Monthly PI meeting

PI Updates

9/21/2022

HEALTH CARE for the HOMELESS

Overview

1. Wake up Trivia
2. Pop Health Updates
3. PI Updates
   - Quality KPI dashboard
     - Disparity data (not covering today)
   - Improvement work
   - Access
4. Draft of 2023 PI goals
5. Announcements (if time)

Wake Up Trivia

Theme: Burgers!

National Cheeseburger day was this past Sunday, September 18th, 2022!

Sources: https://mentalitch.com/interesting-facts-about-hamburgers/#:~:text=Hamburger%20is%20American%2C%20but%20its%20name%20is%20very,Germany%20brought%20to%20the%20US%20by%20German%20immigrants.

Trivia Question: 1 of 5

Question: What is the most popular hamburger topping?

Answer: Cheese. Nearly 3 of 4 people put cheese on their hamburgers.

Trivia Question: 2 of 5

Question: McDonalds holds the record for the restaurant that sold the most hamburgers worldwide. They sell ___ hamburgers each second.

Answer: 75

Trivia Question: 3 of 5

Question: The largest cheeseburger in the world weighed in at _____ pounds

Answer: 2,014! 60 pounds of bacon, 50 pounds of lettuce, 50 pounds of sliced onions, 40 pounds of pickles and 40 pounds of cheese.

Trivia Question: 4 of 5

Question: The average American eats ___ burger(s) per week.

Answer: 3

Trivia Question: 5 of 5

Question: What is the oldest burger chain in America?

Answer: White Castle, which was founded in Wichita, Kansas in 1921.

Back then a hamburger cost 5 cents!

Pop Health Updates

Population Health and Friends

1. Diabetes work
2. Student partnership
3. Flu and Coat Drive
4. Breast Cancer Awareness
5. Upcoming Event!

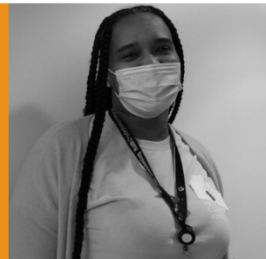
Diabetes

Partnering with Nursing (Julia Davis) and Comms (Rebecca Ritter) to advance development of video-based education tool for Nursing

Video 1 (recorded and in editing): Intro to Diabetes, Diabetes testing, Initial Steps, Support from HCH

English and Spanish

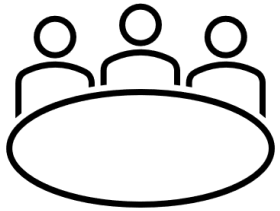
Many thanks to participants: Rebecca Ritter, Faith Timothy, Liz Galbrecht, Stephanie Ference, Marva Veliz, Julia Davis, & Erick Torres



HIV and PrEP

We are committed as an agency to increasing the number of clients we have on PrEP

Approach:



- Workflow around increased rapid testing referral from MAT is drafted and soon to MAT/Medical for review
- Partnering with Comms and Harm Reduction/Rapid Testing to increase confidentiality for lobby recruitment
- Student involvement with recruitment, education and brochure development
- Increased and improved lobby signage

Student Partnerships

Small group from intro course at **UMD MPH Program**: production of easy guide to discussion purpose/option at HCH for HIV/Hep C testing

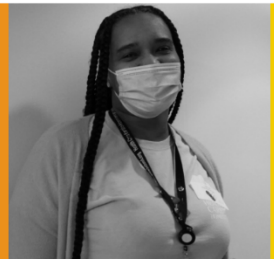
NDUM Nursing – 20 students, 30 hours each.

Clinical: Flu vaccine clinics, Flu & Coat, MAT, Rapid Testing, Breast Cancer Activities, Shadow opportunities in Medical

Non-clinical: Rock Your Socks 5K, Flu & Coat, Emergency Food Pantry

Marc Bowman (Volunteer Manager): mbowman@hchmd.org

Shannon Riley (Pop Health Nurse): sriley@hchmd.org



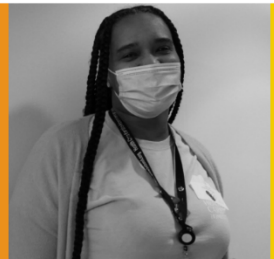
It’s Flu Season!

Current Flu Vaccine Rate (adults): 3% (9/20/22)

Flu vaccine clinic:

- Ongoing for staff and clients (*staff may come for vaccine during client hours as long as no clients are waiting*!)
  - @ 421 Fallsway: hours changing starting today → **8:30-noon Mon-Fri** (due to limited staffing capacity)
  - Dedicated staff clinic **2:30-4** on first floor (middle group room) **this Friday 9-23-22**

Reminder: to complete Health Care Source Training if you haven’t already!



Week of Flu and Coat Drive (Oct 17th-21st)

Flu and Coat Drive: Coats arriving (Lisa), Volunteers/students secured (Marc and Shannon), Maryland Food Bank and Charm City Runs activity (Malcolm), Flyers coming (Hanna), Dedicated CSR (Kimberly)

1. **Final planning meeting - 9/27**
2. **Walk through (on site) - 10/11**
3. **Malcolm to facilitate a staff training (after staff walk through)**

Breast Cancer Awareness Month is October

Planned Pop Health Interventions:

Phone calls

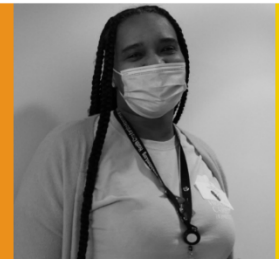
- reminders & assess barriers to mammogram completion
- establish ongoing process for reminders and tracking

Lobby activity

- 1:1 engagement/distribute pins and information
- Front porch activity

Reminder cards in Medical – pilot for cancers

MDH Breast and Cervical Cancer Grant (pop health) FY 22-23: 1 breast campaign event, 1 group event, 2 outreach/lobby education sessions



Women's Health Day

In-person day-long event to draw attention to Women's Health

Last took place in 2020!

Planned activity-loaded event for clients January 2023

Requesting volunteers for planning committee!!

