AMGA

Advancing High Performance Health

AMGA Foundation

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

Ochsner Health System

New Orleans, LA

Organizational Profile

Southeast Louisiana's largest nonprofit, academic, multispecialty healthcare delivery system, Ochsner Health System (OHS) has been providing high-quality clinical and hospital patient care to Louisiana residents since 1942. Comprising more than 18,000 employees and over 1,100 physicians in over 90 medical specialties and subspecialties, the OHS healthcare family is driven by a commitment to serve, heal, lead, educate, and innovate, passions that are shared with every person OHS serves. Coordinated clinical and hospital patient care, all connected electronically to provide convenience for patients, is provided across the region by OHS's 30 owned, managed, and affiliated hospitals and more than 80 health centers and urgent care centers. OHS also includes nine Pharmacy & Wellness retail pharmacies located throughout the Gulf South region that provide prescription drug, mail order, and immunization services to all patients. OHS is continuing to partner with surrounding medical centers and hospitals in the Gulf South region to provide innovative health care to more than 600,000 patients annually from more than 80 countries in specialized care ranging from allergies and asthma to x-rays and 3D mammograms.

OHS is deeply dedicated to patients and honored to have been the only Louisiana hospital recognized by *U.S. News & World Report* as a "Best Hospital" across four specialty categories. OHS is also a national leader in medical research, and conducts more than 600 clinical research studies. Close collaboration between clinicians and scientists helps to bring innovative medical discoveries from the laboratory to patients. The health system is also one of the largest non-university-based physician training centers in the United States. OHS is also very proud to be recognized among the top hospitals in the nation, as recognized by *U.S. News & World Report*, Truven Health Analytics, and CareChex®. This recognition validates OHS's efforts to provide an unparalleled level of care to the people of the Gulf South and beyond while also establishing a benchmark to measure continued success.

Executive Summary

OHS began the journey of improving adult immunizations rates two years prior to teaming up with AMGA's Adult Immunization Best Practices Collaborative (AI Collaborative). The system's Population Health Management Team recognized the importance of vaccination against preventable diseases in their organization and community to improve patient outcomes and overall population health. It also recognized the need to further increase awareness and improve access to adult immunizations. Best practices from the Immunization Action Coalition (IAC) and Centers for Disease Control and Prevention (CDC) highlighted some key areas of improvement when compared against current practices. To start, the System Vaccine Subcommittee—a multidisciplinary team composed of providers, pharmacists, nurses, informatics, inventory management, revenue cycle, and other personnel from each region—was created to communicate, address, and resolve immunization issues across OHS. While they found that several departments were having and addressing immunization issues, they worked in silos. In other words, there was no centralized way to communicate what was occurring. Baseline data obtained on current immunization

Acronym Legend

ACIP: Advisory Committee on Immunization Practices

AI Collaborative: AMGA's Adult Immunization Best Practices Collaborative

CDC: Centers for Disease Control and Prevention

CHF: Congestive heart failure

CDPH: California Department of Public Health

EHR: Electronic health record

FDA: Food and Drug Administration

GSA: Gerontological Society of America

HM: Health maintenance

HPV: Human papillomavirus

HP2020: Healthy People 2020

IAC: Immunization Action Coalition

ICAMP: Immunization Champions, Advocates & Mentors Program

LINKS: Louisiana Immunization Network for Kids Statewide

MAR: Medication administration record

NAIIS: National Adult and Influenza Immunization Summit

NVAC: National Vaccine Advisory Committee

OHS: Ochsner Health System

PCV: Pneumococcal Conjugate Vaccine

PPSV: Pneumococcal Polysaccharide Vaccine

SSP: Shared Savings Payor

WOG: Written Order Guidelines

efforts guided the subcommittee to focus on improving the rates of five adult immunizations: influenza, pneumococcal, human papillomavirus (HPV), tetanus/Tdap, and herpes zoster (shingles). To assist providers with the workflow, immunization standing orders (called Written Order Guidelines [WOG]) were drafted and approved to allow nursing staff to enter immunizations orders for any patient seen in the ambulatory clinics that required a vaccine.

Another concern highlighted as a contributor to OHS's low immunization rates was the inability to collect immunization data from external sources. Patients who received their immunizations at local community pharmacies or other external providers often did not report that information back into OHS's electronic health record (EHR). Although Louisiana's Board of Pharmacy requires their pharmacists to report immunizations administered to the state immunization registry within a reasonable timeframe, everyone's definition of such a timeframe seems to differ. Established in 2001, the Louisiana Immunization Network for Kids Statewide (LINKS) always had the ability to collect adult immunization data; however, it was not promoted initially due to funding contraints. Mass immunization efforts due to Hurricane Katrina in 2005 highlighted the need for tracking adult immunizations. As a result, the system was used to track adult vaccinations; but, there is no mandate that requires adult immunizations to be entered by providers.

To increase immunization awareness, OHS hosted an Immunization Champions, Advocates & Mentors Program (ICAMP) in August 2016 with the help of the Gerontological Society of America (GSA) and financial support from Pfizer. ICAMP educated approximately 70 nurses and pharmacists combined on the importance of immunizations, improving patient access to immunizations, and increasing the immunization rates of their patients. The ICAMP toolkit utilized was aligned with the new standards for adult immunization practice approved in 2013 by the National Vaccine Advisory Committee (NVAC) and supported by the CDC. It provided detailed action items and useful tools in the following areas of patient care: assess, recommend, administer or refer, and document and report. Commencement of the ICAMP was the perfect opportunity for the rollout of the newly approved adult immunizations standing orders across the system. To ensure that all nurses and providers were aware of the changes, OHS collaborated with industry vaccine manufacturers to provide immunization education in all four OHS regions.

