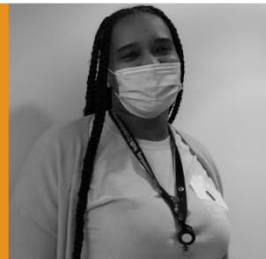
February Monthly PI Committee

2/15/2023

HEALTH CARE for the HOMELESS

Overview

1. Wake-up Trivia
2. The Pulse on Pop Health (Shannon)
   - Women's Health Day announcement
   - Cervical cancer awareness month
   - Colorectal cancer awareness month
   - PrEP Pilot
3. Performance Improvement
   - Quality KPI dashboard (broken out)
   - Updates on PI goals



Wake-Up Trivia

Theme: February

Question 1 of 5

Question: February 27 is the national day for which fruit?

Answer: The Strawberry

Question 2 of 5

Question: Why is Black History Month celebrated in February?

Answer: Abraham Lincoln and Frederick Douglas, two celebrated figures in Black History, both had birthdays in February. The week of celebrating them grew to become Black History Month.

Question 3 of 5

Question: What is the official flower of February? (*hint: not the Rose)

Answer: Violets and Primrose

Question 4 of 5

Question: What is celebrated on February 17?

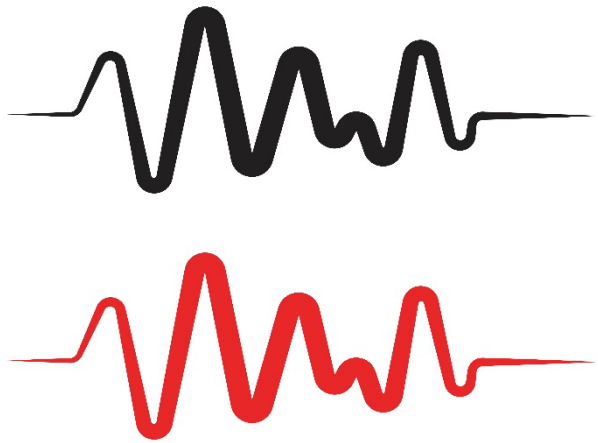
Answer: Random Acts of Kindness

Question 5 of 5

Question: What are people born on February 29th sometimes referred to as?

Answer: Leapers or Leap Babies

The Pulse on Pop Health



Participate in Women's Health Day!

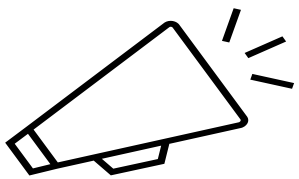
WHAT: A day to ***CELEBRATE*** and ***EDUCATE*** *(food, information, activities)*

WHEN: May – date tbd!

WHERE: On site- HCH

WHO: Target audiences: HCH Clients and Staff/Community Members

We Need Your Help!!



Volunteers needed to make this special day GREAT
Please speak with your departments and contact Shannon Riley @ sriley@hchmd.org with interest!

***a few planning meetings and attendance on the day of event – please obtain supervisor approval.**

“Pap Wars” – friendly contest in medical during January

Battle for the receipt of the coveted **“Golden Speculum Award”**

Categories and Winners!

Highest rate (%) Cervical Cancer Screening completion in 2022:

- **Liz Galbrecht/Shelby Carter**

Highest number (#) Cervical Cancer Screening completion in 2022:

- **Kristin McCurnin/Cheryl Hunter**

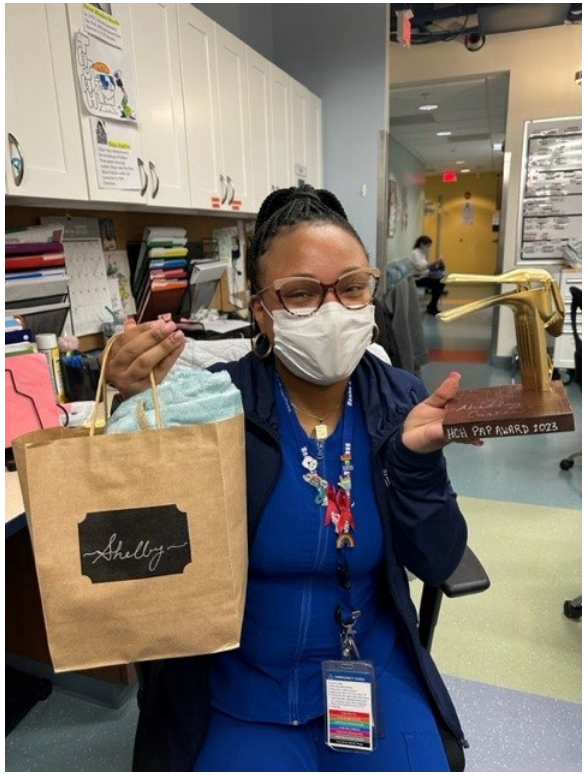
Highest # paps in Jan 2023:

- **Kristin McCurnin/Cheryl Hunter**

Very close second place for both 2022 categories:

- **Marnette Valcin/Crysten Brooks**

2023 Winners and Friends – Trophies and Prizes



March is Colorectal Cancer Awareness Month

CMA & RN Training on CRC screening workflow

- **Cornerstone training (assigned)**
- **In-person competencies**
- **Workflow support**

Staff Awareness Launch (food/cake, information sheets, pins)

Front Porch Activity/Client Outreach (warm drink, info, handouts, community)

Cancer Screening Reminder Pilot – March 2023

PDSA part of BCCP Grant requirement / information share

PrEP (HIV Prevention Med) Pilot/PDSA in MAT

At the end of 2022, 11 clients on PrEP

Goal at the end of 2023 is to have at least 15 clients on PrEP

Develop workflow for same day PrEP initiation and follow up

Identify factors that influence client uptake and adherence

CDC Updated PrEP Guidelines 2022

Baltimore Rapid StART Collaborative (JHH, BCHD, UMD, Chase-Brexton …)

PI updates

Quality KPIs

Maternal and Child Health	HCH 2022	Jan	Feb	2023 Goal
Childhood Immunization Status	8%	0%	0%	25%
Dental Sealants (ages 6-9 Years)				50%
Early Entry into Prenatal Care				80%
Low Birthweight				9%
Wt assessment & counseling for nutrition & PA (Peds)	48%	71%	53%	58%

- **Early Entry into Prenatal Care: OB services have officially commenced** with an initial session completed on 2-9-2023…a historic day at HCH!

Quality KPIs

Disease Management	HCH 2022	Jan	Feb	2023 Goal
IVD: Use of Aspirin/Other Antiplatelet	83%	100%	79%	85%
Statin Therapy for Prevention/Treatment of CVD	81%	83%	82%	85%
HIV Linkage to Care	100%			100%
Depression Remission at Twelve Months	9%	0%	4%	11%

- HIV Linkage to care – low n/d
- Depression Remission @ 12 months – Share out with Jan Ferdous

Measure Description

Depression Remission at Twelve Months

Description

Measure identifies adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9M score greater than nine during the index event, who demonstrate remission at 12 months defined as PHQ-9 or PHQ-9M score less than 5, after the index date.

Note:

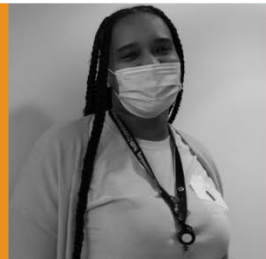
- **Index date -** The date in which the first instance of elevated PHQ-9 greater than nine and diagnosis of depression or dysthymia occurs during the denominator identification measurement period.
- Patients may be screened using PHQ-9 and PHQ-9M up to 7 days prior to the office visit (including the day of the office visit).

Patient Identification

Age: 12 years and older during the index visit

Major depression or dysthymia diagnosis This can be documented in any of the following ways:

- Encounter diagnosis
- Problem list
- Diagnosis recorded in the claim or billing tab or order group



2023 BH PI Goal

Measure Name	2021 Baseline UDS data	Var to 3/15 Athena Data	Trend	*Mar (15th)	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	To goal	2022 Goal
Depression Remission at Twelve Months	9%	-9%		0%	0%	0%	0%	0%	0%	4%	5%	7%	9%	1%	10%
Depression Screening and Follow-Up Pla	42%	-9%		33%	36%	40%	44%	45%	46%	47%	47%	47%	47%	33%	80%

N for 2022: ~60-70 clients

Behavioral Health: By December 31, 2023, 11% of individuals ages 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.

