

Fallout From Covid-19

UPDATE Q1 2021

*Preventative and Chronic Care Measures in
Contra Costa County*

May 2021



**Contra Costa
Regional Medical Center
& Health Centers**

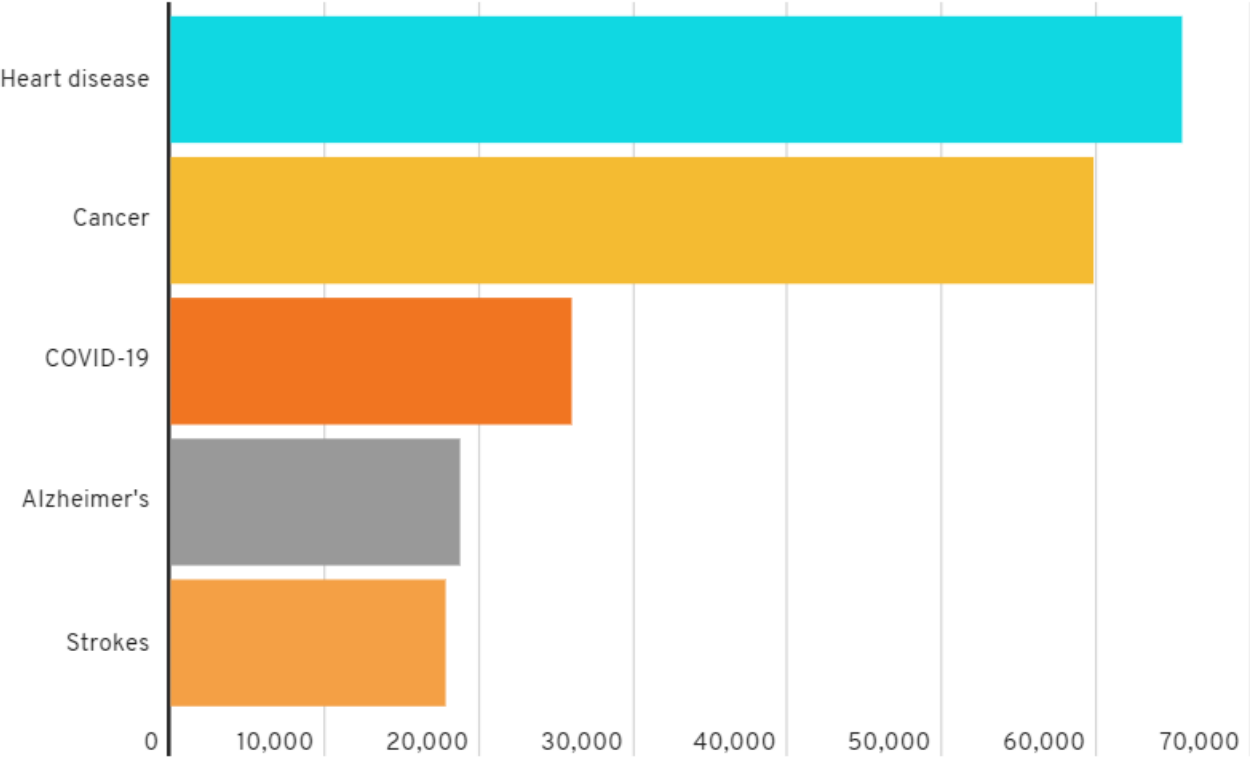
A Division of Contra Costa Health Services

Leading Causes of Death in 2020

- COVID-19 was the third leading cause of death in California in 2020 followed by heart disease and cancer.
- 48K more Californians died in 2020 than in 2019, in large part due to 26K deaths attributed to the pandemic.
- There was a 4% increase in heart disease mortality and 5% increase in stroke mortality.
- Non-COVID-19 emergency room visits dropped 42% nationwide, possibly contributing to increased mortality from the above conditions.
- There was an increase in Alzheimer's related deaths.
- **There was a dramatic increase in opioid deaths; in California up 46%.**

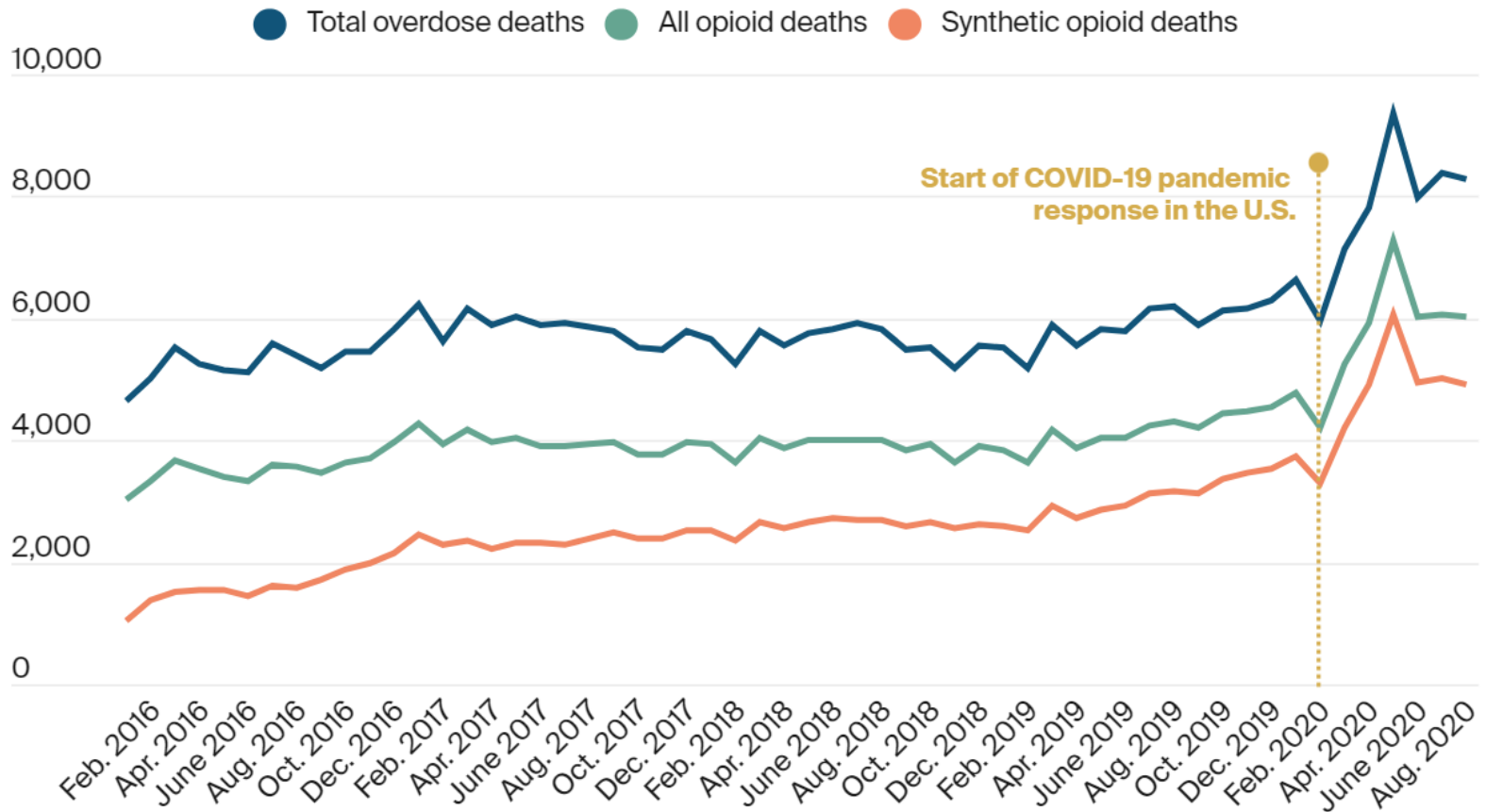
Leading causes of death in 2020

COVID-19 was the third leading cause of death in California, following heart disease and cancer



