AMGA
Advancing High Performance Health

AMGA Foundation

Adult Immunization (AI) Best Practices Learning Collaborative, Group 2: Case Study

Hattiesburg Clinic, P.A.

Hattiesburg, MS

Organizational Profile

Hattiesburg Clinic is the largest physician-owned multispecialty group in Mississippi and one of the largest in the region. Founded in 1963 with 10 physicians, the organization has grown over the years to a staff of more than 400 physicians and mid-level providers and more than 2,400 employees serving the South Mississippi region. The organization currently includes approximately 27 primary care clinics, five immediate care facilities, and 16 dialysis units throughout its 19-county service area. Offering services in more than 45 specialties, Hattiesburg Clinic's goal is to be the state's healthcare provider of choice by providing quality health care in an efficient and cost-effective manner, with emphasis on excellence and service to the patient.

Hattiesburg Clinic comprises a physician-owned ambulatory outpatient facility with two ambulatory service centers, 270 physicians, psychiatrists, psychologists, and optometrists, as well as 155 physician assistants, nurse practitioners, physical therapists, and certified registered nurse anesthetists (CRNAs); 35% of providers are primary care. Hattiesburg Clinic's market area is approximately 438,000 patients with over 815,000 outpatient visits in 2016 (excluding dialysis), and over 24,900 outpatient surgeries/procedures in 2016 at the clinic's ambulatory surgical centers (ASCs).

Executive Summary

In 2011, Hattiesburg Clinic embarked on participating in the Group Practice Reporting Option (GPRO) through the Centers for Medicare & Medicaid Services (CMS) for quality measures. The purpose of this participation was to find out how the clinic's quality ranked among others in the nation and to begin a quality improvement process that sought to improve the quality of patients' care while lowering costs. The first report from CMS in 2012 indicated that the clinic was in the high cost/low quality quadrant among other reporting entities. At that point, the clinic realized it had to move forward with improving quality. To do so, Hattiesburg Clinic began by focusing on mammograms and flu and pneumococcal vaccinations. In July of 2013, Hattiesburg Clinic added best practice advisories (BPAs) in the electronic medical record (EMR) to engage physicians and help them recognize patients who are overdue for these items. The BPAs were to increase visibility of overdue items and increase ordering of those items. As a result, the percentage of pneumococcal conjugate vaccine (PCV13) rates in the +65 population increased from around 30% to 50%. Hattiesburg Clinic has continued to participate in GPRO and has improved quality metrics each year until reaching the high quality/low cost quadrant in 2017 with CMS for its quality metrics.

In 2016, the organization became an Accountable Care Organization (ACO) with CMS and has subsequently engaged in a commercial ACO and other value-based plans to focus on improving quality across the continuum in population health. Continued efforts have been fruitful and results are slowly improving.

Additionally, infrastructure has been built from the ground up to form a Quality Management department consisting of case managers and social workers to manage population health in primary care departments and across specialty departments in the organization. One lesson learned is that in order to move the needle and perform at a level to improve quality in all patient populations, Hattiesburg Clinic must remain constantly engaged with administrators, management, physicians, and clinical staff.

Acronym Legend

ACIP: Advisory Committee on Immunization Practices
ACO: Accountable Care Organization
AI Collaborative: AMGA's Adult Immunization Best Practices Collaborative
ASC: ambulatory surgical centers
BPA: Best practice advisory
CDC: Centers for Disease Control and Prevention
CMS: Centers for Medicare and Medicaid Services
CRNA: certified registered nurse anesthetist
EMR: Electronic medical record
GPRO: Group Practice Reporting Option
HP2020: Healthy People 2020
PCV13: Pneumococcal Conjugate Vaccine
QA: Quality assurance

Program Goals and Measures of Success

The AI Collaborative goals were set by AMGA Foundation based on reviewing the Healthy People 2020 goals from the federal office of Disease Prevention and Health Promotion (HP2020)[1], baseline data for each group, and with input from the AI Collaborative advisors; see Appendix.

By working through the quality metrics in ACOs and value-based plans, Hattiesburg Clinic created goals at both an organizational level and individual physician level in order to improve and move further into the quadrant for low cost and higher quality care for the population it serves. These goals are to meet the AI Collaborative's goals and to also be in the 90th percentile of the clinic's quality metrics for group reporting. In 2017, in terms of the ACO population (approximately 20,000 lives), the clinic was at 66% of pneumococcal vaccinations in ages 65+ (any) and 43% of flu vaccinations. Hattiesburg Clinic started measuring high-risk pneumococcal vaccinations in February 2018 through physician dashboards. Currently, the clinic is only at 23% (all patients) and at 30% (only clinic primary care providers), so continued improvement is needed to obtain a rate of 45% in this population.

Data Documentation and Standardization

The Hattiesburg analytics team used the AI Collaborative measure specifications to develop and test data extraction queries. Immunization data is stored in multiple locations in the EMR and data warehouse (e.g., claims, data from external sources, locally documented immunizations). The quality assurance (QA) process confirmed that the measure calculation included all the available data. (See Appendix)

Population Identification

Hattiesburg Clinic serves a market area of approximately 525,000 patients in a 19-county area. Within that area, the clinic can identify any patient that is overdue for flu or pneumococcal immunizations through overall dashboards in the EMR. Each physician has a dashboard that shows overdue items and can drill down to the patient level to be proactive and call those patients in advance to have them come into the clinic for their overdue immunizations. The clinic also utilizes a call reminder system, texting system, patient portal, and patient calls from the staff to engage patients in their overdue immunizations.

Intervention

Hattiesburg Clinic has continued to leverage EMR to build decision-making tools in smart order sets that allow the physician to appropriately order the correct vaccination (including overdue vaccinations) for patients through the BPAs and Health Maintenance section of the patient's chart. The Quality Management department's case managers (annual wellness nurses and chronic care management nurses) are embedded in primary care offices. These individuals and offices are highly engaged in population health and work with the physicians and their patients to ensure overdue health maintenance measures—including vaccinations—are ordered for the patients. There are various tools that support these efforts, such as the dashboards in EMR, which they can use to identify any patient that is overdue for flu or pneumococcal immunizations. Each physician has a dashboard that shows overdue items and can drill down to the patient level to be proactive to call those patients in advance and have them come into the clinic for their overdue immunizations. The clinic utilizes a call reminder system, texting system, patient portal, and contacting patients as well to engage patients in their overdue immunizations.

