

Adoption of Health Center Performance Measures and National Benchmarks

*Peter Shin, PhD, MPH; Anne Markus, JD, PhD, MHS;
Sara Rosenbaum, JD; Jessica Sharac, MPH*

Abstract: This study examines the adaptability of standardized performance measurement tools in 3 community-based health centers. Although health centers have considerable experience in the area of performance reporting, they do not currently participate in a national reporting system that is transparent and standardized. The analysis of the data collected from health centers indicates that not only can these safety net providers readily integrate standardized measures, the quality of care being provided compare favorably to national benchmarks. With evidence of solid performance may come the types of financial adjustments essential to permitting health centers to move more decisively into the broader private health insurance markets that may exist in their service areas. **Key words:** *community health centers, performance, quality, underserved, vulnerable populations*

MUCH of the current focus on quality can be traced to the Institute of Medicine's seminal reports, *To Err Is Human* (Kohn et al., 1999) and *Crossing the Quality Chasm* (Hurtado et al., 2001), which set out a framework for performance improvement that, among other goals, aims to increase the rate of adherence to performance standards for which there is a strong evidence base. The goal of measurement tools, as the Institute of Medicine has noted, is to promote adherence by health professionals and healthcare entities to the right care, in the right place, at the right time, and in a manner that is consistent with patient needs and values. Standardized performance measurement tools are now in use by hundreds of private employer-sponsored health plans, as well as by the Medicare Advantage program, public employer-sponsored plans, and many state Medicaid programs that purchase managed care products for their beneficiaries.

Safety net providers that serve as major sources of primary care for low-income populations and communities at high risk for poor health outcomes generally lack a national set of quality-of-care measures that may allow public purchasers to ascertain their performance. Notably, the single largest primary healthcare system in the United States include federally-qualified health centers (known as FQHCs) which receive federal operating grants under §330 of the Public Health Service Act and centers and qualify for special Medicare and Medicaid payment rates because they meet all §330 grant requirements. In 2006, the nation's 1002 FQHCs furnished comprehensive primary healthcare to more than 15 million patients, while 100 look-alike health centers furnished care to an additional 1 million persons (National Association of Community Health Centers, 2007). While health centers have considerable experience in the area of performance reporting, particularly to the funding agency, the Health Resources and Services Administration (HRSA) in the Department of Health and Human Services, the reporting measures are not standardized to common market metrics and reporting methods (Chin et al., 2004).

From the Department of Health Policy, School of Public Health and Health Services, George Washington University.

Performance reporting is rapidly becoming a standard expectation in all third-party payment programs, and in the case of private health insurance, may be the key to reversing the existing revenue-to-patient picture, which places per capita private insurance payment levels even below the rate paid by the federal government for uninsured patients, thereby further straining health centers' ability to furnish care to their uninsured patients (Rosenbaum & Shin, 2006). Although the quality of care has been long recognized (Frick et al., 2001; Hadley et al., 2006; Hicks et al., 2006; Landon et al., 2007; Politizer et al., 2003), health centers lack a national reporting system that is transparent and standardized to well-accepted evidence-based measures of clinical quality and patient satisfaction.

This article examines the ability of 3 health centers to adopt national performance standards and their results. The quality-of-care measurement tool and findings from 3 health centers are described.

THE QUALITY-OF-CARE MEASUREMENT TOOL FOR HEALTH CENTERS

For several years, the United Health Foundation (UHF) has been actively engaged in efforts to assist 3 health centers located in Miami, New York, and Washington, DC* to expand access and improve healthcare quality, in communities suffering from high rates of HIV, asthma, diabetes, obesity, and cardiovascular disease.[†] As part of its multiyear grants from UHF, the 3 health centers were required to report on quality performance reporting system that mirrors standardized measurement systems such as HEDIS and thus permits healthcare purchasers, policy makers, and patients to view and compare the quality.

