LakeCounty
Health Department and
Community Health Center

Quality Measures: UDS, HEDIS and the Performance Improvement Committee (PIC)

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November 2024

What are UDS and HEDIS?

- Uniform Data System (**UDS**):
  - HRSA quality metrics
  - Reported every Calendar Year

- Healthcare Effectiveness Data and Information Set (**HEDIS):**
  - Insurance Company quality metrics
  - Reported every Calendar Year

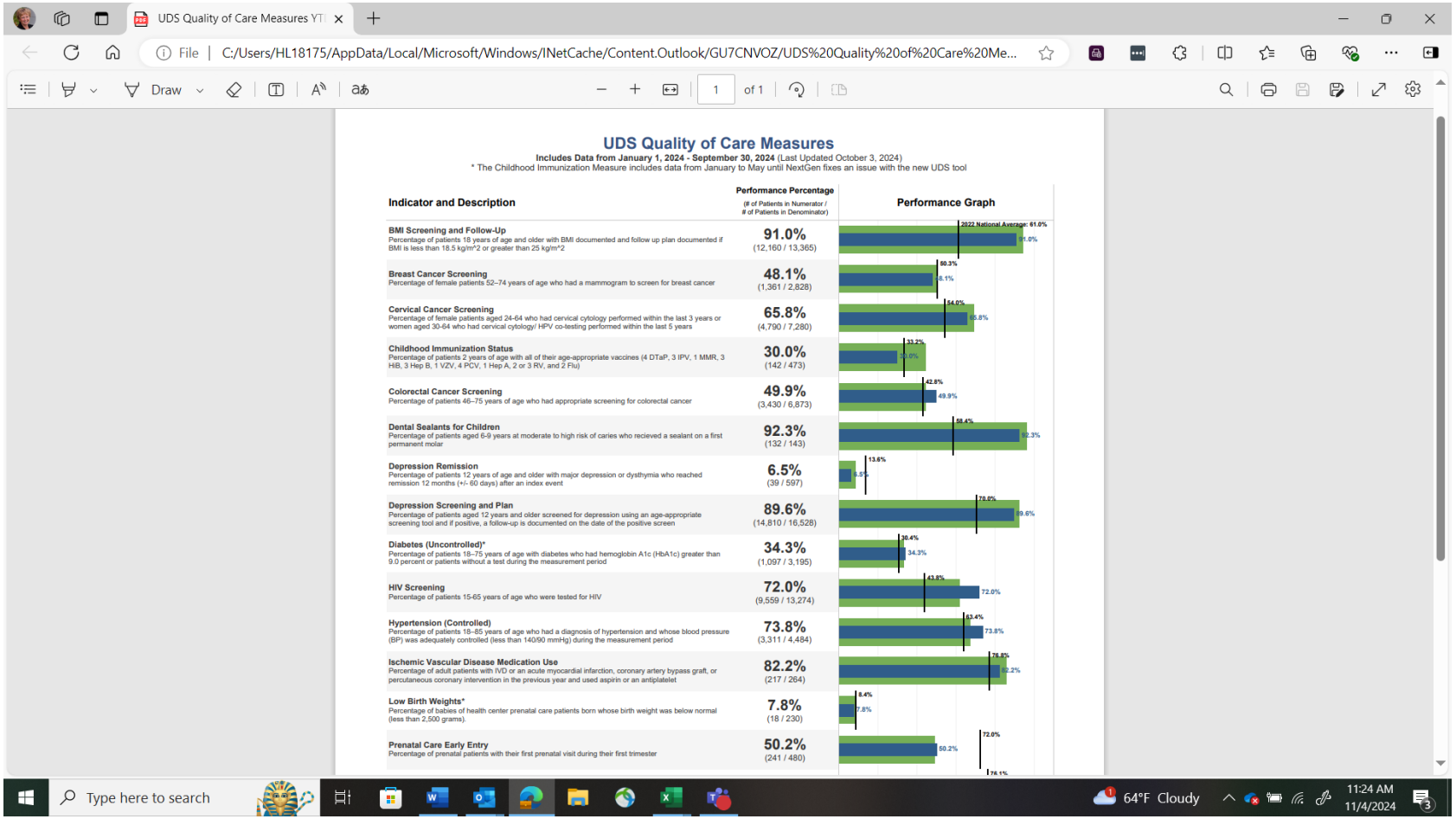
Who is the PIC and how do we identify Opportunities for Improvement?

