Cook County Health:

QPS HEDIS Update & Plans
Adult Diabetes and Pediatric Immunization

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9-17-20

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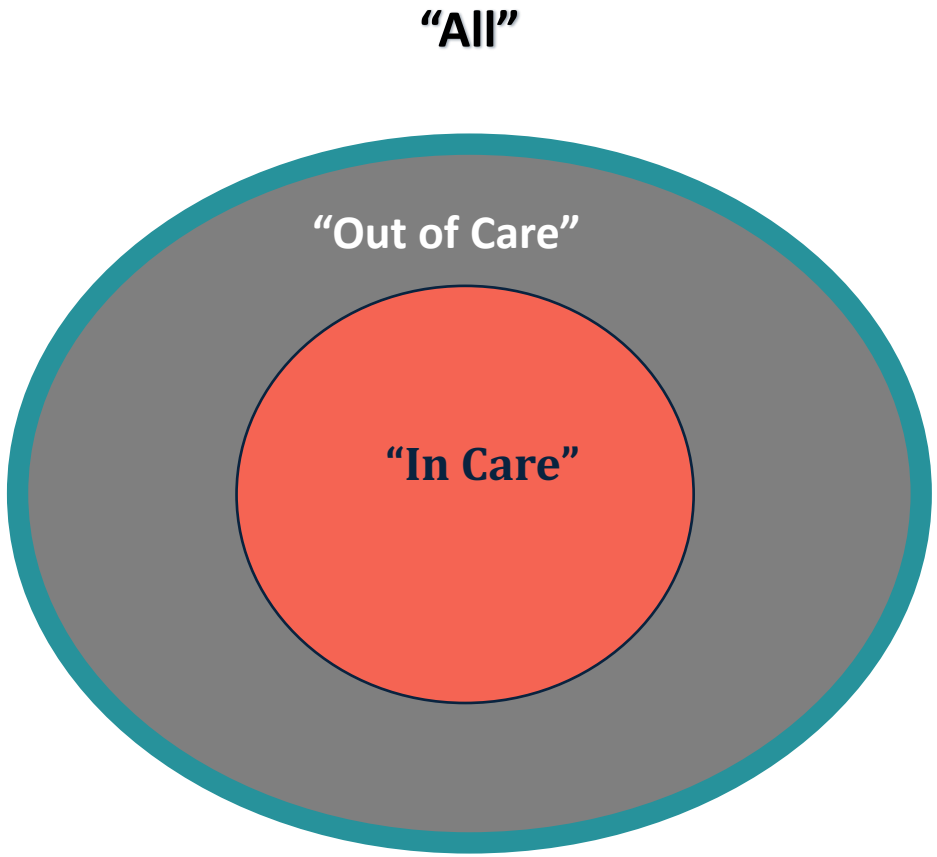
Our Patients – All, In and Out of Care

3 different Patient Populations

Patients **“All”**
- Includes “All” of our patients

Patients **“In Care”**
- Patients who have had 2 visits in past 2 years

Patients **“Out of Care”**
- Managed care patients assigned to our primary care clinics who do not meet criteria for “ in care” or have not been to a CCH health center
- Patients with private insurance, Carelink and others who have not been seen at CCH Health Center



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Major Accomplishments

Telehealth Capability

- March 2020, ACHN developed new appointment processes, workflows, billing and scripts
- Staff and Patients educated on new processes
- Continue improving on Telehealth appointments to include best practices

Identification and outreach of High Risk Populations: (Adult & Pediatric)

- Pediatric patients 0-2 years old / School Age well child visits and immunizations to stay up to date
- Diabetes patients without contact in 3 months (prioritize high Hga1cs, hospital discharge and ED visits)

Targeted Interventions For High Risk Patient Populations:

- Encourage in-person visits for patients
- Telephone visit followed by brief In Person visit for immunizations or lab tests
- Partnership with CCH Care Coordination for Community Health Workers to perform home visits

Diabetes QI Initiatives 2019 Summary

Primary Focus – Patients " In Care"

Diabetes Care Bundle: Interventions at 4 pilot sites from June 2019-Nov 2019

- Pre visit planning
- Self management goals
- HgA1c testing annually
- Nephropathy testing annually
- Retinal exam annually

- Retinal Camera implementation
  - Training completed at 3 sites and 11 cameras delivered to sites
  - Ophthalmology providers unable to support volume, project stalled.

