April 2024 PI Informational Meeting

Marie Stelmack, QI Specialist

Lisa Hoffmann, Director of QI

4/17/2024

Agenda

1. Icebreaker

2. PI data snapshot

3. PI updates

4. This month's PI tool: sustainability plan

5. Questions: pop them in the chat or voice them as we go!

Good morning!

It's Arab-American Heritage Month!

Did you know:

- Around 2 million Americans of Arab heritage live in the United States

- The city with the largest percentage of Arab-American people in the US is... Dearborn, Michigan

- Ice cream cones were invented by an Arab-American

- Steve Jobs, Shakira, and Rashida Tlaib (the first Palestinian-American in Congress) are all of Arab descent

PI Measures

Key
3+ Improvement
1-2+ improvement
Reduction

Disease Management	Feb	Mar	2024 Goal
Colorectal Cancer Screening	30%	30%	40%
Hypertension Disparities	Black M: 62% Black F: 54% White M: 74% White F: 65% Latino M: 70% Latina F: 63%	Black M: 63% Black F: 55% White M: 71% White F: 68% Latino M: 63% Latina F: 64%	Less than 5% disparity
Childhood Vaccinations	2%	0%	18%
PHQ-9 Questions 1 and 6	Q1: 3.2%** Q6: 3.7%**	Q1: 1.8% Q6: 2.0%	5%
Diabetes and A1c Control (inverse measure)	Black M: 27% Black F: 33% White M: 33% White F: 27% Latino M: 45% Latina F: 32%	Black M: 28% Black F: 31% White M: 36% White F: 28% Latino M: 49% Latina F: 34%	27% (reduce disparity by 5% for Hispanic/Latinx clients)

Disease Management	Feb	Mar	2024 Goal
Clients receiving PrEP	23 clients	23 clients	36 clients
Prenatal Early Entry to Care	68%	**52%**	70%
Appointment Access	Med Urgent: 85% Med Routine: 85% BH Urgent: n/a*** BH Routine: n/a*** Dental Urgent: 66% Dental Routine: 100%	Med Urgent: 73% Med Routine: 86% BH Urgent: 77% BH Routine: 77% Dental Urgent: 66% Dental Routine: 100%	Med Urgent: 71% Med Routine: 100% BH Urgent: 80% BH Routine: 80% Dental Urgent: 71% Dental Routine: 100%
Hospital Readmission Rate	18.7%	**15%**	<20%
Closing the Referral Loop	24%	24%	40%
Current Medication Documentation	85%	85%	90%

2024 PI Plan

2 PDSAs in!

1

Reduce the **disparity in hypertension control** rates (less than 140/90 mmHg) among Black, White, and Hispanic/Latino/a women and men by 5%.

Dates: Jan – June

1 PDSA in!

2

Double the number of clients receiving **PrEP**.

Dates: Jan - June

1 PDSA in!

3

Ensure at least 18% of **children** will have all combo 10 **vaccinations** by age 2.

Dates: March - Aug

RCA done!

4

Reduce hospital **readmission rate** (hospitalized within 30 days) by 5%.

Dates: March - Aug

Kick off tomorrow!

5

For clients 12+, improve aggregate score by 5% on the **PHQ-9** for Question 1: little interest or pleasure in doing things and Question 6: feeling bad about yourself; or that you are a failure or have let yourself or family down.

Dates: April - Sept

2024 PI Plan continued

We are here!

RCA done!

6

Improve percent of adults aged 45–75 years who had appropriate **screening for colorectal cancer** to 40%.

Dates: April - Sept

7

Improve overall score (aggregate of all sites and departments) by 5% that clients reported an **ability to access an appointment when needed.**

Dates: May - Oct

8

Reduce the percent of clients aged 18–75 years with **diabetes** who had hemoglobin A1c (HbA1c) greater than 9.0 percent to 30% and **reduce the racial/ethnic gap** by 5% for Hispanic/Latino clients.

Dates: June - Nov

9

Monitor and conduct at least one PI project working to improve care coordination based on KPI data (**closing the loop for referrals or current medication documentation**).

Dates: June – Nov

10

Ensure at least 70% of pregnant clients have **access to and initiate care in the first trimester of pregnancy.**

