# March 2024 PI Informational Meeting

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March 2024

HEALTH CARE for the HOMELESS

# Agenda

1. Introduction/Icebreaker
2. PI Refresh!
3. CQM review and PI measures
4. PI Subcommittee Updates

# Performance Improvement Team at HCH

Lisa Hoffmann
**Director of Quality Improvement**
(she/her)

Marie Stelmack
**Performance Improvement Specialist**
(they/them)

Margaret Flanagan
**Senior Director of Quality**
(she/her)

Tolu Thomas
**Chief Admin and Quality Officer**
(she/her)

# What is Performance Improvement (PI)?

1. **The continuous process of:**
    - assessing the quality and equity of the care we deliver
    - assessing client access to that care
    - adjusting to do better
2. **A systems approach, not a personnel approach**
    - Nothing changes unless our ways of working and ways of thinking change
    - Failures are rarely a "person" issue and more often a "system" issue
    - PI is baked into everything we do
3. **Data-driven**
    - We use data as a driver for improvement and a way to tell us how we're doing
    - Data helps us see what's really happening, not what we think is happening - because our common sense isn't always correct
    - Data allows us to target our work towards things that make real, lasting change

# What role can staff at HCH play?

1. Use data (Quality tab, PVP, MedStatix, etc.)
2. Involve clients in thinking through ways to improve care delivery
3. Attend monthly PI meetings
4. Be a part of a subcommittee!
5. Participate and give feedback on a test of change (PDSA cycle)
6. Contribute an idea or ask a question(s)

# Today’s icebreaker

**It’s Women’s History Month!** Shout out a favorite woman in your life – coworker, family, friend…


# CQM review and PI measures

# PI Measures

Trailing Year Data

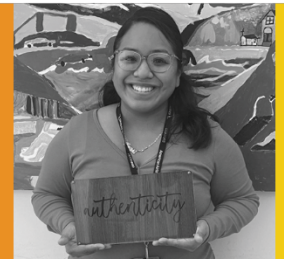
| Key |
| --- |
| 3+ Improvement |
| 1-2+ improvement |
| Reduction |

| Disease Management | Jan | Feb | 2024 Goal |
| --- | --- | --- | --- |
| Colorectal Cancer Screening | 30% | 30% | 40% |
| Hypertension Disparities | Black M: 62%<br>Black F: 56%<br>White M: 73%<br>White F: 65%<br>Latino M: 69%<br>Latina F: 62% | Black M: 62%<br>Black F: 54%<br>White M: 74%<br>White F: 65%<br>Latino M: 70%<br>Latina F: 63% | Less than 5% disparity |
| Childhood Vaccinations | 7% | 2% | 18% |
| PHQ-9 Questions 1 and 6 | N/A | Q1: 3.2%**<br>Q6: 3.7%** | 5% |
| Diabetes and A1c Control (inverse measure) | Black M: 27%<br>Black F: 31%<br>White M: 29%<br>White F: 25%<br>Latino M: 44%<br>Latina F: 29% | Black M: 27%<br>Black F: 33%<br>White M: 33%<br>White F: 27%<br>Latino M: 45%<br>Latina F: 32% | 27%, reduce disparity by 5% for Hispanic/Latinx clients |

| Disease Management | Jan | Feb | 2024 Goal |
|---|---|---|---|
| Clients receiving PrEP | 18 clients | 23 clients | 36 clients |
| Prenatal Early Entry to Care | 59%* | 68% | 70% |
| Appointment Access | Med Urgent: 84%<br>Med Routine: 84%<br>BH Urgent: 100%<br>BH Routine: 100%<br>Dental Urgent: 100%<br>Dental Routine: 100% | Med Urgent: 85%<br>Med Routine: 85%<br>BH Urgent: n/a***<br>BH Routine: n/a***<br>Dental Urgent: 66%<br>Dental Routine: 100% | +5% from baseline |
| Hospital Readmission Rate | TBD | 18.7% | <20% |
| Closing the Referral Loop | 25% | 24% | 40% |
| Current Medication Documentation | 63% | 63% | 90% |

| Key |
|---|
| 3+ Improvement |
| 1-2+ improvement |
| Reduction |

***No respondents for the month of February.



# 2024 PI Plan

We are here!

