



Community Health Center Association of Connecticut

Presentation to the State-wide Health Care Facilities and
Services Plan Advisory Body

Data Available regarding Federally Qualified Health Centers and Primary Care

April 13, 2011

CONNECTICUT COMMUNITY HEALTH CENTERS FACTS, 2009

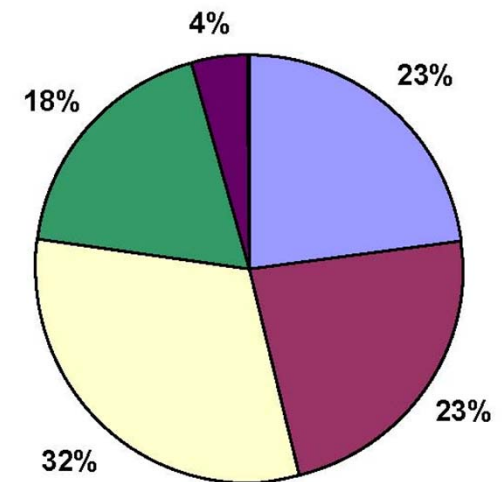
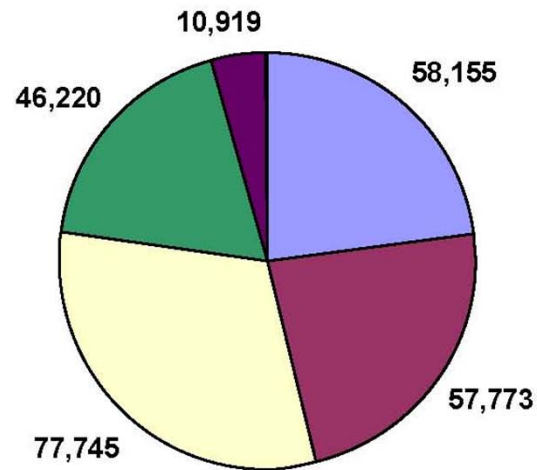
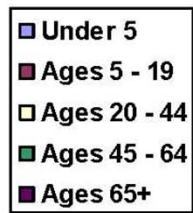
- * 14 Community Health Centers (CHCs) operating 132 sites across the state.
- * Served more than 290,000 patients, approximately 72% of whom had incomes at or below the federal poverty level (FPL) and approximately 95% of whom had incomes at or below 200% of FPL.
- * As part of a national effort to serve 40 million people by 2015, Connecticut health centers are working to expand access to care to additional Connecticut residents statewide.

Connecticut FQHC Data

Patients by Age

Data Year: 2009

Patients: 289,395



Connecticut FQHC Data

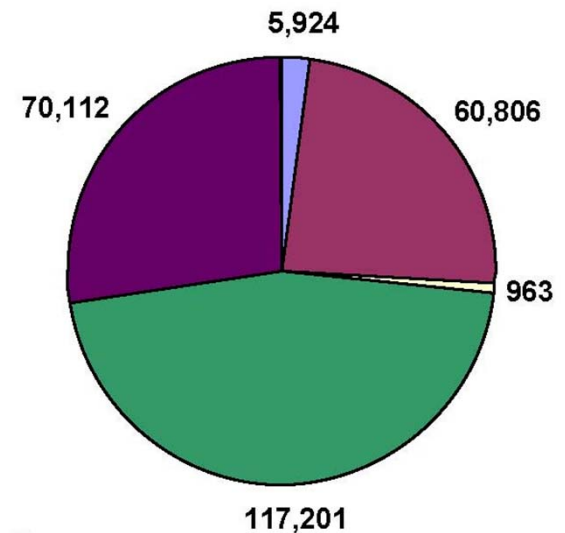
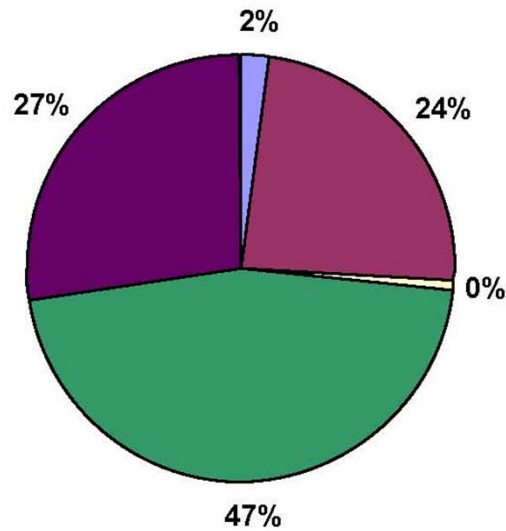
Patients by Race

Data Year: 2009

Patients: 289,395



Hispanic / Latino Patients: 101,233(35%)

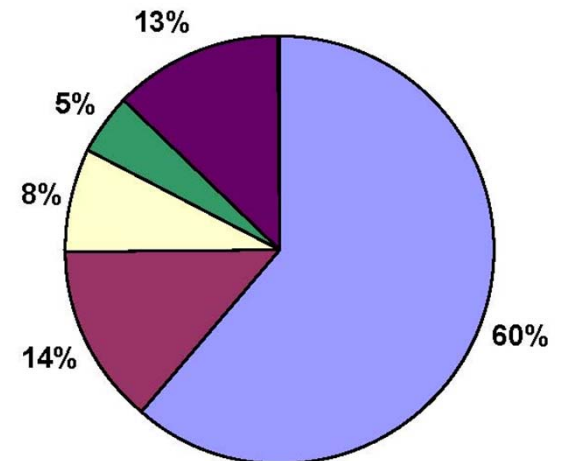
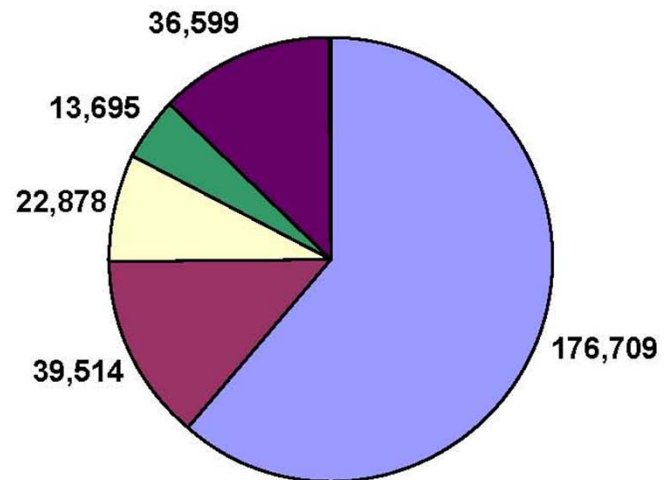


