



Fiscal Year

2019

**Montgomery Cares
Clinical Performance
Measures**

Prepared by



primary care coalition

Approved by Quality Health Improvement Committee

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Executive Summary

Fiscal year 2019 marks the 12th year that the Primary Care Coalition has published selected annual measures for the Montgomery Cares (MCares) program. 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 2019, for the first time, PCC commissioned an evaluation of the costs and benefits over an 18-month period (July 1, 2018 through December 31, 2019) related to hypertension management, diabetes management, and cancer screening in the MCares population. Based on the findings of this independent evaluation, there appear to be significant financial and social benefits derived from providing access to high quality services among MCares participants. The evaluations considered screening, diagnosis and treatment costs (including medication costs, visit costs, and estimated subspecialty care). Benefits included projected additional life years, earnings, potential and avoided medical costs from earlier detection and treatment. The evaluation considered County investments, as well as other leveraged services.

- **Hypertension Control:** ROI \$2.20 for every dollar invested. County investment ROI \$4.40
- **Diabetes Control:** ROI \$8.72 for every dollar invested. County investment ROI \$17.44
- **Breast Cancer Screening:** ROI \$27 for every dollar invested, and a projected 530 additional life years among 27 women.
- **Cervical Cancer Screening:** ROI \$10.94 for every dollar invested, and a projected 2,069 additional life years among 74 women.
- **Colorectal Cancer Screening:** ROI \$2.17 for every dollar invested, and a projected 764 additional life years among 46 men and women.

For the third year in a row, this report includes evaluations of disparities by race, gender and ethnicity. Data for this evaluation is limited to the subset of six clinics on PCC's shared electronic medical record. Statistically significant differences at $p \geq .99$ are reported.

Despite statistically significant differences, measures of diabetes and hypertension control exceeded HEDIS Medicaid benchmarks for both males and females, for Black, White and Asian patients, and for Hispanic and non-Hispanic patients. This is a very noteworthy accomplishment. Additionally, some disparities that were present in the MCares population in previous years have been eliminated,

and others show lower p values, as compared to previous years.

- Gender disparities were noted in diabetes control (good and poor control), with females outperforming males.
- Gender disparities in colorectal cancer screening were reduced to $p=.97$ in FY 2019.
- Where ethnic disparities exist, Hispanic/Latino patients outperform not-Hispanic/Latino patients (blood pressure control, diabetes screening, breast and cervical cancer screening), though reliable evaluation is challenging as a result of limited ethnicity information. These findings are unchanged from FY 2018.
- Racial disparities in diabetes control were reported in previous years. But in FY 2019 there were no statistically significant racial disparities noted in diabetes good control or poor control ($p=.55-.66$)
- Racial disparities are apparent in blood pressure control and in diabetes screening.
 - Black and African American patients have poorer blood pressure control than White or Asian patients, though all exceed HEDIS Medicaid targets.
 - Relative to diabetes screening, Asian patients have the lowest screening rates, with statistically significant differences between White and Asian patients.
- Racial disparities persist in program-wide cancer screening rates, though many clinics do not demonstrate disparities within their own clinic population.
 - Black and African American patients continue to demonstrate higher colorectal cancer screening rates than White or Asian patients. No HEDIS Medicaid benchmarks are available.
 - At the same time, cervical cancer screening rates remain lowest among Black and African American women, with statistically significant differences noted in White v Asian, White v Black and Asian v Black. White and Latina women exceeded HEDIS Medicaid benchmarks for cervical cancer screening.
 - Breast cancer screening rates are lowest among Asian women, with statistically significant differences noted in White v Black, White v Asian, and Black v Asian. White and Latina MCares patients exceed

HEDIS Medicaid benchmarks for breast cancer screening.

Chronic Conditions

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

Cancer Screening

- **Cancer Screening rates approach HEDIS benchmarks**
 - Montgomery Cares clinics continue to improve cervical and colorectal cancer screening rates. There was a slight decline in breast cancer screening rates in FY 2019.

Depression Screening

- **Montgomery Cares clinics routinely screen for depression.**
 - In this fourth 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 2019, 92% of active patients received depression screening within the previous twelve months (a small decrease from the record high 95% in FY 2018).

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.

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.