Dates: July - Dec
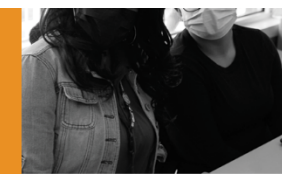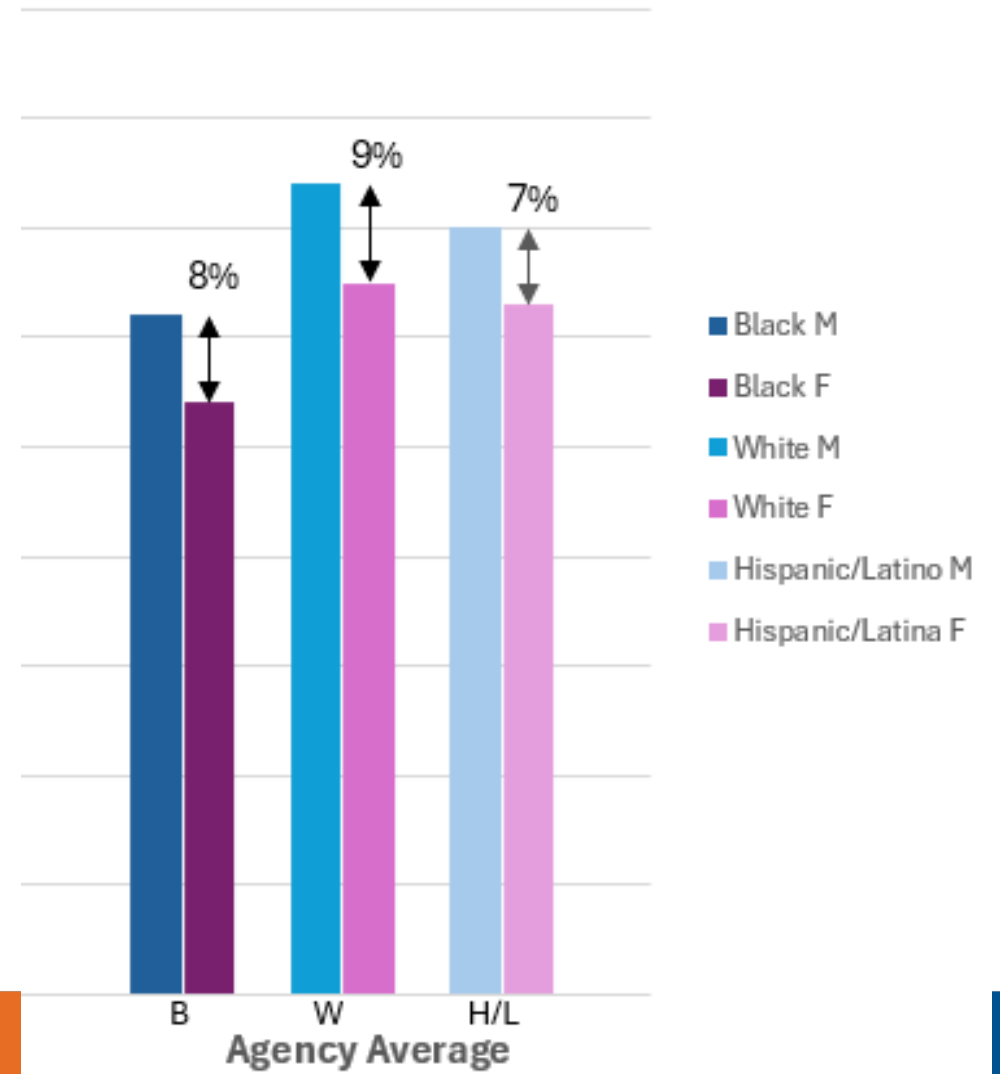
PI Subcommittee Updates

Hypertension Disparity

Reduce the **disparity in hypertension control rates** (less than 140/90 mmHg) among Black, White, and Hispanic/Latino/a women and men by 5%.

Subcommittee:

Heather Douglas, Iris Leviner, Catherine Fowler, Elizabeth Zurek, Kyler Young, Tracy Russell
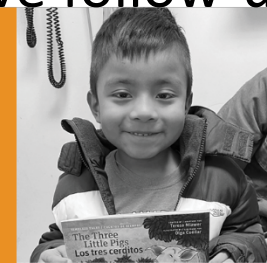
The first PDSA: visit follow-up sheets

- Tested a "follow up sheet" – physical reminder for clients' post-nurse visit for visual reminder and support along the check out process
  - Week-long test with subcommittee nurse, lab tech, and check out staff
  - Nurse team collaborated to make most comprehensive and straightforward form
  - In English and Spanish
- Streamlined pharmacy section with staff input
- Feedback from staff, including providers and unit clerks, was positive: may be rolling out similar sheets to other departments
- No measurable effect on BPs of clients who received yet: more to come as clients have follow-up visits

The second PDSA: care team scorecards

- **Care team scorecards**: each care team can now see their individual performance on gender and racial disparities

- Empowered care teams to create their own PDSAs to address disparities their team is seeing

