Monthly Performance Improvement Meeting

July 20th, 2022

HEALTH CARE for the HOMELESS

Overview

1. Wake-up Trivia [8:00 to 8:10]
2. TAP workgroup updates [8:10-8:15]
3. Pop Health Updates [8:15-8:30]
4. PI Updates [8:30-9:00]
   - Quality KPIs
   - Disparities data
   - Access rates (will discuss in greater detail next month)
   - Additional PI Announcements [if time]

Wake-up Trivia

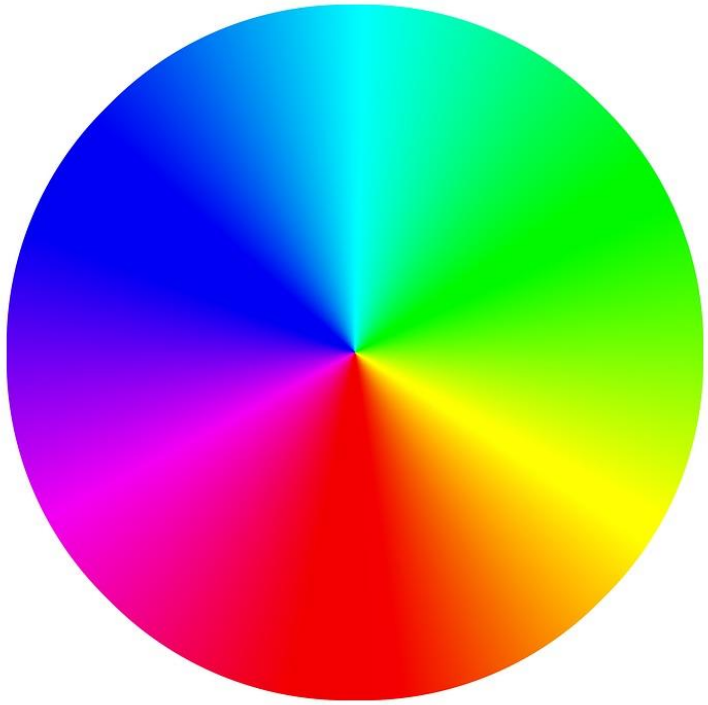
Theme: SLEEP!

https://health.clevelandclinic.org/22-facts-about-sleep-that-will-surprise-you/

Question 1 of 5

Q: Today ____% of people dream in color.

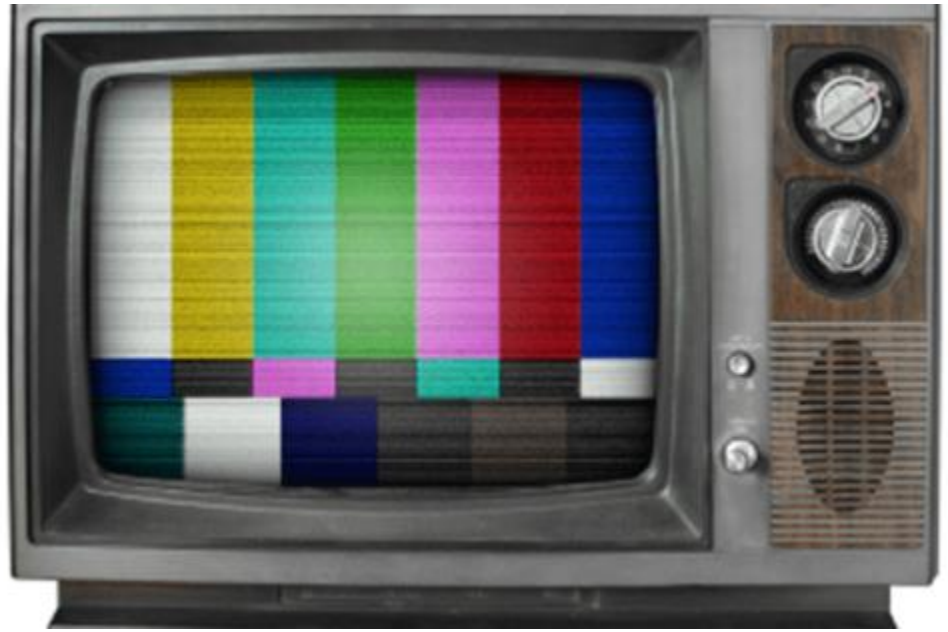
A: 75



Question 2 of 5

Q: Before color television only ____% of the population dreamt in color.

A: 15



Question 3 of 5

Q: Finding it hard to ____(phrase)_____ is a real condition called dysania. It may signal a nutritional deficiency, depression or other problems.

A: Get out of bed in the morning

Question 4 out of 5

Q: Ideally, falling asleep should take you ____ to ____ minutes.

A: 10-15. Falling asleep in less than 5 minutes is a sign of sleep deprivation.

Question 5 of 5

Q: Tiredness peaks twice a day: around ___ AM and ___ PM.

A: 2, 2. That's why you're less alert after lunch.