The Montgomery Cares Population FY 2019

59% of the Montgomery Cares patients identified as Latino/Hispanic; 63% identified as female. The Montgomery Cares patient population speaks 33 different languages; 69% report Spanish as their primary language. 58% of Montgomery Cares patients report incomes below the Federal Poverty Level.

In FY 2019, Montgomery Cares served more than 26,000 individuals, providing more than 72,000 primary care encounters. Project Access—the PCC operated specialty care network—provided more than 4,000 specialty care appointments.

Quality

Medical Directors from Montgomery Cares participating clinics meet quarterly to discuss quality-related 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 and support 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 clinical 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. Quarterly and annual

results are produced using data from the PCC shared instance of eCW (electronic medical record used by six participating organizations) and from data provided by Mary's Center, Catholic Charities Medical Clinic, CCI Health & Wellness, 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 2019, 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 are used in order to report and benchmark Montgomery Cares performance against publicly reported measures of care. While recognizing that we do not share identical technical specifications due to differences in enrollment and claims data limitations, HEDIS Medicaid has been selected by PCC and Montgomery Cares Medical Directors 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.

FY 2019 is the third year that PCC conducted evaluations of disparities by race, gender and ethnicity. Data for this evaluation is limited to the subset of six clinics on PCC's shared electronic medical record: Mansfield Kaseman Health Clinic, Mercy Health Clinic, Mobile Medical Care, Inc., Muslim Community Center Clinic, Pan Asian Volunteer Health Center, and Proyecto Salud. Statistically significant differences at $p \geq .99$ are reported.

Despite statistically significant differences, measures of diabetes and hypertension control exceeded HEDIS Medicaid benchmarks for both males and females, for Black, White and Asian patients, and for Hispanic and non-Hispanic patients. This is a noteworthy accomplishment. Additionally, some disparities have been eliminated, and others show lower p values, as compared to previous years.

- Gender disparities were noted in diabetes control (good and poor control), with females outperforming males, though all exceed HEDIS targets.
- Gender disparities in colorectal cancer screening were reduced to $p=.97$ in FY 2019.
- Where ethnic disparities exist, Hispanic/Latino patients outperform non-Hispanic/Latino patients (blood pressure control, diabetes screening, breast and cervical cancer screening), though reliable evaluation is challenging as a result of limited ethnicity information. These findings are unchanged from FY 18.
- Racial disparities in diabetes control were reported in previous years. But in FY 2019 there were no statistically significant differences noted in diabetes good control or poor control ($p=.55-.66$)
- Racial disparities are apparent in blood pressure control and in diabetes screening.
 - Black and African American patients have poorer blood pressure control than White or Asian patients, though all exceed HEDIS Medicaid targets.
 - Relative to diabetes screening, Asian patients have the lowest screening rates, with statistically significant differences between White and Asian patients.
- Racial disparities persist in cancer screening rates
 - Black and African American patients continue to demonstrate higher colorectal cancer screening rates than White or Asian patients. No HEDIS Medicaid benchmarks are available.
 - At the same time, cervical cancer screening rates remain lowest among Black and African American women, with

statistically significant differences noted in White v Asian, White v Black and Asian v Black. White and Latina women exceeded HEDIS Medicaid benchmarks for cervical cancer screening.

- Breast cancer screening rates are lowest among Asian women, with statistically significant differences noted in White v Black, White v Asian, and Black v Asian. White and Latina MCares patients exceed HEDIS Medicaid benchmarks for breast cancer screening.

Cancer Screening

- Most Montgomery Cares clinics continue to participate in cancer screening improvement efforts including state funded grants and a learning collaborative led by PCC.
- Breast and cervical cancer screening rates remain approximately 3 percentage points behind HEDIS Medicaid benchmarks.
- The Montgomery Cares program continues to demonstrate significant improvement in colorectal cancer screening. 48% of MCares patients had documented colorectal cancer screening in FY 2019.
- No HEDIS Medicaid benchmarks are published for colorectal cancer screening.
- Disparities are noted in all three program-wide cancer screenings, though disparities differ by type of cancer, and many clinics do not demonstrate any disparities within their own clinic population.
 - In breast cancer screening, disparities are observed by race (White v Black, White v Asian and Black v Asian), and by ethnicity (Hispanic v Not Hispanic). Only White MCares patients exceed HEDIS Medicaid benchmarks.
 - In cervical cancer screening, disparities are observed by race (White v Black White v Asian and Asian v Black) and by ethnicity (Hispanic v Not Hispanic).
 - Colorectal Cancer screening is the only one of the three cancers in which Black patients screened at highest rates. Disparities are noted by race (Black v White and Black v Asian). Disparities were also noted by gender (Female v Male), but not by ethnicity.