- Will provide scorecards monthly for three months, until July

BP Control Rates by Race, Ethnicity, and Sex at Birth (Percent under 140/90 at last visit)					
	Green	**Purple**	**Steel**	**Yellow**	**HCH Total**
Hypertension Disparities					
Black M:	**67%** (68/102)	**65%** (101/155)	**64%** (68/106)	**59%** (114/195)	62%
Black F:	**46%** (25/55)	**61%** (52/86)	**55%** (27/49)	**59%** (54/91)	54%
Gender Disparity:	**21%**	**4%**	**9%**	**0%**	**8%**
White M:	**83%** (15/18)	**69%** (18/26)	**65%** (11/17)	**76%** (25/33)	74%
White F:	**63%** (5/8)	**94%** (17/18)	**50%** (4/8)	**88%** (15/17)	65%
Gender Disparity:	**20%**	**-25%**	**15%**	**-12%**	**9%**
Hispanic/Latino M:	**76%** (25/33)	**76%** (28/37)	**71%** (20/28)	**64%** (23/36)	70%
Hispanic/Latina F:	**67%** (38/57)	**71%** (65/92)	**77%** (33/43)	**67%** (55/82)	63%
Gender Disparity:	**9%**	**5%**	**-6%**	**-3%**	**7%**

Gender disparities for each race (% difference between men/women): *negative numbers* mean women are better controlled than men

Scorecard

BP Control Rates by Race, Ethnicity and Sex at Birth (% under 140/90 at last visit)
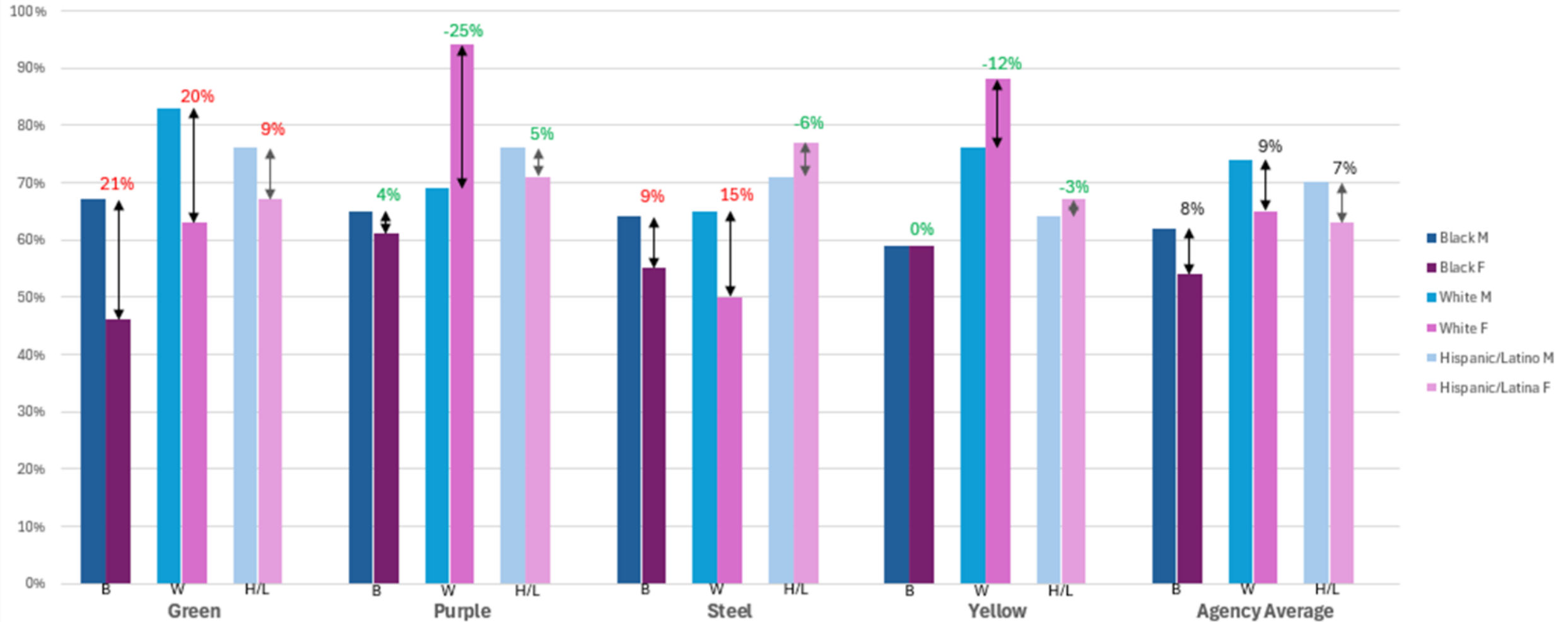
What's next for HTN disparities

- Following care teams through their PDSAs, from idea building to implementation to evaluation
  - Huge kudos to medical for being so receptive and engaged!
- HTN group at Fallsway starts **today, 4/17** and runs for 8 weeks
  - Please refer clients to join if you think they'd benefit: they can come for one week or all 8

PrEP for HIV

Double the number of clients receiving PrEP.