- Additional Projects:
  - Patient outreach to fill Managed Care Organization Care Gaps
  - Enhancement of nursing Care Management visits to include Diabetes Bundle
  - Pilot Point of Care testing for HgA1c at Arlington Heights
  - Documentation changes for foot exams

HEDIS Adult Diabetes Measures

Summary: Annual Compliance for 2018 vs 2019

	Goal %*	Annual Compliance 2018			Annual Compliance 2019			Comments
		All	In Care	Out of Care	All	In Care	Out of Care	
Diabetes: Annual HgA1c Testing*	**91.3**	86	90	41	**80**	83	19	**7% decrease. Hedis DM team working on outreach and HgA1c testing**
Diabetes: Annual Retinal Exam*	**66.3**	47	48	25	**50**	51	27	**3% increase**
Diabetes: Annual Nephropathy Exam*	**92.4**	89	90	76	**84**	84	73	**5% decrease. Hedis DM team working on outreach and screening during visit**
Diabetes Control % with HgA1c <8*	**57.6**	51	54	20	**49**	51	12	**Slight decrease. Hedis DM team working on education, nurse care management visits and self-management goals**
Diabetic Blood Pressure Control* (<140/90)	**73.4**	46	47	23	**43**	44	14	**Slight decrease. BP Improvement Program (Dr. Irons) implementing AMA guidelines for Initial BP measurements, patient preparation and positioning, confirmation and re-checks, staff training/competencies and self home monitoring.**

* HEDIS measure goals set at 80th percentile

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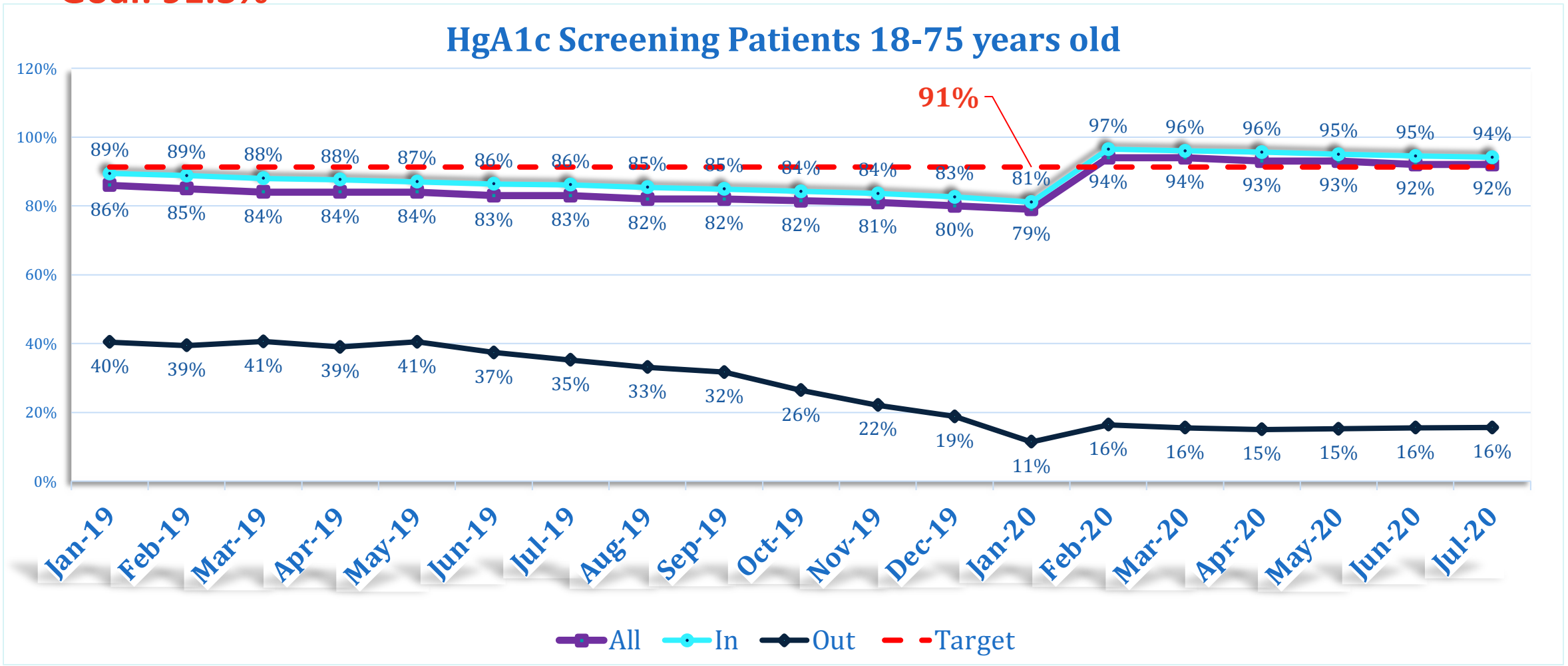
Diabetes Measures Jan 2019-July 2020