Source: California Department of Public Health

Monthly drug overdose deaths

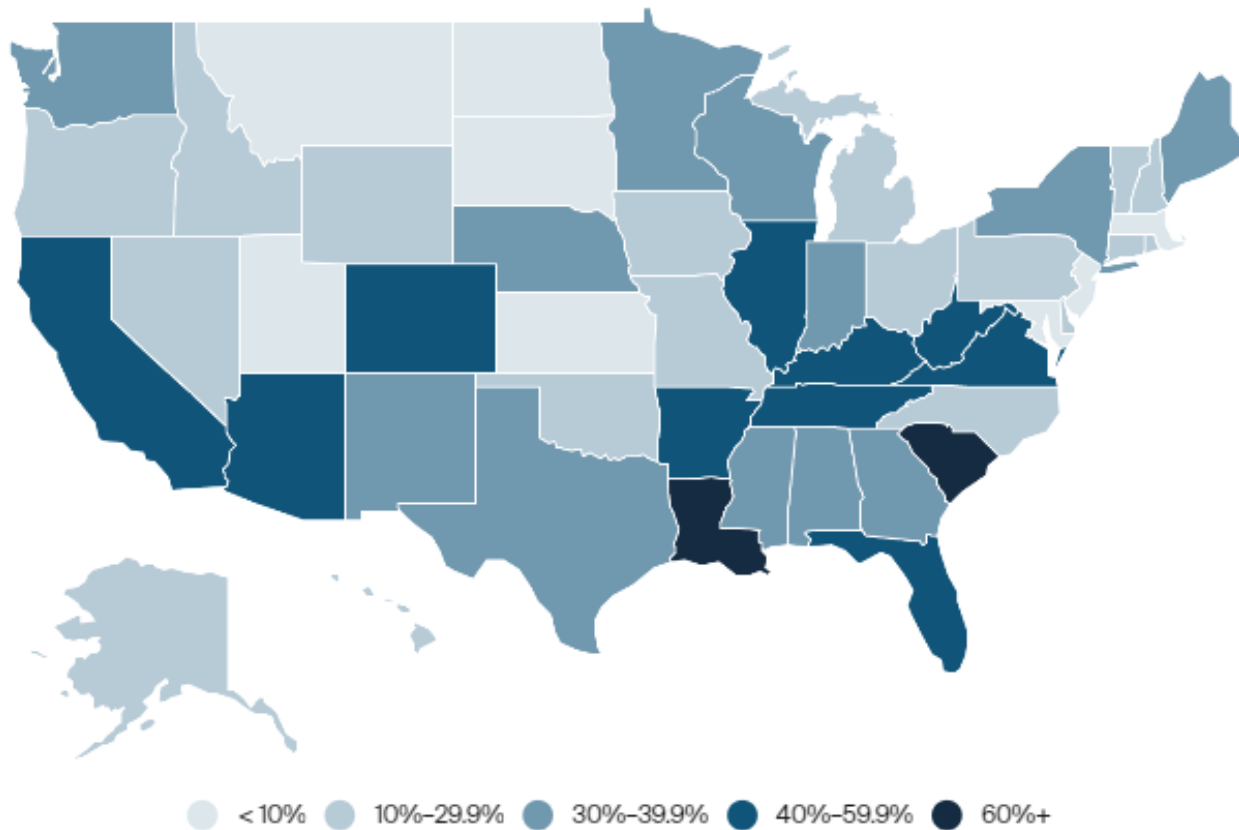


Note: Synthetic opioid deaths exclude those from methadone. Specific drug-class deaths are not mutually exclusive.

Data: Final 2016–2019 monthly totals: CDC WONDER; Estimated 2020 monthly totals: Calculations based on National Vital Statistics System [Provisional Drug Overdose Death Counts](#), CDC WONDER.

Source: Jesse C. Baumgartner and David C. Radley, “The Spike in Drug Overdose Deaths During the COVID-19

Estimated percent increase in overdose deaths, January–August 2020 vs. January–August 2019



Note: District of Columbia had an estimated increase of 72%; South Dakota had an estimated decrease of –4%.

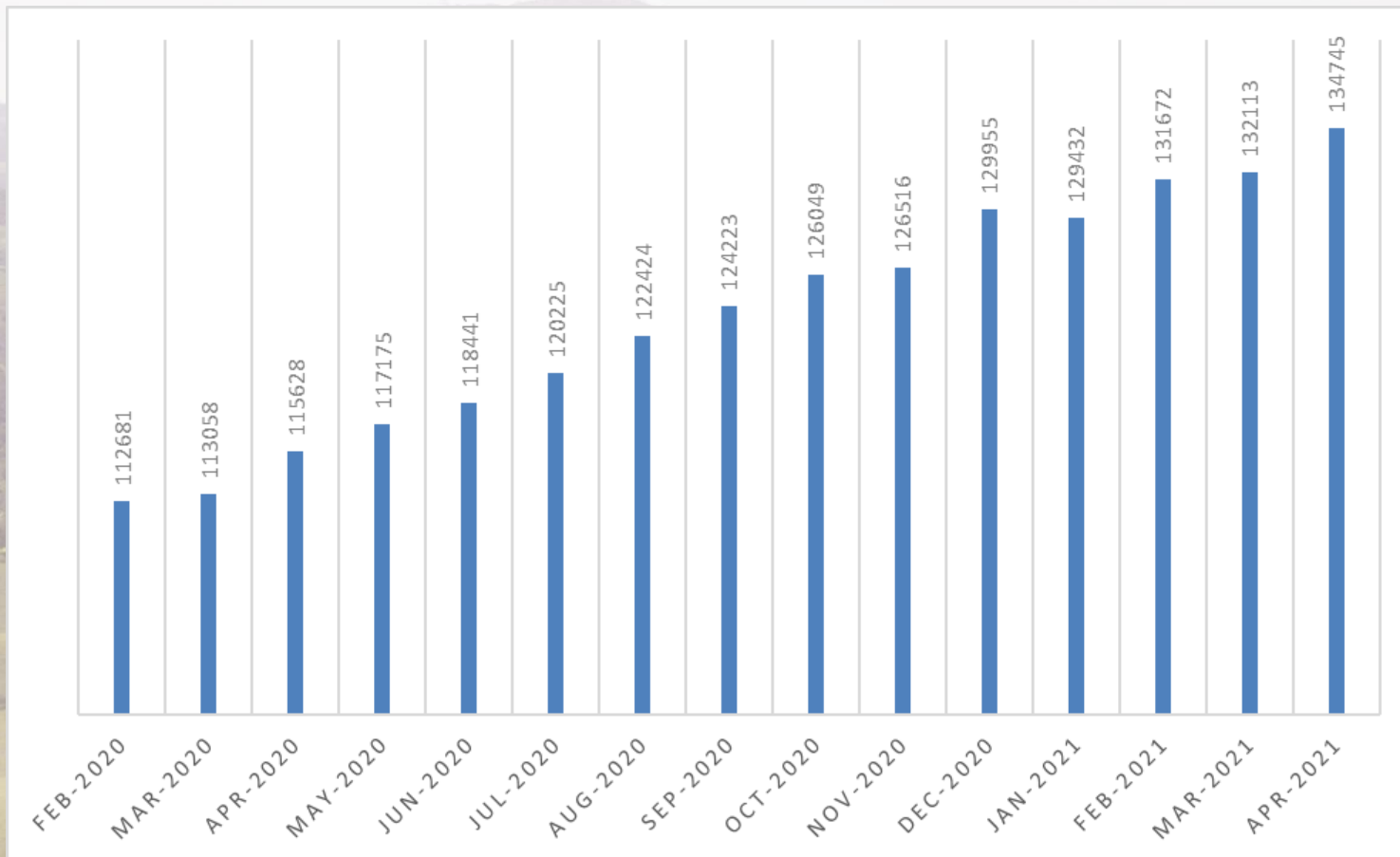
Data: Jan.–Aug. 2019 final totals: CDC WONDER; Estimated Jan.–Aug. 2020 totals: Calculations based on National Vital Statistics System [Provisional Drug Overdose Death Counts](#), CDC WONDER.

Source: Jesse C. Baumgartner and David C. Radley, “The Spike in Drug Overdose Deaths During the COVID-19 Pandemic and Policy Options to Move Forward,” *To the Point* (blog), Mar. 25, 2021.

<https://doi.org/10.26099/gyf5-3z49>

CCRMC & Health Centers Empaneled Patients

Since the beginning of the pandemic CCHP Medi-Cal membership grew by 33,628 patients. CCRMC & Health Center's share of the CCHP Medi-Cal membership grew by **22,178** patients, representing **66%** of CCHP's membership growth.



