Monthly PI Committee

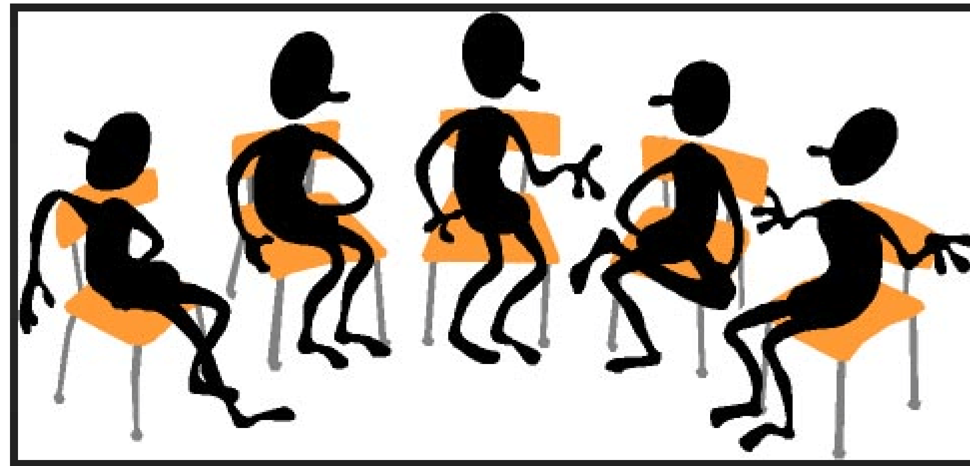
March 15th, 2023

Agenda

1. Group introductions & Icebreaker
2. Get to know Lisa and Marie
3. CQM dashboard & Updates
4. Pop Health Updates

Quick round of introductions

- Share your name and what you do here at HCH!



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Group icebreaker: This or That?

- Hide camera view and turn on camera or raise your hand if a question applies to you!

Get to know Lisa and Marie!

Lisa Hoffmann – Director of Performance Improvement

Two truths and a Lie

A. It’s a lifelong dream of mine to ride on a blimp

B. When I was little my dream job was an elementary school teacher

C. I love any sport that requires hand eye coordination (like basketball and softball)

Marie Stelmack –

Quality Improvement Specialist

Two Truths and a Lie

A. I love to kayak

B. I'm a Linux user at home

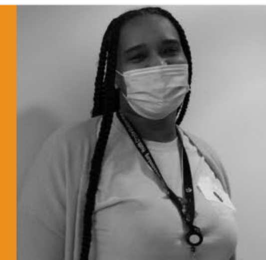
C. I've never been out of the country

Quality Improvement updates

2023 PI Plan

10 goals across the following categories

1. Resource Stewardship
2. Clinical Quality Measures
3. Access
4. Client Experience
5. Care Management



CQM Dashboard

Covers 27 measures, including

- Maternal and Child Health
- Disease Management
- Screening and Preventive Care
- Chronic Conditions
- Other and additional PI goals

This year, we split out dashboard by category to make more digestible

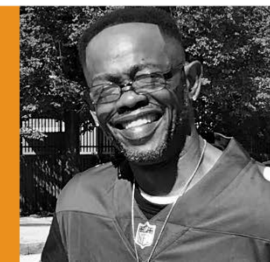
(Anything highlighted is a PI goal for 2023)

Child Health

Child Health	UDS 2022	2023 YTD (Jan + Feb)	2023 Goal
Childhood Immunization Status	9%	**5%**	**25%**
Dental Sealants (ages 6-9 Years)	25%	**0%**	**50%**
Wt. assessment & counseling for nutrition & PA (Peds)	70%	**58%**	**73%**

Immunization and dental sealants have low n/d

- Childhood Immunizations = 2/14 thus far in 2023
- Dental Sealants = 0 denominator (2023 YTD). In 2022, 8 children met denominator criterion



Maternal and Child Health

1. In 2022, we reported 0 clients for the prenatal and birthweight measure
   - This is due to how the UDS requests the information and how we can capture the information within the EMR
2. In 2023, with the addition of on-site prenatal services, we will have more access to prenatal and other data for clients.
   - Early Entry into Prenatal Care Data: currently 44% (7/16) (goal: 80%)
   - Low Birthweight: currently 0% (no deliveries yet; goal: 9%)

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Disease Management

Disease Management	UDS 2022	2023 YTD (Jan + Feb)	2023 Goal
IVD: Use of Aspirin/Other Antiplatelet	85%	**82%**	**87%**
Statin Therapy for Prevention/Treatment of CVD	82%	**83%**	**85%**
HIV Linkage to Care	100%		**100%**
Depression Remission at Twelve Months	10%	**5%**	**11%**

