Monthly Performance Improvement Committee

February 2024

Marie Stelmack, Quality Improvement Specialist

Lisa Hoffmann, Director of Quality Improvement

HEALTH CARE for the HOMELESS

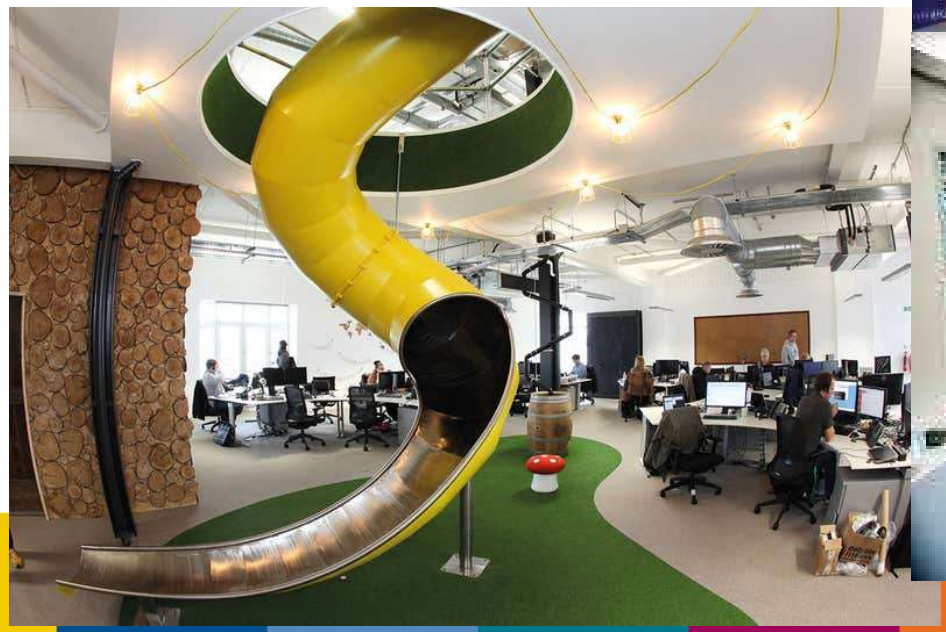
Agenda

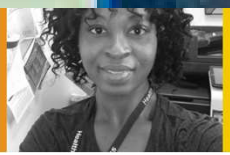
1. Morning chat
2. PI updates
3. PI Reminders
4. Questions and discussion

Good morning!

Today’s icebreaker!

What does your dream office look like?





2024 PI Measures

All data is presented as trailing year
Green = goal met!

3+ Improvement
1-2+ improvement
No change
Reduction

Disease Management	Dec	Jan	2024 Goal
Colorectal Cancer Screening	30%	30%	40%
Hypertension Disparities	Black M: 60% Black F: 56% White M: 75% White F: 64% Latino M: 65% Latina F: 60%	Black M: 62% Black F: 56% White M: 73% White F: 65% Latino M: 69% Latina F: 62%	Less than 5% disparity
Childhood Vaccinations	10%	7%	18%
Depression Remission	6%	6%	pending
Diabetes and A1c Control (inverse measure)	Black M: 27% Black F: 33% White M: 29% White F: 25% Latino M: 42% Latina F: 28%	Black M: 27% Black F: 31% White M: 29% White F: 25% Latino M: 44% Latina F: 29%	27%, reduce disparity by 5% for Hispanic/Latinx clients

PHQ-9 measure coming soon!

2024 PI Measures

All data is presented as trailing year
Green = goal met!

3+ Improvement
1-2+ improvement
No change
Reduction

Disease Management	Dec	Jan	2024 Goal
Clients receiving PrEP	18 clients	18 clients	36 clients
Prenatal Early Entry to Care	58%*	59%*	70%
Appointment Access	N/A	Med Urgent: 84%** Med Routine: 84% BH Urgent: 100% BH Routine: 100% Dental Urgent: 100% Dental Routine: 100%	+5% from baseline
Hospital Readmission Rate	TBD	TBD	<20%
Closing the Referral Loop	26%	25%	40%
Current Medication Documentation	N/A	63%	90%

*Prenatal early entry to care data is currently being validated.
**Low N: ranging from 1 to 6 respondents per category.