Several modifications to improve workflows and EHR utilization were implemented, such as standing orders for the five targeted adult immunizations, collaboration with the LINKS registry program, development of an immunization dashboard to show current rates by clinic region and provider, updates to the health maintenance screen in EPIC to include the targeted adult vaccines, utilizing clinical care coordinators to scrub charts placing orders for overdue immunizations via the standing orders, and partnering with OHS retail pharmacies to increase their goal for immunizing patients. These initial efforts to improve adult immunizations rates received recognition and resulted in OHS receiving the award of Adult Immunization Champion, Honorable Mention from the National Adult and Influenza Immunization Summit (NAIIS) in Atlanta, Georgia, in May 2017.

OHS was one of 20 care provider groups to participate in Group 2 of the AI Collaborative, which focused on improving immunization rates of influenza and pneumococcal in the adult population. The purpose of participating in the AI Collaborative was to identify new learnings that could be incorporated to further improve adult immunization rates and reach the Healthy People 2020 (HP2020) target goals that were previously set. The OHS AI Collaborative team included the following personnel: Medical Director of Accountable Care Management, Director of Performance Improvement-Care Management, Vice President of Primary Care Service Line, Information System EPIC Analyst, Internal Medicine Physician, and Clinical Pharmacist.

With the implementation of the standing orders, staff workflow was redesigned to address each patient's immunization status during the initial stage of their visit. If during the previous day's chart review the clinical care coordinators identified any overdue vaccines needed and queued orders, staff would acknowledge these orders and verify eligibility for these vaccines to be administered during the clinic visit. Education on the importance of completing the vaccine requirements, CDC/ACIP recommendations, ACIP immunization schedule, and specific vaccine information based on Food and Drug Administration (FDA) label was conducted with nursing and provider leads. All educational sessions were provided through partnering with industry vaccine leaders, the Louisiana Department of Health, the American Cancer Society, and OHS internal nursing and clinical pharmacy experts.

Program Goals and Measures of Success

OHS's goal was to change how they vaccinated their patients by reevaluating the delivery model used to optimize adult immunizations throughout their system, which would allow them to provide better patient-centered care, eliminate gaps in fundamental patient care, and improve outcomes in population health. Although OHS has been able to implement several changes within their system to get the ball rolling, they recognized there was still a long way to go. Ultimately, OHS hopes to reach the adult immunization goals identified by HP2020 by the year 2020.

Due to the importance of meeting this standard of care in their adult population, OHS's Population Health Team, under the leadership of their Medical Director of Accountable Care Management, chose to be very aggressive with their target immunization rates by implementing the Healthy People 2020 targets as their internal goals for influenza and pneumococcal vaccinations in adults. Realizing that this would be a tough target to meet within a timeframe of a few years, the team has worked with various departments throughout the system to put improvements in place that would move the organization's rates in the right direction.

Collaborative goals were set for the AI Collaborative (Groups 2 and 3 participants). The AI Collaborative goals were set 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).

Data Documentation and Standardization

At OHS, immunization data is stored in the immunization section within their EHR for the ambulatory setting. If a vaccine is administered in the retail pharmacy, the pharmacy staff enters the immunization data directly into the EHR for the ambulatory staff to reference in real-time. If a vaccine is administered in the ambulatory clinic, the nurse also enters the immunization data directly into the EHR for the ambulatory staff. If a vaccine is administered in the inpatient hospital setting, the vaccine is stored within the immunization record, which contains all medications associated with a given vaccine. This allows any vaccine information documented in the hospital to be transferred to the LINKS registry and to also appear within both the inpatient medication administration record (MAR) and the immunization section within their EHR. The bidirectional flow between their EHR and LINKS also allows staff to reconcile a patient's immunizations into their EHR during a clinic or retail pharmacy visit. The EHR reconciliation step is a manual process; therefore, it can only be completed when the patient's chart is being accessed by staff. However, the bidirectional flow with the state immunization registry allows automatic uploads daily from the OHS EHR to the state registry to upload a patient's immunization data into LINKS.

The OHS analytics team used the AI Collaborative measure specifications to develop and test data extraction queries. Immunization data is stored in multiple locations in the EHR and data warehouse. ICD codes were used to identify the risk populations as defined by the AI Collaborative specs provided. The EHR analyst confirmed that the measured calculation included all available data.

Population Identification

OHS's Primary Care and Wellness ambulatory clinics provide care to all patients aged 19 years and older. All ambulatory clinics can administer influenza and pneumococcal immunizations to eligible patients. Adult patients are identified for their immunization needs in immunization registries based on their age, diagnosis of chronic conditions, and ACIP recommendations. The update to the health maintenance screens allows the influenza and pneumococcal immunizations to be identified for eligible patients. For any patient who is up to date on these vaccines, the vaccine appears with the administration completion date and next due date noted. For any patient who is not up to date on these vaccines, the vaccine appears with the overdue date in a bold red font.

All adult patients aged 19 years and older were targeted to receive the influenza vaccine to achieve the HP2020 goal of 70%. However, the ultimate goal is to vaccinate all OHS patients against influenza. For pneumonia, all adults aged 65 years and older were targeted for the completion of both ACIP-recommended pneumococcal vaccines to achieve the HP2020 goal of 90%. As well, adult patients indicated with high-risk conditions that warrant the pneumococcal immunization prior to the age of 65 were targeted in hopes of meeting the HP2020 goal of 60%. As with the influenza vaccine, the ultimate goal is to vaccinate all OHS adult patients who

require the pneumococcal immunization following the ACIP recommendations.

