomery Cares (MCares) program is a public-private partnership designed to provide high-quality, efficient, accessible, equitable, and outcome-focused health services to low income, uninsured/uninsurable residents of Montgomery County, Maryland. The core focus is on providing primary care services, with additional program areas supporting access to specialty care, medicine, behavioral health services, and cancer screenings. Participants are 18 years of age and older, have incomes at or below 250% of the federal poverty line, reside within Montgomery County, and are unable to otherwise obtain health insurance due to immigration status or affordability constraints. In fiscal year 2023, over 80% of patients identify their Ethnicity as Latino. For Race, 27% identify as White; 14% identify as Black/African American; 8% as Asian; 5% as American Indian, Alaskan or Hawaiian Native or Other Pacific Islander; and 46% decline to report, report Unknown or Other as their Race. The top 6 languages spoken are Spanish, English, Portuguese, French, Amharic and Mandarin.

The program is funded by the Montgomery County government, overseen and administered by the Primary Care Coalition, with direct services being provided by a network of independent, non-profit primary care organizations (see Appendix A). In FY23, the network served 22,693 patients through 61,007 encounters.

## Quality Indicators

The Montgomery Cares Quality Health Improvement Committee (QHIC) is made up of medical directors and quality-related staff from Montgomery Cares (MCares) network health centers. QHIC continually seeks ways to improve health outcomes and service delivery in the target patient population. Since 2007, the QHIC has internally collected and analyzed a set of standard clinical measures, some of which are reported annually to showcase successes and demonstrate accountability to funders, stakeholders, and the community.

The indicators contained in these annual reports highlight the most important impact measures. These measures correlate with improved patient

outcomes, are aligned with conditions highly prevalent in the MCares population, and/or disproportionately affect those served by the network.

In addition to selecting indicators based on their relevance to and impact on the target patient population, MCares aligns its measurement definitions with a subset of those outlined in the National Committee for Quality Assurance’s Healthcare Effectiveness Data and Information Set (HEDIS). The MCares network utilizes the national averages of HEDIS measures customized for Medicaid HMOs as benchmarks for performance

comparison (where they are available). Medicaid HMO averages are chosen due to their patient population aligning most similarly with the MCares community. The HEDIS Medicaid HMO averages referenced in this report are from the NCQA State of Healthcare Quality 2023 report, utilizing national data from calendar year 2022. It's important to note that while the HEDIS measure year aligns with calendar year 2022, the MCares data in this report is for fiscal year 2023 (July 1, 2022 – June 30, 2023).

The following table includes the quality indicators.

**Table 1 – Montgomery Cares Network Quality Indicators**

Measure Name	Denominator	Numerator
<b>Hypertension Control</b>	Patients aged 18-85 with a diagnosis of hypertension who had two face-to-face encounters <sup>1</sup> 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.	Of the denominator patients: <ul style="list-style-type: none"> <li>Adults 18–59 years of age whose blood pressure was &lt;140/90 mm Hg.</li> <li>Adults 60–85 years of age, with a diagnosis of diabetes, whose blood pressure was &lt;140/90 mm Hg.</li> <li>Adults 60–85 years of age, without a diagnosis of diabetes, whose blood pressure was &lt;150/90 mm Hg.</li> </ul>
<b>Hemoglobin A1c (HbA1c) Testing in Patients with Diabetes</b>	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 HbA1c test within one year prior to the end of the measurement period.
<b>Controlled HbA1c in Patients with Diabetes</b>	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 HbA1c test within one year prior to the end of the measurement period and whose last HbA1c test was < 8%.
<b>Uncontrolled HbA1c in Patients with Diabetes</b>	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 HbA1c test within one year prior to the end of the measurement period <b>or</b> whose last HbA1c test was > 9%.
<b>Breast Cancer Screening for Women 50+ years</b>	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.
<b>Cervical Cancer Screening for Women</b>	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	Of the denominator patients: <ul style="list-style-type: none"> <li>Women aged 24–64 who had cervical cytology performed during the measurement</li> </ul>

<sup>1</sup> Encounters include face-to-face visits as well as telehealth visits

	measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period.	<p>period or the two years prior to the end of the measurement period.</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>
<b>Colorectal Cancer Screening</b>	Men and women aged 50-75 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"> <li>• Colonoscopy during the measurement period or within 10 years of the end of the measurement period.</li> <li>• Flexible sigmoidoscopy during the measurement period or within 5 years of the end of the measurement period.</li> <li>• Fecal occult blood or FIT test within 12 months of the end of the measurement period.</li> </ul>
<b>Primary Care Visit Depression Screening</b>	Completed primary care visit (PCV) encounters during the measurement period.	Denominator encounters with a documented PHQ-9 or PHQ-2.