1

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

**Dates: Jan – June**

2

Double the number of clients receiving **PrEP**.

**Dates: Jan - June**

3

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

**Dates: March - Aug**

4

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

**Dates: March - Aug**

5

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.

**Dates: April - Sept**

# 2024 PI Plan continued

6

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

**Dates: April - Sept**

7

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

**Dates: May - Oct**

8

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

**Dates: June - Nov**

9

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**).

**Dates: June – Nov**

10

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

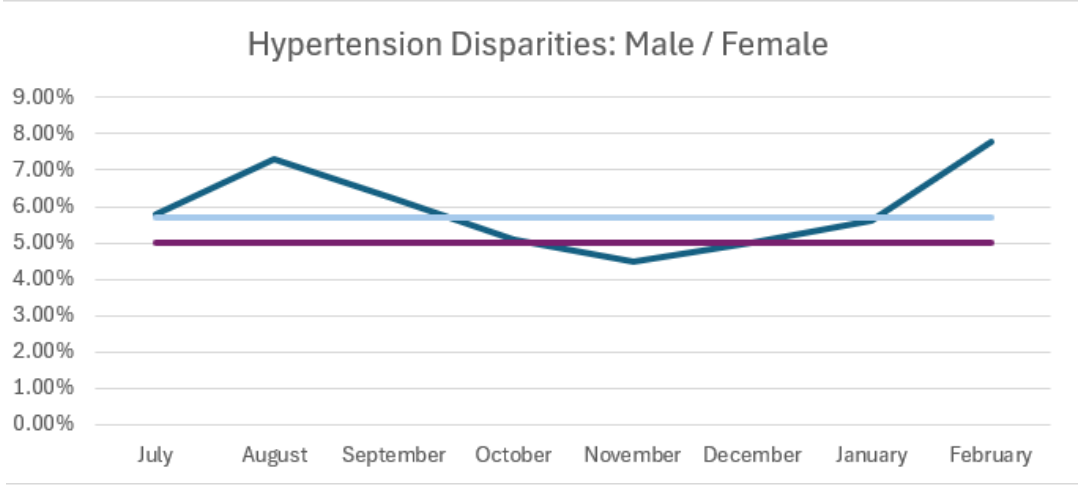
**Dates: July - Dec**

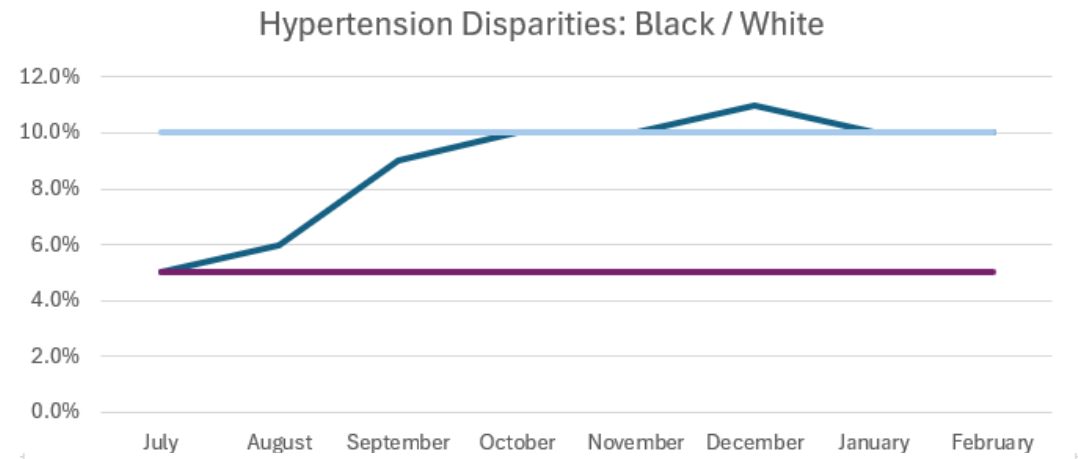
# PI Subcommittee Updates

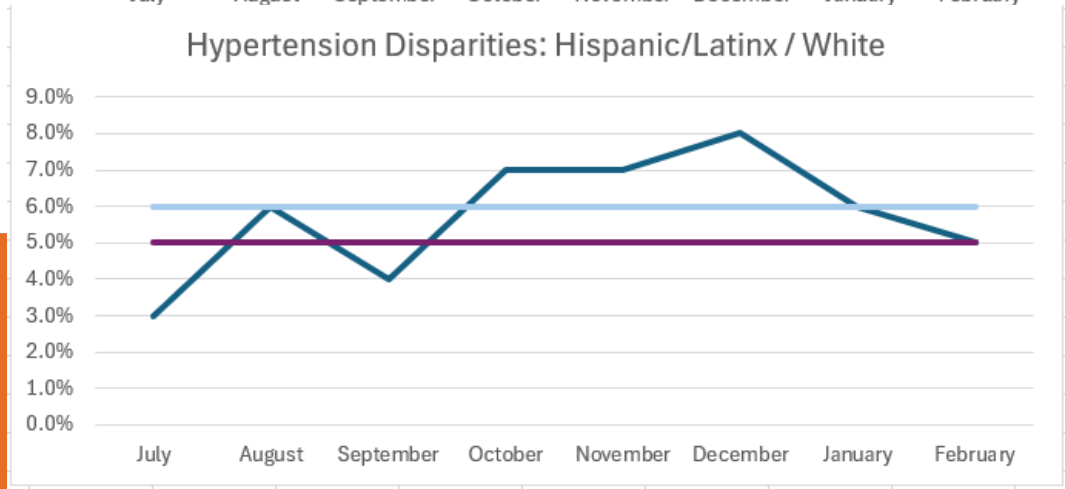
# Hypertension Disparity

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

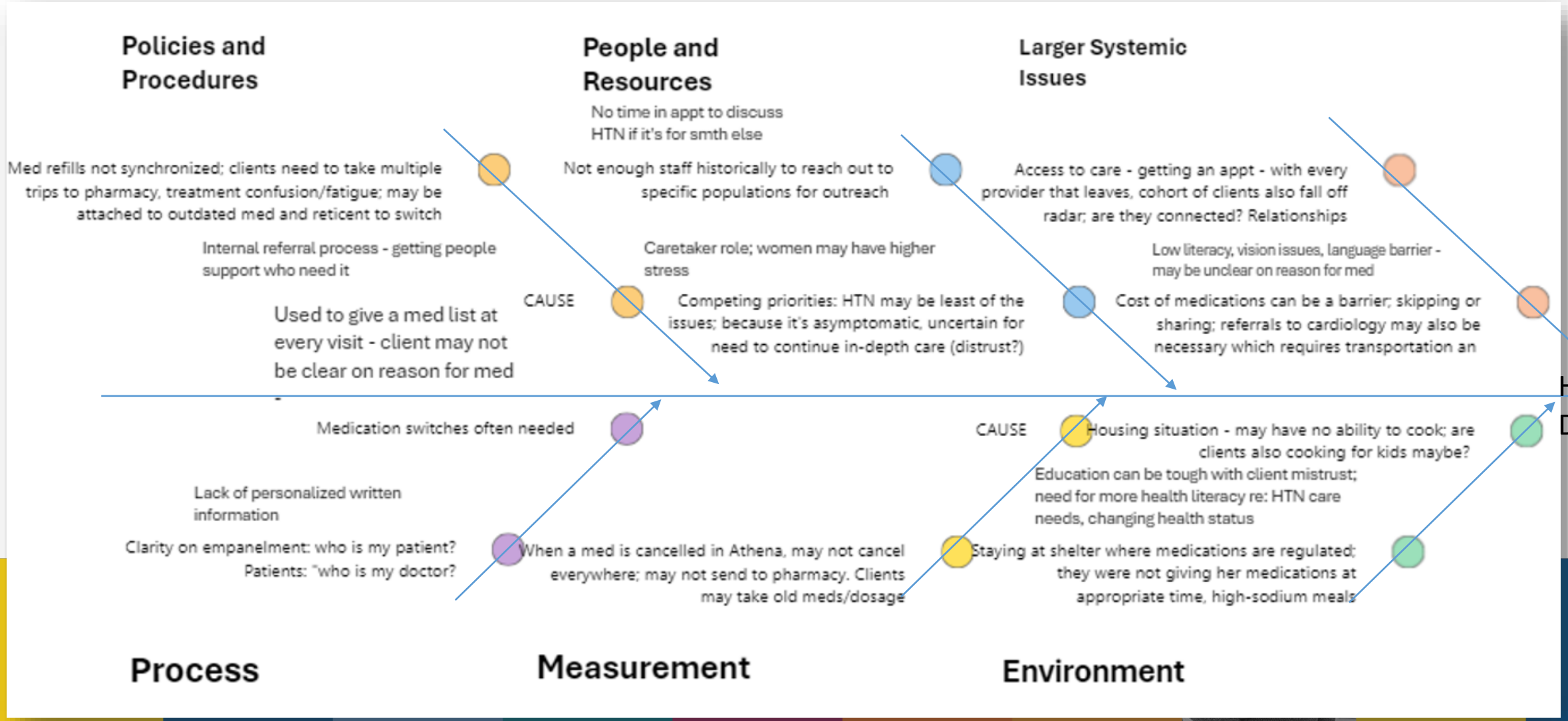
- **Kickoff meeting**
  - Team of nurses, medical provider, and case manager + PI and PH members