The health centers applied 10 of the 21 clinical measures from the Ambulatory Care Quality Alliance (AQA) effort—the AQA in-

cludes a notable range of stakeholder leaders, spanning across private and commercial health plans, healthcare and health advocacy organizations, medical specialty societies, and public and private health benefits purchasers.[‡] In addition, the health centers surveyed the Consumer Assessment of Healthcare Providers and Systems program questions similarly posed under the health center reporting system used by the Bureau of Primary Health Care, HRSA. On the basis of the methodology used by HRSA for its patient survey, the health center manager randomly selected a day to distribute the survey; unlike Consumer Assessment of Healthcare Providers and Systems program, which requires telephone.

Because some of the AQA measures were based on health plan reporting capabilities, minor definition changes were made to accommodate the health center settings. For example, "continuous enrolled" of health plan members in the HEDIS measures were translated as health center users with 3 visits.

Other variations include increase in sample size. The December 2005 rates are based on the pilot testing of the instrument against 25 medical charts, followed by full implementation that involved approximately 200 chart reviews, if not all of the eligible patient population.[§] The reporting measures for the preventive care measurement (ie, tobacco and cervical cancer screening) span 2 to 3 years while the other measures span 1 year. Although the pilot phase included a smaller sample, the rates remain generally consistent with subsequent results and are included in the analysis.

[‡]<http://www.ahrq.gov/qual/aqaback.htm> (Accessed, September 20, 2007)

[§]The sample size for 2 measures on percentage of diabetic patients with documented plan of care for hypertension was 50 and for percentage of patients with asthma who were prescribed medication or treatment was 100 because of small number of eligible patient population. Two health centers reviewed all their charts for measures related to tobacco use or smoking but had less than 100 eligible patients for certain measurement periods.

*A fourth health center in New Orleans was added in 2006.

[†]<http://www.unitedhealthfoundation.org/access.html> (Accessed September 20, 2007).

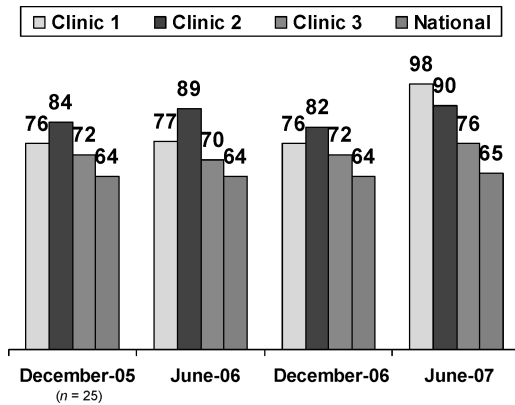


Figure 1. Cervical cancer screening: Percentage of women who had 1 or more Papanicolaou test.

FINDINGS

Unlike annual reports generally submitted by health plans, health centers provided their reports every 6 months to assess the quality of reporting and the measurement, as well as to identify potential areas for improvement in quality of care provided by each of the sites. Where they exist, national HEDIS benchmark averages are included in the figures.

Prevention: Cervical cancer screening

On the basis of HEDIS, the AQA measure examines percentage of women who had 1 or more Papanicolaou tests. Figure 1 shows that all 3 grantees were above the national average for cervical cancer screening. Three clinics reported that 76% or more of women had at least 1 Papanicolaou test in the past 2 years.

Comprehensive diabetes care

Figures 2-6 show the UHF grantee clinics' results for 5 measures of quality of care for persons with diabetes. Figure 2 indicates that all 3 clinics reported higher percentage of patients with diabetes mellitus than the national mean of 81% patients with respect to the percentage of patients with diabetes mellitus who had at least 1 low-density lipoprotein cholesterol test for the reporting period of June 2007. Figure 3 also shows that the percentage of patients with diabetes who had low-density lipoprotein cholesterol below 130mg/dL was well above the national mean of 51%.

