

# Quality Transparency

## Regional Healthcare Quality Report – March 2020

We are pleased to provide the regional summary report of clinical quality performance for data period **January 1, 2019 – December 31, 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 **201 practices** serving a total of **930,092 patients**. Based on information shared by the organizations, we estimate the payer mix for all patients to be: Commercial = 54%, Medicare = 27%, Medicaid = 14%, Self-Pay/Other = 5%.

Quality Measure	Aggregate performance <sup>1</sup>	Total practices reporting	Total patients in denominator	2018 target <sup>4</sup>	# of Practices at Target
Controlling High Blood Pressure	72.5%	195	172,106	75%	42
Colorectal Cancer Screening	62.7%	195	259,550	71%	31
Diabetes Care: Hemoglobin A1c Control <sup>2</sup>	78.3%	194	93,567	91%	11
Diabetes Care: Medical Attention for Nephropathy	79.6%	103	66,987	90%	25
Tobacco Use: Screening & Cessation Intervention	90.8%	193	556,090	95%	37
Depression: Utilization of PHQ-9	39.2%	19	15,415	30%	5
Depression: Remission at Twelve Months	34.3%	36	4,498	2.20%	32
Depression: Response at Twelve Months	5.3%	6	379	-	-
Screening for Clinical Depression and Follow-Up Plan	89.3%	56	182,839	-	-

*Green* – aggregate of reporting practices is above 2018 target; *Red* – aggregate of reporting practices is below 2018 target

<sup>1</sup> Aggregate performance is calculated as the total numerator divided by total denominator of all practices reporting; <sup>2</sup> Reported as inverse of definition (in control); <sup>4</sup> 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 15 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
- Hilliard Family Medicine
- Holmes Family Medicine
- Holzer Health System
- Lower Lights Christian Health Center
- Mount Carmel Medical Group
- OhioHealth Physician Group
- The Ohio State University Wexner Medical Center
- PrimaryOne Health
- Southeast, Inc.
- Syntero

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

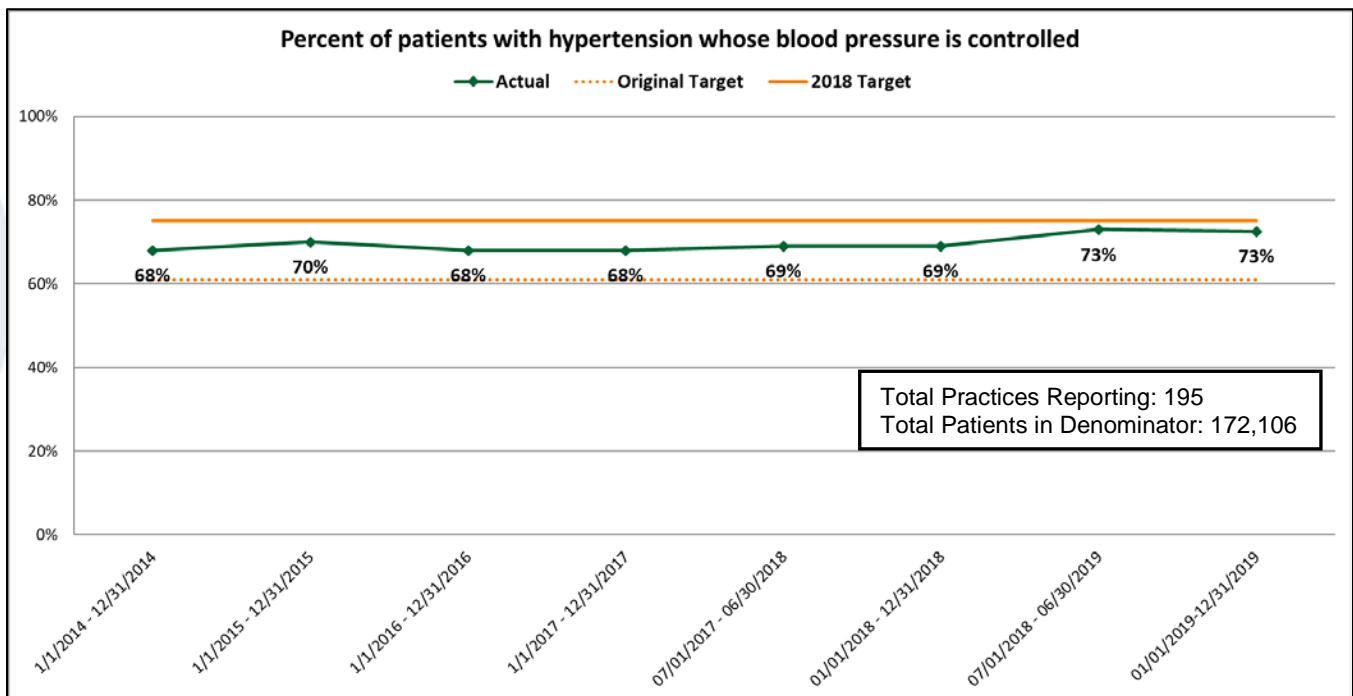
## Controlling High Blood Pressure

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

**Regional performance for the current period = 72.5%**

Observations about regional performance:

- Performance decreased by .5 percentage points from last period.
- We did not meet the regional target of 75%.
- Performance across all practices ranged from 56% to 91.7%.



The top performing practice was MCMG Taylor Station at 91.7%.

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

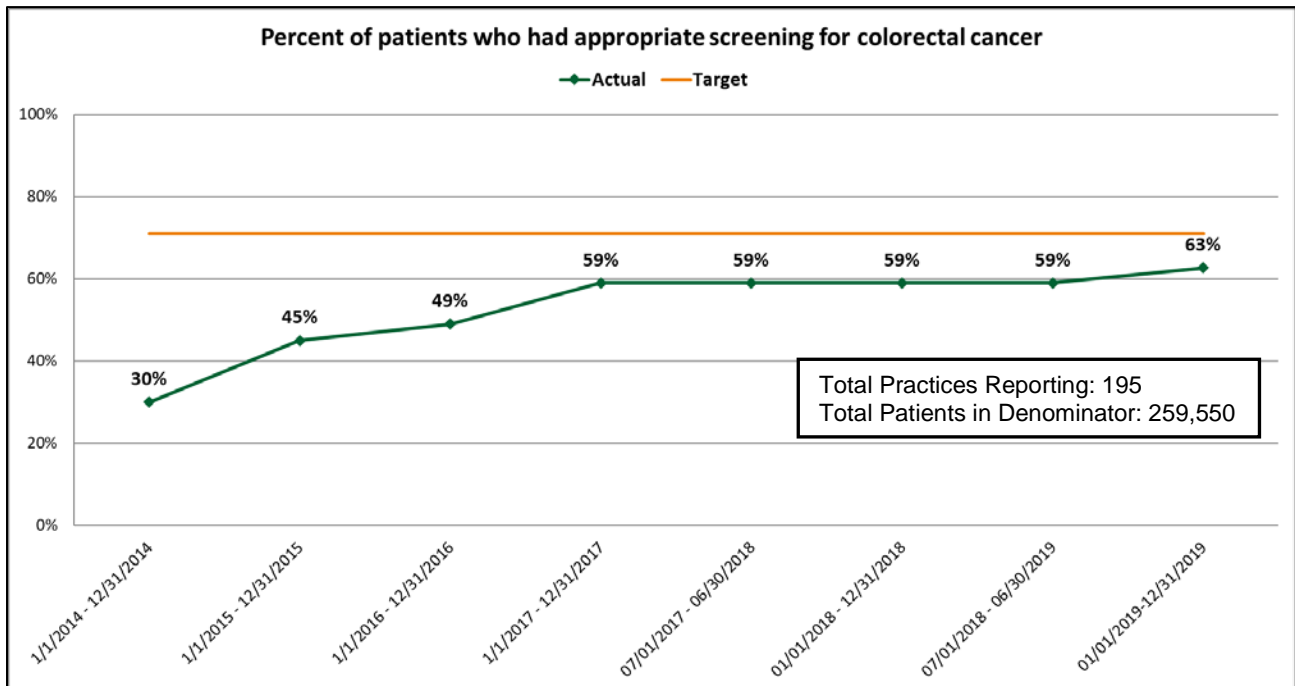
## Colorectal Cancer Screening

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

### Regional performance for the current period = 62.7%

Observations about regional performance:

- Performance increased by 3.7 percentage points from last period.
- We did not meet the regional target of 71%.
- Performance across all practices ranged from 27.7% to 87.5%.