To meet the needs of Medicare patients (where administration of these vaccines may not be covered as a medical cost for the clinic), OHS has nine retail/community pharmacies that can administer the influenza and pneumococcal vaccines to eligible patients and close this care gap. The retail pharmacies also have access to EPIC, where vaccine information can be stored in real time via EHR for future reference by the patient's provider as well as to LINKS to verify the patient's previous immunizations and prevent duplicate administration of vaccines. The improved bi-directional flow with LINKS allows the patient's vaccine information to be pushed over from EPIC into the registry during the evening upload. The retail pharmacy vaccinates any patient in need of an immunization. For any patient who does not receive their routine care from OHS but desires to be vaccinated in the retail pharmacy, pharmacists can enter their immunization information directly into LINKS for their provider to access in the future.

Intervention

Background

OHS stores their adult immunization information in EPIC's immunization screen. Bi-directional flow of data with the state allows them to reconcile immunization information from LINKS into EPIC by performing a series of steps to upload any new immunization record found in LINKS that does not exist in EPIC. A clinic staff member (either a nurse or provider) can only perform immunization reconciliation steps manually. Prior to the updates made to have the health maintenance screen show overdue vaccinations, the staff did not have any resource to alert them of overdue immunizations on the patient during a clinic visit. This led to many missed opportunities due to the staff being unaware or overlooking that area of care. Also prior to the rollout of the nursing standing orders for adult immunizations, the provider was required to address and enter all immunizations for nurse administration. This led to delays in getting vaccines administered due to the provider being in a room on a different patient visit, or missed opportunities to address overdue immunizations due to a focus on managing the treatment of chronic disease states. In their effort to address their immunization rates, OHS's Vaccine Subcommittee surveyed their providers by asking what they envisioned as the process for increasing adult immunization rates. Providers clearly stated that they wanted an immunization process in the clinic that was owned and managed by nursing to give them more time to manage the patients' chronic diseases during a visit. As a result, the subcommittee decided to implement nursing standing orders for adult immunizations. During the timeframe of the start of their participation in the AI Collaborative, the nursing standing orders had been in use for about one year. Baseline rates for influenza and pneumococcal immunizations can be found in attached figures.

Provider and Staff Education

With ownership of adult immunizations shifting from providers to nursing, most of the education efforts were focused on ensuring the nursing staff was equipped with the knowledge they needed to identify patients in need of an immunization, have appropriate conversations with patients about immunizations recommended, and administer the right immunizations to the right patient correctly. Nurses across the system were educated on ACIP recommendations for adults on influenza and pneumococcal immunizations for patients aged 65 years and older. They were also provided educational material found on the CDC and California Department of Public Health (CDPH) websites, which included the laminated ACIP immunization schedule for adults aged 19 years or older and the pneumococcal vaccine timing in adults, as well as a pneumococcal pocket card from the IAC. In addition to periodically attending Primary Care Council meetings to provide updates on immunization recommendations and discuss strategy, the team gave providers educational information on ACIP recommendations for the pneumococcal vaccine in regards to high-risk patients less than 65 years of age who were immunocompromised (including cancers and transplant) or had chronic renal failure, nephrotic syndrome, asplenia, cerebrospinal fluid leaks, or cochlear implants, as well as at-risk patients less than 65 years of age due to diabetes, alcoholism, smoking, and heart, lung, or liver disease. If there were ever any concerns about vaccines required, the team was available to answer any questions from staff.

Patient Education

If a patient was identified as needing an immunization in the health maintenance (HM) screen, the nurses handled education during the rooming process of the visit. The providers handled the education for patients with at-risk or high-risk conditions requiring a pneumococcal vaccine. Patient educational material was not developed to be placed in the patient waiting areas or exam rooms.

Information Technology

Identification of patients in need of an influenza or pneumococcal immunization via the HM screen helped to bring attention to this standard of care. By appearing in bold red font, staff noticed when their patients were overdue for a vaccination. The algorithm used to set up the HM screen was based on the ACIP recommendations. As a result, the guesswork on which pneumococcal vaccine was required was removed. If a patient was due for the pneumococcal 23-valent vaccine due to a diabetes diagnosis, the HM screen clearly stated that pneumococcal polysaccharide vaccine (PPSV) was the required vaccine due to medium risk of infection. Documentation from the immunization record also showed the staff which pneumococcal vaccine had been previously administered in the HM screen, so staff no longer had to toggle back and forth between multiple screens exhausting additional time to verify immunizations. Examples of HM screen influenza and pneumococcal records are in the Appendix.

Utilization of Claims Data

In 2015, OHS built a payor data warehouse to receive external claims data from their Shared Savings Payor (SSP) contracts. Claims data is expected to be delivered monthly, though this does vary by payor. Once the data is received, it is mapped into Kaboodle and the Healthy Planet Registries, which leads to the updating of EPIC HM. At this time, they are not pulling immunizations from claims into EPIC from the payor data warehouse. They are utilizing LINKS and Care Everywhere to pull in outside immunizations; however, with those sources the provider needs to reconcile the information into the patient chart. They have future plans to determine if immunization data can be pulled from claims data as well.

Clinical Support

Prior to the AI Collaborative, pneumonia vaccines were administered in the primary care clinics and pharmacy. Influenza vaccines were administered in the primary care clinics, OBGYN offices, and pharmacy. During the AI Collaborative, the OHS rheumatology department initiated administration of the pneumococcal vaccines due to the medications used to treat this population of patients, putting them at high-risk of infection. The rheumatology team received education on the pneumococcal vaccines, which included assessment, administration, documentation, storage and handling.

