



MEMORANDUM

TO: Shelly Espinosa, UHF

FROM: Peter Shin, Tishra Beeson, and Sara Rosenbaum, GWU

RE: UHF Centers of Excellence: Quality of Care and Patient Satisfaction

DATE: April 18, 2011

This memo summarizes CY2010 year-end results from the ongoing United Health Foundation Centers of Excellence health center grantee reporting project, which was initiated in December 2005. The memo presents semi-annual trends for four grantees—Washington, D.C., New Orleans, New York and Miami—regarding the core clinical care measures for cervical cancer screening, comprehensive diabetes care, asthma pharmacologic therapy, tobacco use screening and cessation counseling, and prenatal HIV screening. Selected patient satisfaction data is also included. Where possible, the national average rates for Medicaid HMO patients are included for comparison.

In keeping with efforts to improve the quality of the care provided by health centers, the grantees agreed to add higher standards for the diabetes measures, including a stricter blood pressure control standard of less than 130/80 mm Hg (in addition to the previous benchmark for controlled blood pressure of less than 140/90 mm Hg; both are permitted under general AQA reporting definitions). In addition, as of June 2008, grantees began collecting data on the percent of diabetic patients with cholesterol levels, or LDL-C, less than 100 mg/dL; and blood glucose levels, or HbA1c, less than seven percent. The grantees also recently agreed to add a moderate HbA1c control measure of between seven and nine percent.

Consistent with previous updates, the four grantees selected by UHF as centers of excellence continue to report strong performance on clinical quality measures and patient satisfaction measures, especially when compared to available national Medicaid average rates. Centers of excellence perform particularly well for cervical cancer screening; blood pressure, cholesterol and hemoglobin monitoring and control in diabetic patients; pharmacologic therapy for patients with persistent asthma; advice to quit smoking; and prenatal HIV screening.

In terms of patient satisfaction, the grantees report moderate levels of satisfaction across most measures, indicating there is still room for improvement in all measures, particularly whether calls are answered on the same day.

We note for purposes of record that the UHF award was transferred directly to Daughters of Charity as an official center of excellence grantee mid-year 2010. We also note that the New York grantee¹ converted to EMR in 2010; D.C. went live in 2009.

Quality Improvement Trends

There is considerable variability between centers in their progress towards quality improvement, but generally, process and clinical measures rates are improving or holding steady above the national average. The most recent report reflects various measurement periods through December 2010 as specified by the National Committee for Quality Assurance (NCQA) and the AQA.

Starting in 2008, HRSA began reporting select quality measures on cervical cancer screening, hypertension, and diabetes. Although, all four measures are based on NCQA definitions, some variation exists in data collection (i.e., HRSA requires minimum of 70 chart reviews while UHF requires closer to 100% of eligible records but may fall below 70 records due to smaller number of patients), definitions (i.e., UHF grantees defined patients as having >1 visit if the measurement period extends beyond one year) and measurement of hypertension (i.e., the hypertension measure of the UHF grantees were modified to focus on patients with diabetes while NCQA includes nearly all adult patients). The following table shows the reported measures for 2009 for UHF grantees and HRSA grantees in the corresponding states (with the exception of hypertension, the percentages in bold indicate where UHF grantees meet or exceed other HRSA grantees quality in the state:

	Cervical Cancer		Hypertension (140/90)		Diabetes ≤ 9		Diabetes < 7	
	UHF	HRSA	UHF	HRSA	UHF	HRSA	UHF	HRSA
DC	82%	87%	62%	51%	74%	76%	41%	39%
FL	78%	53%	61%	57%	67%	62%	30%	34%
LA	85%	47%	59%	62%	71%	59%	29%	31%
NY	91%	61%	71%	67%	78%	73%	38%	42%

Source: HRSA estimates from 2009 UDS data, HRSA.gov

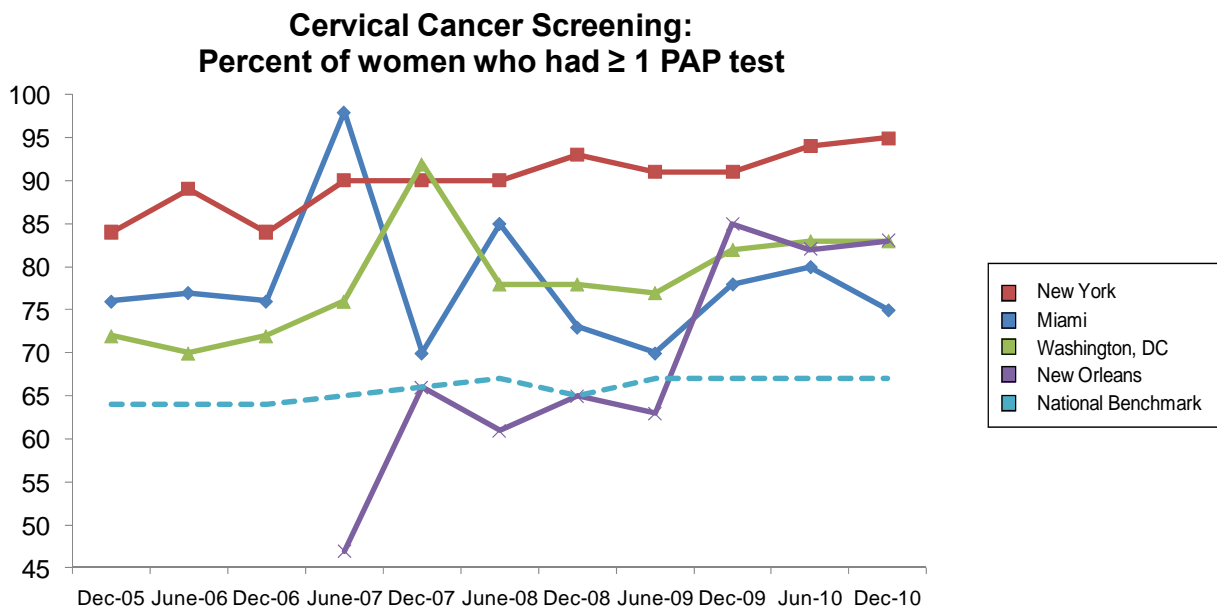
Notes: The hypertension measure differs significantly; UHF grantees chose to apply this measure to only patients with diabetes -- they considered it to be more meaningful to them in providing a better picture of their own quality, especially with a limited number of measures being reported.

¹ In addition, its homeless program received NCQA PCMH level III recognition.

Clinical Care

Cervical Cancer Screening

All four grantees continue to exceed the national average for cervical cancer screening, as shown in Figure 1. Collectively, the centers provided a pap test for approximately 84% of their female patients, compared with the national average of 67%. On the whole, grantees improved their score by 10% over the last 18 months, with New Orleans nearly doubling the rate of testing from 47% in June 2007 to 83% in December 2010. The other three grantees have exceeded the national Medicaid average since the project's inception in December 2005.