Connecticut FQHC Data

Patients by Income Level

Data Year: 2009

Patients: 289,395

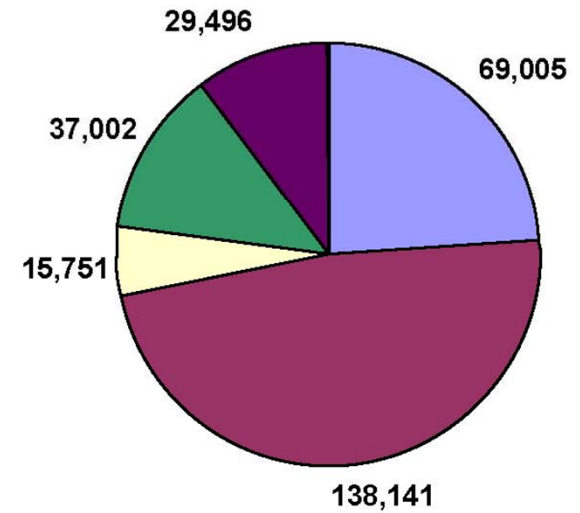
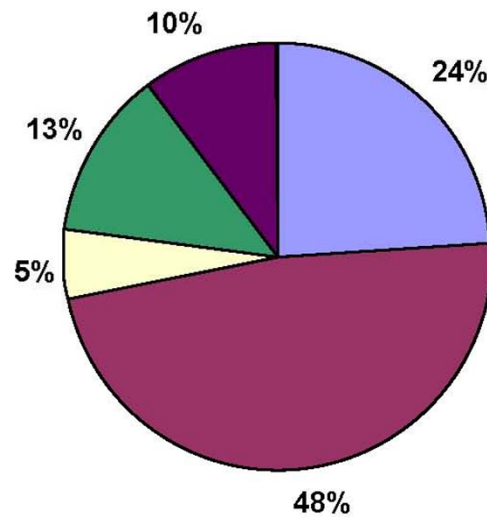
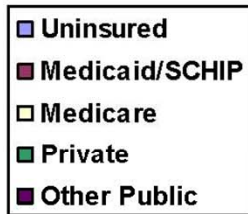


Connecticut FQHC Data

Patients by Insurance Status

Data Year: 2009

Patients: 289,395



Uniform Data System - UDS

- * An integrated reporting system used by all Community Health Centers, Migrant Health, Healthcare for the Homeless and Public Housing Primary Care grantees
- * A core set of information annually that is appropriate for reviewing and evaluating performance and for reporting on annual trends.
- * A calendar year report

Content of the UDS

- * Patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues
- * UDS data are collected from grantees and reported at the grantee, state, and national levels

UDS

The UDS is composed of 11 tables intended to yield consistent clinical, operational and financial data that can be compared with other national and State data and trended over time.

- * Table 3A: Profile of patients by age and gender.
- * Table 3B: Profile of patients by race, ethnicity and language.
- * Table 4: Profile of patients by income (% of poverty level) and third party medical insurance source. It also reports the number of targeted population patients receiving services.

UDS

- * Table 5: Reports staffing full-time equivalents by position, and visits and patients by provider type and service type.
- * Table 6A: Reports on primary diagnoses for medical visits and selected services provided.
- * Table 6B: Reports findings on quality of care indicators.
- * Table 7: Reports findings on health outcomes/disparities.
- * Table 8: Details direct and indirect expenses by cost center.
- * Table 9D: Reports full charges, collections and allowances by payor as well as sliding discounts and patient bad debt.
- * Table 9E: Reports non patient-service income.

Self-selected Mental Health and Dental Measures

Some samples:

- * Mental Health---

- Increase % of medical primary health care patients ages 18 and older receiving mental health/substance abuse screening
- Increase average number of adult mental health visits
- Increase the % of pregnant women screened for Domestic Violence

Dental Measures

- Increase the % of children 0-1 who have their first dental exam
- Dental Treatment Plans will be completed
- Sealants provided to children with their 1st molars (6-8 yrs) and 2nd molars (13-15 yrs) erupted
- % of clients who receive a hygiene visit and a dental treatment visit annually, to improve treatment plan compliance

Use of the UDS

- * Ensure compliance with legislative and regulatory requirements
- * Improve health center performance and operations, and report overall program accomplishments
- * Identify trends over time, enabling HRSA to establish or expand targeted programs and identify effective services and interventions to improve the health of underserved communities and vulnerable populations
- * Inform Health Center Program grantees, partners, and communities about the patients served by Health Centers.