Subcommittee: Rajen Bajracharya, Meredith Johnston, Nicole Maffia, Catherine Fowler, Julia Felton, Katharine Billipp, Tyler Gray
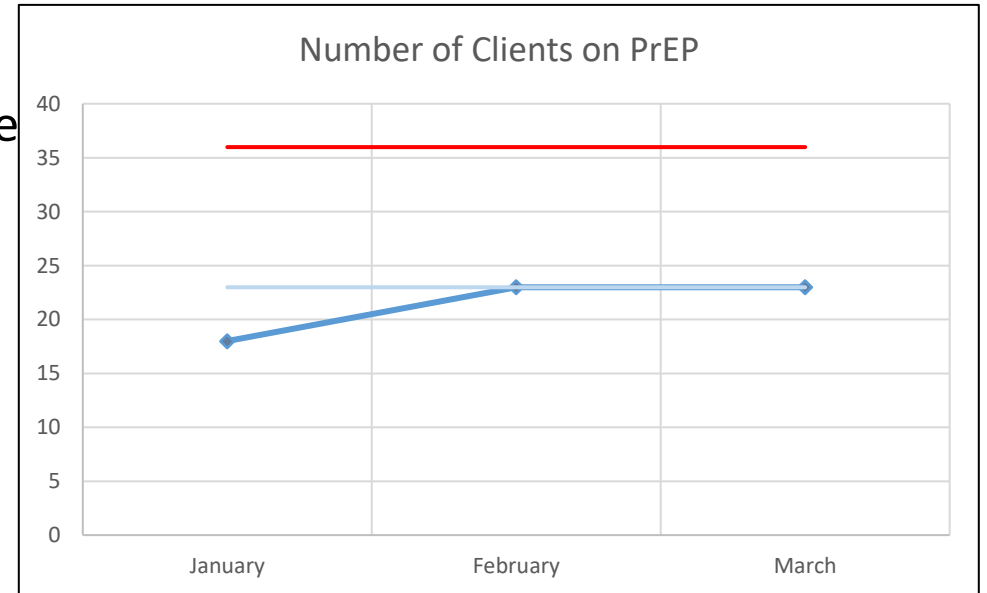
The first PDSA: a unified way of documenting

- Our PrEP data is currently messy because it relies on prescription fill data

- We are now asking providers to **use the pre-exposure prophylaxis diagnosis code** to document clients for whom they prescribe PrEP
  - Please also remove this diagnosis code if you and the client stop PrEP

- Tyler Gray has also created an **order set** for PrEP start and refill to make the process easy
  - It also puts the diagnosis code in for you - no need for an extra step!
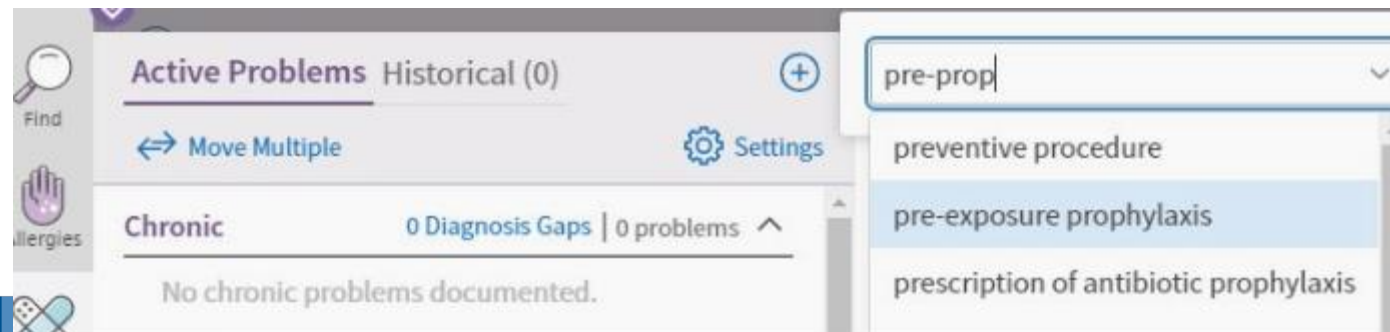
What's next for PrEP

- Continuing to reinforce proper documentation and order sets throughout the month and beyond

- Brainstorming ways to involve clients in this work
  - Front porch campaign?
  - Involvement with queer and trans communities in Baltimore City?
  - Highlight of a client or two on PrEP?