## Network Performance Indicator Results

Overall, the MCares network met or exceeded the majority of the indicator targets. Hypertension control, hemoglobin A1C testing, diabetes control, and breast cancer screening rates exceed the network’s HEDIS benchmarks. Cervical cancer and retinal eye exam screening measures are currently not meeting a national benchmark. 53% of patients received cervical cancer screening, three percentage points below the HEDIS Medicaid HMO average of 56%.

Over the past five years, performance remained relatively steady or improved for most indicators. As we look at chronic conditions, hypertension control increased by 8% last year after experiencing a significant decrease, from 65% to 57% during the pandemic. Current hypertension control is seven percentage points above the benchmark of 61% with a control rate of 68%. The remaining 32% of patients with uncontrolled hypertension remain at increased risk of having a heart attack or stroke. However, this MCares network performance is significantly better than the HEDIS Medicaid HMO average of 40% (a lower percent is better for this measure).

HbA1c testing, which measures blood sugar control, increased over the past year as well, moving from 86% to 90%. Meeting this target is significant because taking an HbA1c test allows providers to work with their patients to make lifestyle and medication changes that further control diabetes and reduce the likelihood of complications. In terms of blood sugar control, the network is at 55%, indicating that more than half of the population has reduced their risk of complications from diabetes. 33% of patients in network have uncontrolled diabetes, with HbA1c rates greater than 9%. This information indicates that we can expect future complications, such as heart disease, chronic kidney disease, nerve damage, oral health, vision, hearing, and mental health over the years stemming from uncontrolled blood sugar rates among a third of the MCares population.

For cancer screening, breast cancer screening increased over the last five years. Currently 59% of women over 50 years of age are receiving breast cancer screenings. The network is seven percentage points above the HEDIS Medicaid HMO average rate of 52%. The cervical cancer screening rate (53%) is below the current HEDIS Medicaid HMO average rate of 56%. Both cervical and colorectal cancer screening experienced decreases in FY22, with colorectal cancer screening recovering in FY23 at a rate of 46%.

**Table 2 – Montgomery Cares Quality Measure Performance Over the Years<sup>2</sup>**

Measure	HEDIS Medicaid HMO Average <sup>3</sup>	Percent of Population Meeting Measure				
		FY19	FY20	FY21	FY22	FY23
Hypertension Control	61%	67%	65%	57%	60%	68%
HbA1c Testing for Patients w/ Diabetes	85%	86%	85%	86%	88%	90%
Controlled HbA1c (≤ 8%)	51%	53%	51%	52%	52%	55%
Uncontrolled HbA1c (≥ 9%)	52%	34%	35%	35%	36%	33%
Breast Cancer Screening 50+ Years	52%	52%	54%	55%	54%	59%
Cervical Cancer Screening	56%	58%	58%	58%	50%	53%
Colorectal Cancer Screening	N/A	48%	45%	44%	35%	46%
Primary Care Visit Depression Screening	N/A	71%	69%	73%	73%	70%

Note: Changes of 5+ percentage points in a positive direction are **green**; changes of 5+ percentage points in a negative direction are **red**; categories not meeting or exceeding the HEDIS Medicaid HMO average benchmark in FY23 are **highlighted**.

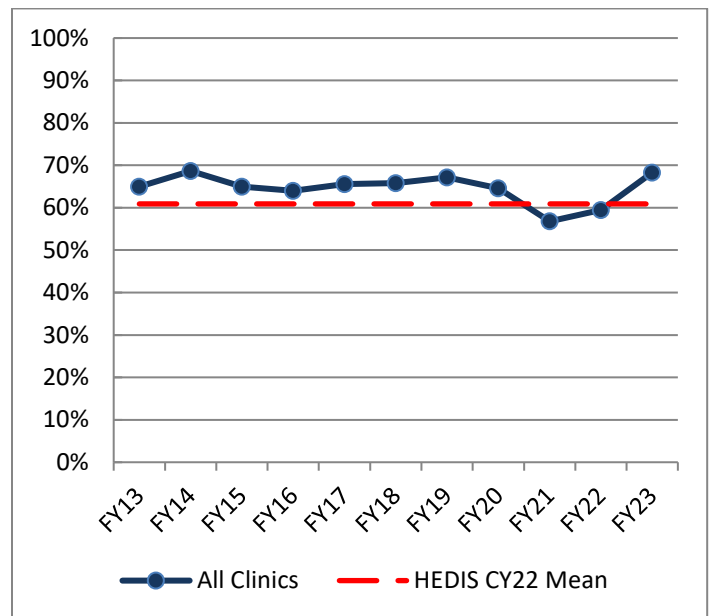
## Annual Trends by Indicator

This section highlights annual trends for each indicator, visually displaying how the measure has changed over time.