Goal: 91.3%



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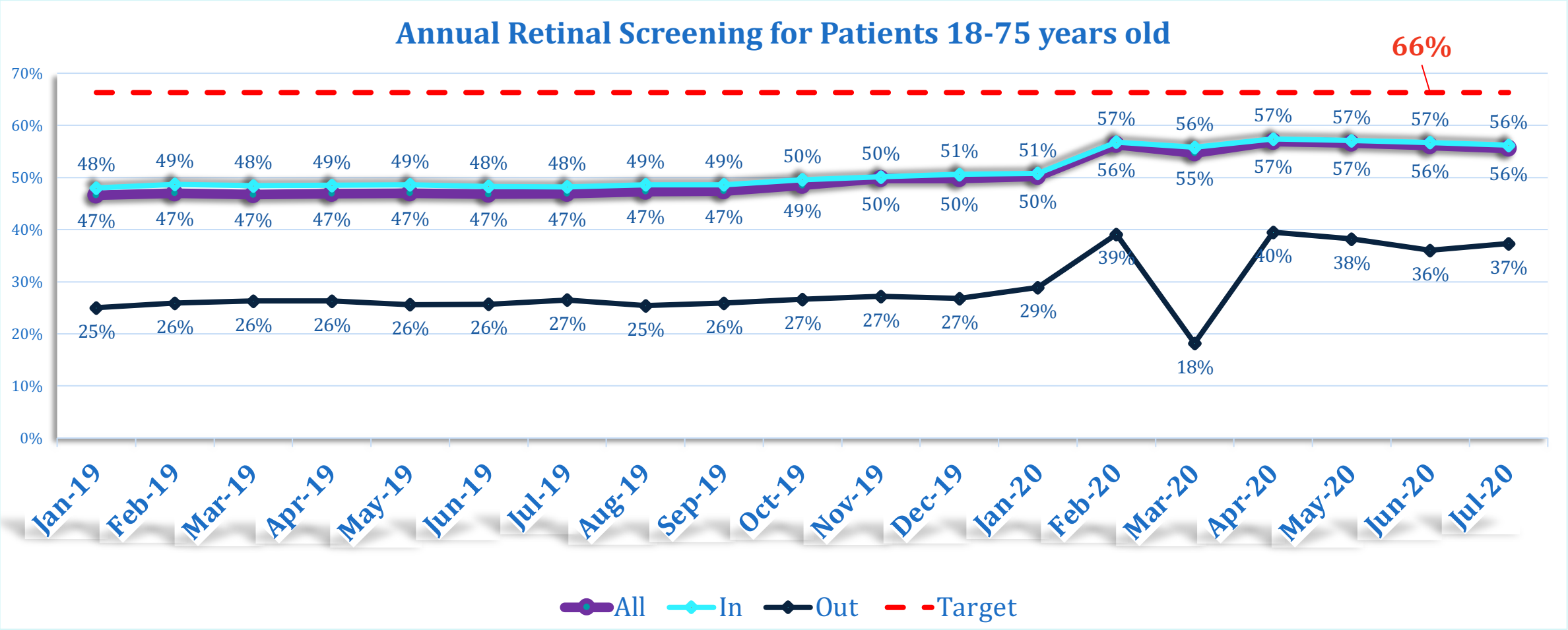
Diabetes Measures Jan 2019-July 2020

