Secrets to Scaling Up and Improving Population Health: How We Can Apply Lessons Learned Increasing Childhood Immunization Rates by 15% in 3 Years in Maine to Improving Adolescent Immunization Rates

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Maine Quality Counts
with slides from Cassie Grantham, MaineHealth and Kim Fox, MPA, Muskie School of Public Service, and AHEC “You are the Key to HPV Cancer Prevention”

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Speaker Disclosures:

I do not have any relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this CME activity.

Maine Quality Counts (QC) does have funding for our Chronic Pain Collaborative from the Pfizer Independent Grants for Learning and Change (IGL&C) group, which provides independent grant support to organizations for healthcare quality improvement and learning and change initiatives. The Pfizer foundation is independent of the Pfizer commercial entity, but we do disclose this funding. I am the Project Director and this funds approx. 4 hrs/week for my time on the project.
Objectives

- Highlight key lessons learned working with primary care practices to improve immunization rates by 15% through the learning collaborative process using Quality Improvement (QI) methodology
- Understand state policy and payment work that makes child health quality improvement work sustainable
- Changing the script around teen vaccines: Review the CDC’s “You are the Key to HPV Cancer Prevention”
- Discuss ways to scale up and spread work: applying lessons learned to improving adolescent immunization rates
In surprising turn, Maine toddlers had nation’s highest vaccination rate in 2014

The coverage for seven vaccines protecting against 11 diseases reached 84.7 percent, a 16.7-point increase over 2013.

This Simple Strategy Helped Maine Achieve The Nation's Highest Vaccination Rate For Toddlers

The state is stepping in to combat anti-vaxxers.

Christina Wilkie

National Reporter, The Huffington Post

2014 - 85%
Highlights from 2015: America’s Health Rankings
Maine increased to #15 overall from #20 partly due to improving immunization rates

Washington ▲
Improved from 13th to 9th.
Disparity in health status by education level decreased 30% in the past year, but excessive drinking increased 2%.

Oregon ▼
Declined from 12th to 20th.
In the past year drug deaths decreased 5%, health disparity by education level increased 10%, and obesity increased 5%.

New Mexico ▼
Declined from 33rd to 37th.
Immunizations among children aged 19 to 35 months increased 16% in the past year, HPV immunization coverage among adolescent females decreased 10%, and violent crime increased 10% from last year.

Maine ▲
Improved from 20th to 15th.
In the past year immunization among children aged 19 to 35 months increased 25%, and physical inactivity decreased 15%.

North Carolina ▲
Improved from 37th to 31st.
Physical inactivity decreased 13%, and HPV immunization among adolescent females increased 65% in the past year.

http://www.americashealthrankings.org/
Immunization Highlights from America’s Health Rankings

• In the past year, immunizations among children aged 19 to 35 months increased 16.7% from 68.0% to 84.7% (#1)

• Adolescent immunizations (13-17 years): HPV for females: 43% (#15), males: 27% (#8), MCV4: 73% (#33), Tdap: 85% (#31)

http://www.americashealthrankings.org/
Getting Started in 2010

Challenges
• Maine 41st in nation for childhood immunizations
• Unfavorable parental attitudes
• Data accuracy and accessibility
• Workflow strain on ambulatory practices

Opportunities
• Dedicated funding - Maine’s Medicaid Program (MaineCare) with VT was the recipient of a Federal CHIPRA Grant called Improving Health Outcomes for Children (IHOC): IHOC gave us dedicated funding for children’s preventive services that was flexible enough to allow innovation over 5 years, so there was enough time for planning, testing, and spread
• Focus on child healthcare quality improvement; aligning measures/data collection
• Documented best practices
• Coordinated patient education/outreach
• Health Information Systems Integration
• Universal Childhood Immunization Program
• State organizations and health systems willing to align work and set goals
What Matters Most When Leading QI Efforts?
Maine M6 Formula:

- Leadership Matters
- Data Matter
- Teams Matters
- Relationships Matter
- Family Stories Matter
- Fun Matters
Leaders Matter: Public-Private Partnerships were created: Maine Child Health Improvement Partnership (ME CHIP)

**Mission**
To optimize the health of Maine children by initiating and supporting *measurement-based* efforts to enhance child health care by fostering public/private partnerships.