### Hypertension

Hypertension control (Figure 1) has shown marked improvement in the Montgomery Cares population since FY21. The network average in this measure rose from below the HEDIS benchmark<sup>4</sup> of 61% during the pandemic and is currently a near record high of 68% in FY23. The remaining 32% of patients with hypertension are at an increased risk of having a heart attack or stroke.

**Figure 1 – Blood Pressure Control Among Patients with Hypertension**



<sup>2</sup> Holy Cross began reporting cancer screening data in FY2022 and Catholic Charities is no longer a part of Montgomery Cares as of FY24.

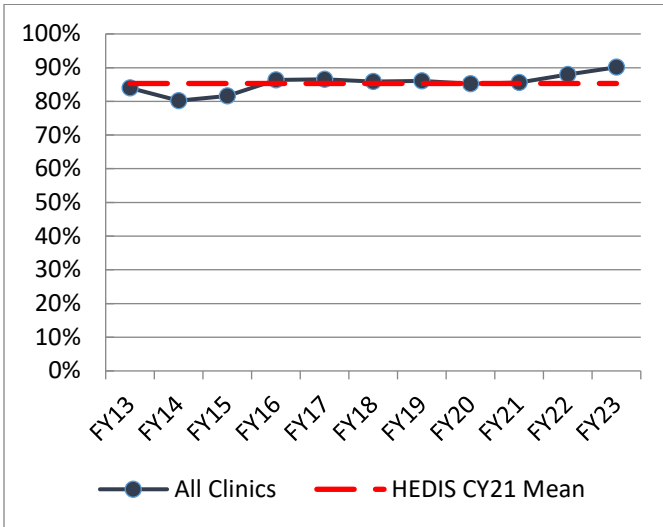
<sup>3</sup> HEDIS Medicaid HMO average benchmarks are from NCQA State of Healthcare Quality 2023 (Plan Performance Year 2022)

<sup>4</sup> HEDIS Medicaid HMO average benchmarks are from NCQA State of Healthcare Quality 2023 (plan performance year 2022)

## Diabetes

Hemoglobin A1c (HbA1c) testing, or blood sugar testing, (Figure 2) is a means to disease control in patients with diabetes. After hovering around the HEDIS Medicaid HMO average rate between FY16 and FY21, the network average in hemoglobin A1c (HbA1c) testing in patients rose above the HEDIS benchmark (85%) in FY22 and continued its upward trend in FY23, reaching 90%.

**Figure 2 – Annual Testing for Patients with Diabetes**

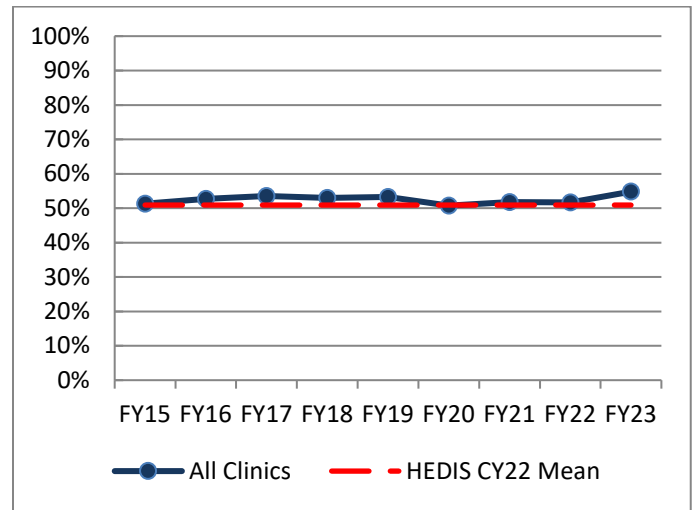


Among patients diagnosed with diabetes, blood sugar control is defined as having HbA1c rates below 8%. HbA1c measures the amount of sugar in an individual’s blood over the course of three months. Rates lower than 8% are known to reduce the complications caused by diabetes. The MCares population includes a greater proportion of patients with diabetes compared to the Medicaid average. Figure 3 illustrates a slight decrease in blood sugar control during the pandemic, which began in FY20. Since the pandemic, the percentage of patients maintaining controlled blood sugar levels has increased from 51% to 55%.