UAD - UDS Analysis Database

- * A tool that can be used by PCAs to track grantee data submitted to the BPHC to:
 - Quickly and accurately compile UDS data for all grantees
 - Produce reports on financial, productivity, and BPHC benchmark measures
 - Use the data to respond to requests from policy makers and to determine best practices at grantee health centers

2009 Connecticut FQHC Data from Table 5

PERSONNEL BY MAJOR SERVICE CATEGORY		FTEs (a)	Clinic Encounters (b)
1.	Family Physicians	45.51	169,085
2.	General Practitioners	0.00	0
3.	Internists	38.10	130,715
4.	Obstetrician/Gynecologists	9.42	36,070
5.	Pediatricians	35.60	127,946
7.	Other Specialist Physicians	3.23	11,028
8.	Total Physicians (Lines 1 -7)	131.86	474,844
9a.	Nurse Practitioners	70.44	188,841
9b.	Physician Assistants	22.66	55,720
10.	Certified Nurse Midwives	12.70	34,747
10a.	Total "Mid-Levels" (9a - 10)	105.80	279,308
11.	Nurses	171.95	41,686
12.	Other Medical Personnel	227.51	
13.	Laboratory Personnel	8.33	
14.	X-ray Personnel	0.40	
15.	Total Medical (Lines 8 + 10a through 14)	662.90	813,574

2009 Connecticut FQHC Workforce Data ~ Table 5

16.	Dentists	54.61	147,496
17.	Dental Hygienists	40.81	81,569
18.	Dental Assistants, Aides, and Techs	89.70	
19.	Total Dental Services (Lines 16 - 18)	201.08	244,055

2009 Connecticut FQHC Workforce Data ~ Table 5

20a.	Psychiatrists	13.06	36,987
20a1.	Licensed Clinical Psychologists	6.83	5,086
20a2.	Licensed Clinical Social Workers	81.29	59,197
20b.	Other Licensed Mental Health Providers	14.61	26,588
20c.	Other Mental Health Staff	39.05	82,030
20.	Mental Health (Lines 20a-c)	194.78	241,934

2009 Connecticut FQHC Workforce Data~ Table 5

24.	Case Managers	70.23	25,802
25.	Patient / Community Education Specialists	36.28	15,461
26.	Outreach Workers	52.79	
27.	Transportation Staff	0.32	
27a.	Eligibility Assistance Workers	9.52	
27b.	Interpretation Staff	6.79	
28.	Other Enabling Services	23.61	
29.	Total Enabling Services (Lines 24-28)	206.14	48,995

2009 Connecticut FQHC State Roll up Data

*Total FTEs = 1,940

*Total Encounters = 1,419,864

UDS Financial Data

- * Trend Analyses by Service
 - Medical, Dental, Mental Health, Substance Abuse, Enabling
 - Cost per encounter
 - Cost per user
 - Users by FTE provider
 - Encounters per user
 - Productivity
- * Trend Analyses by Payor Type
 - Collections
 - Charges
 - Uncompensated care
 - Grant funding

UDS Clinical Outcome Data

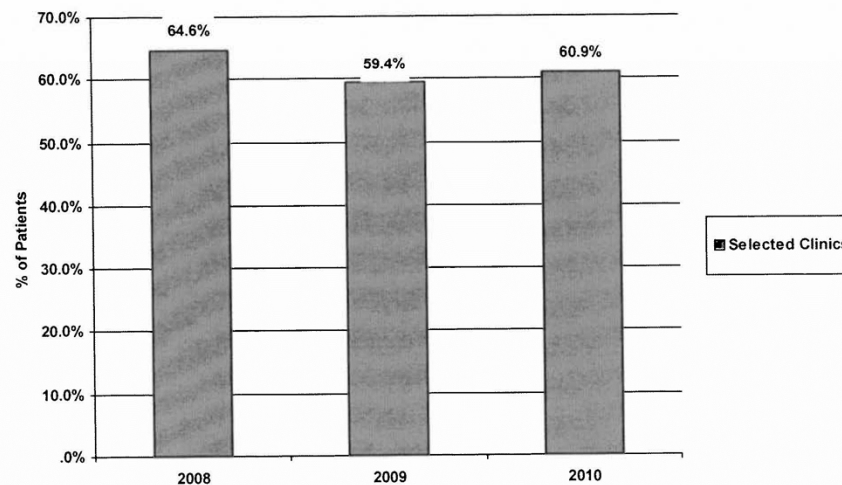
* Clinical Outcome Date

- Prenatal in the first trimester
- Vaccines up to date by 2 years old
- Pap tests
- Birth <2500 grams
- Adult HTN BP<140/90
- DM HbA1c Levels ≤ 9

Trending impact on health outcomes

Clinical Measure - Adult HTN BP<140/90

SELECTED CLINICS



FORMULA (USING UDS TABLE INFO): $T7L8C1 / T7L7C1$

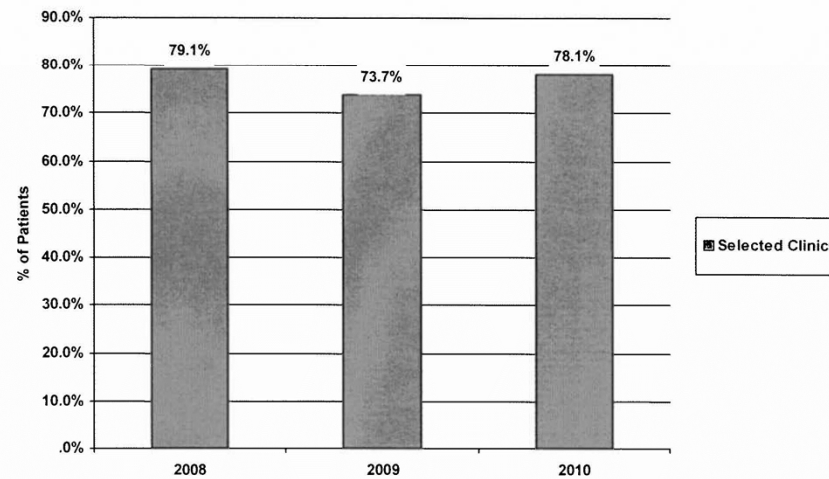
FORMULA NARRATIVE: PATIENTS WITH CONTROLLED BLOOD PRESSURE DIVIDED BY NUMBER OF CHARTS SAMPLED OR EHR TOTAL

SELECTED CLINICS: COMMUNITY HEALTH SERVICES, INC., EAST HARTFORD COMMUNITY HEALTH CENTER, INC., FAIR HAVEN COMMUNITY HEALTH CENTER, INC., GENERATIONS FAMILY HEALTH CENTER, INC., OPTIMUS HEALTH CARE, INC., SOUTHWEST COMMUNITY HEALTH CENTER, INC., STAYWELL HEALTH CARE, INC.