These health maintenance measures can now take place in a variety of locations from a range of providers. The clinic has 20 Family Practice locations with a total of 80 primary care providers. Hattiesburg Clinic also has 181 specialty providers within its specialty departments including surgery. In addition, there are five Immediate Care locations and 16 dialysis units that, in combination with all of the family practice locations, pulmonary, oncology, dialysis, and OB/GYNs, can administer adult vaccinations. For those areas/departments that do not administer vaccinations, they can send their patients to a centralized area in the Infusion Clinic to receive vaccinations.

Hattiesburg Clinic has implemented and developed several action-based plans in 2016 to engage staff, physicians, and patients to become engaged with their gaps in care. These were continued in 2017 and now in 2018. All managers meet monthly in a meeting named "Healthy Planet Manager's Meeting." The purpose of these meetings is to continuously educate the clinical managers on any quality initiative that was engaged with at the clinic. The clinic also engages in "close the gap" campaigns for flu and pneumonia with clinical departments and Quality Management. The clinic has also standardized the operational ordering of vaccines to order the number of vaccines required to close the gaps in care and not just based on past historical data of the number given. In addition, Hattiesburg Clinic has introduced a "Commitment to You" campaign to all patients to ensure they are educated on the importance of why they should be immunized and to leverage information from the Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP).

Outcomes and Results

Hattiesburg Clinic continued to show improvement in several clinic locations with utilization of "close the gap" reports for flu and pneumonia. (See Appendix.)

Lessons Learned and Ongoing Activities

Several lessons have been learned along the way. Hattiesburg Clinic will no longer order vaccinations based on historical administration but rather utilize the EMR tools and the percentage of overdue vaccinations in each physician's practice to determine the appropriate number of vaccinations to order. It has also been vital to engage earlier in the year to increase percentages with "close the gap" campaigns with managers to increase awareness internally and in the patient population. Additionally, the clinic is engaging in population outreach through marketing to increase awareness and extend its reach. The clinic will also be moving into exploring opportunities to engage with the local schools, church organizations, and other community-based organizations.

Hattiesburg Clinic has had to continue engaging its physicians and patients to increase awareness and among physicians and clinical staff to understand the importance of vaccinating the patient populations. In 2018, Hattiesburg Clinic will work toward improvement of overall strategy by expanding the Quality Management department case managers into all the clinic primary care locations and increase population efforts to improve the quality of care for patients. In addition, the clinic will have a centralized vaccination clinic for flu and pneumococcal vaccines to be administered on the first floor of the main clinic building in high visibility to patient traffic.

References

1. Office of Disease Prevention and Health Promotion (ODPHP). Healthy People 2020. healthypeople.gov.

Collaborative Goals

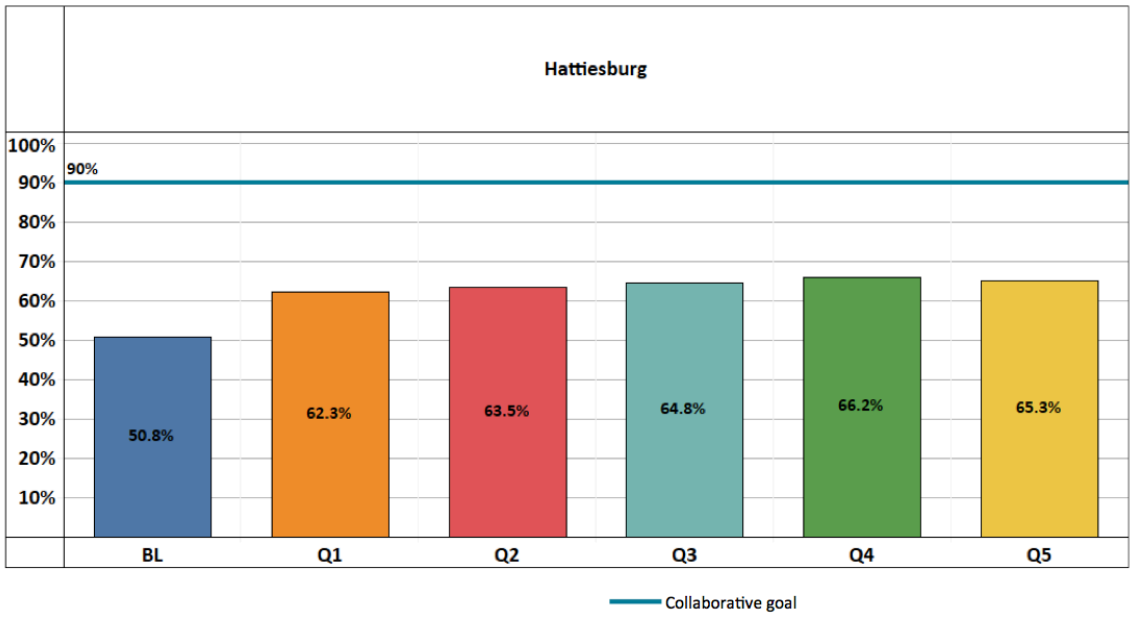
Measure	Healthy People 2020	Collaborative Goal
Measure 1 (65+) Any	90%	90%
Measure 1 (65+) Both PPSV and PCV*	90%	60%
Measure 2 (High-Risk)	60%	45%
Optional Measure 2a (At-Risk)**		
Measure 3 (Flu)	70%/90%***	45%

* Increasing "Both" is a good goal for Groups which are already doing well on "Any"

** According to CDC guidelines, it is not currently recommended that the at-risk population receive PCV. Therefore,"PPSV" or "Unknown pneumococcal vaccination" are numerator options for Measure 2a.