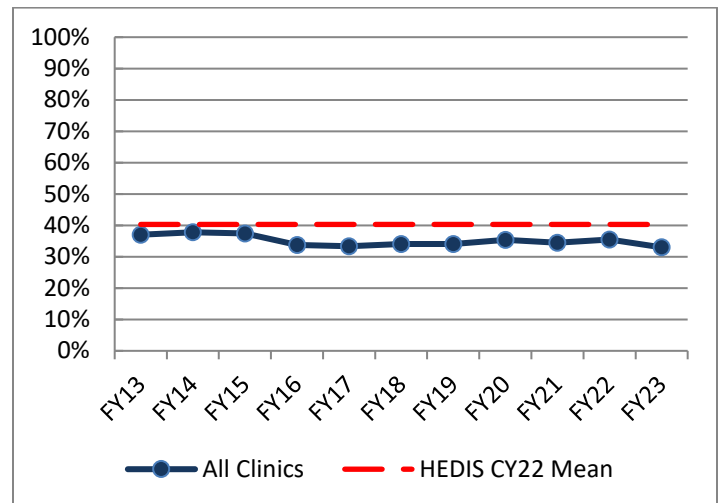
The network’s proportion of patients with uncontrolled blood sugar rates is defined as the proportion of patients with HbA1c test results over 9%. A value over 9% indicates that these patients are at greater risk of complications due to high blood sugar levels. The Montgomery Cares network is surpassing the HEDIS Medicaid HMO average rate of 40% by seven percentage points (a lower

percent is better for this indicator). Our population has an uncontrolled blood sugar rate of 33%. While we are doing better than the Medicaid average, it still means that we can expect that as patients age, a third of our population are at greater risk of complications of diabetes, including kidney disease, vision loss (retinopathy), nerve damage (neuropathy), amputations, gum disease, cancer, heart attack, stroke, impotence among males, and urinary tract infections among females.

**Figure 3 – Blood Sugar Control for Patients with Diabetes**



**Figure 4 – Uncontrolled Blood Sugar Control for Patients with Diabetes**

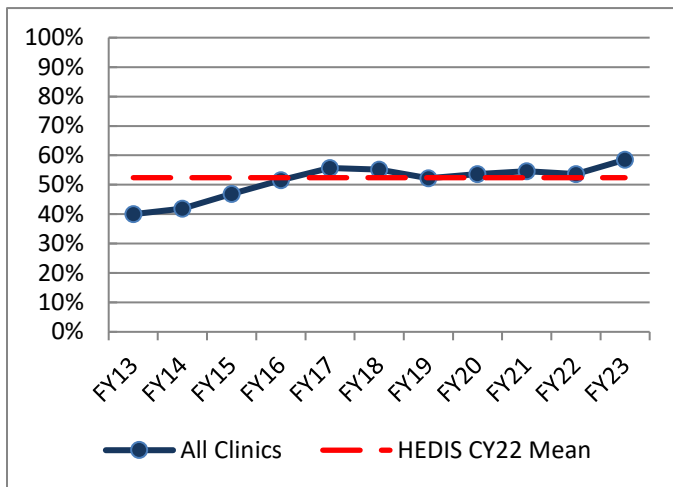




## Cancer Screening

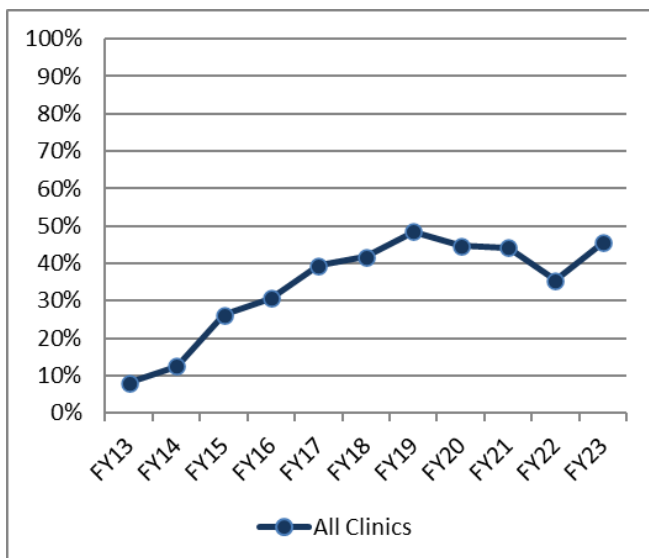
The network made improvements in both breast and colorectal cancer screenings during FY23. Breast cancer screenings (Figure 5) for those aged 50 and over went from 54% in FY22 to 59% in FY23 and outperformed the benchmark of 52%.