# Root Cause Diagram



# Wishbone Section: what do we want this to look like?

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Increased understanding of what meds are, how to take them; how to control their own health

Marie Stelmack

Decreased risk of acute medical conditions (strokes, MI); possible decrease in ER utilization, readmissions

Marie Stelmack

Would have everything they need (food, transportation, med refills, etc) to successfully self-manage

Marie Stelmack

We wouldn't see a disparity

Marie Stelmack

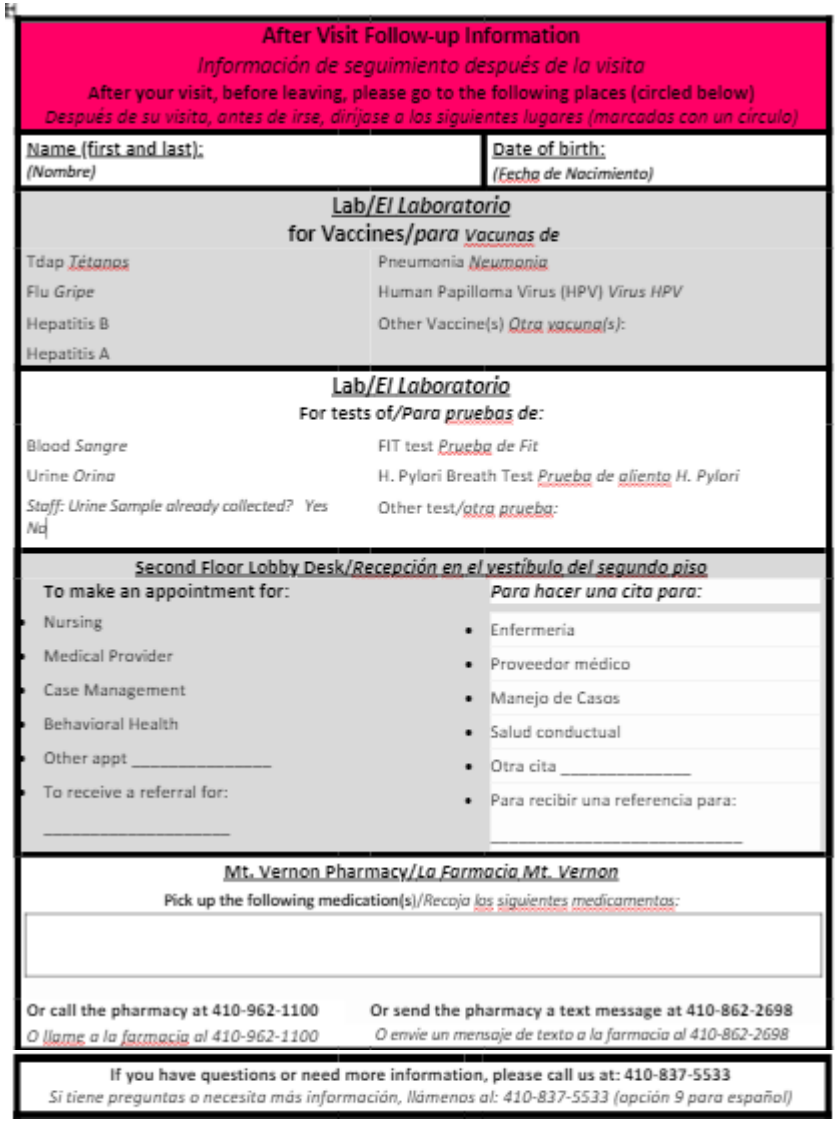
Decrease in medical distrust from clients, because people have a better understanding of how to take care of themselves

