Performance Improvement

Monthly Meeting

August 25th, 2021

Overview

1. Wake-up Trivia

2. Population Health Updates

3. Updates: 2021 PI Goals

4. PI updates: Client Experience Survey, Funding update, IHI conference

5. Spotlight on a PI tool → Conducting a survey

Trivia Questions!

Q: What type of music has been shown to help plants grow better and faster?

A: Classical

Q: Which mammal doesn't have vocal cords?

A: The Giraffe

Q: Which bone are babies born without?

A: The knee cap

Q: What planets literally rain diamonds?

A: Saturn and Jupiter

Q: In the state of Georgia, it's illegal to eat what with a fork?

A: Fried chicken

Pop Health Updates

Structured Nurse Diabetes Education

- Developing Health Tracker with Comms

- Two folders: one for prediabetes (2 visits), one for diabetes (6 visits)
  - Folders to be reviewed by RNs for input
  - Plan to pilot October through Dec
  - Implement Jan 2022

Additional Patient Teaching Tools

- Blood pressure log one-pager (with Comms)

- Medication refill instructional one-pager (with Comms)

- Age-based healthy nutrition/pre-diabetes education for Peds

Med Refill one-pager

HOW TO GET A MEDICATION REFILL

Q: What is a medication refill?
A: Refills let the pharmacy give you more medication if you're running low.

Q: Where can I find how many refills I have left?
A: See the back of this page for instructions. Schedule a visit with your provider when you have 1 refill left.

Q: When should I tell the pharmacy I need a refill?
A: When you have 3-5 days of medications left. Do not wait until you are out of medication.
It is dangerous to miss more than 1 dose of medicine.

If you are out of medication, call the pharmacy or go to the pharmacy for a refill right away.

Q: How can I refill my medication(s) when I have refills left?
A:

Option 1: Call the pharmacy. Mt Vernon Pharmacy has text option: **410-862-2698**
1. Find the prescription number on the pill bottle
2. Call the pharmacy phone number on the pill bottle
3. Follow the message instructions or **pick option 3** to talk to someone.

Option 2: Go to the pharmacy in person to ask for medication refills.
- You may have to wait **2 hours or longer** to pick up your medications.

Q: What should I do if I don't have any refills left?
A: Contact us as soon as possible:

- If it's time to see your medical provider, call **410-837-5533** and pick **option 1** to get scheduled.
  - Your provider will send a new prescription to the pharmacy during your visit.
  - They will order enough refills to last until your next visit.
- If it's not time to see your medical provider but you need more medication, you can:
  - Call the medical triage line at **443-703-1295** to request refills.
  - Come in to Health Care for the Homeless for a same-day visit with a medical provider.
  - Call the pharmacy and they will contact your provider.

HOW TO READ A MEDICINE LABEL

Ask for EASY-OPEN bottle if needed!

MT. VERNON PHARMACY AT FALLSWAY
421 Fallsway, Baltimore, MD 21202   410-962-1100
RX # 0060023-08291 Refills left: 0,   03/15/20
                                        01/18/20

JANE SMITH
456 Main Street, Anytown, US

TAKE TWO TABLETS BY MOUTH TWICE DAILY

Drug 100mg tablets

120

JOHN SMITH, NP
DISCARD AFTER: 06/23/20

- Pharmacy name, address and phone number
- Date your prescription was filled at pharmacy / Date your prescription was written
- Number of refills you still have after this bottle
- Prescription number
- Your information
- How to take medication
- Name, strength and quantity of medication
- Prescriber and provider's name
- Do not use medication from this bottle after this date
- Number of pills in the bottle
- Scan this QR code with your smart phone! Videos and info about this medication are in English and Spanish.

Cancer Screening and PrEP clinic

PI Goal for Cancer Screening:

Increase annual breast and cervical cancer screening rates by 5% by mid 2022

-Reduce structural barriers/reminder systems (Athena improved)

-Increase supporting activities at all 3 clinic sites

Establish PrEP clinic:

-Meeting with outside agencies with established PrEP programs

-Create formal PrEP/STI clinic (owned by MAT nursing, supported by PH)

-Increase number of clients/streamline workflow surrounding PrEP

PI Goal Updates

- Childhood Immunizations: Erick
  - Phone Access: Ziad
  - Referrals: Mona + Tracy
- Depression Remission: Jan + Ziad
  - Diabetes: Laura
  - SDH: Tracy

Childhood Immunization

Childhood immunization: By December 31, 2021, 50% of children will have completed all the recommended vaccines by their second birthday.