**Figure 5 – Breast Cancer Screening Among Females 50+ Years Old**



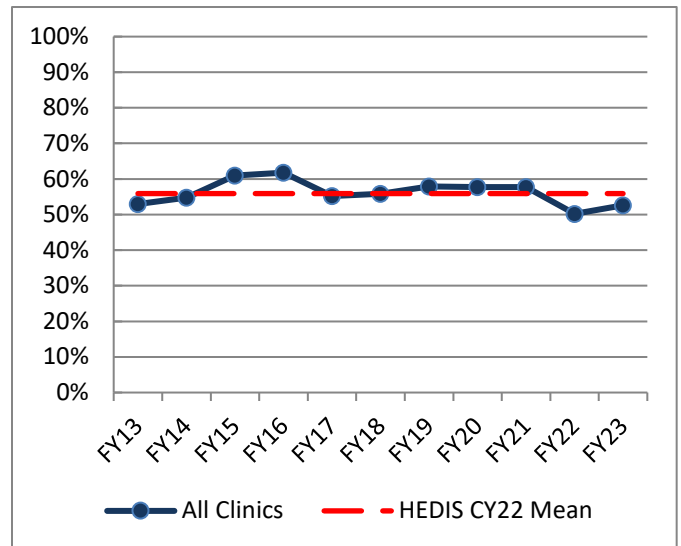
While there are no HEDIS Medicaid HMO averages available for colorectal cancer screening (Figure 6), there was a notable jump in the network average in these tests, rising from 35% to 46% of the targeted population. This FY23 rate marks the highest observed by the network since FY19.

**Figure 6 – Colorectal Cancer Screening**



Cervical cancer screenings (Figure 7), at 53%, remain below the HEDIS benchmark for the second year in a row.

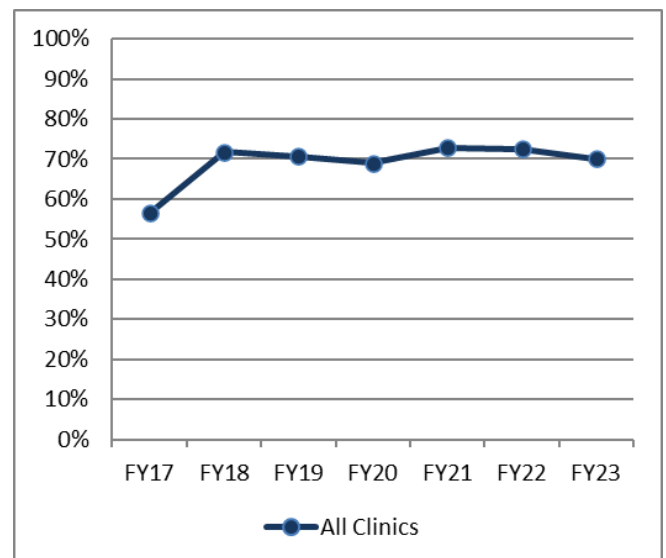
**Figure 7 – Cervical Cancer Screening**



## Depression Screening

In FY23, 70% of MCare patients with primary care visits received a depression screening (Figure 8), a slight dip in performance from the previous two fiscal years.

**Figure 8 – Primary Care Depression Screening**



Indicator trends by race, ethnicity and sex can be found in Appendix A, and below are the noted statistically significant differences between demographic categories for FY23, along with an

identification of categories that did not meet or exceed the HEDIS benchmark.

## Comparison by Race, Ethnicity, and Sex

Given the county's demographics and the mission of MCares, understanding health and service disparities is of great interest to the MCares program. For the purposes of this report, data was analyzed:

- **By racial categories with the largest sample sizes:** White, Black/African American, Asian
- **By ethnicity:** Hispanic/ Latino, Non-Hispanic/Latino
- **By sex:** Male, Female

It should be noted that patients are not required to self-identify for demographic categories. For FY23, 46% of patients declined to report, reported Unknown or reported Other as their Race, and it is typical for a higher proportion of patients to not identify their race (e.g. Black, Asian) compared to 98% of patients who reported their ethnicity (e.g. Latino / non-Latino). Some possible explanations for this may include that someone is of Hispanic/Latino origin and only identifies as such under ethnicity, or a person may otherwise not recognize themselves in the available reporting categories.<sup>5</sup> This should be kept in mind when attempting to draw conclusions from the calculations.

FY23 marks the second year that data from all participating clinics, not just those on a shared PCC-administered electronic health system, were included in the analysis of disparities. Comparisons of a statistical significance (p value of 0.01) are reported. Effect size was not calculated.