Childhood Vaccinations (Combo 10)

Childhood Immunizations

Vaccine excursion causing vaccine stock loss
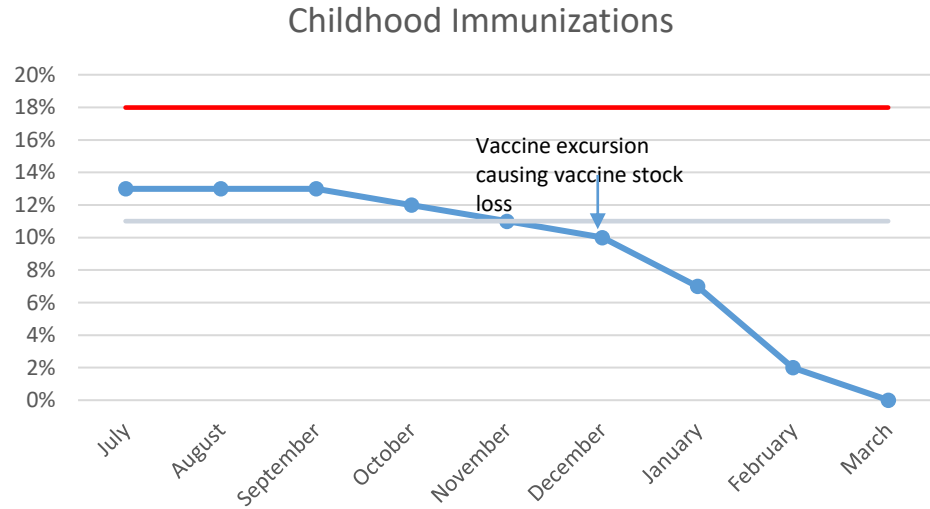
Ensure at least 18% of **children** will have all combo 10 **vaccinations** by age 2.

Subcommittee: Nicole Maffia, Keri Rojas, Natalia Suc, Ash Lane

The first PDSA: direct outreach

- One of the barriers identified in our RCA was appointment availability

- This has been alleviated by having dedicated vaccine clinic slots

- As our first PDSA, Ash, Natalia, and Keri from pediatrics are currently:
  - Performing **direct outreach** from the Azara vaccination registry to clients 16-24 months of age due for vaccines
  - **Flagging charts** with all vaccines needed prior to well visits so that needed vaccines are not missed

What's next for childhood immunizations

- Validating data to ensure all the work peds is doing is being reflected

- Ideas for involving clients in this work
  - Listening to vaccine-hesitant parents and recording their objections to appropriately target educational material?
  - "Parent to parent" advice?
  - Gathering client testimony, particularly from immigrant and Spanish-speaking parents, about their experiences getting vaccines / well-child care in the US vs their country of origin?

Hospital Readmission

Hospital Readmissions

(Chart showing Hospital Readmissions, Average, and Goal lines from February to March. Y-axis ranges from 0.00% to 25.00%. Hospital Readmissions line starts at approximately 18.5% in February and decreases to approximately 15% in March. Average line is at approximately 17%. Goal line is at 20%.)
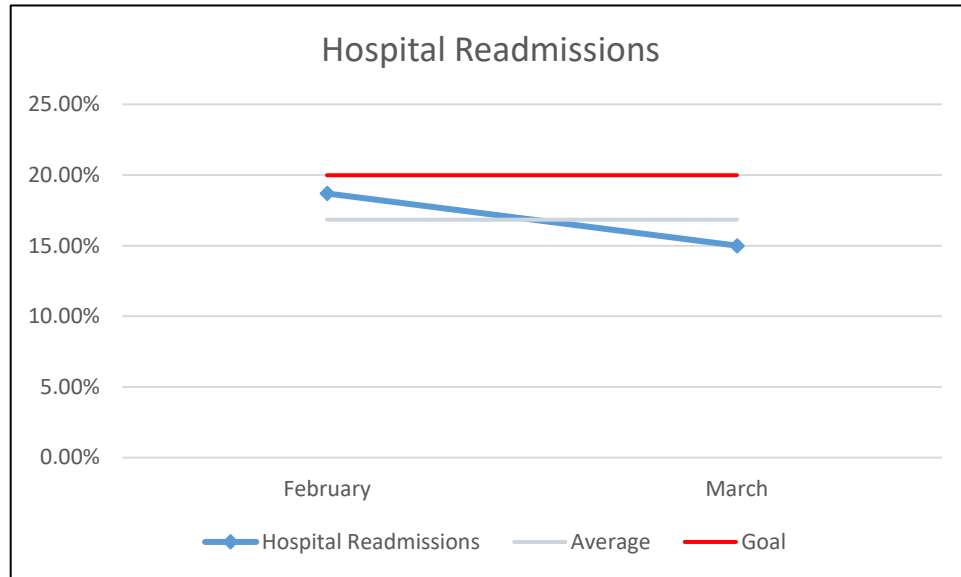
Reduce hospital **readmission rate** (hospitalized within 30 days of discharge) by 5%.

