Monthly Performance Improvement Committee

July 2023

Presenters:

- Lisa Hoffmann, Director of Quality Improvement
- Marie Stelmack, Quality Improvement Specialist

Agenda

1. Morning chat (5 min)
2. PI updates (25 min)
3. PDSA cycle refresher (3 min)
4. PH updates (8 min)
5. Questions and discussion (4 min – can also ask along the way!)

Morning!

Today's icebreaker!

What was your favorite childhood toy or game?

2023 PI Measures

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

Disease Management	HCH 2022	May	June	2023 Goal
Reduce inappropriate antibiotic prescriptions	new	--	100%	<25%
Hospitalization follow-up	new	--	70%	65%
Height and Weight Assessment and Health Counseling	26%	41%	43%	65%
Controlling high blood pressure	58%	58%	59%	65%
Depression Remission at Twelve Months	9%	4%	4%	11%
Care management (with care plan)	67%	96%	96%	75%
FLU: adult vaccination rates	16%	--	N/A	45%
Advance Care Planning	new	1%	2%	5%
Third Next Available: see next slides	new	BC: 9 WB: 13 F: 23	BC: 12 WB: 14 F: 23	Reduce by 5%
Client Experience: see next slides	new	91% (C) 92% (S)	90% 89%	93% (both)

Legend
3+ Improvement
1-2+ improvement
No change
Reduction

July PI

Goal 1: Antimicrobial Stewardship

Throughout 2023, monitor the percentage of patients with a diagnosis of acute bronchitis or upper respiratory infection (URI) who were not prescribed an antibiotic prescription (Goal >75%). The agency will also review data broken down by race, ethnicity, and SOGI to identify and reduce disparities in prescribing practices.

June YTD: 100%

Who is who and what's new

1. **Subcommittee members:** Liz G.; Iris L.; Marie S.; Lisa H.

2. **Recent happenings:**
   - Azara training provided 7/6
     - Empowering providers to review their own data and prescribing practices
     - Well received by providers
     - Measuring success – report of provider viewed reports
       - For this and other measures

3. **Next steps:**
   - Reconvening in October for flu season

Goal 2: Hospitalization Follow Up

By December 31, 2023, the Agency will attempt follow-up within 7 days for 65% of individuals following a hospitalization and identify SDH or racial disparities for client's post-hospitalization.

June 2023: 70%

Who is who and what's new

1. **Subcommittee members:** Catherine F; Julia D.; Tara D.; Katie H.; Muhammed M.; Lisa L.; Margaret F.; Tracy R.; Marie S.; Lisa H.

2. **Recent happenings:**
   - Refining the monthly report
   - Denominator doubled in June (~40/week → ~80/week; heat possible cause?)