Source: National Data obtained from Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios

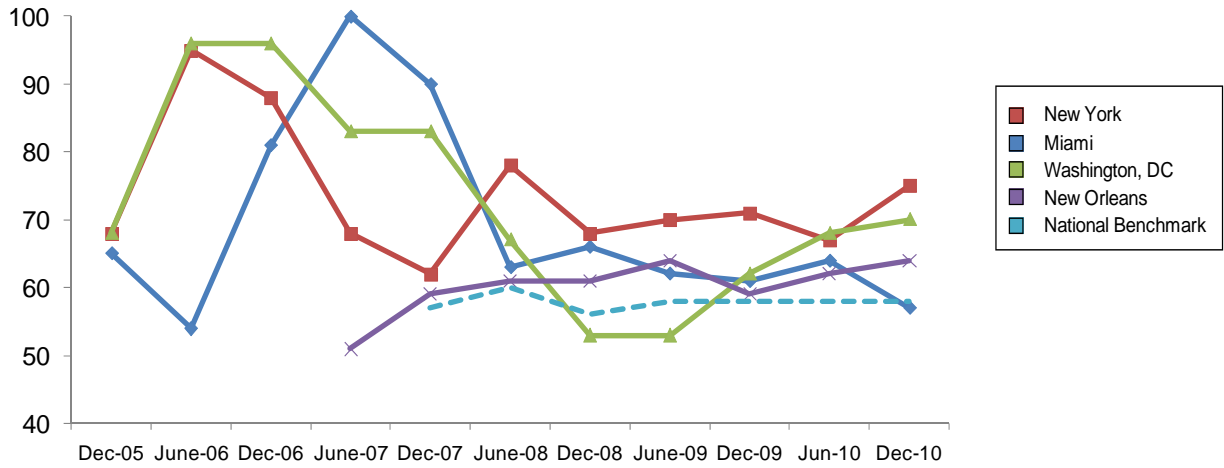
Figure 1

Comprehensive Diabetes Care

Figure 2 shows that all but one of the grantees have exceeded the national average of 58% of diabetic patients with blood pressure less than the critical level of 140/90 mm Hg since December 2009. For the December 2010 reporting period, Miami was the only site that did not improve on this measure and whose performance fell just below the national average, at 57%. D.C. and New Orleans reported improvements of 2 percentage points each, while New York improved by 12 percentage points during the reporting period.

In June 2008, a second, more rigorous, quality standard for blood pressure control (130/80 mm Hg) was instituted by consensus. As with the above blood pressure measure, Miami's most recent percentage (29%) of patients with blood pressure less than 130/80 mm Hg fell just short of the national average of 30%. New York and New Orleans showed slight improvements while D.C.'s percentage decreased from a high of 45% in June 2010 to 42% in December 2010 (Figure 3).

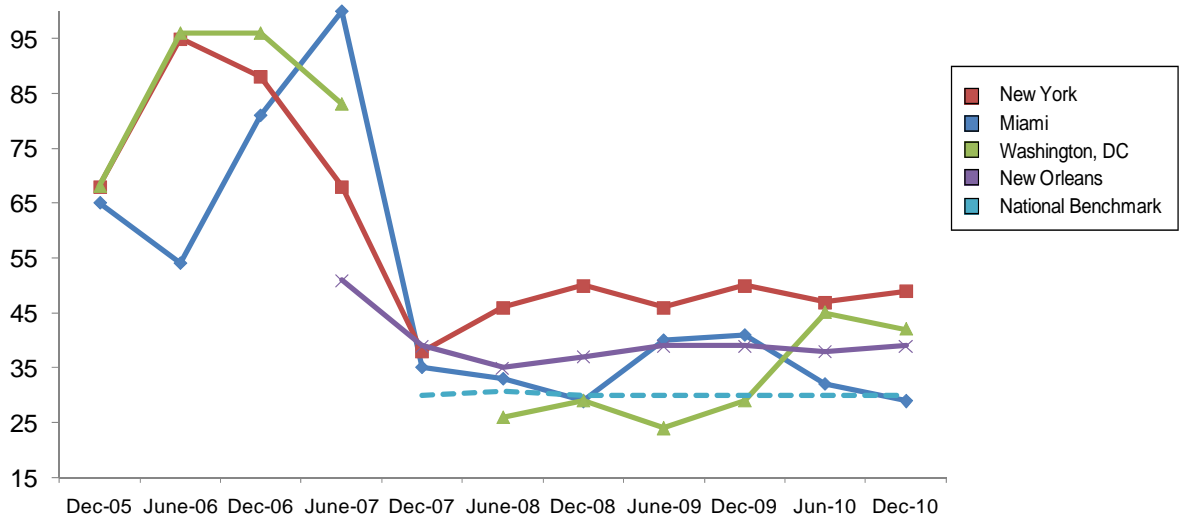
**Diabetes Chart Reviews:
 Percent of patients with blood pressure
 < 140/90 mm Hg**



Source: National data obtained from Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios

Figure 2

**Diabetes Chart Reviews:
 Percent of patients with blood pressure
 < 130/80 mm Hg**



Source: National Data obtained from Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios

Figure 3

All four health centers exceeded the national average of the percent of patients with diabetes that received at least one LDL-C (cholesterol) test over the past year (see Figure 4). The D.C. and New York sites demonstrated increases of 3 and 7 percentage points, respectively during the December 2010 reporting period. While the sites in Miami and New Orleans both showed minimal decreases, they remain well above the national benchmark for this measure.