Kickoff Meeting:

- Subcommittee: Wynona China, Jimmy Miller, Julie Rich, Tyler Gray, Heather Douglas, Lillian Amaya

- Included staff from medical and health IT

- Decided to focus primarily on medical – CRISP is hard to parse with co-occurring conditions and reason for hospitalization, but more effective to focus on one line of service

Hospital Readmission RCA

Cause: Cause: Appointment availability: not just after admission but also for routine care: clients go back to ED if they can't get an appt Contributor(s): -Not enough providers Contributor(s): -

Cause: Cause: Lack of cohesive primary care "connectedness" overall – shifting PCPs, clients feel adrift

Cause: Challenges with med adherence, lack of client understanding of medication, receiving meds…

Cause: - transportation, hospitals likely aren't communicating to clients that they won't be charged, meds covered, labs covered – clients worried they will be charged

Cause: Clients experiencing homelessness – hospitals think that we are a shelter (hospitals dropping clients at our doors at all hours), challenges with information sharing – hospital doesn't share and times that client can't relay information (losing information or not able to verbally recall)

Cause: Perception, particularly among uninsured clients, that they may be turned away in the primary care setting: know they will not be turned away in the ER Contributor(s): access issue

Cause: *Building relationships* with hospitals and other entities: need relationships where these places can call us proactively (and want to do so) – we already have a relationship with Mercy we can look at; WB is in a hospital already, County right next to Franklin Square

Cause: inactive phones, little way to contact: we need more than just a phone number, what does this entail?

Cause: Lack of communication with hospitals: no transit care at hospitals to help assist with f/u, no ability to contact prior to discharge for discharge planning – for MDPCP have done hospital visits before
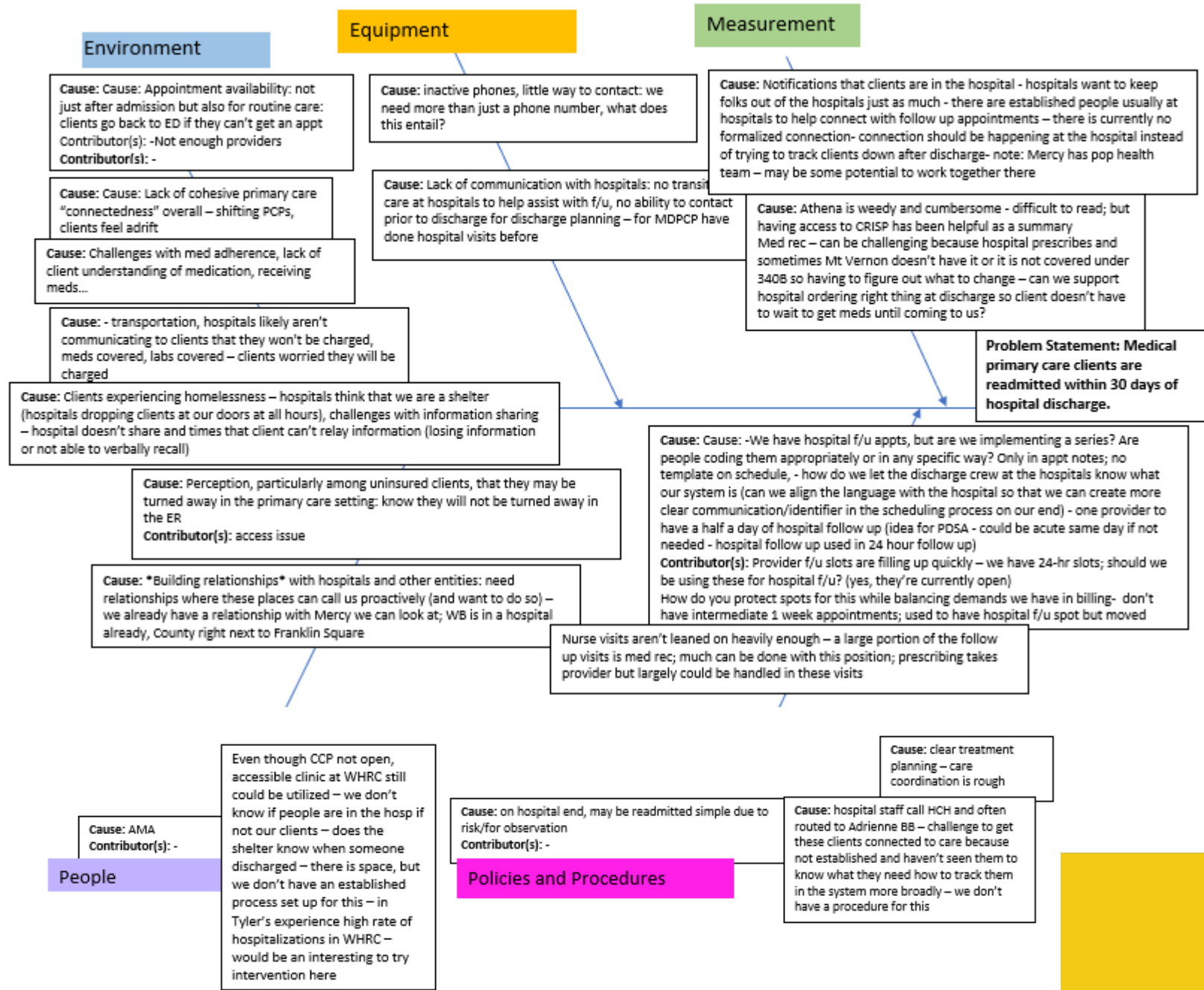
Cause: Notifications that clients are in the hospital - hospitals want to keep folks out of the hospitals just as much - there are established people usually at hospitals to help connect with follow up appointments – there is currently no formalized connection- connection should be happening at the hospital instead of trying to track clients down after discharge- note: Mercy has pop health team – may be some potential to work together there