Please contact Shannon Riley at sriley@hchmd.org

Data

Key
3+ Improvement
1-2+ improvement
No change
reduction
No data

September 2022 Quality CQM and KPI dashboard

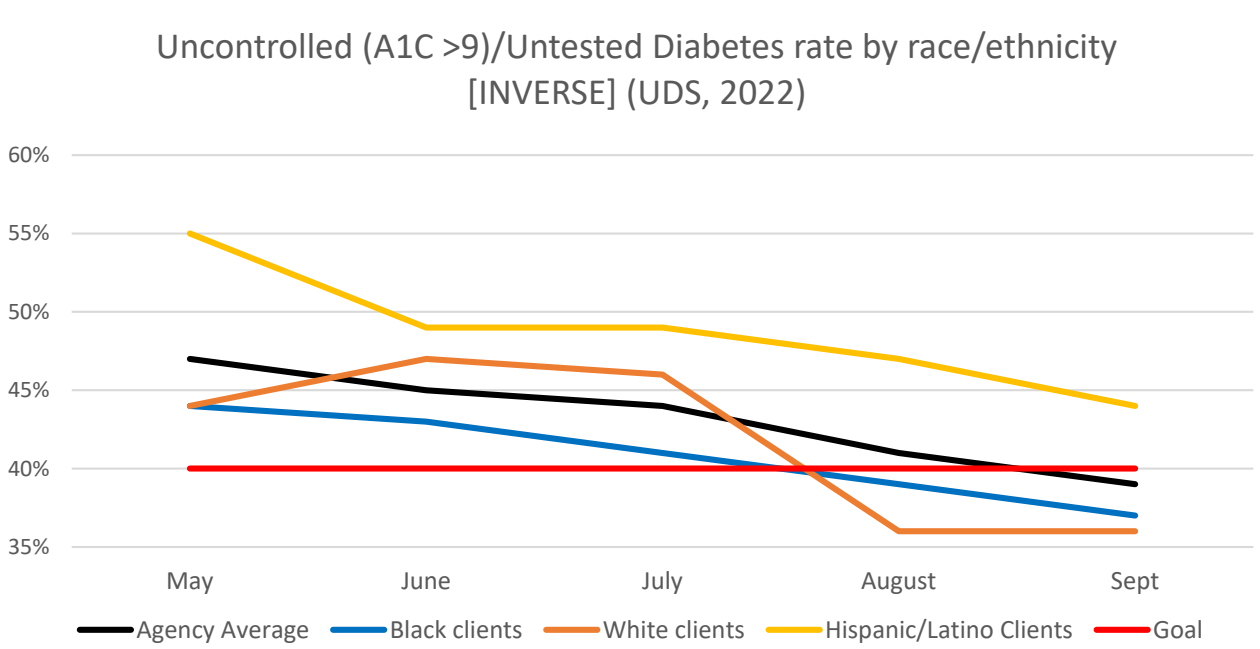
Measure Name	2021 Baseline UDS data	Var to 3/15 Athena Data	Trend	Jan	Feb	Mar (15th)	Apr	May	June	July	Aug	Sept	To goal	2022 Goal
Body Mass Index (BMI) Screening and FollowUp	10%	7%				17%	18%	19%	21%	25%	24%	25%	40%	65%
Breast Cancer Screening	34%	-10%				24%	30%	30%	34%	34%	34%	35%	5%	40%
Cervical cancer screening	41%	-6%				35%	39%	41%	43%	46%	49%	49%	10%	59%
Childhood Immunization Status	24%	-24%				0%	11%	12%	11%	10%	10%	9%	16%	25%
Colorectal cancer screening	25%	-7%				18%	21%	24%	26%	27%	28%	29%	1%	30%
Controlling high blood pressure	48%	-3%				45%	48%	50%	51%	52%	54%	56%	met	55%
Dental Sealants (ages 6-9 Years)	0%	0%												50%
Depression Remission at Twelve Months	9%	-9%				0%	0%	0%	0%	0%	0%	4%	6%	10%
Depression Screening and Follow-Up Plan	42%	-9%				33%	36%	40%	44%	45%	46%	47%	33%	80%
Diabetes: HbA1c poor control (>9%) [inverse]	52%	5%				43%	52%	48%	45%	44%	41%	39%	met	40%
Early Entry into Prenatal Care	78%	n/a												80%
HIV Linkage to Care	100%	-100%				0%	0%	0%	100%	100%	100%	100%	met	100%
HIV Screening	64%	-25%				39%	42%	45%	46%	49%	50%	52%	18%	70%
IVD: Use of Aspirin/Other Antiplatelet	56%	27%				83%	84%	83%	83%	83%	83%	82%	3%	85%
Low Birthweight														
Statin Therapy for Prevention/Treatment of CVD	77%	6%				83%	81%	81%	82%	82%	83%	82%	3%	85%
Tobacco use: screening and cessation intervention	55%	-28%				27%	35%	40%	45%	48%	52%	56%	14%	70%
Wt assessment & counseling for nutrition & PA (Peds)	55%	-46%				9%	11%	16%	20%	25%	29%	32%	26%	58%
*Lab Tracking	n/a											19%		
*Referral Tracking	n/a					23%			19%			25%	15%	40%
**SDH ask rates	n/a									43%		50%		

- *CQM pulled the 5th of each month*
- **represents YTD totals*
- ***represents trailing YTD totals*

Getting Closer to Goal

1. Colorectal cancer screenings
2. Breast Cancer Screenings
3. Cervical cancer screenings
4. Tobacco Use Screening and Cessation

Health Disparities Dashboard: Diabetes

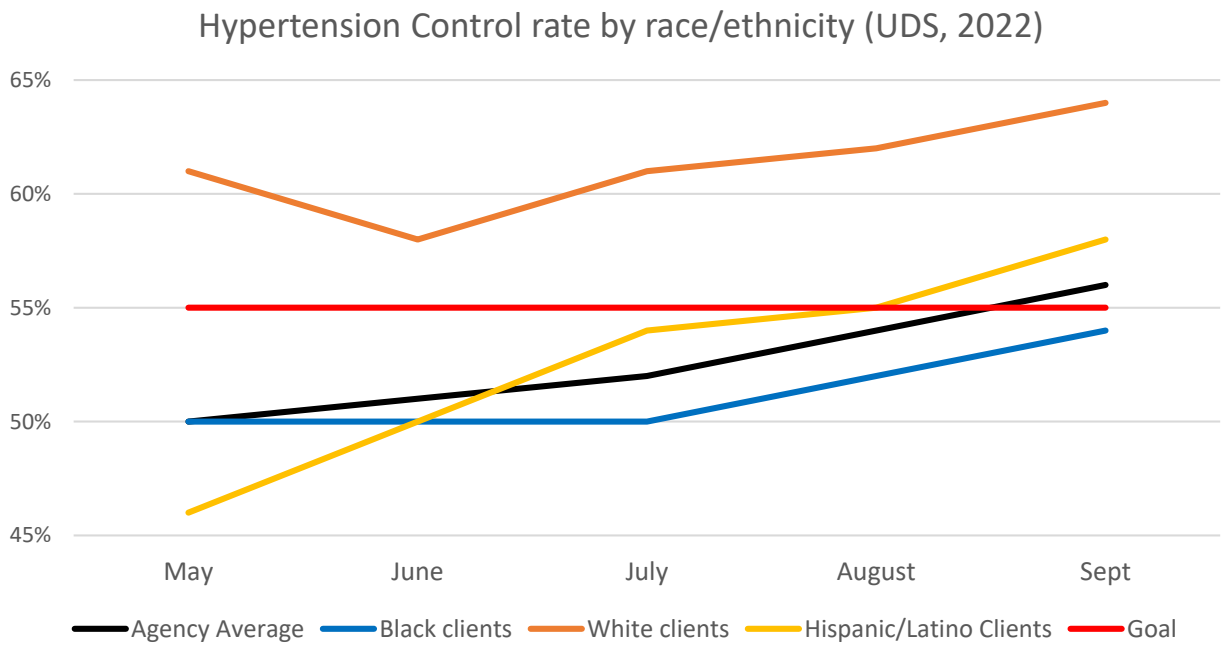


Diabetes (A1C >9) HCH Population	May (47%)	June (45%)	July (44%)	Aug (41%)	Sept (39%)	Sept num/den: 376/964
Black Clients Total:	44%	43%	41%	39%	37%	192/523
Black Male Clients:	45%	45%	42%	41%	40%	134/336
Black Female Clients:	42%	41%	38%	35%	31%	58/187
White Total Clients:	44%	47%	46%	36%	36%	32/88
White Male Clients:	48%	50%	49%	39%	40%	21/53
White Female Clients:	40%	42%	42%	32%	31%	11/35
Hispanic/Latino Total Clients:	55%	49%	49%	47%	44%	142/322
Hispanic/Latino Male Clients:	57%	49%	54%	51%	50%	71/141
Hispanic/Latina Female Clients:	53%	48%	46%	43%	39%	71/181