Childhood Immunization	
Facilitator	**Ziad Amer/Tracy Russell**
Champion	**Iris Leviner**
HIT	**Maia Gibbons**
Members	Erick Torres
	Pam Ford
	Brittany Rice
	Jess Friedman
	Max Romano
	Chris Mehdizadeh

Childhood Immunization

No accurate data available currently
(Azara not accurate, will hopefully be obtain to show this data with Athena)

Since we last met…

- Peds RN worked through the registry of peds clients under age 2
  - Performed chart audits to see who is due for vaccines
  - Made at least 1 call attempt to all clients due for vaccines
    - Began scheduling catch-up appointments for clients needing vaccines
  - Had CDC one-pager of Peds vaccine schedule translated into Spanish
    - Using tool to educate parents on recommended vaccine schedule (include photo of tool)
    - Table of findings
- Contacted VFC to see if vaccines could be ordered sooner to reduce likelihood of being without vaccines

Peds Vaccine Outreach Efforts

Total Count	Key	
12	8	Patient completed: Caught up with vaccines
	4	Patient completed: Unable to act further → moved out of state
18	Patient has upcoming appointment to update vaccines	
9	Unable to reach patient	
LAST UPDATED: 08/19/2021		

CDC one-pager tool for parents

Immunizations and Developmental Milestones for Your Child from Birth Through 6 Years Old

Child's Name _____   Birth Date _____

		Birth	1 MONTH	2 MONTHS	4 MONTHS	6 MONTHS
Recommended Immunizations	Hepatitis B	○ HepB	○ HepB[1]			○ HepB
	Rotavirus			○ RV	○ RV	○ RV
	Diphtheria, Tetanus, Pertussis			○ DTaP	○ DTaP	○ DTaP
	Haemophilus influenzae type b			○ Hib	○ Hib	○ Hib
	Pneumococcal			○ PCV	○ PCV	○ PCV
	Inactivated Poliovirus			○ IPV	○ IPV	○ IPV
	Influenza (Flu)					○ **Influenza**, first dose[2] ○ second dose
Milestones*	Milestones should be achieved by the age indicated. Talk to your child's doctor about age-appropriate milestones if your child was born prematurely.	○ Recognizes caregiver's voice ○ Turns head toward breast or bottle ○ Communicates through body language, fussing or crying, alert and engaged ○ Startles to loud sounds	○ Starts to smile ○ Raises head when on tummy ○ Calms down when rocked, cradled or sung to ○ Pays attention to faces	○ Begins to smile at people ○ Coos, makes gurgling sounds ○ Begins to follow things with eyes ○ Can hold head up	○ Babbles with expression ○ Likes to play with people ○ Reaches for toy with one hand ○ Brings hands to mouth ○ Responds to affection ○ Holds head steady, unsupported	○ Knows familiar faces ○ Responds to own name ○ Brings things to mouth ○ Rolls over in both directions ○ Strings vowels together when babbling ("ah", "eh", "oh")
Growth	At each well child visit, enter date, length, weight, and percentile information to keep track of your child's progress.	WEIGHT / PERCENTILE ___ LENGTH / PERCENTILE ___ HEAD CIRCUMFERENCE ___	WEIGHT / PERCENTILE ___ LENGTH / PERCENTILE ___ HEAD CIRCUMFERENCE ___	WEIGHT / PERCENTILE ___ LENGTH / PERCENTILE ___ HEAD CIRCUMFERENCE ___	WEIGHT / PERCENTILE ___ LENGTH / PERCENTILE ___ HEAD CIRCUMFERENCE ___	WEIGHT / PERCENTILE ___ LENGTH / PERCENTILE ___ HEAD CIRCUMFERENCE ___

Shaded boxes indicate the vaccine can be given during shown age range.

| VISIT DATE	VISIT DATE	VISIT DATE	VISIT DATE	VISIT DATE

Next Steps

- RN to see peds clients at catch-up vaccine appointments

- Begin pulling peds vaccine reports from Athena

- Continue to monitor vaccine inventory to ensure lapses in stocked vaccines are minimized