**Vision**
All practices providing health care to children will have the skills, support, and opportunities for collaborative learning needed to deliver high quality health care.

ME CHIP is part of the National Improvement Partnership Network (NIPN)
Leaders Matter:
Practice and State Leaders Were Willing to Align Efforts to Improve Population Based Health

- **MaineCare/ Muskie School at USM**: led (IHOC) Project and worked to align billing with QI for preventive services
- **ME CHIP/QC**: led First STEPS practice improvement effort as part of IHOC and gathered ideas from NIPN leaders in planning stage
- **Maine CDC/ Maine Immunization Program**: did on site technical assistance with practices and improved state registry
- **The Maine Chapter of the American Academy of Pediatrics**: identified Pediatric Champions Statewide and mentored of younger physicians
- **Maine Universal Childhood Immunization Program and the Maine Vaccine Board**: January 2012: children have universal access to a uniform set of vaccines
- **Maine Immunization Coalition and MaineHealth’s Childhood Immunization Task Force** brought leaders together to develop strategies to improve immunization rates: set target of reaching 82% by 2016
- **Maine Medical Association**: did legislative advocacy
Practices Leaders were given a QI plan so they knew what to expect: First STEPS Learning Initiative

First STEPS (Strengthening Together Early Preventive Services): 4 Year Plan

- Phase 1: Introduce Bright Futures 3rd Ed and Improve Childhood Immunizations: 24 practices

- Phase 2: Developmental, Autism, and Lead Screening: 12 practices: Practice based work on screening led to a Developmental Systems Integration (DSI) work and system based work with partners in 2013

- Phase 3: Healthy Weight and Oral Health: 19 practices

- First STEPS 2014: Spread lessons learned on developmental/autism screening: 44 practices trained in 2014 with 5 regional trainings and 9 completed MOC project

- Each 8 month MOC Project/Phase: 2 Learning Sessions; Monthly Practice Calls, Data Submission and PDSA Cycles

- First STEPS Learning Initiative (1-3) targeted to practices serving high volume of children (>1000) covered by Maine’s Medicaid program; 28 practices collectively serving 37,630 kids enrolled in MaineCare (32% of 118,861 kids)* (based on December 2012 MaineCare data)
Data Matters: Using Data to Create Champions of Change

• Know where you are going: Have clear goals and outcomes from the start
• Teach providers about why we need to shift to population based health goals
• Use data to engage providers
• Need to reduce double entry into EMRs and registries to make population based data more obtainable: MaineHealth worked with the Maine CDC to integrate electronic medical record with the state immunization registry to make immunization record sharing more seamless
• In order for practices to use data to drive improvement, they need to trust the data*

Data: Key Component of the Model for Improvement

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act
Plan
Study
Do

Model for Improvement

Associates in Process Improvement
Set Clear, Data Driven Goals: Improvement in Immunization Rates

First STEPS Phase 1 Final Evaluation Results for 21 Practices

Within 12 months of beginning of learning collaborative, achieve an average increase of 4 Percentage Points in overall immunization rates above baseline, across all First STEPS practices.