The top performing practice was **COPC Amico and Associates** at 87.5%.

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

CarePoint East: Family Medicine  
COPC Amico, Stock & Associates  
COPC Granville Pike Family Physicians  
COPC Northside Internal Medicine  
COPC Westerville  
COPC Worthington Internal Medicine  
MCMG Trivillage  
Ohio State Family Medicine at Thomas Rardin  
Ohio State Primary Care at New Albany

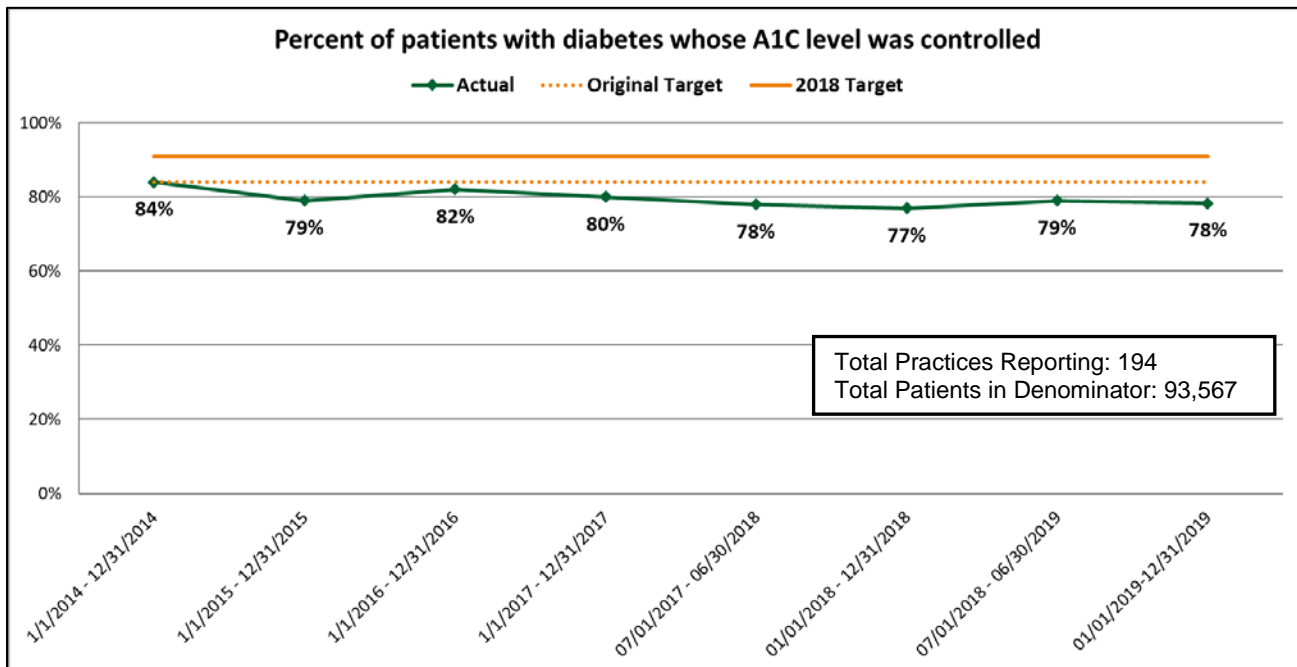
## Diabetes Care: Hemoglobin A1c Control

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 = 78.3%**

Observations about regional performance:

- Performance decreased by .7 percentage points from last period.
- We did not meet the 2018 target of 91%.
- Performance across all practices ranged from 49.4% to 94.8%.



The top practice, performing at 94.8%, was **Ohio State Outpatient Care Lewis Center: General Internal Medicine and Pediatrics**.

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

COPC Granville Pike Family Physicians  
 Internal Medicine and Pediatrics at Grandview  
 Internal Medicine and Pediatrics at Hilliard: General Internal Medicine and Pediatrics  
 Martha Morehouse Medical Plaza: Primary Care – General Internal Medicine  
 MCMG Taylor Station  
 Ohio State Outpatient Care Lewis Center: General Internal Medicine and Pediatrics  
 Ohio State Outpatient Care Upper Arlington: General Internal Medicine  
 Ohio State Primary Care at New Albany  
 Philip Heit Center for Healthy New Albany: Primary Care  
 Stoneridge Medical Services: Primary Care-General Internal Medicine

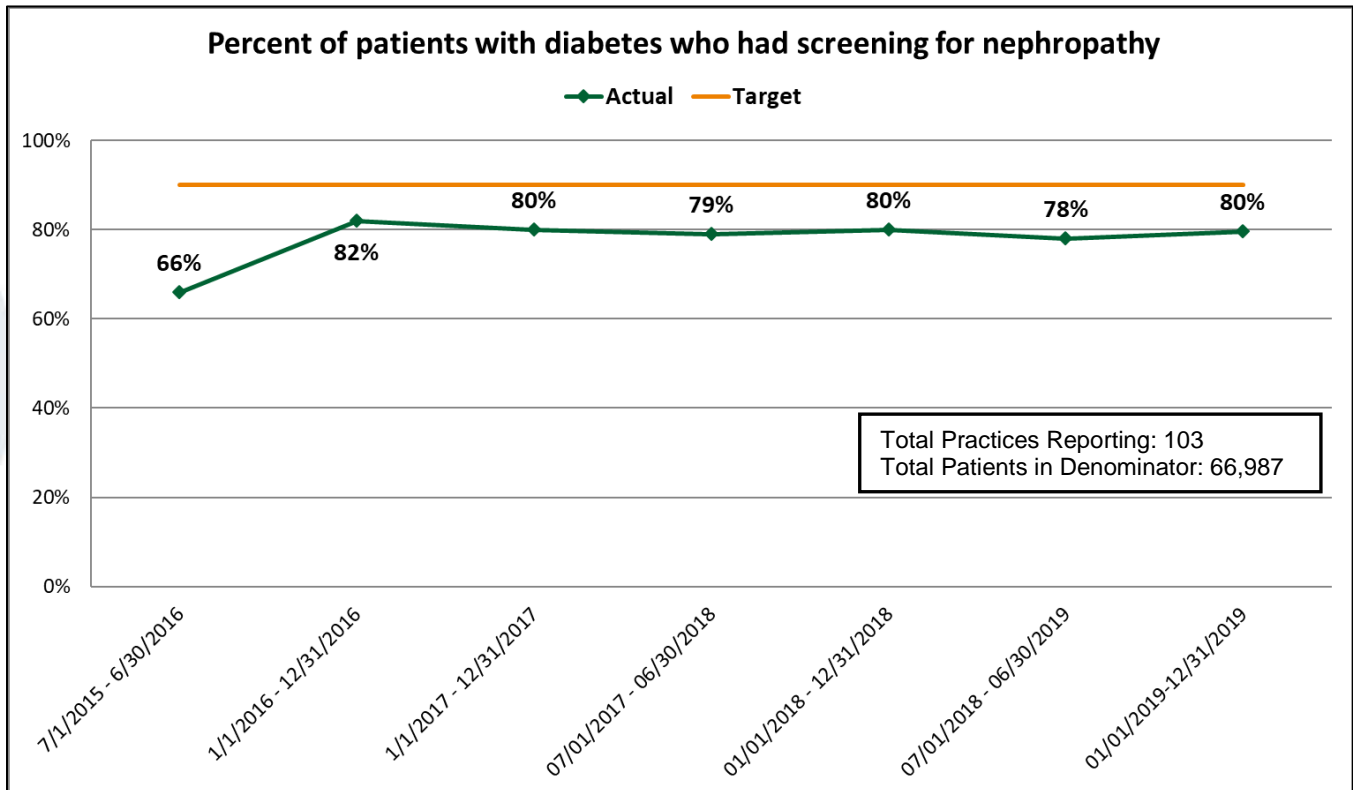
## Diabetes Care: Medical Attention for Nephropathy

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 = 79.6%**

Observations about regional performance:

- Performance increased by 1.6 percentage points from last period.
- We did not meet the regional target of 90%.
- Performance across all practices ranged from 29.4% to 98.6%.



