Monthly Performance Improvement Committee

January 2024

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HEALTH CARE for the HOMELESS

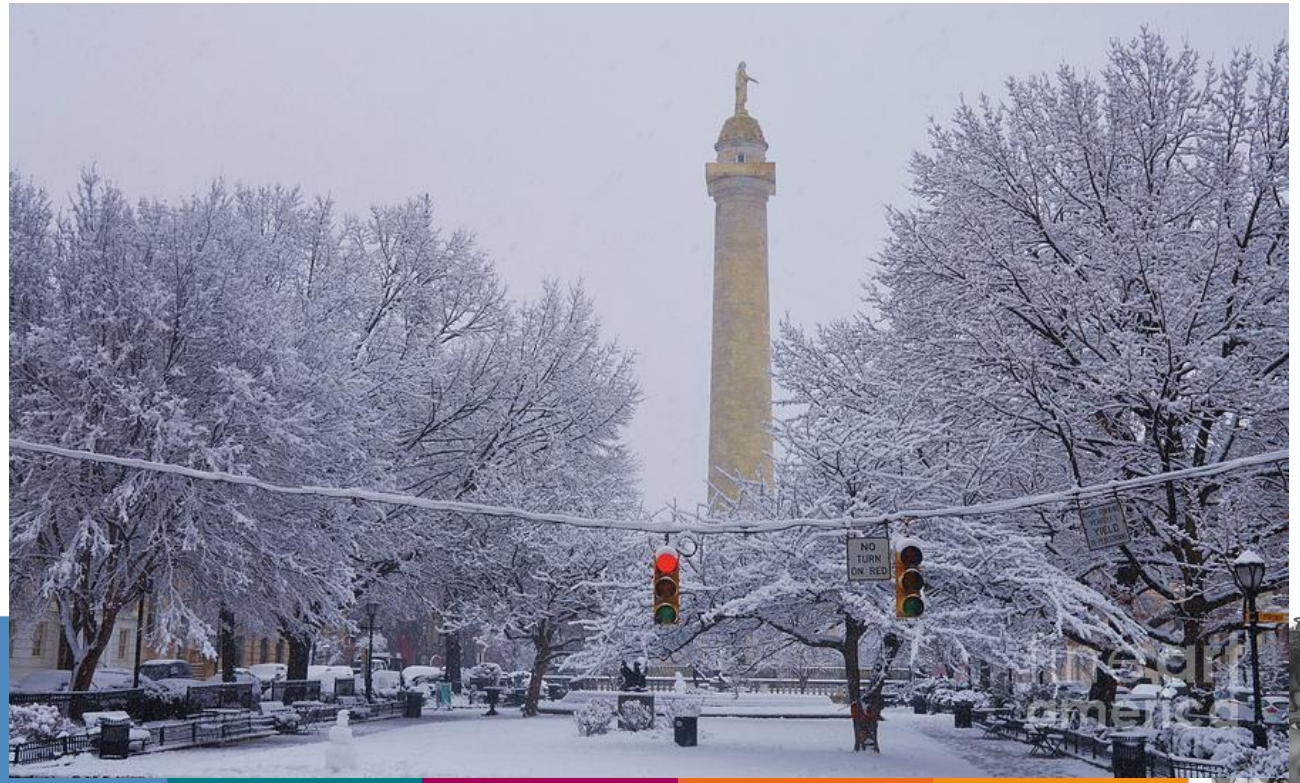
Agenda

1. Morning chat
2. PI updates
3. PI Reminders
   - Portal Page
     - MedStatix data – site, department, and provider level client experience data
     - PI monthly slides
   - OneNote
     - Notes from all subcommittees
4. Questions and discussion

Morning!

Today’s icebreaker!

What are your thoughts on snow?



2023 PI Measures

All data is presented as year to date
Green = goal met!

3+ Improvement
1-2+ improvement
No change
Reduction

Disease Management	Nov	Dec	2023 Goal
Reduce inappropriate antibiotic prescriptions	100%	100%	100%
Hospitalization follow-up	55%	61%	65%
Height and Weight Assessment and Health Counseling	45%	45%	65%
Controlling high blood pressure	62%	60%	65%
Depression Remission at Twelve Months	6%	6%	11%
Care management (with care plan)	97%	97%	75%
FLU: adult vaccination rates	26%	30%	45%
Advance Care Planning	4%	5%	5%
Third Next Available	BC: 13 WB: 16 F: 23	BC: 13 WB: 15 F: 21	Reduce by 5%
Client Experience	R: 92% S: 94%	R: 92% S: 88%	93% (both)

2023 retrospective: what goals did we meet?