Who’s who and what’s new

Hypertension Control and Disparities

- **Subcommittee:** Iris Leviner, Kyler Young, Elizabeth Zurek, Catherine Fowler, Heather Douglas, Katie Healy (HI rep)

- **What's new:**
  - Current disparity data on next slide
  - Completed a root cause analysis to determine possible causes of disparity, what to target
  - Will meet next week (2/29) to develop first PDSA

Hypertension Disparity Data

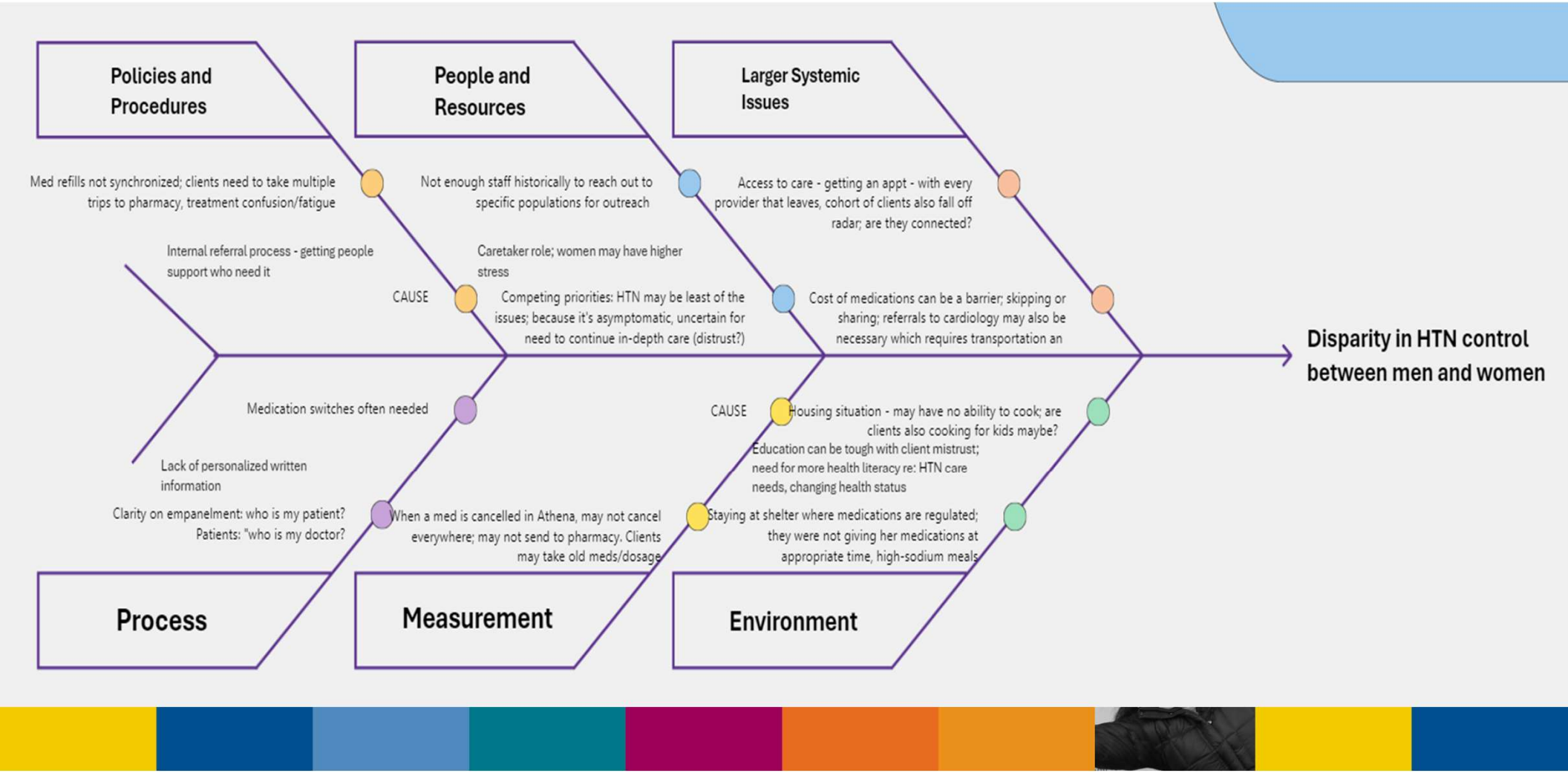
Title	Dec (60%)	Jan (61%)	Jan num/den: 1114/1808
Black Total Clients	59%	60%	674/1124
Black Male Clients	60%	62%	444/715
Black Female Clients	**56%**	**56%**	**216/385**
White Total Clients	70%	70%	151/216
White Male Clients	75%	73%	95/131
White Female Clients	**64%**	**65%**	**51/79**
Hispanic/Latinx Total Clients	62%	64%	295/458
Hispanic/Latino Male Clients	65%	69%	117/170
Hispanic/Latina Female Clients	**60%**	**62%**	**174/279**