TAP workgroup update

Concluded with a final meeting on 7/13/22

Two workgroups: Uninsured clients

1. Uninsured Workgroup led by Tolu Thomas + Adrienne Trustman
   - Ongoing group
2. Time-limited TAP workgroup led by Mona Hadley and Iris Leviner (concluded)
   - Finalized TAP SOP (with guidance on urgent and non-urgent TAP referrals)
     - Have accompanying documents
       - Provider Referral Guidelines for HCH clients without insurance (provider-facing)
       - TAP Brochure (client-facing)
   - Next up: Communication strategy to engage pertinent teams re: above info

Pop Health Updates

YTD Updates

Population Health KPIs

KPI / Measure	Target Date	Goal	YTD	Notes
By December 31, 2022, conduct six month-long awareness campaigns: cervical cancer screenings, breast cancer screenings, colorectal cancer screenings, medication refill, HIV screening, and flu/coat drive	12/31/2022	6	3	Completed cervical cancer screening, Colorectal cancer screening & Medication refill campaign months. Next up: HIV testing week (June 27th) & awareness month in July. Flu/coat drive in October.
HIV Prevention: By December 31, 2022, the agency will increase PrEP enrollment by 100% by enrolling at least 10 additional clients in PrEP	12/31/2022	24	n/a	Report not available but HIT working on this. Addressing process measures (staff trainings around PrEP, joining Baltimore Rapid Start Collaborative, etc.)
Prenatal Services Access: In 2022, ensure at least 75% of uninsurable clients who present to HCH for prenatal care connect with obstetrical care services within 60 days of referral.	12/31/2022	75%	57.5%	As of 6-1-22. We may be re-visiting this goal as it may be clinically appropriate to connect at 60+ days during first trimester.
Complete 12 chronic disease client training videos (6 in English, 6 in Spanish) for use by medical team members	12/31/2022	12	0	Actively working on first 3 videos (in English) – anticipated completion end of this week.
Create 2 culturally-centered resources for client dietary education to be used by medical team members	12/31/2022	2	0	Projected completion dates: 8/1/22 and 10/1/22

HIV Campaign – June/July

HIV Detection and Prevention

- Workflows connecting MAT clients to HIV/Hep C screening and PrEP
- Increase confidentiality for screening
- Incentive kits
- Increased screening/Free Market Day

Cervical and Breast Cancer Screening

- Grants awards
- Pap only visits/Cervical Cancer workflow
- Cervical Cancer Screening Data Reconciliation

Diabetes

- Client representative has joined collaborative
- Videos in August
- REI lens: Culturally literate Education Materials

Upcoming Health Campaigns

1. Flu – student volunteers for Flu and Coat Drive (Notre Dame of Maryland University Nursing)

2. Breast Cancer Awareness in October

2022 Performance Improve (PI) Goals

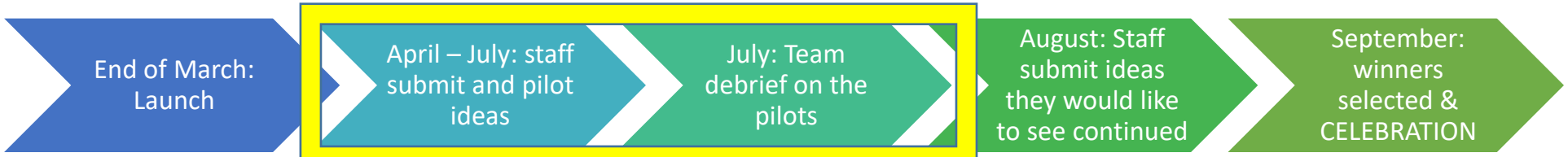
YTD Updates

PI goals Dashboard

Measure/Key Performance Indicator	Due	How measure	Baseline	Goal	May 2022	July 2022
75% of staff (including supervisors) will have attended at least one agency PI training.	12/31/2022	% trained using HCS or in-person	0%	75%	39%	85%
Complete Innovation Challenge	9/31/2022	# staff participate	0	10 ideas	~2	~10
Communicate the Agency quality KPIs on a monthly basis to all staff starting by end of Q1	3/31/2022 + ongoing	# of communications	0	9	2	4
Create a health disparities dashboard that is shared monthly to all staff by end of Q1	3/31/2022 + ongoing	Dashboard created	0	1	Identified measure; draft in progress	1
meet monthly with department leadership to discuss data starting end of Q1	3/31/2022 + ongoing	# of meetings	0	9	2	5
PI project on HIV Screening	ongoing	% HIV test	64%	70%	45%	49%
PI project on preventive care – cervical cancer	ongoing	% screened	41%	59%	41%	46%
PI project on behavioral health – depression screening	ongoing	% screened + plan	42%	85%	40%	45%
PI project on chronic care – hypertension	12/31/22	% controlled	48%	55%	50%	52%
achieve 80% access target	12/31/2022	Access statistics	n/a	80%	74%	75% (as of 6/13)
PI project on number of clients aged 70 and older who are prescribed aspirin ONLY for secondary prevention (i.e. if they have a dx of CAD, MI, etc.) by 15%	12/31/2022	% prescribed aspirin for primary prevention	74%	59%	72%	71%

Innovation Challenge

Area	Measure/KPI	Due	How measure	Baseline	Goal	YTD
PI Goal/KPI	Complete Innovation Challenge	9/30/2022	# staff that pilot ideas	0	10 ideas	~10



- Initial Ideas have been submitted by 7 teams/departments thus far
- Many suggested ideas involve cross-team involvement or financial resources that the challenge cannot support – will share these out with agency leadership at conclusion of challenge
- Staff capacity to pilot ideas has been limited
- Reminder: final push over the next month to submit ideas, test ideas, (supervisors) formally submit ideas for the challenge

Quality KPIs – 2022 month to month data

Key
3+ Improvement
1-2+ improvement
No change
reduction
No data

*pulled on 3/15

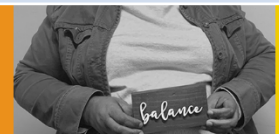
**Data pulled the 5th/6th of each month, reflecting year to date totals