The top performing practice was **Mount Carmel Health Station Parsons** at 98.6%.

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

COPC Stonegate Family Health  
MCMG Big Run  
MCMG Granville  
MCMG Grove City Stringtown  
MCMG Taylor Station  
MCMG Victorian Village  
MCMG Wedgewood  
Mount Carmel Health Station Parsons  
Mount Carmel Health Station Reynoldsburg

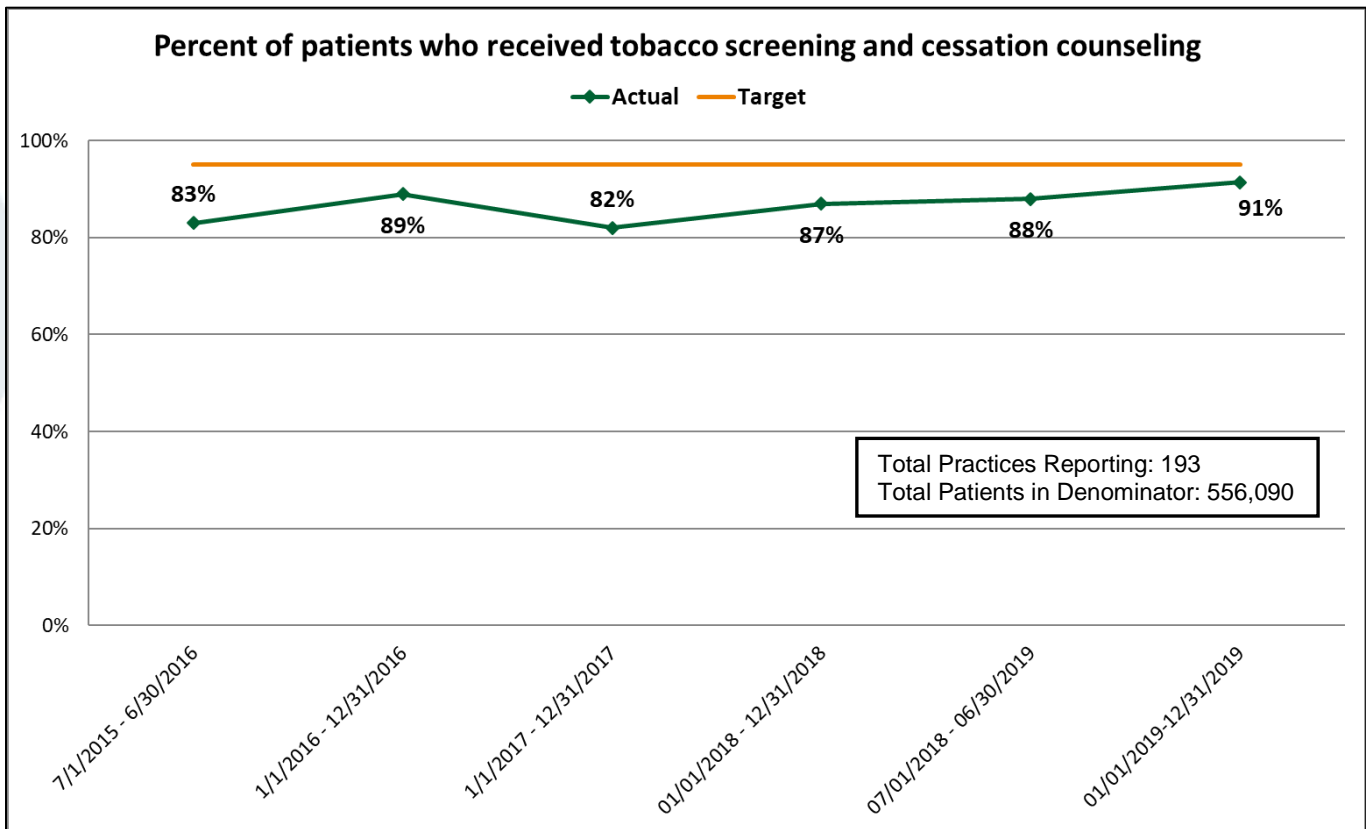
## Tobacco Use: Screening & Cessation Intervention

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 = 90.8%**

Observations about regional performance:

- Performance increased by 2.8% percentage point from last period.
- We did not meet the regional target of 95%.
- Performance across all practices ranged from 69% to 99.6%.



The top practices performing at 99.2% was **COPC Arlington Mill Run**.

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

COPC Arlington Mill Run  
 COPC Granville Pike Family Physicians  
 COPC Jasonway Internal Medicine  
 COPC Lahue Gramann Boezi and Coss  
 COPC McConnell Family Practice  
 COPC Stonegate Family Health  
 COPC Westerville Internal Medicine

Internal Medicine and Pediatrics at  
 Grandview  
 Ohio State Family Medicine at Thomas  
 Rardin  
 Ohio State Outpatient Care Upper  
 Arlington: Family Medicine and Primary  
 Care

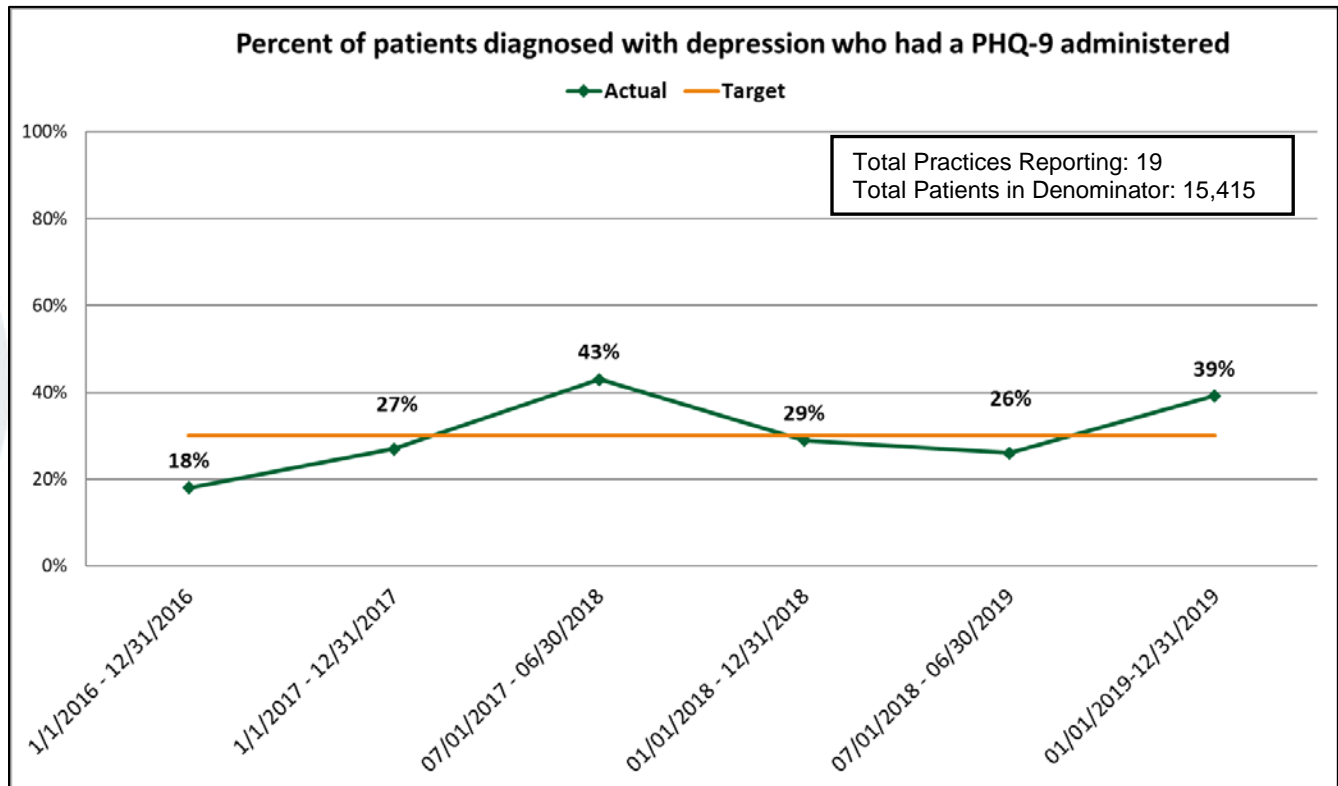
## Depression: Utilization of the PHQ-9 Tool

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 = 39.2%

Observations about regional performance:

- Performance increased by 13.2 percentage points from last period.
- We performed 9.2 percentage points above the regional target of 30%.
- Performance across all practices ranged from 5.4% to 75.5%.