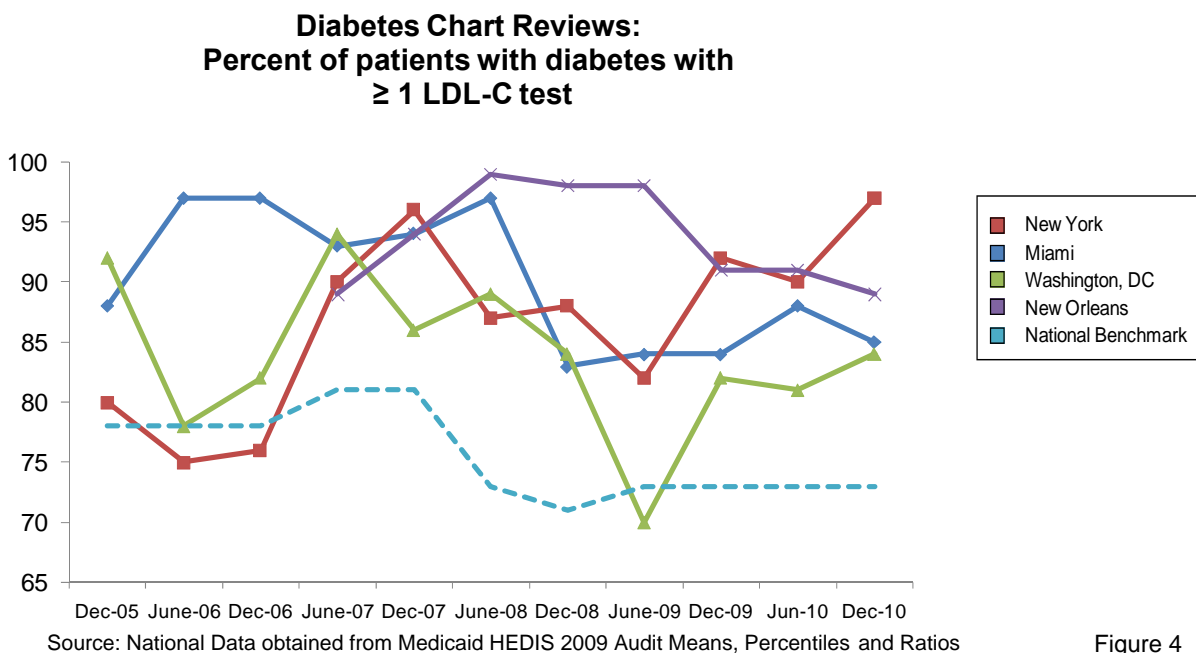


Figure 4

At all four sites, the percent of patients with diabetes whose cholesterol level is under control (defined as less than 130 mg/dL), exceeded the national average of 51% (see Figure 5). The grantees' percentages have shown little change over the past year. Taken as an average across all four sites, 77% of the reporting health centers' patients with diabetes displayed controlled cholesterol levels in December 2010.

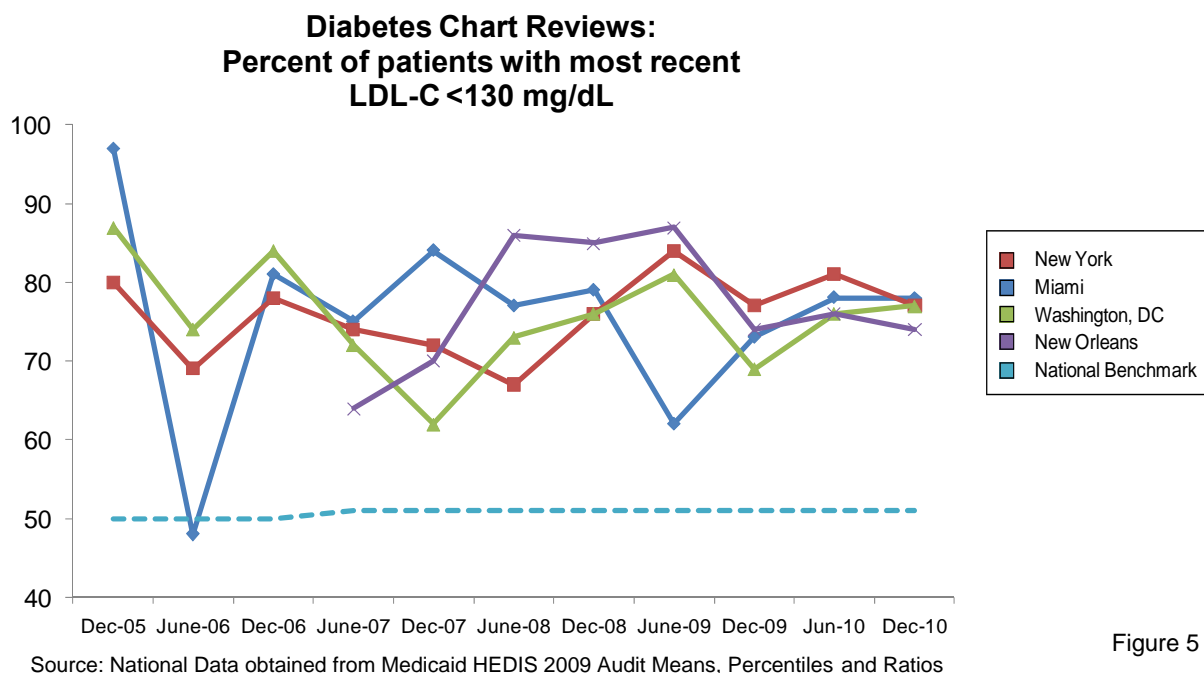
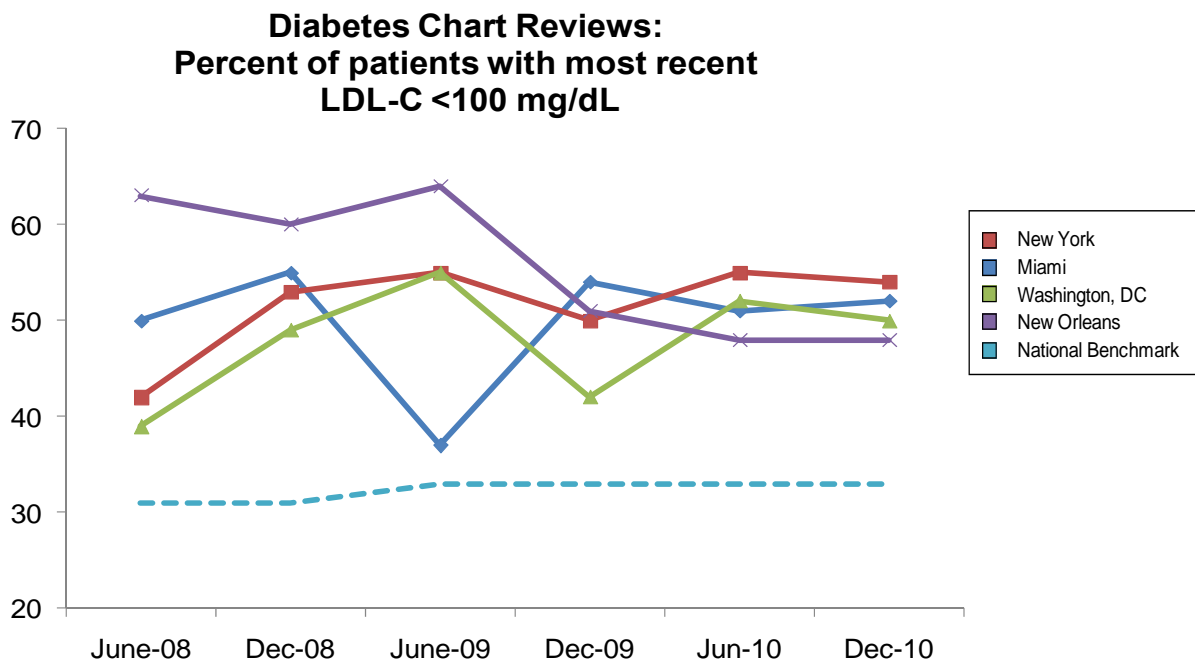


Figure 5

UHF grantees recently developed a more stringent cholesterol measure, using a standardized collection instrument. With approval from grantee sites, this new measure of the percent of patients with diabetes whose LDL-C is less than 100 mg/dL was implemented in 2008. Similar to the above cholesterol measure for patients with diabetes, the four health center grantee sites exceed the national average for the more rigid measure of LDL-C less than 100 mg/dL. Figure 6 shows that all four sites' percentages have remained stable over the past year and were at least 15 percentage points above the national average of 33%.

