Performance Improvement Committee

June 17, 2020

HEALTH CARE for the HOMELESS

June PI Committee Agenda

Monthly Dashboard

- Breast Cancer Screening

- Medication Errors

Improvement Updates – Progress and Challenges

- Food Insecurity

- Depression Remission
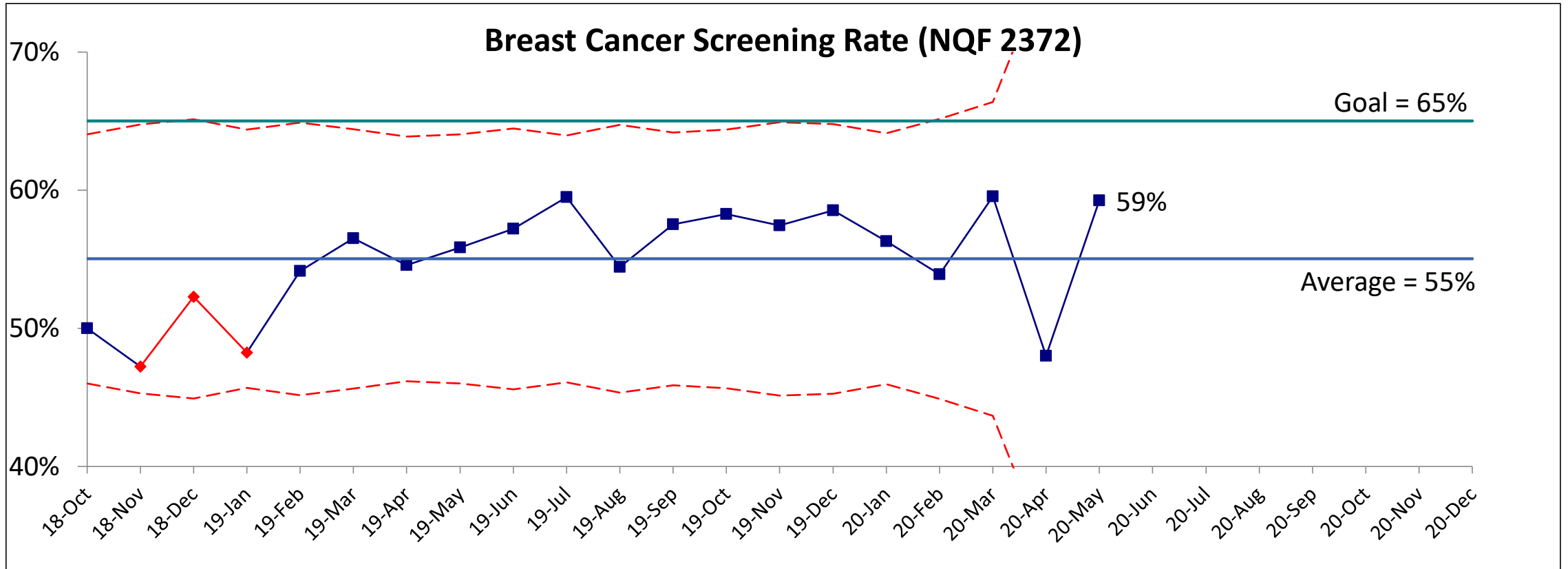
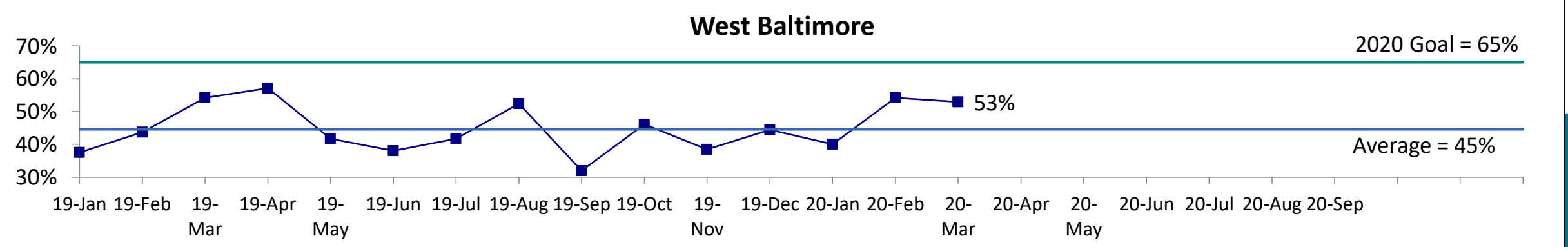- Medication Adherence