### General

The analysis of performance by race, ethnicity, sex relatively reflected overall aggregate results. The

following analyzed categories outperformed HEDIS benchmarks (where one is available): hypertension control, uncontrolled Hemoglobin A1c (HbA1c), and breast cancer screening. Hypertension control also improved by at least five percentage points from FY22 across all race, ethnicity, and sex categories. Colorectal cancer screenings, while still below 50% in each category, similarly improved across all groups following a poorer performance in FY22. Cervical cancer screening remains an area for improvement, with all categories falling below the HEDIS benchmark.

### White Patient Population

The White patient population continues to have the highest rates of uncontrolled diabetes, a trend observed since FY20. In FY23, the White population scored below HEDIS Medicaid HMO measures on HbA1c testing and control. The White population did, however, see an 8 percentage point increase in hypertension control and an 11 percentage point increase in colorectal cancer screening. Despite a noticeable overall decline in performance on the cervical cancer screening measure over the last two years, the White population outperformed the Black/African American population in cervical cancer screening.

### Black/African American Patient Population

Black/African American patients with diabetes showed, on average, higher rates of HbA1c control compared to White patients with diabetes, although below the Asian population in this category. The Black/African American population underperformed both Asian and White patient populations in hypertension control, despite a 5 percentage point improvement over the previous year. The Black/African American population has consistently demonstrated higher rates of colorectal cancer screening since FY18, with this year marking a notable 9 percentage point increase from FY22 and statistically outperforming the Asian patient population. The Black/African American population also saw a 6 percentage point increase in breast cancer screening, and an 11 percentage point improvement in cervical cancer screening from

<sup>5</sup> Kaur, H. (2023). "The Differences Between race and Ethnicity – and Why They Are So Hard to Define." CNN.

<https://www.cnn.com/2023/05/30/us/race-ethnicity-difference-explainer-cec/index.html>

FY22, although with significantly poorer outcomes compared to the White patient population on this measure.

### Asian Patient Population

The Asian patient population performed better in diabetes control compared to both White and Black/African American populations. It also experienced a 6-point percentage increase in hypertension control from FY22 and a statistically higher rate than the Black/African American population on this indicator. The Asian population fell behind the Black/African American population in colorectal cancer screenings and, like all other demographic categories, failed to meet the HEDIS benchmark in cervical cancer screening.

### Hispanic/Latino Patient Population

The Hispanic/Latino patient population saw a 10 percentage point increase in hypertension control

from FY22 and performed better than the non-Hispanic/Latino population in breast and cervical cancer screens (despite remaining below the HEDIS Medicaid HMO average on the latter indicator). It did experience a 6 percentage point decrease in HbA1c testing, bringing it below the HEDIS benchmark for FY23, and statistically outperformed the Black/African American population in cervical cancer screening.

### Sex

Females performed better than males in terms of hypertension control, controlled diabetes, and colorectal cancer screening. Males fell slightly below the HEDIS Medicaid HMO Average in HbA1c testing. Not Available underperformed non-Hispanics/Latinos in uncontrolled diabetes

**Table 3 – Quality Indicators Across Race, Ethnicity, and Sex Categories<sup>6</sup>**

	HEDIS Medicaid HMO Average	All	Race			Ethnicity		Sex		Statistically Significant Findings
			White	Black	Asian	Latino	Non-Latino	Female	Male	
Hypertension Control	59%	68%	70%	66%	73%	69%	68%	70%	65%	<ul style="list-style-type: none"> <li>Asian (73%) and White (70%) have statistically significant higher rates of hypertension control than Black/African American (66%)</li> <li>Female (70%) has statistically significant higher rates of hypertension control than Male (65%)</li> </ul>
HbA1c Testing among patients with Diabetes	85%	90%	83%	86%	87%	84%	86%	85%	84%	<ul style="list-style-type: none"> <li>No statistically significant differences found</li> </ul>
Uncontrolled HbA1c in patients with Diabetes <i>a lower % is preferable</i>	42%	55%	27%	18%	12%	25%	15%	20%	24%	<ul style="list-style-type: none"> <li>Asian (12%) has statistically significant lower rates than Black/African American (18%) and White (27%)</li> <li>Black/African American (18%) has statistically significant lower rates than White (27%)</li> <li>Non-Hispanic/Latino (15%) has statistically significant lower rates than Hispanic/Latino (25%)</li> <li>Female (20%) has statistically significant lower rates than Male (24%)</li> </ul>
Controlled HbA1c in patients with Diabetes	48%	33%	57%	66%	48%	59%	53%	53%	49%	<ul style="list-style-type: none"> <li>Asian (66%) has statistically significant higher rates than Black/African American (57%) and White (45%)</li> <li>Non-Hispanic/Latino (59%) has statistically significant higher rates than Hispanic/Latino (48%)</li> <li>Female (53%) has statistically significant higher rates than Male (49%)</li> </ul>
Breast Cancer Screening Among Women	51%	59%	55%	57%	53%	62%	56%	59%	N/A	<ul style="list-style-type: none"> <li>Hispanic/Latina (62%) have statistically significant higher rates than Non-</li> </ul>

<sup>6</sup> The race/ethnicity/gender analysis does not include depression screening for FY23 but will in FY24.

