

# January Monthly PI Committee

1/18/2023

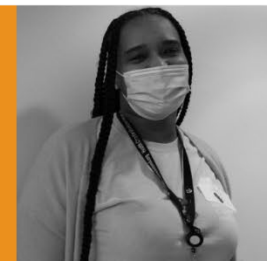


HEALTH  
CARE for  
the  
HOMELESS



# Overview

1. Wake-up Trivia
2. Performance Improvement
  - PI Updates
  - Quality KPI dashboard
  - Final 2023 PI goals & updates/plans
  - Health at Every Size Principles with Arie
3. The Pulse on Pop Health
  - Cervical cancer awareness month
  - List of 2023 awareness campaigns



# Wake-Up Trivia

## Theme: New Years



Sources: <https://parade.com/1131521/jessicasager/new-years-trivia/>; <https://caminhoslanguages.com/blog/new-years-eve-in-brazil/>

## Question 1 of 5

Question: How big is the Times Square New Year's Eve ball in diameter?

Answer: 12 feet



## Question 2 of 5

Question: How much does the Times Square ball weigh?

Answer: 11,875 pounds



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## Question 3 of 5

Question: In Scottish traditions, who do you kiss at midnight on New Year's Eve?

Answer: Everyone in the room



## Question 4 of 5

Question: The Dutch believe eating what on New Year's Day will bring good luck?

Answer: Donuts



## Question 5 of 5

Question: In Brazil, many bring in the new year wearing the color white. Also, jumping seven of **these** on new years is a popular tradition.

Answer: Waves





# PI updates



## 2023 PI Updates

- Staffing update: PI (QI) specialist starting 2/20!
- 9 PI goals are final (approved by P+PI committee on 1/10/23)
- Medstatix surveys continuing in 2023
  - Will include all Medical providers, nurses, Psych, CMs, BHTs, addictions counselor (54 staff)
  - Will defer including dental (recent Athena migration)

## Quality & HIT updates

- Azara DRVS available as a quality resource/tool
  - Trainings → Friday 2/17 @ 11 AM on Azara basics (log-in, PVP, etc.)
  - Getting access → send a ticket to HIT (cc: Wynona China)
- Friendly reminder: Please complete/close out all 2022 encounters ASAP!



# Quality KPIs

Key
*2022 data
**Trailing Year data
***Quarterly data (represents quarter)
Monthly data pulled on/around the 5th of each month
Monthly data is YTD data based on UDS measures + HCH prioritized measures

Measure Name	*Dec	Jan	Num/Den
Body Mass Index (BMI) Screening and Follow Up	26%	21%	40/191
Breast Cancer Screening	38%	47%	14/30
Cervical cancer screening	51%	52%	38/73
Childhood Immunization Status	8%	0%	0/1
Colorectal cancer screening	30%	22%	21/94
Controlling high blood pressure	58%	53%	29/55
Dental Sealants (ages 6-9 Years)			
Depression Remission at Twelve Months	9%	0%	0/9
Depression Screening and Follow-Up Plan	47%	30%	40/134
Diabetes: HbA1c poor control (>9%) [inverse]	35%	77%	27/35
Early Entry into Prenatal Care			
HIV Linkage to Care	100%	n/a	n/a
HIV Screening	54%	56%	99/176
IVD: Use of Aspirin/Other Antiplatelet	83%	100%	4 of 4
Low Birthweight			
Statin Therapy for Prevention/Treatment of CVD	81%	83%	35/42
Tobacco use: screening and cessation intervention	60%	14%	1/7
Wt assessment & counseling for nutrition & PA (Peds)	48%	71%	5/7
FLU: adult vaccination rates	16%	18%	1346/7616
Lab Tracking***	25%		
Referral Tracking (% complete)**	25%		
SDH Ask Rate**	42%		



## As part of the PI plan for 2023, the PI team will:

1. Conduct eight RCA
2. Conduct a minimum of 10 PDSA cycles
3. Establish equity visualizations and plans for each prioritized measure
4. Engage with and seek staff input to identify areas for improvement
5. Partner with clinical departments on measures
6. Present monthly data to leadership
7. Establish sustainability plans for each goal



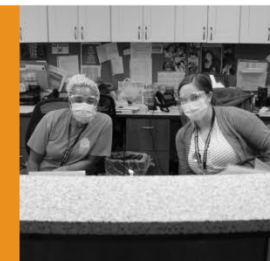
# Resource Stewardship

1. **Cost Savings:** Antimicrobial Stewardship. Throughout 2023, monitor the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis or URI who were prescribed an antibiotic prescription (Goal = <25%). The agency will also review data broken down by race, ethnicity, and SOGI to identify and reduce disparities in prescribing practices.
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 clients post-hospitalization.