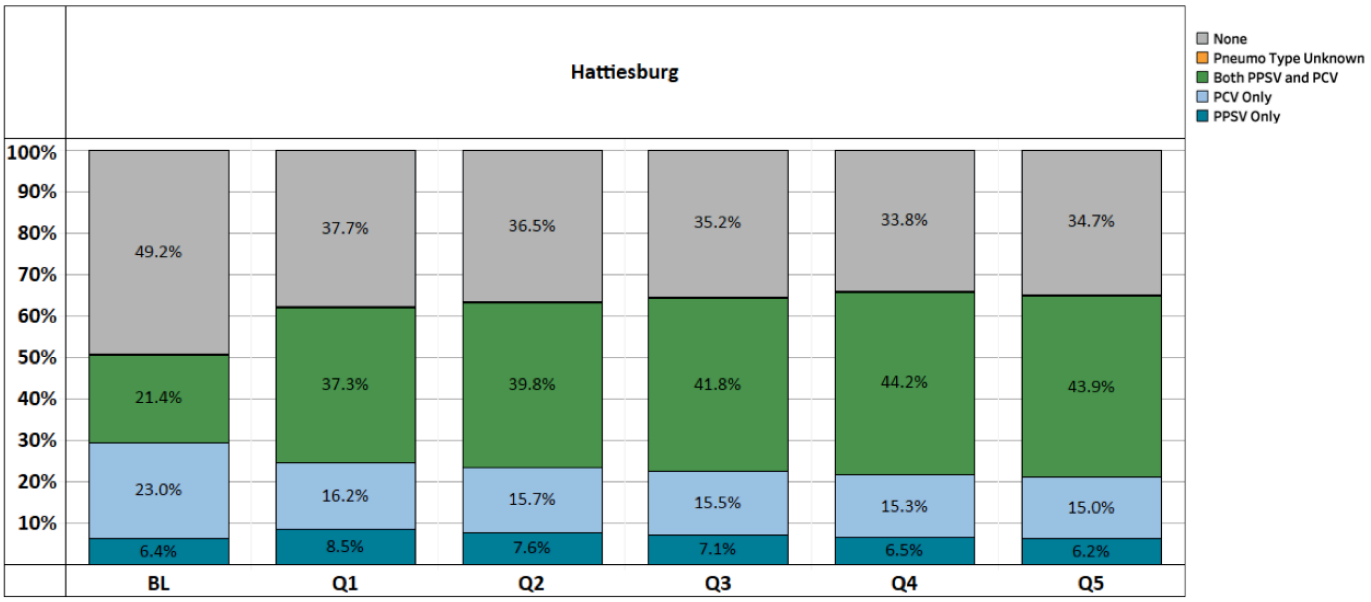
*** 70% for all patients, 90% for Medicare patients