Goal: 66.3%



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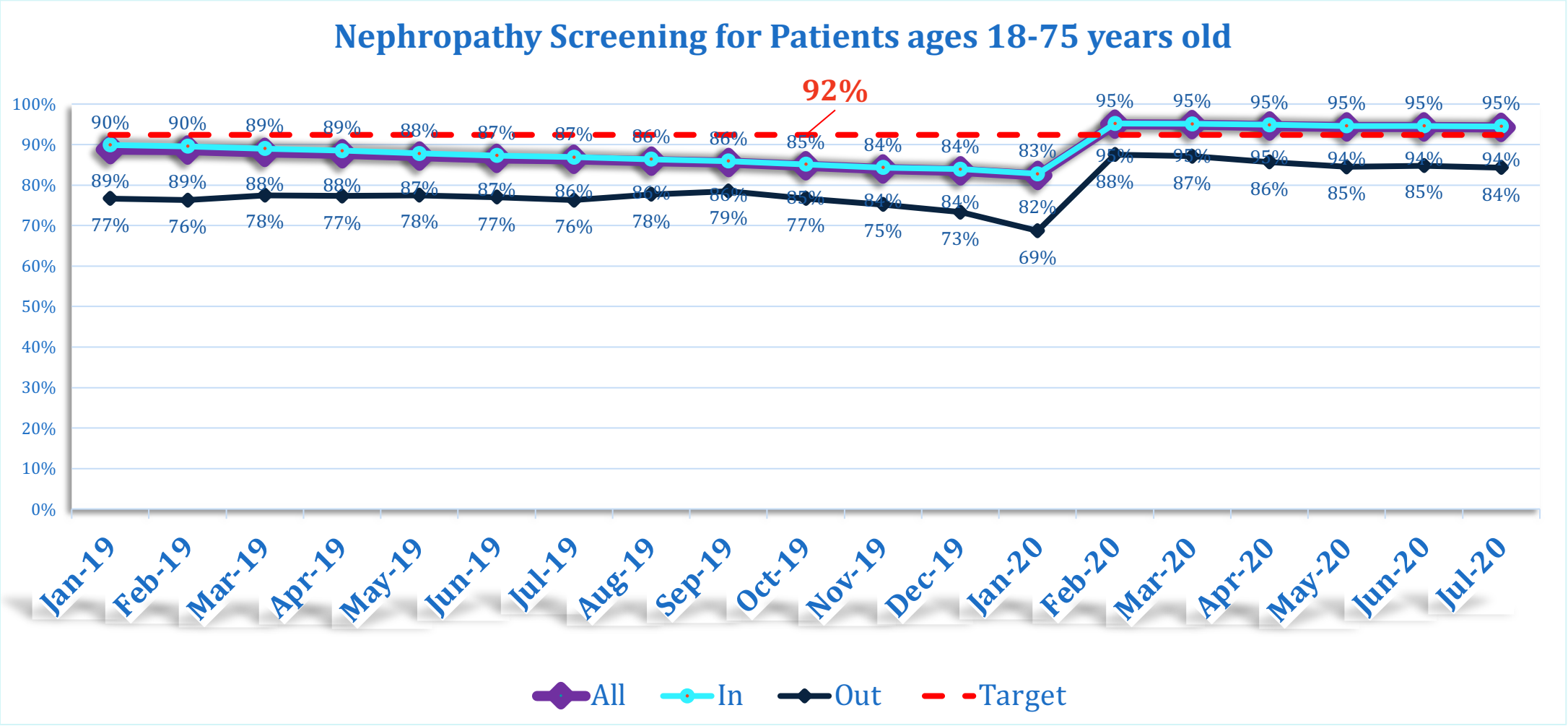
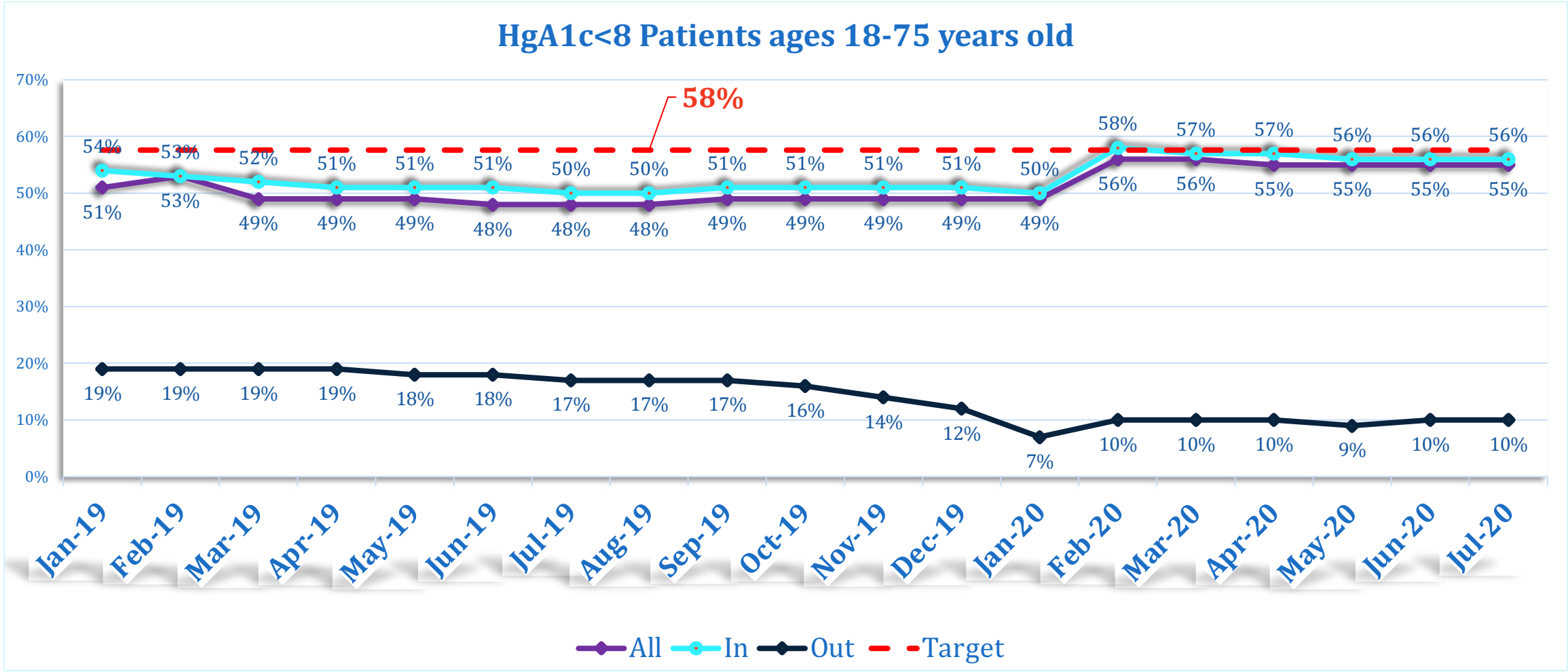
Diabetes Measures Jan 2019-July 2020

