Quality is in the eye of the beholder. For patients, quality health care may mean short wait times or a doctor that speaks their language. For clinicians, quality care means keeping people healthy and helping them recover faster when they become sick. To achieve quality care, Community Clinics and Health Centers (clinics) focus on both improving health outcomes and providing patient-centered care.

A COMMITMENT TO QUALITY

Clinics rapidly incorporate and share evidence-based practices regarding quality improvement.\(^1\) For the past decade, CCALAC members have collected and shared data on multiple quality indicators for three major areas of adult primary care—diabetes, hypertension and preventive services. Quality indicators, and their benchmarks, are determined by nationally-recognized quality control organizations, such as the US Preventive Services Task Force, and are aligned with CCALAC Clinical Advisory Group (CAG)* recommendations. Selected indicators reflect key aspects of chronic disease management and prevention of complications.

CCALAC collects data on eighteen quality indicators at 28 clinic sites in Los Angeles County. Clinic participation in these efforts has increased substantially: in just the past two years, the number of CCALAC members monitoring diabetes quality indicators doubled from 14 to 28. Documentation, data collection and subsequent analysis of these quality indicators require relentless commitment from providers and other staff. Clearly, clinics value evidenced-based practice and providing quality care for their patients. Additionally, research supports monitoring quality indicators generates other indirect benefits. One study of over 8,700 diabetics found associations between increased number of indicators and both improved cholesterol and increased patient satisfaction.\(^2\) The indicators in this study

MEASURING UP

For over ten years, CCALAC members have collected data on 18 quality indicators:

**Diabetes**
- HbA1C $\leq 7$
- Blood Pressure $< 130/80$
- Retinal exam
- Patients $\geq 55$ on ACE or ARB
- Foot exam
- Self management goal
- Pneumococcal vaccine
- Screened for depression

**Hypertension**
- Change in Blood Pressure
- Body Mass Index
- Lifestyle modification
- Baseline electrocardiogram
- Diabetic screening
- LDL Cholesterol $< 10$

**Adult Preventive**
- Colon Cancer screening
- Breast Cancer screening
- Tetanus
- HIV screening

\*The CCALAC Clinical Advisory Group is comprised of chief medical officers from member organizations.
included diabetes screening, blood pressure, cholesterol, patient satisfaction with care and patient-rated quality of care.

**FOCUS ON PREVENTION**

Focusing on disease prevention, as well as treatment, improves quality of care because it aims to maintain healthy living as long as possible. Clinics, as part of their core mission, provide preventive services to vulnerable populations, including immunizations, health education, mammograms, pap smears, and other preventive screenings. By focusing on preventive care, clinics improve rates of important screening services. Clinics also improve birth outcomes by offering prenatal services that treat health conditions before they escalate.iii

Thirty-six percent of CCALAC members monitor four quality indicators for adult preventive care: breast cancer screening; colon cancer screening; tetanus vaccine administration and HIV screening. CCALAC members are exceeding their benchmark for breast cancer and colon cancer screening. Clinics’ efforts to track quality indicators and their success in surpassing benchmarks for these key preventive screenings demonstrate a true focus on offering preventive care. Clinics identify health conditions early and initiate treatment before they become emergencies. This focus on prevention not only improves health outcomes but also results in substantial cost savings for the health care system.

**CHRONIC DISEASE MANAGEMENT**

Clinics meet or exceed nationally accepted practice standards for treatment of chronic conditions. In fact, the Institute of Medicine and the US Government Accountability Office have recognized clinics as models for screening, diagnosing and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer and HIV.iv Clinics’ efforts have led to improved health outcomes for their patients, as well as lowered the cost of treating patients with chronic illness.v

**Diabetes**

Diabetes is a preventable, yet prevalent, chronic disease among clinic patients. The need for diabetes monitoring is high among the uninsured and those living in poverty. In Los Angeles County, one in four adult diabetics is uninsured and over half are low-

![Comparison of CCALAC Quality Indicators to Benchmark Goals](image)
Measuring Up

- Forty-two percent of CCALAC members monitor six quality indicators related to hypertension.
- CCALAC members consistently exceed the benchmark of “diabetic screening for 80% of hypertensive patients.”
- Clinics facilitate access to care for minority and underrepresented groups: Los Angeles clinic patients are at least 65 percent white, 10 percent African American and 6 percent Asian/Pacific Islander, while at least 66 percent of all races are Hispanic. 53% of clinic patients do not speak English as their primary language.