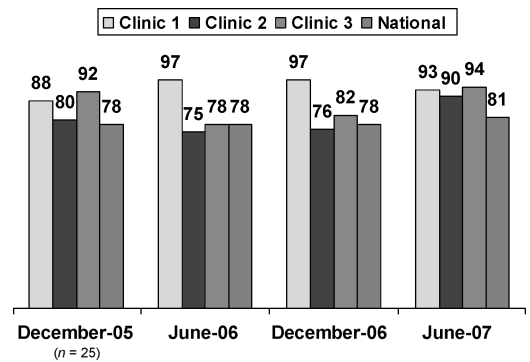


Figure 2. Diabetic patients: Percentage of patients with diabetes with 1 or more low-density lipoprotein cholesterol test.

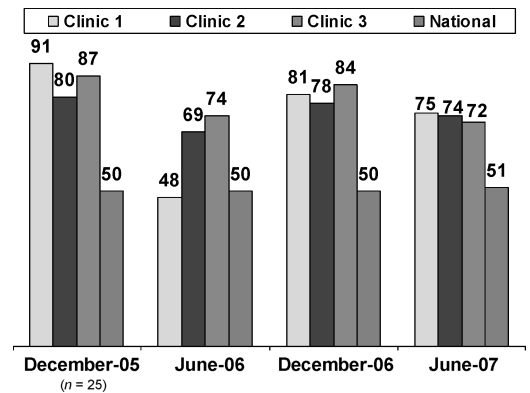


Figure 3. Diabetic patients: Percentage of patients with most recent low-density lipoprotein cholesterol level less than 130 mg/dL.

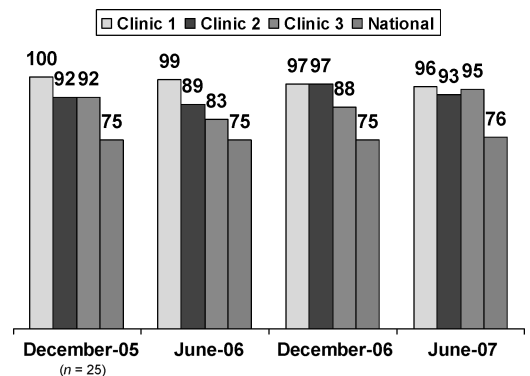


Figure 4. Diabetic patients: Percentage of patients with diabetes with 1 or more HbA1c test.

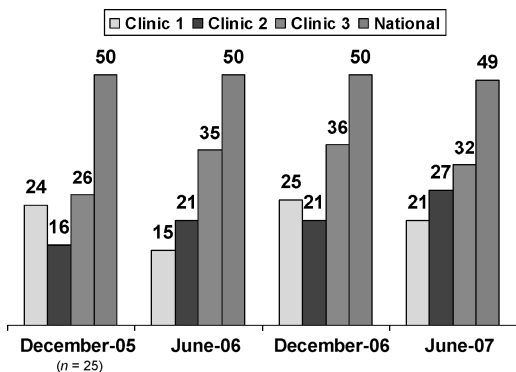


Figure 5. Diabetic patients: Percentage of patients with most recent HbA1C level 9.0% or more.

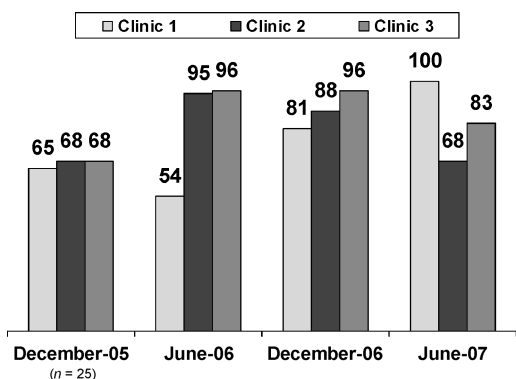


Figure 6. Diabetic patients: Percentage of patients who had their blood pressure more than 140/90 mm Hg with a documented plan of care.