Marie Stelmack

Increased communication between client, care team, and support system around HTN (and other conditions) to normalize it

# Hypertension Disparity

- **Meeting 2**
  - Prioritization Matrix (aim for high impact/low effort)
    - Team identified challenges with client flow of scheduling next appointment, completing labs, and picking up prescriptions as first test of change
  - PDSA #1 plan: test a “follow up sheet” – physical reminder for clients' post-nurse visit for visual reminder and support along the check out process
    - Week-long test with subcommittee nurse, lab tech, and check out staff
    - Nurse team collaborated to make most comprehensive and straightforward form
    - In English and Spanish
    - Will track completion of these items and the longer term impacts on BP control – looking at women specifically



**After Visit Follow-up Information**

*Información de seguimiento después de la visita*

After your visit, before leaving, please go to the following places (circled below)

*Después de su visita, antes de irse, diríjase a los siguientes lugares (marcados con un círculo)*

Name (first and last): *(Nombre)*

Date of birth: *(Fecha de Nacimiento)*

**Lab/*El Laboratorio***

for Vaccines/*para Vacunas de*

- Tdap *Tétanos*
- Flu *Gripe*
- Hepatitis B
- Hepatitis A
- Pneumonia *Neumonia*
- Human Papilloma Virus (HPV) *Virus HPV*
- Other Vaccine(s) *Otra vacuna(s)*:

**Lab/*El Laboratorio***

For tests of/*Para pruebas de:*

- Blood *Sangre*
- Urine *Orina*
- *Staff: Urine Sample already collected? Yes No*
- FIT test *Prueba de Fit*
- H. Pylori Breath Test *Prueba de aliento H. Pylori*
- Other test/*otra prueba:*

**Second Floor Lobby Desk/*Recepción en el vestíbulo del segundo piso***

To make an appointment for:

- Nursing
- Medical Provider
- Case Management
- Behavioral Health
- Other appt _____
- To receive a referral for: _____

*Para hacer una cita para:*

- Enfermería
- Proveedor médico
- Manejo de Casos
- Salud conductual
- Otra cita _____
- Para recibir una referencia para: _____

