Ambulatory complies with the CCH mission to deliver integrated health services with dignity and respect, regardless of a patient’s ability to pay; to foster partnerships with other health providers and communities in order to enhance the health of the public; and to advocate for policies which promote and protect the physical, mental and social wellbeing of the people of Cook County.
CCH-Ambulatory Outpatient Sites

* Denotes Primary Care Medical Home

- Arlington Heights Health Center*
- Austin Health Center*
- Children’s Advocacy Center
- Cicero Health Center*
- Cottage Grove Health Center*
- Ruth Rothstein CORE Center
- Englewood Health Center*
- General Medicine Primary Care*
- Logan Square Health Center*
- Morton East Adolescent Health Center
- Near South Health Center*
- Oak Forest Health Center*
- Prieto Health Center*
- Robbins Health Center*
- Stroger Central Campus Specialty Care Clinics
- Sengstacke Health Center*
- Woodlawn Health Center*
Quality Plan Overview
Ambulatory – Goals of the Quality Plan

- Integrate all patients into a Primary Care Medical Home and attach them to a Primary Care Provider of their choice.
- Actively engage patients and their families in their care and self-management.
- Organize evidence-based patient care across all elements of the broader health system.
- Improve the Quality of Care at Cook County Health (CCH)
- Improve Health Equity
- Improve Chronic Diseases Management
- Overcoming barriers related to the Social Determinants of Health
Ambulatory Quality Priorities

• Outline the governance structure for ACHN quality
• Utilize the (STEEEP Model) STEEEP stands for Safe, Timely, Effective, Efficient, Equitable and Patient-centered care and is used to prioritize the six critical aims of health care.
• Maintain compliance with Joint Commission Primary Care Medical Home certification requirements.
• Define key performance metrics which measure the quality of ambulatory care across the system
• Describe and align with reporting requirements for Meaningful Use
• Diabetes
• Hypertension
• Childhood Immunization
• Patient Experience

**STEEEP is an acronym coined by Baylor Scott & White Health, and trademarked by Baylor Health Care System in 2001.**
*Ambulatory Quality is integrated into Stroger and Provident Hospitals’ Quality & Patient Safety Committees
Structure: Ambulatory Leadership Quality & Patient Safety Oversight

Regulatory Compliance
- Accreditation / PCMH
- Laboratory / CLIA

Patient Safety
- Medication Safety
- Falls
- Infection Control

Environment of Care
- Hazardous Waste
- Facilities
- Fire Safety
- Clinical Engineering

Performance Improvement
- HEDIS
- Meaningful Use
- MIPS

Ambulatory Leadership

Ambulatory Quality & Patient Safety Partners
Staff Workgroups
Chief Quality Officer
Quality & Patient Safety Department
Chief Operating Officer, Ambulatory Services
Chief Operating Officer, Stroger Hospital & Central Campus
Operating Officer, Provident Hospital
Ambulatory Medical Director
Associate Medical Director, Pediatrics, Ambulatory Services
Associate Nurse Executive, Ambulatory Services
ACHN Facilities Manager
Regional Operations Directors Northwest Cluster, South Cluster, South Suburban Cluster
Care Management Specialist
Clinic Decision Support Analysts
CountyCare Quality Administration
Business Intelligence Director
Business Intelligence Analyst
Clinical Informatics Director
Clinical Informatics Analyst
Chief Medical Information Officer
Meaningful Use Coordinator
Director of Life Safety
Health Information Systems
Director of Patient Relations
Director of Public Safety & Security

(4) Community Advisory Boards, Arlington Heights, Cottage Grove, Englewood and Robbins Health Centers
Patient Safety Adverse Events: Reporting & Review

Safety Event Hierarchy

- Patient Adverse Event or Near Miss Event
  - Adverse Event
    - Attending Physician Notified
    - Sentinel Event: Significant Risk
      - Notify Risk Management Immediately
      - Notify Chief Quality Officer
      - Leadership Notification: COO, Medical Director
      - Disclosure to Patient and/or Representative
    - Not Sentinel Event: No Critical Factors per Attending Physician
    - Notify Department Chair & Chief Quality Officer
    - Notify Supervisor
    - Enter into On-Line Event Reporting System
      - Not Patient Harm
  - Near Miss Event: No Patient Harm
    - Notify Department Chair & Chief Quality Officer
    - Notify Supervisor
    - Enter into On-Line Event Reporting System
      - No Critical Factors
    - Disclosure to Patient and/or Representative