Improvement measured month-to-month totals

Measure Name	2021 Baseline UDS data	Var to 3/15 Athena Data	Trend	Jan	Feb	*Mar (15th)	**Apr	**May	**June	**July	To goal	2022 Goal
Body Mass Index (BMI) Screening and FollowUp	10%	7%				17%	18%	19%	21%	25%	40%	65%
Breast Cancer Screening	34%	-10%				24%	30%	30%	34%	34%	6%	40%
Cervical cancer screening	41%	-6%				35%	39%	41%	43%	46%	13%	59%
Childhood Immunization Status	24%	-24%				0%	11%	12%	11%	10%	15%	25%
Colorectal cancer screening	25%	-7%				18%	21%	24%	26%	27%	3%	30%
Controlling high blood pressure	48%	-3%				45%	48%	50%	51%	52%	3%	55%
Dental Sealants (ages 6-9 Years)	0%	0%										50%
Depression Remission at Twelve Months	9%	-9%				0%	0%	0%	0%	0%	10%	10%
Depression Screening and Follow-Up Plan	42%	-9%				33%	36%	40%	44%	45%	35%	80%
Diabetes: HbA1c poor control (>9%) [inverse]	52%	5%				43%	52%	48%	45%	44%	4%	40%
Early Entry into Prenatal Care	78%	n/a										80%
HIV Linkage to Care	100%	-100%				0%	0%	0%	100%	100%	0%	100%
HIV Screening	64%	-25%				39%	42%	45%	46%	49%	21%	70%
IVD: Use of Aspirin/Other Antiplatelet	56%	27%				83%	84%	83%	83%	83%	2%	85%
Low Birthweight												
Statin Therapy for Prevention/Treatment of CVD	77%	6%				83%	81%	81%	82%	82%	3%	85%
Tobacco use: screening and cessation intervention	55%	-28%				27%	35%	40%	45%	48%	22%	70%
Wt assessment & counseling for nutrition & PA (Peds)	55%	-46%				9%	11%	16%	20%	25%	33%	58%
Lab Tracking	n/a											
Referral Tracking	n/a											
SDH ask rates	n/a											

Conduct Improvement projects on five quality measures

Prioritized Measure	Baseline	YTD	Goal	Updates
HIV Screening (preventive)	64%	46%	70%	Shannon and Julia meeting with others (MAT) to strengthen referrals process (for rapid HIV testing)
Cervical cancer (preventive)	41%	43%	59%	Champions: Max, Faith, Mykia – Conducting pilot: offering clients who initially decline/defer paps f/u pap-only visit, data rec (centricity and unsatisfied athena clients), documenting workflow
Depression screening	42%	44%	85%	Updating medical team on how to satisfy the measure (change from the video training guidance)
Hypertension (chronic)	52%	51%	55%	Anticipate engaging in medication reconciliation projects. Potential for curbside consults/training amongst medical providers. validatebp.org and targetbp.org
De-prescribing aspirin (resource stewardship)	74%	72%	59%	Yellow sticky note reminders in EMR (w/ upcoming appts), Quarterly report to Medical providers (July, October), medical provider modeling conversation with client

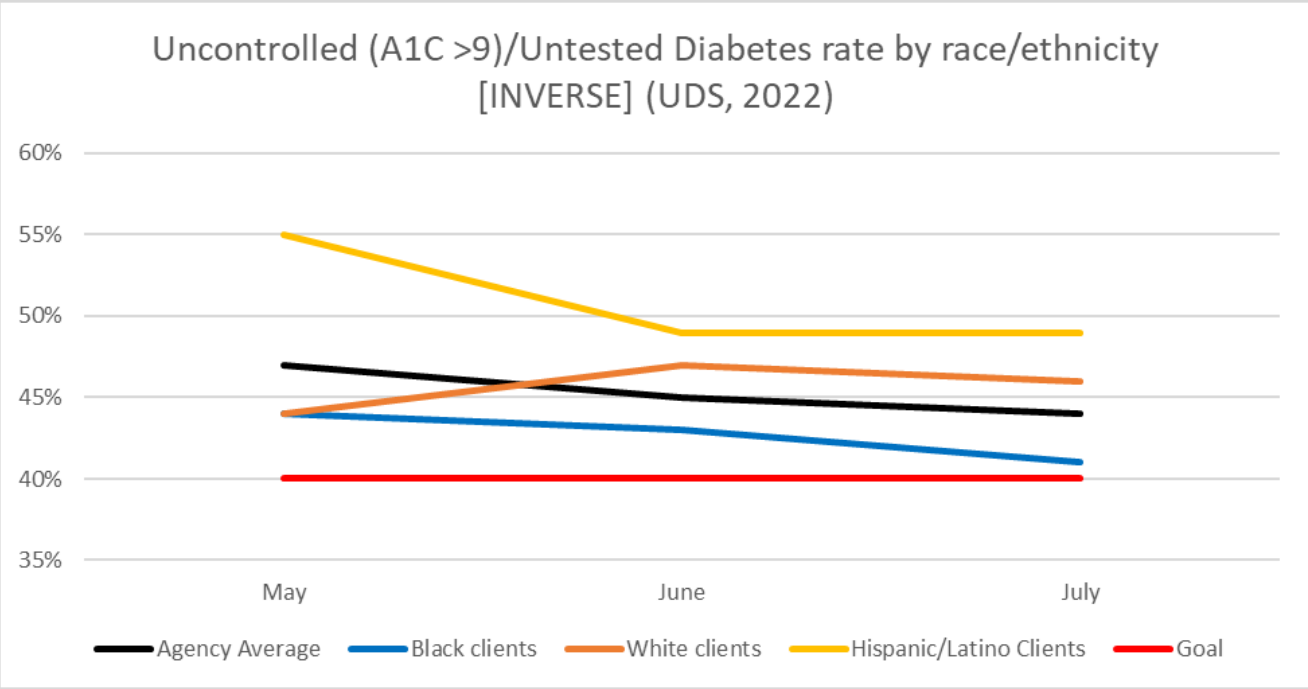


Health Disparities Data

Health Disparities Dashboard

1. Prioritized five measures – 2 chronic and 3 preventive – to begin displaying disparity data
   - Of the 5 measures, two are also prioritized PI initiatives (cervical cancer screening and hypertension)
2. Dashboard is shared at PI Committee and is on our staff portal with more detail
   - Each measure has a description of the measure for an introduction and how we are addressing each as an agency
3. The Health Equity Specialist (Arie!) now attends QA team meetings to discuss next steps to address disparity data