Impact on health outcomes

Clinical Measure - DM HbA1c Levels ≤ 9

SELECTED CLINICS



FORMULA (USING UDS TABLE INFO): $(T7L11CI + T7L12CI) / T7L10CI$

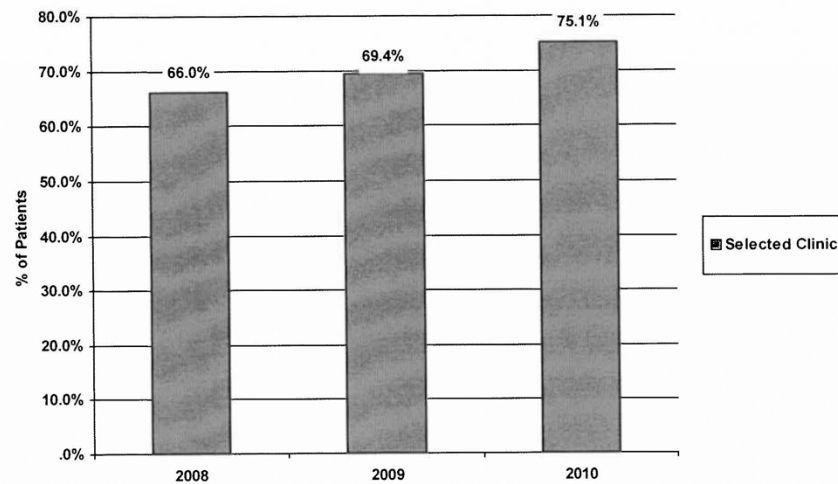
FORMULA NARRATIVE: PATIENTS WITH ELEVATED GLYCATED HEMOGLOBIN LEVELS DIVIDED BY NUMBER OF CHARTS SAMPLED OR EHR TOTAL

SELECTED CLINICS: COMMUNITY HEALTH SERVICES, INC., EAST HARTFORD COMMUNITY HEALTH CENTER, INC., FAIR HAVEN COMMUNITY HEALTH CENTER, INC., GENERATIONS FAMILY HEALTH CENTER, INC., OPTIMUS HEALTH CARE, INC., SOUTHWEST COMMUNITY HEALTH CENTER, INC., STAYWELL HEALTH CARE, INC.

Impact on health outcomes

Clinical Measure - Prenatal Care in 1st Trmst.

SELECTED CLINICS



FORMULA (USING UDS TABLE INFO): (T6BL7CA + T6BL7CB) / T6BL6A

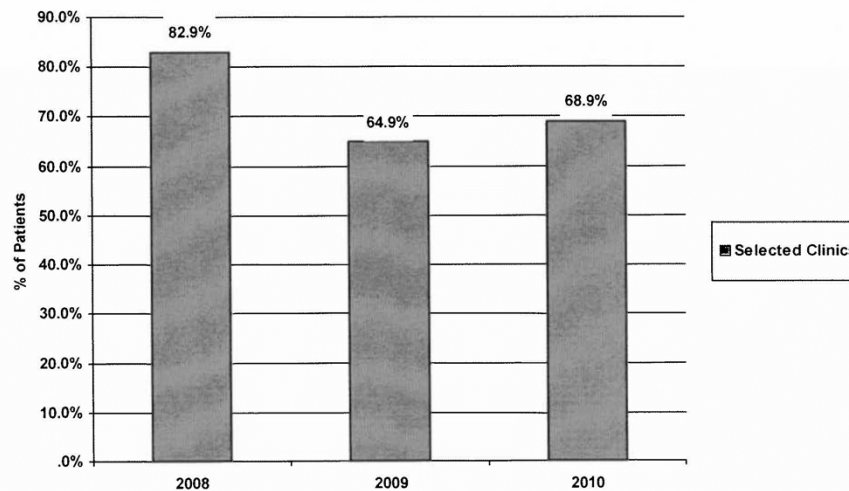
FORMULA NARRATIVE: WOMEN HAVING FIRST VISIT IN FIRST TRIMESTER (WITH GRANTEE + WITH PROVIDER) DIVIDED BY TOTAL PRENATAL PATIENTS

SELECTED CLINICS: COMMUNITY HEALTH SERVICES, INC., EAST HARTFORD COMMUNITY HEALTH CENTER, INC., FAIR HAVEN COMMUNITY HEALTH CENTER, INC., GENERATIONS FAMILY HEALTH CENTER, INC., OPTIMUS HEALTH CARE, INC., SOUTHWEST COMMUNITY HEALTH CENTER, INC., STAYWELL HEALTH CARE, INC.

Impact on health outcomes

Clinical Measure - Vaccines Up-To-Date by 2yo

SELECTED CLINICS



FORMULA (USING UDS TABLE INFO): T6BL10CC / T6BL10CB

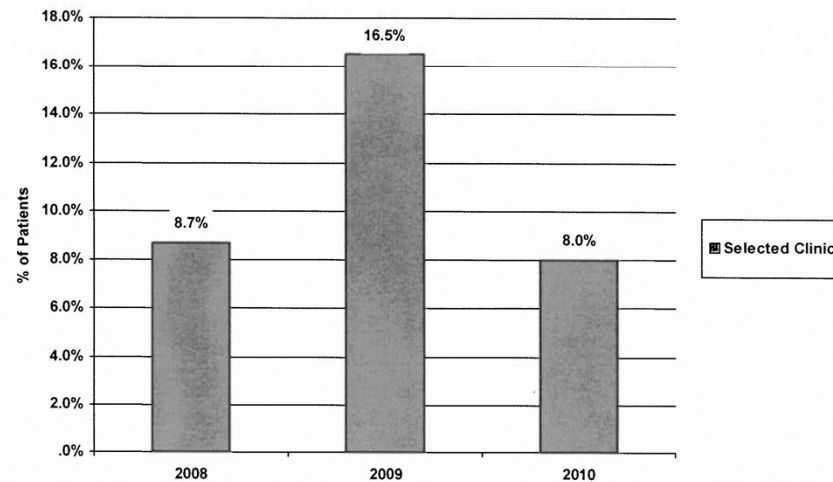
FORMULA NARRATIVE: NUMBER OF CHILDREN WHO RECEIVED REQUIRED VACCINES DIVIDED BY NUMBER OF CHARTS SAMPLED OR EHR TOTAL