										Hispanic/Latina (56%) and White (48%) patients
Cervical Cancer Screening Among Women	56%	53%	48%	44%	45%	54%	45%	53%	N/A	<ul style="list-style-type: none"> <li>Hispanic/Latina (54%) has statistically significant higher rates than Non-Hispanic/Latina (45%)</li> <li>Black/African American (44%) has statistically significant lower rates than White (48%)</li> </ul>
Colorectal Cancer Screening	Not available	46%	42%	45%	39%	46%	43%	46%	42%	<ul style="list-style-type: none"> <li>Female (46%) has statistically significant higher rates than Male (42%)</li> </ul>

Note: Averages that meet or exceed the HEDIS Medicaid HMO average are **green**; those that do not are **red**.

## Discussion and Recommendations

We continue to see improvement in MCAres clinics' quality indicators, with increases in many categories since declines observed during the COVID-19 pandemic. The network average was above the HEDIS benchmarks in nearly all categories, including hypertension control, diabetes screening and control, and breast cancer screening. Further, the network has very high screening rates for depression and anxiety. We can attribute these high behavioral health screening rates to the network's primary care model, which integrates behavioral health into the primary care setting. While these improvements indicate improved health in the county's adult population of uninsured residents, there are areas which, if not addressed, will increase the cost of care, reduce the quality of life of our residents, and increase the disease burden on our healthcare system and community. Two areas that emerged as important to watch and address include hypertension control and diabetes control.

With regards to hypertension, 32% of patients with hypertension are at risk of having a heart attack or stroke. Similarly, 33% of our population with diabetes has uncontrolled HbA1c (blood sugar) levels. Uncontrolled diabetes will lead to a myriad of complications, including kidney disease, vision loss (retinopathy), nerve damage (neuropathy), amputations, gum disease, cancer, heart attack, stroke, impotence among males, and urinary tract infections among females. This means that in the

future, as patients with these diseases progress, we can expect them to suffer from complications that will be costly to treat. Greater utilization of specialty care, more emergency department visits, and more hospitalizations will have financial impacts to our county's healthcare system as a whole.

When analyzing by race, ethnicity, sex, all categories outperformed the HEDIS benchmark in hypertension control, uncontrolled diabetes, and breast cancer screening. There were marked improvements in colorectal cancer tests and hypertension control, both generally and across all analyzed demographic groups. Diabetes testing and control in the White population, as well as HbA1c testing in Hispanic/Latino and male populations should be watched for trends over time. Room for improvement remains in relation to cervical cancer testing rates. However, analysis by race and ethnicity, while informative, has some limitations. Patients are not required to self-identify for demographic categories, and it is typical for a higher proportion of patients to not identify their race (e.g. Black, White, Asian) compared to ethnicity (e.g. Latino / non-Latino). Some possible explanations for this may include that someone is of Hispanic/Latino origin and only identifies as such under ethnicity, or a person may otherwise not recognize themselves in the available reporting categories.<sup>7</sup> Further, our dataset does not include documentation for patients who identify as LGBTQI+, making it hard to determine if disparities for this population exist. Greater standardization in

<sup>7</sup> Kaur, H. (2023). "The Differences Between race and Ethnicity – and Why They Are So Hard to Define." CNN. <https://www.cnn.com/2023/05/30/us/race-ethnicity-difference-explainer-cec/index.html>

data capture may enhance our ability to report on healthcare disparities.

The indicators analyzed in this annual report contain relevant impact measures as defined by the Montgomery Cares Quality Health Improvement Committee. These measures are a subset of national HEDIS measures, correlate with improved patient outcomes, and are aligned with conditions highly prevalent in the MCares population and/or that disproportionately affect those served by the network. As there are there are new ways to evaluate quality care and new HEDIS measures are introduced at the national level, it will be important for the MCares QHIC to continually assess and update measures to ensure adequate evaluation of quality care across the network.

# Appendices

## Appendix A: FY23 Providers in the Montgomery Cares Network

During FY23, there were 10 participating health centers in the Montgomery Cares network. Two of the organizations are linguistically focused. Project Salud primarily serves patients who speak Spanish, and the Chinese Culture and Community Center / Pan-Asian Volunteer Health Center (CCACC/PAVHC) was designed to serve patients who primarily speak Chinese (Mandarin or Cantonese). Since its beginning, the CCACC/PAVHC has increasingly served patients who speak Spanish. However, a large proportion of the patient population continues to speak Mandarin.