Cancer Screening	Highest Performance	Lowest Performance
Breast	White	Asian
Cervical	White	Black
Colorectal	Black	Asian

Depression Screening

- In this fourth year of reporting, rates of annual depression screening among MCares participants remain high and far exceed the 75% target set when depression screening was initiated. FY 2019 is the second consecutive year in which depression screening rates exceed 90%; this as a result of robust collaborative care models that integrate behavioral health and primary care, and focused attention on quality improvement among the Montgomery Cares Behavioral Health Program. In FY 2019, 92% of active patients received depression screening within the previous twelve months.

Table 2 below summarizes Montgomery Cares' performance in fiscal years 2008-2019, and compares results of the Montgomery Cares system to the most recent HEDIS Medicaid benchmarks where such benchmarks are available. Results in bold meet or exceed HEDIS Medicaid benchmarks in that year.

Table 2: 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	Target: Average Medicaid HMO Performance NCQA "State of Healthcare Quality 2019"
Diabetes: Annual A1c Testing	54%	74%	77%	83%	84%	84%	80%	82%	86%	87%	86%	86%	87.8% (Medicaid HMOs improving while MCares stable below target)
Diabetes: A1c Control (<8)	N/A	N/A	N/A	N/A	N/A	53%	39%	51%	53%	53%	53%	53%	48.7% (Medicaid HMOs slipping while MCares stable/exceeds target)
Diabetes: Poor A1c Control	57%	44%	37%	36%	42%	37%	38%	37%	34%	33%	34%	34%	41.2% (Medicaid HMOs slipping while MCares stable/exceeds target)
Hypertension: BP Control	52%	60%	65%	64%	62%	65%	69%	65%	64%	66%	66%	67%	58.9% (Medicaid HMOs improving; MCares far exceeds target)
Breast Cancer Screening >50 years old	N/A	N/A	29%	32%	33%	40%	42%	47%	51%	56%	55%	52%	58.4 (Medicaid HMOs improving; MCares slipping)
Cervical Cancer Screening	7%	15%	29%	39%	50%	53%	55%	61%	62%	55%	56%	58%	59.3% (Medicaid HMOs stable, MCares improving but slightly below target)
Colorectal Cancer Screening	1%	2%	2%	3%	4%	8%	12%	26%	31%	39%	42%	48%	N/A for Medicaid
Annual Depression Screening	N/A	63%	74%	85%	95%	92%	N/A HEDIS						

Diabetes Poor A1c Control reflects patients with A1c >9 or no annual A1c testing

Condition Specific Results

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 seventh leading cause of death in the U.S.¹

Diabetes is more prevalent in minority populations. In an American Heart Association study of 26 million American adults (data from 2013-2016), 9.8% of American adults had diagnosed diabetes. But there is wide variation by race and ethnicity.²

- 7.3% of non-Hispanic white females
- 9.4% of non-Hispanic white males
- 9.9% of non-Hispanic Asian females
- 12.8% of non-Hispanic Asian males
- 13.4% of non-Hispanic black females
- 14.7% of non-Hispanic black males
- 14.1% of Hispanic females
- 15.1% of Hispanic males

Among the MCares population, nearly 3500 patients (13% of patients seen in FY 2019) had a diagnosis of diabetes.

The American Diabetes Association has called out the disproportionate impact of diabetes among minority populations.³

- **African American community.** Compared to the general population, African Americans are disproportionately affected by diabetes and it is considered one of the most serious health problems that the African American community faces today.
- **Latino and Hispanic community.** Diabetes is an urgent health problem in the Latino community, where diabetes rates are nearly double those of non-Latino whites. Nearly 13% of the Hispanic/Latino population in the U.S. live with diabetes.