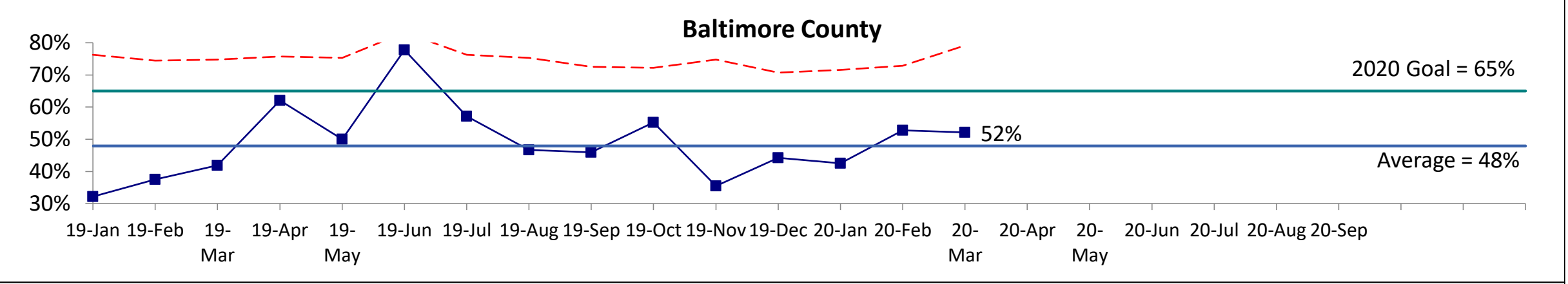- Phone Access

Monthly PI Dashboard

Breast Cancer Screening
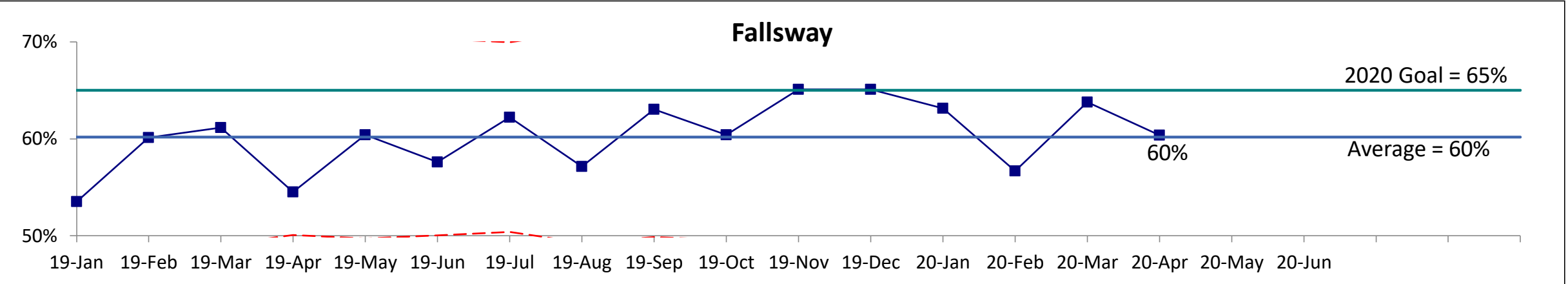
Mammogram Completion Goal: By December 2020, 65% of women recommended to have a completed mammogram will have documentation of screening

Breast Cancer Screening Rate (NQF 2372)

Breast Cancer Screening: Rate By Site

Fallsway

2020 Goal = 65%

Average = 60%

60%

Baltimore County

2020 Goal = 65%

Average = 48%

52%

West Baltimore

2020 Goal = 65%

Average = 45%

53%

Medication Errors

Client Safety Goal: By June 2020, Medication Errors will decrease to 0

Number of Medication Error Incidents Reported
June 2018 - May 2020
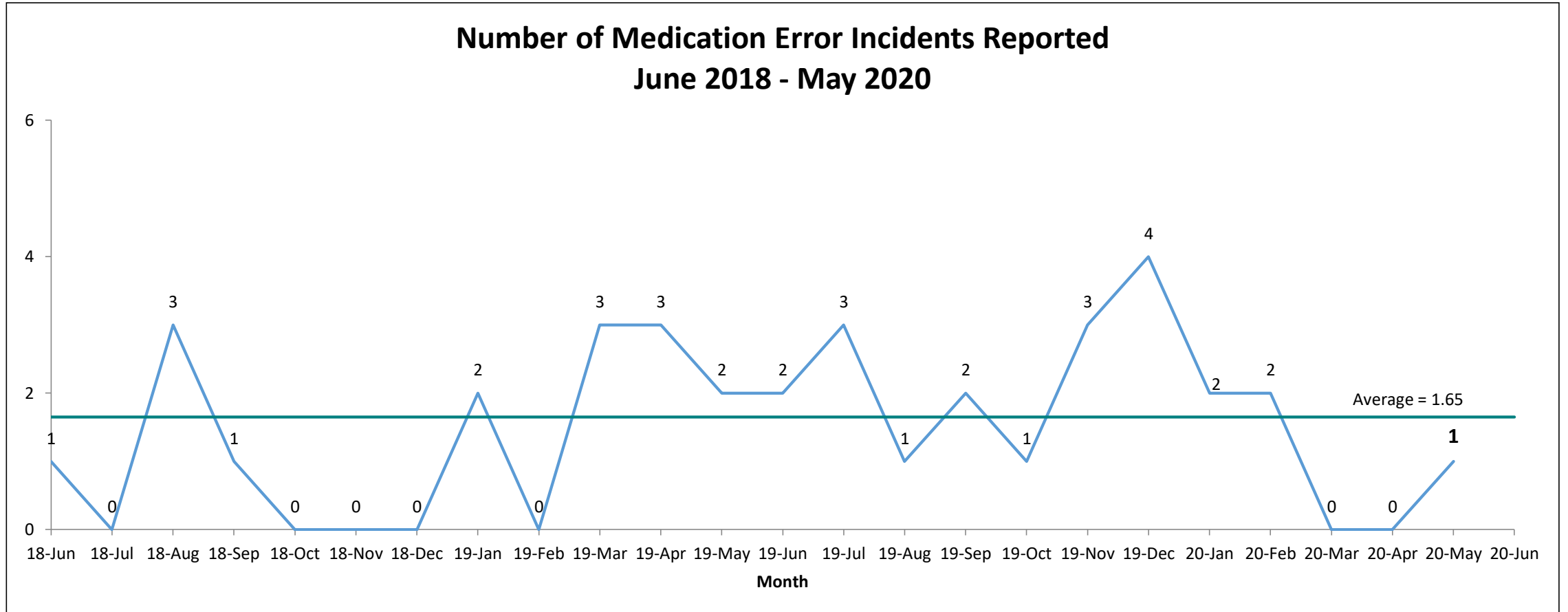
Food Insecurity

Food Security Goal: By December 2020, 90% of clients who identify as having food insecurity on the PREPARE tool will be connected to Case Management*