Red = worse than agency average for the month

Green = better than agency average for the month

Health Disparities Dashboard: Hypertension

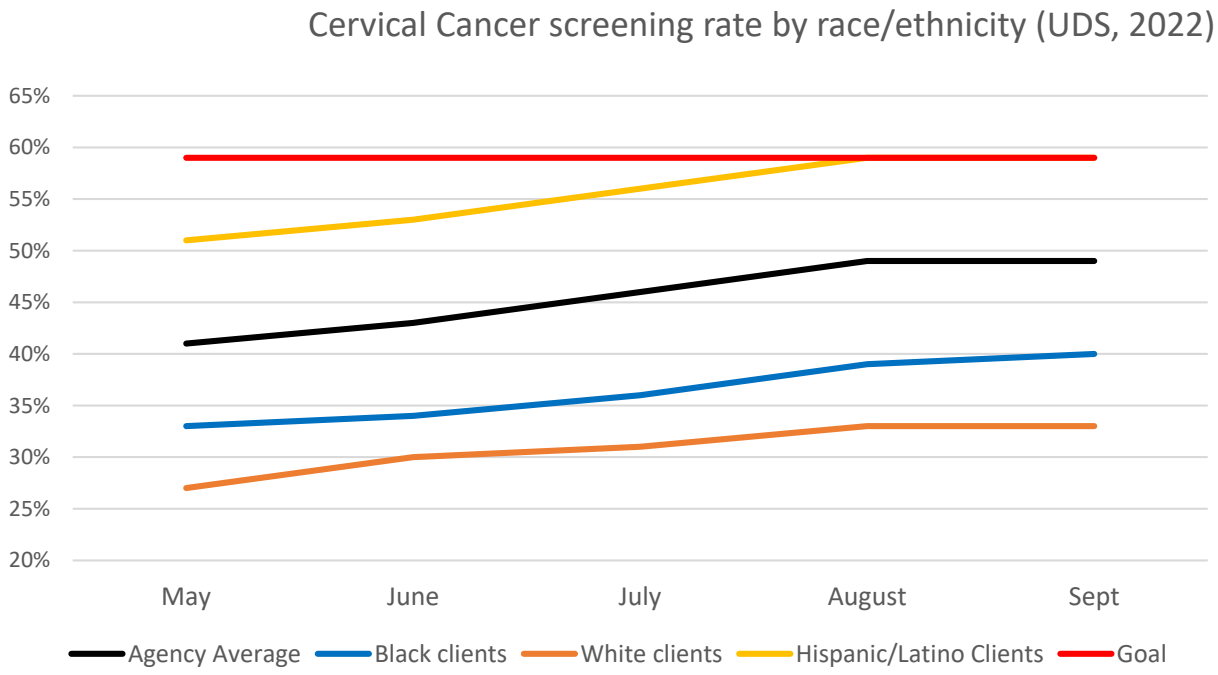


Hypertension Control HCH Population	May (50%)	June (51%)	July (52%)	Aug (54%)	Sept (56%)	Sept num/den: 925/1644
Black Clients Total:	50%	50%	50%	52%	54%	581/1071
Black Male Clients:	50%	51%	51%	53%	55%	401/725
Black Female Clients:	49%	49%	48%	50%	52%	180/346
White Total Clients:	61%	58%	61%	62%	64%	118/184
White Male Clients:	63%	60%	62%	63%	64%	84/131
White Female Clients:	57%	55%	60%	60%	64%	34/53
Hispanic/Latino Total Clients:	46%	50%	54%	55%	58%	211/362
Hispanic/Latino Male Clients:	47%	46%	56%	57%	58%	88/152
Hispanic/Latina Female Clients:	45%	53%	52%	54%	59%	123/210

Red = worse than agency average for the month

Green = better than agency average for the month

Health Disparities Dashboard: Cervical Cancer Screenings



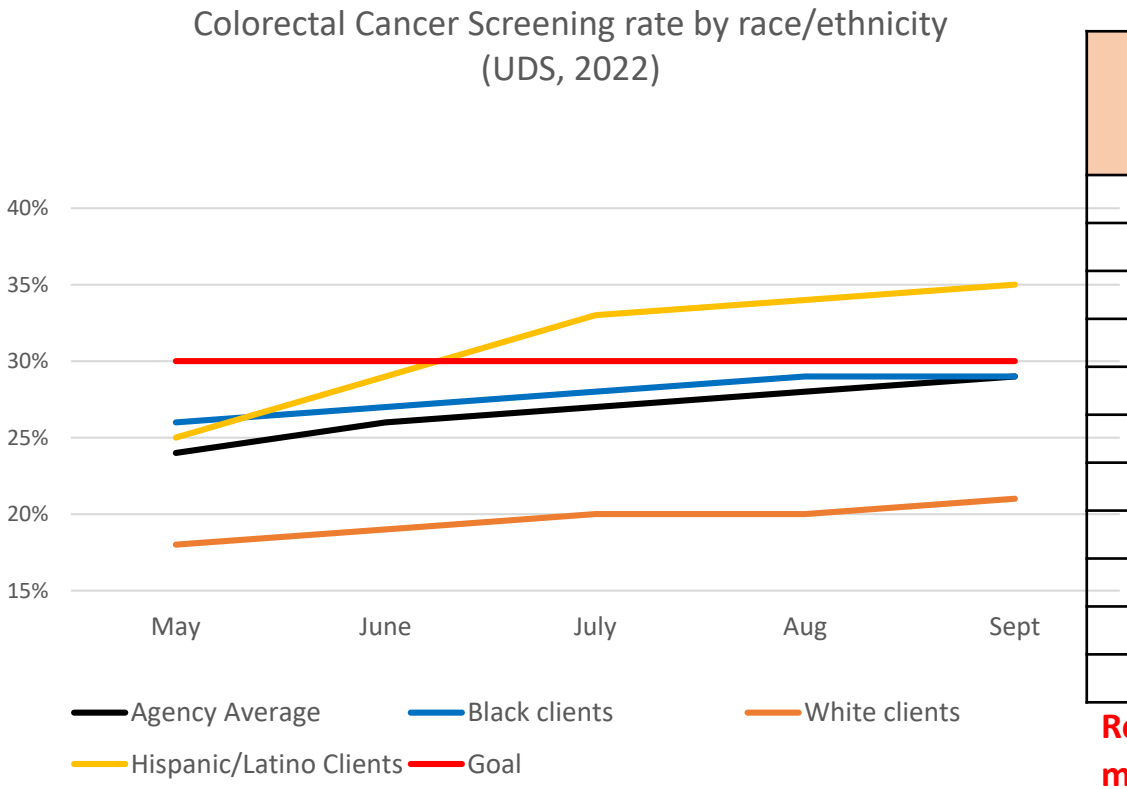
*Cervical Cancer Screening HCH Population	May (41%)	June (43%)	July (46%)	Aug (49%)	Sept (49%)	Sept num/den: 1159/2348
Black Clients	33%	34%	36%	39%	40%	279/693
White Clients	27%	30%	31%	33%	33%	100/299
Hispanic/Latino/-a Clients	51%	53%	56%	59%	59%	796/1351