Measure 1 – Pneumococcal (Any) Immunization for Adults Ages ≥ 65

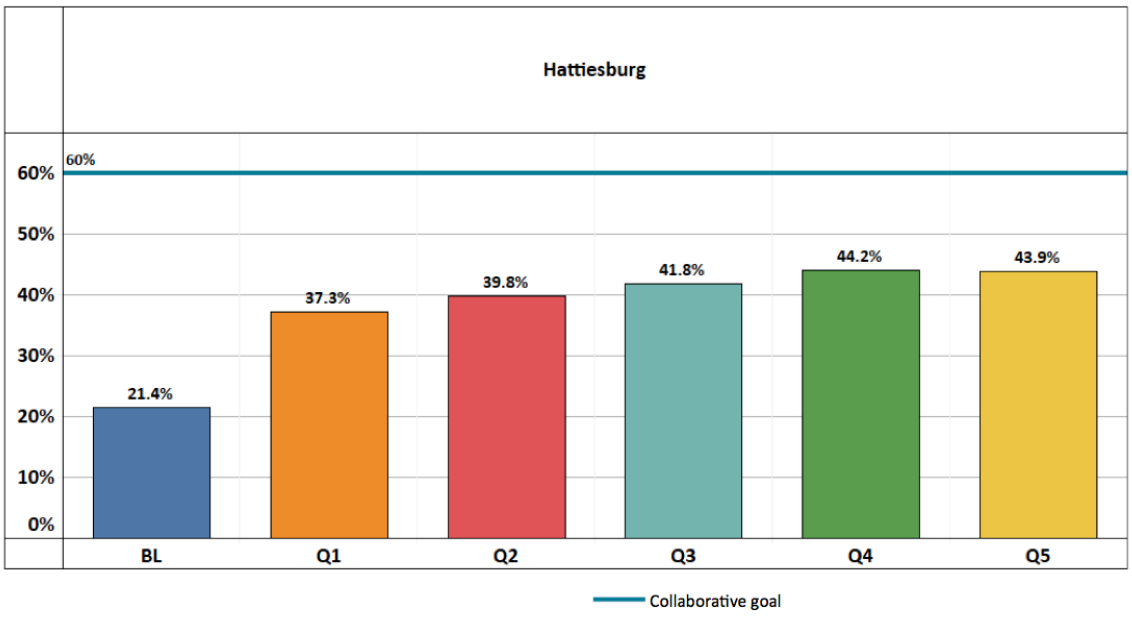


Appendix

Measure 1 – Pneumococcal (Any) Immunization for Adults Ages ≥ 65

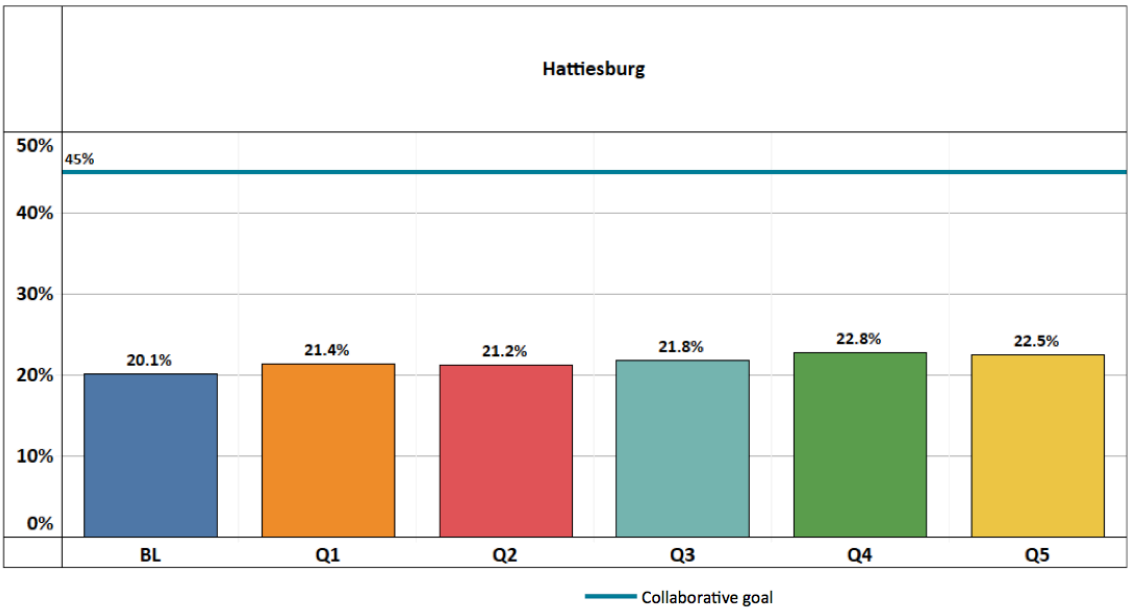


Measure 1 – Both PPSV and PCV Immunization for Adults Ages ≥ 65

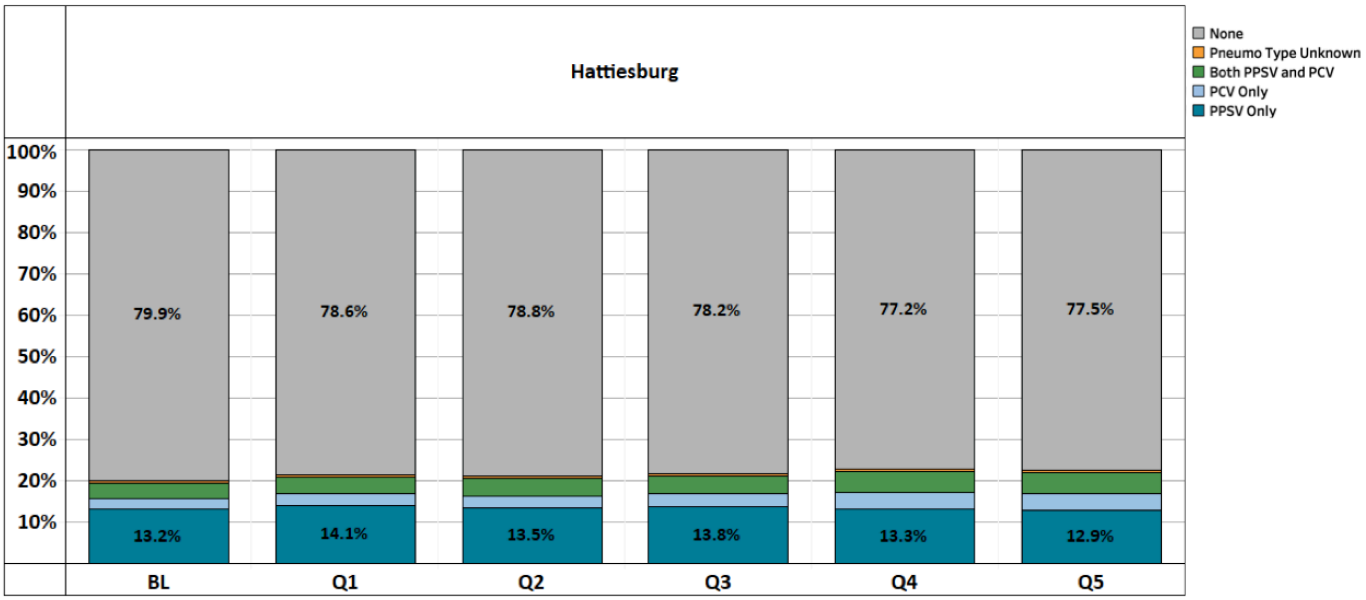


Appendix

Measure 2 – Pneumococcal (Any) Immunization for Adults Ages 19–64 with High-Risk Conditions

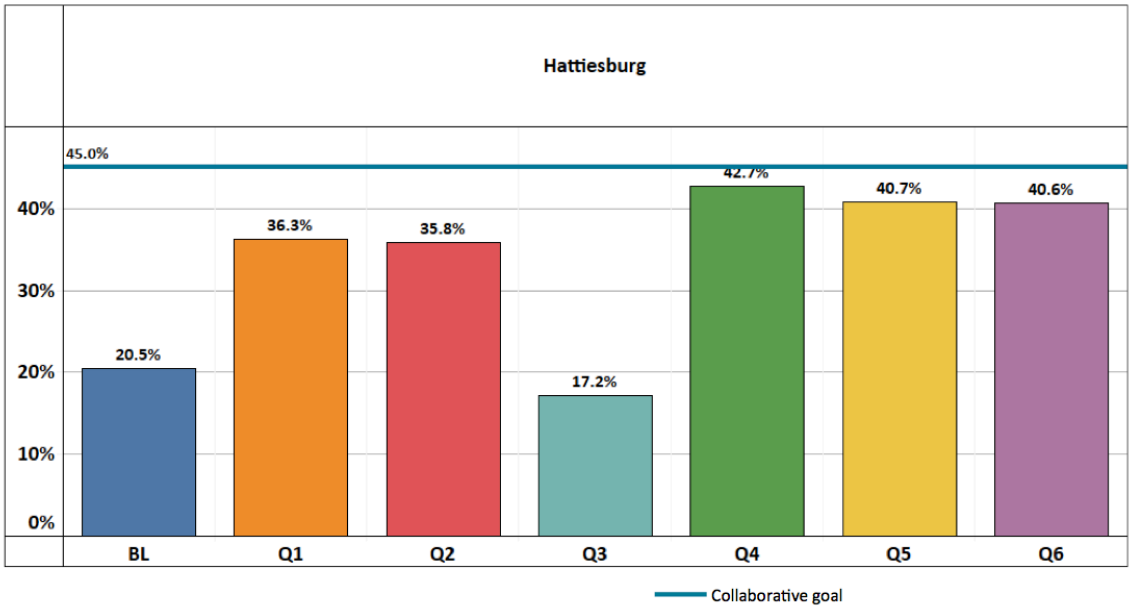


Measure 2 – Pneumococcal (Any) Immunization for Adults Ages 19–64 with High-Risk Conditions



