Quality Transparency
Regional Healthcare Quality Report – October 2019

We are pleased to provide the regional summary report of clinical quality performance for data period
July 1, 2018 – June 30, 2019. The purpose of this report is to promote healthcare quality transparency and
improvement in the Greater Columbus region.

REGIONAL PERFORMANCE SNAPSHOT

Aggregated data represent 109 practices serving a total of 643,522 patients. Based on information shared by the
organizations, we estimate the payer mix for all patients to be: Commercial = 56%, Medicare = 26%, Medicaid = 13%, Self-
Pay/Other = 5%.

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Aggregate performance</th>
<th>2018 target</th>
<th>Total practices reporting</th>
<th>Percent of practices ≥ target</th>
<th>Total patients in denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure</td>
<td>73%</td>
<td>75%</td>
<td>105</td>
<td>37%</td>
<td>130,112</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>59%</td>
<td>71%</td>
<td>105</td>
<td>16%</td>
<td>205,067</td>
</tr>
<tr>
<td>Diabetes Care: Hemoglobin A1c Control</td>
<td>79%</td>
<td>91%</td>
<td>77</td>
<td>10%</td>
<td>46,231</td>
</tr>
<tr>
<td>Diabetes Care: Medical Attention for Nephropathy</td>
<td>78%</td>
<td>90%</td>
<td>102</td>
<td>25%</td>
<td>62,591</td>
</tr>
<tr>
<td>Tobacco Use: Screening &amp; Cessation Intervention</td>
<td>88%</td>
<td>95%</td>
<td>103</td>
<td>35%</td>
<td>357,551</td>
</tr>
<tr>
<td>Depression: Utilization of PHQ-9</td>
<td>26%</td>
<td>30%</td>
<td>12</td>
<td>33%</td>
<td>11,419</td>
</tr>
<tr>
<td>Depression: Remission at Twelve Months</td>
<td>20%</td>
<td>2.2%</td>
<td>39</td>
<td>79%</td>
<td>3,601</td>
</tr>
<tr>
<td>Depression: Response at Twelve Months</td>
<td>2%</td>
<td>-</td>
<td>11</td>
<td>N/A</td>
<td>944</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
<td>79%</td>
<td>-</td>
<td>48</td>
<td>N/A</td>
<td>148,907</td>
</tr>
</tbody>
</table>

Green – aggregate of reporting practices is above 2018 target; Red – aggregate of reporting practices is below 2018 target
1 Aggregate performance is calculated as the total numerator divided by total denominator of all practices reporting; 2Reported as inverse of definition (in control); 4 Regional targets were collaboratively agreed upon in 2018 by project partners based on past regional performance and alignment with Comprehensive Primary Care Plus (CPC+) and other quality targets and benchmarks identified over the course of the project.

ABOUT THE PARTICIPANTS

The following 11 healthcare organizations contributed data for this performance period:

- Ajay Chawla, MD
- Central Ohio Primary Care
- CompDrug
- Concord Counseling Services
- Heart of Ohio Family Health Centers
- Holmes Family Medicine
- Lower Lights Christian Health Center
- Mount Carmel Medical Group
- The Ohio State University Wexner Medical Center
- PrimaryOne Health
- Southeast, Inc.

Heart of Ohio Family Health Centers, Lower Lights Christian Health Center, PrimaryOne Health, and Southeast,
Inc. are Federally Qualified Health Centers (FQHCs). They provide healthcare services to citizens and non-
citizens who are medically underserved, underinsured, or uninsured. Southeast, Inc. serves homeless, most with
mental health or substance use disorders.
REGIONAL PERFORMANCE DETAIL

Controlling High Blood Pressure

Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period. (NQF#0018)

Regional performance for the current period = 73%

Observations about regional performance:
- Performance increased by 4 percentage points from last period.
- We did not meet the regional target of 75%.
- Performance across all practices ranged from 52% to 89%.

The top performing practices were COPC Granville Pike Family Physicians and COPC Worthington Internal Medicine at 89%.