SELECTED CLINICS: COMMUNITY HEALTH SERVICES, INC., EAST HARTFORD COMMUNITY HEALTH CENTER, INC., FAIR HAVEN COMMUNITY HEALTH CENTER, INC., GENERATIONS FAMILY HEALTH CENTER, INC., OPTIMUS HEALTH CARE, INC., SOUTHWEST COMMUNITY HEALTH CENTER, INC., STAYWELL HEALTH CARE, INC.

Impact on health outcomes

Clinical Measure - Births < 2,500 grams

SELECTED CLINICS



FORMULA (USING UDS TABLE INFO): $(T7L3CI + T7L4CI) / (T7L3CI + T7L4CI + T7L5CI)$

FORMULA NARRATIVE: LOW BIRTH WEIGHT BIRTHS DIVIDED BY TOTAL BIRTHS

SELECTED CLINICS: COMMUNITY HEALTH SERVICES, INC., EAST HARTFORD COMMUNITY HEALTH CENTER, INC., FAIR HAVEN COMMUNITY HEALTH CENTER, INC., GENERATIONS FAMILY HEALTH CENTER, INC., OPTIMUS HEALTH CARE, INC., SOUTHWEST COMMUNITY HEALTH CENTER, INC., STAYWELL HEALTH CARE, INC.

Measuring Economic Impact

EB2

In 2009, Connecticut Community Health Centers

- * Injected \$186 million of operating expenditures directly into the local economies, and stimulated additional indirect and induced economic activity of \$164 million.
- * Had an overall economic impact of \$350 million.
- * Directly generated 1,940 full-time jobs.
- * Supported an additional 1,115 jobs in other industries.

Slide 27

EB2

MG- Need a footnote to the Capital Link report

Evelyn Barnum, 4/11/2011

Reporting Challenges

- * Differences in number of health centers reporting
 - 2007 + 2008 = 10
 - 2009 = 13
 - 2010 = 14
- * Difference in measures reported
 - 2007 = Financial and statistical
 - 2008 = Added clinical measures*
 - Dental and mental health measures self selected but not reported in the UDS
- * Undetected differences in interpretation/definition
- *not all centers are required to report all measures

Restrictions on Use

- * All information developed from the UDS must be presented as aggregate information at the state level.

Beyond UDS... Looking at Unmet Need

- * UDS data is corporation specific not site specific but UDS Mapper to the rescue.....
- * Goal = To create access to tools and data that can assist in evaluating the geographic reach, penetration, and growth of the Section 330-funded Health Center Program and its relationship to other federally-linked health resources.