3. **Next steps:**
   - Proposal for automation moving to leadership

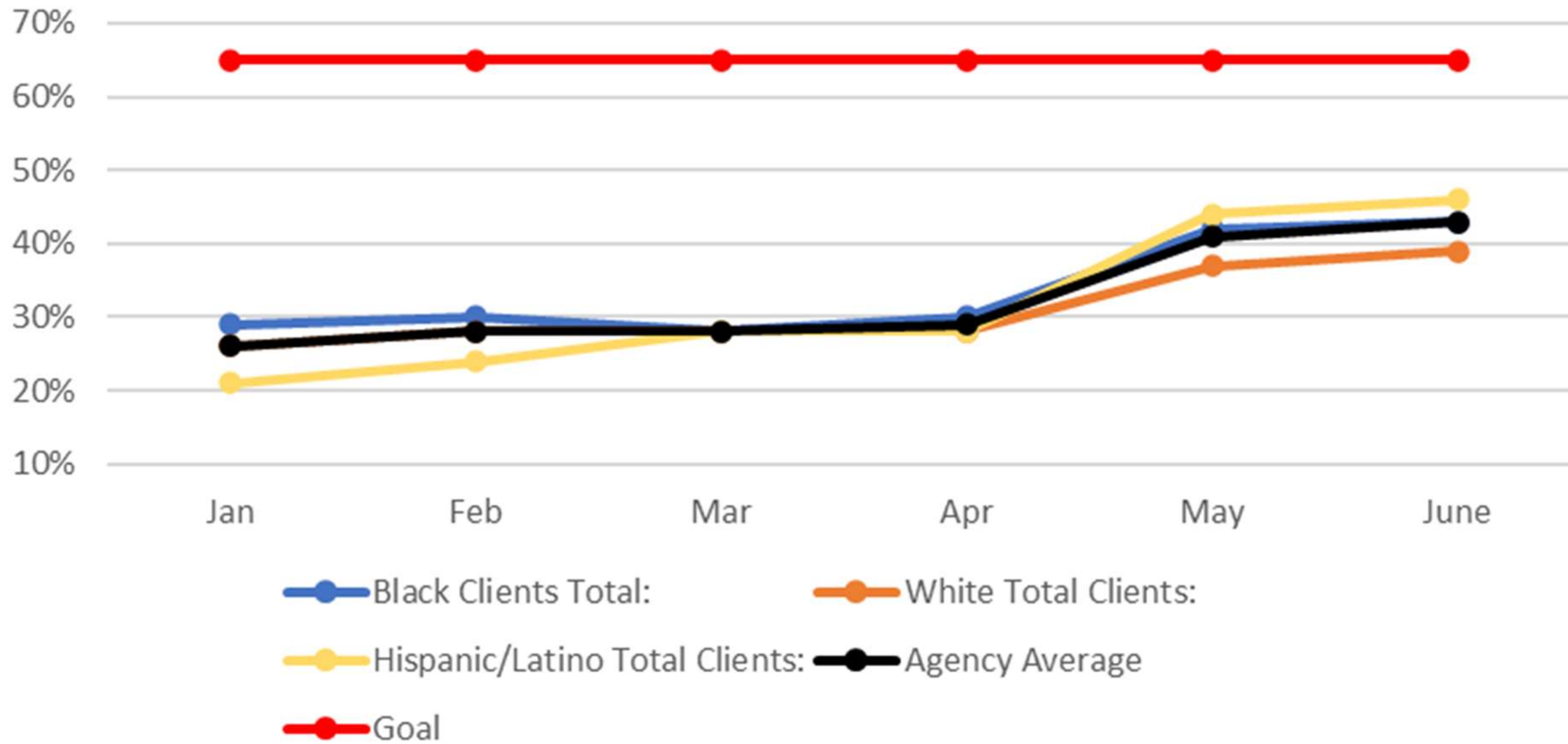
Goal 3: Height and Weight Assessment and Health Counseling

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.

June YTD: 43%

Disparity Data

	June
Black Clients Total	43%
White Clients Total	39%
Hispanic/Latino Clients Total	46%
Agency Average	43%
Goal	65%



Who is who and what's new

1. **Subcommittee members:** Arie HS.; Amelia J.; Meredith J.; Molly G.; Adrienne T.; Marie S.; Lisa H.
2. **Recent happenings:**
   - Health at Every Size training to Behavioral Health (now Med, Psych, and BH trained)
     - Assessing impact on provision of care via survey
   - Equipment accessible and convenient in all departments
3. **Next steps:**
   - Developing order sets with resource recommendations and guidance in conversations
     - Subcommittee recommending EHR available client education handouts that are in line with HAES principles and food security lists