The top performing practice was **PrimaryOne Health Parsons Ave** at 75.5%.

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

PrimaryOne Health Parsons Ave

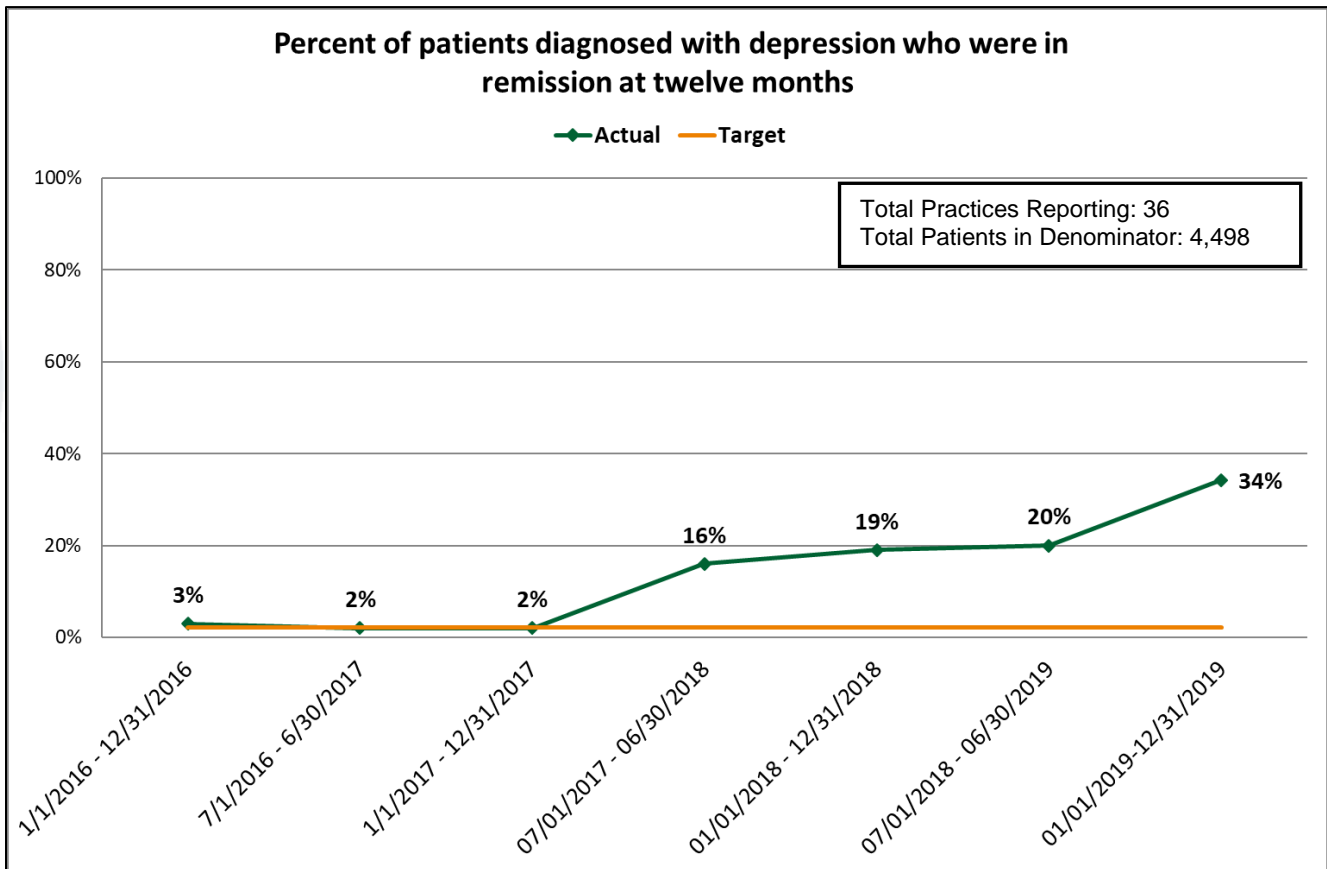
## Depression: Remission at Twelve Months

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 = 34.3%**

Observations about regional performance:

- Performance increased by 14.3 percentage point from last period.
- We exceeded the regional target of 2.2%
- Performance across all practices ranged from 2.6% to 61.1%.



The top performing practice was **MCMG Polaris** at 61.1%.

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

MCMG Big Run  
MCMG Polaris

## 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 #1885)

### Regional performance for the current period = 5.3%

Observations about regional performance:

- Performance increased by 4.3 percentage points from last period.
- There is currently not a regional target for this measure.
- Performance across all practices ranged from 0% to 100%.
- Total Practices Reporting: 6
- Total Patients in Denominator: 379

The top performing practice was **PrimaryOne Health East 17th Avenue** at 100%.

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

PrimaryOne Health East 17th Avenue

## 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 = 89.3%

Observations about regional performance:

- Performance increased by 10.3 percentage points from last period.
- There is currently not a regional target for this measure.
- Performance across all practices ranged from 25.5% to 98%.
- Total Practices Reporting: 56
- Total Patients in Denominator: 182,839

The top performing practice was **PrimaryOne Health South High Street** at 98%.

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  
Mount Carmel Health Station Reynoldsburg  
PrimaryOne Health South High Street

## COLLABORATIVE TERMS OF USE

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

<b>Collaborative Terms of Use</b>	
<i>Participating Organizations</i>	<ul style="list-style-type: none"> <li>• Use reports to improve quality of care provided by your organization</li> <li>• Share lessons learned to help improve healthcare transparency in Greater Columbus</li> <li>• Will not use content to promote or publicize physician practices</li> </ul>
<i>Healthcare Collaborative of Greater Columbus</i>	<ul style="list-style-type: none"> <li>• Maintain safe-space to enable the sharing of learning with participants</li> <li>• Apply learning to catalyze best practices to improve transparency in Greater Columbus</li> <li>• Will not use content to promote or publicize physician practices</li> </ul>

## 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.

<b>Measures</b>	<b>Reporting Year</b>						
	2014	2015	2016	2017	2018	2019	2020
Controlling High Blood Pressure (ages 18-85)	X	X	X	X	X	X	X
Colorectal Cancer Screening (ages 50-75 years)	X	X	X	X	X	X	X
Diabetes Care: Hemoglobin A1c Control (reported as in control) (Ages 18-75)	X	X	X	X	X	X	X
Diabetes Care: Medical Attention for Nephropathy (Ages 18-75)		X	X	X	X	X	X
Tobacco Use: Screening & Cessation Intervention (Ages 18+)		X	X	X	X	X	X
Depression: Utilization of PHQ-9 Tool (Ages 18+)			X	X	X	X	X
Depression: Remission at Twelve Months (Ages 18+)			X	X	X	X	X
Depression: Response at Twelve Months (Ages 18+)			X	X	X	X	X
Screening for Clinical Depression and Follow-Up Plan (Ages 12+)					X	X	X
<b>Total Number of Practice Sites Reporting At Least One Measure</b>	<b>107</b>	<b>131</b>	<b>145</b>	<b>157</b>	<b>159</b>	<b>109</b>	<b>201</b>

Notes: Southeast, Inc (3), Syntero (4), and OhioHealth Physician Group (85) reported at the organization level.

## CENTRAL OHIO PATHWAYS HUB DATA SNAPSHOT

HCGC is pleased to provide a summary report of social determinants of health data related to HCGC reported clinical quality measures for the period March 1, 2019-February 29, 2020. The purpose of this addition is to provide related information and insights about those citizens 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.