Percentage of clients identifying food insecurity who are connected to CM/CHWs

Goal = 90%

Av = 73%

71%
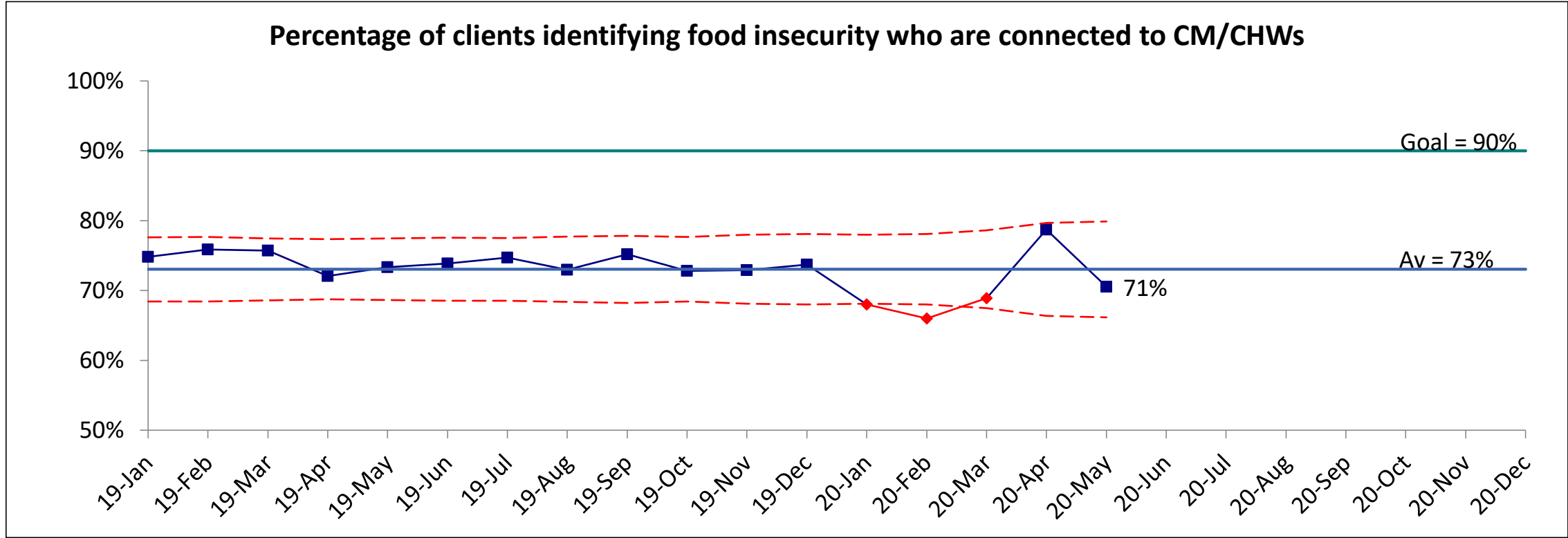
*Includes Community Health Workers

Food Insecurity: Progress

Kickoff Meeting via zoom included the following staff: *Lilian Amaya, Greg Rogers, Laura Garcia, Lawanda Williams, Kim Carroll, Lucho Vasquez, Tracy Russell*

Project Elements:

- Elevate how we utilize the PRAPARE screening for care coordination (If we are taking the time to ask, are we using the information to help clients?)