***Includes clients assigned female at birth (AFAB)**

Red = worse than agency average for the month

Green = better than agency average for the month

Health Disparities Dashboard: Colorectal Cancer Screenings

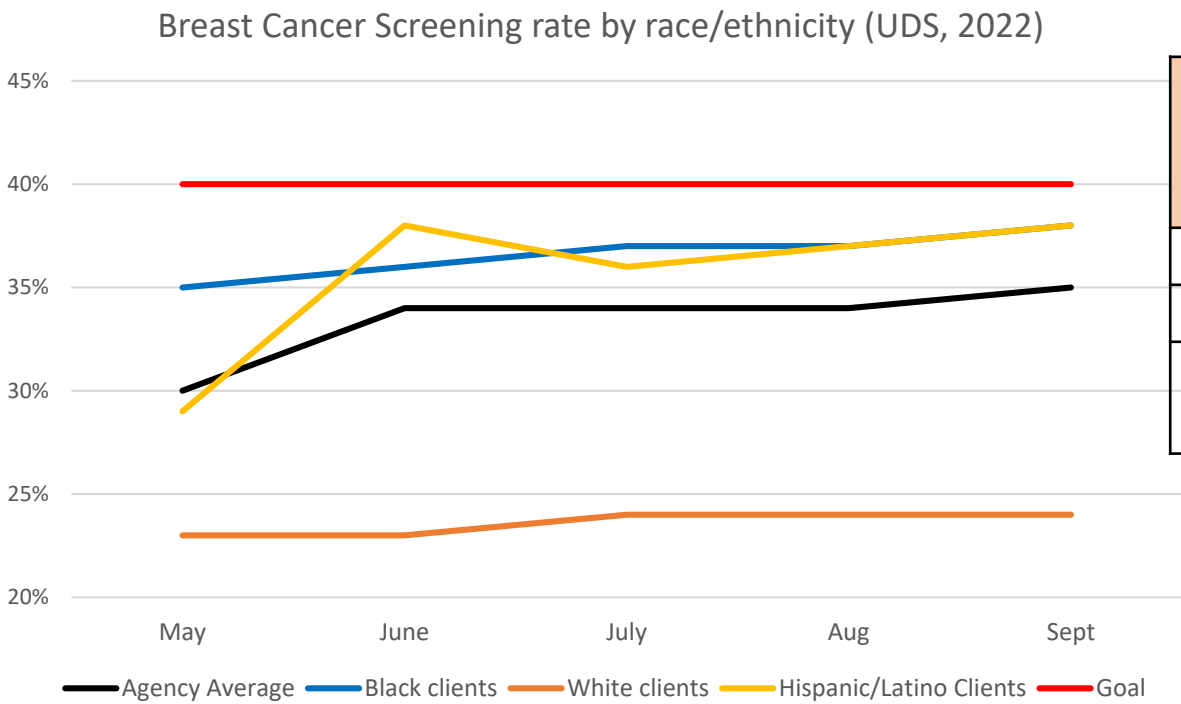


Colorectal Cancer Screening HCH Population	May (24%)	June (26%)	July (27%)	Aug (28%)	Sept (29%)	Sept num/den: 673/2337
Black Clients Total:	26%	27%	28%	29%	29%	447/1528
Black Male Clients:	25%	27%	28%	29%	29%	313/1065
Black Female Clients:	26%	28%	28%	28%	29%	134/463
White Total Clients:	18%	19%	20%	20%	21%	76/367
White Male Clients:	20%	22%	23%	22%	24%	59/251
White Female Clients:	14%	14%	16%	16%	15%	17/116
Hispanic/Latino Total Clients:	25%	29%	33%	34%	35%	138/390
Hispanic/Latino Male Clients:	23%	27%	30%	32%	32%	53/168
Hispanic/Latina Female Clients:	26%	30%	35%	35%	38%	85/222

Red = worse than agency average for the month

Green = better than agency average for the month

Health Disparities Dashboard: Breast Cancer Screenings



*Breast Cancer Screening HCH Population	May (30%)	June (34%)	July (34%)	Aug (34%)	Sept (35%)	Sept num/den: 259/749
Black Clients	35%	36%	37%	37%	38%	165/438
White Clients	23%	23%	24%	24%	24%	26/109
Hispanic/Latino/-a Clients	29%	38%	36%	37%	38%	71/188

*Includes clients assigned female at birth (AFAB)

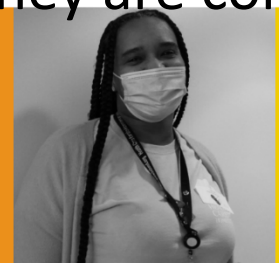
Red = worse than agency average for the month

Green = better than agency average for the month

Improvement projects

Prioritized measures

- HIV screenings – Pop health has/continues to work on some efforts to promote these
- Cervical Cancer Screenings – past PI champions focus, want to find ways to continue to improve work
- Depression screening & Follow-up – reminder to continue to screen and manually satisfy for + clients with f/u plan
- HTN control – Medical completed a lot of great work in this area! (see recap on next slide)
- De-prescribing Aspirin – decided to adjust goal – sun-setting the measure itself (achieving certain rate of de-prescribing)
  - Taking step back – initial focus on creating a perfect report to use but realizing more worthwhile to focus on providers and being sure they are comfortable with the guidelines