Health Disparities Dashboard: Diabetes

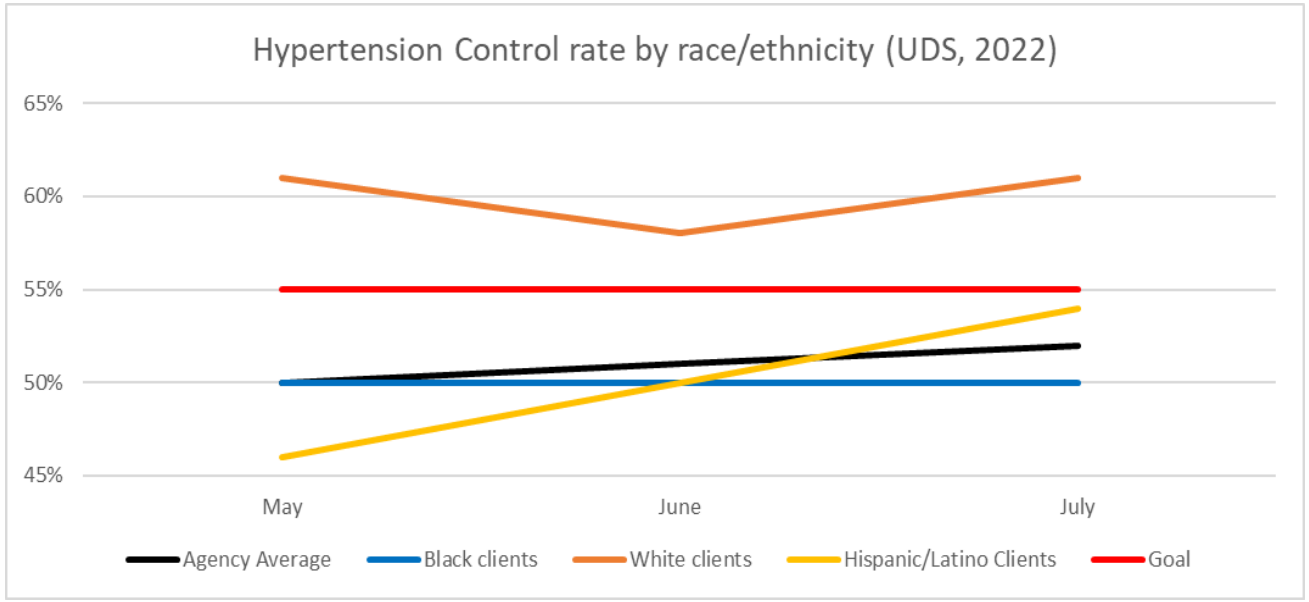


Diabetes (A1C >9) HCH Population	May (47%)	June (45%)	July (44%)	July num/den Agency: 372/854
Black Clients Total:	44%	43%	41%	190/468
Black Male Clients:	45%	45%	42%	126/301
Black Female Clients:	42%	41%	38%	64/167
White Total Clients:	44%	47%	46%	37/80
White Male Clients:	48%	50%	49%	23/47
White Female Clients:	40%	42%	42%	14/33
Hispanic/Latino Total Clients:	55%	49%	49%	136/276
Hispanic/Latino Male Clients:	57%	49%	54%	64/119
Hispanic/Latina Female Clients:	53%	48%	46%	72/157

Red = worse than agency average for the month

Green = better than agency average for the month

Health Disparities Dashboard: Hypertension



Hypertension Control HCH Population	May (50%)	June (51%)	July (52%)	July num/den agency: 845/1622
Black Clients Total:	50%	50%	50%	527/1057
Black Male Clients:	50%	51%	51%	364/716
Black Female Clients:	49%	49%	48%	163/341
White Total Clients:	61%	58%	61%	111/181
White Male Clients:	63%	60%	62%	80/129
White Female Clients:	57%	55%	60%	31/52
Hispanic/Latino Total Clients:	46%	50%	54%	191/354
Hispanic/Latino Male Clients:	47%	46%	56%	84/149
Hispanic/Latina Female Clients:	45%	53%	52%	107/205