Review of eMERS Reported Events

Managers can:
- View and edit the event report
- Read and audit other manager reviews
- Consult with managers
- Enter and ‘submit’ their own reviews commenting on contributing factors and corrective actions
- Attach documents

Q/R Managers can:
- Unsubmit a report
- Reject/Delete a report
- Document Harm Score
- Close a report
- Submit reports to the PSO

Timeline
- Event Submitted in e-MERS: < 48 Hours
- Initial Manager(s) Review: < 14 Days
- Consultant Review (if applicable): < 30 Days
- Submission to PSO
- < 48 Hours
- < 14 Days
- < 30 Days

All information provided in these expanded materials is compiled at the direction of the Department of Quality and Patient Safety and is privileged and confidential to be used solely in the course of quality control and for the purpose of reducing mortality and morbidity and improving the quality of patient care. This confidential Patient Safety Work Product is protected under the Federal Patient Safety and Quality Improvement Act and the Illinois Medical Studies Act.

Disclosure to Patient and/or Representative

Leadership Notification: COO, Medical Director

Consultant Review (if applicable)

Submission to PSO
## Primary Care Medical Home (PCMH) Requirements/Major Goals

### OPERATIONAL CHARACTERISTICS & REQUIREMENTS

| Coordinated Care | Care is coordinated across the broader health care system. Transitions of care between care sites emphasize discharges from hospitals and ED.  
|                  | • Use of internal and external resources to meet patients’ needs  
|                  | • Responsible for care coordination |
| Comprehensive Care | Team-based health care  
|                  | • Provide acute, preventive, comprehensive care  
|                  | • Use of external and internal resources to meet patients’ needs  
|                  | • Care addressing phases of lifespan, including end of life care  
|                  | • Disease management |
| Human Touch: Patient Centered Care | Relationship-based care  
|                  | • Patient selects Primary Care Provider (PCP)  
|                  | • Consider patient’s preferences, cultural, linguistic & education needs  
|                  | • Patient is involved in establishing the treatment plan & self management plans |
| Hours of Operation: Superb Access | Services are accessible with short waiting times. Enhanced hours, around the clock telephone access.  
|                  | • Enhanced access –timely responses to patients needs  
|                  | • 24/7 availability |
| System-based approach to quality and safety | Use evidence based medicine and clinical decision support tools. Use data to manage population health, chronic disease and performance improvement.  
|                  | • Population based care  
|                  | • Use of Health IT |
What is HEDIS?

The Healthcare Effectiveness Data Information Set (HEDIS) is used by most of America's health plans to measure performance on care and service. It contains 90 measures across 6 domains of care. Many plans collect HEDIS data and the measures strictly defined making it possible to compare the performance of health plans on an "apples-to-apples" basis.

6 Domains of Care:

1. Effectiveness of Care
2. Access/Availability of Care
3. Experience of Care
4. Utilization and Risk Adjusted Utilization
5. Health plan Descriptive Information
6. Measures Collected Using Electronic Clinical Data Systems

**https://www.ncqa.org/hedis**
Descriptions of our Populations

**ACHN**: Any patient in Cerner with at least two ACHN primary care visits within the last two years (irrespective of payor)

**HEDIS**: ACHN population **PLUS** Any ACHN- empaneled member from CountyCare.

- **In Care**
  - +
- **Out of Care**

Leads to Large Population Denominator
## ACHN Primary Care Health Center Dashboard December 2018

<table>
<thead>
<tr>
<th></th>
<th>Goal</th>
<th>All Patients</th>
<th>In Care</th>
<th>Out of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBA1C &gt; 9</td>
<td>&lt; 34.7%</td>
<td>41.9%</td>
<td>39.9%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>63.7%</td>
<td>34.0%</td>
<td>34.5%</td>
<td>21.3%</td>
</tr>
<tr>
<td>Immunizations (2 yrs)</td>
<td>76.5%</td>
<td>40.9%</td>
<td>59.9%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Mammography</td>
<td>66%</td>
<td>62.6%</td>
<td>64.8%</td>
<td>21.5%</td>
</tr>
</tbody>
</table>