The following practices (listed alphabetically) performed in the top 10% of all practices reporting this measure:

- COPC Amy R Kelley MD
- COPC Family Medicine North
- COPC Granville Pike Family Physicians
- COPC Northside Internal Medicine
- COPC Suburban Internal Medicine
- COPC Westerville
- COPC Worthington Internal Medicine
- MCMG Taylor Station
- MCMG Worthington

The percent of patients with hypertension whose blood pressure is controlled:

1/1/2014 - 68%  7/1/2014 - 70%  1/1/2015 - 70%  7/1/2015 - 69%  1/1/2016 - 68%  7/1/2016 - 71%  1/1/2017 - 68%  7/1/2017 - 69%  1/1/2018 - 69%  7/1/2018 - 73%
Colorectal Cancer Screening

The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.
(NQF#0034)

Regional performance for the current period = 59%

Observations about regional performance:
- There was no change from the last two periods of performance.
- We did not meet the regional target of 71%.
- Performance across all practices ranged from 19% to 88%.

The top performing practice was COPC Amico and Associates at 88%.

The following practices (listed alphabetically) performed in the top 10% of all practices reporting this measure:

COPC Amico and Associates
COPC Granville Pike Family Physicians
COPC Northside Internal Medicine
COPC Westerville
COPC Worthington Internal Medicine
Heart of Ohio Family Health Centers
MCMG TriVillage
MCMG Worthington
Diabetes Care: Hemoglobin A1c Control

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year. (NQF#0059) (reported as in control)

Regional performance for the current period = 79%

Observations about regional performance:
- Performance increased by 2 percentage points from last period.
- We did not meet the new target of 91%.
- Performance across all practices ranged from 52% to 94%.

The top practice, performing at 94%, was Internal Medicine and Pediatrics at Grandview.

The following practices (listed alphabetically) performed in the top 10% of all practices reporting this measure:

COPC Scioto View Family Practice
Internal Medicine and Pediatrics at Grandview
Martha Morehouse Medical Plaza: Primary Care – General Internal Medicine
Ohio State Outpatient Care Lewis Center: General Internal Medicine and Pediatrics
Ohio State Primary Care at New Albany
Philip Heit Center for Healthy New Albany: Primary Care
Stoneridge Medical Services: Primary Care-General Internal Medicine
Diabetes Care: Medical Attention for Nephropathy

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening or monitoring test or had evidence of nephropathy during the measurement year. (NQF#0062)

Regional performance for the current period = 78%

Observations about regional performance:
- Performance decreased by 2 percentage points from last period.
- We did not meet the regional target of 90%.
- Performance across all practices ranged from 26% to 96%.

The top performing practice was MCMG Taylor Station at 96%.

The following practices (listed alphabetically) performed in the top 10% of all practices reporting this measure:

- Lower Lights Union Star
- MCMG Big Run
- MCMG Grove City
- MCMG Grove City Broadway
- MCMG Taylor Station
- MCMG Wedgewood
- Mount Carmel Health Station Parsons
- Mount Carmel Health Station Refugee
- Mount Carmel Health Station Reynoldsburg
Tobacco Use: Screening & Cessation Intervention

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. (NQF#0028)

Regional performance for the current period = 88%

Observations about regional performance:
- Performance increased by 1 percentage point from last period.
- We did not meet the regional target of 95%.
- Performance across all practices ranged from 65% to 100%.

The top practices performing at 100% were Ajay Chawla, MD and Ohio State Outpatient Care Upper Arlington: Family Medicine and Primary Care.

The following practices (listed alphabetically) performed in the top 10% of all practices reporting this measure:

- Ajay Chawla, MD
- COPC Granville Pike Family Physicians
- COPC Jasonway Internal Medicine
- COPC Lahue Gramann Boezi and Coss
- COPC McConnell Family Practice
- COPC Stonegate Family Health
- COPC Upper Arlington Preventative Primary Care
- COPC Arlington Mill Run
- Ohio State Outpatient Care Upper Arlington: Family Medicine and Primary Care
- Stoneridge Medical Services: Primary Care-General Internal Medicine
Depression: Utilization of the PHQ-9 Tool

Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during the four-month measurement period. (NQF#0712)

Regional performance for the current period = 26%

Observations about regional performance:
- Performance decreased by 3 percentage points from last period.
- We performed three percentage points below the regional target of 30%.
- Performance across all practices ranged from 7% to 70%.