Appendix

Measure 3 – Influenza Immunization, Age ≥ 18



Immunizatioin Data

Close the Gaps by Department: Pneumococcal Immunization Ages ≥ 65, December 2017

Pneumococcal vaccination (65+)		As of 4-1-17				As of 11-1-17				As of 12-1-17				
Clinic	Manager	Measure satisfied	Overdue patients	Eligible patients	Measure completion rate	Measure satisfied	Overdue patients	Eligible patients	Measure completion rate	Measure satisfied	Overdue patients	Eligible patients	Measure completion rate	trend
Hypertension Center	Deborah Courtney	359	31	390	92%	340	22	362	94%	337	23	360	94%	↔
Prentiss Family Practice Clinic	Nina Mitchell	271	43	314	86%	270	31	301	90%	272	28	300	91%	←
Ellisville Family Clinic	Melissa Thames	649	106	755	86%	669	83	752	89%	684	87	771	89%	↔
Purvis Family Practice Clinic	Charles Weatherford	869	197	1066	82%	921	122	1043	88%	923	123	1046	88%	↔
Bellevue Family Medicine	Jessica Gurganus	1287	176	1463	88%	1441	194	1635	88%	1479	205	1684	88%	↔
Comprehensive Care Clinic	Deborah Courtney	308	61	369	83%	442	68	510	87%	530	77	607	87%	↔
Downtown Medical Associates	Elaine Newsom	604	146	750	81%	621	114	735	84%	636	110	746	85%	←
Runnelstown Clinic	Trevor Wigley	135	32	167	81%	150	29	179	84%	153	30	183	84%	↔
Nephrology/Dialysis	Tina Green	52	34	86	60%	66	12	78	85%	65	13	78	83%	→
The Poplarville Clinic	Amanda Hickman	1069	356	1425	75%	1160	240	1400	83%	1169	234	1403	83%	↔
Lincoln Road Family Medicine	Michelle McIlwain	669	178	847	79%	669	142	811	82%	678	139	817	83%	←
Collins Family Practice Clinic	Becky Tough	695	170	865	80%	707	152	859	82%	714	151	865	83%	←
Internal Medicine	Lisa Grantham	786	402	1188	66%	1153	239	1392	83%	1202	260	1462	82%	→
Family Clinic of Seminary	Kelli Cox	840	226	1066	79%	873	200	1073	81%	880	196	1076	82%	←
Wiggins Clinic	Sharon Alexander	781	249	1030	76%	866	209	1075	81%	868	207	1075	81%	↔
Family Practice - Main	Alecia Crawford	779	271	1050	74%	822	215	1037	79%	829	212	1041	80%	←
Oak Grove Family Clinic	Patsy Sanford	627	327	954	66%	732	221	953	77%	739	201	940	79%	←
Columbia Family Practice Clinic	Wanda Johnson	1023	384	1407	73%	1043	285	1328	79%	1101	303	1404	78%	→
Sumrall Medical Center	LaShunda Rucker	593	185	778	76%	603	183	786	77%	604	185	789	77%	↔
Picayune Family Practice Clinic	Julia Threadgill	473	246	719	66%	510	172	682	75%	511	160	671	76%	←
Petal Family Practice Clinic	Shannon Smith	1952	900	2852	68%	2088	702	2790	75%	2102	602	2775	76%	←
Lincoln Center Family Practice	Michelle McIlwain	515	205	720	72%	523	178	701	75%	530	176	706	75%	↔
Lumberton Family Medicine					#DIV/0!	20	7	27	74%	21	7	28	75%	←
Internal Medicine: Tah-Clayton	Melissa Smith	243	162	405	60%	267	124	391	68%	269	120	389	69%	←
FGH Family Medicine Residency	Alecia Crawford	221	126	347	64%	224	109	333	67%	331	148	479	69%	←
Laurel Family Medicine	Heather Hood	306	304	610	50%	436	214	650	67%	448	214	662	68%	←
The Family Clinic - Purvis	Connie Arnold	709	452	1161	61%	767	420	1187	65%	770	394	1164	66%	←
Immediate Care - Carriere	Melissa Smith	23	84	107	21%	69	66	135	51%	73	60	133	55%	←
Weight Management	Krystal Flatt	6	13	19	32%	4	5	9	44%	4	5	9	44%	↔
Monticello Family Medicine	Melissa Smith				#DIV/0!	79	145	224	35%	99	193	292	34%	→
	Totals	**16853**	**6078**	**22931**	**73.5%**	**18535**	**4903**	**23438**	**79.1%**	**19021**	**4863**	**23955**	**79.4%**	←

(Decile 8)

<30th MIPS %ile	<24.03%		
30-50th MIPS %ile	24.03-48.52%		
50-90th MIPS %ile	48.52-90.20%	*3872 needed to get to 90th %ile*	*2586 needed to get to 90th %ile*
>90th %ile	>90.20%		