- PIC Composition:
  - Core Members
  - Rotation based on focused opportunity

- PIC Selection of Opportunities:
  - UDS/HEDIS Quality Measures
  - Operational Metrics

UDS Quality of Care Metrics

As of September 30, 2024



UDS Quality of Care Measures

Includes Data from January 1, 2024 - September 30, 2024 (Last Updated October 3, 2024)

* The Childhood Immunization Measure includes data from January to May until NextGen fixes an issue with the new UDS tool

Indicator and Description	Performance Percentage (# of Patients in Numerator / # of Patients in Denominator)
BMI Screening and Follow-Up Percentage of patients 18 years of age and older with BMI documented and follow up plan documented if BMI is less than 18.5 kg/m^2 or greater than 25 kg/m^2	91.0% (12,160 / 13,365)
Breast Cancer Screening Percentage of female patients 52–74 years of age who had a mammogram to screen for breast cancer	48.1% (1,361 / 2,828)
Cervical Cancer Screening Percentage of female patients aged 24-64 who had cervical cytology performed within the last 3 years or women aged 30-64 who had cervical cytology/ HPV co-testing performed within the last 5 years	65.8% (4,790 / 7,280)
Childhood Immunization Status Percentage of patients 2 years of age with all of their age-appropriate vaccines (4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 RV, and 2 Flu)	30.0% (142 / 473)
Colorectal Cancer Screening Percentage of patients 46–75 years of age who had appropriate screening for colorectal cancer	49.9% (3,430 / 6,873)
Dental Sealants for Children Percentage of patients aged 6-9 years at moderate to high risk of caries who recieved a sealant on a first permanent molar	92.3% (132 / 143)
Depression Remission Percentage of patients 12 years of age and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event	6.5% (39 / 597)
Depression Screening and Plan Percentage of patients aged 12 years and older screened for depression using an age-appropriate screening tool and if positive, a follow-up is documented on the date of the positive screen	89.6% (14,810 / 16,528)
Diabetes (Uncontrolled)* Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent or patients without a test during the measurement period	34.3% (1,097 / 3,195)
HIV Screening Percentage of patients 15-65 years of age who were tested for HIV	72.0% (9,559 / 13,274)
Hypertension (Controlled) Percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period	73.8% (3,311 / 4,484)
Ischemic Vascular Disease Medication Use Percentage of adult patients with IVD or an acute myocardial infarction, coronary artery bypass graft, or percutaneous coronary intervention in the previous year and used aspirin or an antiplatelet	82.2% (217 / 264)
Low Birth Weights* Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams).	7.8% (18 / 230)
Prenatal Care Early Entry Percentage of prenatal patients with their first prenatal visit during their first trimester	50.2% (241 / 480)

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Cervical Cancer Screening Compliance

LakeCounty Health Department and Community Health Center

Cervical Cancer Screening PIP

General Medicine: Dr. Sukkar's Clinic

Sept 27, 2024

3. Aim Statement Increase Cervical Cancer Compliance for 3 BMB General Medicine (Sukkar, Chou, Zahedi) providers from 83.2% to 88.2% by August 15, 2024.

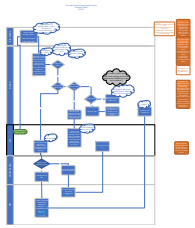
PLAN

1. Describe the Problem: not all patients who need pap smears get them; it is difficult to determine which pt is due because of inaccuracies in the huddle report and care guidelines.

2. QI Project Team

Lead: Dr. Sukkar
Facilitator: Amber & Michele
Members: Yesenia Albarran (MA), Kim Chapman

4. Examine the Current State



Baseline Data (UDS Compliance Workbook)
Aggregate: 83.2% (Drs. Sukkar, Chou, and Zahedi)
Dr. Sukkar: 85.3%
Dr. Zahedi: 86.5%
Evelyn Chou: 73.3%

5. Solutions

1. Improved Accuracy of the Huddle and UDS Report (Data Quality):
A. Updated Care Guidelines
B. Automating Exclusion of Appropriate Hysterectomy options to complete care guidelines
C. Updated LOINC Codes
D. Improved Hysterectomy Options in PSx
E. Clean-up process for free texted Hysterectomy
F. Closing OPEN Pap Smear Orders

2. Improve Access to CCS Care (while minimizing new appts)
A. New MA PVP Huddle Process
B. Addition of pap smears to non-well visits
C. Add 1 PDSA slot per week for paps
D. PAC outreach process for paps due at last encounter yet not done (dec 2022-Sept 16,2024)

DO

Test the Change

6. Test the Change

1. Improved Accuracy of the Huddle and UDS Report (Data Quality): Complicated process to improve data quality. Open orders solution created, SNOMED code Mapping and hysterectomy option updates to be completed within a week.

2. Improve Access to CCS Care (while minimizing new appts)
Since June 4th: **27 paps** have been done during non-well visits as identified by MAs.