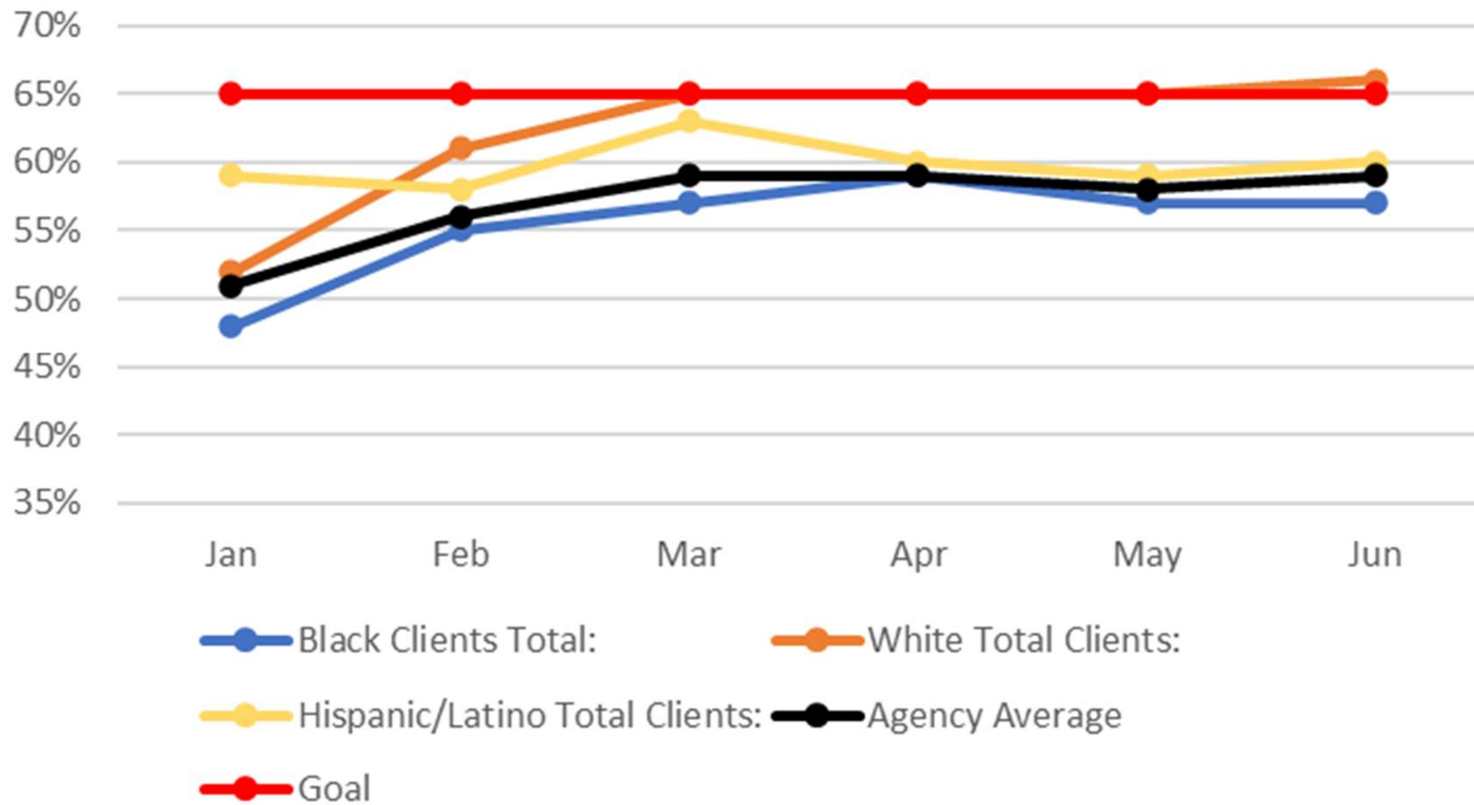
Goal 4: Blood Pressure Control

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%.

June YTD: 59%

Disparity Data

	Jun
Black Clients Total	**57%**
White Clients Total	**66%**
Hispanic/Latino Clients Total	**60%**
Agency Average	**59%**
Goal	**65%**



Who is who and what's new

1. **Subcommittee members:** Tyler C.; Faith T.; Julia D.; Marie S.; Tracy R.; Lisa H.
2. **Recent happenings:**
    - Hang tags → conversations with clients
    - Sticky notes for clients on monotherapy
        - Assessing and learning from providers about impact
    - Literature review and Health Equity Training about disparities in HTN control
        - Community power building
        - Connecting with HCH program that participated in past CMS program Million Hearts
3. **Next steps:**
    - Addressing disparity