Close the Gaps by Department: Influenza Immunization Ages ≥ 65, December 2017

Influenza vaccination		As of 9-1-17			As of 10-1-17			As of 11-1-17			As of 12-1-17		
Clinic	Manager	Overdue patients	Eligible patients	Measure completion rate	Overdue patients	Eligible patients	Measure completion rate	Overdue patients	Eligible patients	Measure completion rate	Overdue patients	Eligible patients	Measure completion rate
Lumberton Family Medicine	Melissa Smith	59	61	3%	74	77	4%	64	88	27%	20	90	78%
Hypertension Center	Deborah Courtney	558	559	0%	480	539	11%	283	477	41%	142	450	68%
Comprehensive Care Clinic	Deborah Courtney	830	833	0%	743	850	13%	483	877	45%	418	1048	60%
Prentiss Family Practice Clinic	Nina Mitchell	923	935	1%	832	922	10%	556	903	38%	382	868	56%
Nephrology/Dialysis	Tina Green	244	244	0%	184	245	25%	121	238	49%	115	234	51%
Columbia Family Practice Clinic	Wanda Johnson	3871	4198	8%	3564	4269	17%	3174	4321	27%	2080	4120	50%
Bellevue Family Medicine	Jessica Gurganus	4781	4922	3%	4195	5035	17%	3117	5189	40%	2686	5318	49%
Collins Family Practice Clinic	Becky Tough	2208	2214	0%	1998	2223	10%	1381	2123	35%	1076	2098	49%
Ellisville Family Clinic	Melissa Thames	2335	2351	1%	2059	2387	14%	1521	2355	35%	1224	2335	48%
Internal Medicine	Lisa Grantham	2443	2466	1%	2287	2459	7%	1546	2269	32%	1385	2512	45%
Petal Family Practice Clinic	Shannon Smith	9463	9510	0%	8727	9556	9%	7236	9614	25%	4749	8563	45%
Weight Management	Krystal Flatt	20	20	0%	17	21	19%	13	22	41%	14	25	44%
Internal Medicine: Tah-Clayton	Melissa Smith	1281	1283	0%	1168	1267	8%	777	1127	31%	630	1122	44%
Purvis Family Practice Clinic	Charles Weatherford	4034	4059	1%	3895	4077	4%	2835	4048	30%	2328	4032	42%
Laurel Family Medicine	Heather Hood	1562	1573	1%	1521	1597	5%	1175	1538	24%	926	1569	41%
Downtown Medical Associates	Elaine Newsom	2130	2205	3%	1659	1947	15%	1285	1947	34%	1168	1971	41%
Lincoln Road Family Medicine	Michelle McIlwain	3310	3351	1%	2818	3351	16%	2309	3358	31%	2037	3372	40%
Sumrall Medical Center	LaShunda Rucker	2634	2674	1%	2336	2667	12%	1889	2679	29%	1650	2665	38%
Runnelstown Clinic	Trevor Wigley	641	643	0%	565	640	12%	453	648	30%	409	660	38%
Family Practice - Main	Alecia Crawford	2191	2204	1%	2033	2200	8%	1548	2199	30%	1402	2250	38%
FGH Family Medicine Residency	Alecia Crawford	1238	1246	1%	1162	1263	8%	994	1311	24%	1062	1697	37%
Picayune Family Practice Clinic	Julia Threadgill	2336	2341	0%	2188	2310	5%	1525	2048	26%	1222	1941	37%
Immediate Care - Carriere	Melissa Smith	730	731	0%	700	742	6%	646	769	16%	492	760	35%
Family Clinic of Seminary	Kelli Cox	3690	3822	3%	3289	3817	14%	2705	3707	27%	2423	3712	35%
Lincoln Center Family Practice	Michelle McIlwain	1730	1737	0%	1498	1716	13%	1270	1728	27%	1144	1734	34%
Wiggins Clinic	Sharon Alexander	3785	3895	3%	3495	3917	11%	2942	3935	25%	2651	3861	31%
The Poplarville Clinic	Amanda Hickman	5643	5694	1%	5276	5733	8%	4551	5750	21%	4175	5761	28%
Monticello Family Medicine	Melissa Smith	881	884	0%	813	883	8%	688	883	22%	773	1065	27%
The Pediatric Clinic	Logan Brenner	21291	21390	0%	18256	19025	4%	14304	16981	16%	12201	16745	27%
Oak Grove Family Clinic	Patsy Sanford	6270	6296	0%	5835	6283	7%	5202	6277	17%	4180	5663	26%
The Family Clinic - Purvis	Connie Arnold	5237	5247	0%	5142	5245	2%	4505	5243	14%	3552	4745	25%
The Children's Clinic	Barnard Shows	13499	13566	0%	13276	13663	3%	12372	13835	11%	9909	12031	18%
	Totals	**111854**	**113160**	**1%**	**102087**	**110928**	**8%**	**83470**	**108488**	**23%**	**68625**	**105018**	**35%**

<30th MIPS %ile	<21.40%
30-50th MIPS %ile	21.40-41.32%
50-90th MIPS %ile	41.32-91.84%
>90th MIPS %ile	≥91.84%