# Clinical Quality Measures

- 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
- 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%.
- 5. *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.
- 6. *Additional measures*:** 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.



# Client Access & Experience

7. **Access:** 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).

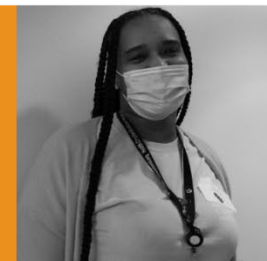
8. **Client Experience:** By December 31, 2023, the Agency will identify, measure, and improve upon one area of Client Experience based on feedback, and choose a goal that aims to reduce disparities.

9. **Care Management:** 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



# Updates on 2023 PI goals

- 1. *Cost Savings:*** Antibiotic use with acute bronchitis or URI
  - Plan: sharing quarterly updates with medical providers via newsletter
  - Will share out data starting next month
- 2. *Care Coordination:*** Hospitalization follow-up
  - Community sites already doing this work regularly
  - Workgroup meeting monthly to determine workflow (Fallsway)
    - Call center nurse pilot
      - Pulling CRISP ENS list
      - Capacity for calling clients post-hospitalization
    - Documenting procedure





## ...Updates continued...

### 3. **Preventive:** Adult BMI and follow-up utilizing Health at Every Size framework

- Involving MAT team (expanding primary care services to interested clients in MAT)
- Involving Psych team in this work (along with in tobacco screening and f/u measure)
- Basics of Health at Every Size Principles/utility with Arie



## ...Updates continued...

### 4. **Chronic:** Blood pressure control and reduce disparities

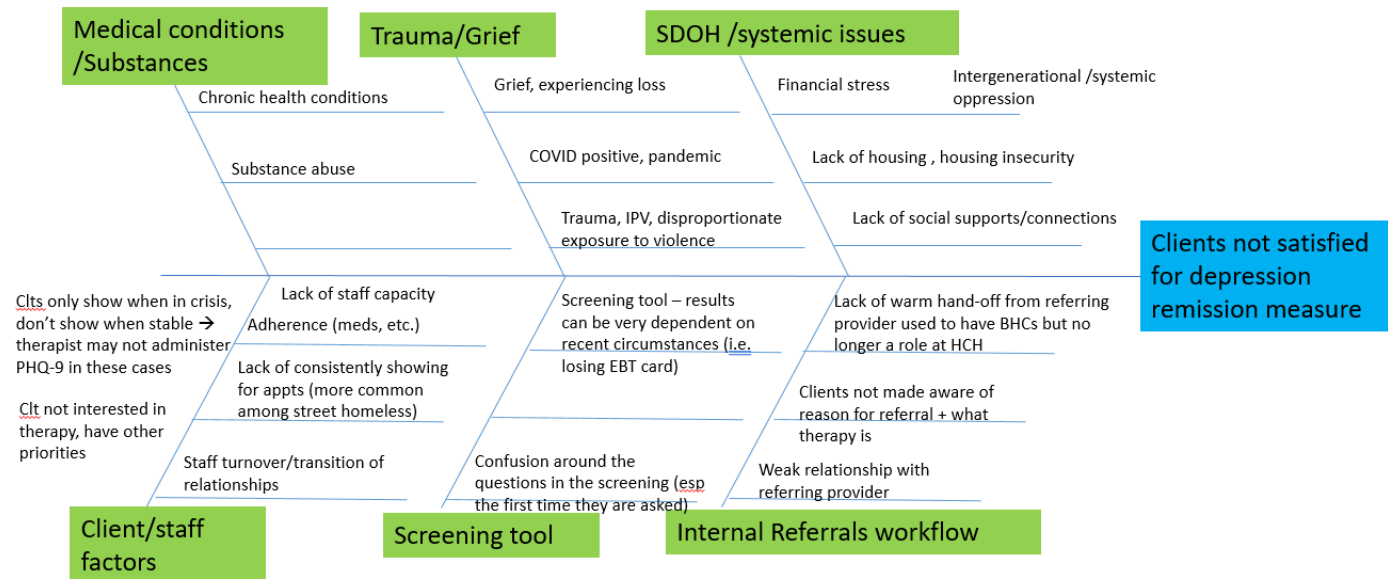
- Q1: Begin with Medical Providers to discuss approaches to improving BP control and address disparities
- Q2: Continue discussion with nursing



# ...Updates Continued...

## 5. Behavioral Health: Depression Remission

- BH team discussed goal and conducted RCA on 1/5/2023
  - Began discussing next steps & areas of opportunity



## ...Updates Continued...

6. ***Additional measures***: Id, measure, improve upon 2 additional clinical measures
  - TBD based on data
  - Hope to set end-of-year goals with Medical this month on quality KPIs