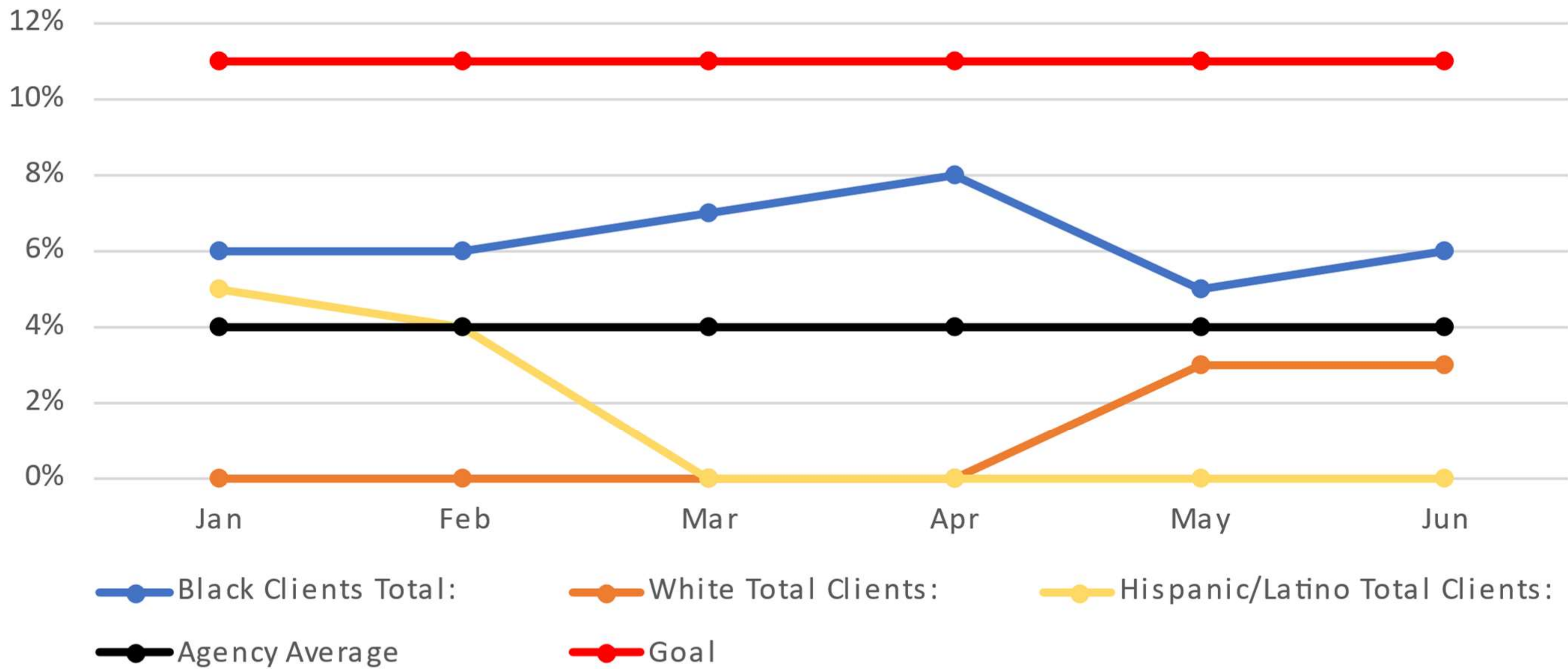
Goal 5: Depression Remission

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.

June YTD: 4%

Disparity Data

	Jun
Black Clients Total:	6%
White Clients Total:	3%
Hispanic/Latino Clients Total:	0%
Agency Average	4%
Goal	11%



Who is who and what's new

1. **Subcommittee members:** Jan F.; Arianne J.; Kellie D.; Lawanda W.; Taavon B.; Marie S.; Lisa H.
2. **Recent happenings:**
   - Challenges in meeting this measure due to our client population – investigating whether other HCH programs have had success (and how)
   - Modifying Quality Tab view for Behavioral Health Therapists and Therapist Case Managers and re-training on Quality Tab usage for depression remission
   - Looking into prescribing practices as an intervention
3. **Next steps:**
   - Review literature on interventions to address disparities

Goal 6: Time to Third Next Available

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).

YTD:

Department	2023 Goal	May	June
HCH - Baltimore County	**12**	9	12
HCH - West Baltimore	**19**	13	14
HCH-421 Fallsway	**23**	23	23
Agency Average	**22**		

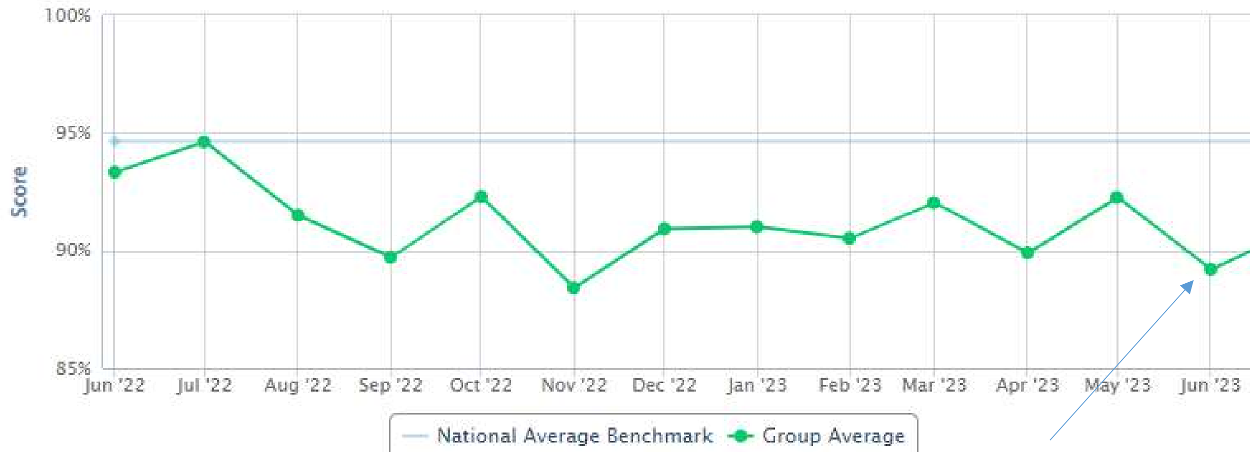
Who is who and what’s new

1. **Subcommittee members:** Alkema J., Marie S.; Tolu T.; Lisa H.