Quality Improvement (QIP) Metrics

QIP Projects	QIP Metrics	Rate as of 12/31/2020	PY4 Target	# Patients to Meet Target	PY4 25th percentile	PY4 90th percentile	Denominator Population
Primary Care Access & Preventive Care	Chlamydia Screening in Women (16-24yo Total)	65.71%	66.3%	13	51.3%	71.4%	2231
	Childhood Immunization Status (CIS 10)	49.50%	49.8%	4	30.2%	52.1%	1196
	BMI, Weight Assessment & Counseling for Nutrition	74.93%	76.5%	189	71.3%	90.80%	11783
	Lead Screening in Children	69.76%	71.5%	21	63.5%	86.6%	1217
	Breast Cancer Screening	66.33%	66.6%	22	52.9%	69.2%	7487
	Cervical Cancer Screening	61.49%	62.6%	222	55.2%	72.7%	19768
	BMI Screening and Follow-up	55.60%	41.1%	4318	55.6%	95.7%	29773
	Colorectal Cancer Screening	54.32%	55.3%	140	31.1%	64.1%	14272
	Tobacco Assessment and Counseling	Rate2 31.28%	37.3%	1678	6.7%	92.0%	27956
		Rate1 97.98%	97.0%		79.9%	97.0%	5039
	Influenza Immunization	85.96%	63.0%		19.2%	63.0%	33480
	Immunizations for Adolescents	53.79%	50.9%		31.0%	50.9%	699
	Developmental Screening in the First Three Years of Life	69.19%	45.0%		15.1%	45.0%	2713
	HIV Screening Measure	84.72%	Benchmark not released		TBD	TBD	25544
	Screening for Depression and Follow-Up Plan		Data not ready yet		59.0%	92.9%	
	Well-Child Visits in the First 30 Months of Life	80.14%	Benchmark not released		TBD	TBD	1626
Child and Adolescent Well Care Visits	44.37%	Benchmark not released		TBD	TBD	22171	
Acute & Chronic Conditions	Comprehensive Diabetes Care: Eye Exam	62.06%	63.5%	79	52.1%	76.4%	5480
	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	29.91%	29.7%	11	46.0%	28.0%	5480
	Comprehensive Diabetes Control: Medical Attention for Nephropathy	88.30%	82.1%	340	88.3%	93.3%	5480
	Controlling High Blood Pressure	64.05%	64.9%	56	54.0%	72.8%	6901
	Asthma Medication Ratio	59.60%	61.0%	18	57.6%	73.4%	1250
	Statin Therapy For The Prevention And Treatment Of CVD	75.60%	76.4%	39	64.8%	83.2%	5458
	Heart Failure (HF): ACE/ARB/ARNI Therapy for LVSD	79.69%	80.9%	4	60.4%	92.0%	256
	HIV Viral Load Suppression	77.10%	72.3%	20	77.1%	82.2%	416
	Coronary Artery Disease: Antiplatelet Therapy	86.98%	87.4%	5	71.4%	91.0%	1198
	CAD: ACE/ARB Therapy for Diabetes or LVSD	83.81%	83.2%		66.9%	83.2%	494

QIP Projects	QIP Metrics	Rate as of 12/31/2020	PY4 Target	# Patients to Meet Target	PY4 25th percentile	PY4 90th percentile	Denominator Population
Health Equity	Health Equity metric Diabetes Poor Control	AA 34.5% Latino 33.7%	33.85% 33.13%	6 11	46.0%	28.0%	866 1782
	Health Equity metric placeholder(Well Child 3-21)	AA 35%	Benchmark not released		TBD	TBD	
Care Coordination	Plan All-Cause Readmissions		Data not ready yet		10.0%	8.0%	
	Med reconciliation post discharge (MRP)	99.14%	78.0%		44.0%	78.0%	2200
Maternal/Perinatal Health	PC-02: Cesarean Birth	18.04%	22.0%		24.3%	22.0%	521
	Prenatal and Postpartum Care (Postpartum Care)	99.87%	84.2%		71.3%	84.2%	756
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	91.53%	92.0%	4	84.2%	95.9%	756
	Exclusive Breast Milk Feeding (PC-05)	72.41%	72.8%	1	48.2%	75.9%	116
Behavioral Health	Concurrent Use of Opioids and Benzodiazepines	5.71%	9.2%		14.7%	9.2%	1454
	Use of Opioids at High Dosage in Persons Without Cancer	2.63%	3.4%		4.7%	3.4%	1066
Experience of Care	Advance Care Plan		Data not ready yet		18.7%	91.0%	
Overuse Appropriateness	Use of Imaging Studies for Low Back Pain	90.59%	82.0%		71.3%	82.0%	1020
	Appropriate Treatment for Upper Respiratory Infection	91.41%	91.6%	7	85.6%	93.5%	3072
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	60.67%	61.1%	2	45.1%	65.3%	417
Patient Safety	Perioperative Care: VTE Prophylaxis	99.33%	92.0%		47.6%	92.0%	745
	Prevention of CVC - Related Bloodstream Infections	93.67%	92.0%		44.9%	92.0%	158

The Quality Incentive Program (QIP) is a pay for-performance program for California’s public health care systems that converts funding from previously-existing supplemental payments into a value-based structure. QIP payments are tied to the achievement of performance on a set of established quality measures for Medi-Cal managed care enrollees.

<https://caph.org/2018/09/14/quality-incentive-program-medicare-managed-care-rule/>

Adult Chronic Care Measures

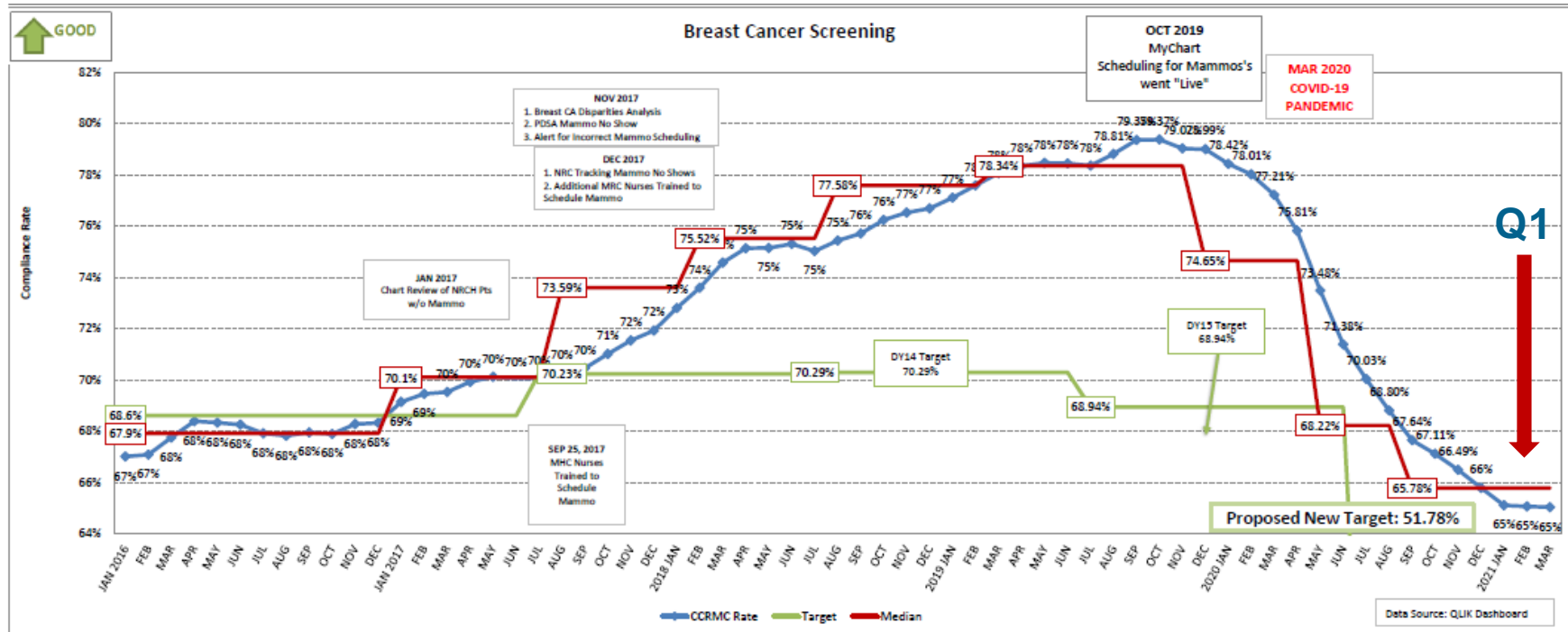
- One-third of Californians who had an urgent health problem unrelated to COVID-19 and wanted to see a physician did not receive care, according to a poll of 2,249 adults conducted last summer by the California Health Care Foundation. Half of those surveyed didn't receive care for their nonurgent physical health problem.