LH0

Slide 8

LH0 please put in December column (% only) so that there is a comparison
Lisa Hoffmann, 2024-02-19T15:36:17.689

Hypertension Control and Disparities



PrEP for HIV

- **Members**: Ashley Williams, Katharine Billipp, Adrienne Trustman, Meredith Johnston, Liz Galbrecht, Keri Rojas, Catherine Fowler, Sarah Barry, Tyler Gray, Julia Felton, Nicole Maffia, Rajen Bajracharya (HI rep)
  - I had to reduce the font size – the interest in this measure is huge!

- **What's new:**
  - First subcommittee meeting 2/29 – will complete an RCA
  - Possibility for direct outreach and care management of PrEP clients
  - Identifying a cascade of care for PrEP clients
    - Next slide
  - Refined PowerBI report: identifying clients who have been prescribed **and filled** a PrEP medication by HCH in the past 12 months

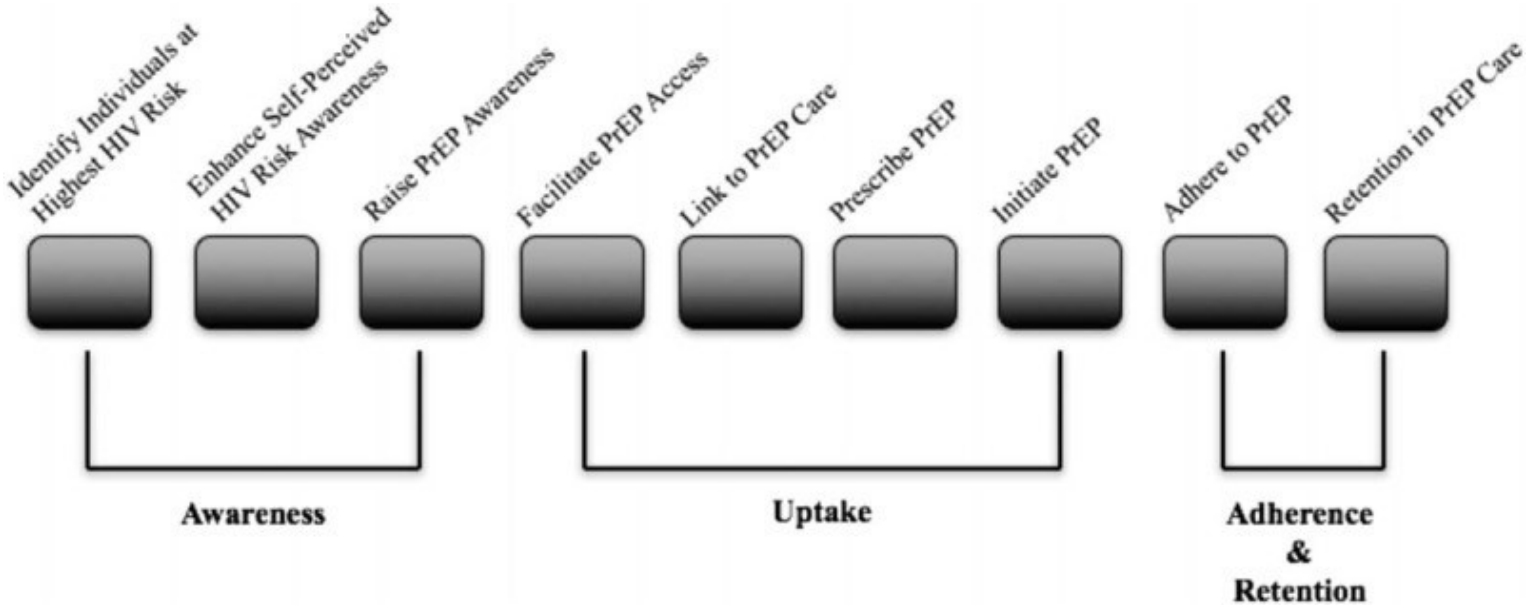
LH0

Slide 10

LH0 Could we please remove this for now? I think it could be one thing we look at, but it really hasn't been a big topic to date and some other topics such as creating a care cascade and refining our PowerBi report have been more top of mind for everyone so I would include those here instead. Tyler sent us access to the care cascade so I think that is worth a mention and then talking about how we are identifying clients on the PowerBi report is useful as well.

Lisa Hoffmann, 2024-02-19T15:42:14.715

PrEP Care Cascade



What's coming up soon

- **Childhood immunizations** starting in March
  - Reviewing data for most frequently missed vaccine doses

- **Hospital readmission** starting in March

- **Colorectal Cancer Screening Month** in March
  - Reaching out to clients for FIT testing
  - PI subcommittee starts in April

A reminder of our 2024 PI goals…

2024 PI Plan

1	2	3	4	5