**Mt. Vernon Pharmacy/*La Farmacia Mt. Vernon***

Pick up the following medication(s)/*Recoja los siguientes medicamentos:*

Or call the pharmacy at 410-962-1100 *O llame a la farmacia al 410-962-1100*

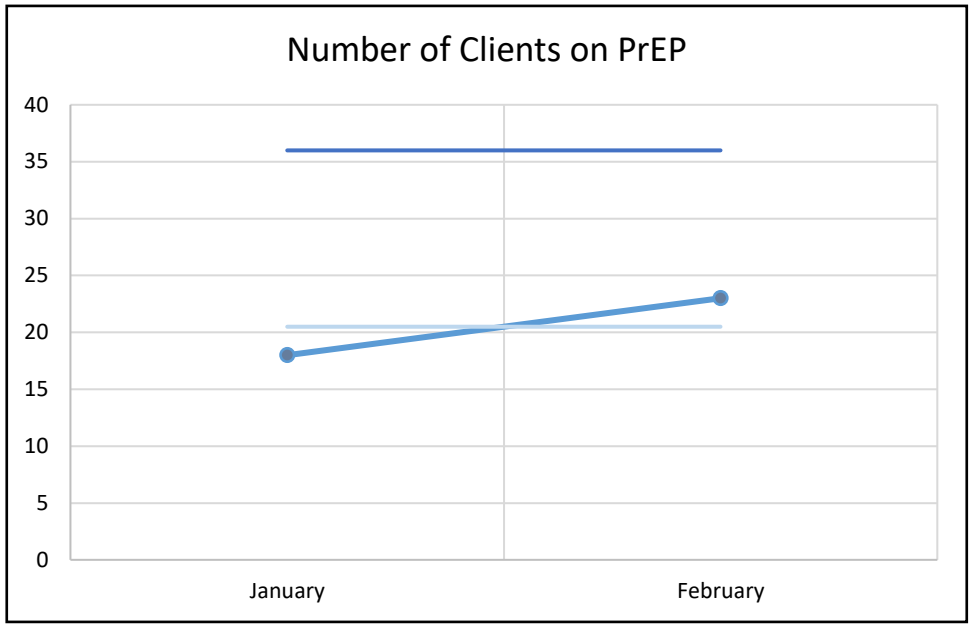
Or send the pharmacy a text message at 410-862-2698 *O envíe un mensaje de texto a la farmacia al 410-862-2698*

If you have questions or need more information, please call us at: 410-837-5533

*Si tiene preguntas o necesita más información, llámenos al: 410-837-5533 (opción 9 para español)*

# PrEP (Pre-exposure prophylaxis to prevent HIV)

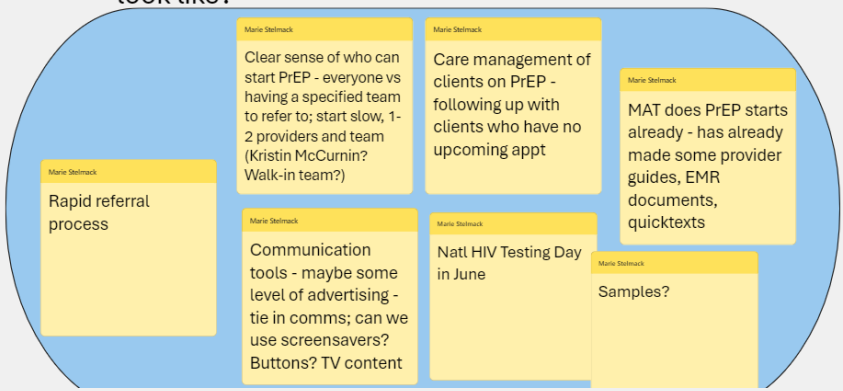
Double the number of clients receiving PrEP.




- **Kickoff Meeting**
  - Our largest subcommittee! Includes adult, pediatric, psychiatry and MAT providers, nurses, and HIV/HCV Care Advocate