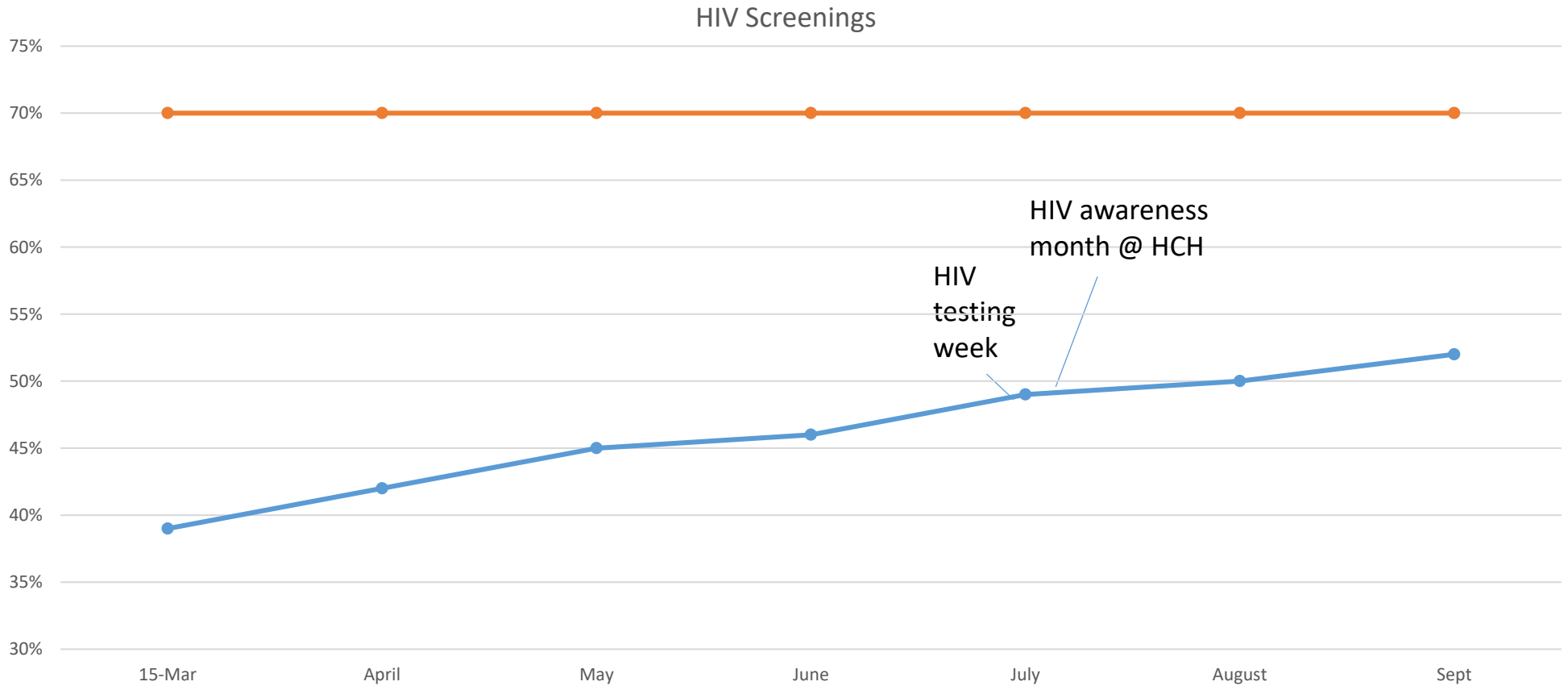
Hypertension Work done this year

- Medical
  - Emphasis on home BP cuffs when possible
  - Second BP reading with medical provider if first is high with CMA
  - Starting 2 meds at the same time
  - Prescribing more meds faster (ARBs)
  - Diagnosing HTN earlier (updated 2019 guidelines); lifestyle interventions
  - Utilizing nursing for BP visits is a big piece of this work
- Community Sites discussing more nurse BP visits
  - Targeting disparities between Black and White clients: proactive outreach to clients who are black with uncontrolled blood pressure
  - Looking at evidence-based practice to reduce health inequities

Other prioritized measures

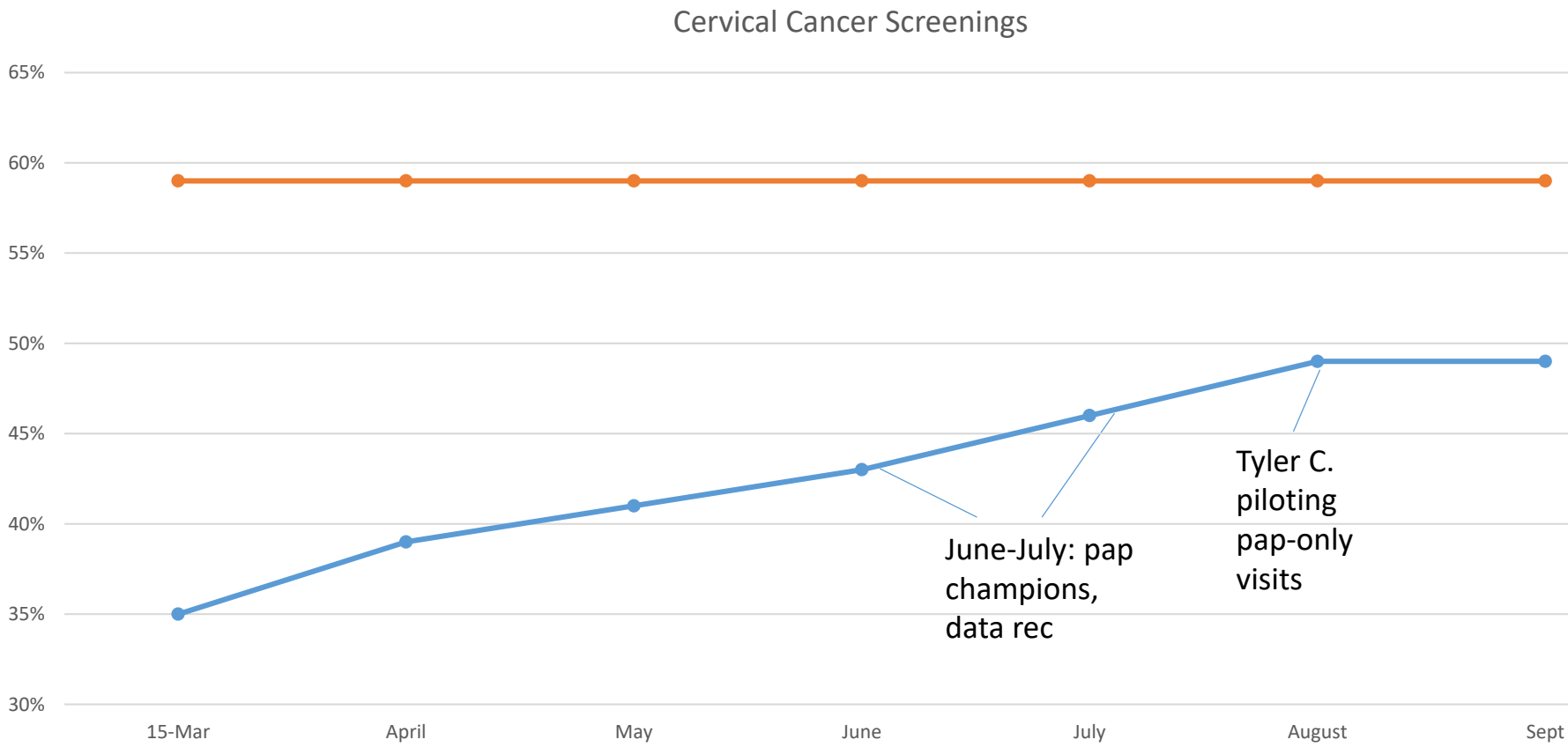
- Depression Remission: BH team receiving monthly list of clients due for re-screening
  - Note: if you see in quality tab that client is due, clt requires a full PHQ-9 screening (not just PHQ-2)
- Colorectal Cancer Screenings – PI Champions: Max, Faith, Mykia
  - **Pilot** - provide option and instructions for client mailing in FITs whenever offering FIT – would like to make mailing option a standard practice if possible
  - **Educational handout** (one-pager in English and Spanish)
  - **Evidence-based messaging** when offering CRC screenings