**# Not in Care Patients**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29,254</td>
</tr>
</tbody>
</table>
ACHN Quality Initiatives

• Comprehensive Diabetes Care HbA1c Testing
• Comprehensive Diabetes Care HbA1c Control (<8%)
• Comprehensive Diabetes Care Eye Exam
• Comprehensive Diabetes Care Nephropathy Screening
• Blood Pressure Control (<140/90 mm Hg)

• Childhood Immunizations
• Well-Child Visits
• Breast Cancer Screening (BCS)
• Cervical Cancer Screening
• Prenatal / Post natal Care
• Behavioral Health Integration
• MAT
• Influenza Vaccination Rates
• Patient Experience (The Compassion Journey)
• Leadership Development
• Clinical Workflows
# Ambulatory 2019-2021 Key Performance Indicators

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>GOAL</th>
<th>Cook County Health 2018</th>
<th>Cook County Health 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEDIS 75&lt;sup&gt;TH&lt;/sup&gt; %tile</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization Status (2 years)</td>
<td>75%</td>
<td>51%</td>
<td>42%</td>
</tr>
<tr>
<td><strong>Adult</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HgA1c &lt;8 (Diabetic Control)</td>
<td>55%</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td><strong>Infection Control</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seasonal Influenza Vaccination</td>
<td>60%</td>
<td>43%</td>
<td>41%</td>
</tr>
<tr>
<td><strong>Patient Experience/Press Ganey Data</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Satisfaction</strong></td>
<td>Top Box Score – 15&lt;sup&gt;th&lt;/sup&gt; %tile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Courtesy of Registration Staff</td>
<td>72.7</td>
<td>52.6</td>
<td>52.9</td>
</tr>
<tr>
<td>Courtesy of Care Provider</td>
<td>80.6</td>
<td>58.8</td>
<td>59.2</td>
</tr>
<tr>
<td>Courtesy of Nurse/Asst.</td>
<td>75.9</td>
<td>56.5</td>
<td>57.2</td>
</tr>
<tr>
<td>Staff Worked Together</td>
<td>74.9</td>
<td>56.9</td>
<td>57.8</td>
</tr>
<tr>
<td>Sensitivity to Patient’s Needs</td>
<td>72.5</td>
<td>48.1</td>
<td>48.7</td>
</tr>
</tbody>
</table>
What is *Our Compassionate Journey*?

It is a way in which we will carry out our work, where we

- show **Ourselves** compassion
- show **One Another** compassion
- show **Our Patients** compassion

Through Acts of

- Empathy
- Kindness
- Courtesy

toward **Ourselves**

toward **One Another**

toward **Our Patients**

*Compassion In Our Health Centers...*
What is Compassion and why does it matter?

Compassion

“sensitivity shown in order to understand another person's [or one self’s] suffering, combined with a willingness to help and to promote the wellbeing of that person [or self], in order to find a solution to their [or one’s own] situation.”

Perez-Bret E, Altisent R², Rocafort J³.

I have learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.

Maya Angelou
Our Response: *Compassion In Our Health Centers*...

Compassion

Empathy
Kindness
Courtesy

Oneself
One Another
Our Patient

Team Trust, Team Communication, and Team Cohesion

Collaborative Team Caring for Our Patients

↑ Employee Engagement
↑ Patient Experience
Our Culture of Compassion... through Empathy, Kindness and Courtesy

The Journey Begins with Each of Us...
How Can I Show **Our Patients** Empathy, Kindness & Courtesy?

**Fuel Our Patients Gas Tanks**

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<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>IN CARE</th>
<th>VS</th>
<th>OUT OF CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HgA1c &lt;8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Diabetic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control)</td>
<td></td>
<td>50%</td>
<td></td>
<td>44%</td>
</tr>
<tr>
<td><strong>Pediatric</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status (2 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>old)</td>
<td></td>
<td>62%</td>
<td></td>
<td>17%</td>
</tr>
</tbody>
</table>

**Diabetes Goal 55%**

**Immunization Goal 75%**
Englewood HC
May 2019 through October 2019
Pediatric Childhood Immunizations UTD by 2 years old for patients with a scheduled appointment “Missing Opportunities” Snapshot table