# ...Updates Continued...

7. **Access:** Reduce time to third available appointments by 5% (for below departments)

- Goals listed below by # days to third available appt (excluding weekends)

By Department	2023 Goal
Behavior Health	23
Case Management	18
Medical	29
Nurse	13
Psychiatry	15

Site	HCH - Baltimore County	HCH - West Baltimore	HCH-421 Fallsway
2023 Goal	12	19	23



## ...Updates continued

### 8. **Client Experience:** Id, measure and improve upon one area

- TBD based on client feedback

### 9. **Care Management:** Care Management for clients who may be at higher risk

- Three roles have received training on enrolling clients in Care management and documenting care plans.
  - Nurses: Clients with newly diagnosed or uncontrolled diabetes
  - BHTs: Clients with depression
  - CMs: Clients with housing instability or low/no income

#### • **Important note to Nurses, Case managers, BHTs:**

- Please add the following problems exactly as listed to the problem list as this is how HIT knows who is empaneled:
  - **Nursing care management session (Nursing)**
  - **Psychosocial analysis management (Case Management)**
  - **Depression care management (Behavioral Health)**



# HAES Principles

**WEIGHT INCLUSIVITY** Accept and respect the inherent diversity of body shapes and sizes and reject the idealizing or pathologizing of specific weights.

**HEALTH ENHANCEMENT** Support health policies that improve and equalize access to information and services, and personal practices that improve human wellbeing, including attention to individual physical, economic, social, spiritual, emotional and other needs.

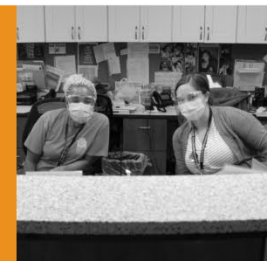
**EATING FOR WELL-BEING** Promote flexible, individualized eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control.



# HAES Principles Continued

**RESPECTFUL CARE** Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socio-economic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.

**LIFE-ENHANCING MOVEMENT** Support physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose.





# WAIT after the Weight

BMI screening and follow up is a UDS measure we use here at HCH

We are required to document and follow up on the BMI of our patients if deemed outside of a “normal” range

You have the power to determine how educational follow up looks like

That’s when you **WAIT**

- **W**- What else is there to consider?
- **A**- Acknowledge your biases
- **I** – Inquire about your patients’ health habits, lifestyle, barriers and facilitators of health
- **T**- Tailor your follow up plan to your patients’ individual needs and circumstance



# Reframing the Conversation

- When talking with patients, keep in mind the HAES principles
- Center health, not weight
- Set health goals, not weight goals
- Keep an ear out for stereotype threat
- Pay close attention to the language you use
- Choose words that do not perpetuate weight stigma
- Talk with, not at your patients
- Include patients in health-goal setting process



# Resources For More Learning

Fatphobia and Racism: <https://www.npr.org/2020/07/20/893006538/fat-phobia-and-racist-past-and-present>

Adolphe Quetelet: <https://pubmed.ncbi.nlm.nih.gov/7890752/>

From weight focused to Health Focused:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4605176/>

Weight stigma and weight gain: <https://pubmed.ncbi.nlm.nih.gov/29225670/>

Health at Every Size: <https://asdah.org/about-asdah/>

Public Health Needs to Decouple Weight and Height Resource guide:

[https://indigo.uic.edu/articles/educational\\_resource/Public\\_Health\\_Needs\\_to\\_Decouple\\_Weight\\_and\\_Health/16823341](https://indigo.uic.edu/articles/educational_resource/Public_Health_Needs_to_Decouple_Weight_and_Health/16823341)



# The Pulse on Pop Health



# Population Health

January is Cervical Cancer Awareness Month

1. Poll
2. Facts/Quality Tab
3. Events



# Cervical Cancer in the United States (CDC, 2023)

13,000 new cases annually

4,000 deaths from cervical cancer

Hispanic women have the highest rates of developing cervical cancer.

Black women have the highest rates of dying from cervical cancer.



# Who gets screened?

People ages 23-65 who have a cervix (Athena Quality tab)

Frequency of screening depends on type of test and previous results, but generally every 3 or 5 year.

Can be an HPV test alone, HPV with Pap (co-testing) or Pap Smear.