Reduce the **disparity in hypertension control** rates (less than 140/90 mmHg) among Black, White, and Hispanic/Latino/a women and men by 5%.	Double the number of clients receiving **PrEP**.	Ensure at least 18% of **children** will have all combo 10 **vaccinations** by age 2.	Reduce hospital **readmission rate** (hospitalized within 30 days) by 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: Jan – June	**Dates: Jan - June**	**Dates: March - Aug**	**Dates: March - Aug**	**Dates: April - Sept**
PI Lead: Marie	PI Lead: Marie	PI Lead: Lisa	PI Lead: Lisa	PI Lead: Lisa

The PI Lead facilitates subcommittee meetings and coordinates action items for PDSAs. We are both always available and happy to talk about any of the measures, but this gives everyone a POC for each measure – we are going to try it this year and see how it works!

2024 PI Plan continued

6	7	8	9	10
Improve percent of adults aged 45–75 years who had appropriate **screening for colorectal cancer** to 40%.	Improve overall score (aggregate of all sites and departments) by 5% that clients reported an **ability to access an appointment when needed.**	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.	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**).	Ensure at least 70% of pregnant clients have **access to and initiate care in the first trimester of pregnancy.**
Dates: April - Sept	**Dates: May - Oct**	**Dates: June - Nov**	**Dates: June – Nov**	**Dates: July - Dec**
PI Lead: Marie	PI Lead: Marie	PI Lead: Lisa	PI Lead: Marie	PI Lead: Lisa

The PI Lead facilitates subcommittee meetings and coordinates action items for PDSAs. We are both always available and happy to talk about any of the measures, but this gives everyone a POC for each measure – we are going to try it this year and see how it works!

Interested in being more involved?