- **Reducing inappropriate antibiotic prescriptions**
  - We stayed at 100% all year
- **Care management**
  - Our providers are consistently documenting and updating care plans for eligible clients
  - Sent out best practices “Monday minute” videos this year highlighting care plan champions
  - Emphasis on SMART goals, making care plans work for client and provider rather than just “checking the box”

2023 retrospective: what goals did we meet?

- **Dental sealants (notable CQM, not on PI 2023 plan)**
  - The Dental and Pediatrics teams are working hard to identify pediatric patients in-clinic who are eligible for dental sealants
  - **91%** of at-risk children received at least one treatment!
- **Advance care planning**
  - Reached 5% goal for older adults
  - Created an SOP this year to define these conversations
  - Developed and gave an advance directive training from a peer-to-peer perspective
    - This is now on Cornerstone as an optional training

2023 retrospective: what do we need to work on?

- **Depression screening and remission**
  - Tough measure to crack: our clients, because of their life circumstances, are more likely to have recurrent major depression
    - It may not be reasonable to expect the illness to “remit” in a typical fashion
  - As such, can work on improving function via use of SMART goals and improving specific symptoms – just because challenging measure, doesn't mean we shouldn't still try!
- **Flu vaccination rates**
  - Remember, it’s still flu season! Keep offering the flu shot and “snoozing” via the Quality tab if declined

2023 retrospective: what do we need to work on?

- **Cancer screenings (notable CQM, not on 2023 PI plan)**
  - Literature suggests *direct outreach to clients* is what works best
  - Will work with Population Health on cancer screening identified PI goals in 2024
- **Hypertension control and disparities**
  - Goal for 2024: see next slides
- **Diabetes disparities (notable CQM, not on 2023 PI plan)**
  - Still seeing poorer rates of A1c control among Hispanic/Latinx population
  - 2024 PI goal: plan to identify root causes and create an action plan

2024 Q1 focus: hypertension disparities

- Looking at December 2023 data:
  - 9% disparity between white male and female clients
  - 5% disparity between Hispanic/Latinx male and female clients
  - 4% disparity between Black/African American male and female clients
    - Down from 7% in November… but entirely due to a decline in control rates for Black men
    - Important to aim to *lift* everyone, not artificially reduce disparity by decreasing one group

2024 Q1 focus: hypertension disparities

- What's being done now?
  - BP control group with Heather to educate and promote peer support
    - These clients also received at-home BP monitors, which are shown to promote BP control in patients with hypertension
    - We can't use readings done at home for the measure, but they're an important tool for clients to use on their own
- What's to come?
  - First meeting with HTN subcommittee next week, 1/25

2024 Q1 focus: PrEP for HIV

- More clients on PrEP at HCH than we had initially thought- **57 clients**!
- Breaking down the numbers…
  - 37 (64%) are on Medicaid; 15 (26%) are uninsured
  - 31 (53%) are doubling up with another household, 9 (15%) are street homeless, and 7 (12%) are in shelters
    - Appears that clients with less stable housing situations may have greater difficulty with a daily pill
    - Options for long-acting injectable PrEP exist, but are not covered by Medicaid
    - Though, other organizations in Baltimore are pushing for injectable PrEP coverage – more to come on this
  - Only 21 (36%) have an upcoming appointment scheduled
    - May be worth exploring appointment adherence and continuity of care for PrEP clients

2024 Q1 focus: appointment access

- Current system is inadequate to support appointment access for all our clients who need to be seen
  - Significant walk-in volume (lack of schedulable appointments as contributor)
  - MCOs and hospitals are calling to schedule as well as clients themselves
- Trialing new systems in Q1 of 2024:
  - Treating walk-ins as 24-hr appt slots
  - Many walk-ins have needs that do not require provider slots (e.g. refills, referrals, paperwork); taking care of these needs appropriately without using provider slots
- Anecdotally, has significantly increased appointment access
  - Will be reviewing Medstatix feedback for client feedback - "ability to access an urgent apt when needed"

A reminder of our 2024 PI goals…

(this time with baseline data!)

2024 Goals

1

Improve percent of adults aged 45–75 years who had appropriate **screening for colorectal cancer** to 40% (baseline 30%).

2

Reduce the **disparity in hypertension control** rates (less than 140/90 mmHg) among Black, White, and Hispanic/Latino/a women and men by 5% (baseline 4%, 5%, 9%).

3

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

4

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 (baseline 6%).

5

Reduce the percent of clients aged 18–75 years with **diabetes** who had hemoglobin A1c (HbA1c) greater than 9.0 percent to 30% (baseline 30%) and **reduce the racial/ethnic gap** by 5% for Hispanic/Latino clients (baseline 4%).

2024 Goals Continued

6

Double the number of clients receiving **PrEP** (baseline 57 clients).

7

Ensure at least 70% of pregnant clients have **access to and initiate care in the first trimester of pregnancy** (baseline 58%).

8

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

9

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

10

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**).

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

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

Questions? Concerns?