- Assess helpfulness of utilizing one-pager tool with parents

- Hopefully incorporate Peds this year into the Flu & Coat drive event

Phone Access

All Workgroups - % of Phone Calls answered by a person

Average = 47%

69%
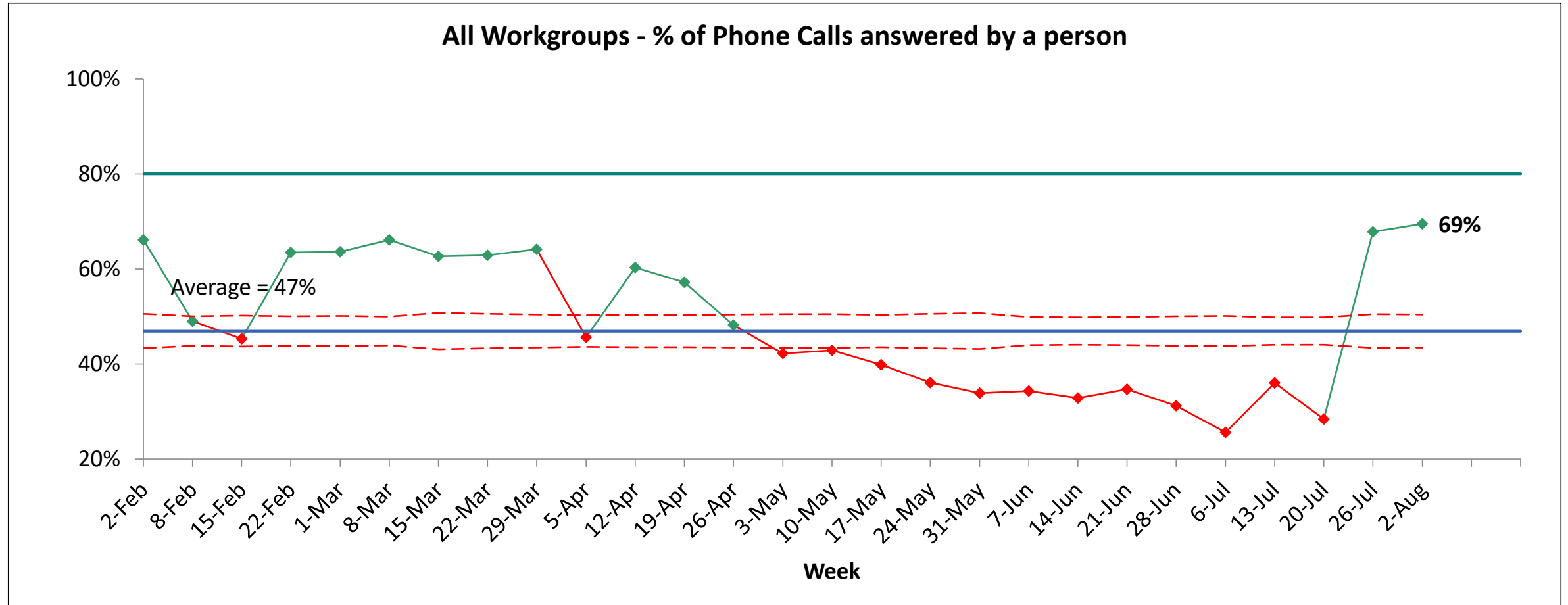
Updates

1. Mitel Call Center:
   - We have held 3 demo sessions on the Mitel Call Center software capabilities
     - Integration into Athena?
   - Upgrade this software to support the increase in call center staffing and model
2. Staffing:
   - Increase in staff by 4 people
     - 1 coordinator for the call center department
3. Development of SoPs and Trainings for the new Call Center
   - Outline the responsibilities and workflows of the call center

Referrals Tracking

40% of referrals will be completed (specialist/radiology appointment completed and note scanned into EMR) within 3 months of referral initiation

Baseline Data: 7%

January Launch	Referrals Tracking	
	Facilitator	**Tolu Thomas/Tracy Russell**
	Champion	**Mona Hadley**
	HIT	**Wynona China**
	Members	Greg Myers
		Wanda Hopkins
		Max Romano
		Angela Robinson
		Lisa Hoffman
		Margaret Flanagan

Referral Completion by Month
(April 2020 - July 2021)