Medical conditions /Substances

Chronic health conditions

Substance abuse

Trauma/Grief

Grief, experiencing loss

COVID positive, pandemic

Trauma, IPV, disproportionate exposure to violence

SDOH /systemic issues

Financial stress

Intergenerational /systemic oppression

Lack of housing , housing insecurity

Lack of social supports/connections

Clients not satisfied for depression remission measure

Lack of staff capacity

Clt not interested in therapy, have other priorities

Adherence (meds, etc.)

Clts only show when in crisis, don't show when stable → therapist may not administer PHQ-9 in these cases

Lack of consistently showing for appts (more common among street homeless)

Staff turnover/transition of relationships

Client/staff factors

Screening tool – results can be very dependent on recent circumstances (i.e. losing EBT card)

Confusion around the questions in the screening (esp the first time they are asked)

Screening tool

Lack of warm hand-off from referring provider used to have BHCs but no longer a role at HCH

Clients not made aware of reason for referral + what therapy is

Weak relationship with referring provider

Internal Referrals workflow

Next steps

BH team decided to do a pilot on warm hand-off to help increase Depression Remission completion.

Two week pilot:

- Medical/CM team will reach out to WIP (walk-in provider) via Athena text
- WIP will see the client
- WIP provider will do assessment
- Schedule client with an ongoing BH provider
- WIPs can introduce BH and help completing a BHPA during walk-in or be scheduled with a provider

Discuss result from Pilot in March team meeting

Quality KPIs

Screening and Preventive Care Measures	HCH 2022	Jan	Feb	2023 Goal
Body Mass Index (BMI) Screening and Follow-Up	26%	21%	26%	65%
Breast Cancer Screening	38%	47%	37%	45%
Cervical cancer screening	51%	52%	51%	57%
Colorectal cancer screening	30%	22%	24%	37%
Depression Screening and Follow-Up Plan	47%	30%	32%	75%
HIV Screening	54%	56%	64%	70%
Tobacco use: screening and cessation intervention	60%	14%	33%	70%

- Psych team has been working over the past 4 weeks on the tobacco measure
  - Psych to target BMI measure next!
- Back to the basics: Reviewed with medical team how to satisfy BMI measure, Depression screening measure and advance care planning measure in Feb

Quality KPIs

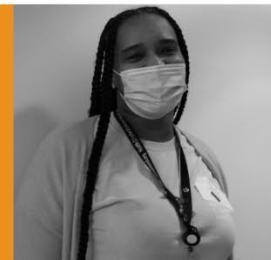
Chronic Disease Management	HCH 2022	Jan	Feb	2023 Goal
Controlling high blood pressure	58%	53%	50%	65%
Diabetes: HbA1c poor control (>9%) [inverse]	35%	77%	65%	32%

- Diabetes – was selected by medical as one of the two additional clinical measure goals
- Looking to re-introduce registries at care team meetings and both are potential options
- Hope is to conduct RCA with medical providers next around barriers to controlling high blood pressure and create action items from there
- Also focus on health equity and reducing disparities

Quality KPIs

Additional HCH priorities	HCH 2022	Jan	Feb	2023 Goal
Lab Tracking	25%			60%
Referral Tracking (% complete)	25%		19%	50%
SDH Ask Rate	42%			80%
FLU: adult vaccination rates	16%	18%	19%	45%
Suicide assessment follow-up	59%			85%
Care management		96%		75%

- A lot of work happening in referrals among referrals team with a monthly workgroup meeting to look at the data
- Arie will be taking on SDH work this year including looking into best practices, identifying workflow, creating all-staff training
- Suicide Assessment follow-up added



Care Management + Care Plans

By December 31, 2023, Therapists, Case Managers and Nurses will identify and offer care management to appropriate individuals, ensuring that 75% of clients enrolled at each site (Fallsway, Baltimore County and West Baltimore) have a documented care plan

- **Care Management:** working to complete any outstanding training for all any CMs, BHTs, Nurses
  - Jan provided another training for BH team recently
  - 1:1 training support to capture a few outstanding staff members

Quality KPIs

Pending data	HCH 2022	Jan	Feb	2023 Goal
Prescribing antibiotics for URI and acute bronchitis				
Hospitalization f/u				65%

Hospitalization Follow-up (Led by Nursing team + Call center staff)