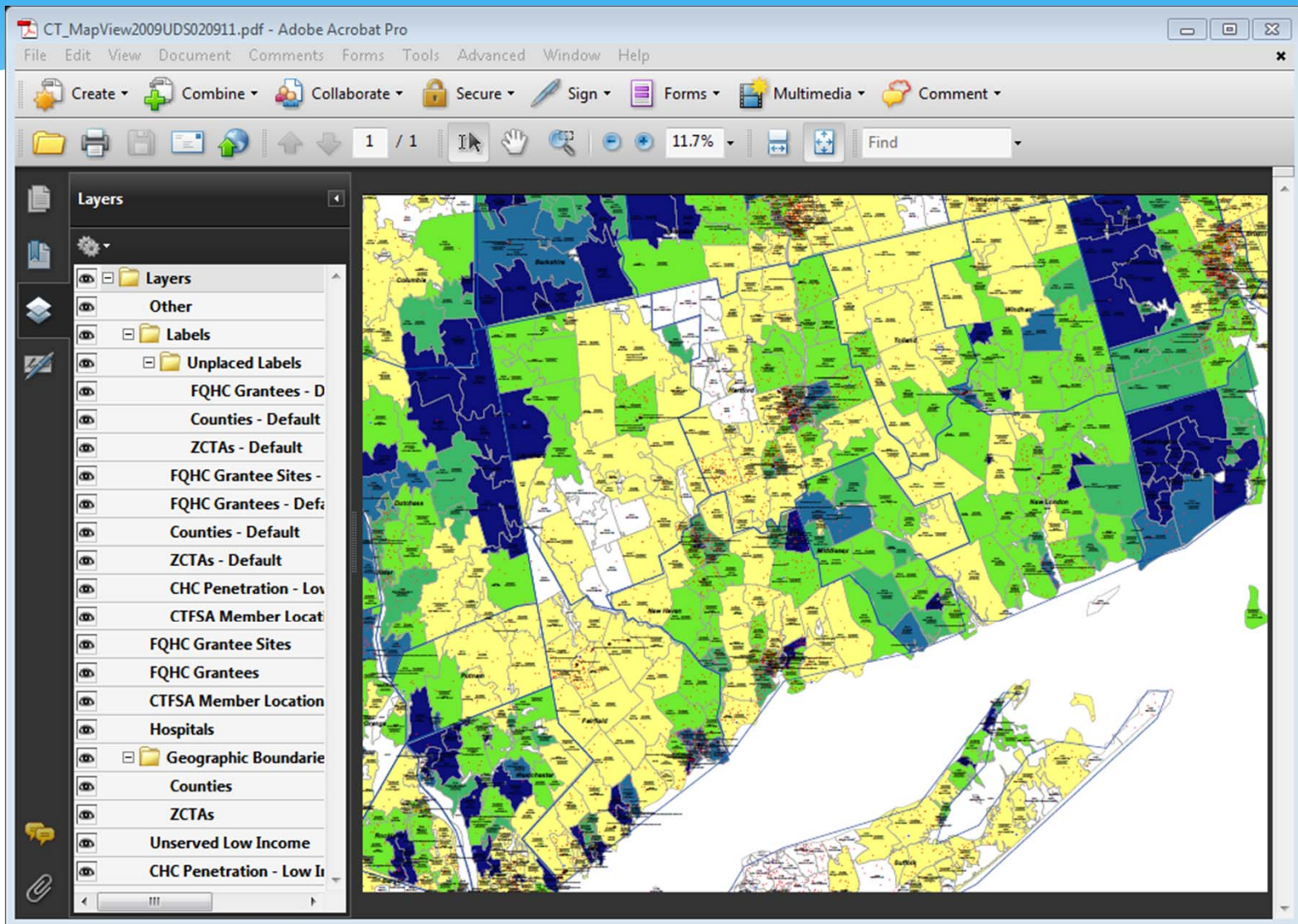
The world according to ZCTAs

The information available in the UDS Mapper includes estimates of the collective service area of these health centers by [ZCTA](#), including the ratio of Section 330-funded health center patients reported in the Uniform Data System (UDS) to the target population, the change in the number of those reported patients over time, and an estimate of those in the target population that remain unserved by Section 330-funded health centers reporting data to the UDS (but may be served by other providers).

UDS mapper ~ Available Maps

- * **Grantee Dominance by ZCTA** :the colors on the map are only attributed to dominant Section 330 grantees by ZCTA, and therefore are not representing the individual service areas of all grantees.
- * **All Grantee Penetration of Low Income Population** - displays the penetration rate of patients in a [ZCTA](#) (from all Section 330 grantees with over 10 patients in that ZCTA) as a ratio of the population at or below 200% of the 1999 Federal Poverty Level (otherwise known as the 'low-income' population) in that same ZCTA (the latter population number is based on Census 2000 data). In other words, for each ZCTA the total number of Section 330 patients (2009) is divided by the number of low-income residents.
- * **All Grantee Penetration of Total Population** - displays the penetration rate of patients in a [ZCTA](#) (from Section 330 grantees with over 10 patients in that ZCTA) as a ratio of the total population in that ZCTA (total population based on Census 2000 data). In other words, for each ZCTA the total number of patients is divided by the number of total residents. Lighter shaded ZCTAs therefore are believed to have a larger share of residents that do not utilize services provided by Section 330 grantees, but may be served by other types of providers. Because of the mismatch in reporting years, this measure is only an estimation and should be interpreted as such.
- * **Low Income Not Served by Grantees** - displays the estimated number of low-income (at/below 200% FPL) residents per ZCTA that are not served by Section 330 grantees (but may be served by providers from health centers not funded by Section 330). This number is calculated by subtracting the number of total Section 330 grantee patients reported in the UDS per [ZCTA](#) (from all grantees with over 10 patients residing in that ZCTA) from the number of low-income (at/below 200% FPL, Census 2000) residents in that same ZCTA.
- * **# of Grantees Serving ZCTA** - displays the number of all Section 330 grantees (**not** the number of sites) serving at least 10 patients in a given [ZCTA](#).
- * **2007-2009 (2-Year) % Change in Patients** - displays the percent change in reported Section 330 patients over previous two UDS reporting years by [ZCTA](#). ZCTAs are not shaded at all if they had zero reported Section 330 patients in both reporting years 2007 and 2009.
- * **2008-2009 (1-Year) % Change in Patients** - displays the percent change in the current reporting year's (2009) reported Section 330 patients (from all Section 330 grantees reporting more than 10 patients in that ZCTA) from the previous reporting year (2008). ZCTAs are not shaded at all if they had zero reported Section 330 patients in both reporting years 2008 and 2009.
- * **% Poverty (Pop at/below 100% FPL), 2000** - displays what percentage of a [ZCTA's](#) total population is at/below 100% of the Federal Poverty Level (FPL).
- * **% Low-Income (Pop at/below 200% FPL), 2000** - displays what percentage of a [ZCTA's](#) total population is at/below 200% of the Federal Poverty Level (FPL) (otherwise known as the 'low-income' population).
- * **% Non-White, 2000** - displays what percentage of a [ZCTA's](#) total population self-identifies as Non-White.
- * **% Hispanic, 2000** - displays what percentage of a [ZCTA's](#) total population self-identifies as Hispanic.

UDS Mapper



UDS Mapper Output - Legend

November 2010

Legend for Sites

- FQHC Grantee Sites - various colors
- FQHC Grantees - various colors

Other Federally Linked non-FQHC Sites

- 🏠 Alaskan Native Tribal Population
- 🏠 FQHC Look A Like
- 🏠 Indian Health Service Facility
- 🏠 Native American Tribal Population
- ✚ Rural Health Clinic
- ★ Stand Alone NHSC PC Sites

Hospitals

- 🏠 Other Hospital Types
- 🏠 Critical Access Hospitals
- 🏠 Short Term

Highway

Road Classification

- Limited Access
- Highways

2008 - 2009 User Change 2007 - 2009 User Change

- 🔴 -100% - -50%
- 🟠 -49.9% - -10%
- 🟡 -9.9% - 10%
- 🟢 10.1% - 50%
- 🟣 50.1% +
- 🟦 Newly Served
- ☐ No Users

Shortage Designations

- 🟤 Governor MUP
- 🟤 Medically Underserved Area
- 🟤 Medically Underserved Population
- 🟤 Geographical Area HPSA
- 🟤 Population Group HPSA
- 🟤 Single County HPSA