Average = 34%

14%
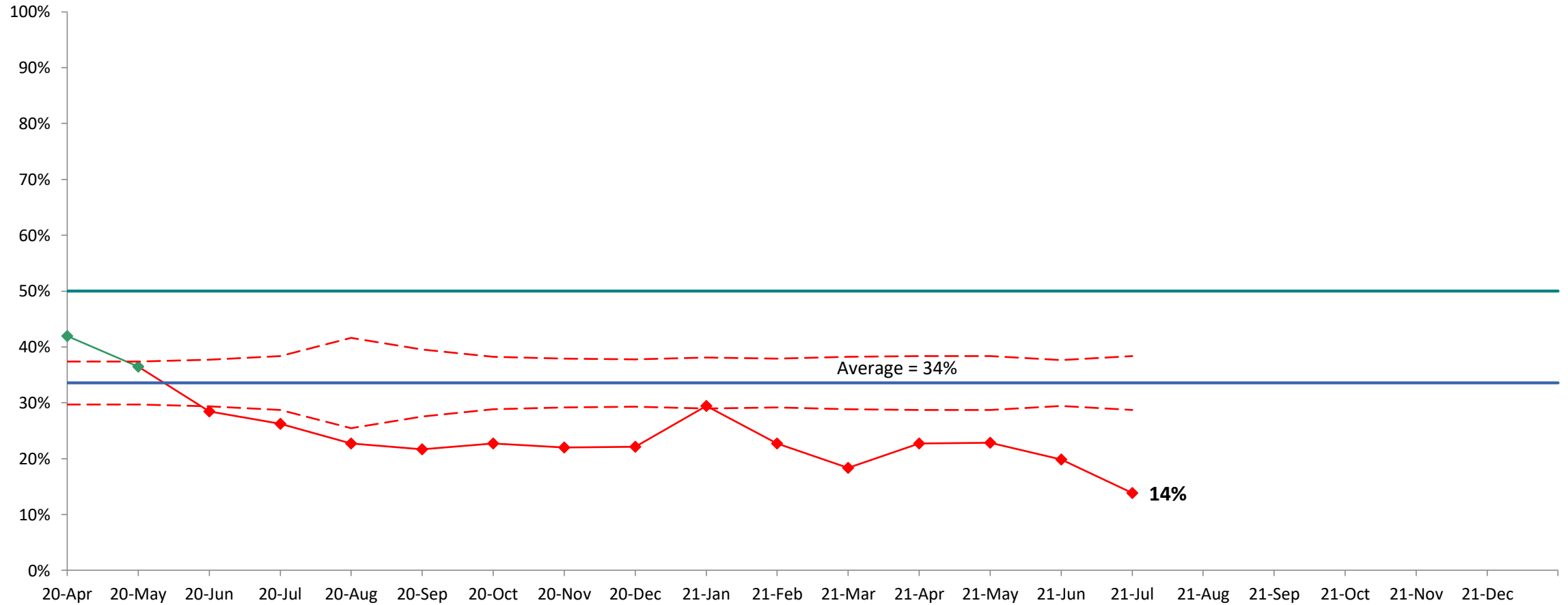
120/868

Since we last met…

- Pilot expanded to purple team (7/19)

- TAP workflow draft

- Athena migration happened – put pilot on temporary hold

Next Steps

- Training CSRs on referrals workflow in Athena (in the next 1-2 weeks)

- Expand pilot to additional care teams

Other Referrals-related news:

- Ophthalmology residents will return to HCH on 9/10/21

- We have begun referring clients needing prenatal services to Metropolitan OB @ MMC
  - Insured & uninsured
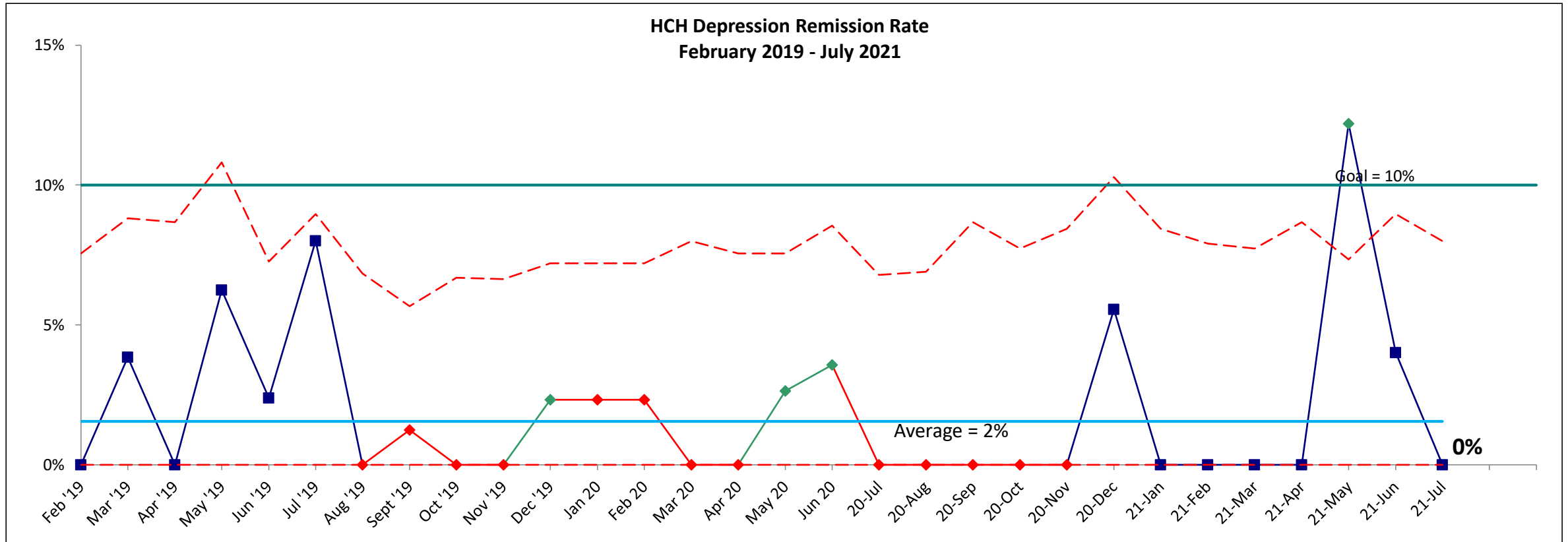
Depression Remission

A. Remission:

10% of adults diagnosed with major depression or dysthymia who scored positively on an initial PHQ9 (>9) will demonstrate remission *between 10-14 months*

Baseline Data: 2.3% (2020 anticipated UDS)

February Launch	Depression Remission	
	Facilitator	Ziad Amer
	Champion	Jan Ferdous
	HIT	**Maia Gibbons**
	Members	Arianne Jennings
		Karen Ross-Taylor
		Meredith Johnston
		Tyler Gray - consult

Depression Remission

HCH Depression Remission Rate
February 2019 - July 2021

Goal = 10%

Average = 2%

0%

Remission:

10% of adults diagnosed with major depression or dysthymia who scored positively on an initial PHQ9 (>9) will demonstrate remission *between 10-14 months*