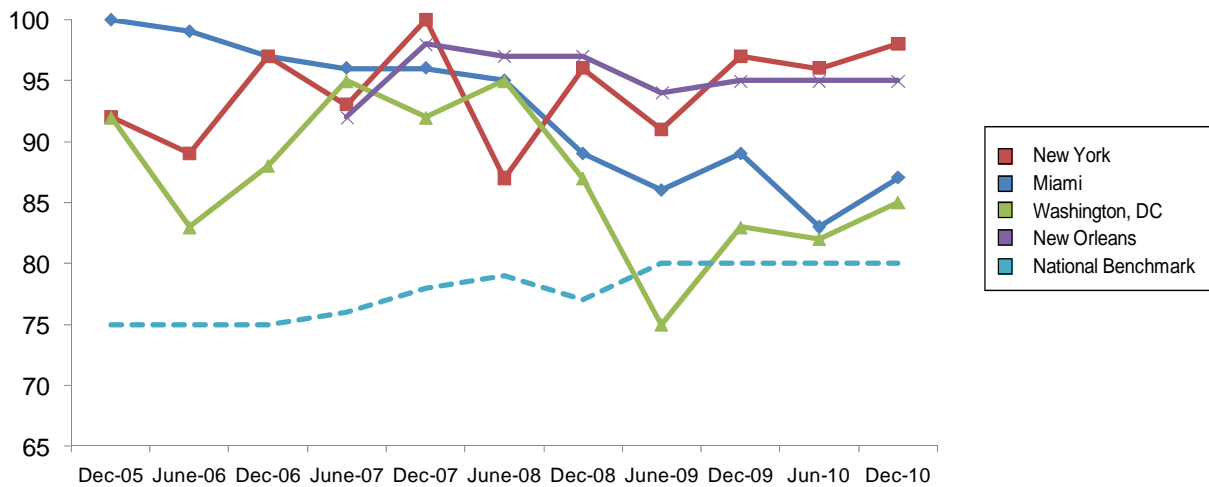


Source: National Data obtained from Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios

Figure 6

Since December 2009, all four health centers have exceeded the national average for the percent of patients with diabetes receiving at least one HbA1c test (which detects the level of glycated hemoglobin in the blood) over the past year. From June 2010 to December 2010, New Orleans maintained a stable level of 95% of patients with diabetes receiving at least one HbA1c test, while sites in the District of Columbia and Miami showed improvements of 3 and 4 percentage points, respectively (see Figure 7). As of December 2010 the grantee in New York ensured that nearly all (98%) of their patients with diabetes received an HbA1c test in the last year. Taken as an average across the four health centers, 91% of patients with diabetes had an HbA1c test in the past year, an average that is 14% higher than the national mean for HbA1c testing.

**Diabetes Chart Reviews:
 Percent of patients with diabetes with
 ≥ 1 HbA1c test**

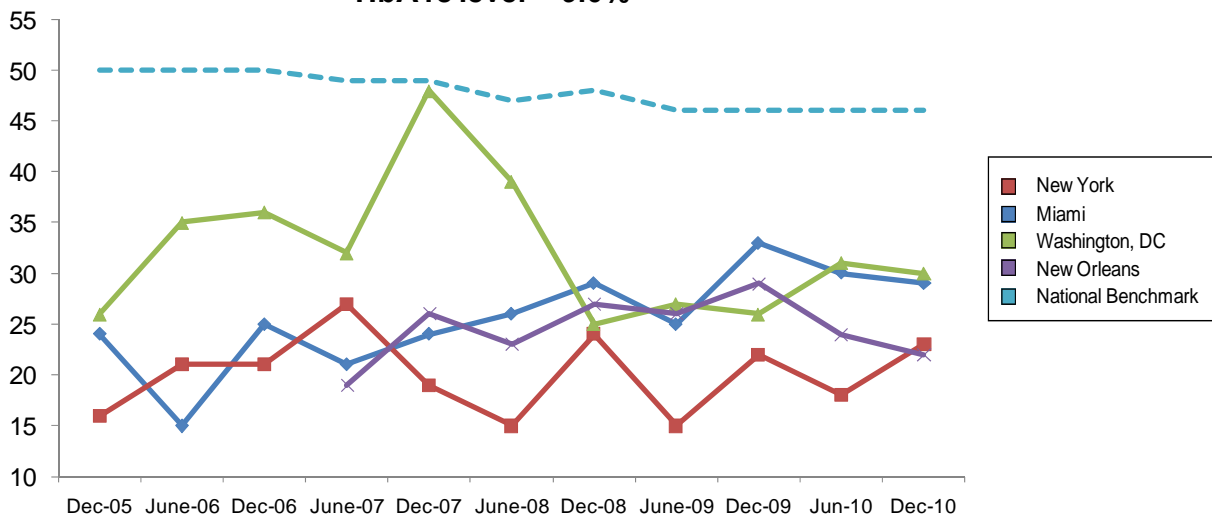


Source: National Data obtained from Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios

Figure 7

HbA1c testing is a measure both of the quality of diabetes control that patients receive from health centers and of diabetes control. Diabetes control is categorized as poor control (HbA1c levels > 9%, see Figure 8), moderate control (HbA1c levels between 7% and 9%; see Figure 9), and good or desired control (HbA1c levels < 7%; see Figure 10).

**Diabetes Chart Reviews:
 Percent of patients with most recent
 HbA1c level > 9.0%**



Source: National Data obtained from Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios

Figure 8

Following a 4-year period of fluctuation, the past year has seen more stable percentages of poor diabetes control at the grantee centers. Compared to the national average of 46% of patients who have poor diabetes control, the health center grantees have much lower percentages, ranging from 22% to 30% in December 2010. During this reporting period, Miami, D.C., and New Orleans demonstrated improvements in the measure of diabetes patients with poor control. Only New York had a slight increase in the percent of diabetic patients with poor control from, but remains well below that of the national average (46%) of patients with poor blood HbA1c control.