Five health centers were initiated as health ministries of faith-based organizations. These include Mercy Health Clinic, Mansfield Kaseman Clinic, Holy Cross Health Centers, Catholic Charites Medical Clinic, Muslim Community Center Medical Center.

Lastly, three members of our network are Federally Qualified Health Centers: Mary’s Center, Community Clinic, Inc., and Mobile Medical Care, Inc.

Health Centers Participating in FY23	
Linguistically Focused	<ul style="list-style-type: none"> <li>▫ Chinese Culture and Community Center / Pan-Asian Volunteer Health Center</li> <li>▫ Proyecto Salud</li> </ul>
Faith-Based Origins	<ul style="list-style-type: none"> <li>▫ Mercy Health Clinic</li> <li>▫ Mansfield Kaseman Clinic</li> <li>▫ Holy Cross Health Centers</li> <li>▫ Catholic Charites Medical Clinic</li> <li>▫ Muslim Community Center Medical Center</li> </ul>
Federally Qualified Health Centers	<ul style="list-style-type: none"> <li>▫ Mary’s Center</li> <li>▫ Community Clinic, Inc.</li> <li>▫ Mobile Medical Care, Inc.</li> </ul>

## Appendix B: Race/Ethnicity/Sex Performance by Indicator Over Time

Changes of 5+ percentage points in a positive direction are **green**

Changes of 5+ percentage points in a negative direction are **red**

Categories not meeting or exceeding the HEDIS benchmark in FY23 are **highlighted**

Hypertension Control (HEDIS = 61%)						
	FY18	FY19	FY20	FY21	FY22	FY23
White	67	67	63	60	62	70
Black/African American	62	61	61	62	61	66
Asian	67	67	69	62	67	73
Hispanic/Latino	70	70	65	61	59	69
Non-Hispanic/Latino	64	63	63	65	63	68
Female	67	67	65	65	62	70
Male	63	64	62	57	56	65

Breast Cancer Screening Age 50+ (HEDIS = 52%)						
	FY18	FY19	FY20	FY21	FY22	FY23
White	61	61	60	64	51	55
Black/African American	51	51	50	54	51	57
Asian	45	45	48	47	50	53
Hispanic/Latino	61	61	62	67	59	62
Non-Hispanic/Latino	49	49	49	52	51	56

HbA1c Testing in Patients with Diabetes (HEDIS = 85%)						
	FY18	FY19	FY20	FY21	FY22	FY23
White	86	86	82	90	89	83
Black/African American	82	84	82	85	88	86
Asian	79	79	81	90	86	87
Hispanic/Latino	86	86	83	88	90	84
Non-Hispanic/Latino	82	82	81	87	87	86
Female	83	83	82	88	89	85
Male	85	85	82	87	88	84

Cervical Cancer Screening (HEDIS = 56%)						
	FY18	FY19	FY20	FY21	FY22	FY23
White	65	65	64	66	52	48
Black/African American	32	33	39	43	33	44
Asian	40	40	36	38	41	45
Hispanic/Latino	67	69	45	68	54	54
Non-Hispanic/Latino	34	34	41	43	36	45

HbA1c Control in Patients with Diabetes (HEDIS = 51%)						
	FY18	FY19	FY20	FY21	FY22	FY23
White	55	55	48	56	49	45
Black/African American	56	56	55	60	60	57
Asian	56	57	55	64	63	66
Hispanic/Latino	53	53	48	53	49	48
Non-Hispanic/Latino	56	56	55	60	61	59
Female	59	59	55	60	54	53
Male	49	49	47	52	49	49

Colorectal Cancer Screening (No HEDIS available)						
	FY18	FY19	FY20	FY21	FY22	FY23
White	36	36	40	45	31	42
Black/African American	43	43	46	42	36	45
Asian	35	35	33	37	36	39
Hispanic/Latino	42	42	45	49	37	46
Non-Hispanic/Latino	40	40	41	40	35	43
Female	41	41	44	44	37	46
Male	39	39	41	45	35	42

Uncontrolled HbA1c in Patients with Diabetes (HEDIS = 40%)						
	FY18	FY19	FY20	FY21	FY22	FY23
White	32	32	23	23	27	27
Black/African American	32	32	15	15	15	18
Asian	33	33	14	13	12	12
Hispanic/Latino	34	34	22	22	27	25
Non-Hispanic/Latino	33	33	15	15	14	15
Female	31	31	16	17	22	20
Male	37	37	20	20	26	24