- Better understand and articulate how we as an agency are able to address food insecurity, including role clarification and limitations (both organizational scope and policy)
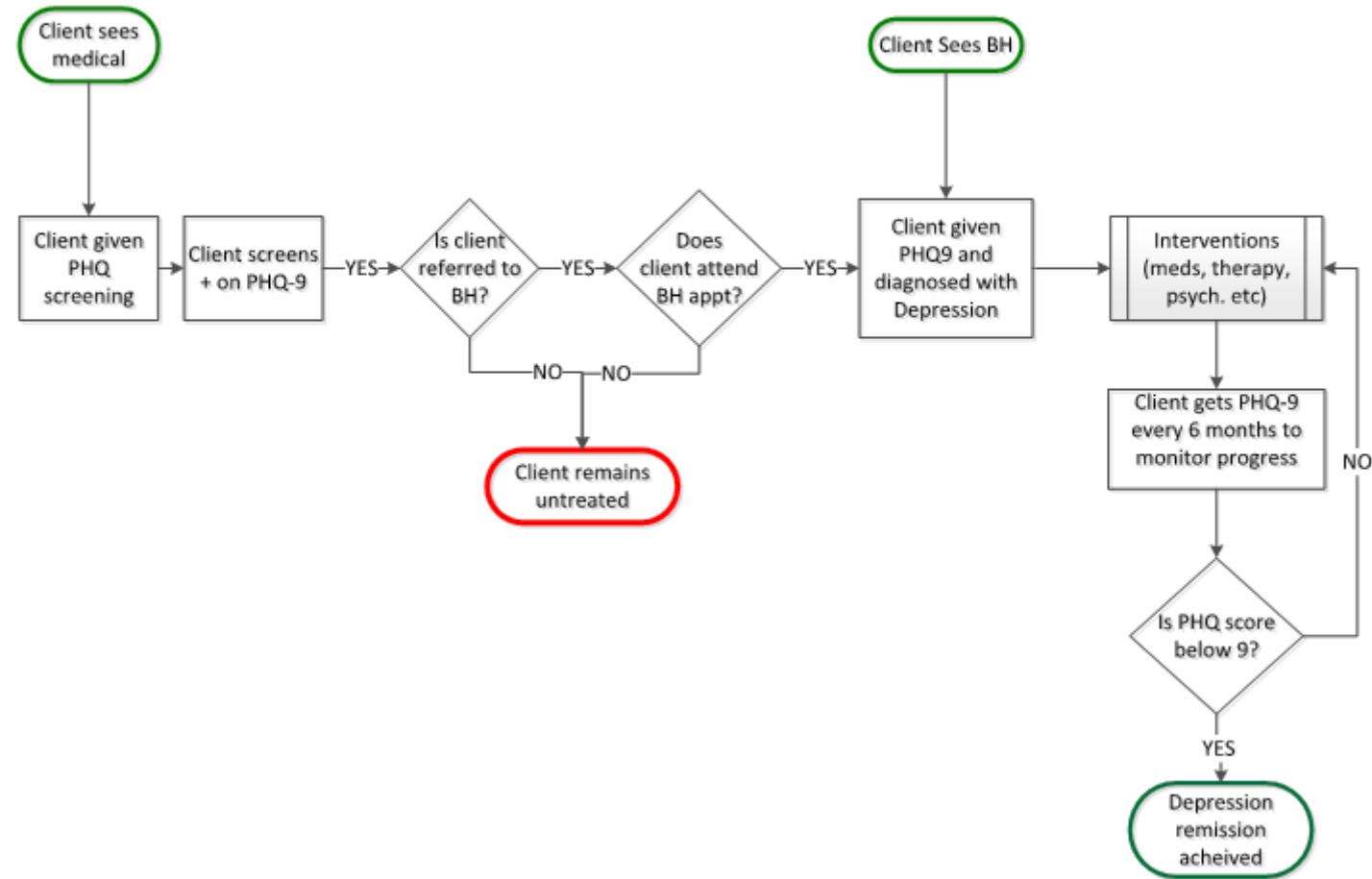
Food Insecurity: Progress
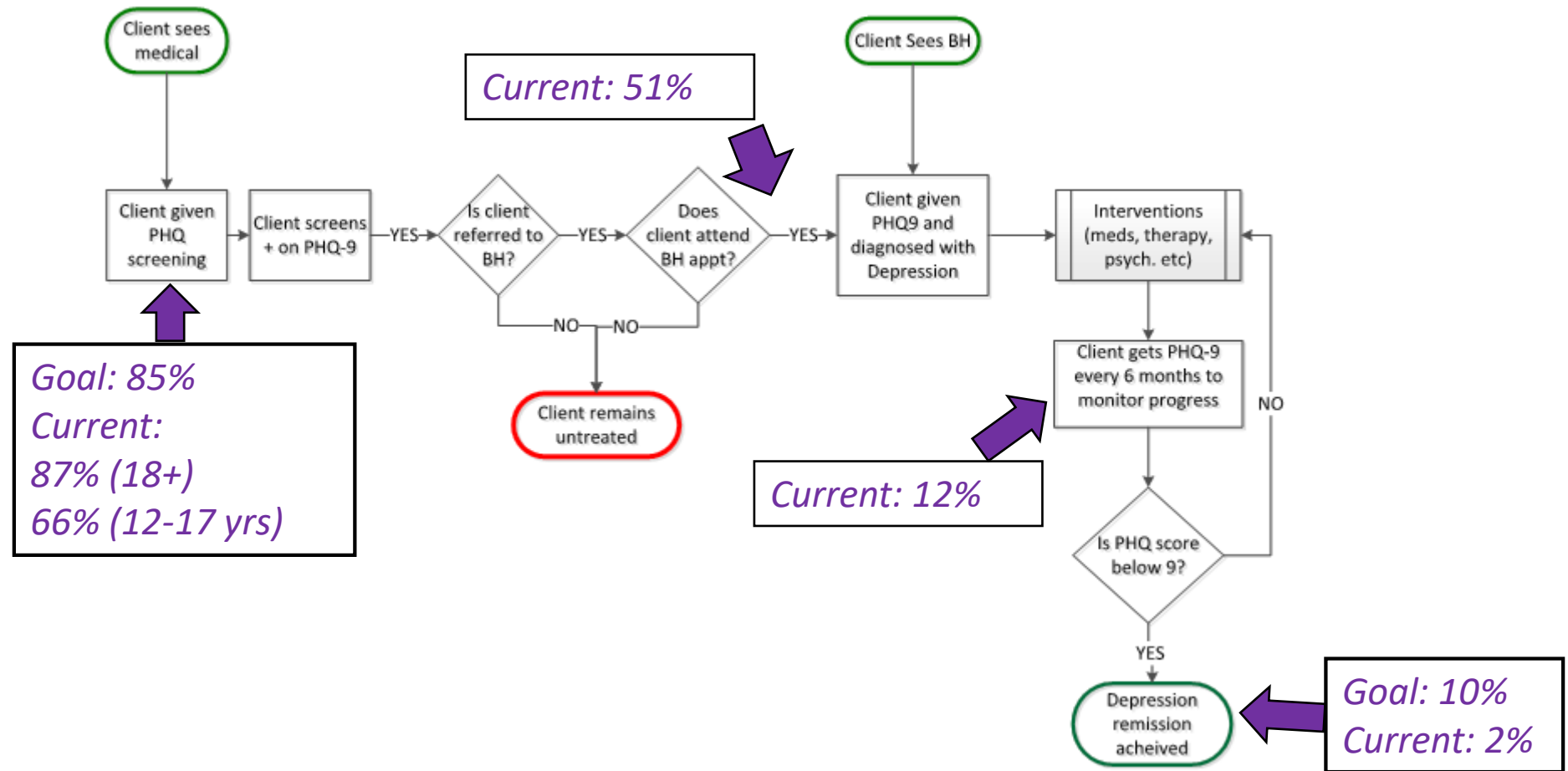
Questions discussed:

- Who is asking this particular SDoH questions and how often?

- Is it part of all provider's workflow to look at the answers to the SDoH? If not, why not?