### AVAILABLE PATHWAYS

- Adult education
- Behavioral health
- Developmental referral
- Developmental screening
- Education
- Employment
- Family planning
- Health insurance
- Housing
- Immunization referral
- Immunization screening
- Lead screening
- Medical home
- Medical referral
- Medication assessment
- Medication management
- Postpartum
- Pregnancy
- Smoking cessation
- Social service referral

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](http://www.hcgc.org).

## ABOUT THE PARTICIPANTS

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

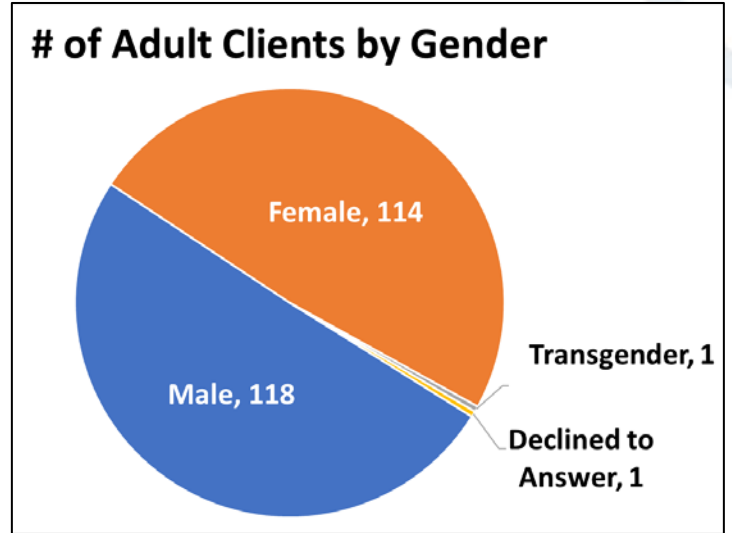
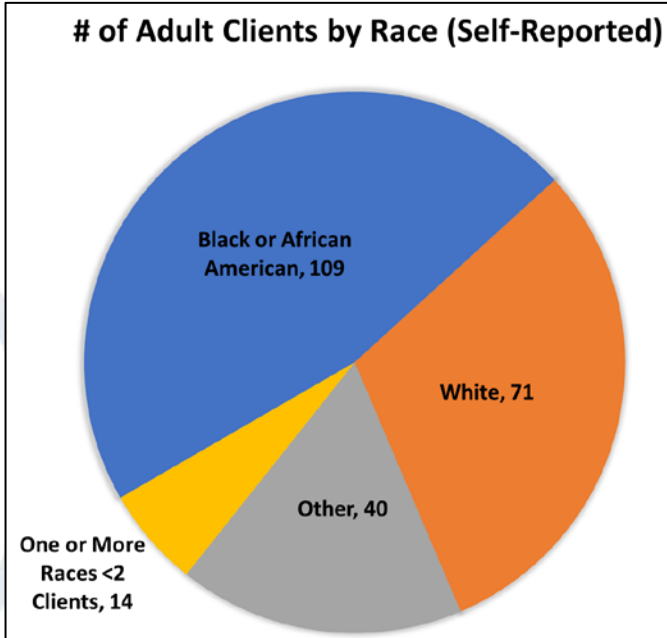
- CelebrateOne
- Columbus Urban League
- Franklin County Public Health
- Heart of Ohio Family Health Centers
- OhioHealth
- PrimaryOne Health
- Physicians CareConnection
- The Breathing Association
- Urban Strategies Inc.
- Wellness First

## OVERALL HUB DATA

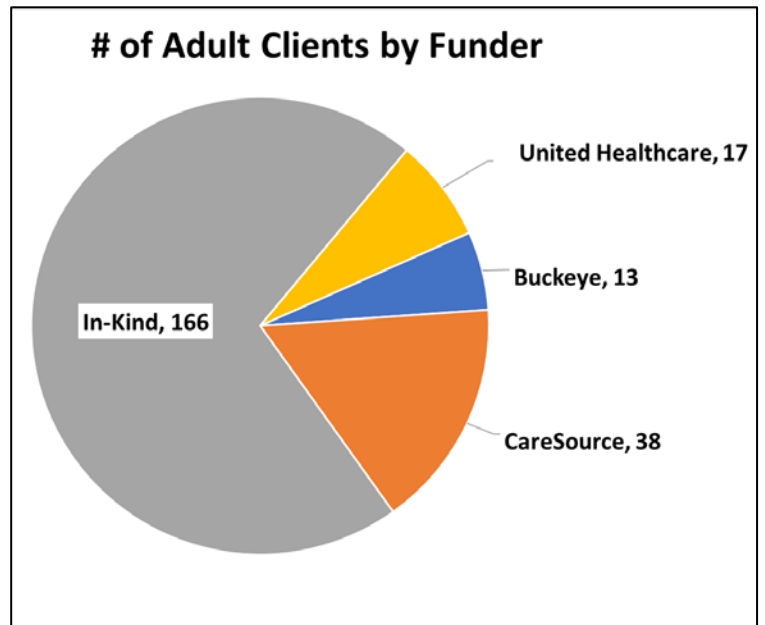
	Reporting Period
	03/1/19-2/29/2020
Total # of Adult Clients ( <i>men age 18+ and women age 45+</i> )	234
Total Maternal Clients ( <i>women ages 18-44</i> )	248
Total Pregnant Clients ( <i>all pregnant women</i> )	261
Total Pathways Initiated	5,780
Total Pathways Completed	3,561

## ADULT CLIENT DEMOGRAPHICS: AGE, RACE, GENDER, & FUNDER

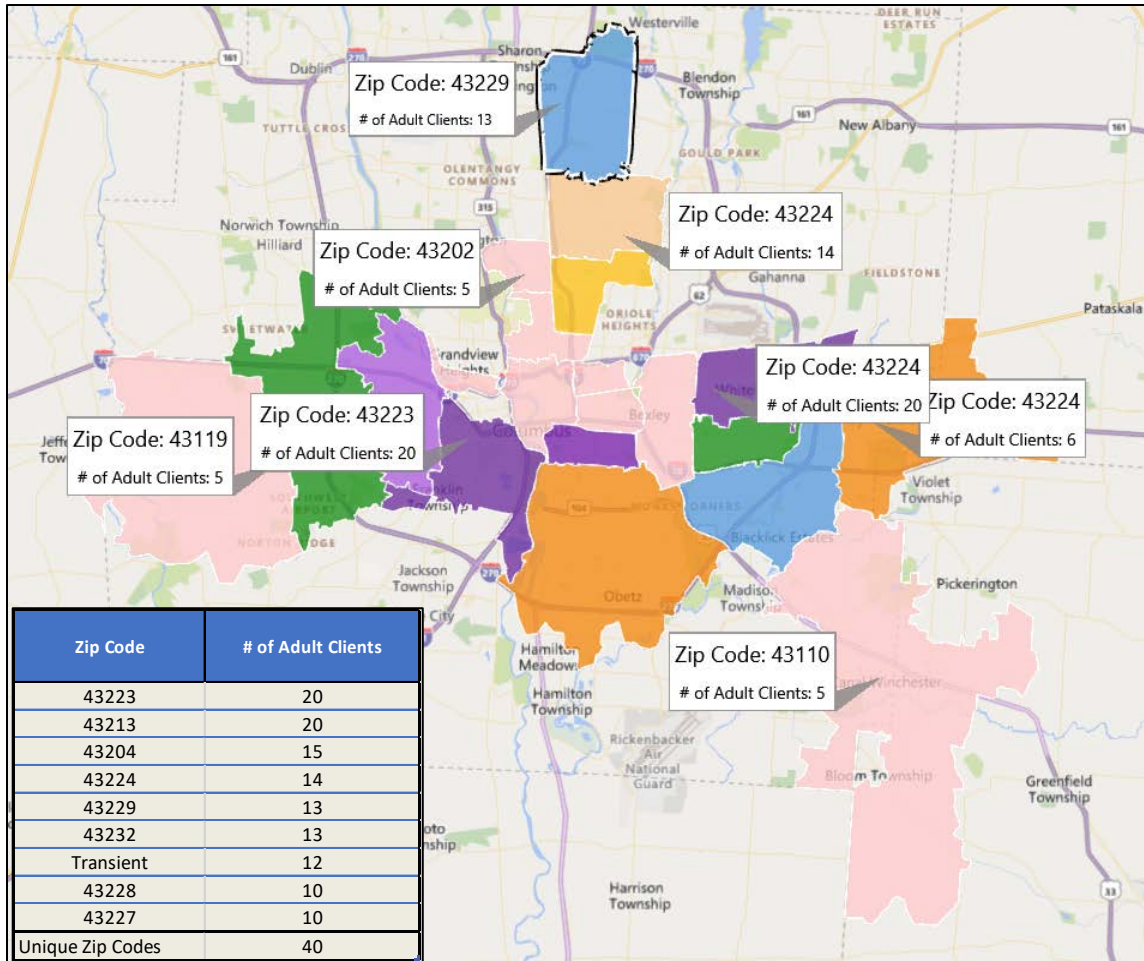
For the purposes of this section of the data snapshot, adult eligibility category only is highlighted below, with adults self-reporting hypertension (high blood pressure), highlighted.