Sept 2012: 12 months after beginning of learning collaborative, data showed an average increase of: 5.1 Percentage Points in overall immunization rates above baseline, across all First STEPS practices - ACHIEVED

Dec 2012: 15 months after beginning of learning collaborative, data showed an average increase of: 7.1 Percentage Points in overall immunization rates above baseline, across all First STEPS practices - ACHIEVED

Data Matters:
In order to get buy-in from practices, we needed to align metrics

• Through CHIPRA/IHOC we spent the first several years building a child health measures list for QI for the state- several health systems adopted immunization metrics into quality programs
• Need to understand Immunizations metrics
  • Accountable Care
  • Maine Patient Centered Medical Home- 4 Pediatric practices in a pilot with 25 practices
  • Pathways to Excellence at Maine Health Management Coalition (Employer/Payer Coalition)- 2 year old metrics
  • CHIPRA Metrics- 2 and 13 year old metrics
  • Meaningful Use- 2 year old metric
Reporting

• **Data for Improvement**
  – Use of ImmPact registry-based reporting
  – Piloting IHOC measures in First STEPS practices helped gain support to use these measures in public reporting efforts in Maine

• **Data for Accountability**
  – Pathways to Excellence-Led by employer coalition- Maine Health Management Coalition- Public Reporting of CHIPRA core set of measures- 2 yr and 13 yr old
Data Matters: Need to find ways to show practices change over time: Run charts, Excel, QI Team Space

Example:
First STEPS
Sample Practice
Monthly Report

Immunization
Data Run Charts

Source: Muskie School of Public Service, University of Southern Maine
The “IHOC Quick Picks” generate reports for four IHOC Immunization Measures (At Age 2, 6, and 13 years). These reports generate rates and patients lists of children not up to date at the time of their birthday. Practices can also generate patient lists for reminder letters of children that are currently not up to date.

Instructions on how to print Childhood Immunization Metrics from ImmPact are available at:
http://www.mainequalitycounts.org/image_upload/IHOC%20Quick%20Picks%20in%20ImmPact%20Info%202014.pdf
First STEPS Phase 1 Evaluation Highlights: Increase in Overall Immunization Rates

Immunization Rates in First STEPS Phase I Practices from Aug 2011 to Nov 2013:
Immunization Rates in First STEPS practices increased 7.1% in 15 months and 11.1% at 26 months
In response to a national shortage of Haemophilus Influenza B vaccine in 2009, clinicians were encouraged to delay booster shots. These delays reduced Up-to-Date rates for the series graphed above.

In 2009, the National Immunization Survey began reporting a measure that more accurately estimated the true Up-to-Date rate in each state. These more accurate estimates (lines from 2009-2014) are not directly comparable to the older measure’s rates in 2007-2009.

See notes below (Slide courtesy of Tim Cowan, MaineHealth)
Relationships Matter

• Innovation requires a “Queen Bee” and “Swarm” approach
• Need to create strong relationships within a practice team, within the community, and across community partners
• Recognize that building relationships takes time
• Progress happens at the “Speed of Trust” (Steven Covey)
• Some groups to include: Home Visiting, Early Head Start, Public and Community Health Nursing, Child Development Services (CDS), United Way, Family Voices, Parents and Families
• Need to develop a common language among groups
• Spreading and sustaining changes depends on relationships
Teams Matter

• **Intentionally building teams is critical to quality improvement**
  - Consider formal team training- Team STEPPS in Primary Care is one example
  - Make sure you include everyone from the front office staff, nurses, medical assistants, providers, billers/coders, etc. and use everyone to their highest ability
  - Look at quality improvement support available to your practices- both internal and external coaching partners
  - Develop better ways to communicate: you cannot build a team or change behavior by email edicts
  - Develop clear goals, workflows, and training to guide the work
  - Decide how you will spread your work to everyone involved in health care delivery at your office

*Source: Jeanne McAllister, MHA, Center for Medical Home Improvement, Crotched Mountain Foundation, New Hampshire  (McAllister, Cooley et al. “Medical Home Transformation in Pediatric Primary Care-What Drives Change?, Annals of Family Medicine, v1supp1, 2013)*
Significant Changes in Immunization-Related Office Systems

• Training staff in how to discuss importance of vaccinations with hesitant patients/parents

• Establishing shared goals and a standardized immunization schedule for all providers in the practice
  − Changing the immunization schedule (e.g. administering the Hepatitis A vaccine to children at 18 months instead of at 24 months)