Diabetes, especially when unmanaged, can cause serious health complications, including heart disease and stroke, hypertension, kidney failure, lower-extremity amputation, blindness, and premature death. Research shows that every 1% decrease in the A1c level in a diabetes patient can remarkably lower the risk of complications. With each 1 unit reduction in A1c, the risk

of cardiovascular, pedal, ocular, and renal complications reduces by 14%, 43%, 19%, and 37%, respectively.⁴

In addition to medical impacts, diabetes results in significant economic costs. Estimated annual productivity costs per person – including absenteeism, lost productivity while at work (presenteeism) for the employed population, reduced productivity for those not in the labor force, inability to work because of disease-related disability, and lost productivity due to premature deaths attributed to diabetes was \$3,640 in 2017 dollars⁵, which would be \$3,806 in 2019.⁶

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 considered to be in poor control (Note: Lower rates are better for this measure).

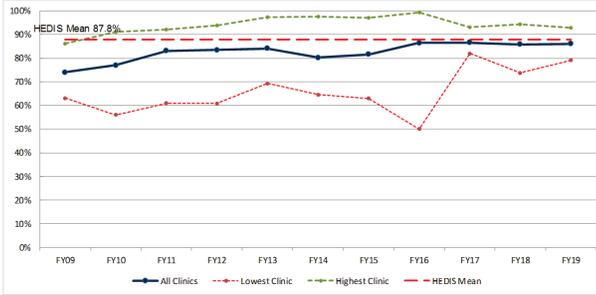
Outcome Measure Definition: BP Control

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

Diabetes Clinical Performance

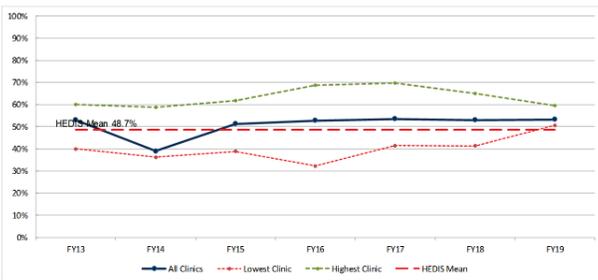
Clinics continue to meet or exceed HEDIS Medicaid benchmarks. A1c control measures exceed HEDIS Medicaid benchmarks by approximately 5 percentage points. Diabetes blood pressure control exceeds HEDIS Medicaid benchmarks by 15 percentage points.

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



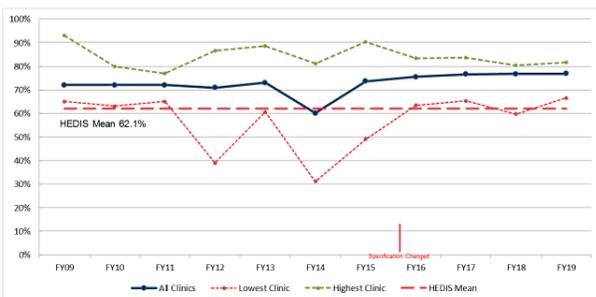
Includes patients who had a Hemoglobin A1c test result < 8. (Data not reported from HCHC clinic)

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, by constriction of arteries or by an increase in the amount of blood pumped by the heart. It increases the risk of heart disease, stroke, heart attack, congestive heart failure and kidney disease.⁷

In 2017, the American College of Cardiology lowered thresholds for the diagnosis of hypertension. Today, 116.4 million, or 46% of US adults are estimated to have hypertension.⁸

In FY 2019, nearly 10,000 (38%) of Montgomery Cares patients had a diagnosis of hypertension. This number has increased significantly (from 6,000 patients), largely due to the 2017 redefinition of hypertension, which lowered the threshold for diagnosis.

Life expectancy for people with hypertension is approximately 5 years shorter than for people with normal blood pressure.⁹

African Americans are at highest risk of hypertension. African Americans develop hypertension at younger ages and are at higher risk of complications. Researchers do not have definitive explanations for these differences, but many believe that both genetic and environmental factors contribute.¹⁰

Managing hypertension improves morbidity and mortality.