% Pop Low Income - ZCTA

- 🟢 <15%
- 🟡 15-30%
- 🟠 30-45%
- 🟤 45-60%
- 🔴 >60%

Geographic Boundaries

- 🟦 Counties
- ☐ ZCTAs

Unservd Low Income

- 1 Dot = 100

CHC Penetration - Low Inc Denom

- 🟡 <20%
- 🟢 20-40%
- 🟣 40-60%
- 🟤 60-80%
- 🟦 >80%
- ☐ No Penetration

- 🟤 Dominant Grantee Dissolve - various colors

UDS Mapper ~ Optional Layers

OPTIONAL LAYERS

- * **Grantee Locations** - locations of all the diverse public and non-profit organizations and programs that receive federal funding under section 330 of the Public Health Service (PHS) Act, --Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Primary Care Public Housing Health Centers.
- * **Grantee Service Access Points** - locations of service access points/sites of diverse public and non-profit organizations and programs that receive federal funding under section 330 of the Public Health Service (PHS) Act
- * **NHSC Sites (by # of Primary Care Provider FTEs)** - National Health Service Corps (NHSC) sites as per the number of NHSC-obligated primary care providers at each site.
- * **FQHC Look-Alikes** - location of all FQHC Look-Alikes, as defined by the Social Security Act § 1905(l)(2)(B), including their satellite locations
- * **Rural Health Clinics** location of all active Rural Health Clinics, as defined by Title XVIII, Section 1861(aa) of the Social Security Act,
- * **Hospitals** - location of all U.S. hospitals by type (Short-term, Critical Access, and other).
- * **Medically Underserved Areas/Populations** - Medically Underserved Areas/Populations (MUA/Ps), which may be a whole county or a group of contiguous counties, a group of county or civil divisions, a group of urban census tracts in which residents have a shortage of personal health services, or Exceptional/Governor designated. Medically Underserved Populations (MUPs) may include groups of persons who face economic, cultural or linguistic barriers to health care.
- * **Health Professional Shortage Areas** - (primary medical care Health Professional Shortage Areas (HPSAs), which may be designated as having a shortage of primary medical care, may be urban or rural areas, population groups, or medical or other public facilities.
- * **Facility and Point HPSAs** - locations of six additional types of federally-linked provider delivery sites which have HPSA designation (FQHC Look-Alikes, Rural Health Clinics, Alaskan Native Tribal Population Facilities, Indian Health Service Facilities, Native American Tribal Population Facilities and Comprehensive Health Centers).
- * **Highways** - U.S. highways and interstates; **County Labels/Boundaries**- county names; **Tract Boundaries** - U.S. census tract boundaries; **ZCTA Labels and Boundaries** [ZCTA](#) ID and Post Office name; **State Boundaries** .

UDS Mapper ~ Data Tables

- * **# of Grantees Serving ZCTA** - the number of all Section 330 grantees (not the number of sites) serving at least 10 patients in the given [ZCTA](#).
- * **Dominant Grantee** - the name of the grantee with the greatest number of reported Section 330 patients (from Section 330 grantees serving at least 10 patients in the specified ZCTA).
- * **% Dominance** provides the percent of patients served in the specified [ZCTA](#) by the dominant Section 330 grantee.
- * **Total Population** provides the total population for each and all selected [ZCTAs](#).
- * **Low Income Population 2000** provides the total number (for each and all selected [ZCTAs](#)) of the population that is at/below 200% of the Federal Poverty Level (FPL).
- * **Total # of Sect. 330 Patients** provides the number of reported Section 330 patients (from all Section 330 grantees reporting over 10 patients in that [ZCTA](#)) for each and all selected ZCTAs.
- * **Unservd (by Grantees) Low Income** - provides the estimated number of low income residents that are not served by Section 330 grantees (for each and all selected [ZCTAs](#)). Number calculated by subtracting the number of total Section 330 grantee patients reported in the UDS per [ZCTA](#) (from all grantees with over 10 patients residing in that ZCTA) from the number of low-income (at/below 200% FPL, Census 2000) residents in that same ZCTA.
- * **All Grantee Penetration of Low Income** - provides the ratio of reported Section 330 patients (from Section 330 grantees reporting more than 10 patients in that ZCTA) to low-income (at/below 200% FPL) residents for each and all selected ZCTAs
- * **All Grantee Penetration of Total Population** - provides the ratio of reported Section 330 patients (from all Section 330 grantees reporting more than 10 patients in that ZCTA) to the number of total residents for each and all selected ZCTAs. Because of the mismatch in reporting years, this measure is only an estimation and should be interpreted as such.
- * **08-09 Patient % Change** - provides, for each and all selected ZCTAs, the percent change in the current reporting year's (2009) reported Section 330 patients (from all Section 330 grantees reporting more than 10 patients in that ZCTA) from the previous reporting year (2008).
- * **07-09 Patient % Change** -provides, for each and all selected ZCTAs, the percent change in reported Section 330 patients (from all Section 330 grantees reporting more than 10 patients in that ZCTA) over the previous two UDS reporting years.
- * **07-09 Patient Change (#)** - provides, for each and all selected ZCTAs, the change in number of reported Section 330 patients (from all Section 330 grantees reporting more than 10 patients in that ZCTA) over the previous two UDS reporting years.
- * **% Population in Poverty 2000** - provides, for each and all selected ZCTAs, the percentage of the total population that is at/below 100% of the Federal Poverty Level (FPL).
- * **% Low-Income Population 2000** - provides, for each and all selected ZCTAs, the percentage of the total population that is at/below 200% of the Federal Poverty Level (FPL).
- * **% Non-White 2000** -provides, for each and all selected ZCTAs, the percentage of the total population that self-identifies as Non-White.
- * **% Hispanic 2000** - provides, for each and all selected ZCTAs, the percentage of the total population that self-identifies as Hispanic.