• Using recall and reminder systems for children due or past due for vaccinations- had to adjust timeframe to 15-18 months of age to meet metrics requirements by 24 months

Testing Changes: Examples of Supports and Resources for MaineHealth Practices with their Clinical Improvement Plan

• First STEPS Change Package Toolkit (system index, checklist of improvement ideas, action planning and full change package as needed)

• Access to a Practice Improvement Advisor

• Centralized resources and programs (free):
  o ImmPact-Epic Interface
  o Childhood Immunizations Education and Training Program for clinical support staff
  o Patient education materials
  o MOGE service (Moved or Gone Elsewhere) to update registry
  o Reminder/recall systems
  o Other (projects as defined by the MH Childhood Immunizations Task Force, e.g. Standing Orders, Common Pediatric Immunization Schedule for MaineHealth)
Sustainability: Need to Align Data/Measures with Reimbursement

- Maine now has vaccines available at no-cost through Maine Vaccine Board-Universal Coverage Law passed in 2010, vaccines became available in 2012 a few months after QI project started
- MaineCare worked with IHOC team on policy changes that clarify or expand reimbursement and billing to encourage practice improvement and organizational support.
- Understand requirements of the ACA to cover preventive services so that the quality efforts are also supported by billing and payment: Modifier -33 (new since 2011)
- In Maine, we are providing input to the State Innovation Model (SIM) Value Based Insurance Design (VBID) group to align preventive service coverage across insurers
Sustainability: Need to Align QI Measures and Projects with Incentives

• Find out what the providers need as incentives to do the work: public recognition, awards dinner, prizes
• Several health systems built incentives into their provider contracts
• Design projects with QI measures/methodology so that practices can obtain Board Certification credit-Maintenance of Certification Credit (MOC)
• Offer CME for educational sessions/webinars if possible
Fun Matters

• Make the work fun during events and in the office
• Offices develop fun campaigns: “V” campaign at Martin’s Point Pediatrics
• Develop Slogans: “Put Your Best Arm Forward”
• Have practices pick theme songs: “Hit Me With Your Best Shot™
• Come up with creative contests to share ideas and raffles
How Do We Scale Up and Immunization Work?

- What will it take to get all of our adolescent rates to 90% over the next 6 years?
- Apply lessons learned to improving adolescent immunization rates
- Change the script around teen vaccines: Review the CDC’s “You are the Key to HPV Cancer Prevention”
- Implement Practice Changes using QI Methodology
Family Stories Matter

- Include families in your QI work
- Make it easy for families to get consistent health care following Bright Futures guidelines in your office
- Highlight the importance of maintaining healthy bodies, minds, teeth, and smiles
- Relook at your communication materials and scripting
HPV vaccine is cancer prevention.

Talk to the doctor about vaccinating your 11–12 year old sons and daughters against HPV.

#UCanStopHPV

Evidence-Based HPV Disease Prevention

HPV VACCINE
You are the Key to HPV Cancer Prevention

Understanding the Burden of HPV Disease, the Importance of the HPV Vaccine Recommendation, and Communicating about HPV Vaccination

Updated June 25, 2015
HPV Infection

- Most females and males will be infected with at least one type of mucosal HPV at some point in their lives
  - Estimated 79 million Americans currently infected
  - 14 million new infections/year in the US
  - HPV infection is most common in people in their teens and early 20s
- Most people will never know that they have been infected

New Cancers Caused by HPV per Year
United States 2006-2010

CDC, United States Cancer Statistics (USCS), 2006-2010

Women (n = 17,600)

- Cervix n=10,400 (59%)
- Anus n=2,600 (15%)
- Vulva n=2,200 (13%)
- Vagina n=600 (3%)
- Oropharynx n=1,800 (10%)

Men (n = 9,300)