Since we last met…

- Supervision pilot continued
  - Few sessions conducted so far due to difficulties coordinating around Athena transition
  - Feedback: going well so far! Discussing clients with depression during supervision helps to do the following:
    - provide some structure to supervision
    - keep the work of depression remission on the radar of BHTs
  - BHTs continuing to receive monthly reports
  - Ensuring all providers know how to access the PHQ-9 in Athena
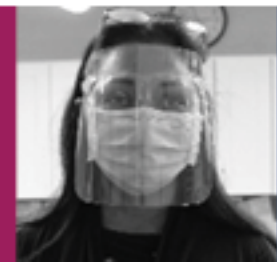
Next Steps

- Exploring PHQ-9 in Athena
  - Can providers see most recent scores, due dates, past dates etc.
  - Continuing to build supervision lists
    - Can Athena support client lists that are in need of a PHQ-9 and/or are seeing no progress on their depression

Diabetes

A. By December 2021, the proportion of clients across the Agency who have an A1C <9 or who are tested will increase to 87%.
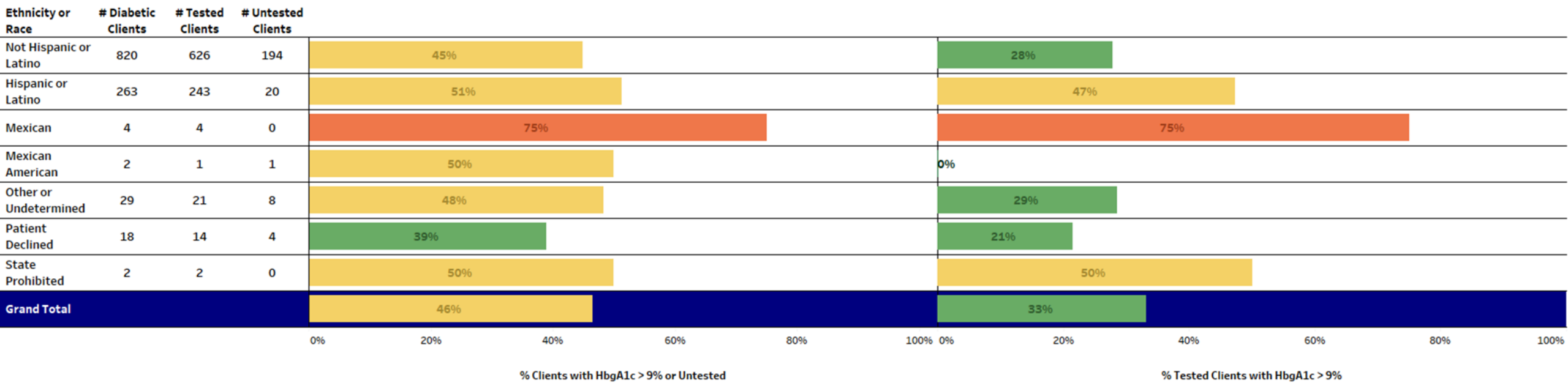
Baseline Data: 56%

B. Reduce disparities within racial and ethnic groups by **25%** for clients who have an A1C >9 or who were not tested compared to the agency average

February Launch	Diabetes	
	Facilitator	Tracy/Ziad
	Champion	Laura Garcia (green team)
	HIT	Joseph VerValin
	Members	Julia Davis (green team)
	REI rep	N/A
		Kelsey Nicks
		Client Representative
		Shannon Riley
		421 nursing team - consult

Trailing Year Data on Diabetes control

Rate of Uncontrolled HbgA1c among Diabetic Clients Seen in the Trailing Year (8/10/2020 - 8/9/2021) by Ethnicity

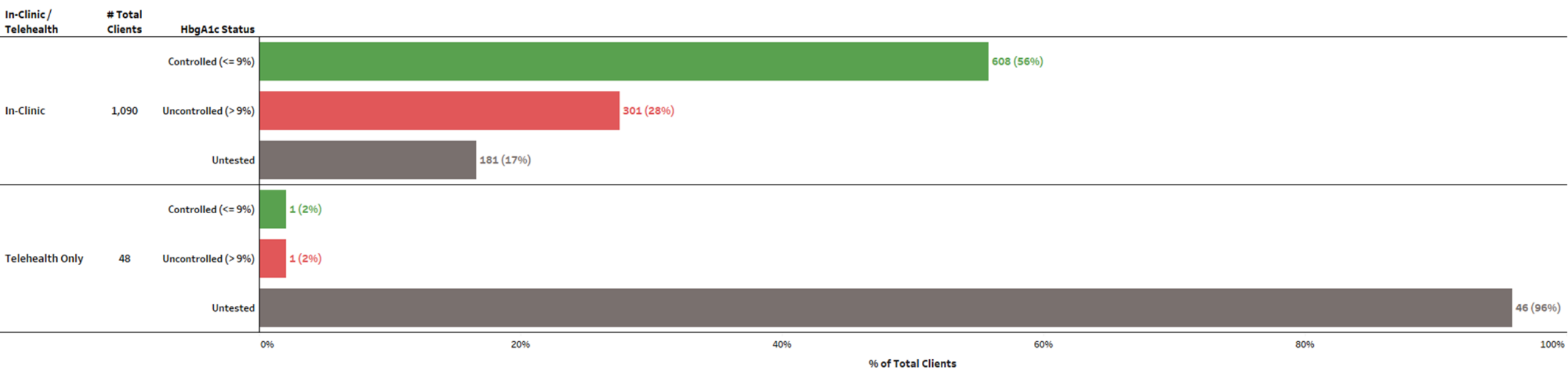| Ethnicity or Race	# Diabetic Clients	# Tested Clients	# Untested Clients	% Clients with HbgA1c > 9% or Untested	% Tested Clients with HbgA1c > 9%
Not Hispanic or Latino	820	626	194	45%	28%
Hispanic or Latino	263	243	20	51%	47%
Mexican	4	4	0	75%	75%
Mexican American	2	1	1	50%	0%
Other or Undetermined	29	21	8	48%	29%
Patient Declined	18	14	4	39%	21%
State Prohibited	2	2	0	50%	50%
Grand Total				46%	33%