In 2008, the Health Resources and Services Administration (HRSA) established new reporting requirements for diabetic patients at health centers that led GW, with grantee approval, to institute the moderate control category in order to provide additional data to better assess care quality. Although there is no national average for comparison, Figure 9 displays the health centers' percentage of diabetic patients with moderate control over the past two and a half years.

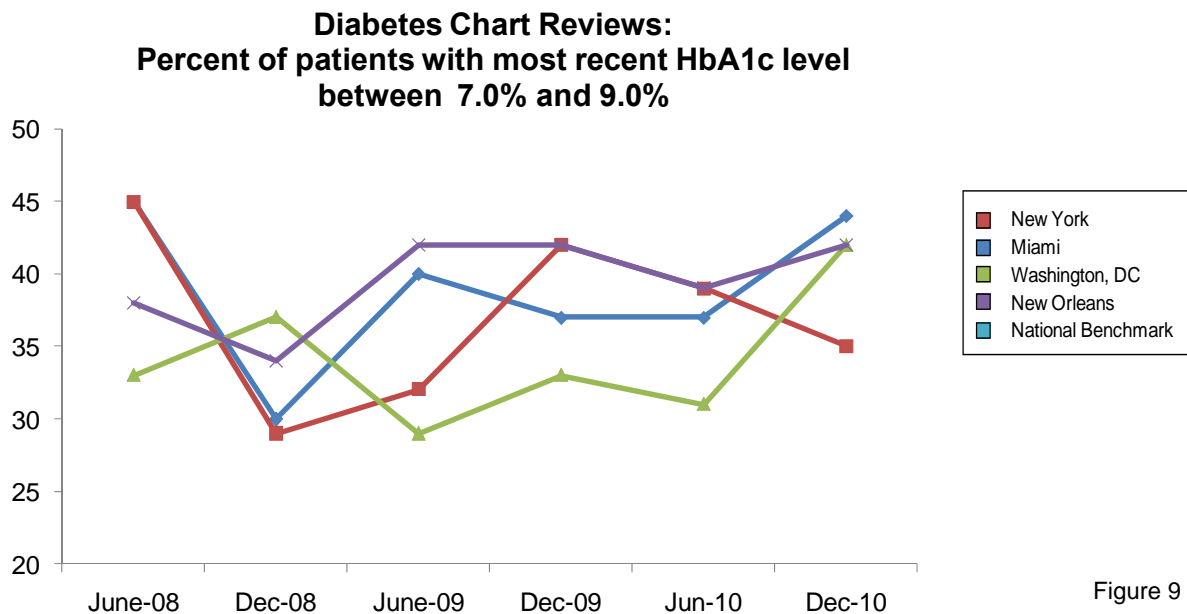
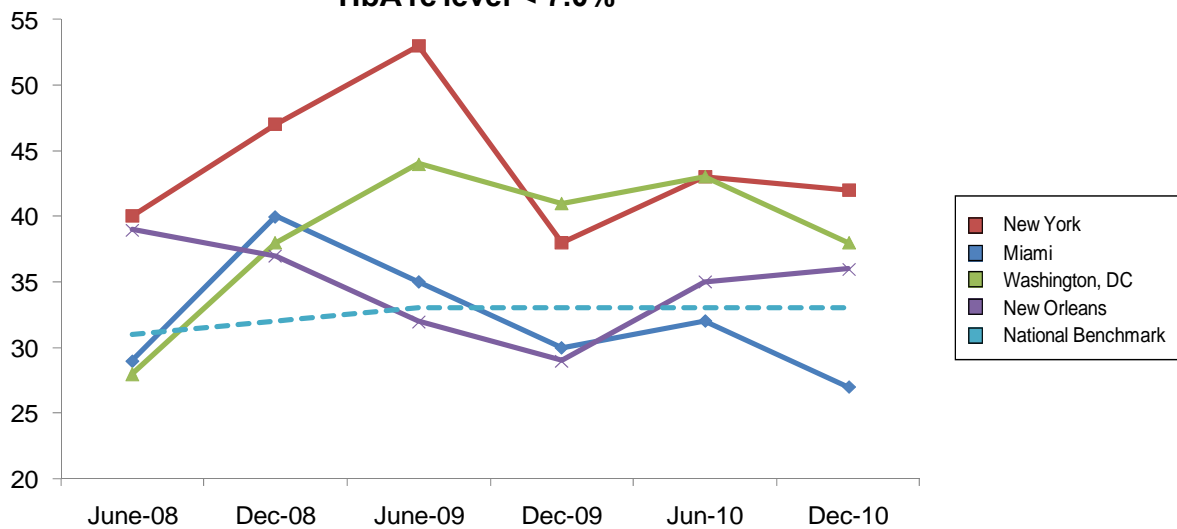


Figure 9

During this reporting period, the New York, D.C., and New Orleans health center grantees reported higher percentages of diabetic patients with good HbA1c control (<7% HbA1c) than the national average of 33%, as shown in Figure 10. Although the percentages for New York and D.C. grantees dropped slightly, the New Orleans site has continued its improvement since December 2009. After showing improvements in June 2010, Miami's most recent measure of the percentage of diabetic patients with good HbA1c control (27%) is the lowest it has reported since measure was implemented. Still, the four sites' average of 36% of diabetic patients with good control exceeds the national average of 33% of diabetic patients with HbA1c levels under 7%.

**Diabetes Chart Reviews:
 Percent of patients with most recent
 HbA1c level < 7.0%**



Source: National Data obtained from Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios

Figure 10

Asthma

The original asthma measurement determined the percent of patients who were diagnosed with mild, moderate, or severe persistent asthma and who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment. In June 2008, a new measure that focused only on patients with severe persistent asthma was introduced. For the first part of the measure, the number of eligible patients that receive an asthma assessment and severity test is measured, then for the second part of the measure, the percent of patients diagnosed with persistent asthma on appropriate pharmacologic therapy is evaluated. Only the last three reporting periods are included in this report owing to the change in the measure's definition.

As shown in Figure 11, in December 2010 the four sites provided severity assessments to the majority of their asthmatic patients, ranging from 59% in Miami to 94% in New York. Since reporting for this measure began in June 2008, Miami and New Orleans have shown improvements in this measure (particularly Miami, which rose from 17% to 59% from June 2008 to December 2010), although New York and D.C. have yet to duplicate their highest reported percentages of assessed patients (100% and 94%, respectively, in June 2008). No national benchmark could be identified for this measure.