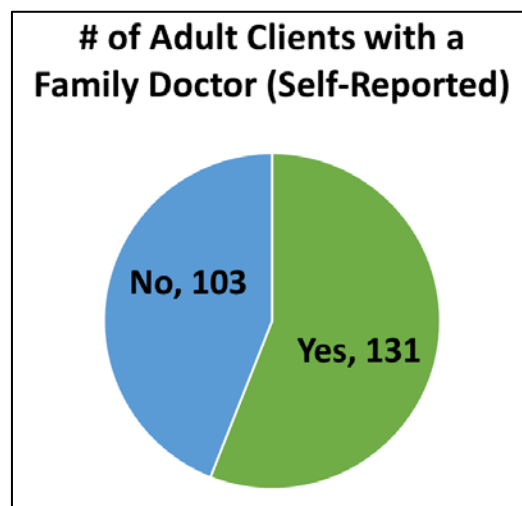
Adult Clients	
Mean Age	51.6 yrs
Age Range	20-66



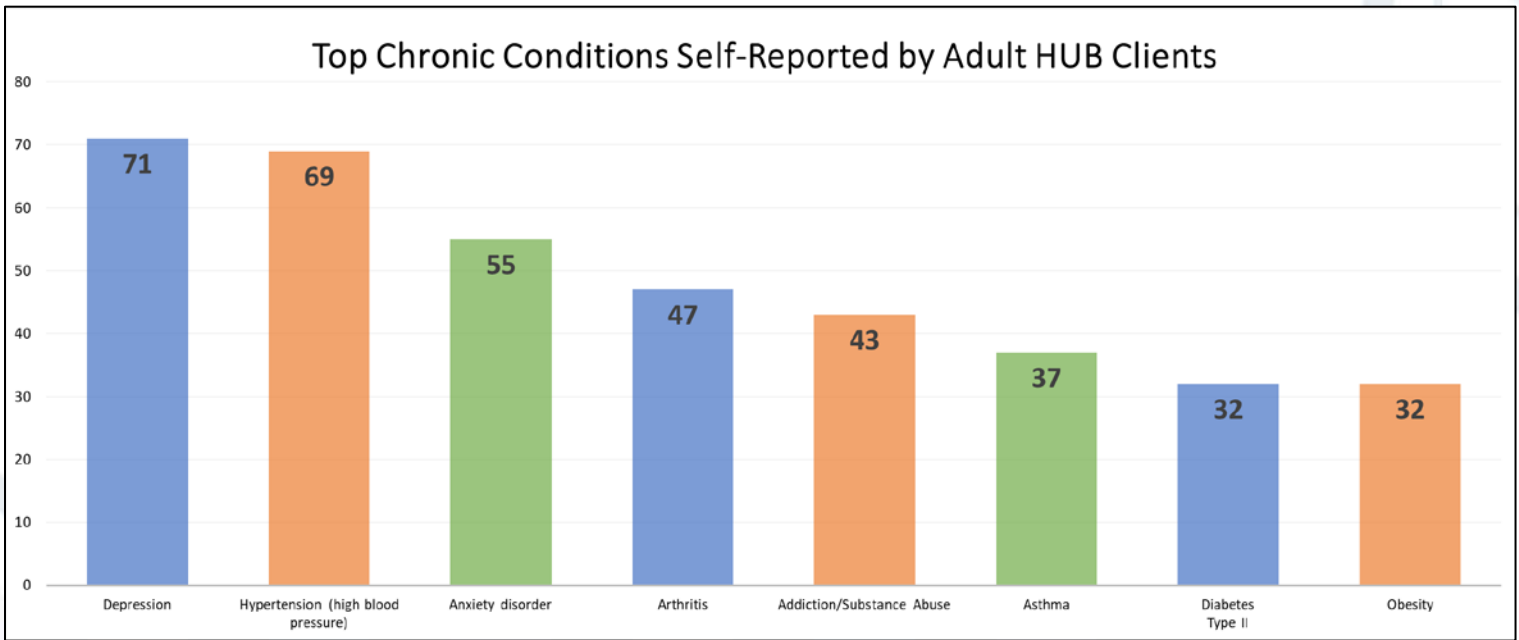
## ADULT CLIENTS: GEOGRAPHIC LOCATION



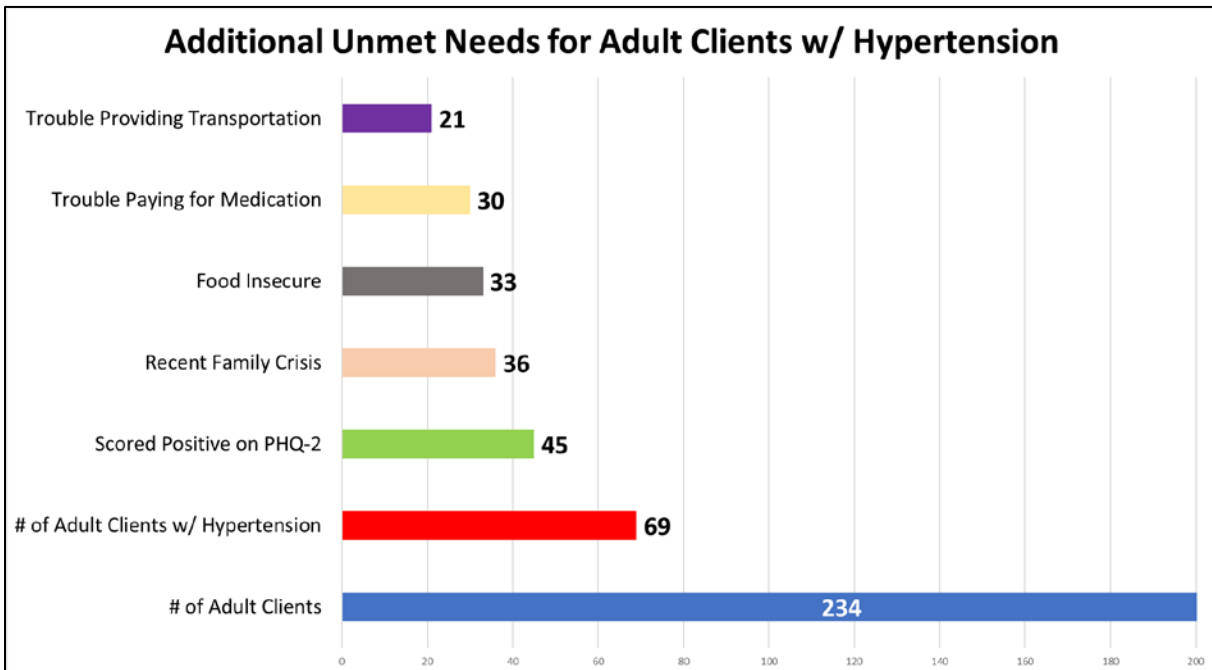
## ADULT CLIENTS: DO YOU HAVE A FAMILY DOCTOR?