Goal 75%

Immunization Compliance % (Total Pts. Scheduled/ Total Pts. Seen and UTD after visit)

BI data captured on 11.8.2019
Near South HC
May 2019 through October 2019
Pediatric Childhood Immunizations UTD by 2 years old for patients
with a scheduled appointment “Missing Opportunities” Snapshot table

Goal 75%

Immunization Compliance % (Total Pts. Scheduled/ Total Pts. Seen and UTD after visit)

<table>
<thead>
<tr>
<th></th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance %</td>
<td>60.00%</td>
<td>70.00%</td>
<td>60.00%</td>
<td>80.00%</td>
<td>60.00%</td>
<td>50.00%</td>
</tr>
</tbody>
</table>

BI data captured on 11.8.2019
The Centers for Medicare & Medicaid Services (CMS)

Meaningful Use

Certified EHR Technology used in a Meaningful Way

**http://www.cms.gov**
# Meaningful Use & Physician Quality Reporting System

## 2019-20 MU Measures

### Cook County Health & Hospitals System

<table>
<thead>
<tr>
<th>Eligible Clinician Meaningful Use Objectives</th>
<th>2019 Thresholds</th>
<th>Tentative 2020 Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPOE of Med Orders</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>CPOE of Lab Orders</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>CPOE of Rad Orders</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>ePrescribe</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>ePatient Specific Education</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>VDT 1 - Offer Access</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**2 out of 3 Must be Met**

| VDT 2 - Patient Access                      | 15%             | 15%                       |
| Secure Messaging                             | 10%             | 10%                       |
| Patient Generated Information               | 5%              | 5%                        |

**2 out of 3 Must be Met**

| Electronic Transition of Care               | 50%             | 50%                       |
| Incorporate Available Data                  | 40%             | 40%                       |

**These measure count as 1**

| Clinical Rec of Meds                        | 80%             | 80%                       |
| Clinical Rec of Problems                    | 80%             | 80%                       |
| Clinical Rec of Allergies                   | 80%             | 80%                       |

*EMR interoperability measures submitted for all Eligible Clinicians

## PQRS Measures

**2019 PQRS/MIPS Measures**

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Measure Domain</th>
<th>Decile</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGF-4018/CMS-163v6 = Controlling High Blood Pressure</td>
<td>Effective Clinical Care</td>
<td>3</td>
</tr>
<tr>
<td>NGF-0022.1/CMS-130v6 = Drugs to be Avoided in the Elderly</td>
<td>Patient Safety</td>
<td>4</td>
</tr>
<tr>
<td>NGF-0022.2/CMS-136v6 = Drugs to be Avoided in the Elderly</td>
<td>Patient Safety</td>
<td>N/A</td>
</tr>
<tr>
<td>NGF-0032/CMS-124v6 = Cervical Cancer Screening</td>
<td>Effective Clinical Care</td>
<td>6</td>
</tr>
<tr>
<td>NGF-0034/CMS-110v6 = Colorectal Cancer Screening</td>
<td>Effective Clinical Care</td>
<td>5</td>
</tr>
<tr>
<td>NGF-0038/CMS-117v6 = Childhood Immunization Status</td>
<td>Community/Population Health</td>
<td>5</td>
</tr>
<tr>
<td>NGF-0041/CMS-197v7 = Influenza Immunization</td>
<td>Community/Population Health</td>
<td>5</td>
</tr>
<tr>
<td>NGF-0059/CMS-122v6 = Diabetes, Hemoglobin A1c (HbA1c) Poor Control (% &gt; 9%)</td>
<td>Effective Clinical Care</td>
<td>6</td>
</tr>
<tr>
<td>NGF-0068/CMS-164v6 = Ischemic Vascular Disease (IVD); Use of Aspirin or Another Antiplaque</td>
<td>Effective Clinical Care</td>
<td>8</td>
</tr>
<tr>
<td>NGF-0069/CMS-154v6 = Appropriate Treatment for Children with Upper Respiratory Infection</td>
<td>Efficiency and Cost Reduction</td>
<td>7</td>
</tr>
<tr>
<td>NGF-0070.1/CMS-135v6 = Coronary Artery Disease (CAD); Beta-Blocker Therapy-Prior Myocardial Infarction</td>
<td>Effective Clinical Care</td>
<td>5</td>
</tr>
<tr>
<td>NGF-0070.2/CMS-134v6 = Coronary Artery Disease (CAD); Beta-Blocker Therapy-Prior Myocardial Infarction</td>
<td>Effective Clinical Care</td>
<td>N/A</td>
</tr>
<tr>
<td>NGF-0083/CMS-135v6 = Heart Failure (HF): ACE Inhibitor or ARB Therapy for LVD</td>
<td>Effective Clinical Care</td>
<td>3</td>
</tr>
<tr>
<td>NGF-0083/CMS-144v6 = Heart Failure (HF): Beta-Blocker Therapy for LVD</td>
<td>Effective Clinical Care</td>
<td>3</td>
</tr>
<tr>
<td>NGF-2372/CMS-125v6 = Breast Cancer Screening</td>
<td>Effective Clinical Care</td>
<td>7</td>
</tr>
<tr>
<td>CMS-65v6 = Hypertension; Improvement in blood pressure</td>
<td>Effective Clinical Care</td>
<td>3</td>
</tr>
<tr>
<td>CMS-146v6 = Appropriate Testing for Children with Pharyngitis</td>
<td>Efficiency and Cost Reduction</td>
<td>7</td>
</tr>
<tr>
<td>CMS-137v6 = Pneumococcal Vaccination Status for Older Adults</td>
<td>Community/Population Health</td>
<td>7</td>
</tr>
<tr>
<td>NGF-0421/CMS-69v6 = Body Mass Index (BMI) Screening and Follow-Up</td>
<td>Community/Population Health</td>
<td>8</td>
</tr>
<tr>
<td>NGF-0419/CMS-86v7 = Documentation of Current Medications in Medical Record</td>
<td>Patient Safety</td>
<td>3</td>
</tr>
</tbody>
</table>