Run chart: HIV Screenings

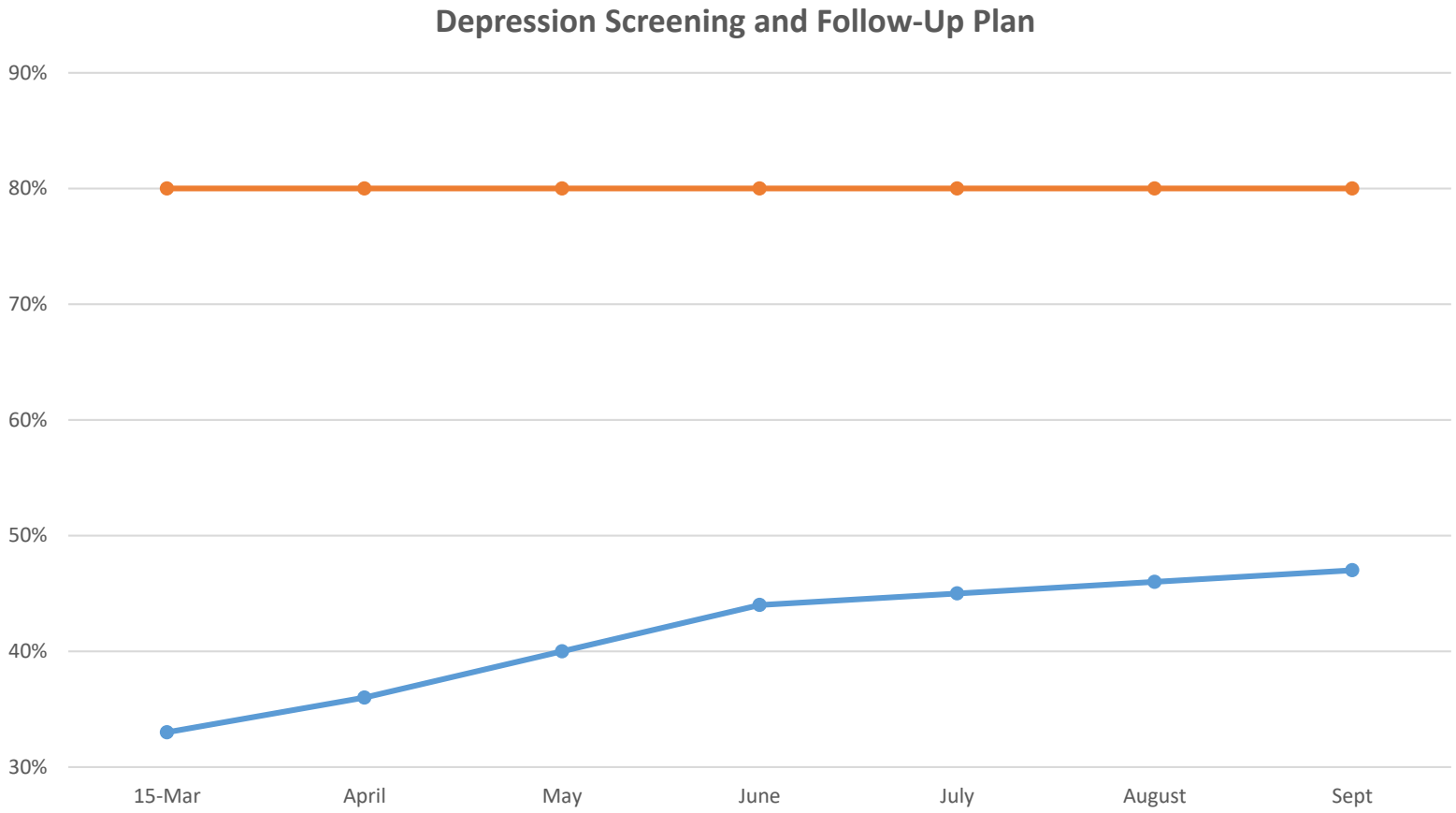


Run chart: Cervical cancer screenings

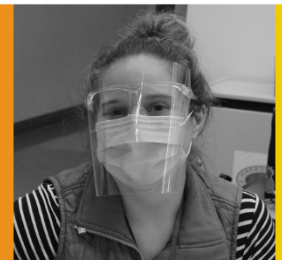
Ideas for moving this measure forward?



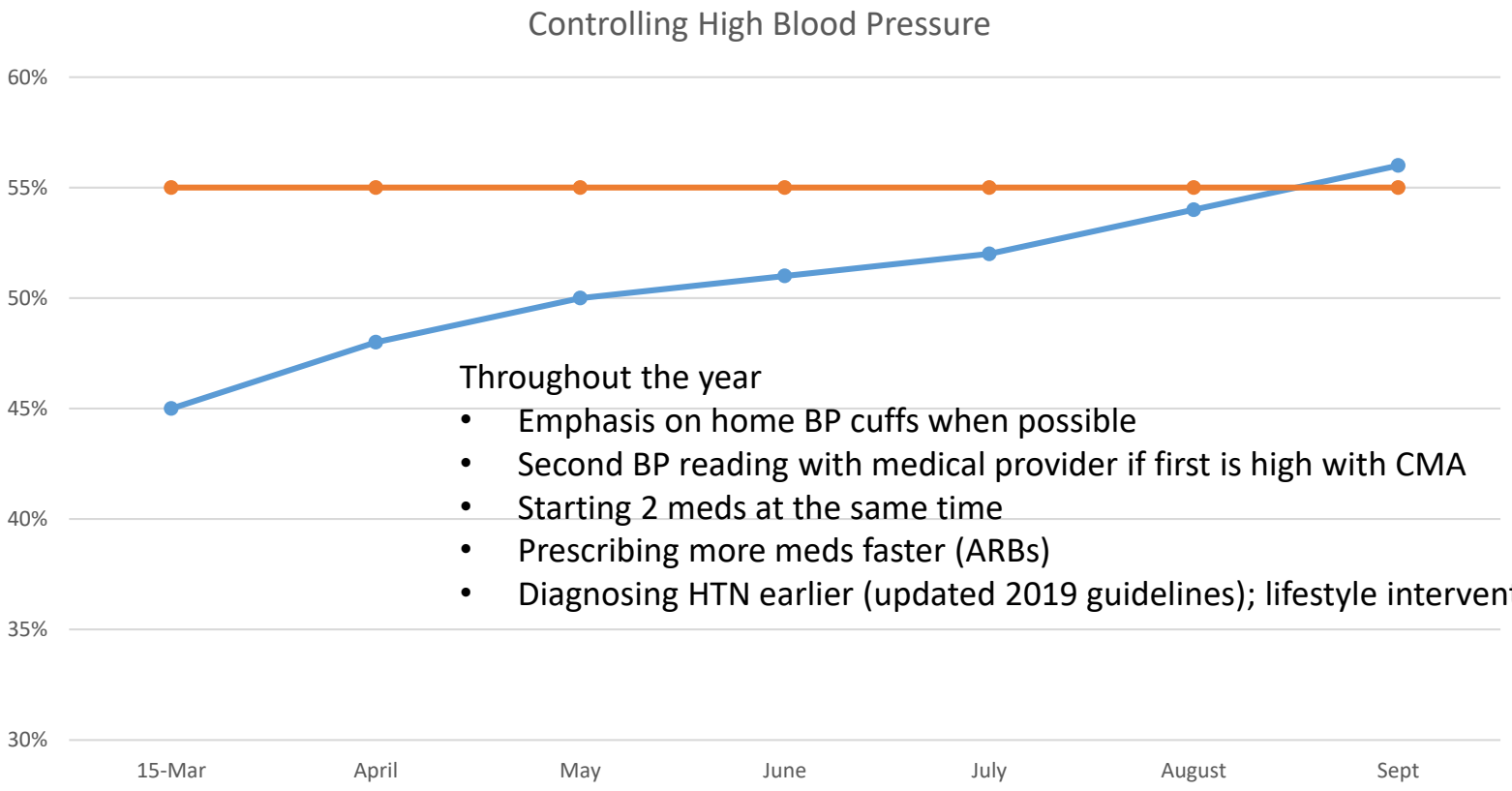
Run Chart: Depression Screening and follow-up plan



Ideas for moving this measure forward?