## ADULT CLIENTS: CHRONIC CONDITIONS



## WHAT DO PATIENTS IN THE HUB WITH HYPERTENSION NEED TO HELP THEM MANAGE THEIR CONDITIONS?



## QT REPORT & PATHWAYS HUB: BEHAVIORAL HEALTH

The following maps and data display an intersection of information from HCGC's Pathways HUB and our quality transparency reporting partners. Using data from both projects allow stakeholders to see regional trends and the opportunity to drill down into granular details about individual zip codes and populations living there.

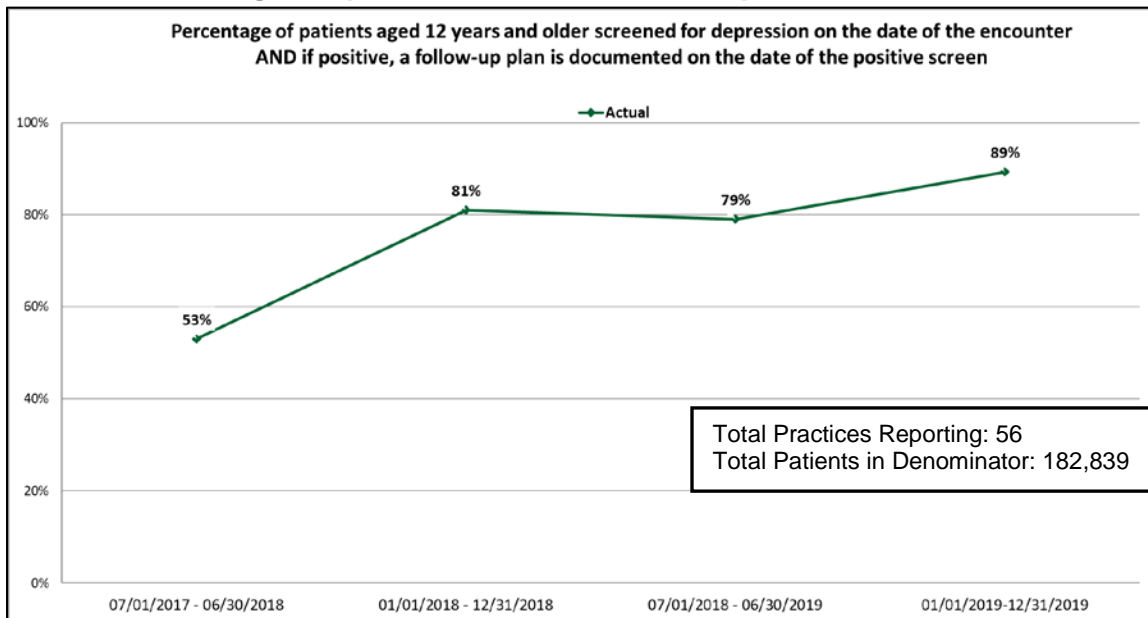
All HUB client types (Adult, Maternal, & Pregnant) are included. At each face-to-face meeting, CHWs administer a PHQ2 and clients who answer affirmatively to either PHQ2 question are also given a PHQ9.

Central Ohio Pathways HUB PHQ-9 Data (All Client Types) 3/1/2019 - 1/31/2020			
	Total	Average Severity Score	
# Clients w/ PHQ 9 Administered	313	6.4	
# PHQ9's Administered	655	6.2	
# PHQ9's w/ Score >9	160	13.8	
	Initiated	Completed	Finished-Incomplete
Total Behavioral Health Pathways	55	18	5
Total Medical Referral Pathways -Mental Health	40	8	18
Total Medical Referral Pathways - Substance Use	11	4	4

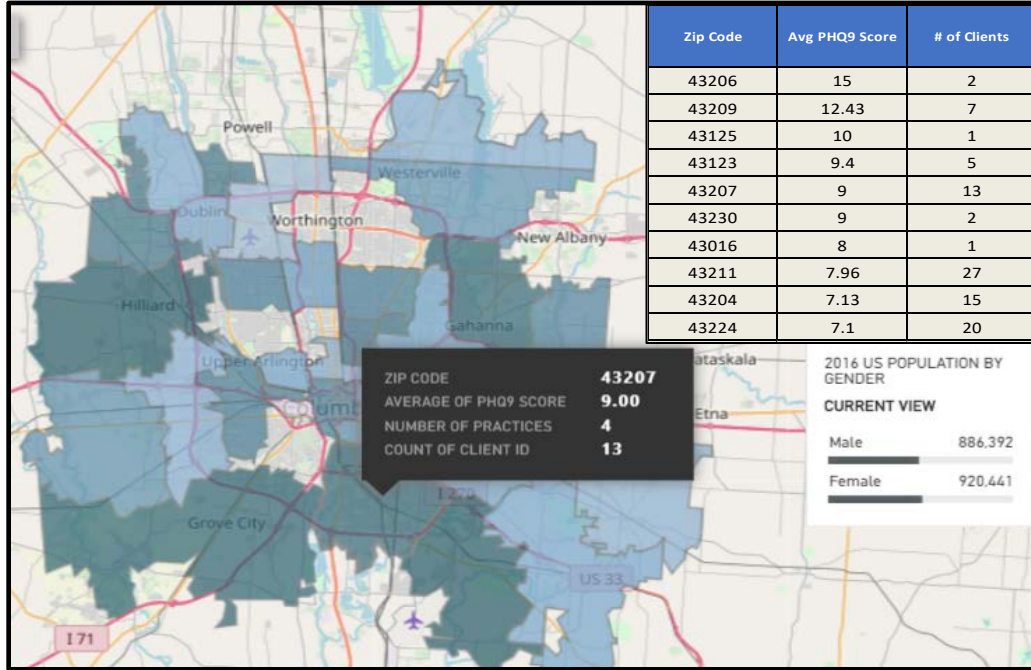
## QT Report: Screening for Clinical Depression and Follow-Up Plan

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)

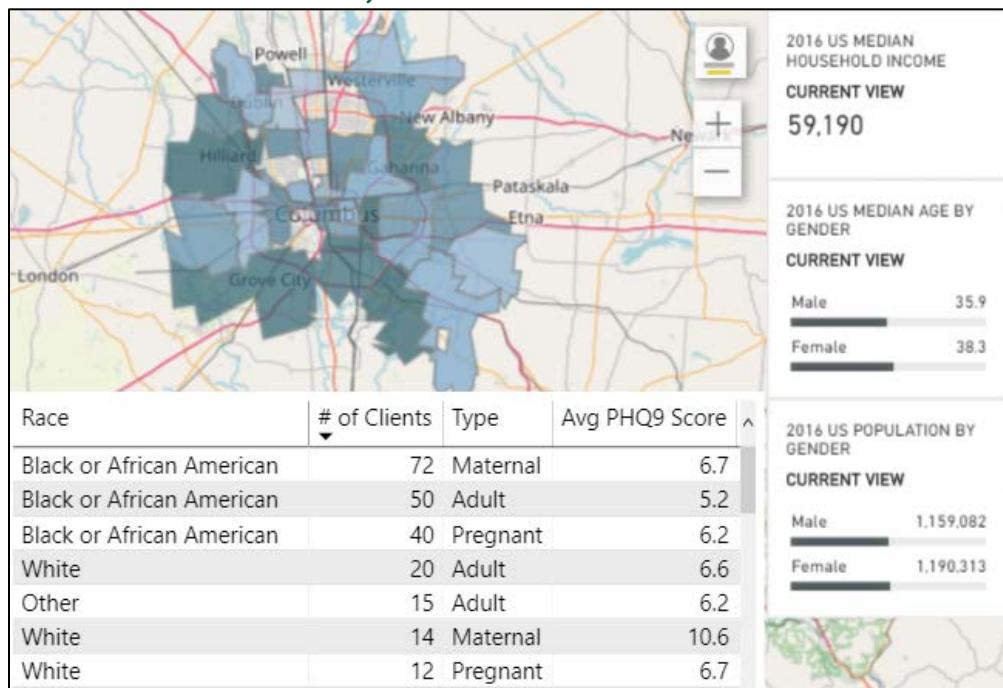
**Regional performance for the current period = 89.3%**