*Data for 6 PQRS measures must be submitted from the list. The top performing 2019 measures are highlighted in green.
CCH - FINAL MEANINGFUL USE (CMS) COMPOSITE SCORE

2018 Final Score

COOK COUNTY's Performance Score

The details below are your performance scores in each category.

- **Performance Category Scores**
  - Quality: 60 of 60
  - Promoting Interoperability: 25 of 25
  - Improvement Activities: 15 of 15
  - Cost: N/A
  - Additional Awarded Bonus Points: 4.26

- **MIPS Adjustment(s)**
  - Payment Adjustment: 0.31%
  - Exceptional Performance Adjustment: 1.37%
  - Total: +1.68%

Payment Adjustment Date
January 1, 2020

Learn More

* 2019 Final score pending

**The Centers for Medicare & Medicaid Services (CMS)**
Continuous Quality Improvement (CQI)

OVERSIGHT:

**Senior Leadership**
Claudia Fegan MD – Chief Medical Officer, Cook County Health
Iliana Mora – Chief Operations Officer, Ambulatory Services
Lamorris Perry MD – Medical Director, Ambulatory Services

**Dyad High Reliability Group**
Mark Loafman MD – Chair of the Department of Family and Community Medicine
Kathy Pavkov RN – Associate Nurse Executive, Ambulatory Services

**Ambulatory Provider Champion - Childhood Immunizations for Patients < or = 2 Years Old**
Denise Cunill MD – Associate Medical Director – Pediatrics, Ambulatory Services

**Ambulatory Provider Champion Diabetes**
Yolanda Escalona MD – Lead Physician – Arlington Heights Health Center

**Quality Improvement**
Marilisa ‘Mari’ Ferrer – Director of Quality Improvement, Ambulatory
Continuous Quality Improvement (CQI)

“Inspect What You Expect”

**Diabetes Measures**
- Accountability
- Clear goals and responsibilities
- Pre-visit planning
- Medication adherence
- Educational materials ABCs of Diabetes for patients
- Care management appointments with nurse to provide additional education and support

**Immunization**
- Accountability
- Clear goals and responsibilities
- Pre-visit planning
- Create Immunizations Taskforce
- Print I - Care Immunization record forms for every clinic visit
- Educate staff on the Protocols / Guidelines of Childhood Immunizations
Thank You...