- **10,000 more cancer deaths predicted because of COVID-19 pandemic – NBC News**

<https://www.nbcnews.com/health/health-news/10-000-more-cancer-deaths-predicted-because-covid-19-pandemic-n1231551>

Cancer Screening

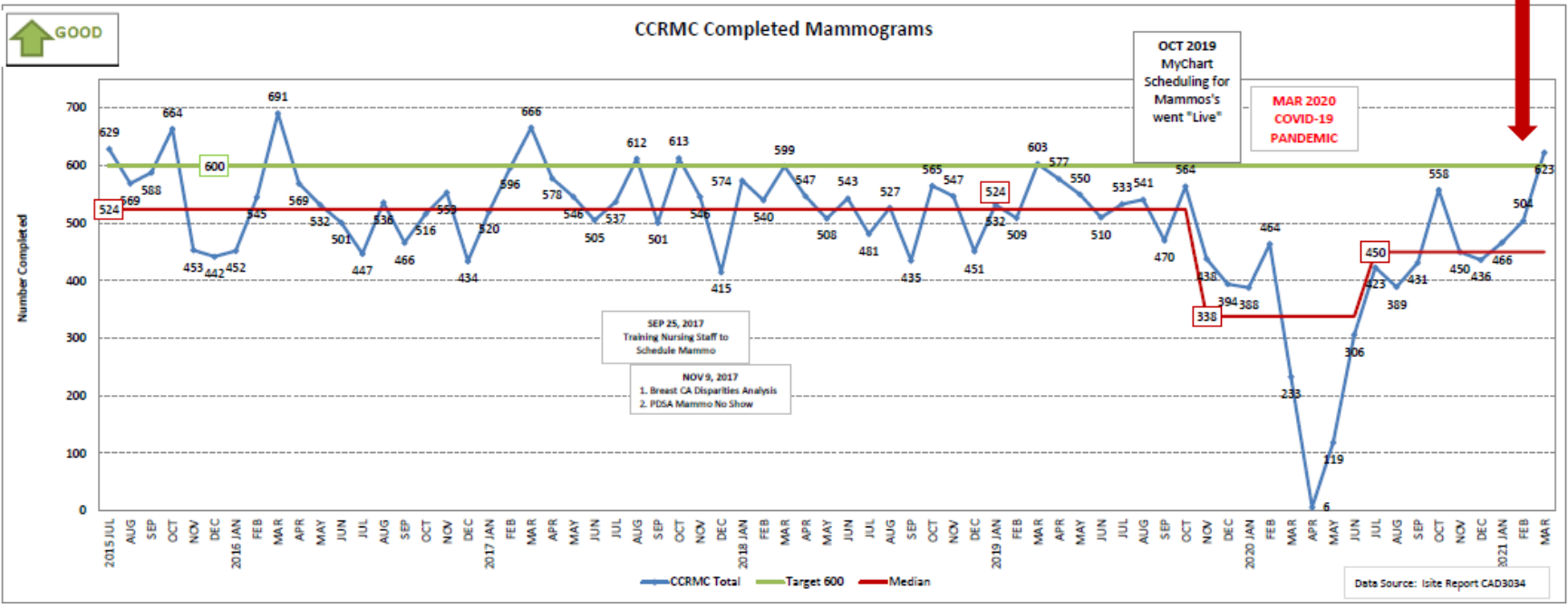
Breast Cancer Screening



CCRMC & Health Centers patients age 50-74 who received a mammogram during the measurement period

Cancer Screening Completed Mammograms

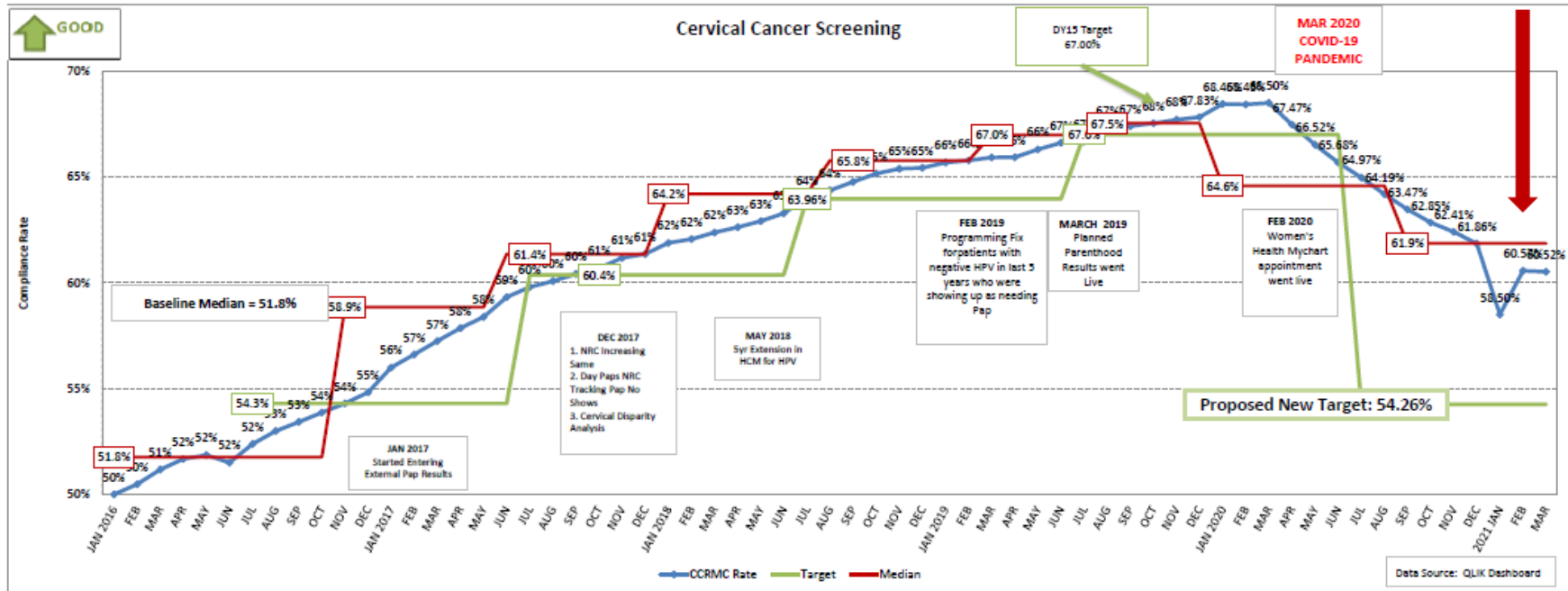
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Cancer Screening

Cervical Cancer Screening

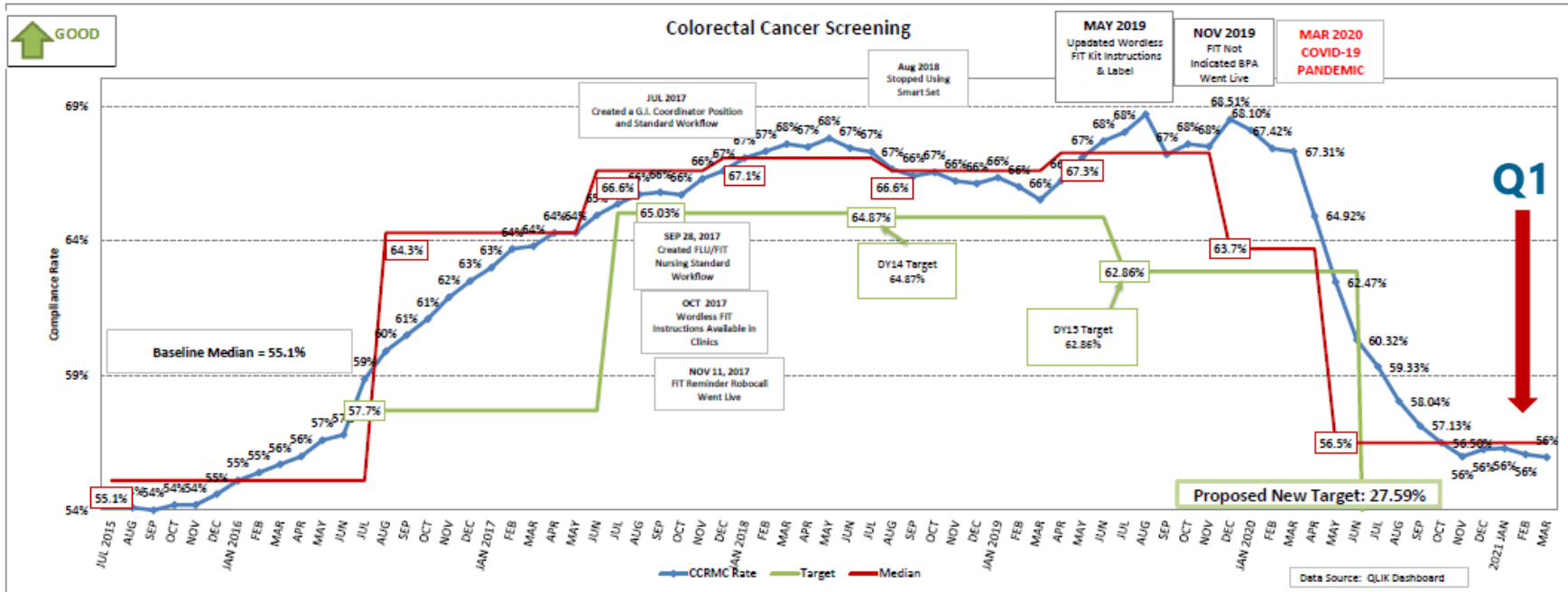
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CCRMC & Health Centers patients age 24-64 who were screened for cervical cancer during the measurement period