- Oropharynx n=7,200 (77%)
- Penis n=700 (8%)
- Anus n=1,400 (15%)
- Oropharynx n=1,800 (10%)
Without vaccination, annual burden of genital HPV-related disease in U.S. females:

4,000 cervical cancer deaths
10,846 new cases of cervical cancer

330,000 new cases of HSIL: CIN2/3
(high grade cervical dysplasia)

1 million new cases of genital warts

1.4 million new cases of LSIL: CIN1
(low grade cervical dysplasia)

Nearly 3 million cases and $7 billion

American Cancer Society. 2008; Schiffman *Arch Pathol Lab Med.* 2003; Koshiol *Sex Transm Dis.* 2004; Insinga, Pharmaco economics, 2005
HPV Vaccine Recommendation

Girls & Boys can start HPV vaccination at age 9

Preteens should finish HPV vaccine series by 13\textsuperscript{th} birthday

Plus girls 13-26 years old who haven’t started or finished HPV vaccine series

Plus boys 13-21 years old who haven’t started or finished HPV vaccine series
# HPV Vaccine Comparison

## HPV Types Included in Vaccine

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<th>Type</th>
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<td>Quadrivalent</td>
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## HPV Types and Their Effects

- **Genital warts**: ~66% of HPV Types cause genital warts.
- **Cervical Cancers**: ~15% of HPV Types cause cervical cancers.

*HPV: You are the key to cancer prevention.*
# Updated ACIP Recommendations

## Age
- **Routine vaccination at age 11 or 12 years***
- Vaccination recommended through **age 26 for females** and through **age 21 for males** not previously vaccinated
- Vaccination recommended for men **through age 26** who have sex with men (MSM) or are immunocompromised (including persons HIV-infected)

### Formulation by gender (assuming availability)

<table>
<thead>
<tr>
<th></th>
<th>9vHPV</th>
<th>4vHPV</th>
<th>2vHPV</th>
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<td><strong>Females</strong></td>
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<td>✔</td>
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<tr>
<td><strong>Males</strong></td>
<td>✔</td>
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*Vaccination series can be started at 9 years of age

MMWR 2015;64:300-4
Updated ACIP Recommendations: Interchangeability

If vaccination providers do not know, or do not have available the HPV vaccine product previously administered, or are in settings transitioning to 9vHPV:

For protection against HPV 16 and 18,

- **Females**: Any HPV vaccine product may be used to continue or complete the series
- **Males**: 4vHPV or 9vHPV may be used to continue or complete the series

MMWR 2015;64:300-4
ACIP Recommendations:  
Timing of the Series

2vHPV, 4vHPV and 9vHPV are each administered in a 3-dose schedule
- Interval between doses 1 → 2: ~6 weeks (1-2 months)
- Interval between doses 1 → 3: 6 months

If the vaccine schedule is interrupted, the series does not need to be restarted
HPV Vaccine
Duration of Immunity

- Studies suggest that vaccine protection is long-lasting; no evidence of waning immunity

  - Available evidence indicates protection for at least 8-10 years

  - Multiple cohort studies are in progress to monitor the duration of immunity
Impact of Eliminating Missed Opportunities by Age 13 Years in Girls Born in 2000

Missed opportunity: Healthcare encounter when some, but not all ACIP-recommended vaccines are given. HPV-1: Receipt of at least one dose of HPV. MMWR. 63(29);620-624.
Talking about HPV vaccine

FRAMING THE CONVERSATION
Clinicians Underestimate the Value Parents Place on HPV Vaccine

Give a Strong Recommendation to Receive HPV Vaccine at Ages 11 or 12

- A strong recommendation from you is the main reason parents decide to vaccinate

- Many moms in focus groups stated that they trust their child’s doctor and would get the vaccine for their child as long as they received a recommendation from the doctor

MMWR 2014; 63(29);625-633;
Unpublished CDC data, 2013.
Make an Effective Recommendation

**Same way:** Effective recommendations group all of the adolescent vaccines
Recommend HPV vaccination the *same way* you recommend Tdap & meningococcal vaccines.