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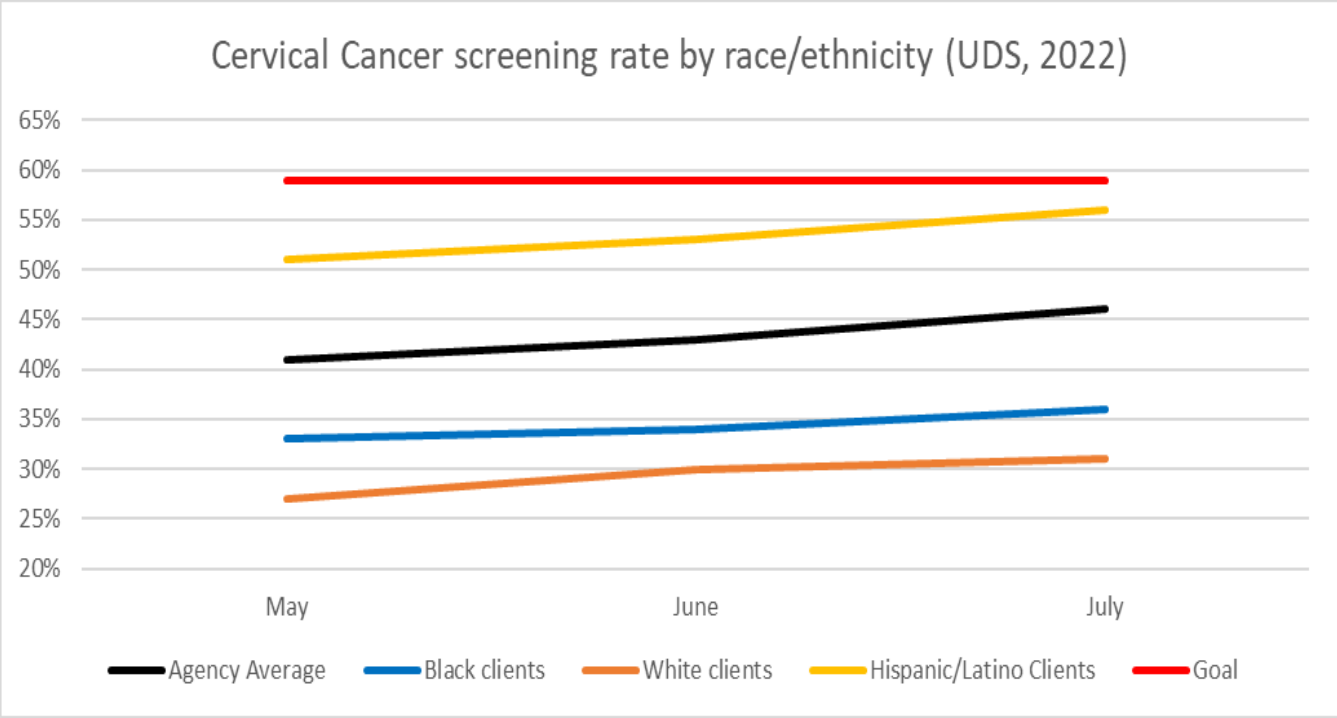
Health Disparities Dashboard: Cervical Cancer Screenings



*Cervical Cancer Screening HCH Population	May (41%)	June (43%)	July (46%)	July num/den Agency: 887/1940
Black Clients	33%	34%	36%	215/600
White Clients	27%	30%	31%	77/250
Hispanic/Latino/-a Clients	51%	53%	56%	609/1086

*Includes clients assigned female at birth (AFAB)

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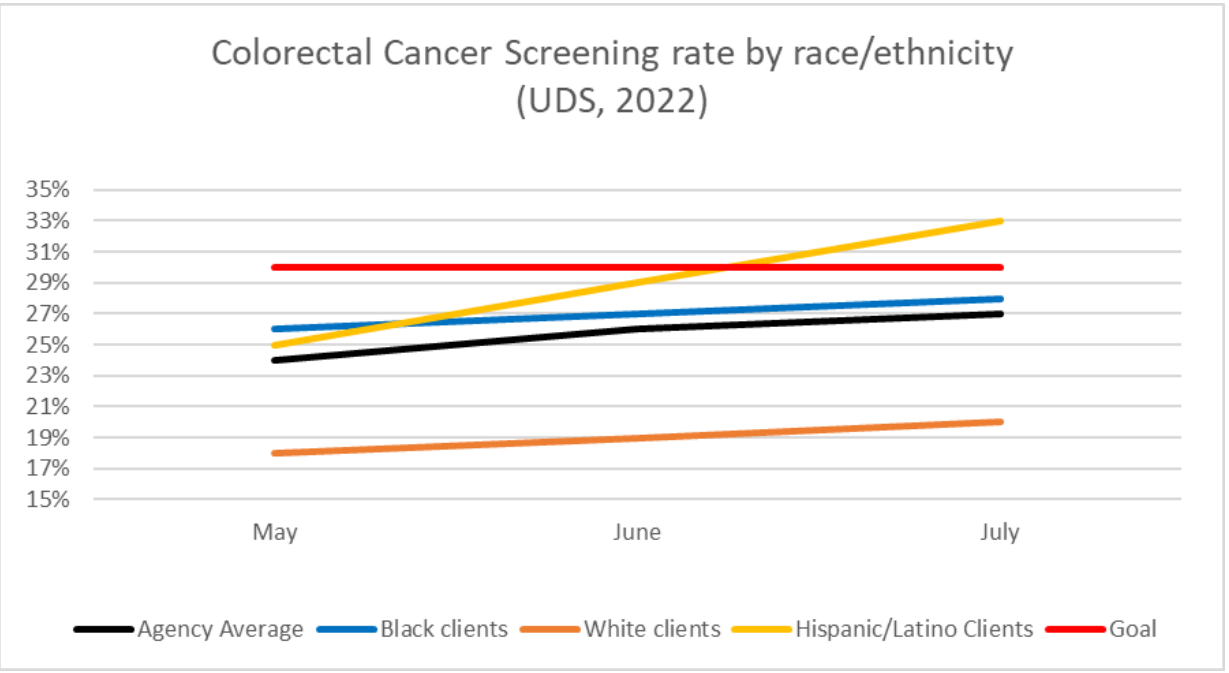
Health Disparities Dashboard: Colorectal Cancer Screenings