This view shows the rate of uncontrolled HbgA1c among diabetic clients who completed at least one appointment in the trailing year (8/10/2020 - 8/9/2021) stratified by Ethnicity. Uncontrolled HbgA1c was determined based off a client's most recent HbgA1c result and defined as a value > 9%. Diabetic clients with no HbgA1c result in the trailing year were categorized as uncontrolled. In addition to showing the rate of uncontrolled HbgA1c among all diabetic clients seen in the trailing year, this view also includes the rate excluding untested clients.

In-clinic vs. telehealth data

Distribution of HbgA1c Statuses among Diabetic Clients Seen in the Trailing Year (8/10/2020 - 8/9/2021) by In-Clinic / Telehealth Appointment Category

In-Clinic / Telehealth	# Total Clients	HbgA1c Status	
In-Clinic	1,090	Controlled (<= 9%)	608 (56%)
		Uncontrolled (> 9%)	301 (28%)
		Untested	181 (17%)
Telehealth Only	48	Controlled (<= 9%)	1 (2%)
		Uncontrolled (> 9%)	1 (2%)
		Untested	46 (96%)

% of Total Clients

This view shows the distribution of HbgA1c statuses among diabetic clients who completed at least one appointment in the trailing year (8/10/2020 - 8/9/2021) stratified by in-clinic / telehealth appointment category (in-clinic vs. telehealth only). HbgÀ1c status was determined based off a client's most recent HbgA1c result collected in the trailing year. Clients with no HbgA1c result in the trailing year were defined as untested.

Since we last met…

- Optional curbside consults continuing on a weekly basis (4 thus far)

- Looked more into several health literacy tools:
  - BRIEF (4 questions)
  - SAHL-E & SAHL-S (18 questions)

- ON HOLD due to data limitations: diabetes-focused care team discussions

- Pop Health leading patient education sub-committee (aforementioned in PH updates)

Next Steps...

- Have had challenges with capacity to obtain client feedback from Hispanic/Latino clients on our diabetes care
  - Applied through SOURCE for JHSPH student intern to take on this project starting in October → accepted
  - In the meantime obtain feedback on patient ed tools

- Nursing
  - Explore possibility of a nurse-focused diabetes medication in-service
  - Pilot folders
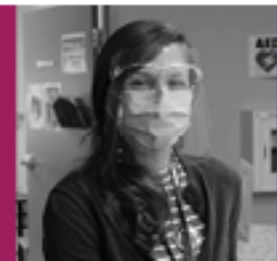
…Next Steps continued