Cause: Athena is weedy and cumbersome - difficult to read; but having access to CRISP has been helpful as a summary Med rec – can be challenging because hospital prescribes and sometimes Mt Vernon doesn't have it or it is not covered under 340B so having to figure out what to change – can we support hospital ordering right thing at discharge so client doesn't have to wait to get meds until coming to us?

Problem Statement: Medical primary care clients are readmitted within 30 days of hospital discharge.

Cause: Cause: -We have hospital f/u appts, but are we implementing a series? Are people coding them appropriately or in any specific way? Only in appt notes; no template on schedule, - how do we let the discharge crew at the hospitals know what our system is (can we align the language with the hospital so that we can create more clear communication/identifier in the scheduling process on our end) - one provider to have a half a day of hospital follow up (idea for PDSA - could be acute same day if not needed - hospital follow up used in 24 hour follow up) Contributor(s): Provider f/u slots are filling up quickly – we have 24-hr slots; should we be using these for hospital f/u? (yes, they're currently open) How do you protect spots for this while balancing demands we have in billing- don't have intermediate 1 week appointments; used to have hospital f/u spot but moved

Nurse visits aren't leaned on heavily enough – a large portion of the follow up visits is med rec; much can be done with this position; prescribing takes provider but largely could be handled in these visits

Even though CCP not open, accessible clinic at WHRC still could be utilized – we don't know if people are in the hosp if not our clients – does the shelter know when someone discharged – there is space, but we don't have an established process set up for this – in Tyler's experience high rate of hospitalizations in WHRC – would be an interesting to try intervention here

Cause: AMA Contributor(s): -

Cause: on hospital end, may be readmitted simple due to risk/for observation Contributor(s): -

Cause: clear treatment planning – care coordination is rough

Cause: hospital staff call HCH and often routed to Adrienne BB – challenge to get these clients connected to care because not established and haven't seen them to know what they need how to track them in the system more broadly – we don't have a procedure for this

What's next for hospital readmission

- Met with Mercy to discuss their discharge planning and transitional care processes
  - Discussing streamlining link points between Mercy and HCH

- Ways to involve clients in our work for this measure
 - Involve frequent hospital utilizers?
  - Open to any input!

Colorectal Cancer Screening

Increase the percentage of clients who have **received colorectal cancer screening** to 40%.

Subcommittee: Pandora Bruton, Katharine Billipp, Elizabeth Zurek, Tracy Russell, Kim Taylor

Enlisting the care team triad at West Baltimore as part of the subcommittee

- We're trying to trial small tests of change with just this care team triad

CRC Screening, January 2023-March 2024
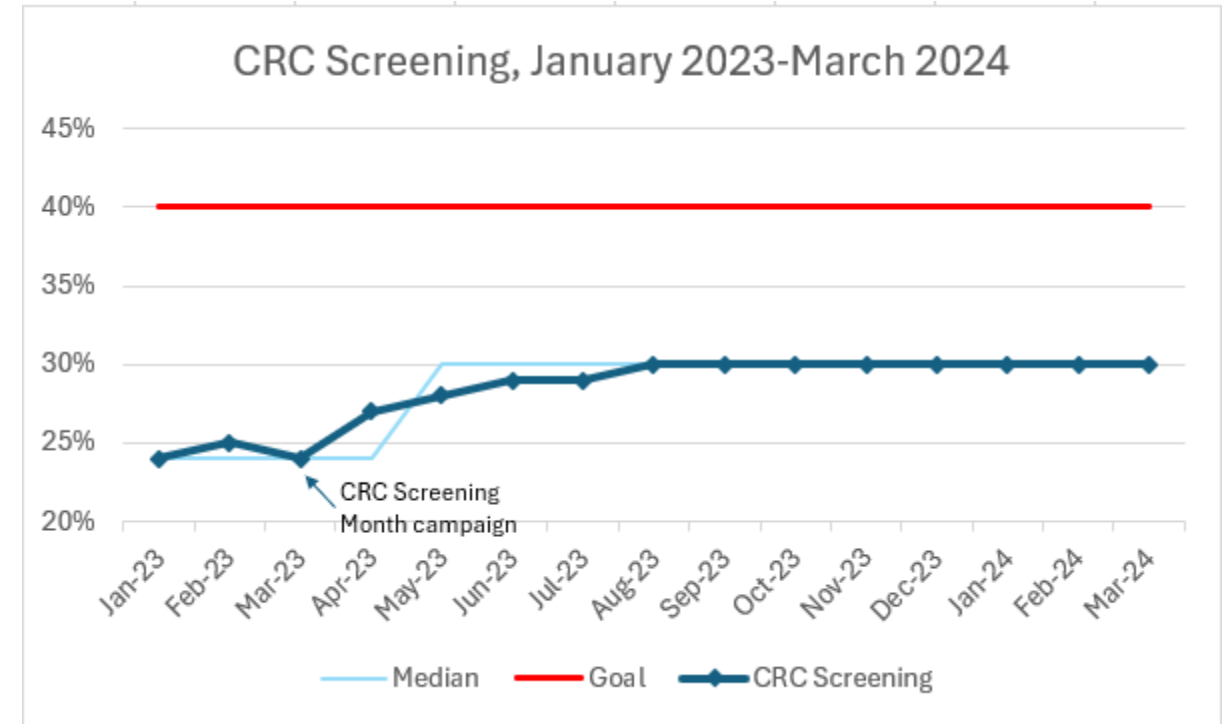
Policies and Procedures