A 20-point higher systolic blood pressure or a 10-point higher diastolic blood pressure is associated with *double the risk of death* from a heart attack, stroke, or other cardiovascular complication (like abdominal aortic aneurysm or heart failure).¹¹

In one meta-analysis that included 464,000 people, the authors showed that for a BP reduction of 10 mmHg systolic or 5 mmHg diastolic, there was a 22% reduction in coronary heart disease events and a 41% reduction in stroke.¹²

Hypertension carries an economic burden, as well. The adjusted incremental medical expenditure for individuals with hypertension is estimated to be \$1,920 (95% CI, \$1724–\$2117), as compared with individuals without hypertension in a given year.¹³ The incremental annual medical costs of hypertension per patient is \$2,049 when inflated to 2019 dollars.¹⁴

According to a 2011 study entitled, “Measuring Health-Related Productivity Loss,¹⁵ the annual productivity cost

per person (including both absenteeism and presenteeism) with hypertension was \$230 in 2008 dollars, which would be \$269 in 2019¹⁶

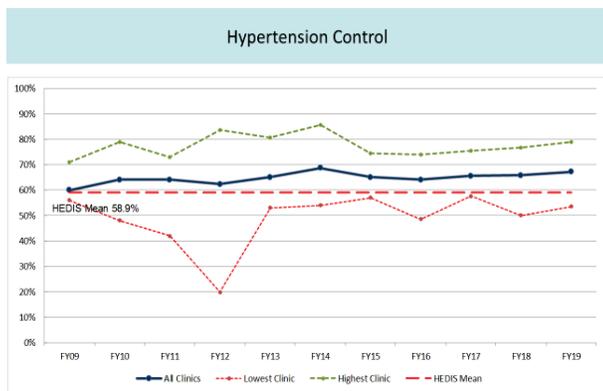
Measure Definition: Hypertension BP Control

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

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 exceeds HEDIS benchmarks for White, Black and Asian patients, as well as for males, females, Hispanics and non-Hispanics.



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 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. 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.¹⁷

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 screenings. Latina patients obtained breast and cervical cancer screenings at higher rates than non Latina patients. Colorectal cancer screening was higher among females than males.

Breast Cancer

Other than skin cancers, breast cancer is the most common cancer in women regardless of race or ethnicity. It is the most common cause of death from cancer among Hispanic women, and the second most common cause of death from cancer among White, Black, Asian/Pacific Islander, and American Indian/Alaska Native women.¹⁸

Measure Definition: Breast Cancer Screening

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

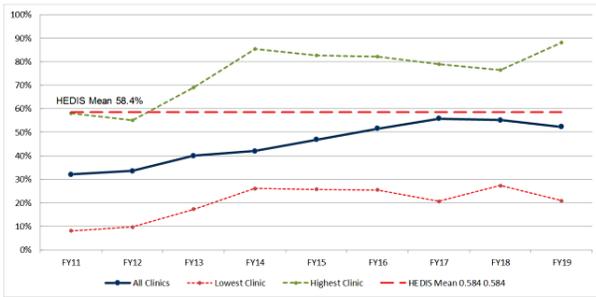
Breast Cancer Screening Clinical Performance

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

Significant differences in breast cancer screening were noted by race. White women had the highest screening rates; Asian women the lowest breast cancer screening rates. The rate of screening among white women (60%) exceeds HEDIS Medicaid target of 58.4%, but screening rates in Black and Asian women are 51.3% and 44.7% respectively.

Approximately 8.37% of MCares mammograms are found to have potential abnormalities; a finding that is in keeping with a Cleveland Clinic report¹⁹ that reported potential abnormalities in 6 to 8 percent of screening mammograms.

Breast Cancer Screening (Age 50-74)



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

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 screening detects cancerous and pre-cancerous cells. Cervical cancer is the easiest gynecologic cancer to prevent with regular screening tests and follow-up. It also is highly curable when found and treated early.

The human papillomavirus (HPV) is the main cause of cervical cancer. HPV is a common sexually transmitted virus. HPV vaccination protects against the types of HPV that most often cause cervical, vaginal, and vulvar cancers.

In the United States, Hispanic women are most likely to get cervical cancer, followed by African-Americans, American Indians and Alaskan natives, and whites. Asians and Pacific Islanders have the lowest risk of cervical cancer in this country.²⁰

Most cervical precancers develop slowly, so cancer can usually be prevented if a woman is screened regularly. Cervical cancer incidence rates declined by more than half between 1975 and 2015 largely due to the widespread uptake of screening with the Pap test. However, declines have slowed in recent years, especially among women younger than age 50, and overall incidence from 2006 to 2015 was stable.²¹