Colorectal Cancer Screening HCH Population	May (24%)	June (26%)	July (27%)	July num/den Agency: 565/2079
Black Clients Total:	26%	27%	28%	380/1369
Black Male Clients:	25%	27%	28%	265/956
Black Female Clients:	26%	28%	28%	115/413
White Total Clients:	18%	19%	20%	67/329
White Male Clients:	20%	22%	23%	51/226
White Female Clients:	14%	14%	16%	16/103
Hispanic/Latino Total Clients:	25%	29%	33%	111/338
Hispanic/Latino Male Clients:	23%	27%	30%	45/152
Hispanic/Latina Female Clients:	26%	30%	35%	66/186

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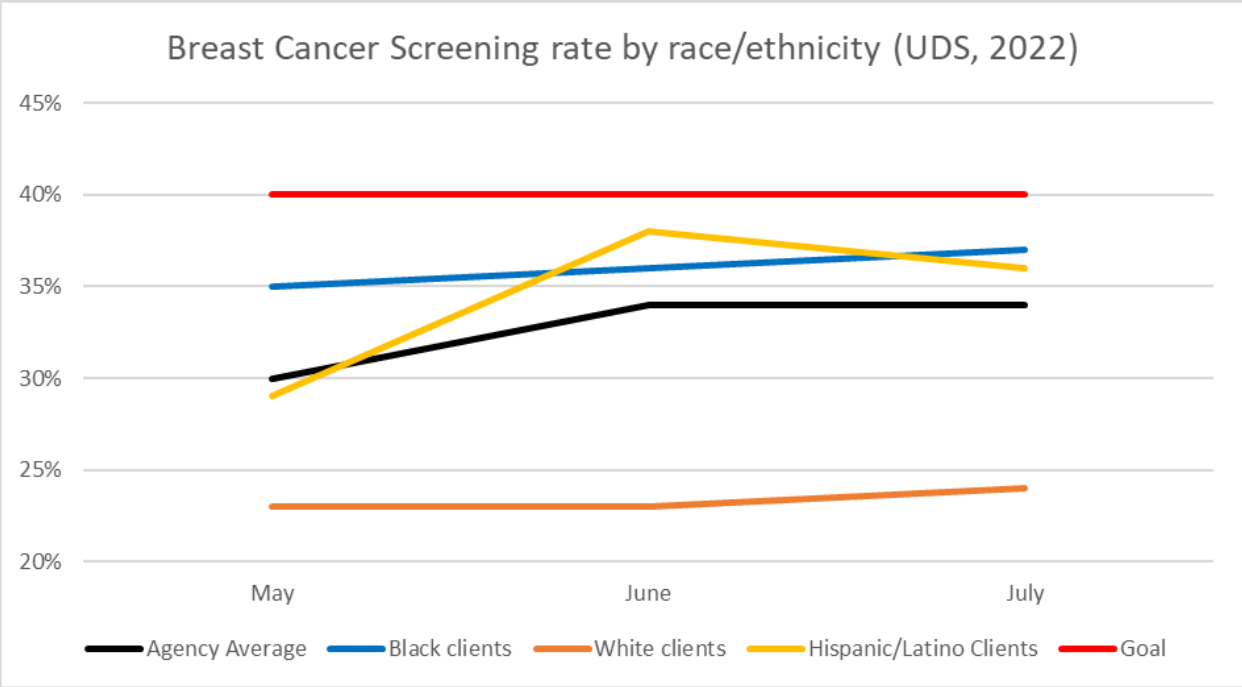
Health Disparities Dashboard: Breast Cancer Screenings



*Breast Cancer Screening HCH Population	May (30%)	June (34%)	July (34%)	228/662
Black Clients	35%	36%	37%	148/395
White Clients	23%	23%	24%	23/97
Hispanic/Latino/-a Clients	29%	38%	36%	57/159

*Includes clients assigned female at birth (AFAB)

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Discussion on Disparity Data

- Complex – shouldn't take this data at face value
  - More clients from one race/ethnicity may represent a larger proportion of clients seen for certain visit types (i.e. MAT and Mobile clinic) where certain measures may not regularly be addressed (preventive cancer screenings, etc.) Other factors at play (SDoH)
  - Clients may satisfy a measure but we may not have updated medical records
  - Other factors?
- Discussed as a quality team – want to use evidence-based research and practice to change and improve practices
- Other considerations around next steps to moving health disparities work forward?