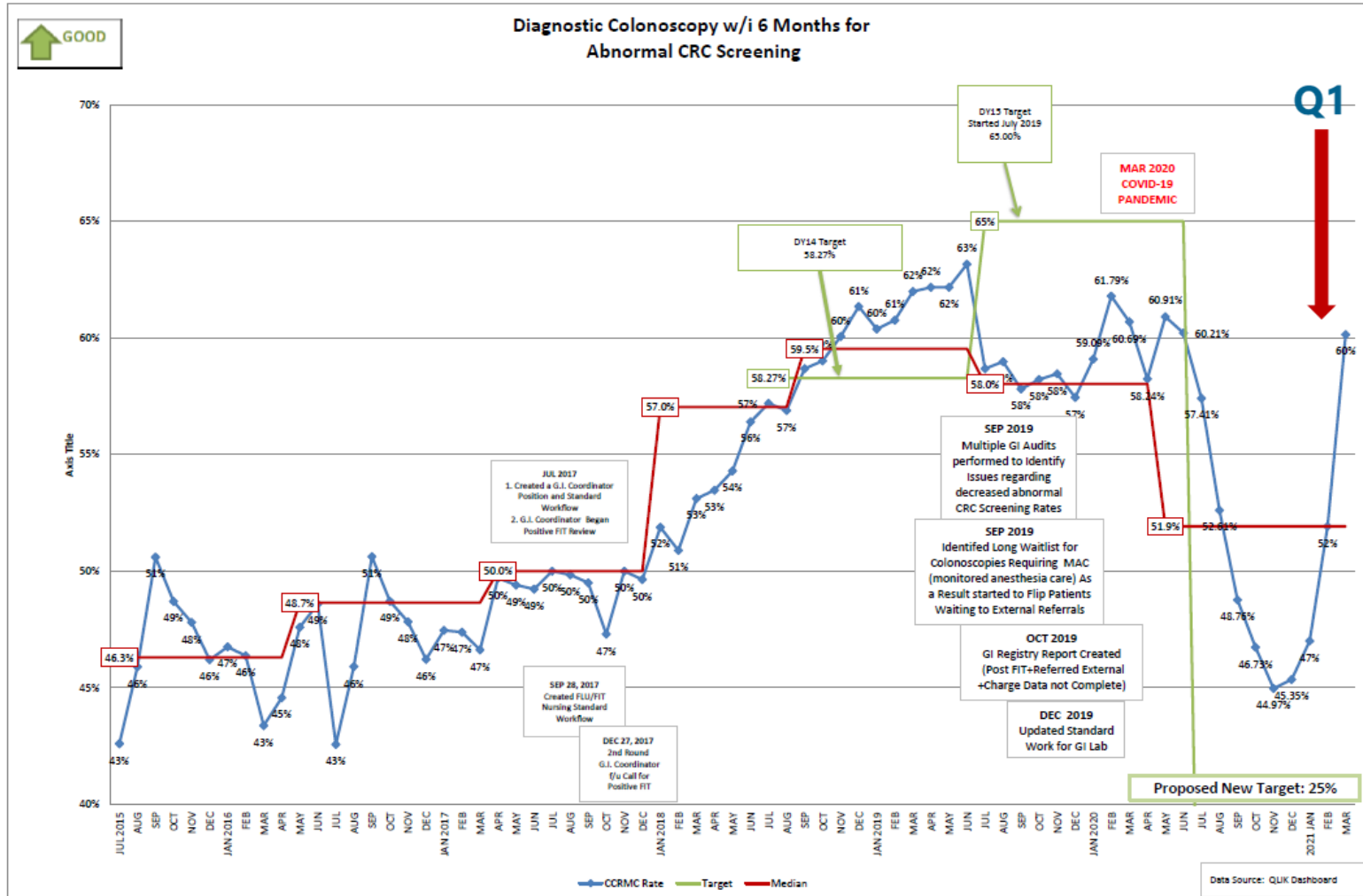
Cancer Screening

Colorectal Cancer Screening



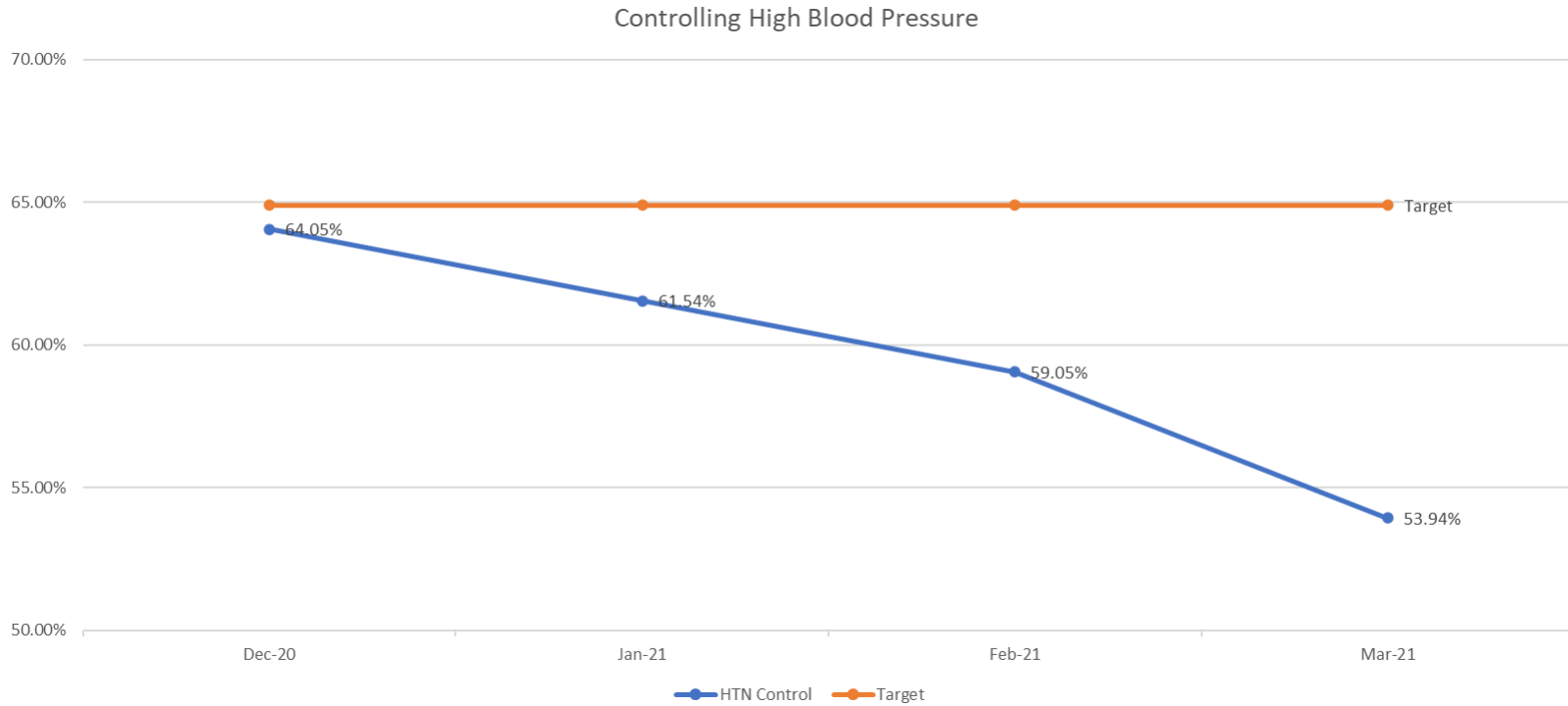
CCRMC & Health Centers patients age 50-75 who were screened for colon cancer during the measurement period

Cancer Screening Diagnostic Colonoscopy



CCRMC & Health Centers patients age 50-75 who received a colonoscopy in the 6 months following a positive FIT/FOBT result