***ALL ARE GOOD TESTS AS LONG AS THEY ARE DONE REGULARLY!***

***(USPSTF, ACOG and American Cancer Society)***



### Adult TEST

38yo F | 06-23-1984 | #199897 | E#199897  
G 1 P 0 0 0 0, 4.0, 09-26-2023, B-

**Other Measures** NEEDS ATTENTION (5) +

View by amclaughlin40  
Last Updated 4:45 PM ↻

**Cervical Cancer Screening - (with and without co-testing)** e

Satisfied By	Date
PAP test performed within 3 years	12-08-2022 <span>x</span>

Additional assertion :

Due date varies  
Adult Preventive Care Guidelines

NOTE

[EDIT SETTINGS](#) | [VIEW INFO](#)

Screening for Depression in Adults

### Care Management

[Go to Care Plan](#) »

Care Programs  
None

Recent Event Summary  
None recorded

Goals  
None recorded

### OB Episode

[View Episode](#)

G 1 P 0 0 0 0 | 4 weeks 0 days | EDD 09-26-2023 | Blood B-

### Last Visit with Family Medicine

Recent Activity ⚙

#### OB - New, 01-13-2023 (OPEN)

Performed by Tolulope Thomas, RN, Family Medicine, (410) 837-5533

#### First trimester pregnancy



# “Pap Wars” – friendly contest in medical

## ❖ Awards to the CMAs and Providers with:

- ❖ Highest # paps performed by next medical team meeting (YTD through 2/7)
- ❖ Highest # up-to-date paps based on provider in 2022
- ❖ Highest % of up-to-date paps based on provider in 2022

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

Past winners: Kristin McCurnin, Katharine Billipp and Max Romano



# Friday, Jan 20 @ 9:00 am / Front Porch Campaign



# 1:1 Education and Support: Cervical Cancer Reminder Cards

Almost complete!

Thank you, Rebecca!!

Color-coded cards to serve as physical reminders!

*Also:*

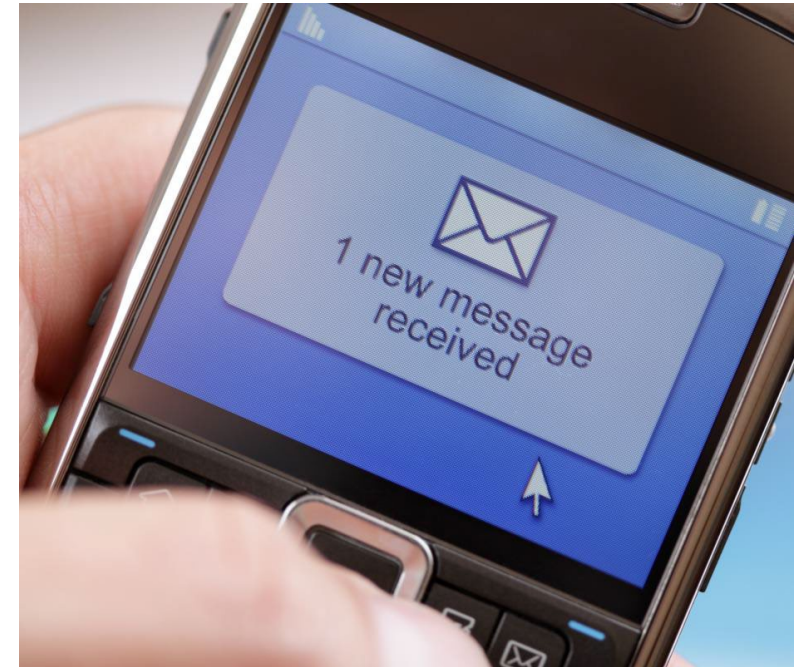
Pap Only Visits and Pap Comfort Kits!

Find me soon in TEAL!



# Pop Health Outreach Message going out today

- HIT helped to set up a message to go out today, 1/18/23, to all clients in Athena who are past due for CRC screening
- Message will go out by phone, text or e-mail (depending on their preferred method of communication) to 1598 clients
  - We will be able to see on the back end how many clients received/didn't receive the message
- Plan to send out several additional campaign messages via this system over 2023



# HPV Vaccinations

Available in the Family Clinic (VFC)

Given to boys and girls – usually ages 11-12 but may start at age 9.  
(Ideally given before sexual activity)

Two dose series – a second vaccine give at 6-12 months after the first.

Recommended through age 26 if not fully vaccinated when younger.

*Can be controversial – please encourage full discussion about safety and cancer prevention!*



# 2023 Population Health Campaigns

## *Monthly Campaigns:*

- Cervical Cancer (Jan)
- Colorectal Cancer (Mar)
- Breast Cancer (Oct)

National HIV Testing Day/World AIDS DAY – June 27/December 1

Flu Campaign– starts September/Flu & Coat October

World Prematurity Day (UNICEF) – November 17

Women's Health Day - May



happy  
NEW  
Year!  
Mohamed Amir



HEALTH  
CARE for  
the  
HOMELESS