Appendix

Close the Gaps by Department: Pneumococcal Immunization Ages ≥ 65, April 2018

Pneumococcal vaccination (65+)		As of 2-1-18				As of 3-1-18				As of 4-1-18				
Clinic	Manager	Measure satisfied	Overdue patients	Eligible patients	Measure completion rate	Measure satisfied	Overdue patients	Eligible patients	Measure completion rate	Measure satisfied	Overdue patients	Eligible patients	Measure completion rate	trend
Hypertension Center	Deborah Courtney	337	25	362	93%	338	25	363	93%	334	27	361	93%	↔
Prentiss Family Practice Clinic	Nina Mitchell	269	29	298	90%	264	28	292	90%	262	28	290	90%	↔
Ellisville Family Clinic	Melissa Thames	683	79	762	90%	696	76	772	90%	705	80	785	90%	↔
Bellevue Family Medicine	Jessica Gurganus	1482	197	1679	88%	1511	203	1714	88%	1525	189	1714	89%	←
Purvis Family Practice Clinic	Charles Weatherford	929	118	1047	89%	941	116	1057	89%	948	121	1069	89%	↔
Comprehensive Care Clinic	Deborah Courtney	555	69	624	89%	602	83	685	88%	631	84	715	88%	↔
Downtown Medical Associates	Elaine Newsom	637	110	747	85%	641	109	750	85%	657	110	767	86%	←
Internal Medicine	Lisa Grantham	1070	179	1249	86%	1084	178	1262	86%	1087	182	1269	86%	↔
Runnelstown Clinic	Trevor Wigley	148	26	174	85%	146	28	174	84%	144	26	170	85%	←
Collins Family Practice Clinic	Becky Tough	634	114	748	85%	646	121	767	84%	663	121	784	85%	←
The Poplarville Clinic	Amanda Hickman	1171	236	1407	83%	1182	239	1421	83%	1189	231	1420	84%	←
Family Clinic of Seminary	Kelli Cox	881	181	1062	83%	890	180	1070	83%	898	176	1074	84%	←
Wiggins Clinic	Sharon Alexander	772	168	940	82%	766	165	931	82%	805	168	973	83%	←
Family Practice - Main	Alecia Crawford	825	210	1035	80%	852	190	1042	82%	876	185	1061	83%	←
Nephrology/Dialysis	Tina Green	67	12	79	85%	64	12	76	84%	61	13	74	82%	→
Lincoln Road Family Medicine	Michelle McIlwain	398	96	494	81%	374	87	461	81%	371	90	461	80%	→
Columbia Family Practice Clinic	Wanda Johnson	1079	274	1353	80%	1103	284	1387	80%	1128	281	1409	80%	↔
Oak Grove Family Clinic	Patsy Sanford	746	194	940	79%	749	192	941	80%	754	195	949	79%	→
Picayune Family Practice Clinic	Julia Threadgill	519	152	671	77%	525	153	678	77%	524	151	675	78%	←
Lincoln Center Family Practice	Michelle McIlwain	536	171	707	76%	540	167	707	76%	544	168	712	76%	↔
Petal Family Practice Clinic	Shannon Smith	2132	667	2799	76%	2143	673	2816	76%	2158	680	2838	76%	↔
Sumrall Medical Center	LaShunda Rucker	605	186	791	76%	608	194	802	76%	614	194	808	76%	↔
Lumberton Family Medicine	Melissa Smith	22	6	28	79%	23	6	29	79%	23	8	31	74%	→
FGH Family Medicine Residency	Alecia Crawford	269	118	387	70%	290	117	407	71%	302	115	417	72%	←
Laurel Family Medicine	Heather Hood	467	218	685	68%	475	216	691	69%	478	214	692	69%	↔
The Family Clinic - Purvis	Connie Arnold	772	396	1168	66%	774	398	1172	66%	776	393	1169	66%	↔
Immediate Care - Carriere	Melissa Smith	75	59	134	56%	78	61	139	56%	82	58	140	59%	←
Monticello Family Medicine	Melissa Smith	84	154	238	35%	85	154	239	36%	85	156	241	35%	→
	Totals	**18164**	**4444**	**22608**	**80.3%**	**18390**	**4455**	**22845**	**80.5%**	**18624**	**4444**	**23068**	**80.7%**	←

Close the Gaps by Department: Influenza Immunization Ages ≥ 65, April 2018

Influenza vaccination		As of 1-1-18			As of 2-1-18			As of 3-1-18			As of 4-1-18		
Clinic	Manager	Overdue patients	Eligible patients	Measure completion rate	Overdue patients	Eligible patients	Measure completion rate	Overdue patients	Eligible patients	Measure completion rate	Overdue patients	Eligible patients	Measure completion rate
Hypertension Center	Deborah Courtney	102	447	77%	82	442	81%	72	443	84%	62	443	86%
Comprehensive Care Clinic	Deborah Courtney	350	1002	65%	317	1034	69%	302	1122	73%	276	1170	76%
Prentiss Family Practice Clinic	Nina Mitchell	286	816	65%	264	807	67%	227	798	72%	210	794	74%
Laurel Family Medicine	Heather Hood	824	1578	48%	750	1625	54%	601	1643	63%	499	1626	69%
Bellevue Family Medicine	Jessica Gurganus	2626	5497	52%	2317	5341	57%	2181	5491	60%	1938	5549	65%
Collins Family Practice Clinic	Becky Tough	791	1742	55%	711	1762	60%	652	1805	64%	657	1881	65%
Lumberton Family Medicine	Melissa Smith	22	93	76%	26	92	72%	33	101	67%	41	111	63%
Columbia Family Practice Clinic	Wanda Johnson	1984	4317	54%	1615	4005	60%	1591	4099	61%	1610	4246	62%
Ellisville Family Clinic	Melissa Thames	1229	2436	50%	1048	2308	55%	950	2340	59%	916	2370	61%
Nephrology/Dialysis	Tina Green	111	238	53%	107	236	55%	108	235	54%	90	230	61%
Petal Family Practice Clinic	Shannon Smith	4420	8607	49%	4204	8702	52%	3882	8743	56%	3719	8851	58%
Lincoln Road Family Medicine	Michelle McIlwain	1847	3286	44%	855	1826	53%	807	1822	56%	788	1818	57%
Internal Medicine	Lisa Grantham	1111	2235	50%	995	2162	54%	972	2187	56%	994	2203	55%
Family Practice - Main	Alecia Crawford	1345	2301	42%	1249	2227	44%	1064	2182	51%	1002	2220	55%
FGH Family Medicine Residency	Alecia Crawford	1075	1799	40%	889	1550	43%	864	1668	48%	825	1765	53%
Purvis Family Practice Clinic	Charles Weatherford	2166	4036	46%	2076	4035	49%	2019	4036	50%	2007	4054	50%
Downtown Medical Associates	Elaine Newsom	1108	1969	44%	1075	1976	46%	1029	1982	48%	1008	2017	50%
Sumrall Medical Center	LaShunda Rucker	1538	2626	41%	1490	2641	44%	1435	2660	46%	1389	2656	48%
Runnelstown Clinic	Trevor Wigley	394	657	40%	378	653	42%	358	644	44%	342	636	46%
Picayune Family Practice Clinic	Julia Threadgill	1142	1891	40%	1118	1901	41%	1098	1927	43%	1088	1929	44%
Lincoln Center Family Practice	Michelle McIlwain	1096	1727	37%	1057	1727	39%	1010	1728	42%	1003	1738	42%
Family Clinic of Seminary	Kelli Cox	2285	3688	38%	2230	3688	40%	2151	3650	41%	2148	3652	41%
Immediate Care - Carriere	Melissa Smith	478	773	38%	485	790	39%	494	812	39%	498	832	40%
Wiggins Clinic	Sharon Alexander	2503	3481	28%	2512	3790	34%	2400	3752	36%	2342	3793	38%
The Pediatric Clinic	Logan Brenner	11578	16803	31%	11218	16820	33%	10901	17013	36%	10415	16851	38%
Oak Grove Family Clinic	Patsy Sanford	3975	5673	30%	3874	5689	32%	3769	5730	34%	3734	5766	35%
The Poplarville Clinic	Amanda Hickman	4092	5778	29%	4025	5786	30%	3961	5831	32%	3918	5837	33%
Monticello Family Medicine	Melissa Smith	1005	1332	25%	647	917	29%	644	919	30%	646	927	30%
The Family Clinic - Purvis	Connie Arnold	3460	4748	27%	3408	4750	28%	3360	4762	29%	3341	4773	30%
The Children's Clinic	Barnard Shows	9814	12150	19%	9588	12227	22%	9353	12392	25%	9288	12462	25%
	Totals	**64757**	**103726**	**38%**	**60610**	**101509**	**40%**	**58288**	**102517**	**43%**	**56794**	**103200**	**45%**