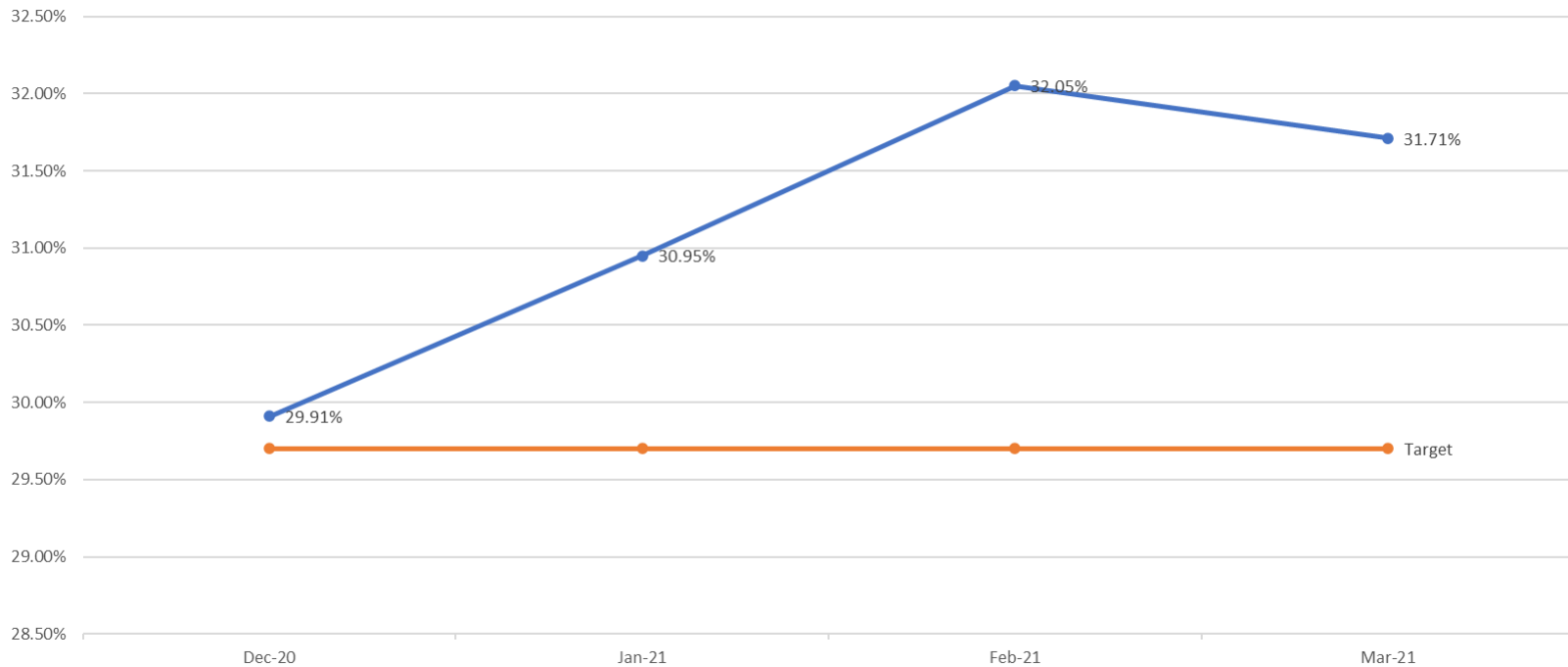
Blood Pressure Control



CCRMC & Health Centers patients age 18-85 whose blood pressure was adequately controlled (140/90 mm Hg) during the last 12 months

Diabetes Care

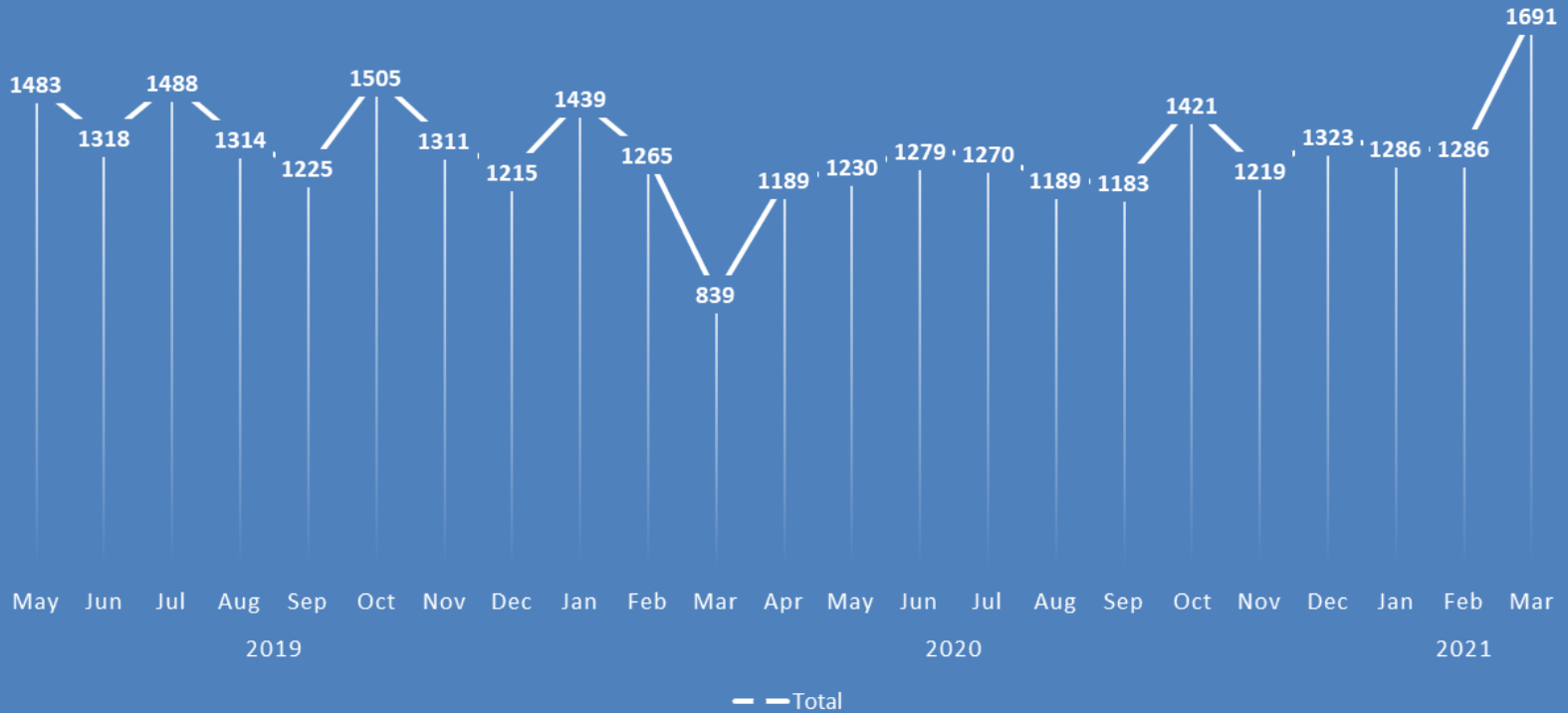
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)



CCRMC & Health Centers patients age 18-75 with no HbA1C on file or with a last HbA1C > 9 during the measurement period