**Same day:** Recommend HPV vaccine *today*
Recommend HPV vaccination the *same day* you recommend Tdap & meningococcal vaccines.

Unpublished CDC data, 2013.
Clinicians can give a strong and effective HPV vaccine recommendation by announcing:

Sophia is due for three vaccines today. These will help protect her from meningitis, HPV cancers, and pertussis. We’ll give those shots at the end of the visit.
If main concern is “Why does my child need this vaccine” try saying:

*HPV vaccine is very important because it prevents cancer.*

*I know we’d like to protect Maureen from cancer and I’d feel better if she got her first dose of the HPV vaccine series today.*
If main concern is “My daughter will wait for marriage/won’t be exposed”, try saying:

*HPV is so common that almost everyone will be infected at some time.*

When your daughter marries, she could catch HPV from her husband. He might have been infected before he ever met her.
If main concern is “why now, let’s wait until child is older,” try saying:

*HPV vaccine produces a more robust immune response in preteens than in older teens which is why I recommend starting the HPV vaccine series today.*
If main concern is “would you give it to your child,” try saying:

Yes, I gave it to my child (or grandchild, etc) because I think preventing cancer is very important.
If main concern is “side effects,” try saying:

Vaccines, like any medication, can cause side effects. With HPV vaccine most are mild, primarily pain or redness in the arm. This should go away quickly.

HPV vaccine has not been linked with any serious or long-term side effects.
Before leaving the exam room, **remind parents when to come back.** Try saying:

To work, Robert needs the full HPV vaccine series, so …

Please make sure to make appointments for the next shot on the way out, and put that appointment on your calendar before you leave the office today!
HPV VACCINE IS CANCER PREVENTION
And YOU are the key!

#WeCanStopHPV
How do we apply these lessons learned to raising adolescent vaccine rates?
Use the Model for Improvement!

What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?

Act
Plan
Study
Do

From: Associates in Process Improvement
Set Your Aim- What will it take to get to 90%?

- **Set your aim for adolescent immunizations rates:**
  - In one year, our practice will increase our all of our adolescent rates by 10% using ImmPact data as the source.

- **Current MHMC PTE Benchmarks (1st is CDC NIS Average 2013, 2nd is based in First STEPS 2013 data - 75th percentile)**
  - 13 YR Old-1 dose of TdaP or Td >10 yrs of age
    - CDC NIS average ≥90%**  First STEPS 2013 ≥91%
  - 13 Yr Old-1 dose MCV
    - CDC NIS average ≥76%** First STEPS 2013 ≥90%
  - 13 Yr Old- 3 doses of HPV for Girls
    - CDC NIS average ≥26%** First STEPS 2013 ≥35%
  - 13 Yr Old- 3 doses of HPV for Boys
    - CDC NIS average ≥12%** First STEPS 2013 ≥30%
Data Matters: Key Component of the Model for Improvement

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Model for Improvement

Act
Plan
Study
Do

Associates in Process Improvement
Use a Key Driver Diagram as a Guide

Aim:
To improve preventive services for Maine's children.
Aim/Outcome: Between September 2011 & September 2012, improve immunization rates (2010) by > 4% in practices that serve a high volume of MaineCare.

DRIVERS

Team based and evidence based system of care with informed, engaged and competent staff

Leaders as champions for change

Access to care

Immunization information and tracking systems (HIT) that support improving immunizations

Engage partners in improving immunization rates

Measures

Immunization Rates for:
- 2-Year Olds
- 6 Year Olds
- 13 Year Olds

http://www.mainequalitycounts.org/page/2-688/phase-i-updates)
Use the ImmPact Rate Reports

- The “IHOC Quick Picks” generate reports for four IHOC Immunization Measures (At Age 2, 6, and 13 years)
  - Three of the four immunization measures align with CHIPRA measures for 2 year olds and 13 year olds
  - One of the four immunization measures aligns with the National Quality Forum’s Meaningful Use measures for children and adolescents

- The IHOC Quick Picks were designed for use by authorized ImmPact users to run practice-level immunization reports in support of quality improvement efforts at practices and health systems. Practices need to submit per client dose information to run reports.