Appendix

Measurement Period		Measure 1: Pneumococcal Immunization age ≥ 65						
			Numerator[2]					
Phase	Report Period	Denominator[1]	PPSV only	PCV only	Pneumo-Unknown Only	Both PPSV & PCV	Total Numerator	Percentage
PV Baseline Year	1/1/16 - 12/31/16	33294	2127	7664	1	7136	16928	51%
PV Qtr 1	1/1/17 - 3/31/17	25039	2116	4068	80	9346	15610	62%
PV Qtr 2	4/1/17 - 6/30/17	24768	1885	3892	76	9870	15723	63%
PV Qtr 3	7/1/17 - 9/30/17	25024	1779	3891	68	10472	16210	65%
PV Qtr 4	10/1/17 - 12/31/17	25292	1639	3879	58	11168	16744	66%
PV Qtr 5	1/1/18 - 3/31/18						0	#DIV/0!

PV = Pneumococcal Vaccine

[1] *There are no exclusions or exceptions for the immunization measures in this collaborative. Please include unique count of patients in the denominator who meet the criteria in the reporting period.*

[2] *These numerator categories should be mutually exclusive. If you have 2 data points, and one is more specific and one is less specific, keep the more specific data and omit the less specific data.*

Measurement Period		Measure 2: Pneumococcal Immunization for adults age 19–64 with High-Risk Conditions[1]										
		High-risk Conditions[2]					Numerator[4,5]					
Phase	Report Period	Immunology (Y or N)	Nephrology Renal Conditions (Y or N)	Oncology (Y or N)	Surgical Transplant (Y or N)	Denominator[3]	PPSV only	PCV only	Pneumo-Unknown	Both PPSV & PCV	Total Numerator	Percentage
PV Baseline Year	1/1/16 - 12/31/16	Y	Y	Y	Y	11263	1488	282	63	436	2269	20%
PV Qtr 1	1/1/17 - 3/31/17	Y	Y	Y	Y	7623	1072	214	33	310	1629	21%
PV Qtr 2	4/1/17 - 6/30/17	Y	Y	Y	Y	7723	1046	222	40	330	1638	21%
PV Qtr 3	7/1/17 - 9/30/17	Y	Y	Y	Y	7727	1069	231	55	332	1687	22%
PV Qtr 4	10/1/17 - 12/31/17	Y	Y	Y	Y	7901	1048	312	39	401	1800	23%
PV Qtr 5	1/1/18 - 3/31/18	N	N	N	N						0	#DIV/0!

PV = Pneumococcal Vaccine

[1] *If a HCO is reporting on both Measure 2 and 2a (2a being optional), and a patient falls into both measures (both high-risk and at-risk categories), report them in both measures (in order to simplify reporting).*

[2] *Refer to collaborative measure value sets for diagnosis codes corresponding to each high-risk condition. Please address at least one condition per reporting period, with a goal of addressing all 4 conditions by the end of the collaborative. A value of Yes or No is required for each condition cell.*

[3] *There are no exclusions or exceptions for the immunization measures in this collaborative. Please include unique count of patients in the denominator who meet the criteria in the reporting period.*

[4] *These numerator categories should be mutually exclusive. If you have 2 data points, and one is more specific and one is less specific, keep the more specific data and drop the less specific data.*

Appendix

Measurement Period		Measure 3: Influenza Immunization for adults age ≥ 18[1,2]		
Phase	Report Period	**Denominator[5]**	Numerator	Percentage
IV Baseline Flu Season	7/1/15 - 6/30/16	95130	19487	20%
IV pre-Qtrs[3]	7/1/16 - 12/31/16	79136	25560	32%
IV Qtr 1	1/1/17 - 3/31/17	62404	22636	36%
IV Qtr 2	4/1/17 - 6/30/17	61219	21916	36%
IV Qtr 3	7/1/17 - 9/30/17	61803	10604	17%
IV Qtr 4	10/1/17 - 12/31/17	61401	26195	43%
IV Qtr 5	1/1/18 - 3/31/18			#DIV/0!
IV Qtr 6 (optional)[4]	4/1/18 - 6/30/18			#DIV/0!

IV = Influenza Vaccine

[1] Flu seasons starts July 1 and end June 30th each year for the purposes of this collaborative.

[2] Patient status starts over as unvaccinated each July 1st.

[3] Influenza vaccine "Pre-quarters" are included between the baseline period and when interventions can feasibly start.

[4] Influenza Vaccine Qtr 6 falls after the formal end of the collaborative. Reporting this additional quarter is encouraged but not mandated. It would enable data capture of 3 complete flu seasons.

[5] There are no exclusions or exceptions for the immunization measures in this collaborative. Please include unique count of patients in the denominator who meet the criteria in the reporting period.

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