1. Write in the chat what goal you are interested in
2. Send us an email at lhoffmann@hchmd.org or mstelmack@hchmd.org
3. Talk to us in person as you see us in the clinic
4. Schedule a meeting to learn more

9/3/20XX

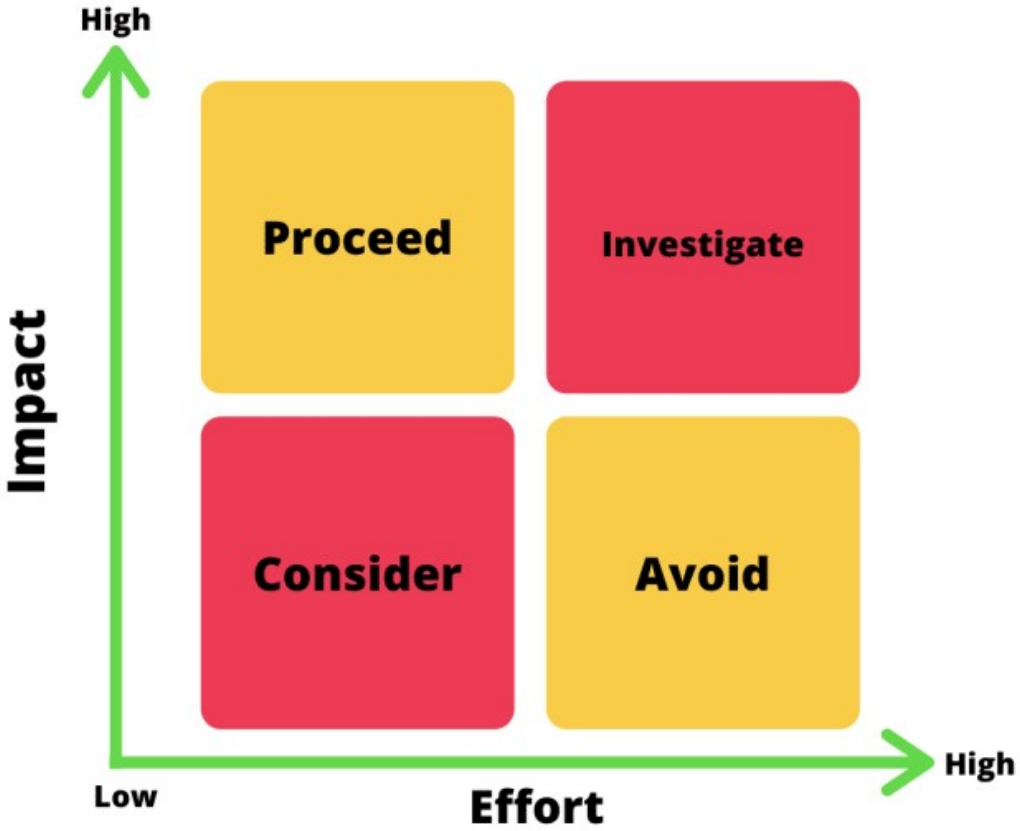
Some PI reminders

1. Portal Page
   - MedStatix data – site, department, and provider level client experience data
   - PI monthly slides
2. OneNote
   - Notes from all subcommittees and PI related work
   - Now available from the portal!

PI Tools Spotlight: Priority Matrix

Why do I need a priority matrix?

- OK, I have all these great improvement ideas… where do I start?
- I need some way to prioritize, sort, figure out what to pursue
- A **priority matrix** is a tool to sort, based on *impact* and *effort*, which ideas to look at closer and which to avoid
  - Imagine putting all your ideas on post-it notes and placing them on a physical graph, where the X axis is effort to implement and the Y axis is the impact it will have
- You may have seen a similar tool under the term **urgent-important matrix**, but this one is slightly different



Priority Matrix

- High impact, low effort: **proceed**
- High impact, high effort: **investigate**
- Low effort, low impact: **consider**
- High effort, low impact: **avoid**

Questions? Concerns?