Goal: 92.4



Diabetes Measures Jan 2019- July 2020

Goal: 57.6%



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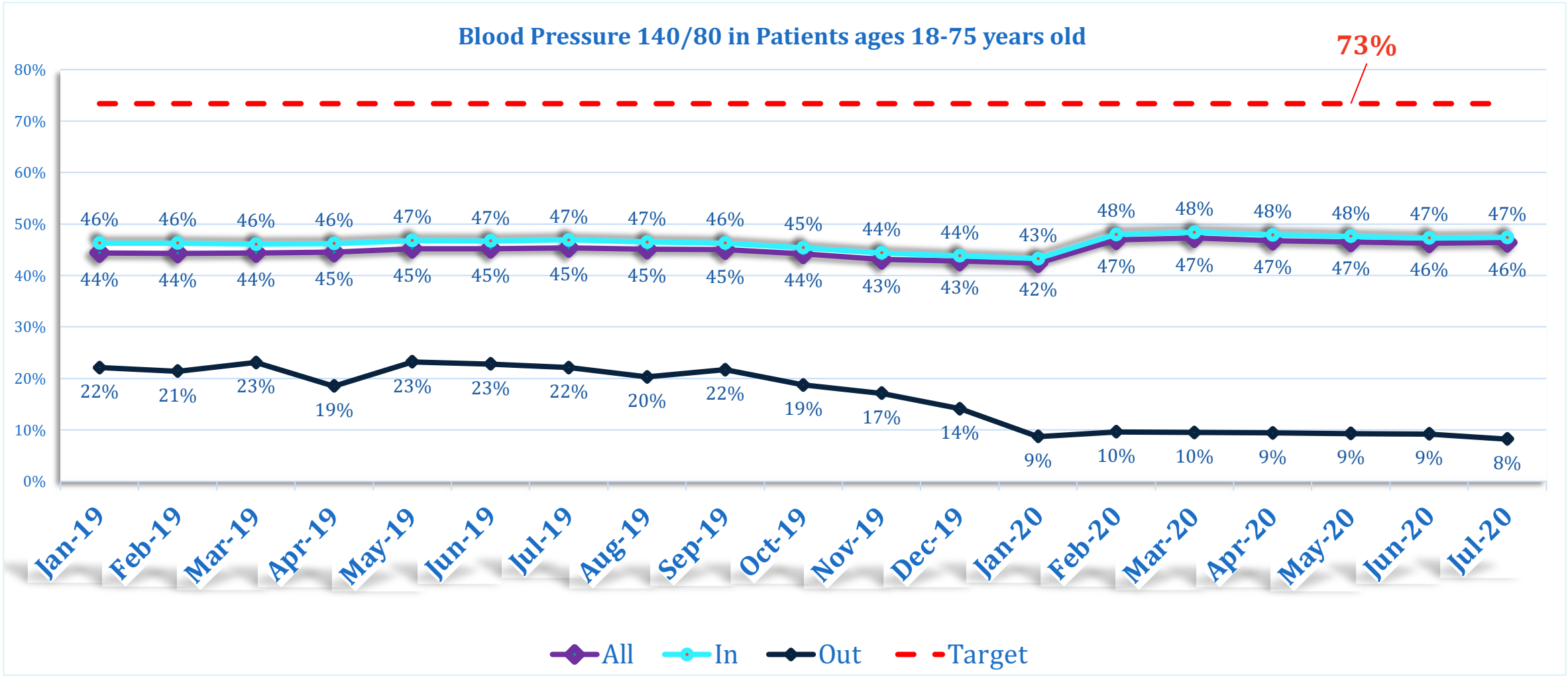
Diabetes Measures Jan 2019- July 2020

Goal: 73.4%



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HEDIS Childhood Immunizations <2 years old

PDSA Process Measure Training

July 2019: Rolled out to Englewood and Near South

January 2020: Rolled out to Austin and Logan Square