On to Electronic Health Records

- * ARRA > HITECH > State Regional Extension Centers > eHealthConnecticut > Connecticut “REC”
- * Promotes the adoption and meaningful use of interoperable, certified health information technology (HIT)

What is Meaningful Use?

Meaningful Use means using certified EHR technology to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and families in their health care
- Improve care coordination
- Improve population and public health
- All the while maintaining privacy and security

Stage 1 Meaningful Use Objectives

- Capture information in a structured format
- Use information to track key clinical conditions
- Communicate information for care coordination purposes
- Use decision support tools for disease and medication management
- Engage patients & families
- Report clinical quality measures

Examples of Data that Will be Recorded on > 50% of Patients

- * An up-to-date problem list of current and active diagnoses.
- * Active medication & medication allergy lists
- * Population demographics: Preferred language, Gender, Race, Ethnicity, Date of Birth
- * Changes in vital signs: Height, Weight, Blood Pressure, Body Mass Index (BMI), Growth Charts for children 2–20 years, including BMI
- * Smoking status for patients 13 years old or older.

Clinical Quality Measures: Required Reports

Clinical Quality Measure
Hypertension: Blood Pressure Measurement
Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment b) Tobacco Cessation Intervention
Adult Weight Screening and Follow-up
Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older
Childhood Immunization Status
Weight Assessment and Counseling for Children and Adolescents

Additional Clinical Quality Measures

1. Diabetes: Hemoglobin A1c Poor Control
2. Diabetes: Low Density Lipoprotein (LDL) Management and Control
3. Diabetes: Blood Pressure Management
4. Heart Failure (HF): ACE Inhibitor or ARB Therapy for Left Ventricular Systolic Dysfunction (LVSD)
5. Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
6. Pneumonia Vaccination Status for Older Adults
7. Breast Cancer Screening
8. Colorectal Cancer Screening
9. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
10. Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
11. Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment
12. Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
13. Diabetic Retinopathy: Documentation of Presence / Absence of Macular Edema & Level of Severity of Retinopathy
14. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
15. Asthma Pharmacologic Therapy
16. Asthma Assessment
17. Appropriate Testing for Children with Pharyngitis
18. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
19. Smoking and Tobacco Use Cessation, Medical Assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies
20. Diabetes: Eye Exam

... etc.

FQHC Participation in Connecticut REC

FQHC	# Providers Signed	Scope
StayWell	20	Meaningful Use
Southwest	10	Selection, Implementation, Meaningful Use
Optimus	10	Meaningful Use
East Hartford	13	Meaningful Use
Generations	17	Selection, Implementation, Meaningful Use
Torrington	8	Selection, Implementation, Meaningful Use
UCFS	8	Selection, Implementation, Meaningful Use
Norwalk	13	Implementation, Meaningful Use
1Danbury	8	Implementation, Meaningful Use
1CHS	3	Meaningful Use
Fair Haven	0	<i>in selection phase</i>
Charter Oak	0	<i>fully implemented</i>
Hill Health	0	<i>has selected a system</i>
Total	110	



Performance Appraisal Data Pulls			
Measure	Denominator	Numerator	Completed Yes or NO
Percent of Women ages 42-69 with mammogram ordered in last two years	Women 42-69 with at least two visits with PCP in last year	Women with mammogram ordered in last two years	Yes
Percent of Women ages 21-65 with pap smear ordered in last three years	Women 21-65 with at least two visits with PCP in last year	Women with PAP Smear ordered in last three years	Yes
% of patients 50+ with Colonoscopy in last 10 years or FOBT in the last year	All patients 50+ with at least two visits with PCP in last year	Patients with Colonoscopy within last 10 years or FOBT within last year	Yes
% of Patients 18+ with an HIV test ever.	All patients 18 + with at least two visits with PCP in last year	Patients with HIV test ever documented	Yes
Adult Vaccines			
% of patients with Gardasil Vaccine for female patients (ages 18-26)	Women 18-26 with at least two visits with PCP in Last Year	Women with Gardasil Vaccine	Yes
% of patients Tdap for adult patients (or Td for age > 65)	Patients ages 18+ with at least two visits with PCP in Last Year	Patients with Vaccine	Yes
% of Patients with Influenza vaccine for adults > 50	Patients ages 50+ with at least two visits with PCP in Last Year	Patients with Vaccine	Yes
% of Patients with Pneumonia vaccine age > 65,	Patients ages 65+ with at least two visits with PCP in Last Year	Patients with Vaccine	Yes



Performance Appraisal Data Pulls			
Measure	Denominator	Numerator	Completed Yes or NO
Pediatric vaccines			
Pediatric vaccines given age 2	Patients age 2 with at least two visits with PCP in Last Year	Patients with all of the following: DTAP/DT = 4, IPV=3, MMR=1, HiB=2, Hep B=3, Varicella=1, Pneumococcal = 4	Yes
Gardasil for female patients (ages 11-17)	Women 11-17 with at least two visits with PCP in Last Year	Patients with Vaccine	Yes
Influenza vaccine for appropriate children (children > 6 months and <19)	Patients 6months - 18 years with at least two visits with PCP in Last Year	Patients with Vaccine	Yes
Chronic Disease-- Diabetes			
% of patients who had 2 a1c tests in last year	Patients with Diabetes with at least two visits in last year with PCP	Number of Patients with Diabetes with 2 a1c tests ordered in last year	Yes
% of patients with Diabetes with blood pressure control	Patients with Diabetes with at least two visits in last year with PCP	Number of Patients with diabetes with blood pressure control	Yes
a1c less than 9	Patients with Diabetes with at least two visits in last year with PCP and valid result	Number of patients a1c less than 9	Yes
Chronic Disease-- Hypertension			
% of patients with blood pressure control			USING HTN Scorecard



- Meaningful use
- Fully integrated statewide electronic health record since 2007
- 55 Medical providers (MD's, APRNs)
- 33 Dental providers
- 42 Behavioral Health providers

