

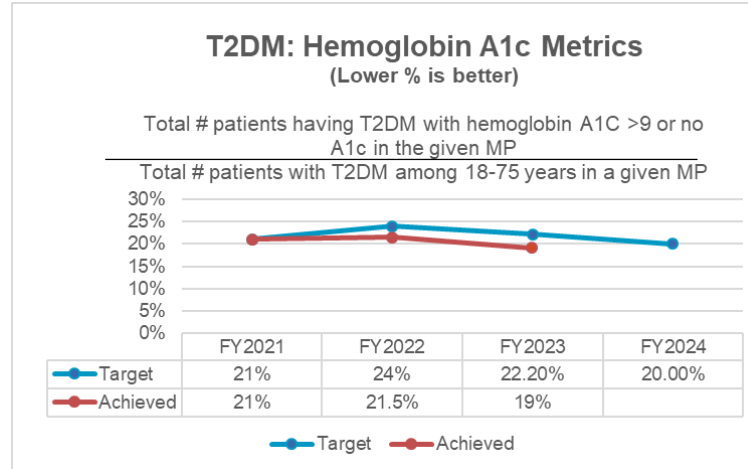
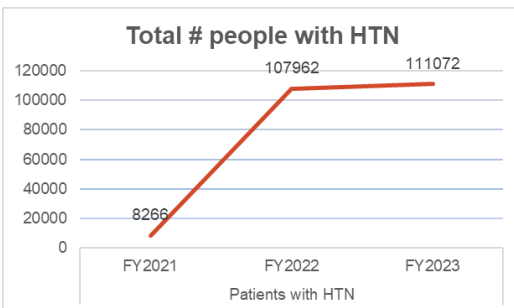
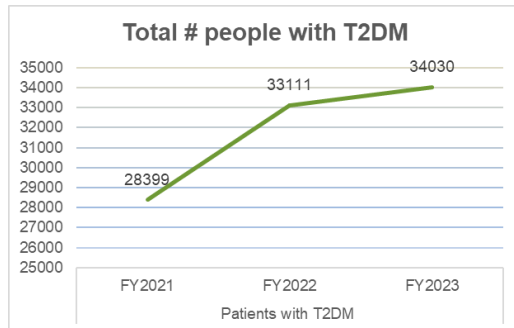
Introduction:

Hartford Healthcare Medical Group (HHC MG) implemented a quality metric board (Healthy Planet) in the health record system (Epic) to observe HEDIS measure performance. Considering the US disease burden, we focused on quality care in Type 2 Diabetes Mellitus (T2DM) and hypertension (HTN) management. Initially, the quality department focused on patient outreaches to encourage care engagement. It has now evolved into a population health department that identifies barriers, provides strategic solutions, and develops best practice guidelines for clinicians. We use a 9 month Measurement Period (MP), Jan-Sept, to incorporate HEDIS measurement year with HHC fiscal year.

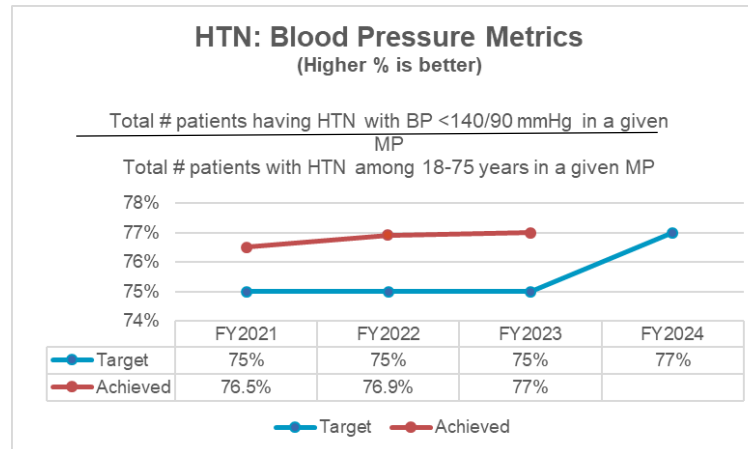
Methods:

- Baseline year (2021) we piloted at HHC MG offices with patients on Medicare Advantage plans.
- In subsequent years, the population was expanded to include primary care patients with HTN and T2DM in other HHC offices, regardless of insurance status.
- Per HEDIS recommendations, we considered hemoglobin A1C >9 uncontrolled T2DM and blood pressure <140/90 mmHg controlled HTN.

For both measures, we observed patients with blood pressure or A1c not controlled (clinical opportunity) or patients who did not have a blood pressure or A1c recorded (operational opportunity) for the given MP.



- In addition to all colleagues having access to Healthy Planet dashboards, detailed data reports were socialized monthly with practice managers and providers. Using the data, offices leveraged lean daily management huddles to identify opportunities and develop strategies to attain best practice.
- Strategies always focused on equity, diversity and inclusion to enhance healthcare access.



Discussion:

Healthy Planet dashboard helped in understanding current status.

Clinical strategies	Operational strategies
<ul style="list-style-type: none"> - Implemented standardized clinical best practice recommendations. - Developed patient education resources. 	<ul style="list-style-type: none"> - Streamlined appointment scheduling - Standardized colleague education and clinical documentation.

- Even though our offices performed above the target range, surveillance and stratified analysis provide opportunities for continuous improvement at multiple levels.
- We used the CDC social vulnerability index applied to zip codes and observed a consistent disparity of 2.7%.

Strengths: Workforce (clinical and non-clinical professionals)

Limitations: Reporting depends on EPIC documentation. Missed or inaccurate documentation might skew data analysis (e.g. demographics).

Future:

- Stratified and longitudinal data analysis to identify additional clinical and operational opportunities.
- Focus towards equity: Launch SDoH screening workflow in the primary care offices to address the social needs of our patient population.

Conclusion:

- Quality surveillance needs to be a continuous process.
- Transparent and timely data leads to positive evolution of health care delivery.
- To attain equity there needs to be focused interventions.