**Asthma Chart Reviews:
 Percent of asthma patients who had a severity assessment**

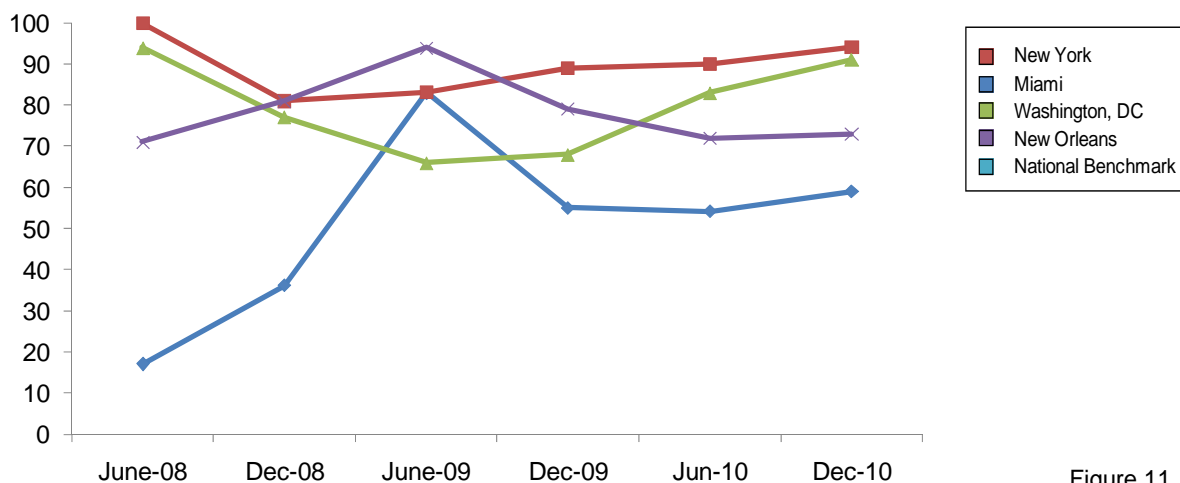
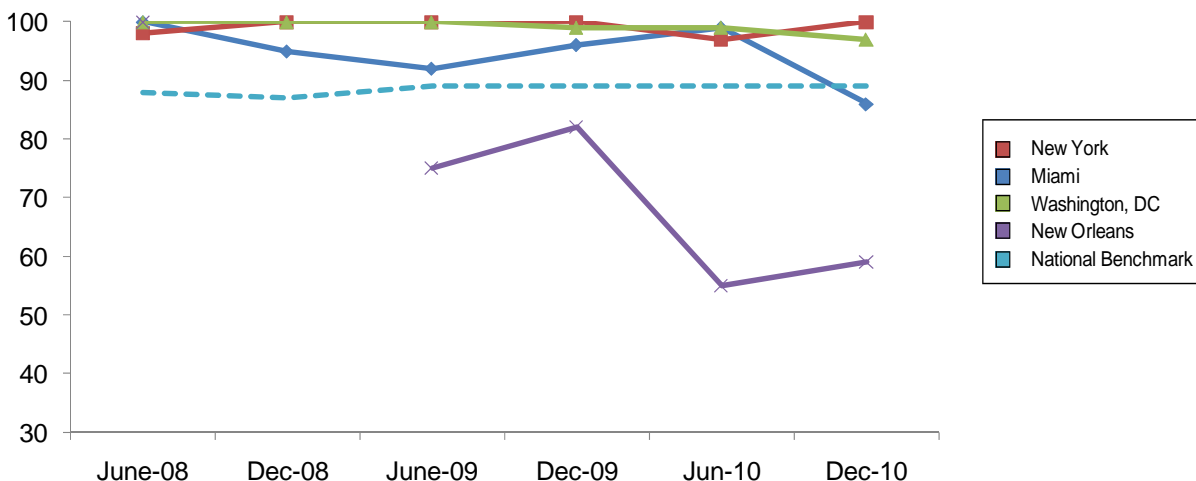


Figure 11

Figure 12 shows the percentage of patients who were diagnosed with persistent asthma and who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment during the measurement period. In December 2010, two grantees reported percentages that were well above the national benchmark, with 100% of New York’s patients and 97% of D.C.’s patients with persistent asthma receiving appropriate pharmacologic therapy in 2010. Miami dropped slightly below the national average for the first time since it began reporting, with 86% of patients with severe persistent asthma receiving the appropriate pharmacologic therapy in December 2010. New Orleans’ most recently reported percentage (59%) is an improvement from June 2010 but still remains low, relative to the national average.

**Asthma Chart Reviews:
 Percent of patients with persistent diagnosis in appropriate pharmacologic therapy**



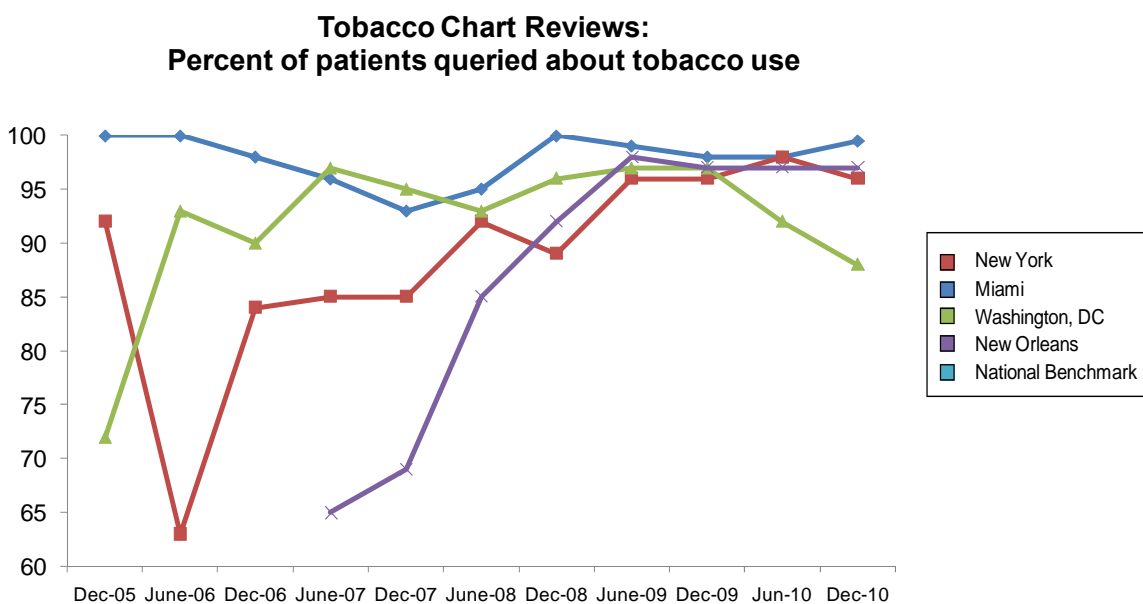
Note: National benchmark is for ages 5-56, CHC percentages are for ages 5-40.