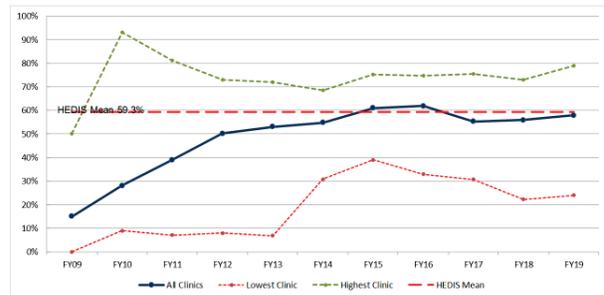
Cervical Cancer Screening Clinical Performance

The MCares program has significantly improved cervical cancer screening rates

PCC reports highest cervical cancer screening among White women, and lowest among Black women. Cervical cancer screening rates among white women (65%) exceed HEDIS Medicaid benchmarks (59.3%), but cervical cancer screening among Asian (39.8%) and Black women (32.9%) are far below benchmarks.

The rate of abnormal results found among Montgomery Cares' patients of 10.3% is about double the rate that is prevalent in the United States.²² This likely reflects the MCares population as compared to U.S. population

Cervical Cancer Screening (Last reported HEDIS Medicaid benchmark for calendar year 2015)



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)

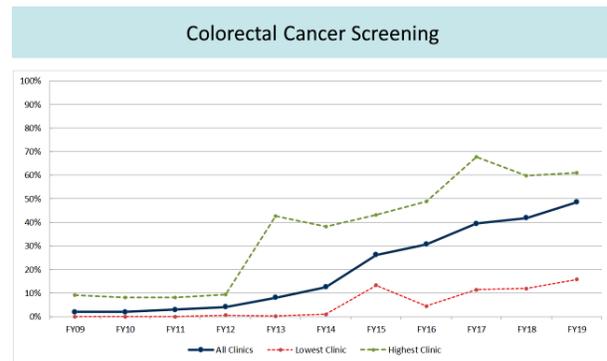
Colorectal Cancer

Of cancers affecting both men and women, colorectal cancer (cancer of the colon and rectum) is the third most common cancer in men and women, and the second leading cancer killer of men and women combined in the United States,²³ but it doesn't have to be. Screening can find precancerous polyps—abnormal growths in the colon or rectum—so they can be removed before turning

into cancer. Screening also helps find colorectal cancer at an early stage, when treatment often leads to a cure.

In the United States, disparities in incidence and mortality in colorectal cancer continue to persist between African Americans and non-Hispanic Whites, despite the provision of widespread screening and improved treatments for colorectal cancer.²⁴

Colorectal cancer incidence has been declining for several decades due to changes in risk factor exposures and the uptake of screening. However, the overall trend is driven by older adults (who have the highest rates) and masks increasing incidence in younger age groups. From 2006 to 2015, incidence rates declined by 3.7% annually among adults 55 years of age and older, but increased by 1.8% annually among those younger than age 55.²⁶



 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)

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.)

Colorectal Cancer Screening Clinical Performance

Montgomery Cares participating clinics continue to improve colorectal cancer screening rates and have experienced significant improvements year after year. Relevant HEDIS Medicaid benchmarks are not available for comparison.

MCares reported statistically significant differences in colorectal cancer screening rates among Black v White and Black v Asian patients. In FY 2019, MCares Black/African American patients had the highest reported screening rate (42.9%); significantly higher than White (36.2%) or Asian (35.2%).

The reported rate of abnormal results found among PCC's patients (4.1%) is a little more than half the expected rate of 7% to 8% that has been generally found in large studies.²⁵ This may be due to the fact that patients at higher than normal risk are referred to a state funded program for screening colonoscopy, and positive findings may not be documented in such a way as to pick them up in the clinical measures.

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

Hypertension Control FY 2019 HEDIS Medicaid Mean = 58.9%

White v Black
Asian v Black
Hispanic v Non-Hispanic

Sum of Total_Patients				vs white	vs black	vs asian
Hypertension Control	Denominator	Numerator	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	20	13	65.00%			
Asian	584	392	67.12%	0.53	0.99	
Black or African American	1433	880	61.41%	0.99		0.99
Native Hawaiian or Other Pacific Islander	8	3	37.50%			
Other Race	1197	836	69.84%			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	145	96	66.21%			
White	527	355	67.36%		0.99	0.53379441
All Races	3914	2575	65.79%			