3. PAC outreach
Very tedious process and they found data quality issues, in depth patient history insights, and discovered missed opportunities where pts had vaginal exams but no pap (even though they were due). In working the data from Jan-March 2024, 50 patients either scheduled for an appt (10) or paps added to already upcoming scheduled appt (40).
Total: 122 paps added as recommended to already scheduled appts.

STUDY

Use Data to Study Results of the Test

7. Results

Aggregate (UDS Compliance CCS) (BMB Providers)
April 2024: 83.2 % July 2024: 78.8%
Dr. Sukkar
April 2024: 85.3% August 2024: 93%

Although the aggregate did not increase and actually went down, Dr. Sukkar's % increased 7.7% This is likely due to the implementation of the new MA Huddle process in which the other providers declined and chose to continue with their routine process.

ACT

Standardize the Improvement & Establish Future Plans

8. Standardizing the Improvement

Dr. Sukkar is working on standardizing the MA PVP Huddle process across BMB so that those providers compliance can also improve.

9. Future Plans

Working on identifying clinical team that can take on the outreach/care gap work that the PAC is doing and extend the outreach efforts beyond BMB data.

Childhood Immunizations

LakeCounty Health Department and Community Health Center

Childhood Immunizations

General Medicine: Dr. Shair's Clinic

Sept 27, 2024

3. Aim Statement: *Original: Decrease the null rate by 25% of children due/past due vaccines that do not have appt scheduled.*
New: Increase appt scheduled rate (patients due/or past due for vaccines age 2 and under who do not have an appt scheduled) by 5%.

PLAN

1. Describe the Problem: Childhood Immunization rates are not as high as they should be. Patients who come in for acute visits are not routinely vaccinated and there are many opportunities for improvement in the current clinic process starting at the time of scheduling

2. QI Project Team

Lead: Dr. Shair
Facilitator: Amber & Michele
Members: Denise Flores, Anai, Jackie, Kim Chapman

4. Examine the Current State

5. Identify Potential Solutions and Plan them out

1. *Improve the null rate (No appt yet past due/due for vaccines)*
   Baseline Data: July 2024: 52.64%
   A. PAC outreach for pts under age 2 and 1 month away from upcoming WCC appt yet not scheduled
   B. Clinic no show recall process for age up to age 2
   No Baseline data except 0 as this wasn't done before
   C. Clinic Outreach for pts due/past due
   New process from IZ team

2. Improve Vaccine record acquisition and input into EHR
   A. PAC informs new pts to email/drop off vaccine record to HIM email, HIM sends task to IZ team, IZ team updates/reconciles IZ module

3. Update Vaccine Policy and create expected scripting for MAs and nurses to align with policy

4. Ensure appts are schedule upon patient leaving clinic

DO
Test the Change

6. Test the Change

1. Improve the null rate (No appt yet past due/due for vaccines)
   A. PAC was able to easily identify these patients and perform outreach , started with 1 and 2mo old, then quickly expanded to 1,2,4,9,12,15,18,24 mo WCC visit gaps.
   B.New Email that directs to HIM: myvaxrecords@lakecouty.

2. Improve Vaccine record acquisition and input into EMR

   A.Time saving for MA team at POC
   B.Increased Accuracy of IZ module

3. Update Vaccine Policy and create expected scripting for MAs and nurses to align with policy
Policy update, script created and sent to MAs and RNs to complete learning by 10.18.24. Also added to newsletter and NM mtgs

4. Ensure appts are schedule upon patient leaving clinic
MAs schedule appointments or place recalls for all patients.

STUDY

7. Results

1. The rate of patients who are due or past due for vaccines without appts (Null rate) improved from July 2024 of 52.6% to 61.59% as of Sept 24,2024
2. 27 vaccine records have been tasked to IZ team
3. 145 patients have been scheduled for WCC due to PAC outreach since July 2024
4. 32% reschedule capture rate for no show appts due to clinic outreach (25 appts scheduled (April – July)

Learning:
Tackling this problem required looking at it from multiple angles and MDS team approach to determine where the holes in process were (i.e. no f/u appts scheduled , no shows not being tracked, no proactive outreach, vaccine record acquisition and accuracy issues, etc..)

ACT
Standardize the Improvement & Establish Future Plans

8. Standardizing the Improvement

1. PAC outreach will continue and is for all LCHD clinical sites
2. IZ team will continue to receive tasks to input IZ records; care teams are engaging more and sending tasks directly to the IZ team
3. Annualized vaccine policy and scripting education

9. Future Plans

Create 1 liner /key points for MA/RNs to use for vaccine questions/refusals/etc.

Next PIC Opportunities:

Increase statin (cholesterol) prescriptions for specific diseases (quality metric)

Improve access to care for Family Planning patients (operational metric)

Questions

LakeCounty

Health Department and
Community Health Center

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HealthDepartment

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