- Practices can use these reports to submit data to the Pathways to Excellence (PTE) program.

- Questions about reports should be directed to the ImmPact Support Line @1-800-906-8754

- Instructions on how to print Childhood Immunization Metrics from ImmPact are available at: http://www.mainequalitycounts.org/image_upload/IHOC%20Quick%20Picks%20in%20ImmPact%20Info%202-24-2014.pdf
IHOC Quick Picks

The “IHOC Quick Picks” generate reports for four IHOC Immunization Measures (At Age 2, 6, and 13 years). These reports generate rates and patients lists of children not up to date at the time of their birthday. Practices can also generate patient lists for reminder letters of children that are currently not up to date.

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Immunization Coverage Report
Criteria Page Gender Label and Dropdown:
## Sample Excel Coverage Report for IHOC at Age 2 Measure

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<td>Site</td>
<td>Total Clients</td>
<td>Number Dose Count Met</td>
<td>Number Off Schedule</td>
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<td>Report Run On</td>
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<td>11</td>
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<td><strong>Organization</strong></td>
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<td>Total Clients</td>
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<td>DTP/aP4</td>
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<td>MMR 1</td>
<td>Hib 3</td>
<td>HepB 3</td>
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<td>DCM Percentile</td>
<td>10%</td>
<td>50%</td>
<td>94%</td>
<td>75%</td>
<td>85%</td>
<td>85%</td>
<td>72%</td>
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Assess Your System and Gather Resources

- Look at the First STEPS Change Package Toolkit
  - Complete Readiness Survey
  - Review System index and Best Practices
- Review materials including CDC Resources on HPV and AHEC List of Resources
- Watch Several Short Videos on HPV
- Get involved in the National HPV Collaborative this Spring with NIPN/NIPA
- Have AHEC come to do an on-site educational session on HPV
Create a QI Plan: 90 Day Cycles

• Phase 1
  – Organize Lead Team, complete readiness assessment

• Phase 2
  – Assess practice using office system survey and get baseline data from ImmPact, assess staff comfort with adolescent vaccines- decide how much training is needed; has staff agreed on standardized schedules for vaccines

• Phase 3
  – Prioritize and Assign the Work for the Work Period, starting to think in 30 day blocks, start monthly PDSA cycle, decide what improvement process you will flowmap, collect monthly data an review with your practice teams

• Phase 4
  – Teams Work Period—Test & Implement

• Phase 5
  – Recalibrate and Prepare to Launch Another 90-Day Cycle
Look at your workflow

...ALL Work is a Process!

LEADER – “How I think things work or should work”

FRONT-LINE – How things really work: unintended variation

Confusion...Conflict...Complexity...Chaos
Example of Practice Immunization Workflow from MaineHealth
Standardize Your Schedules
Implement QI

• Build a training plan for staff
• Talk about how to standardize immunization schedules across providers and teams
• Start early- providers should set expectations for adolescent vaccines at 7-9 year old well visits
• Start recall/reminders at 11 yrs 1 day old
• Develop scripts with those who schedule appointments, check-in patients, and prep patients
• Enhance patient and staff awareness through promotional information available from the CDC
• Gather a list of patient education materials
• Set some goals for your project and initiate with frequent revisions (study your PDSAs!)
Lessons Learned in Raising Immunization Rates in Maine