Outpatient Adult Mental Health

ADULT MENTAL HEALTH VISITS

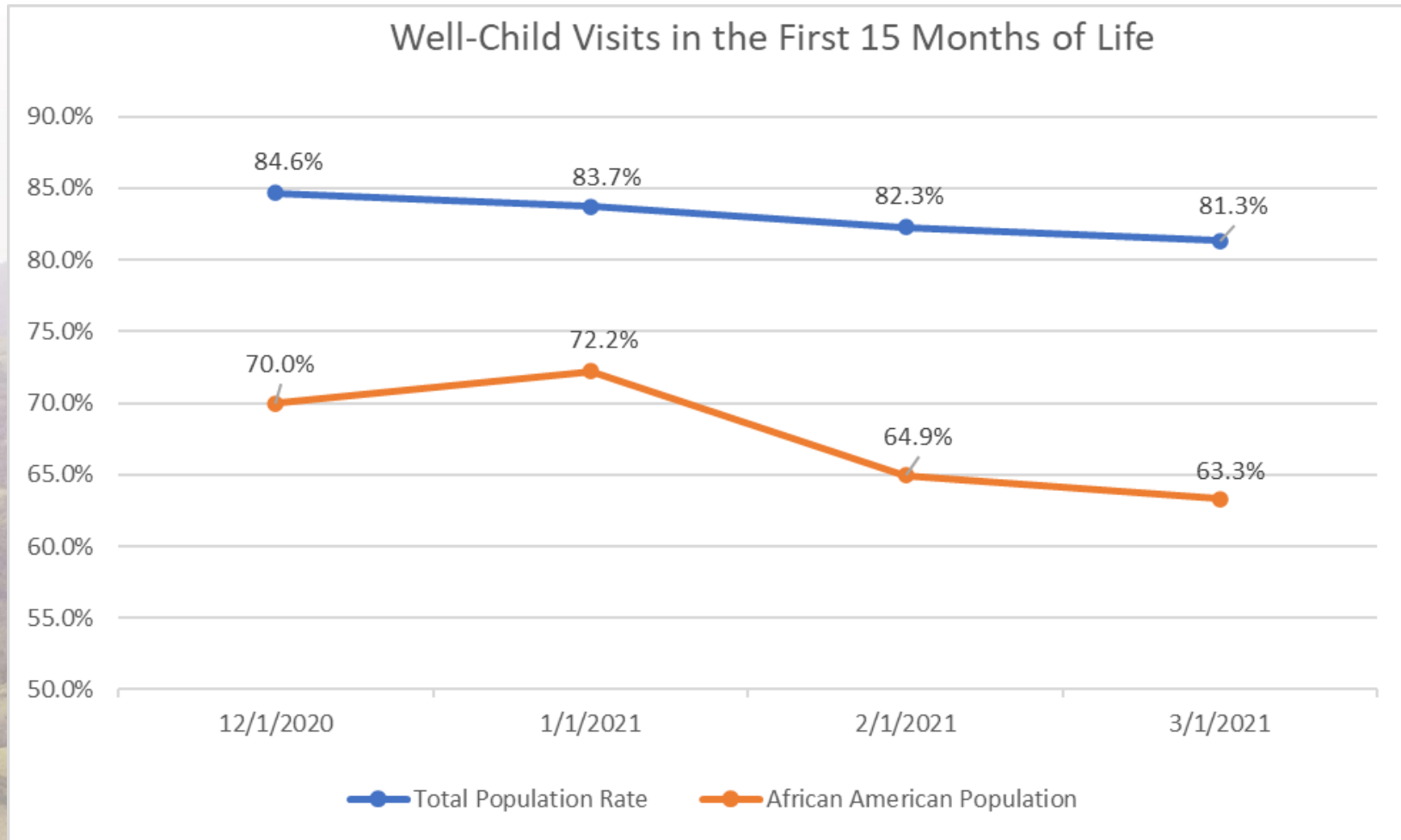


Dentistry (all ages)



Pediatric Care

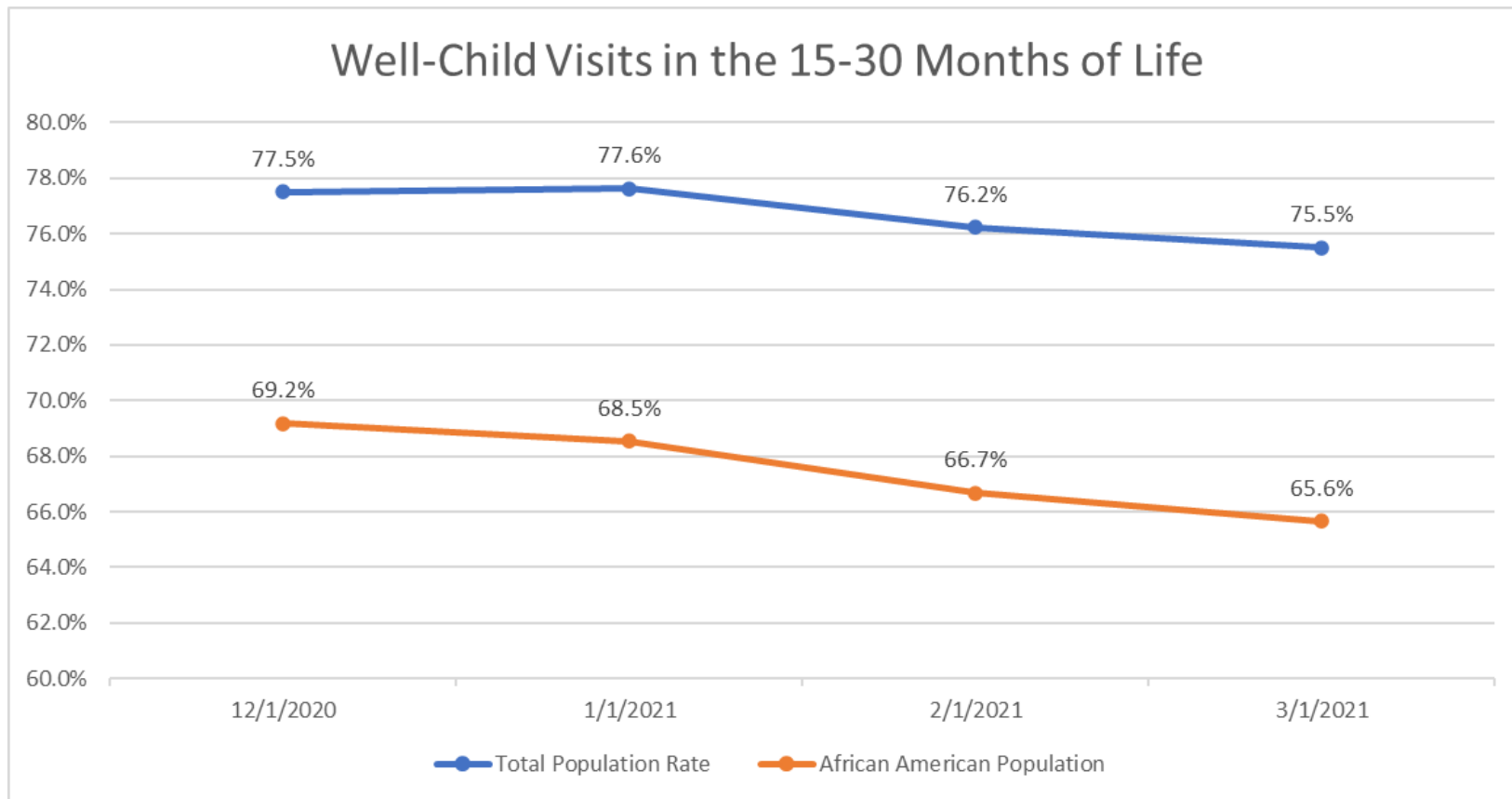
Well-Child Visits



CCRMC & Health Centers patients who turned 15 months old during the measurement year who have had 6 or more well-child visits

Pediatric Care

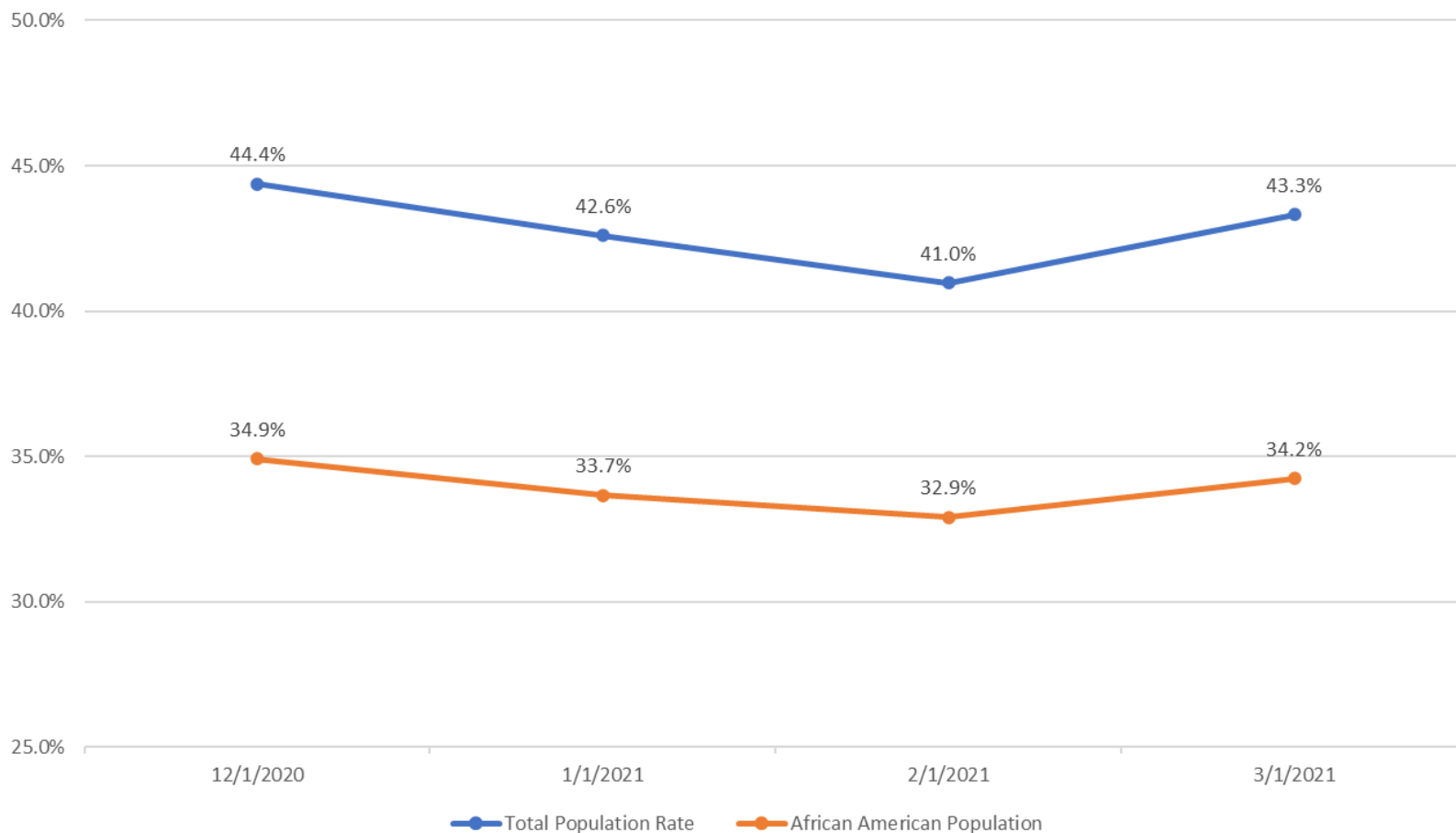
Well-Child Visits



CCRMC & Health Centers patients who turned 30 months old during the measurement year who have had 2 or more well-child visits