As well, during the AI Collaborative OHS decided to pilot an immunization station in their largest clinic location. The immunization station was a partnership between the ambulatory clinic and retail pharmacy where both a nurse and pharmacy technician would manage the station. OHS retail pharmacies do not process medical billing claims; therefore, if the immunization station was to be successful, it required both a nurse and pharmacy technician. Patients identified as needing a vaccination in the clinic were escorted to the immunization station by a nurse with a note identifying which vaccine the patient needed. Upon arrival to the station, the pharmacy technician processed a prescription order for the required vaccination. Because pharmacies can perform real-time adjudication, the technician was able to determine if the patient had pharmacy or medical insurance benefits to cover the vaccine. If the vaccine had pharmacy drug coverage, the technician would message the pharmacist, who then stepped out of the retail pharmacy next door to administer the vaccine to the patient. The pharmacy could then process the claim for the service as a drug benefit, as well as document the immunization record in EPIC. If the vaccine did not have pharmacy drug coverage, the nurse would enter an immunization order for the vaccine in the clinic, administer the vaccine to the patient, and document the immunization record in EPIC. The vaccine claim would then be processed as a medical benefit. Utilization of the immunization station has increased vaccine administration efficiencies in this clinic location. Prior to the station, there was no way of tracking if the patient went to the retail pharmacy when referred for a pneumococcal immunization. There was also a significant delay in getting information back into EPIC when a patient was vaccinated at an outside community pharmacy. By creating this new workflow, several uncertainties have been eliminated and administration of recommended vaccines has improved.

Compensation

Currently, immunization rates are not part of compensation for physicians or staff at OHS.

Outcomes and Results

OHS's participation in the AI Collaborative was a success and experienced many positive outcomes. Although only the influenza immunization met the goal set by the AI Collaborative, all of the immunization numbers increased, moving in a positive direction. OHS's baseline influenza vaccination rate for 2016 was measured at 27.6% for adults aged 18 years and older.

By the end of the AI Collaborative, this rate had improved to 59.3%, exceeding the AI Collaborative goal of 45%.

OHS's baseline pneumococcal vaccination rate for adults aged 65 years and older who had received any pneumococcal immunization was 71.5% in baseline year of 2016. At the end of the AI Collaborative, this rate had improved to 77.2%, falling short of the AI Collaborative goal of 90%. The pneumococcal immunizations were further evaluated to find that, by the end of the AI Collaborative, 48.9% of adults aged 65 years and older had received both the pneumococcal conjugate vaccine (PCV) and PPSV vaccines. This was a 16.6% increase from the baseline rate of 32.3% but did not meet the AI Collaborative goal of 60%. Adults aged 65 years and older who had only received the PCV vaccine in baseline year was 27.3%. By the end of the AI Collaborative, this rate had decreased to 22%, showing 48.9% completion of the immunization requirement in these adults. The data for this group also showed that at the start of the AI Collaborative, 28.5% of adults aged 65 years and older had not been vaccinated against pneumonia; however, by the end of the AI Collaborative, this rate had also decreased 5.7%, showing that these adults were being immunized.

Measure 2 also showed improvements over the course of the year. Starting at a baseline value of 34.2%, this measure fell shy of the AI Collaborative goal (45%), resulting in 42.1%. The data collected showed that there was about an 8% decrease in the adults who had high-risk conditions and required vaccination and that there was no record that the vaccination had been completed in the EHR. High-risk conditions included adults who were immunocompromised or had renal conditions, cancers or surgical transplant.

OHS also collected data on the optional measure of any pneumococcal immunization in adults aged 19 to 64-years-old with at-risk conditions (chronic heart conditions, diabetes, lung disease, chronic liver disease, smoking, or alcoholism). At baseline, the immunization rate for these adults was 25.6%. At the end of the AI Collaborative, the immunization rate against pneumococcal was 37.8%—an increase of 12.2%.

While OHS may not have met all of the immunization goals set by the AI Collaborative, their efforts to make improvements in practice, processes, and data collection showed significant improvements in their pneumococcal and influenza immunization rates over the year where all measures increased, resulting in more patients being vaccinated against these diseases.

Lessons Learned and Ongoing Activities

Data collection from outside sources such as LINKS, claims data, and patient self-reporting were essential to ensuring that EHR immunization records were up to date for OHS's patient population. The inability to capture and store data in real time was identified as one of the key reasons that immunization rates were so low.

Next Steps

To date, piloting the immunization station has proven to be very successful in its current location. The clinics have been able to eliminate a lot of the guess work around immunization coverage, patient tracking for completing a recommended vaccine, and getting documentation of completed vaccines back into EHR in real time. Both providers and patients reported satisfaction with having a centralized location to direct patients for their immunizations regardless of their insurance coverage. The potential for utilizing the immunization station in other clinic locations will be reviewed, but a key critical aspect of the shot location will be the ability to partner with an OHS retail pharmacy on the campus.

Having one of their largest rheumatology clinics decide to begin immunizing against pneumococcal was a major accomplishment for OHS. Future goals are to evaluate other specialty clinics like cardiology, endocrinology, and oncology of the benefits to being able to vaccinate their patients for protection against pneumococcal disease (and influenza) within their clinics without having to refer the patient back to their primary care provider.

OHS is continuing their partnership with the state immunization registry team to further improve the bi-directional flow of immunization data from EPIC to LINKS and vice versa. One issue that continues to be an ongoing problem is the deduplication process for record mismatches. When there is not a 100% match on demographics for a patient within EPIC and LINKS, the patient's immunization administration goes through a manual deduplication process with the state where the state employee must check all demographics of the patient and determine if the information is close enough to accept the administration record in the system. Small things like a mismatch on the patient address can cause the vaccines to go into deduplication. Obtaining a daily report on the issue is a challenge as well. End users in the clinics serve as the critical communicators for issues when they occur. Reports of errors

from clinic staff prompted investigation from the OHS EPIC team and led to resolution of many issues. As well, having a good understanding of the CDC's requirements for CPT/CVX codes and HL7 interface guidelines has been very beneficial to the OHS EPIC analytics team. Having a rapport with the state immunization registry team has had its benefits as well by allowing OHS to identify issues within LINKS and notifying the state of new EPIC enhancements and features that could potentially lead to breaks in the bi-directional flow during the transfer of immunization data. Being aligned with the state immunization program clearly has defined opportunities to improve patient care and prevent potential patient safety issues.