• Dedicated funding and leadership is key to moving the work forward.
• Aligning measures across state initiatives is important for provider buy-in and to sustain quality improvement work after grant funding.
• Child health measures need to be actionable and easily available at the practice-level to improve performance.
• Data source matters - Measures cannot be operationalized without reliable methods for capturing, collecting, calculating, and reporting the data.
• Integrating data system improvements as part of child QI efforts helps increase visibility and accuracy of data and demonstrates how data can be ‘meaningfully used’ to sustain quality improvement over time.
• Changing Population Health Outcomes takes time- set big and little goals, celebrate success at each interval!
• The Maine M6 Formula: Leadership, Teams, Data, Relationships, Family Stories, and Fun Matters!!
• We should use these lessons learned to work on Adolescent Immunization Rates to get at least 90% teens vaccinated!
Contact Information

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  **IHOC/First STEPS evaluation reports:**

- **Cassandra Cote Granthan**, MA, Director, Child Health, Community Health Improvement, MaineHealth, cotec1@mainehealth.org
- **Zoe Hull**, Research Assistant, HPV Vaccination Project Coordinator, School of Community and Population Health, University of New England, 207.221.4463, zhullsfredo@une.edu. If your practice wants a full presentation on HPV, please contact Zoe.
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Project Overview

• Improving Immunization Rates and Enhancing Disease Prevention through Partnerships with Providers and National Organizations that focus on Public Health (CDC Cooperative Agreement)
  – Academic Pediatric Association as lead applicant
  – Goal: enhance education, awareness & strength of HPV vaccine recommendations for providers, including those who train primary care residents
  – National Immunization Partnership with the APA (NIPA)

• Partnerships w/providers & national organizations
  – Strengthen clinician HPV vaccine recommendation by direct outreach & education in every state/territory
  – Promote CDC & other tools to improve practice efforts at both a national and local level Establish the “HPV Virtual Learning and Improvement Network”: NIPN 2nd cohort (10 state: AZ, IA, ID, IN, FL, ME, NH, NJ, TN and VT /100 practices) & CORNET (15 practices)

• Goal: increase HPV vaccination rates among adolescents ages 11-17 y.o.

• Use QI methods to:
  – Give Strong Provider Recommendation (all practices)
  – Reduce missed opportunities (“menu”):
    • Provider Prompts
    • Reminder-Recall
    • Standing Orders
Participant Benefits

• Earn 25 credits towards ABP Maintenance of Certification (MOC), Part 4, or Maintenance of Certification for Family Physicians (MC-FP) from the American Board of Family Medicine, Part IV
• Receive QI coaching and support, including project-specific customized tools and materials (regularly updated virtual toolkit http://www.academicpeds.org/NIPA/)
• Receive assistance in assessing your system for HPV vaccine delivery, recognizing barriers, and selecting evidence-based strategies to test with PDSA cycles
• Participate on monthly Learning Collaborative webinars on topics such as delivering a strong provider recommendation for HPV vaccine and reducing Missed Opportunities for vaccination
• Track your practice’s progress through monthly feedback reports
Timeline

February 2016

**Enrollment Phase** (1 hour)
- Project Overview
- Practice Teams Established
- Contact Information Form

March-April 2016

**Pre-Intervention Phase** (3 hrs/month)
- Practice Readiness Assessment (0.5 hour)
- Office Systems Inventory (0.5 hour)
- Baseline HPV vaccination rates (3 hours)
- Project Orientation & QI Training (1 hour)
- Strategy Selection (1 hour)

May-October 2016

**Learning Collaborative Implementation Phase** (3.5 hr/month)
- Strategy Implementation
- Monthly Team Meeting to review data and plan (1 hour)
- Monthly Learning Collaborative Webinars (1 hour)
- Monthly PDSA Self Assessments (0.5 hour)
- Monthly Chart Reviews (16/month) (1 hour)
- Staff Impact Survey (Midpoint)

November 2016

**Wrap Up Phase** (2 hours)
- Staff Impact Survey (Endpoint) (0.25 hour)
- Office Systems Inventory (0.5 hour)
- Post HPV rates (1 hour)
- Project Evaluation (0.25 hour)