- January RCA with BH team → team interest in improving handoffs from other teams to BH team
- **Conducting a two-week pilot (3/6-3/17)**
  - CM/Medical teams will reach out to BH WIP via athena text
  - WIP will see the clt, assess, schedule with ongoing BH provider
    - WIP role: introduce BH to clt and help complete/schedule BHPA completion
  - Will have results of pilot in April

Screening and Preventive Care

Screening and Preventive Care Measures	UDS 2022	2023 YTD (Jan + Feb)	2023 Goal
Body Mass Index (BMI) Screening and Follow-up	40%	37%	65%
Breast Cancer Screening	47%	47%	53%
Cervical cancer screening	56%	53%	60%
Colorectal cancer screening	38%	32%	40%
Depression Screening and Follow-Up Plan	55%	43%	75%
HIV Screening	70%	79%	73%
Tobacco use: screening and cessation intervention	63%	43%	70%

Side note: Care team facilitators met and thought this would be a great registry to re-introduce to care teams (with focus on clients with elevated PHQ-9 scores). To go to care teams this month as pilot.

BMI goal: 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

- Met with Arie, health equity specialist, to plan for trainings and roll out
- PI provided trainings to medical & psych teams around how to satisfy this measure in Athena
- Arie is working on a number of things around approaching conversations with a HAES perspective
  - Trainings: Medical and Psych. End of March: CM and BH teams.
  - One-page resource tool in exam rooms (HAES Principles and WAIT acronym) to guide conversations

Chronic Disease Management

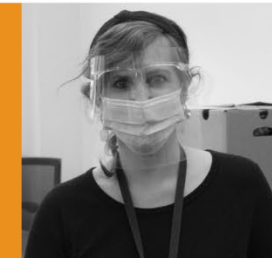
Chronic Disease Management	UDS 2022	2023 YTD (Jan + Feb)	2023 Goal
Controlling high blood pressure	58%	56%	65%
Diabetes: HbA1c poor control (>9%) [inverse]	35%	50%	32%

65% of individuals will have blood pressure controlled and reduce disparities between Black or African American and White individuals by 5%.

Additional measures

Additional HCH priorities	HCH 2022	2023 YTD (Jan + Feb)	2023 Goal
Advance Care Planning	n/a	1%	5%
Lab Notifications	25%	15%	60%
*Referral Tracking (% complete)	25%	29%	40%
**SDH Ask Rate	42%	57%	70%
***FLU: adult vaccination rates	16%	20%	45%
Suicide assessment follow-up	59%	52%	85%
Care management (with care plan)	n/a	96%	75%

- Lab, referral, suicide assessment, and ask rates are all quarterly goals
- Lab notification prioritized for provider training + documentation (Tolu provided training 3/9)
- SDH ask rates being spearheaded by Arie, Health Equity Specialist
- Referral tracking on risk management plan and has an operations workgroup



Additional Measures PI goals

Immunization: The Agency will achieve a 45% vaccination rate for the 2023-2024 flu season.

- Will focus work using lessons learned on next flu season

Care of Older Adults - Advanced care planning: By December 31, 2023, create standardized workflows and achieve a rate of 5% completion for qualifying individuals and ensure no disparities to advanced care planning completion.

- Engaging with medical leadership on creation of SOP and training for CM to discuss with eligible individuals (66+)

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.

- Meeting goal, next step includes focusing more on clients who may benefit from care management enrollment

Access

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).

Department	2023 Goal	2023 YTD Average Third Next Available
HCH - Baltimore County	**12**	10
HCH - West Baltimore	**19**	9
HCH-421 Fallsway	**23**	25
Agency		24

Team by Agency	2023 Goal	2023 YTD Average Third Next Available
Behavior Health	23	21
Case Management	18	20
Medical	30	34
Nurse	13	13
Psychiatry	15	11

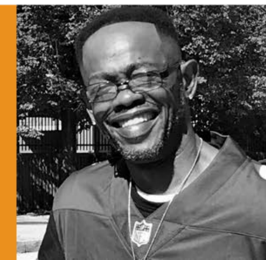
Resource Stewardship PI goals

Cost Savings: 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%) and view demographic data to address disparities.

- Due to codes used, need to add URI to existing report –Report is a priority for HIT and is coming soon!

Care Coordination: By December 31, 2023, the Agency will follow-up with 85% of individuals following a hospitalization and identify SDH or racial disparities for client's impacting hospitalizations.