The top performing practice was **Concord Counseling Services (3 Sites)** at 70%.

The following practices (listed alphabetically) performed in the top 10% of all practices reporting this measure:

Concord Counseling Services
Depression: Remission at Twelve Months

Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. (NQF#0710)

Regional performance for the current period = 20%

Observations about regional performance:
- Performance increased by 1 percentage point from last period.
- We exceeded the regional target of 2.2%
- Performance across all practices ranged from 0% to 43%.

The top performing practice was MCMG Lewis Center at 43%.

The following practices (listed alphabetically) performed in the top 10% of all practices reporting this measure:

MCMG East
MCMG Lewis Center
Depression: Response at Twelve months

Patients age 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9) score greater than nine who demonstrate remission at twelve months (+/- 30 days after an index visit) defined as a PHQ-9 score less than five (NQF #0710)

Regional performance for the current period = 1%

Observations about regional performance:
- Performance decreased by 12 percentage points from last period.
- There is currently not a regional target for this measure.
- Performance across all practices ranged from 0% to 22%.

The top performing practice was Holmes Family Medicine at 22%.

The following practices (listed alphabetically) performed in the top 10% of all practices reporting this measure:
- Holmes Family Medicine

Screening for Clinical Depression and Follow-Up Plan

Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the positive screen (NQF #0418)

Regional performance for the current period = 79%

Observations about regional performance:
- Performance decreased by 2 percentage points from last period.
- There is currently not a regional target for this measure.
- Performance across all practices ranged from 16% to 96%.

The top performing practice was Mount Carmel Health Station Reynoldsburg at 99%.

The following practices (listed alphabetically) performed in the top 10% of all practices reporting this measure:
- MCMG Big Run
- MCMG Grove City Stringtown
- MCMG Lewis Center
- MCMG West
- Mount Carmel Health Station Reynoldsburg
COLLABORATIVE TERMS OF USE

The project partners participate under the following collaborative terms of use:

<table>
<thead>
<tr>
<th>Collaborative Terms of Use</th>
<th>Participating Organizations</th>
<th>Healthcare Collaborative of Greater Columbus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use reports to improve quality of care provided by your organization</td>
<td>• Share lessons learned to help improve healthcare transparency in Greater Columbus</td>
<td>• Maintain safe-space to enable the sharing of learning with participants</td>
</tr>
<tr>
<td>Share lessons learned to help improve healthcare transparency in Greater Columbus</td>
<td>• Will not use content to promote or publicize physician practices</td>
<td>• Apply learning to catalyze best practices to improve transparency in Greater Columbus</td>
</tr>
<tr>
<td>Will not use content to promote or publicize physician practices</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ABOUT THE MEASURES AND DATA

Through collaborative agreement, project partners have selected measures that are meaningful in helping them improve quality for their patients and the region and align with quality improvement initiatives they are currently focused on. Organizations provide practice site-level data from their electronic health records and performance is then calculated for their practice site and the region. Data represent all patients and all payers for each practice site, which is based on the unique practice address.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure (ages 18-85)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening (ages 50-75 years)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care: Hemoglobin A1c Control (reported as in control) (Ages 18-75)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care: Medical Attention for Nephropathy (Ages 18-75)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tobacco Use: Screening &amp; Cessation Intervention (Ages 18+)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Depression: Utilization of PHQ-9 Tool (Ages 18+)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression: Remission at Twelve Months (Ages 18+)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression: Response at Twelve Months (Ages 18+)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan (Ages 12+)</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number of Practice Sites Reporting At Least One Measure</td>
<td>107</td>
<td>131</td>
<td>145</td>
<td>157</td>
<td>159</td>
<td>109</td>
<td></td>
</tr>
</tbody>
</table>

Notes: Southeast, Inc.: 3 practice sites reported at the organization level
CENTRAL OHIO PATHWAYS HUB DATA SNAPSHOT

New for this report, we are pleased to provide a summary report of social determinants of health data related to HCGC reported clinical quality measures for the period March 1-October 2, 2019. The purpose of this addition is to provide related information and insights about vulnerable adults receiving HUB services in our region.