Run Chart: Controlling High Blood Pressure



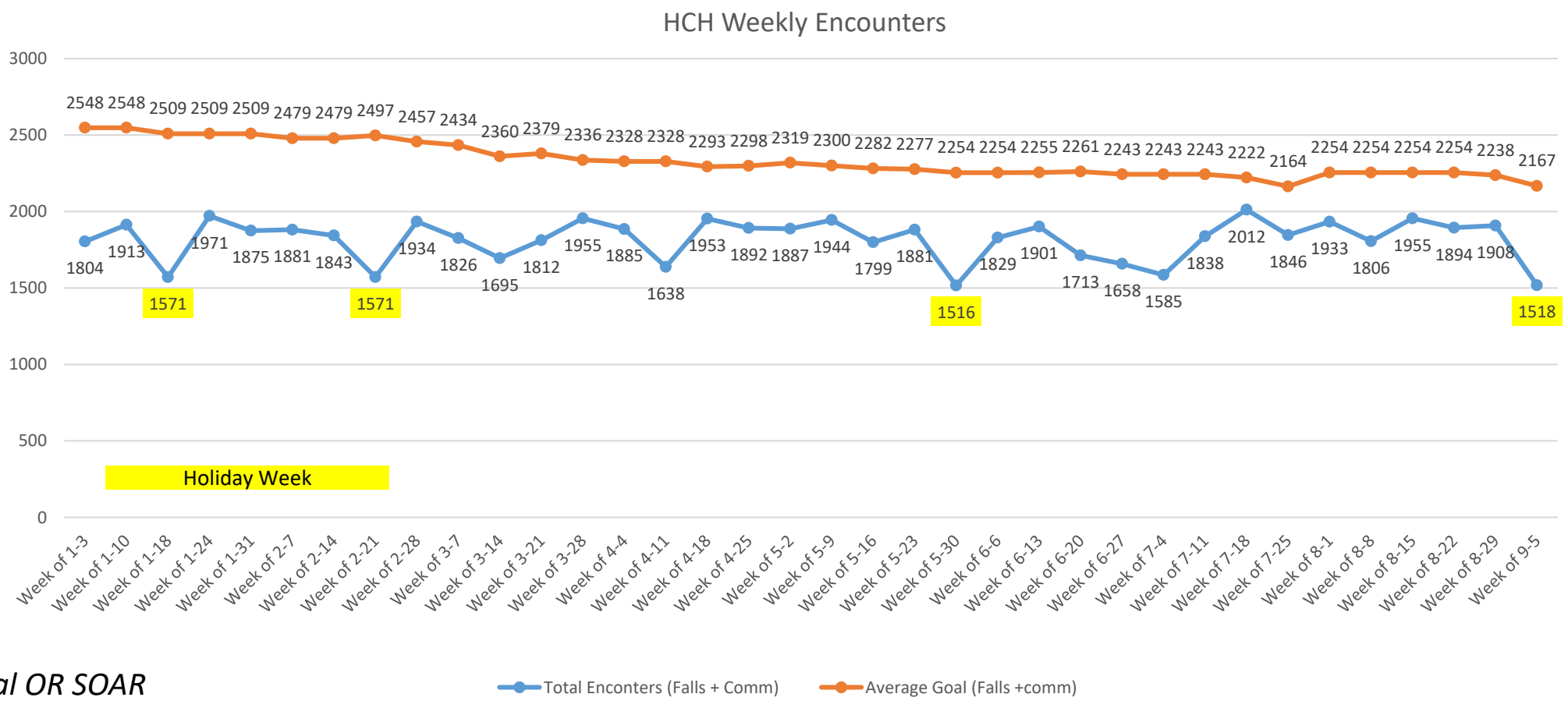
Throughout the year

- Emphasis on home BP cuffs when possible
- Second BP reading with medical provider if first is high with CMA
- Starting 2 meds at the same time
- Prescribing more meds faster (ARBs)
- Diagnosing HTN earlier (updated 2019 guidelines); lifestyle interventions

Access

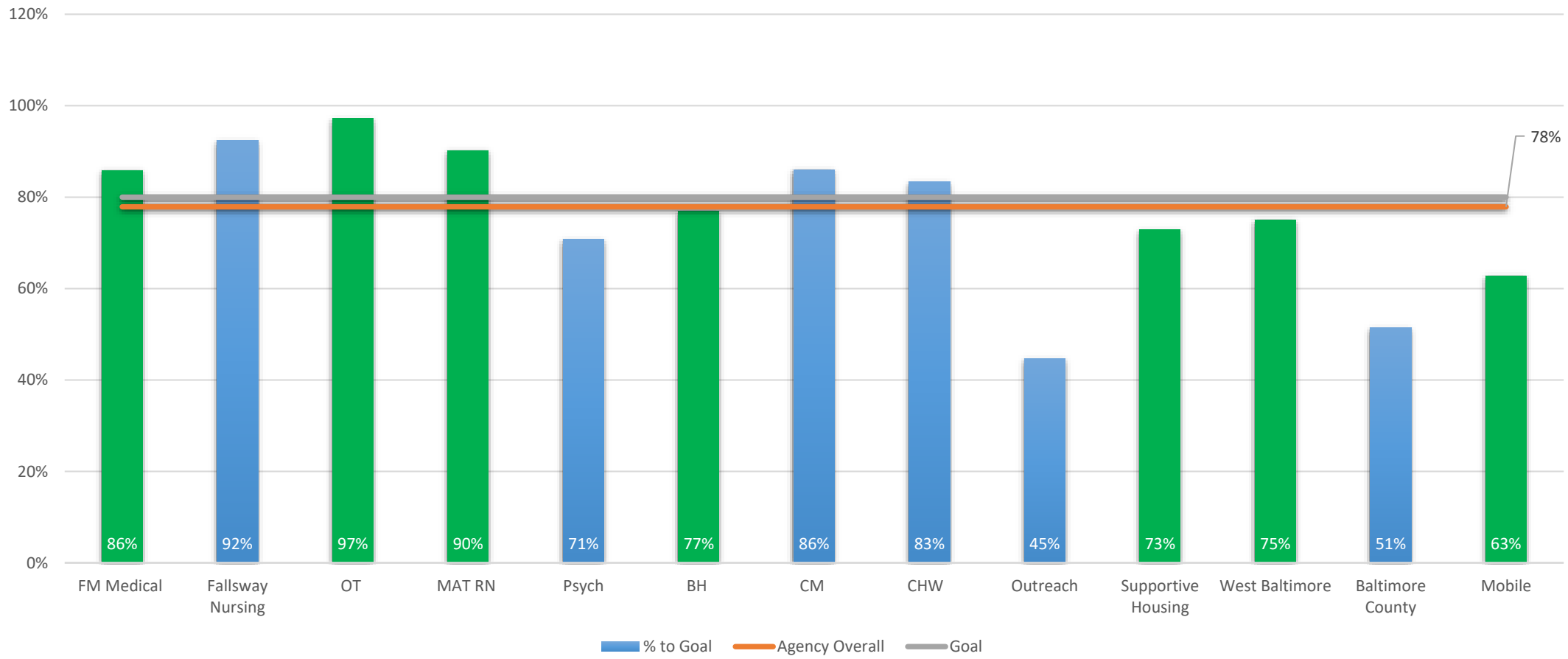
Agency Clinical Departments - Weekly Encounters

Average Weekly Goal Encounters*
2334
Average Weekly Encounters*
1827
% To Goal
78%

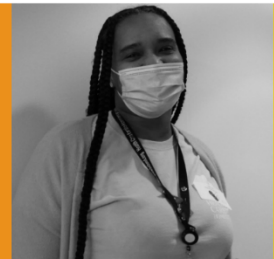


* *Does not include Dental OR SOAR*

YTD (Jan - Week of September 5th-Department % to Goal)