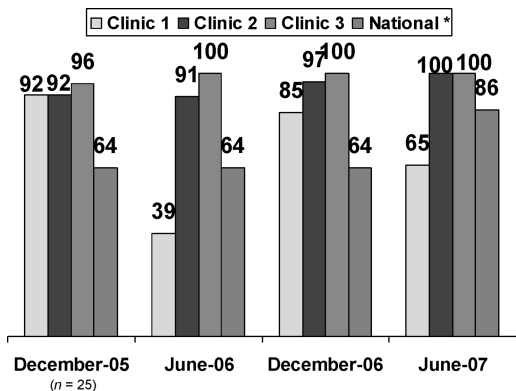


Figure 7. Patients with asthma: Percentage of patients in pharmacologic therapy. *Note:* National benchmark is for patients aged 5–56 years; and community health center percentages are for patients aged 5–40 years.

Figures 4 and 5 also indicate that the quality of care provided to patients with diabetes at the clinics is high. Figure 5 shows a relatively high percentage of patients with diabetes who had at least 1 HbA1c test over the past year. The lowest percentage was 92%, well above the national average of 75%. Figure 5 also supports the evidence of higher quality of care for patients with diabetes, in which none of the health centers reported in excess of 32% of patients with diabetes with poorly controlled HbA1c levels greater than 9%.

In Figure 6, the fluctuating changes in the measures reflect largely changes in the methodology and definition of the measures. For example, health centers were unclear if “plan of care” referred to documentation that results in good outcomes or simply documentation of the existence of a care plan. In general, the majority of the diabetes measures indicate significant favorable clinical performance with respect to diabetes-related care. No national benchmarks exist for this measure, which were designed by clinics.

Asthma

The asthma measure reports on the percentage of all individuals with mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment during the measurement period. In general, the health centers performed on average favorably to the national benchmark. The large fluctuations for one health centre reflect the fact that it did not have as large sample to draw the data for some of the measurement periods.

Tobacco and smoking

Figures 8 and 9 show the percentage of adult patients who were queried about tobacco use or smokers who were advised to quit. Although no national benchmarks exist for these measures, grantees reported that 65% to 96% of patients were queried about tobacco use and that 64% to 72% of smokers were advised to quit. The fluctuations in some cases again reflect the fact that some clinics had a very small sample of charts to draw.

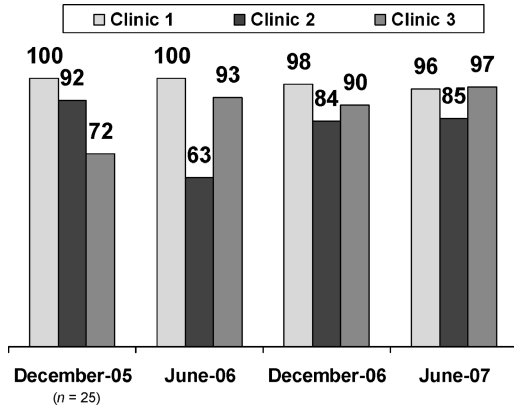


Figure 8. Tobacco chart reviews: percentage of patients queried about tobacco use.

Prenatal care HIV screening

Figure 10 reports on the percentage of pregnant women who were screened for HIV during the first and second trimester. Because of the health centers’ high performance on the measure in first 3 reports and the lack of national benchmarks, health centers amended the measure to report on the percentage of pregnant women who were screened again for HIV in their 28th–32nd weeks’ gestation* in the June 2007 report.

PATIENT SATISFACTION

The results of the patient satisfaction survey show that all health centers performed well against the national satisfaction rate for Medicaid health plans. Figure 11 shows the results of all 7 questions. Because the methodology for the survey differs significantly from HCAPS, no benchmarks are provided. The measures show relatively high rates of satisfaction among all health centers with provider but vary on services related to answering calls on the same day, providing information in the waiting room, referring to specialists, and following up with laboratory results.