- Ongoing from 2022 risk management plan, focused work involving call center RNs
  - Empaneled clients go to care team RNs for follow-up
  - Call center RN reviews discharge summary: clients just requiring appt sent to call center reps, clients higher acuity are called by call center RN
- Largest barriers: Contact information, client picking up the call, nurse capacity continue to be large barriers
- Tableau report coming – will be able to prioritize clients who are engaged in care



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Final Goal – Client experience

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.

- Quality team using Medstatix data to determine areas for improvement
- Discussing with Client Relations Committee 3/24
- Will also complete risk assessment of client comments to identify areas to address

The Pulse on Pop Health

Colorectal Cancer (CRC) Awareness Month

Multi-pronged approach

- Equip medical team to address cancer screenings. Recorded ppt training (CMAs/RNs) on how to complete CRC screening → assigned in LMS
  - Included MAT nurses, who are also addressing CRC screenings this month as they are able
- Athena pop health campaign message to ~3,000 HCH clients who are past due
- Went out via text on 3/7
- Pop health opened schedule specifically to address these clients who may call back to address CRC screenings → schedule is already ~~getting filled~~ **FULL!!** (64 clients)
- Nursing/CMA + CHW teams continuing to provide CRC screening and navigation support

CRC Front Porch Campaign

Another robust front porch campaign.

About 70 community members engaged.

Dispensed a good amount of:

- Giveaways
- Info about CRC screenings!
- Info about HCH services

Cancer Reminder Card Pilot

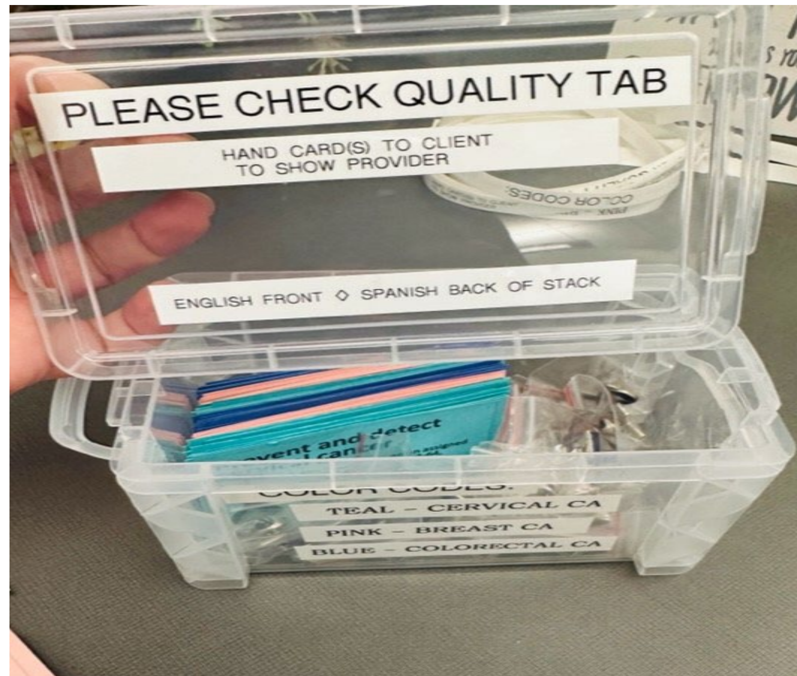
- **Plan**: Place cancer reminder cards (15 each) in each exam room. As CMAs room clients and ask eligible, past-due clients if they wish to complete their screening, they will hand the client the respective reminder cards to carry into provider part of the visit.

  Reminder cards serve as a **visual** cue to providers and clients

- **Goal:** to increase the number of cancer screening performed across HCH
- **Measuring Impact**: By # cards dispensed, by asking for feedback from CMAs and medical providers after pilot about usefulness of cards

Cancer Reminder Card Pilot

Pilot and PDSA part of work under and technically supported by MDOH Breast and Cervical Cancer Program (BCCP)



Women’s Health Day

- Initial Kick-off Planning Meeting: 3/2
  - Planned Date: **May 18**
  - Planned Location: 3rd floor Conference Rooms (with garage as back-up)
  - Education: Story-telling by staff members and loop 10 min pre-recorded Eng/Esp
  - Activity Ideas: create stress reduction tools and herb gardens
  - Give Aways: pamper packs
- ***Next planning Meeting:*** Thursday at 3pm! Please contact me (Shannon Riley) at sriley@hchmd.org if you'd like me to send you an invitation!

Questions or comments?

Thank you!