Due to the importance of addressing care gaps in immunizations and further improving those rates, OHS is also working on a partnership with a major community retail pharmacy to receive their immunization data to update EPIC Health Maintenance for immunizations. With the passing of House Concurrent Rule No. 51 by the Louisiana legislature requesting the Louisiana Department of Health to require that all physicians, nurses, and other healthcare providers (including pharmacies) who administer immunizations to children or adults in this state record immunization information on both children and adults using the LINKS system software, future gathering of patient immunization records should be significantly improved, resulting in better patient outcomes and further close of this gap in standard care.

References

1. Centers for Disease Control and Prevention (CDC). Vaccine Information for Adults. https://www.cdc.gov/vaccines/adults/rec-vac/index.html.
2. Office of Disease Prevention and Health Promotion (ODPHP). Healthy People 2020. healthypeople.gov.

Appendix

Collaborative Goals

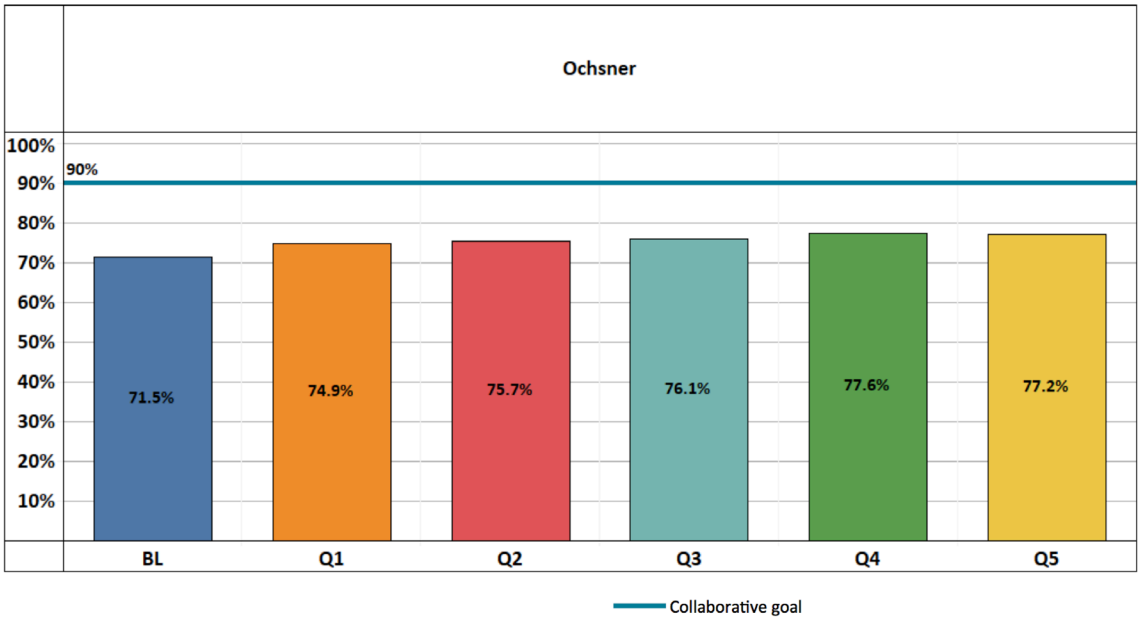
Measure	Healthy People 2020	Collaborative Goal
Measure 1 (65+) Any	90%	90%
Measure 1 (65+) Both PPSV and PCV*	90%	60%
Measure 2 (High-Risk)	60%	45%
Optional Measure 2a (At-Risk)**		
Measure 3 (Flu)	70%/90%***	45%

* 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.

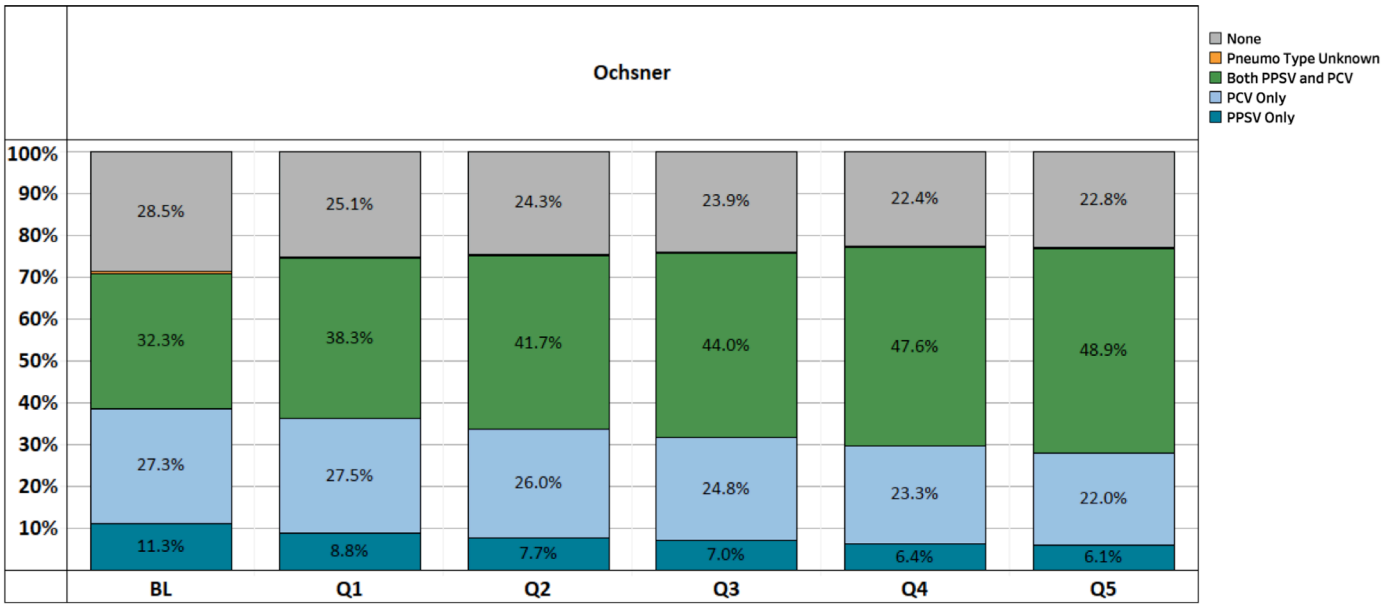
*** 70% for all patients, 90% for Medicare patients