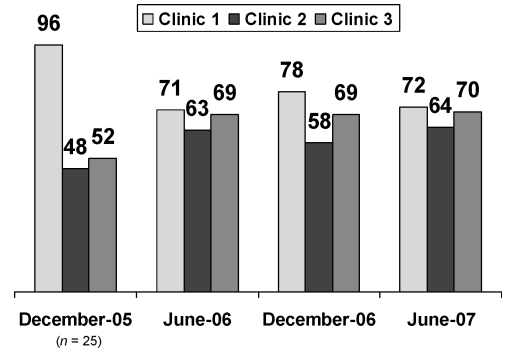


Figure 9. Tobacco chart reviews: percentage of patients who were advised to quit smoking.

CONCLUSIONS

The analysis shows that health centers can adopt national performance standards to report on and improve quality of care. With adequate resources and support, health centers can readily adapt to standardized reporting systems that give communities, patients, healthcare purchasers, program administrators, and policy makers access to standardized, transparent quality of care and patient satisfaction data using measures that are evidence-based and that have achieved broad consensus in the field of quality measurement. At the same time, these results show that health centers are not simply high-quality providers for medically underserved

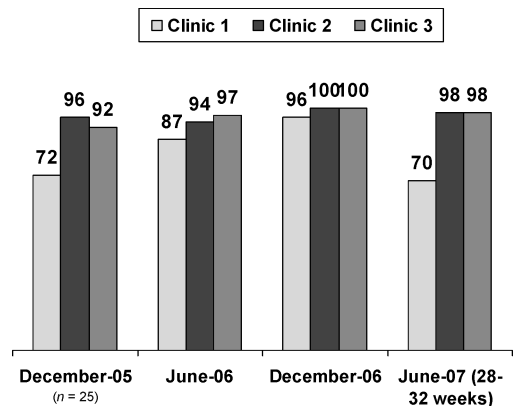


Figure 10. Prenatal care: HIV screening: percentage of patients who were screened for HIV during the first or second prenatal care visit.

*In accordance with some states, such as Florida, and organizational guidelines (eg, Association of Maternal and Child Health Programs).

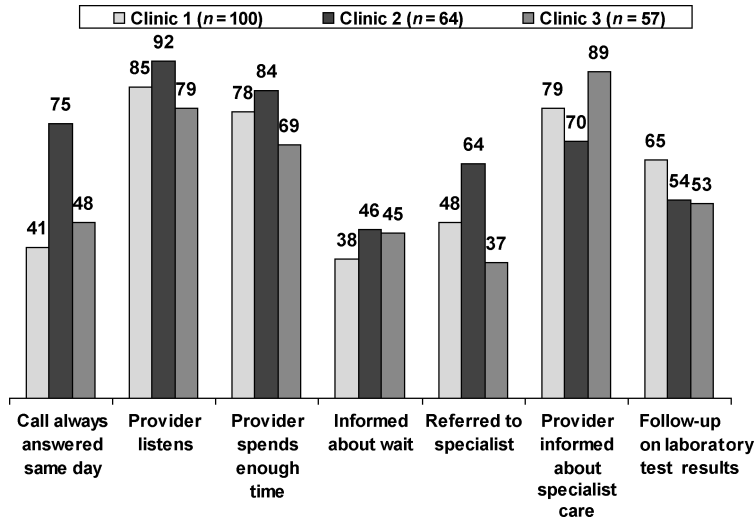


Figure 11. Patient surveys, June 2007 (“always/almost always”).

populations, but valuable sources of health-care for *any* group of patients. Given the complex healthcare needs of a disproportionately low-income and at-risk patient population, the data are especially impressive, showing that the quality of care provided often exceeds the national average.

Whether demonstration of quality will in turn translates into improved payment levels to ensure that health center grant funds remain available for the care of uninsured persons remains a separate and important question. In addition, as Medicaid, Medi-

care, and the private health insurance industry moves toward the widespread use of performance-based payment structure, health centers' ability to demonstrate quality may be critical. With evidence of solid performance may come, the types of financial adjustments essential to permitting health centers to move more decisively into the broader private health insurance markets that may exist in their service areas. Had we risk adjusted the population these health centers serve, the quality of care estimated most likely would have been substantially greater.

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