Source: National Data obtained from Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios

Figure 12

Tobacco and Smoking

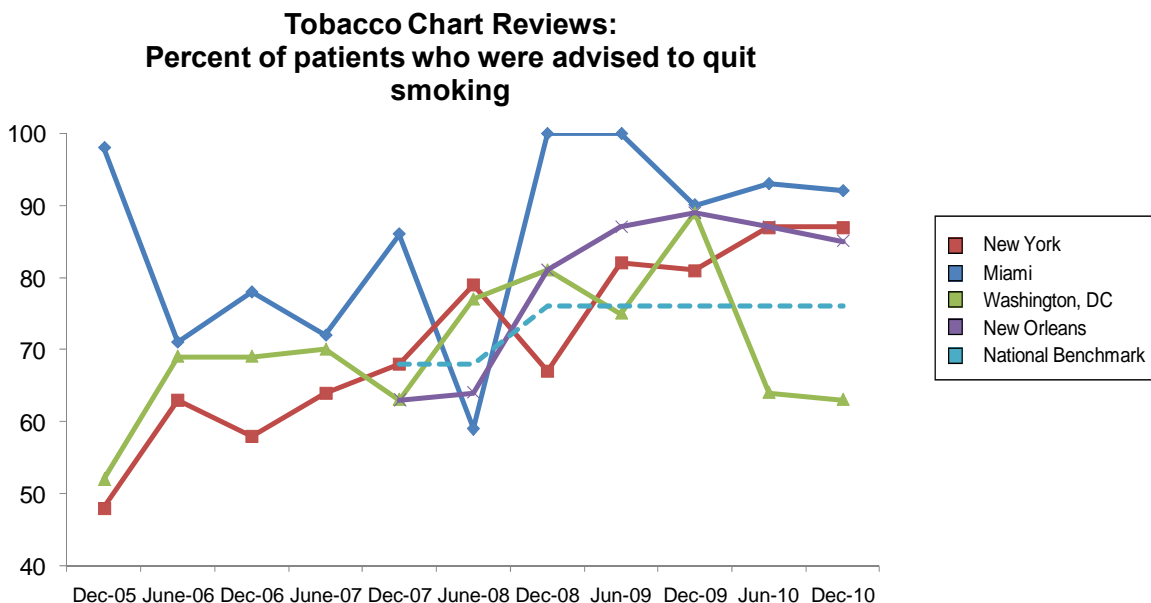
Figures 13 and 14 illustrate the health centers' performance in querying adult patients about tobacco use and advising smokers to quit. Although there are currently no national benchmarks for querying about tobacco use, Miami (99.5%), New York (96%), and New Orleans (97%) asked nearly all of their adult patients about tobacco use during the last reporting period. 88 percent of patients at the D.C. health center grantee were queried about tobacco use, which is an improvement from the 72% reported in December 2005.



Source: National Data obtained from Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios

Figure 13

Of the four grantees, three reported percentages that stayed the same (New York) or slightly decreased (Miami and New Orleans), yet still exceeded the national average of 76% for advising smokers to quit. After four years of gradual improvement, the D.C. grantee reported a decline to 63% of smokers who were advised to quit this past year.



Source: National Data obtained from Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios

Figure 14

Prenatal care HIV screening

Although there are no national averages for prenatal HIV screening by which to compare performance, three health centers screened nearly all of their pregnant patients for HIV during early prenatal care visits (see Figure 15). Since initial reporting on this measure began, New York and D.C. have consistently screened over 90% of pregnant patients for HIV during the first or second prenatal visit, while Miami has increased its percentage from 72% in December 2005 to 94% in December 2010. While New Orleans only recently began reporting this measure, they reported 73% of patients were screened for HIV during the first or second prenatal care visit during the 2010 reporting period.

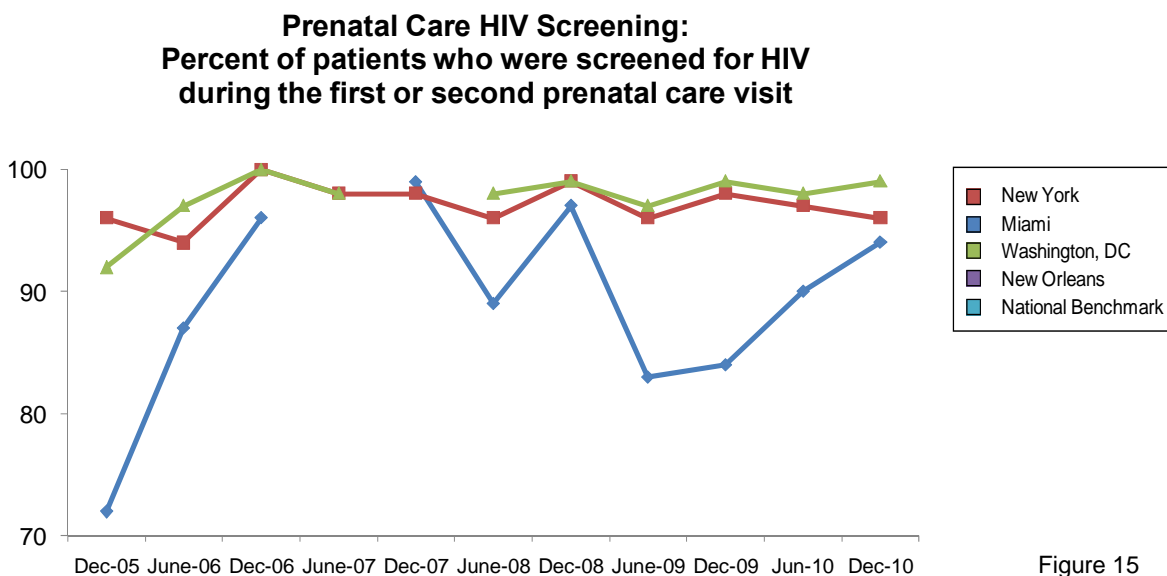


Figure 15

In compliance with recommended practice standards, in 2009 grantees agreed to expand upon the above measure by including the percent of prenatal patients re-screened for HIV during the third trimester (28-36 weeks). As shown in Figure 16, the D.C. center has the highest rate of screening, which has increased from 55% in December 2008 to 90% in December 2010.