# Root Cause Diagram

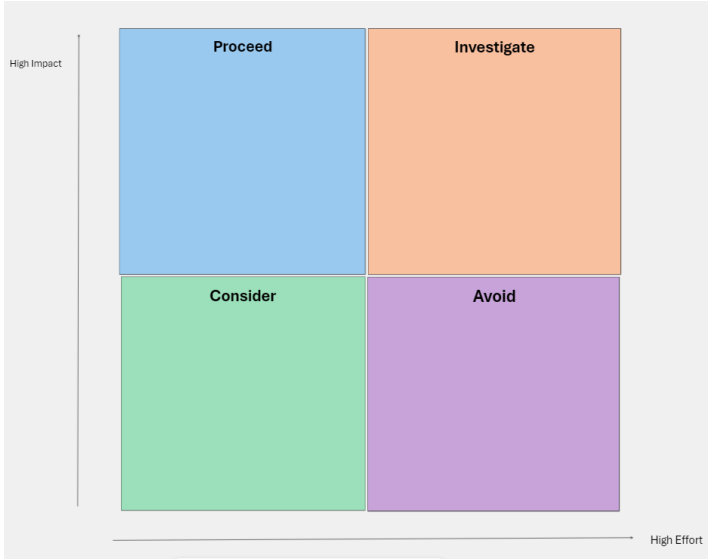
Wishbone Section: what do we want this to look like?





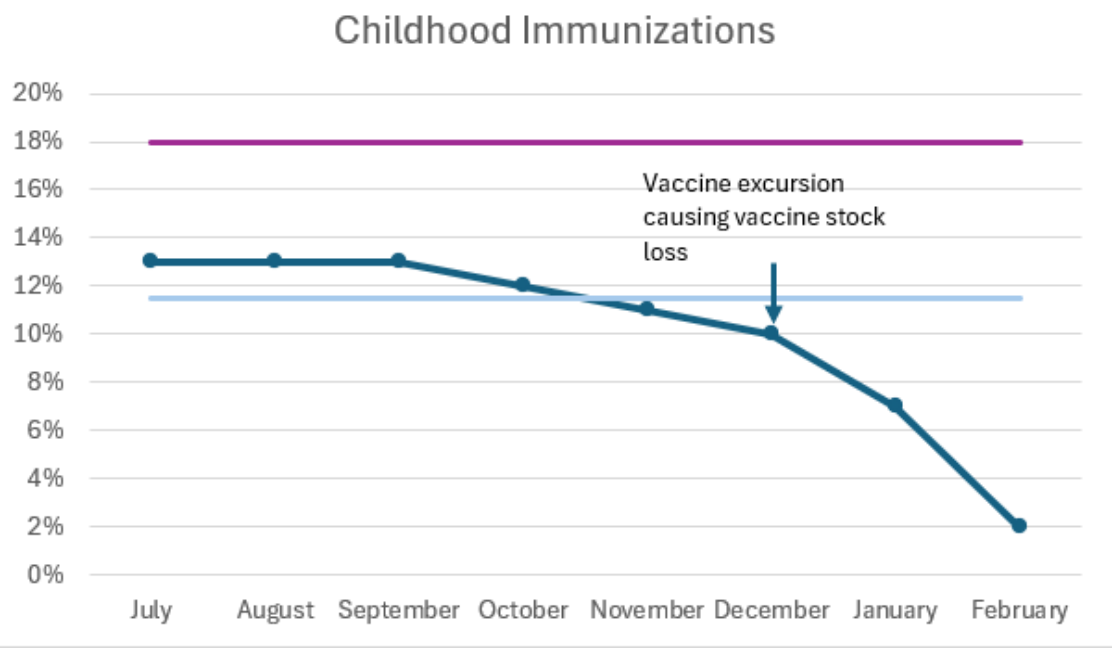


# PrEP Next Steps




1. Next meeting March 28
   - Develop test of change ideas
     - Promising ideas:
       - Improving documentation (currently no clear dx or problem code) in Athena for improved identification of clients in report
       - Developing a rapid referral system
       - PrEP prescribing SOP
       - Communication tools (e.g. screensavers or buttons to encourage conversation)
   - Input into the Priority Matrix
   - Brainstorm ways to engage clients in this PI project