Because hypertension and diabetes are often co-occurring, it is imperative to identify diabetes early in hypertensive patients to prevent damage to the kidneys and other organs. CCALAC members have been proactive and vigilant in diabetes screening, as well as pursuing the other quality indicators for hypertension. Every quarter for the past two years, these CCALAC members have consistently exceeded the benchmark of “diabetic screening for 80 percent of hypertensive patients.” Last quarter, a remarkable 94 percent of hypertensive patients were screened for diabetes.

Reducing Health Disparities

Disparities are differences between two groups that are not inherent but rather preventable. Since the groundbreaking release of Unequal Treatment by the Institute of Medicine in 2003, there has been a substantial increase in both awareness of health disparities and efforts to eliminate them. Despite this increased commitment to ensure equality in healthcare, health disparities persist across racial, ethnic, geographic and economic lines. Disparities are evident in all levels of care—from preventive primary care screenings to acute, costly tertiary care in hospitals. Disparities begin with limited access and continue to mortality, accounting for the shortened life expectancy for certain racial/ethnic minorities.

In Los Angeles County, disparities are prevalent among those with chronic conditions. Twenty-eight percent of Los Angeles County residents with chronic conditions identify barriers to utilizing health care—such as lack of insurance, difficulty communicating with doctors and no usual source of care. These barriers—and others such as limited income, unemployment, limited transportation and limited access—are a true impediment to receiving quality healthcare. Barriers are associated with disproportionately adverse health outcomes. On the other hand, research has indicated that diabetic patients who self-report that they have “no barriers” have significantly improved control of their diabetes.

Clinics help reduce or even eliminate health disparities by providing affordable, culturally-competent preventive care services to low-income, uninsured, racial and ethnic minority individuals who would not otherwise have access to certain services.

Clinic patients are diverse: 10 percent of Los Angeles clinic patients are African American, 6 percent are...
Asian/Pacific Islander and 2 percent are more than one race, while at least 66 percent of all patients are Hispanic. In addition, more than half of all patients do not speak English as their primary language. Clinics facilitate access to care for minority and underrepresented groups by offering enabling services to patients, such as insurance enrollment assistance, transportation and translation.

Furthermore, clinics narrow gaps in health disparities through routine screenings. Low-income pregnant women seeking prenatal care at clinics experience lower rates of low birth weight babies compared to all such women. This trend holds true for each racial/ethnic group. The Institute of Medicine recognized the crucial role of clinics across the nation in increasing access to care and in improving health outcomes for patients receiving care, especially racial/ethnic minorities. One study actually found no disparities by race/ethnicity or insurance status in delivery of preventive care services at clinics. Because clinics treat diverse populations, expanding clinic capacity will help clinics continue to reduce ongoing health disparities.

**ENDNOTES**


viii. CCALAC. Community Health Indicators, December 2010.

ix. Ibid.


xi. CCALAC. Community Health Indicators, December 2010.

xii. Chronic Conditions of Californians: California HealthCare Foundation.


**INTEGRATED, TEAM-BASED CARE**

Clinics provide comprehensive services, including dental, mental health and pharmacy, as well as health education programs that motivate healthy behaviors. Clinics comprehensively address patients’ needs by involving multiple health professionals with varied skills in patient care, including physicians, nurse practitioners, physician assistants, nurses, social workers, case managers, behavioral health specialists, dental providers, health educators, community health workers and others. Research shows that this type of integrated, team-based care improves patient outcomes.

**CONCLUSION**

Clinics lead the way in offering high-quality care to their patients by focusing on prevention, reducing health disparities, effectively managing chronic disease and providing integrated, team-based care.

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