Sum of Total Patients				
Hypertension Control	Denominator	Numerator	Percentage	vs hispanic
Hispanic or Latino	1573	1093	69.49%	0.99
Not Hispanic or Latino	2295	1454	63.36%	
Refused to Report	46	28	60.87%	
Unknown	0	0	#DIV/0!	
All Ethnicities	3914	2575	65.79%	

Sum of Total Patients				
Hypertension Control	Denominator	Numerator	Percentage	vs male
female	2515	1684	66.96%	0.98004379
male	1399	891	63.69%	
Unknown	0	0	#DIV/0!	
All Gender	3914	2575	65.79%	

Diabetes Screening FY 19 HEDIS Medicaid Mean =87.8%

**White v Asian
Hispanic v non-Hispanic**

Sum of Total Patients				vs white	vs black	vs asian
	Denominator	Numerator	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	14	13	92.86%			
Asian	458	361	78.82%	0.99	0.98361148	
Black or African American	865	724	83.70%	0.85801171		0.98361148
Native Hawaiian or Other Pacific Islander	9	7	77.78%			
Other Race	822	704	85.64%			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	116	96	82.76%			
White	325	280	86.15%		0.85801171	0.99
All Races	2609	2185	83.75%			

Sum of Total Patients	D002	D003	Percentage	vs hispanic
Hispanic or Latino	1061	917	86.43%	0.99
Not Hispanic or Latino	1514	1240	81.90%	
Refused to Report	34	28	82.35%	
Unknown	0	0	#DIV/0!	
All Ethnicities	2609	2185	83.75%	

Sum of Total Patients	D002	D003	Percentage	vs male
Female	1528	1267	82.92%	0.9159152
Male	1081	918	84.92%	
Unknown	0	0	#DIV/0!	
All Gender	2609	2185	83.75%	

Diabetes A1c Control <8 FY 19 HEDIS Medicaid Mean = 48.7%

Female v Male

	D002	D006	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	14	7	50.00%			
Asian	458	259	56.55%	0.6587182	0.55071424	
Black or African American	865	486	56.18%	0.63405837		0.55071424
Native Hawaiian or Other Pacific Islander	9	5	55.56%			
Other Race	822	426	51.82%			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	116	60	51.72%			
White	325	179	55.08%		0.63405837	0.6587182
All Races	2609	1422	54.50%			

Sum of Total Patients				
	D002	D006	Percentage	vs hispanic
Hispanic or Latino	1061	565	53.25%	0.86829752
Not Hispanic or Latino	1514	840	55.48%	
Refused to Report	34	17	50.00%	
Unknown	0	0	#DIV/0!	
All Ethnicities	2609	1422	54.50%	

Sum of Total Patients				
	D002	D006	Percentage	vs male
Female	1528	895	58.57%	0.99999967
Male	1081	527	48.75%	
Unknown	0	0	#DIV/0!	
All Gender	2609	1422	54.50%	

Diabetes Poor Control A1c >9 (or no test) FY 19 HEDIS Medicaid Mean =41.2% (lower is better on A1c>9)

Female v Male

	D002	D005	Percentage	vs white p-value	vs black pvalue	vs asian pvalue
American Indian or Alaska Native	14	6	42.86%			
Asian	458	149	32.53%	0.56244992	0.52398701	
Black or African American	865	280	32.37%	0.54846846		0.52398701
Native Hawaiian or Other Pacific Islander	9	4	44.44%			
Other Race	822	282	34.31%			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	116	47	40.52%			
White	325	104	32.00%		0.54846846	0.56244992
All Races	2609	872	33.42%			

Sum of Total Patients				
	D002	D005	Percentage	vs hispanic
Hispanic or Latino	1061	357	33.65%	0.61584705
Not Hispanic or Latino	1514	501	33.09%	
Refused to Report	34	14	41.18%	
Unknown	0	0	#DIV/0!	
All Ethnicities	2609	872	33.42%	

Sum of Total Patients				
	D002	D005	Percentage	vs male
Female	1528	475	31.09%	0.99861465
Male	1081	397	36.73%	
Unknown	0	0	#DIV/0!	
All Gender	2609	872	33.42%	