- How do providers assess what intervention a client/family might need (what is the distinction between referring to Case Management vs a CHW)?

- How do we as an agency find out about different resources to address food insecurity?

- Would it be valuable to the agency to more clearly document the process for collecting and disseminating resources to address food insecurity?

- How is our process different for staff and clients during COVID-19?
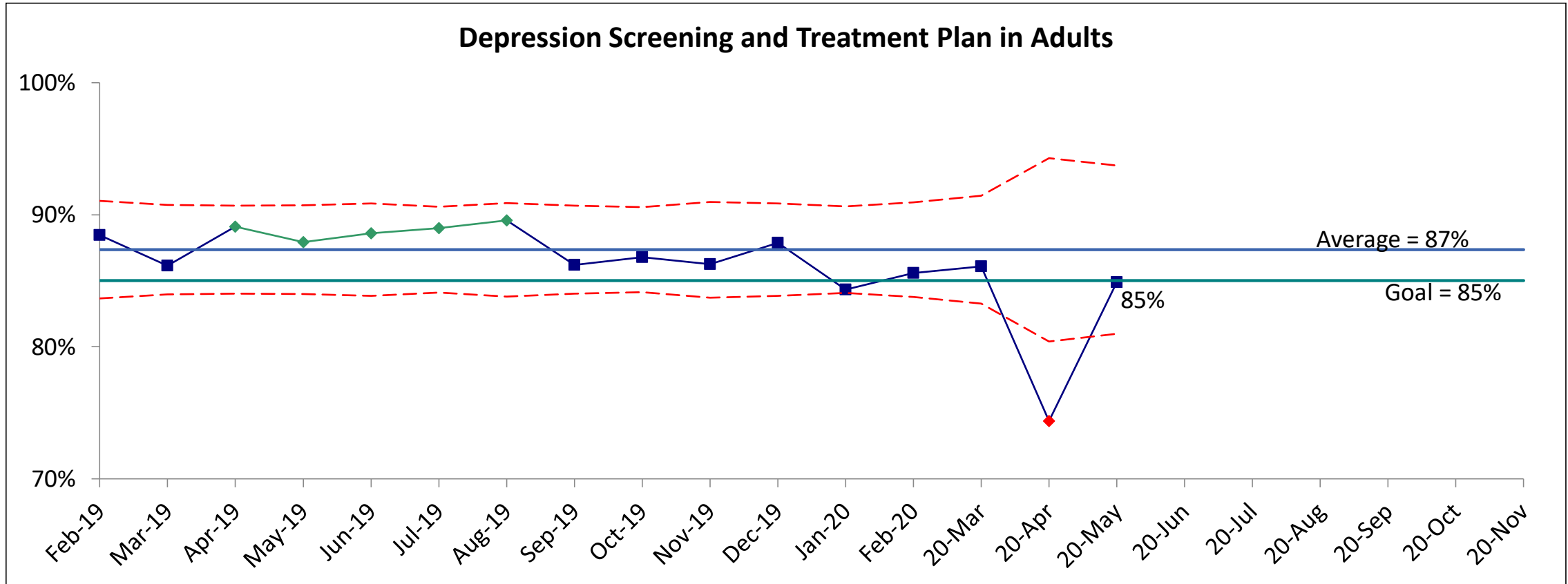
Depression Screening and Treatment

Depression Screening and Treatment

Client sees medical → Client given PHQ screening → Client screens + on PHQ-9 —YES→ Is client referred to BH? —YES→ Does client attend BH appt? —YES→ Client given PHQ9 and diagnosed with Depression → Interventions (meds, therapy, psych. etc) → Client gets PHQ-9 every 6 months to monitor progress → Is PHQ score below 9?

Client Sees BH → Client given PHQ9 and diagnosed with Depression

Is client referred to BH? —NO— / Does client attend BH appt? —NO→ Client remains untreated

Is PHQ score below 9? —NO→ (back to Interventions)
Is PHQ score below 9? —YES→ Depression remission acheived

Current: 51%

Goal: 85%
Current:
87% (18+)
66% (12-17 yrs)

Current: 12%

**Goal: 10%**
Current: 2%

11

Depression Screening and Treatment - Adults

Depression Screening Goal: By August 2020, 85% of clients over 18 years of age will be screened for depression using a validated tool.

Depression Screening and Treatment Plan in Adults

Average = 87%

Goal = 85%

85%

Depression Screening and Remission - Adolescents

Depression Screening Goal: By August 2020, 85% of clients ages 12-17 will be screened for depression using a validated tool.