- Ultimately: select and pilot a health literacy tool

- Explore closing gap on diabetic foot exams at a more systemic level
  - Athena: Determine how best to document foot exams
  - Train nurses + CMAs on diabetic foot exams, encourage foot exams become routine part of diabetes visit workflow @ HCH
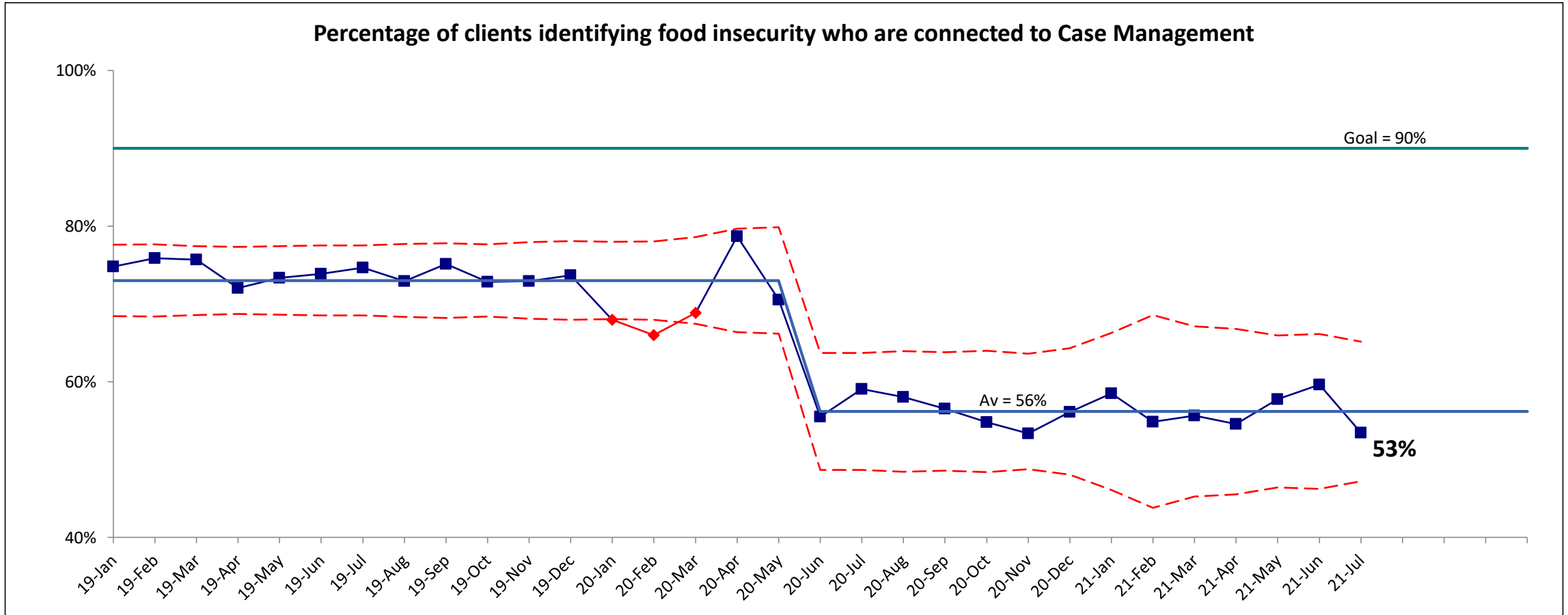
SDH– Food Insecurity and Transportation Challenges

90% of clients who answer "yes" to food insecurity **OR** transportation challenges will be connected to a Case Manager or Community Health Worker
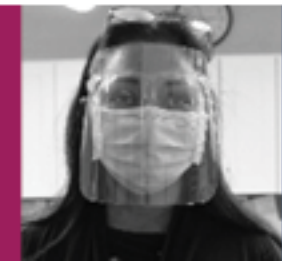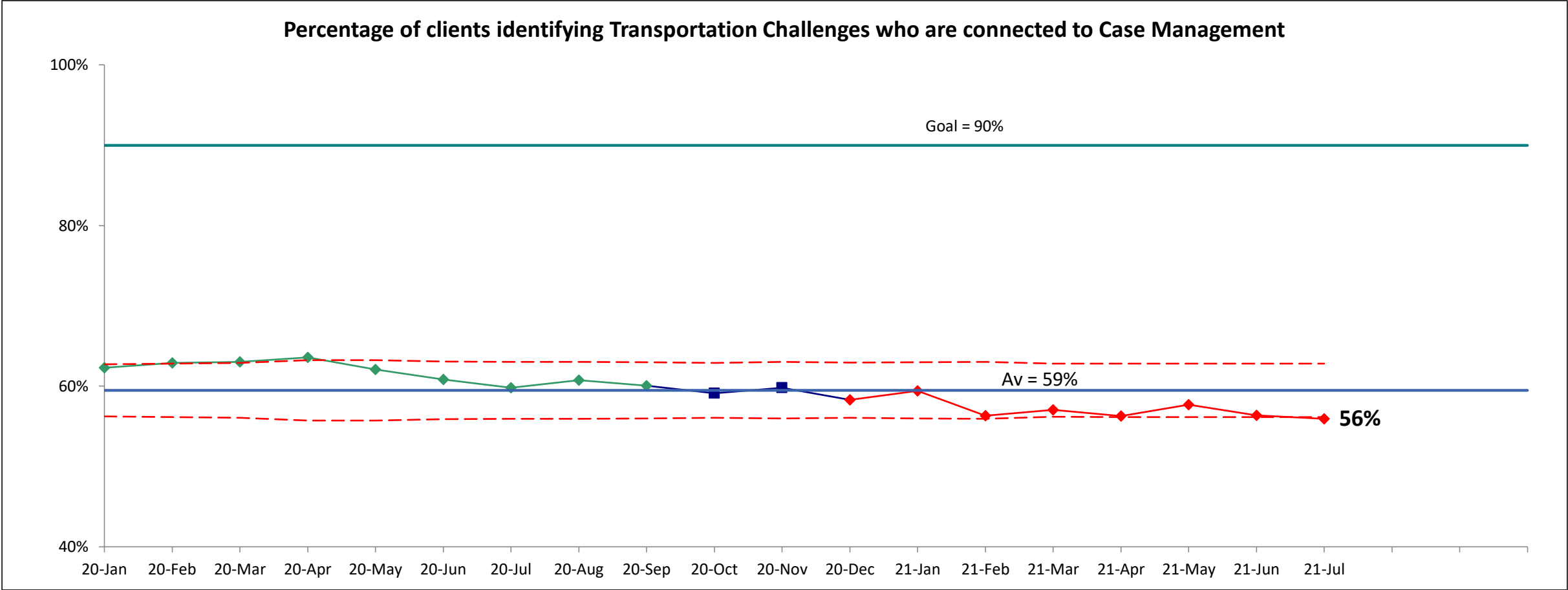
Baseline Data: 71% (2020 PI plan data)