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

White v Black

White v Asian

Black v Asian

Hispanic v non-Hispanic

Sum of Total Patients				vs white	vs black	vs asian
	C32	C33	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	14	10	71.43%			
Asian	553	247	44.67%	0.99	0.99	
Black or African American	1631	837	51.32%	0.99		0.99
Native Hawaiian or Other Pacific Islander	8	4	50.00%			
Other Race	1019	605	59.37%			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	203	87	42.86%			
White	461	279	60.52%		0.99	0.99
All Races	3889	2069	53.20%			

Sum of Total Patients				
	C32	C33	Percentage	vs hispanic
Hispanic or Latino	1358	833	61.34%	1
Not Hispanic or Latino	2491	1219	48.94%	
Refused to Report	40	17	42.50%	
Unknown	0	0	#DIV/0!	
All Ethnicities	3889	2069	53.20%	

Cervical Cancer Screening (Female 24-64yo) FY 19 HEDIS Medicaid Mean = 59.3%

White v Asian
 White v Black
 Asian v Black
 Hispanic v non-Hispanic

Sum of Total Patients				vs white	vs black	vs asian
	C34	C35	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	24	11	45.83%			
Asian	625	249	39.84%	1	0.99	
Black or African American	1746	575	32.93%	1		0.99
Native Hawaiian or Other Pacific Islander	11	4	36.36%			
Other Race	3112	2109	67.77%			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	315	114	36.19%			
White	1274	829	65.07%		1	1
All Races	7107	3891	54.75%			

Sum of Total Patients				
	C34	C35	Percentage	vs hispanic
Hispanic or Latino	4209	2889	68.64%	1
Not Hispanic or Latino	2837	964	33.98%	
Refused to Report	61	38	62.30%	
Unknown	0	0	#DIV/0!	
All Ethnicities	7107	3891	54.75%	

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

**Black v White
Black v Asian**

Sum of Total Patients				vs white	vs black	vs asian
	C38	C39	Percentage	p-value	pvalue	pvalue
American Indian or Alaska Native	25	10	40.00%			
Asian	928	327	35.24%	0.66401781	0.99997385	
Black or African American	2175	933	42.90%	0.99935867		0.99997385
Native Hawaiian or Other Pacific Islander	12	2	16.67%			
Other Race	1488	625	42.00%			
Unknown	0	0	#DIV/0!			
Unreported/Refused to Report	266	115	43.23%			
White	734	266	36.24%		0.99935867	0.66401781
All Races	5628	2278	40.48%			

Sum of Total Patients				
	C38	C39	Percentage	vs hispanic
Hispanic or Latino	1986	831	41.84%	0.92336381
Not Hispanic or Latino	3581	1428	39.88%	
Refused to Report	61	19	31.15%	
Unknown	0	0	#DIV/0!	
All Ethnicities	5628	2278	40.48%	

Sum of Total Patients				
	C38	C39	Percentage	vs male
female	3744	1548	41.35%	0.97005954
male	1884	730	38.75%	
Unknown	0	0	#DIV/0!	
All Gender	5628	2278	40.48%	

Appendix II: Annual Clinical Quality Measures (Measure Definition)

Primary Care Coalition of Montgomery County

Measure Name	Denominator	Numerator
CHRONIC CONDITION MANAGEMENT		
<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 whose 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 whose 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

WELLNESS AND PREVENTIVE CARE	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 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"> • Adults 18–59 years of age whose blood pressure was <140/90 mm Hg. • 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.
	Cancer Screening		
	Breast Cancer Screening 40years	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 50years	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.	Of the denominator patients : <ul style="list-style-type: none"> • 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. • Women 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.
	Colorectal Cancer Screening	Men and women ages 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.	Denominator patients who received one of the following tests: <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 HEALTH

<p>Primary Care Visit Depression Screening</p>	<p>Completed primary care visit (PCV) encounters during the measurement period.</p>	<p>Denominator encounters with a documented PHQ-9 or PHQ-2.</p>
<p>Active Patient Depression Screening</p>	<p>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.</p>	<p>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.</p>
<p>Behavioral Health Follow Up After Positive Depression Screen</p>	<p>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.</p> <p><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).</p>	<p>Denominator patients who receive any BH visit (excluding phone visits) within two months of the positive PHQ screen.</p>
<p>Depression Symptom Reduction</p> <p>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)</p>	<p>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.</p> <p>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></p> <p>AND at least one additional PHQ9 score at any type of visit before the end of the measurement period.</p>	<p>Denominator patients whose:</p> <p>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>.</p> <p>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>.</p>

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