Additional goal areas listed in PI goals

1. Immunizations: Flu later in the year (Pop Health)
2. Care Coordination: Closing the loop on Referrals

This will allow us to prioritize more than 5 (at least 7) throughout the year

Resource Stewardship Goal – de-prescribing aspirin

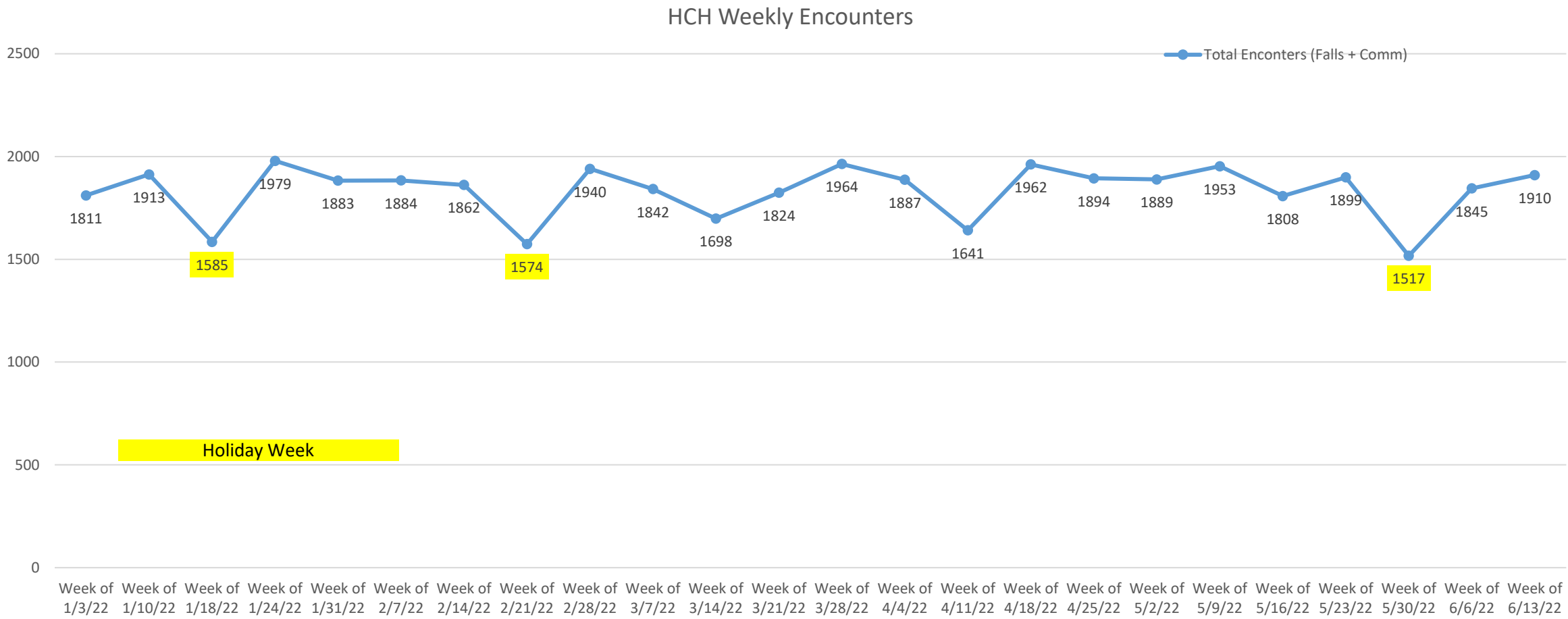
Measure/Key Performance Indicator	Due	How measure	Baseline	Goal	YTD
Decrease proportion of clients aged 70 and older who are on aspirin for primary prevention by 15% [inverse measure]	12/31/2022	% prescribed aspirin for primary prevention	74%	59%	71%

- Report by provider is sent out quarterly
- One of the medical providers led a medical provider training modeling how to have a conversation with clients who are on aspirin for primary prevention around de-prescribing
- Visual reminders in client charts (those with upcoming appts) to consider de-prescribing