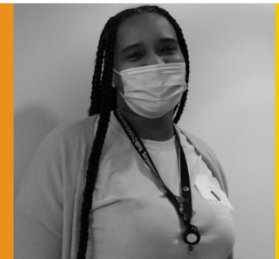
Green – improvement since Wk. of Jan 3 to Wk. of August 1st



Draft of 2023 PI goals

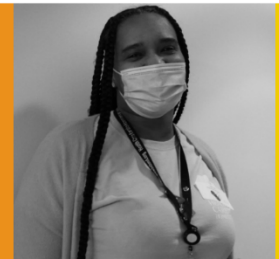
2023 Goal Setting

1. Annually, we assess our current state that includes external expectations and top areas for improvement
2. This year's goals include a combination of identified goals and some flexibility on goals to choose throughout 2023 depending on trends
3. They are grounded in equity, current performance, agency priorities + strategic plan, and staff capacity
4. Goals are divided into four areas:
   - Resource Stewardship
   - Clinical Quality Measures
   - Client Experience and Access
   - Care Management



Resource Stewardship Goals

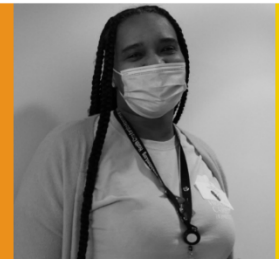
1. Cost savings
    - By December 31, 2023, the Agency will reduce hospital readmission rates by 10% for clients within six months of admission. The Agency will review demographic and SDH data to identify disparities and plans to address.
        - Rationale: Over 200 clients are admitted and discharged monthly who are identified as clients at the Agency. Readmissions are costly to the health system, but more importantly can be traumatic for the individual needing care and can lead to worse health outcomes.



Resource Stewardship (continued)

2. Care coordination

- By December 31, 2023, the Agency will attempt follow-up with 85% of individuals following a hospitalization and identify SDH or racial disparities for client's post-hospitalization.
  - Rationale: Building on a risk management goal for 2022, this goal seeks to further our care coordination and follow-up with client's post-hospitalization. Following up with an individual post-hospitalization is crucial to engagement, accessing vital primary or behavioral health care, and preventing future health concerns.



Clinical Quality Measures Goals

3. Preventive

- By December 31, 2023, utilizing the Health at Every Size framework, 65% of individuals 18 years and older will have height and weight documented annually, with a follow-up plan if indicated in the EMR
  - Rationale: Due to COVID and our Athena transition, we have seen a decrease in this measure, where historically we performed very well. This measure seeks to ensure we are documenting appropriately, while considering cultural and personal characteristics to health. (10% in 2021; 25% YTD 2022)

4. Chronic

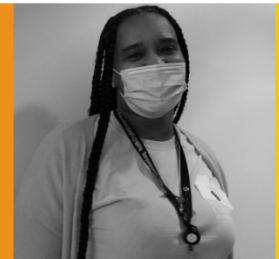
- By December 31, 2023, 65% of individuals will have blood pressure controlled and reduce disparities between Black or African American and White individuals by 5%
  - Rationale: We have hit our goal for 2022, which is encouraging and due to the hard work of the medical team. However, we continue to see opportunities for improvement and racial disparities in control rates. The momentum of 2022 will help to achieve this goal and put us above national averages (61%) for this measure. (current disparity is 10%)

Clinical Quality Measures (continued)

5. Behavioral Health

- By December 31, 2023, 11% of individuals 12+ diagnosed with depression will achieve depression remission. The Agency will review data and stratify data to identify and address disparities identified for housing status, race, ethnicity, sexual orientation, or gender identity
  - Rationale: This measure, a challenging one, continues to be fine-tuned by the BH team. Focusing on PHQ re-screening and using supervision as a tool to engage with the department on remission will help to improve our rates (currently 4%)

6. Additional: The Agency will identify, measure, and improve upon at least two additional clinical quality measures based on staff input, performance, and opportunities to reduce inequities in 2023



Client Access and Experience

7. Client Access

- By December 31, 2023, the Agency will reduce the time to third next available appointment by x percentage at all sites
    - Rationale: Also an Agency strategic goal KPI, this measure will ensure we have sufficient access for clients and are measuring equity in access.

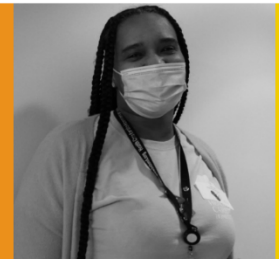
8. Client Experience

- By December 31, 2023, the Agency will identify, measure, and improve upon one area of Client Experience based on feedback, and choose a goal that aims to reduce disparities
    - Rationale: Our current feedback process allows us to see and act on issues in real-time. This flexibility will help to identify an area for concern and address it in a timely manner.

Care Management

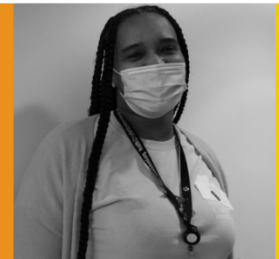
9. Care Management

- By December 31, 2023, 75% of clients enrolled in care management will have a documented care plan that is offered to clients at every visit.
  - Behavioral Health – depression
  - Case Management – housing instability, low/no income
  - Nursing – Diabetes, hypertension, medication adherence, HIV, Hepatitis C
    - Rationale: Individuals diagnosed with or experiencing these conditions may benefit from extra focus and assistance offered through care management. Focusing on care management ensures that the Agency working to improve health with clients as partners in their care. Care Management is associated with improved health outcomes, care coordination, and reduced hospitalizations.



Additional Goals and KPI

1. Population Health and Health Equity will also lead work on the PI plan and have goals that complement the PI goals. These are still in discussion, but include:
   - Health literacy (equity)
   - Healthy at every size framework (equity)
   - SDH (equity)
   - Immunizations (pop health)
   - Nursing care management (pop health)
   - Preventive screening campaigns (pop health)
2. New KPI may also be added to the dashboard to include suicide screening and follow-up plan and NCQA measures



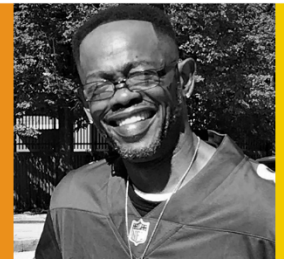
Announcements

First Fridays

- Every first Friday Salad potluck in 3rd floor large conference room
- Bring/sign up for 1-2 ingredients to share and enjoy a salad lunch!
  - Already washed/cut greens
  - Proteins: nuts, cheese, eggs
  - Carbs: chips, cookies, fruit

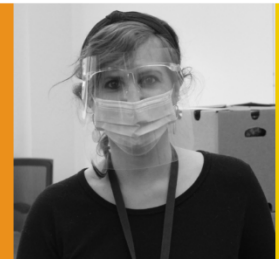
Medstatix Surveys Ramping up

- Began pilot in July with 5 providers being surveyed, 12 in August
- 22 providers being surveyed this month
- 38-40 providers being surveyed next month onwards
- Monthly report cards sent to Agency Ops after the 10th of the month



Innovation Celebration Event

Moving from September 29th in-service day to October all-staff



PI Champions biweekly meeting

Other medical staff invited to participate!

Virtual meetings 1st and 3rd Thursdays from 2:45-3:30

Questions?