Pediatric Care Well-Child Visits

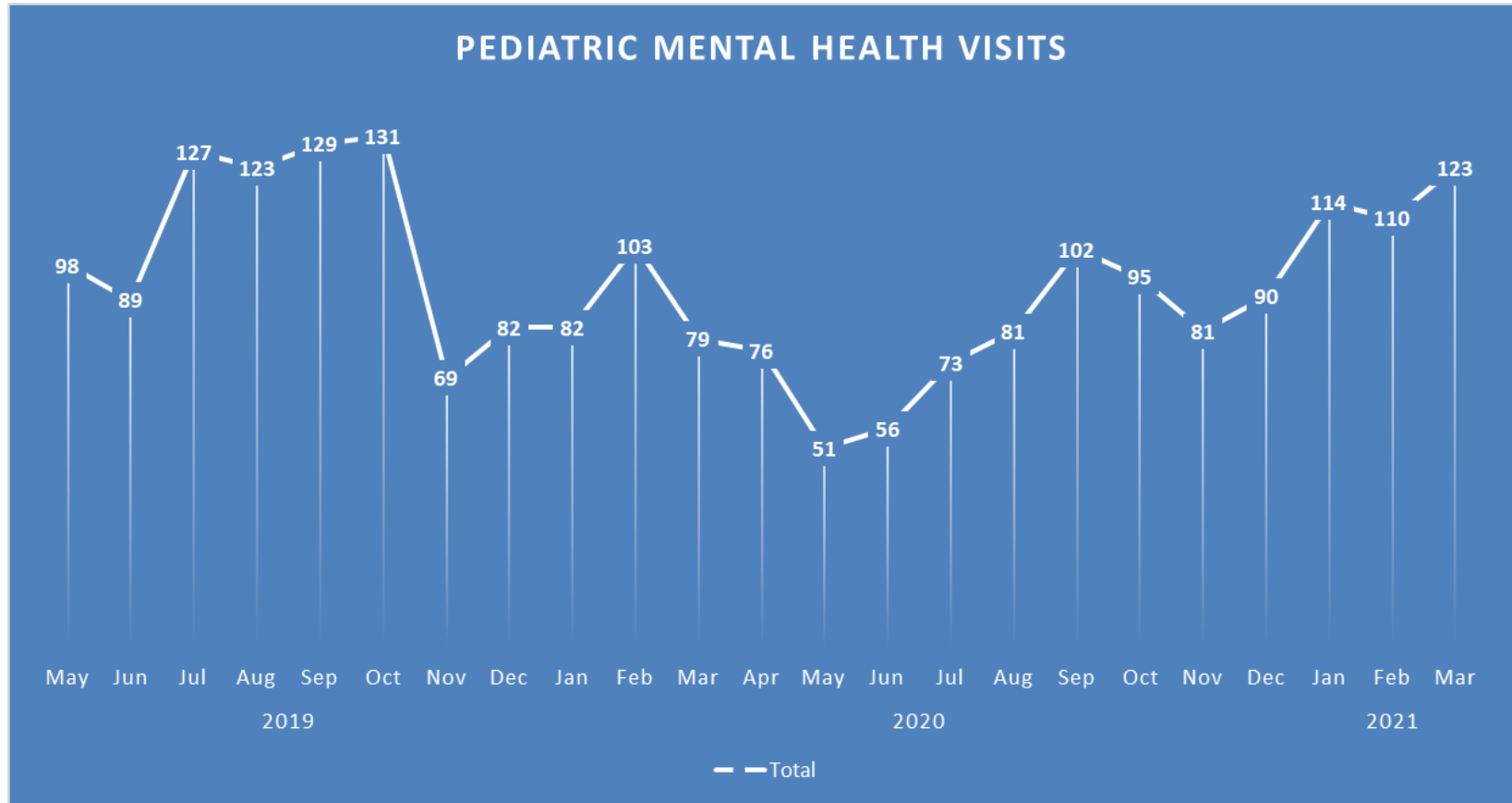
Child and Adolescent Well Care Visits(3-21 years old)



CCRMC & Health Centers patients age 3-21 years who have had 1 or more well-child visits during the measurement year

Pediatric Care

Outpatient Mental Health



Pediatric Care Dentistry

PEDIATRIC DENTAL VISITS



Next Steps

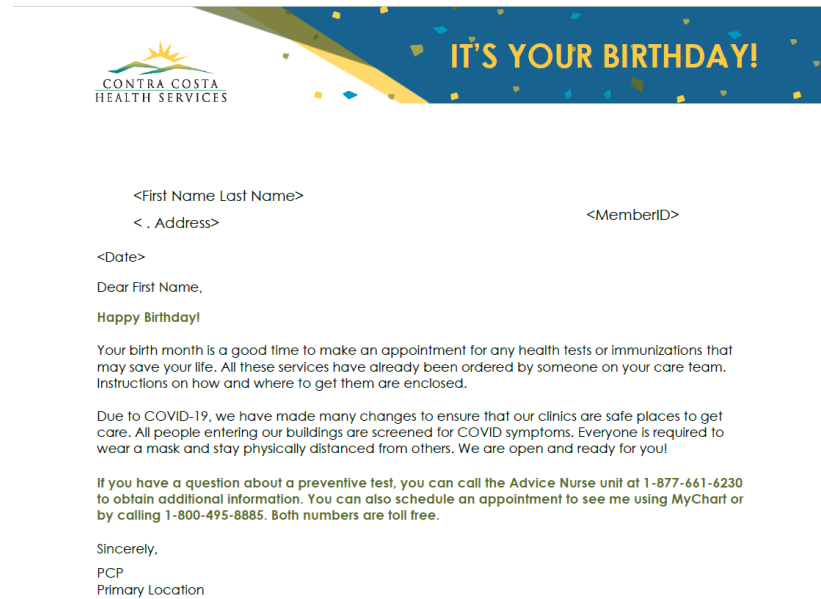
- Conduct mass childhood immunization efforts, like we do for influenza.
- Return women's health clinics, school-based clinics, and dental vans to care delivery.
- Continue provider recruitment.
- Bring staff back to work that have been out on COVID admin leave.
- Redeploy nursing resources from the COVID-19 response back to all other health care needs.
- Increase the number of in-person clinics; the relative demand for telehealth is not as pronounced, particularly for pediatric patients, as in-person clinics.
- Ability to expand Medication-assisted treatment (MAT) to non-face to face encounters and for Nurse Practitioners to prescribe.
- Robust teamwork between nursing, providers, PH, CCHP, PIO is needed to improve many of the QIP metrics that are in the red at this time.

Next Steps:

Working with Contra Costa Health Plan

Continue to partner with the Health Plan on population level health care including outreach.

- Updated annual birthday letters (health maintenance reminders) for adults and pediatrics to include more up to date information and improved design. Status: in production
- Updated “welcome packet” to have one mailing instead of three, and for improved information and design. Status: in production
- Initiated campaign to reach out to new members that have not sought care within 120 days of enrollment. Status: in planning



Next Steps:

Working with PIO to develop a Communications Plan

Background

- We are undertaking a communications campaign, including direct patient outreach, in response to the concerning dropoff in preventive care since the onset of the COVID-19 pandemic.

Goals

- Reaching CCRMC patients in our system who are due for preventive care
- Reach out to thousands of patients that have not sought care in over 12 months (about 20,000 patients)
- Increasing patient utilization of preventive healthcare services
- Raise awareness among public, patients and staff of need for preventive healthcare

Audiences

- Current CCRMC patients/parents we are in touch with
- Current CCRMC patients/parents who might not respond to existing channels/platforms
- CCRMC staff

Next Steps:

Working with PIO to develop a Communications Plan

Tactics

- Designing direct outreach materials like postcards
- Designing social media graphics to use to support targeted advertising reminders
- Press release(s) and/or media pitches
- Robocalls and SMS text message reminders