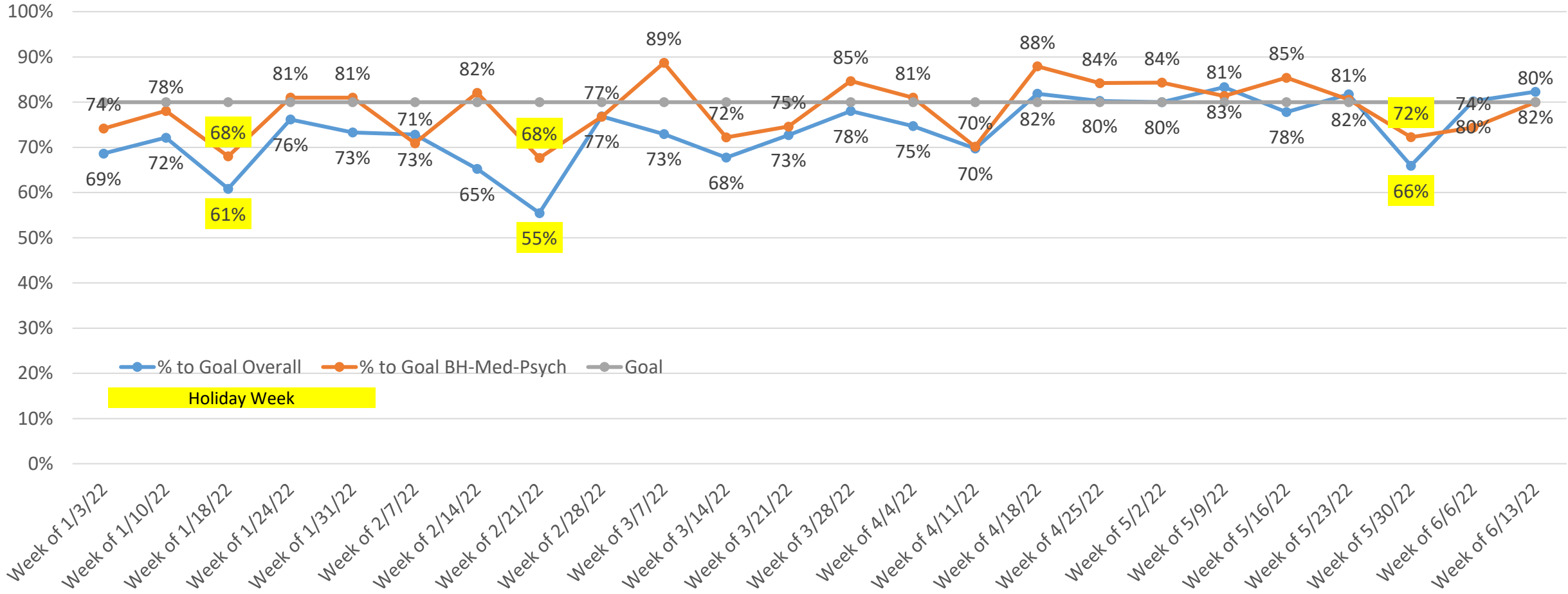
Access Utilization Goal

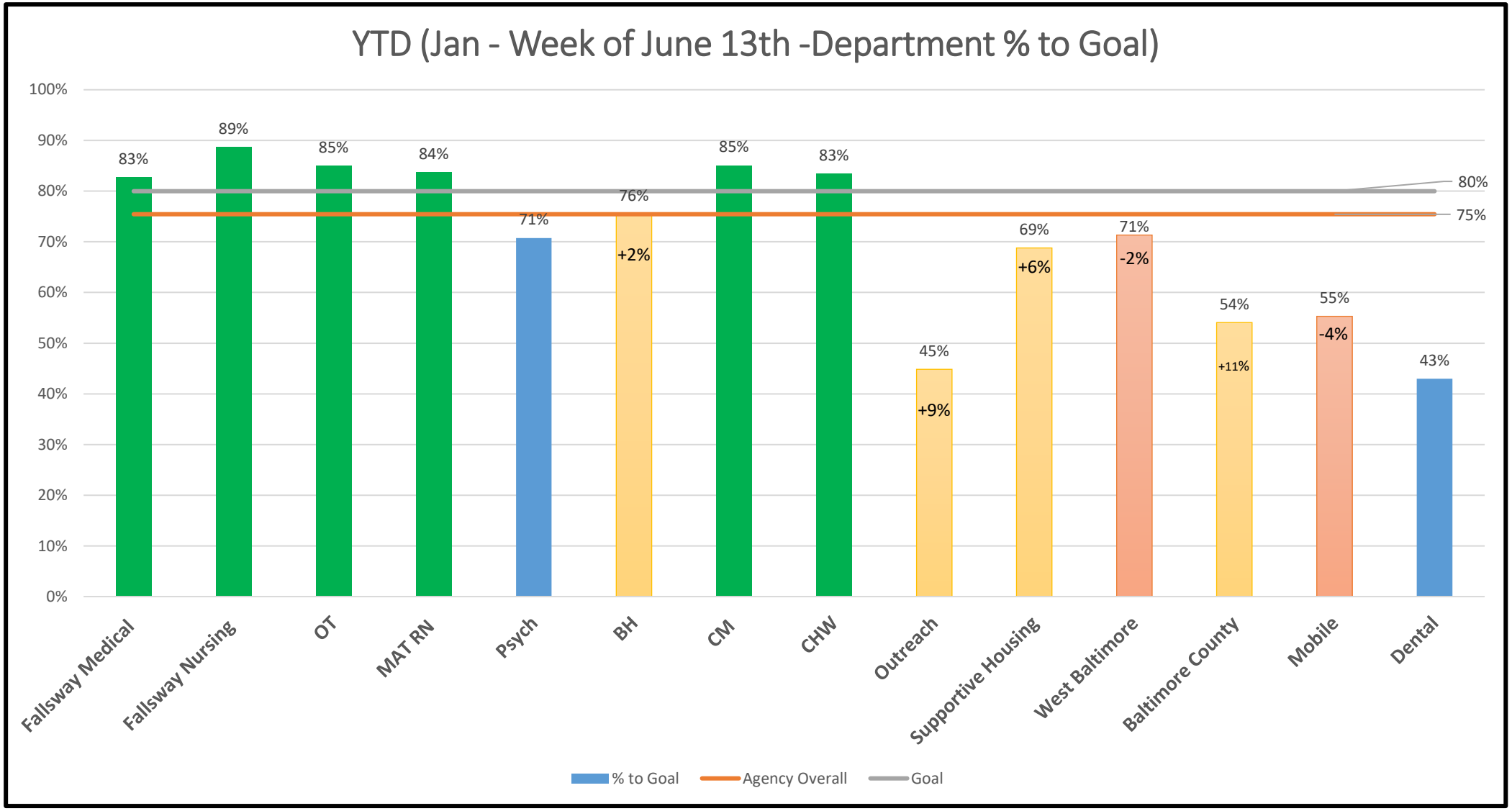
Access Utilization	Due	How measure	Goal	YTD
Rate of Appointment Completions (Goal 80%)	12/31/2022	Average # of encounters /Average # of weekly goal b	80%	75%

Agency Clinical Departments - Weekly Encounters



Rate of Appointment Completions (Goal 80%)





Key

	meeting goal
#	% increase from last MTM meeting
#	% decrease from last MTM meeting

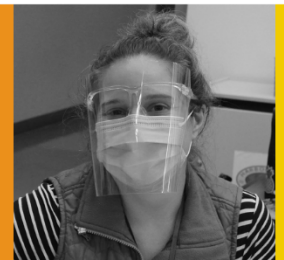
Last MTM date frame was Week of 1/6 to Week of 4/25

PI announcements

Client Experience Survey update

- Previously, plan was to pilot real-time feedback + traditional survey; however, decided to change course and only do the Medstatix pilot for 2022
- Beginning July 1st, some clients began receiving a text link following a visit to complete a survey
- By October will survey 40 staff to include:
  - All medical providers
  - All BHTs and addiction counselors
  - All Psychiatrists
  - Rotate through CMs + Nurses

Month	# staff surveyed
July	5
August	12-15
September	22-30
October	40
November	40
December	40



First Fridays

- Enjoy lunch with co-workers over salad (3rd flr conference room – socially distanced)
  - Noon-1 pm
  - Leftovers in conference room/break room
  - If inclined: sign-up to **bring one ingredient** (sign-up sheet will be in break room 2 weeks prior)

Questions?