The Central Ohio Pathways HUB is a care coordination model, nationally certified, and operated by HCGC for Franklin and contiguous counties. The HUB model utilizes partners in a community, called Care Coordination Agencies (CCAs), who deploy Community Health Workers (CHWs), to find and support clients in three eligibility categories: adults (defined as men age 18+ and women age 45+), maternal (defined as any women age 18-44), and pregnant women. By utilizing a tracking technology, Care Coordination Systems (CCS), CHWs visit with clients in their home or a community setting at least once per month in addition to other communications (text, phone call, emails) and help clients reach their health and social goals in the form of "pathways" (see box, right). Pathways’ progress is tracked and reported and when a successful outcome is achieved, it is considered "closed" and complete. The HUB has contracts with payers such as Medicaid Managed Care Plans, community partners, and other foundations to invoice for payments based on successful outcomes. The agency leadership and the HUB track process and quality assurance within the CCS system; the HUB also provides training, communication and leadership development for CHWs involved in the Central Ohio Pathways HUB.

It is the intention of HCGC to share data about the Central Ohio Pathways HUB with the same regional transparency and quality improvement culture that initiated the HCGC Quality Transparency report with our clinical providers. In addition, we believe clinical providers and the region generally may benefit from this data. As we continue to evolve our work, we anticipate standardized HUB data sets and quality improvement opportunities among clinical and community agencies. For more information about the central Ohio Pathways HUB, please visit www.hcgc.org.

ABOUT THE PARTICIPANTS

The following 10 Care Coordination Agencies (CCAs) provide data to the HUB.

- CelebrateOne
- Columbus Urban League
- Franklin County Public Health
- Heart of Ohio Family Health Centers
- Ohio Health
- PrimaryOne Health
- Physicians CareConnection
- The Breathing Association
- Urban Strategies Inc.
- Wellness First

OVERALL HUB DATA

<table>
<thead>
<tr>
<th>Overall HUB Data</th>
<th>Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>03/1/19-10/2/2019</td>
</tr>
<tr>
<td>Total Adult Clients</td>
<td>125</td>
</tr>
<tr>
<td>Total Maternal Clients</td>
<td>143</td>
</tr>
<tr>
<td>Total Pregnant Clients</td>
<td>133</td>
</tr>
<tr>
<td>Total Pathways Initiated</td>
<td>2908</td>
</tr>
<tr>
<td>Total Pathways Completed</td>
<td>1607</td>
</tr>
</tbody>
</table>
For the purposes of this data snapshot, adult eligibility category only is highlighted below, with adults reporting hypertension, the highest reported chronic condition, highlighted.

ADULT CLIENT DEMOGRAPHICS: AGE, RACE/ETHNICITY AND GENDER

ADULT CLIENTS: RACE

ADULT CLIENTS: FAMILY DOCTOR

ADULT CLIENTS: PAYER TYPE
ADULT CLIENTS: GEOGRAPHIC LOCATION

ADULT CLIENTS: CHRONIC CONDITIONS

Top Chronic Conditions Self-Reported by # of Adult Clients

<table>
<thead>
<tr>
<th>Condition</th>
<th># of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension (high blood pressure)</td>
<td>34</td>
</tr>
<tr>
<td>Depression</td>
<td>31</td>
</tr>
<tr>
<td>Arthritis</td>
<td>25</td>
</tr>
<tr>
<td>Asthma</td>
<td>22</td>
</tr>
<tr>
<td>Diabetes Type II</td>
<td>21</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>20</td>
</tr>
<tr>
<td>Obesity</td>
<td>18</td>
</tr>
<tr>
<td>Vision loss or impairment</td>
<td>18</td>
</tr>
</tbody>
</table>
What do patients in the HUB with hypertension need to help them manage their conditions?

**Additional Unmet Needs for Adult Clients w/ Hypertension**

- Trouble Providing Transportation: 8
- Client or Someone in Home is Tobacco User: 10
- Food Insecure: 14
- Scored Positive on PHQ-9: 16
- Trouble Paying for Medication: 16
- # of Adult Clients w/ Hypertension: 34
- # of Adult Clients: 125