2. **Recent happenings/next steps:**
    - Reviewing 24 hour follow up appointments and ensuring being used properly

Goal 7: Client Experience

By December 31, 2023, the Agency will achieve three consecutive months in which both "Respected by check-in and check-out staff" and "Respected by scheduling staff" rate at or over 93%



Scheduling staff: 89%

June:

Check-in/out staff: 90%

Who is who and what's new

1. **Subcommittee members:** Juanita P.; Muhammed M.; Gia J.; Lisa L.; Hala S.; Tara D.; Malcolm W.; Maonry L.; La Keesha AV.; Mona H.; Lisa H.
2. **Recent happenings:**
   - Physical set up at check-in interventions to reduce noise
     - Paddle signs to signal next available CSR
     - Corresponding colored signs for desk numbers
     - Sign and line changes to improve flow; clarifying which line is the appt vs walk-in line
     - Organizing huddles to proactively meet client needs at check-in (County)
3. **Next steps:**
   - Develop change idea with Scheduling

Goal 8: 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.

June YTD: 96%

Agency Care Plan Totals

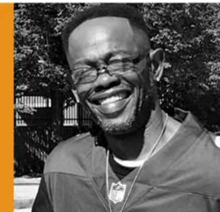
Category	DIAGNOSIS	Cohort	CarePlans	% Care Plans Co..
Null	Null	0	0	
Behavioral Health	Depression care management	112	112	100%
Case Management	Psychosocial analysis management	160	156	98%
Nursing	Nursing care management session	82	75	91%

Who is who and what's new

1. **Subcommittee members:** Tracy R.; Marie S.; Lisa H.

2. **Recent happenings:**
   - Drafting Monday Minute videos to spotlight champions and best practices
     - 3 departments – sent to all in departments
   - Working toward 75% offer rate for printing (riding this wave)
   - Simplified paper handout

3. **Next steps:**
   - Creating and disseminating videos and paper handouts



Goal 9: Flu Vaccination Rate

Forty-five percent (45%) of eligible clients have documentation of an influenza vaccination in the electronic health record.

YTD: N/A (last flu season ended at 20%)

Who is who and what's new

1. **Subcommittee members:** Tracy R.; Catherine F.; Julia D.; Shannon R.; Hanna M.; Rebecca R.; Marie S.; Lisa H.
2. **Recent happenings:**
   - Kickoff meetings!
   - Identifying medical workflow @ 421 for administering flu vaccines
     - Clients outside of in-person medical appointments will be added to CMA schedule
3. **Next steps:**
   - Running an RCA to address challenge areas
   - Meeting with Comms to identify flu campaign strategies
   - Kickoff meeting for Flu and Coat drive event on 7/20
   - Identify workflow @ Community Sites

Goal 10: Advance Care Planning

Improve the percentage of adults 66 years and older who had an advance care planning discussion completed or documented in the medical record by 5% and create one SOP.

June YTD: 2%

Who is who and what's new

1. **Subcommittee members:** Tyler G.; Iris L.; Tracy R.; Marie S.; Lisa H.

2. **Recent happenings:**
   - Medical provider training coming up
   - First meeting to plan for lunch and learn 7/18

3. **Next steps:**
   - Lunch and Learn in September
   - Working with Communications Team to promote

Let’s get a refresher on PDSAs!

https://www.youtube.com/watch?v=szLduqP7u-k

3 min

Population Health Updates

Athena Mass Messaging Campaign for Breast Cancer

New mass messaging campaign in July for clients past due for breast cancer screening:

- **Text**
- **Email**
- **Voicemail**

Plan

1) Contact client through Athena mass messaging (*1st contact*)

2) Clients encouraged to contact HCH for appointment/referral

3) Call Center will direct clients to Shannon Riley via Patient Case

4) Team* will divvy up call back work, order and coordinate navigation needs (*2nd contact*)

Team: Tracy Russell (Director), Shannon Riley (PH RN), Kim Taylor (CHW- West), Isaac Epstein (CHW- County)

HIV Prevention and Awareness at HCH

Front Porch Campaign and **PrEP Activity** (last week of June)

Front Porch: 45 clients

- MCO provides coffee/hot chocolate/donuts
- Use Outreach support for client engagement
- Specific health topic is highlight of discussion
- CSR, Medical, Outreach/CHW, Other Support!

Activity/Testing (pilot): 6 clients

- Stations: give aways/food, short education/discussion, HIV testing and follow up permission

Photos from HIV Awareness & PrEP Activity June 2023

Interested in any of these goals or have questions? Reach out to

Director of QI, Lisa Hoffmann or

QI Specialist, Marie Stelmack.