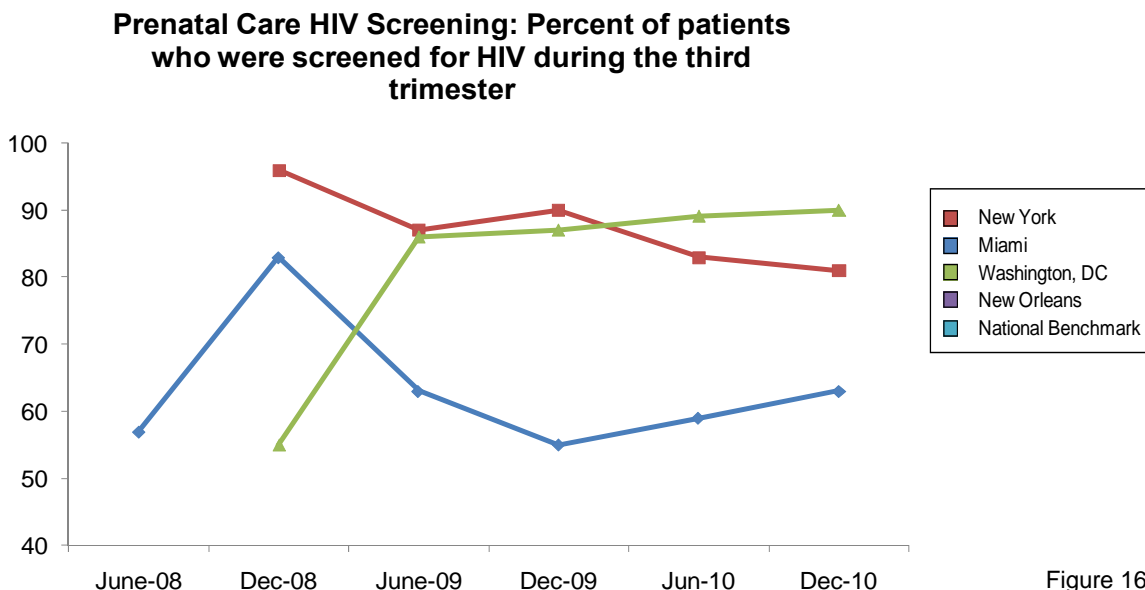
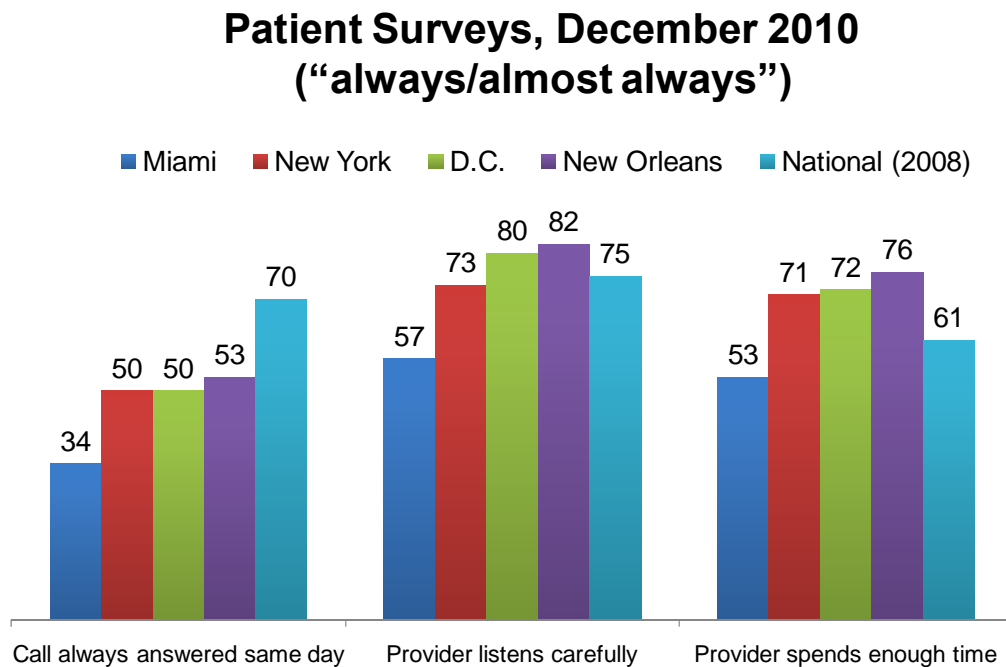


Figure 16

Patient Satisfaction

Unlike the quality of care measures, a survey conducted in December 2010 found mixed results for measures of patient satisfaction in comparison to national averages, as seen in Figure 17.



Note: New Orleans data just for St. Cecelia's clinic

Figure 17

The health centers perform below the national average for calls answered on the same day and, taken as an average across the four sites, less than half (47%) of calls are answered on the same day compared to the national average of 70%. With the exception of Miami, the health centers exceeded the national average on the measure of "provider spends enough time" and exceeded or approached the national average for the measure "provider listens carefully."

Access and Cost

UHF grant-related expenditures were predominantly used to expand access and services, as well as adding personnel to respond to the growing patient population. In New York, 61% of UHF grant-related expenditures were attributed to physician, nurse, and specialist capacity and an additional 13% of funding was allocated to enabling services in 2010. Miami also committed 56% of UHF funding to medical care and an additional 4% to enabling services. Similarly, New Orleans reported that approximately 97% of UHF grant funding was designated for medical personnel or support. The remainder of funding for all grantee sites was spent on HIT and other expenditures.

Between 2006 and 2010, Miami reported an increase of 2% in the number of unduplicated patients seen. New York reported a slight decrease over the past year, which they attributed to a number of provider vacancies during the reporting period; however the overall number of patients seen has remained fairly steady since the program began tracking this measure. New

Orleans reported the largest growth of 25% in the number of patients seen since 2007, and a 36% increase in the number of annual patient visits over the same three years. The District of Columbia grantee did not report their cost and access data at the time of this writing.

Discussion

Using quality measures that are comparable to national standards, this pilot project demonstrates that all four grantees are high performers relative to national averages on most measures. Nearly all grantees report high performance relative to national averages for the diabetes, cervical cancer, and asthma measures; and in some cases, meet or exceed quality of care provided by other HRSA grantees in the state. In the past year, grantees have improved on advising smokers to quit smoking, and now performance is above the national benchmark for all but one grantee. Overall, the sustained results and high performance of these four centers of excellence continue to confirm that they are good sites to identify and replicate best practices. For example, New York's treatment rate of 100% of patients with persistent asthma in appropriate pharmacologic therapy and their 94% asthma severity assessment rate set an example for other grantees. In view of the organizational and financial realities in which they operate, extra attention should be paid identifying 'model of care' that would lend itself to diffusion to other safety net primary care providers.

While these findings are substantial, a more detailed assessment of how the UHF funding (and possibly ARRA funds in 2009 for some of the clinics) were used to expand, enhance, and transform care delivery is needed to better understand the extent to which these providers are able to overcome or mitigate the challenges in serving low-income communities, such as staffing shortages, difficulties in establishing specialty referral networks, limited access to information technology, and the problems of developing a means of financing known and effective specialty interventions for uninsured patients. No doubt, the UHF funds will even more critical for supporting ongoing efforts as federal (and state) funding are likely to diminish over the next year.