Depression Screening Ages 12-17

Goal = 85%

Average = 66%

83%
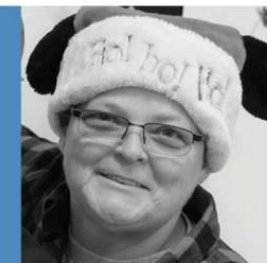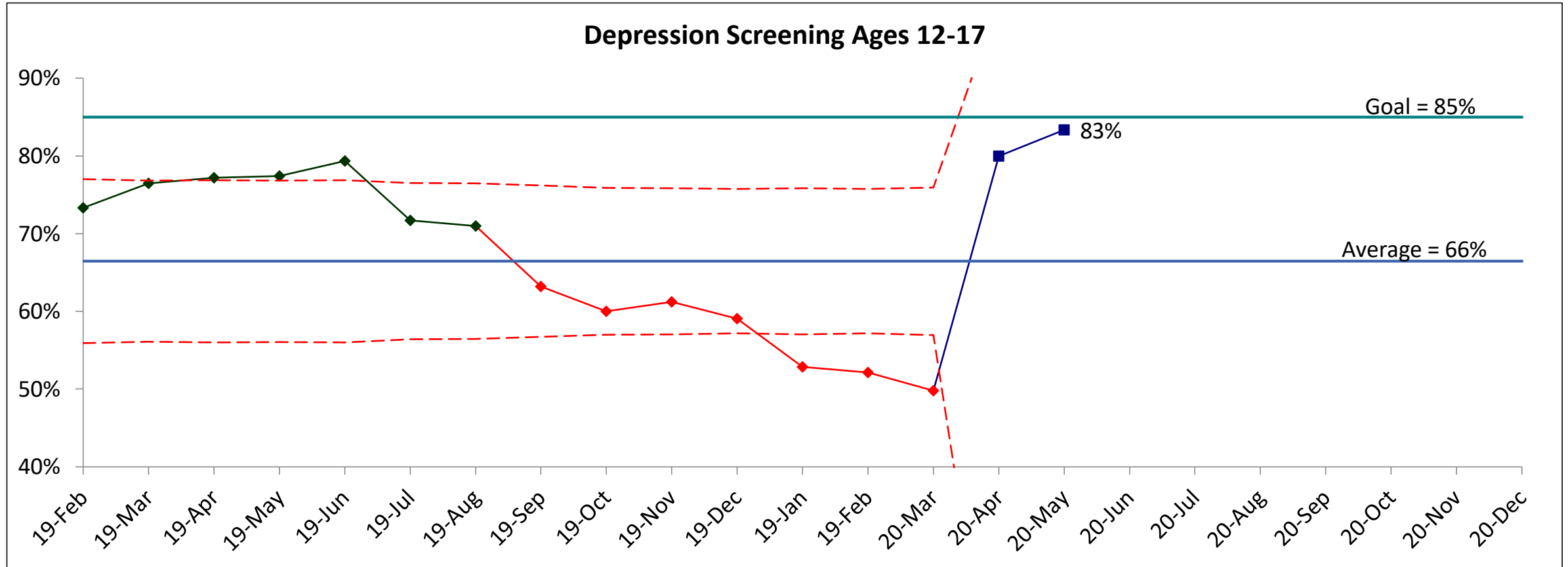
Depression Remission

Depression Treatment Goal: By December 2020, 10% of adults diagnosed with major depression or dysthymia who scored positively on an initial PHQ-9 (>9) will demonstrate remission at 6 months (PHQ <5)


Depression Remission Rate
February 2019 - May 2020
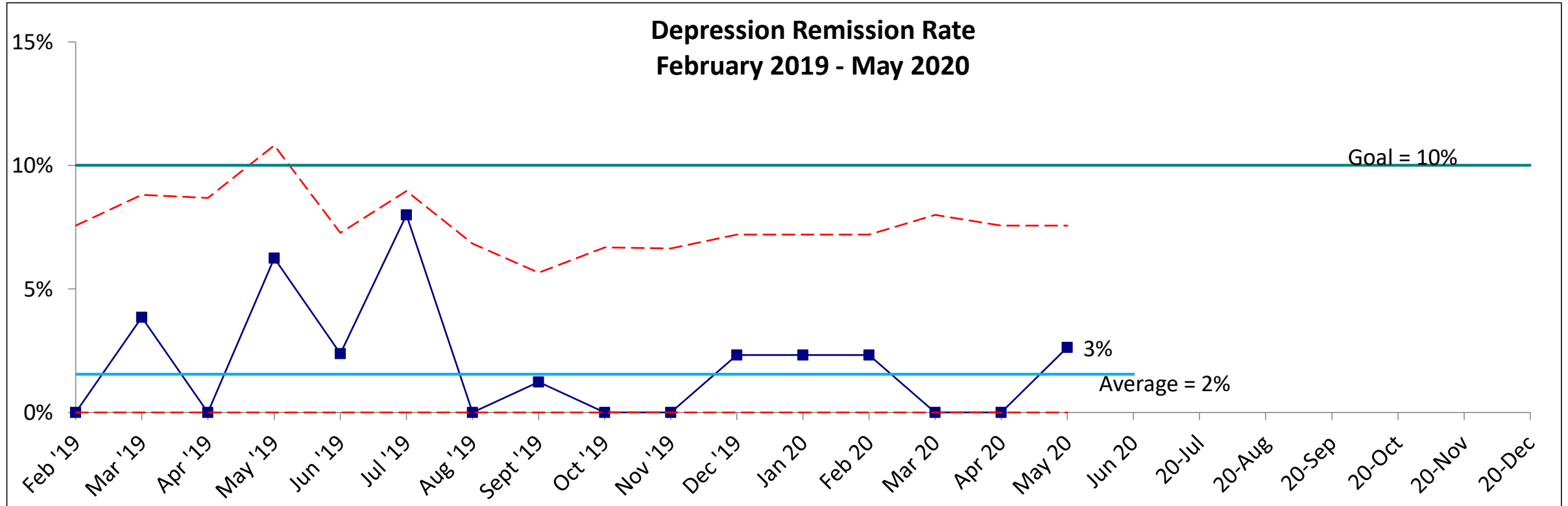
Depression Screening and Remission

Depression Screening + Follow up Strategies:

- Focus on repeated PHQ-9 administration at 5-7 months
  - Long term: Improving the PHQ-9 form in the EHR
  - Short term: Requested registry as a provider tool
- Improved client connection to Behavioral Health
  - Currently at 51% of clients who screened positively in a medical visit on the PHQ were connected to BH
  - Requested a care-team centric registry, will pilot to see if it is effective in connecting more clients.