- *Optimize each patient visit*
  - Pre-Visit Planning
  - Day of Care Huddles
  - Staff training on computer systems
  - Reports to show compliance pre/ post visit with drill down
  - Follow up on No shows
- *Outreach*
  - Systematic process to identify patients
  - Focus on current patients and new CountyCare members

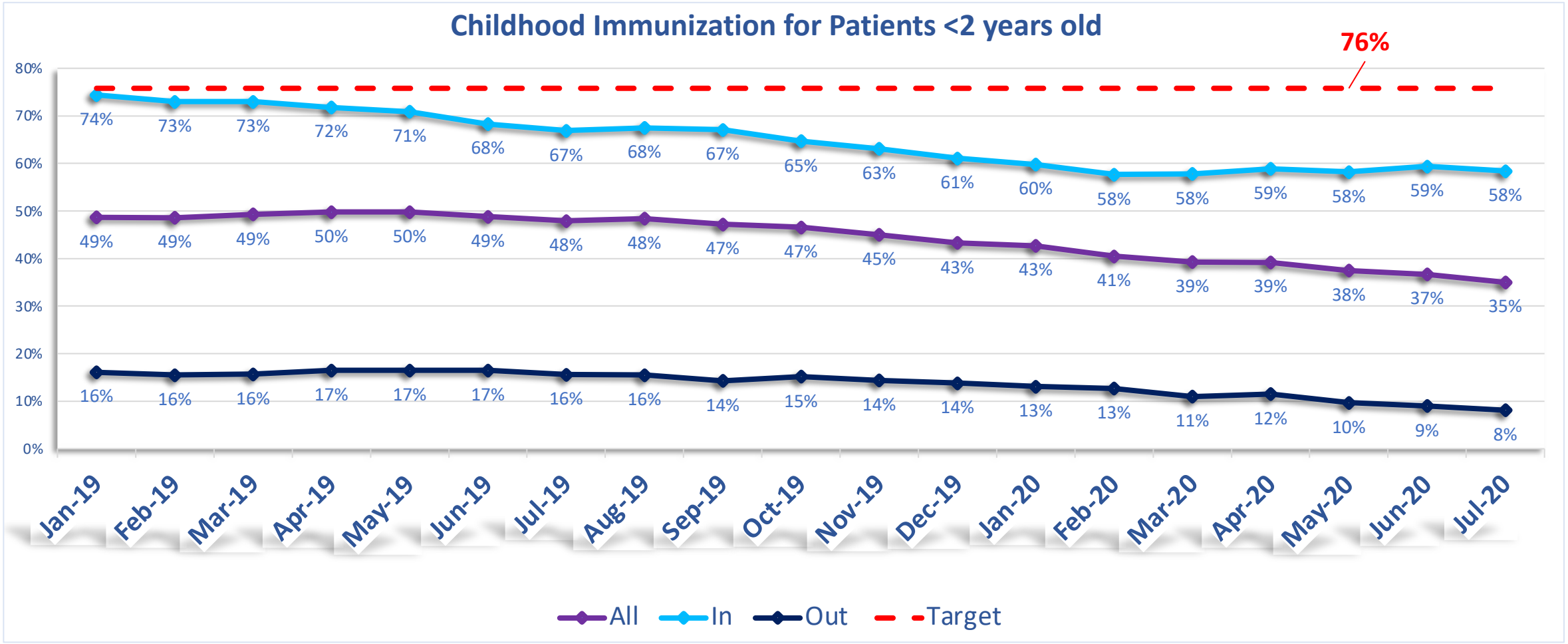
HEDIS Childhood Immunizations by 2 years old