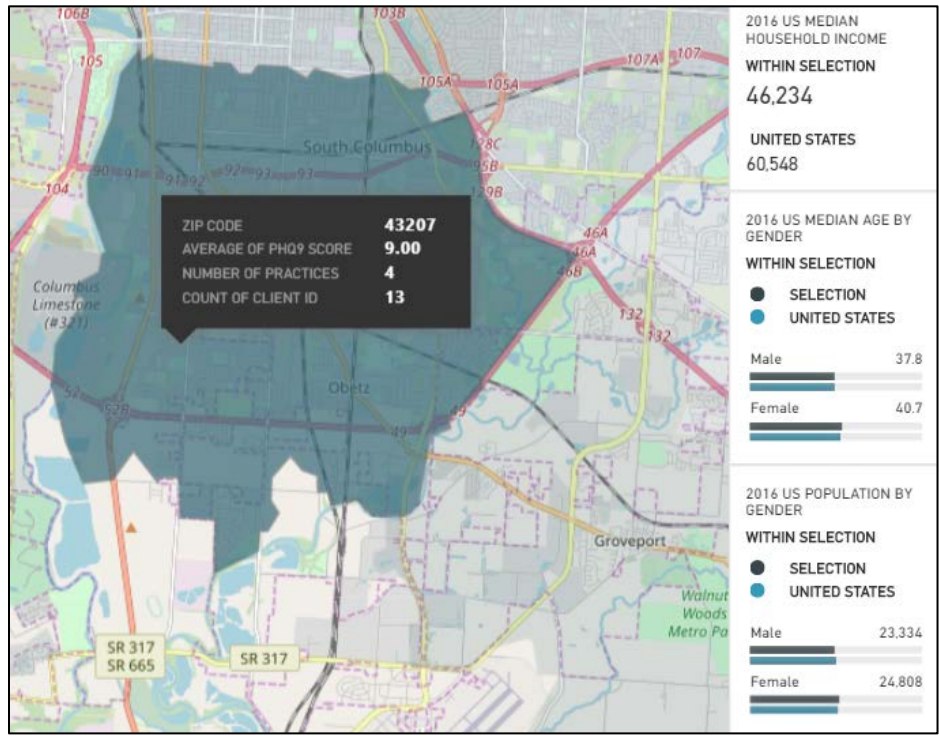
## ZIP CODES WITH HIGHEST AVERAGE PHQ9 SCORE, # OF CLIENTS, & # OF PRACTICES IN QT REPORT



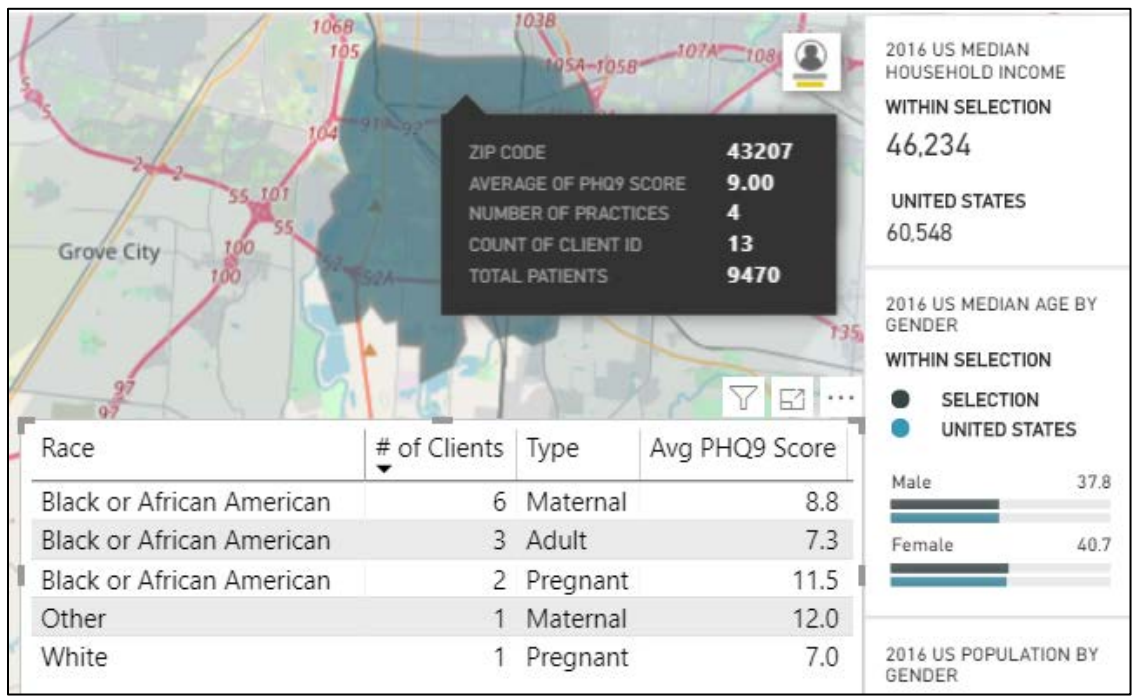
## ZIP CODES WITH HIGHEST AVERAGE PHQ9 SCORE, # OF PRACTICES, CLIENTS & CENSUS DATA



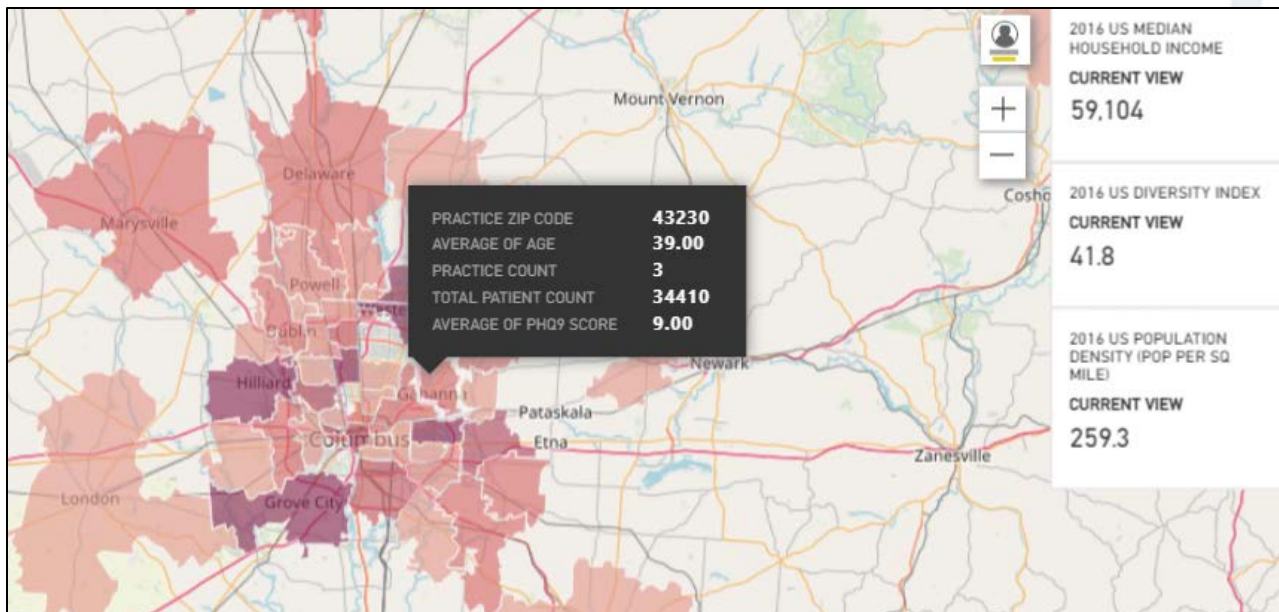
## DRILLDOWN: ZIP CODES WITH HIGHEST AVERAGE PHQ9 SCORE, # OF PRACTICES, CLIENTS & CENSUS DATA



## DRILLDOWN: ZIP CODES WITH HIGHEST AVERAGE PHQ9 SCORE, # OF PRACTICES, CLIENTS & CENSUS DATA



## CITIES WITH # OF PRACTICES, PATIENTS, AVERAGE PHQ9 SCORE, AND US CENSUS DATA



## DRILLDOWN: CITIES WITH # OF PRACTICES, PATIENTS, AVERAGE PHQ9 SCORE, AND US CENSUS DATA