Depression Screening and Treatment
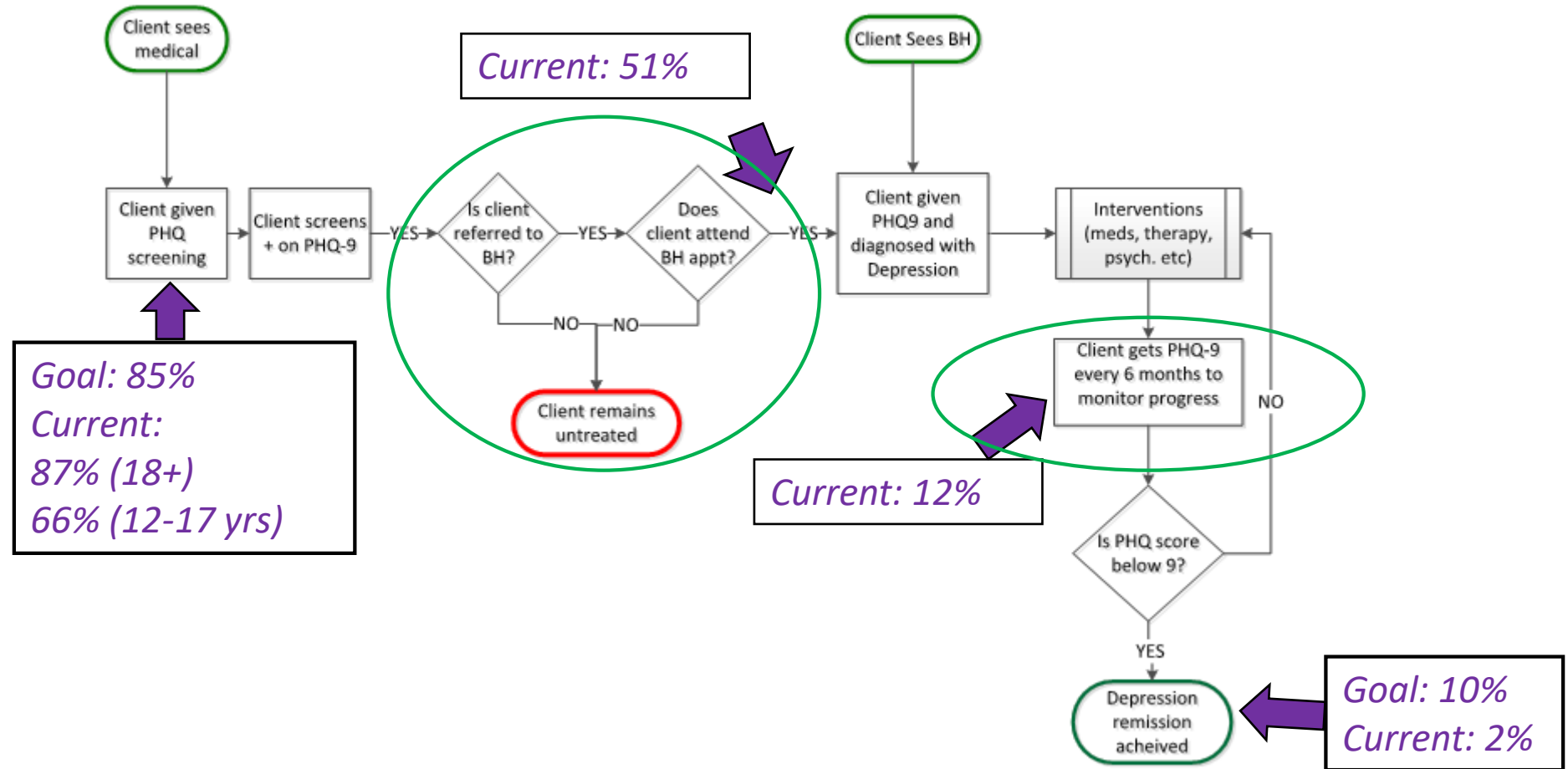
Medication Adherence

Medication Adherence Goal: By December 2020, 80% of eligible clients will be screened for medication adherence barriers using a validated tool (ASK-12).

- Completed PDSA round with Max Romano testing the OT medication adherence intervention algorithm with the following results:

  - Challenges only in finding time to implement the interventions – not in the interventions themselves

  - Recommendation to print the med list for clients – we have explored this before

  - The most useful recommendation from the algorithm are OT and RN referrals for further evaluation and treatment

  - Challenges may arise with clients who have literacy or visual impairments

ASK-12 Intervention Decision Tree

If client response is:	Sometimes Problematic	Very Problematic

INCONVENIENCE/ FORGETFULNESS

Lifestyles

1 I just forget to take my medicines some of the time.
2 I run out of my medicine because I don't get refills on time.
3 Taking medicines more than once a day is inconvenient.

Provide pillbox
May need education and teaching on how to use pillbox

Pharmacy Education
Education and teaching on how to communicate with pharmacy

Teaching how to anticipate needing refills

Refer to OT
For specific recommendations, pillbox teaching, health and medication management skill building

TREATMENT BELIEFS

Attitudes and Beliefs

4 I feel confident that each one of my medicines will help me.
5 I know if I am reaching my health goals.

Health Education
Education on conditions, symptoms, and role of medications

Adapted Medication List
List relating symptoms, conditions, and role of medications

Help From Others

6 I have someone I can call with questions about my medicines.

Talking With Healthcare Team

7 My doctor/nurse and I work together to make decisions.

Provider Role Education
Educate clients on roles of provider, methods to contact providers regarding various questions

Refer to RN
For extended individualized education on health issues and needs

BEHAVIOR

Taking Medicines

Have You...

8 Taken a medicine more or less often than prescribed?
9 Skipped or stopped taking a medicine because you didn't think it was working?
10 Skipped or stopped taking a medicine because it made you feel bad?