Summary: Annual Compliance for 2018 vs 2019

Key Quality Indicator	Benchmark for 2019 75.8%	Annual Compliance Average 2018	Annual Compliance Average 2019	Comments:
Childhood Immunization status Up to date at 24 months	All 75.8% In 75.8% Out 75.8%	All 49.2% In 75.7% Out 15.8%	All 43.3% In 61.1% Out 13.8%	15% decrease. Created Immunization Focus Group to concentrate on implementation of pre-visit planning, daily team huddles, ICARE data, tracking & rescheduling no-shows, outreach, observation audits and patient portal.

HEDIS Childhood Immunizations

Goal: 75.8%



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HEDIS Childhood Immunizations

ACHN Primary Care:

- Ended December 2019 with 61.1% compliance for patients In Care and are currently at 58.4% compliance for patients In Care.
- Created new multidisciplinary workgroup which includes Quality Improvement Nurse, Physician Champions, Health Center Managers, Nurse Clinicians and Business Intelligence.
- Updated Project Charter with specific process measures
- Creating new roles and responsibilities for Physician Champions and clinic staff at each health center to focus on PI initiatives.
- Focus on implementation, coaching, monitoring and accountability.

Moving Forward:

Opportunities and Lessons Learned

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Opportunities

COVID-19:

- Focus on Staying Healthy and Improving Health of those most vulnerable
- Model Infection Control Principles
- Optimize every patient encounter to meet the patient's needs

Diabetes

- Relaunch Retinal Camera project with gradual ramp up July 2020
- Flu Vaccine Promotion/ combine with other testing
- Pilot: Arlington Heights- Nurse contacts in between provider visits for A1c >9:
  - Assessment of potential problem areas (meds, self monitoring, activity, diet)
  - Self management interventions/ goals (SMART Goals)
  - Use of Point of Care Testing
- Focus on Med Adherence and make changes as needed
- Synergy with MAP BP Improvement Project (**M**easure Accurately, **A**ct Rapidly, **P**artner with patients)

Pediatrics

- Site by Site Audits with Champions to identify issues and reasons
- Power-orders for immunizations
- Establish Catch Up schedules / Promotion of Flu Vaccine

Lessons Learned

Creating a Culture of Care

- Prioritize quality and patient safety in each practice
- Nurture Leaders to Cultivate their employees
- Provide Compassionate Care for Each Other/ Our Patients
- Utilize AIDET and ICARE Principles – Integrity, Collaboration, Accountability, Respect, Excellence
    - When we make progress – highlight and recognize
    - When we falter- learn from the experience and move forward
- Keep it Simple- PDSA
- Coach and Empower Staff

Thank you.

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