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

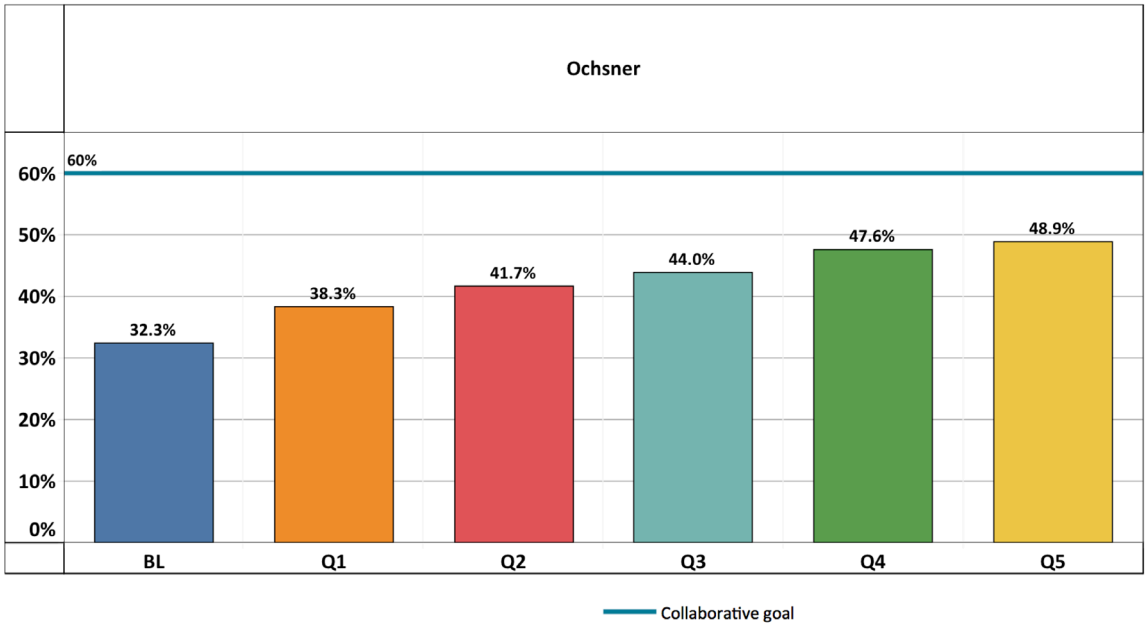


Appendix

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

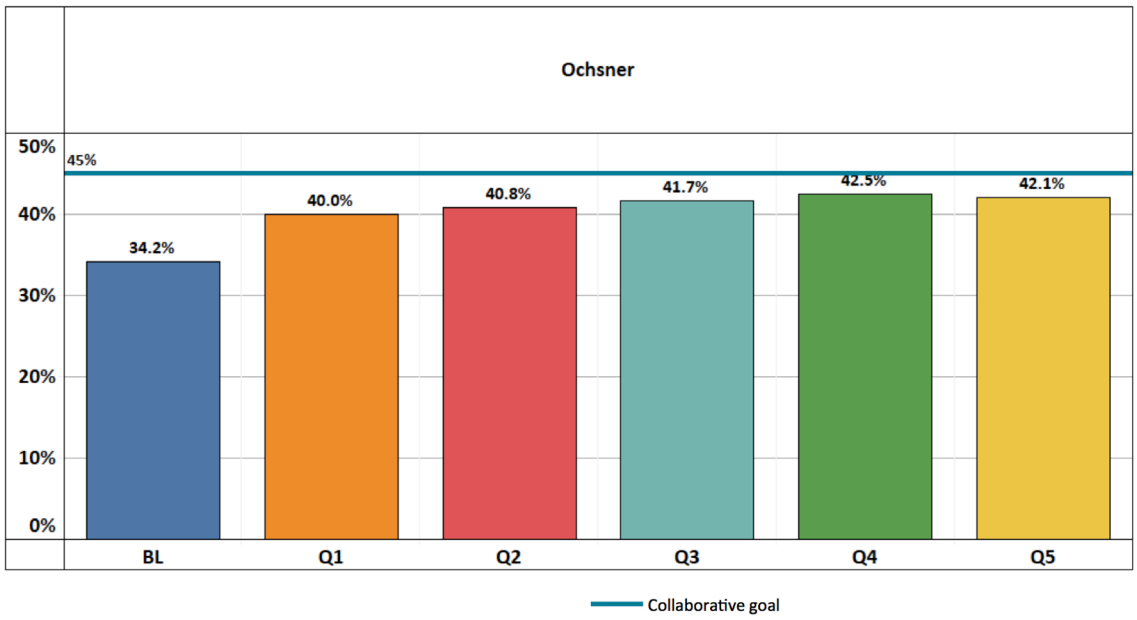


Measure 1 – Both PPSV and PCV Immunization for Adults Ages ≥ 65