Provide pillbox
May need education and teaching on how to use pillbox

Health Education
Education on conditions, symptoms, and role of medications

Refer to RN
For extended individualized education on health issues and needs
May need to transition to weekly adherence

11 Skipped, stopped, not refilled, or taken less medicine because of the cost?
12 Not had medicine with you when it was time to take it?

Connect with Enrollment
For insurance coverage

Transfer medications to Mt. Vernon pharmacy

Refer to OT
For specific recommendations, pillbox teaching, health and medication management skill building

Medication Adherence

- Round 2 PDSA - Telehealth
  - 2 teams will use the intervention decision tree:
    - 1 team with the medical provider (Dr. Trustman) conducting the ASK-12
    - 1 team with the CMA (Latanya) conducting the ASK-12
    - Latanya will be conducting the ASK-12 during the Telehealth visits for Max Romano who will then add notes about where clients scored and the relevant intervention options
    - We will also begin the testing of going through the recommendations – i.e. if the client needs an internal referral to OT we will make one, if the client would be better suited for a change in dosing schedule, we will make one (if possible)

Phone System Access

Client Phone Access Goals: By December 2020, 80% of calls will be answered by a human and 80% of voicemails will be returned within 1 business day.

Calls Answered by a live person - Agency Wide*
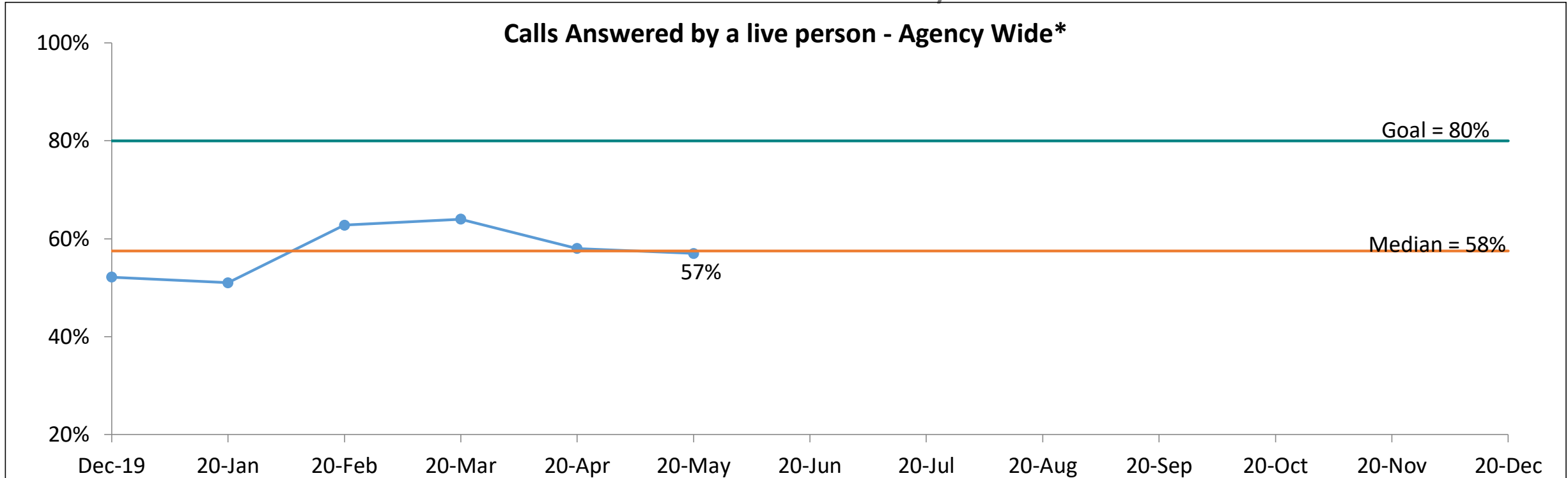
Data includes Scheduling line, Medical Records, Referrals, Medical Triage line, West Baltimore Main*, Baltimore County Main*, & Fallsway Front Desk. Data excludes weekends

Phone System Access: New Workgroup

Vision for client experience by phone

• A simple way to reach the person who can address their needs

• Calls answered in a timely, courteous fashion

• Messages returned in a timely, courteous fashion

• Phone conversations that are plain-spoken and easy to understand

• Information about services available that is clear, accurate and timely

• An easy system to register complaints, compliments or suggestions (as well as a workflow to direct, address and respond as necessary)

• Information documented in a manner that supports or improves their care

Phone System Access: New Workgroup

Co-Chairs: Gary Welch, CFO & Keiren Havens, CSO

Members:

- Kim Carroll, Case Management Coordinator
- Aisha Darby, Director of Clinic Operations
- Julia Davis, Registered Nurse
- Jan Ferdous, Director of Behavioral Health
- Kate Leisner, Strategic Plan Project Manager II
- Crystal Lee, Client Access Manager
- Eddie Martin, Jr., Director of Engagement
- Hanna Mast, Communications Manager
- Aaron Perseghin, IT Analyst
- Jen Tate, Director of Performance Improvement
- Adrienne Trustman, Chief Medical Officer
- *Two client representatives (not yet present)*

Phone System Access: New Workgroup

- Meeting minutes/progress will be available on the Portal
- PI will still collect and report data: Answer Rate & Voicemail Return Rate

Population Health Updates

Population Health Updates - June

Diabetes

- The Prediabetes Project: Survey sent out to staff in CM, CHW/Outreach, SH, BHT, Nursing to get feedback on resources that would be helpful in supporting them having conversations with clients around healthier eating habits.

Cancer Screenings

- CMAs/RNs: last-minute call campaign over the coming 1-2 weeks to remind clients that they are overdue for colorectal cancer screenings and mail interested clients FIT kits to complete and get caught up on this cancer screening.
- Dr. Schreiber's biweekly GI clinic is back up and running – medical providers made aware. Trying to connect eligible clients with positive FITs to these appointments.