People and Resources

Continuity of care at HCH: clients fall out of care easily, leading to missed FITs, not-followed-up colo referrals, ...

Client may not be aware of new testing guidelines, may not think it's applicable to them

Providers and clts may not be aware of available resources to help complete screening eg medstar, UMMS transportation and navigation

Larger Systemic Issues

Access to colos: undocumented clients are often sent to Schreiber, who prioritizes based on urgency

Staff turnover: clients slipping thru cracks

Fear of the process: clients may have trauma or not be willing to be anesthetized for other reasons

Bathroom access: colo prep is a long process, clt may not be willing to prep using our restrooms/shower

Lab issues: WB has a lab on-site that is not connected with HCH, so FITs get lost if no req with them

Name/DOB forgotten on FIT, causing kit to be tossed rather than processed

FIT kits being given out didn't have order sheets for awhile, so they just got thrown away

Staff/LabCorp not offering mail-in option, so staff think they need to go on-site to hand in kit

No colo records from prior to athena migration

Process

Measurement

Environment

What's next for CRC screening

- Next meeting: designing our first PDSA

- Ways to involve clients in this work
  - Front porch campaign(s)?
  - Client testimonies about what their CRC screening was like (attempt to reduce fear)?

PI tool: MOCHA / sustainability plan

- Congratulations! Your PDSA went great

- But improvement work, even if the initial test was time-limited, should be carried on and forward if it works

- Enter the **sustainability plan**
  - Hashes out who will own the work going forward, how you will monitor performance, and how to deal with problems that may crop up

IHI's Sustainability Planning Worksheet
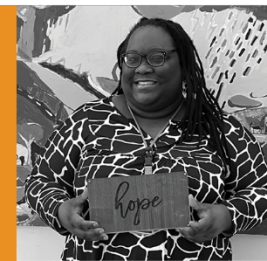
This worksheet offers five areas (which conveniently spell MOCHA) for your team to consider when planning for the long-term sustainability of your improvement effort. Use the questions below to help you plan for success.

Areas for Consideration	Notes
Measurement 1. What will we continue to measure? 2. What will we stop measuring? 3. What will we do if we see trouble in the data?	1. - 2. - 3. -

Ownership
1. Who will own the new standard work?
    a. Are they engaged and onboard with the improvement?
	1. -
	
	    a. -

Communication and Training 1. How will we communicate about the change and who will be the messengers? 2. How will we support individuals in the new "right way"? 3. What type of training will we use?	1. - 2. - 3. -

Hardwiring the Change
1. How will we make it hard to do the wrong thing and easy to do the right thing?
    a. Can we reduce reliance on human memory?
2. How will we standardize?
    a. Do we need new documentation and resources?
3. How will we ensure backup if staff who normally complete the task leave or are absent?
	1. -
	
	    a. -
	2. -
	
	    a. -

Assessment or Workload
1. Are our changes increasing the overall workload to the system?
    a. If so, how can we decrease the workload?
    b. If not, how will we communicate about what is changing and not changing?
	1. -
	
	    a. -
	    b. -

Resources

Lately, staff have been reaching out to ask for the PI templates we use – this:

1. Makes us so happy – you go, all you PI champions!
2. Think that it is a good idea to give a reminder that these are stored on our PI Communal OneNote page, linked here:

    PI Communal OneNote: Templates Tab
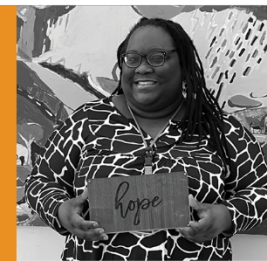
Thank you, and happy Wednesday!

For any questions, email:

mstelmack@hchmd.org

lhoffmann@hchmd.org