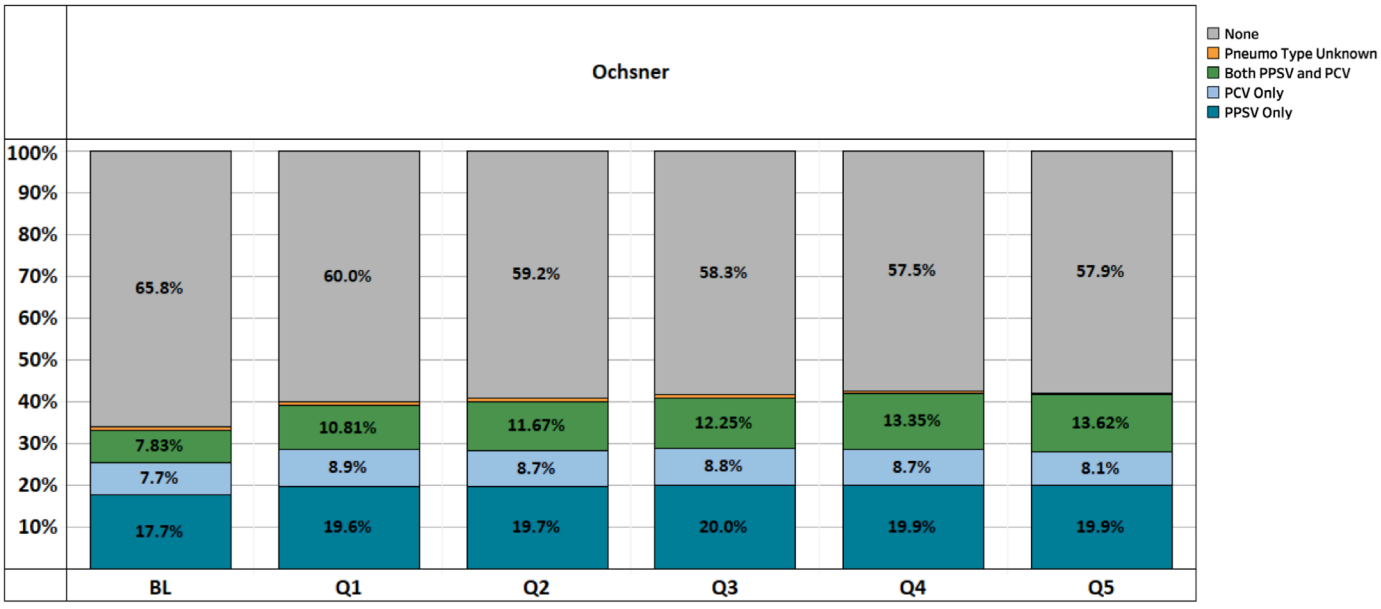


Appendix

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

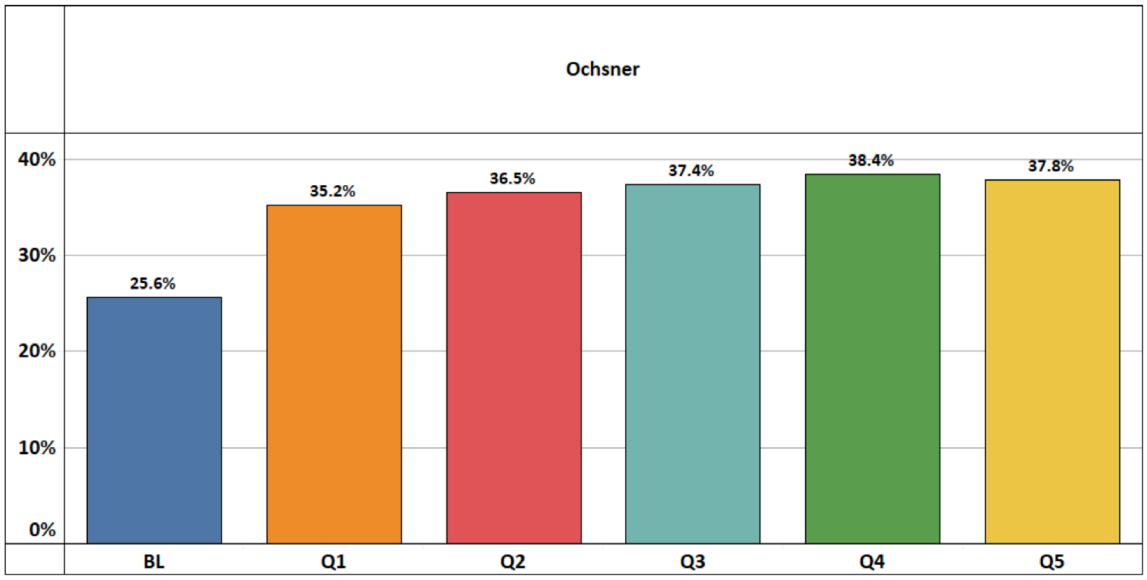


Measure 2 – Pneumococcal (Any) Immunization for Adults Ages 19–64 with High-Risk Conditions