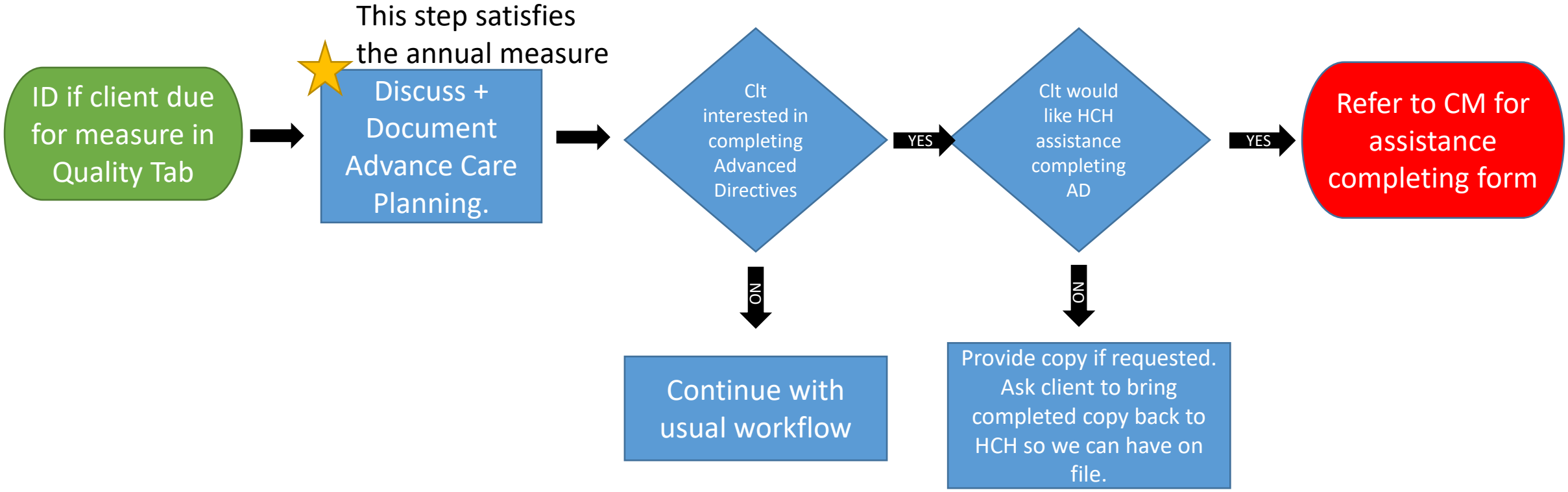
- Monthly workgroup meeting to strategize how to do this work
- Targeting clients discharged from an inpatient admission within the past 7 days (about 100 clients/week)
- Call Center nurses (Kayla & Steph) take the list and are responsible for reviewing the list, delegating the list to other nurses or assigning to themselves (to take on medical judgment and follow-up piece) → then coordinating/directing care depending on level of urgency, who the client needs to re-engage with
    - The work takes a lot of time, so when possible, utilizing call center staff (with nurse-directed guidance) to reach out to clients to schedule appointments or delegating to respective disciplines outside of medical

Two additional clinical measures identified

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 by December 31, 2023.

- Advance Care Planning --> have yet to set a specific SMART goal
- Diabetes control

Advance care planning workflow



Case Managers are willing + able to help clients complete Advance Directives forms

Note Please ask clients who fill the form out on their own to bring a completed copy to HCH to have scanned into their medical records

Client Experience Goal

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.

- TBD in Q1 or Q2
- Utilizing client feedback from Medstatix to make this decision
- *Please note: **monthly medstatix report card is available** on the PI meeting minutes page of the **portal** to all staff (but not available publicly)
  - Will be posted on or just after the 10th of each month
  - Includes agency level data as well as individual staff level data

Time to Third next available appointment

By December 31, 2023, the Agency will reduce the time to third next available appointment by 5% at all sites for identified and prioritized departments (e.g. Medical).

Department	2023 Goal	2023 YTD Average Third Next Available
HCH - Baltimore County	**12**	10
HCH - West Baltimore	**19**	9
HCH-421 Fallsway	**23**	25
Agency		24

Team by Agency	2023 Goal	2023 YTD Average Third Next Available
Behavior Health	23	21
Case Management	18	20
Medical	30	34
Nurse	13	13
Psychiatry	15	11

Thank you!