Food Insecurity Data

Percentage of clients identifying food insecurity who are connected to Case Management

Goal = 90%

Av = 56%

53%

147/275

Transportation Challenges Data

Percentage of clients identifying Transportation Challenges who are connected to Case Management

Goal = 90%

Av = 59%

56%

1097/1961

Since we last met…

- Disbanded SDH committee in order to meet with individual departments regarding SDH work
  - PI met with the following teams:
    - Medical
    - CHW/outreach
    - Both Community Sites
- Athena: Added an abbreviated SDH tool into EMR under social histories (11 questions)

Social History Template Preview : Social Determinants of Health (SDH)

Template Name
Social Determinants of Health (SDH)

Template

Question		
FOOD: 1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?	▾	Notes
FOOD: 2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	▾	Notes
HOUSING/UTILITIES: 3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?	▾	Notes
HOUSING/UTILITIES: 4. Are you worried about losing your housing?	▾	Notes
HOUSING/UTILITIES: 5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?	▾	Notes
TRANSPORTATION: 6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?	▾	Notes
INTERPERSONAL SAFETY: 7. Do you feel physically or emotionally unsafe where you currently live?	▾	Notes
INTERPERSONAL SAFETY: 8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?	▾	Notes
INTERPERSONAL SAFETY: 9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?	▾	Notes
OPTIONAL: IMMEDIATE NEED: 10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.	▾	Notes
OPTIONAL: IMMEDIATE NEED: 11. Would you like help with any of the needs that you have identified?	▾	Notes
Notes		

Next Steps

- Continue meeting with remaining Departments re: SDH
  - Reminding staff to **LOOK! ASK! REFER!**
  - Have yet to meet with the following teams:
    - Behavioral Health (9/2)
    - Case Management (9/2)
    - Supportive Housing (in 2-3 weeks)
- Addressing SDH in Athena
  - Train clinical staff to **LOOK! ASK! REFER!** → **Erica creating a training for staff**

PI updates

Client Experience Survey Update

- Volunteers on-site at 421, West Balt, Baltimore County all month long (August 2021) administering surveys for in-person clients in waiting rooms
  - 1-3 volunteers max at a time
  - In-person surveys administered by paper or via link
  - Feedback will be used to inform what we focus on to improve our care in 2022
  - Our third party vendor will be calling clients by phone to administer the survey

Update on Survey numbers* as of 8/23/21

As of _____	Site	# English surveys completed	# Spanish surveys completed	Minimum required for in-person surveys
8/23/21	Fallsway	131	53	54
	WB	18	0	3
	BC	2+	0	3

*Note: we do not yet have an update on # of surveys completed by phone by Research America

Continued Funding

- Development team working hard to meet with donors to continue funding in 2022
  - Emergency food pantry
  - Home blood pressure cuffs

- Upcoming flu & coat drive
  - Development seeking funding to include Peds this year

Annual IHI Conference: December 5-8, 2021 (Sun-Wed)

Two options: **IHI**

Virtual $750 per person

In Person   General Conference: $1,250 per person (early bird rate until 10/1)

Pre-Conference (Sunday): $450 per person

Pre-Conference (Monday):$650

More info:

http://www.ihi.org/education/Conferences/National-Forum/Pages/default.aspx
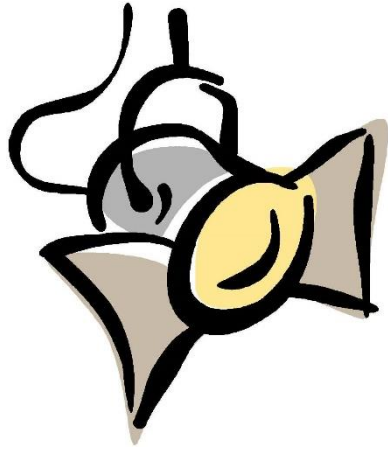
Spotlight on PI Tool
Conducting a Survey

How to develop and implement a survey!

Why to use a survey

- Easy, quick, effective to gain immediate feedback

- Direct and specific questions that can target specific clients for information

- Can be used alongside a PDSA to get feedback from clients, providers, staff on the improvement process

How to create a survey

1. Identify the purpose of the survey.

2. Design 1 to 5 simple questions that will provide the needed information.

3. Test the questions on 5 to 10 patients/families to see if the questions are easily understood and if, when completed, the questions actually yield the information that is being sought.

4. Rewrite the questions based on what was learned from testing them.

How to create a survey

5. Design a method for distribution (e.g., a nurse may give patients the survey and ask them to place it in a sealed box when finished).

6. Collect the surveys on a daily or weekly basis.

7. Display the data on a run chart whenever possible and analyze for trends, data points out of control limits, etc.

8. Be prepared to respond quickly to complaints or other feedback warranting immediate follow-up.

Example Survey from the IHI

Questions?