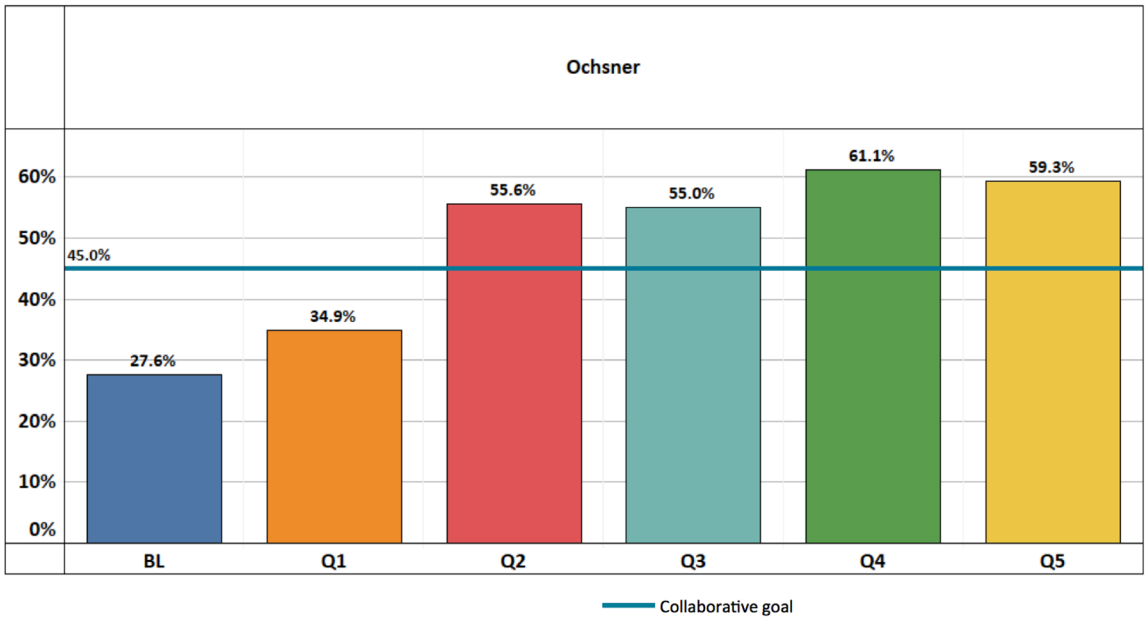


Appendix

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



Measure 3 – Influenza Immunization, Age ≥ 18



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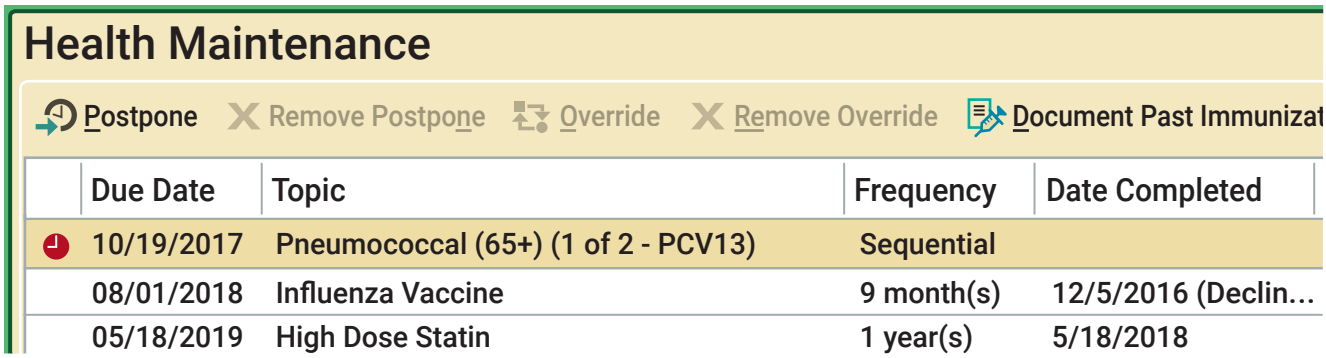

HM screen example #1:

Pneumococcal (65+)	**Completed**		
	Done	6/9/2017	Imm Admin: Pneumococcal Polysaccharide - 23 Valent
	Done	12/8/2015	Imm Admin: Pneumococcal Conjugate - 13 Valent

Influenze Vaccine	**Next Due**	**8/1/2018**	
	Done	10/10/2017	Imm Admin: Influenza - High Dose
	Done	10/10/2016	Imm Admin: Influenza - High Dose
	Done	12/8/2015	Imm Admin: Influenza - High Dose
	Done	1/15/2015	Imm Admin: Influenza - High Dose
	Done	12/11/2013	Imm Admin: Influenza - Trivalent - PF (ADULT)
	Patient has more history with this topic...		

HM screen example #2:

Pneumococcal (65+)	**Overdue**	**4/18/2018**	
	Done	2/10/2017	Imm Admin: Pneumococcal Conjugate - 13 Valent
Influenza Vaccine	**Next Due**	**8/1/2018**	

HM screen, patient with congestive heart failure CHF example #3:

Pneumococcal PPSV23 (Medium Risk)	**Next Due**	**5/7/2023**	
	Done	5/7/2018	Imm Admin: Pneumococcal Polysaccharide - 23 Valent

HM screen, pneumococcal vaccines completed out of sequence example #4:

Pneumococcal (65+)	**Completed**		
	Done	3/20/2018	Imm Admin: Pneumococcal Conjugate - 13 Valent
	Done	6/2/2015	Imm Admin: Pneumococcal Polysaccharide - 23 Valent

HM screen, pneumococcal requirements for 51-year-old type 2 diabetes patient, example #5:

Pneumococcal PPSV23 (Medium Risk)	**Overdue**	**7/19/1984**	

Appendix

Group 2 Reporting Periods and Due Dates

Measures 1, 2 (& 2a optional) Pneumococcal Vaccine (PV)		Measure 3 Influenza Vaccine (IV)			Due Date
Reporting Period	**Dates to Report**	**Reporting Period**	**Flu Season**	**Dates to Report**	
		IV Baseline Flu Season	1	7/1/15–6/30/16	3/31/2017
PV Baseline Year	1/1/16–12/31/16	IV pre-Qtrs*	2	7/1/16–12/31/16	
PV Qtr 1	1/1/17–3/31/17	IV Qtr 1	2	Same as PV	6/30/17
PV Qtr 2	4/1/17–6/30/17	IV Qtr 2	2	Same as PV	9/29/17
PV Qtr 3	7/1/17–9/30/17	IV Qtr 3	3	Same as PV	12/22/17
PV Qtr 4	10/1/17–12/31/17	IV Qtr 4	3	Same as PV	3/30/18
PV Qtr 5	1/1/18–3/31/18	IV Qtr 5	3	Same as PV	6/29/18
		IV Qtr 6**	3	4/1/18–6/30/18	9/28/18

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

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