# Childhood Vaccinations (Combo 10)

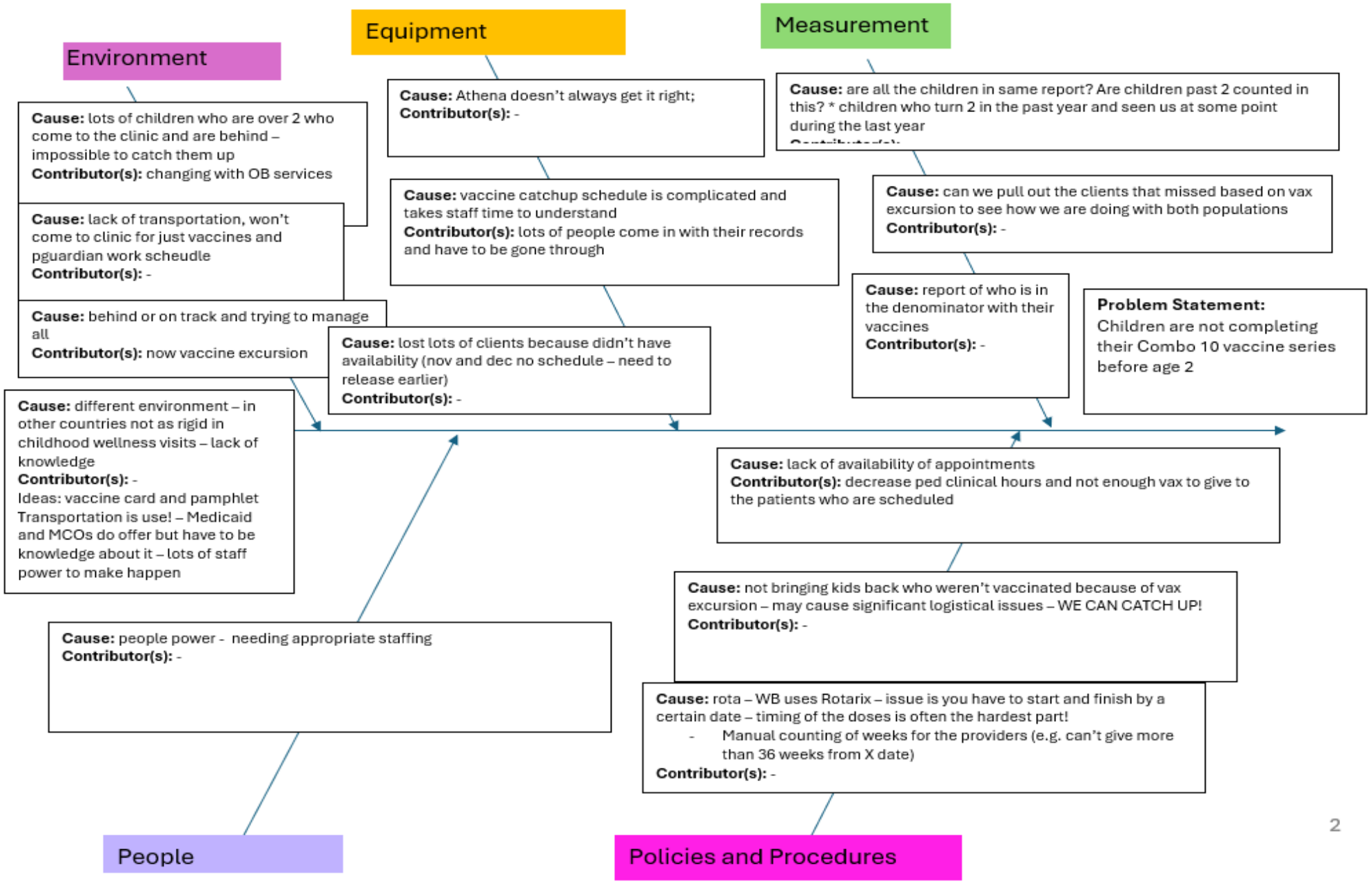



Ensure at least 18% of **children** will have all combo 10 **vaccinations** by age 2.

**Kickoff Meeting:**

- Performed root cause analysis with pediatrics: Nicole Maffia, Ash Lane, Keri Rojas, Natalia Suc, Pattie Aldave

# Childhood Vaccination RCA



# Next Steps: Childhood Vaccinations

1. Validating reports to support improved tracking and outreach
2. Further development of first PDSA

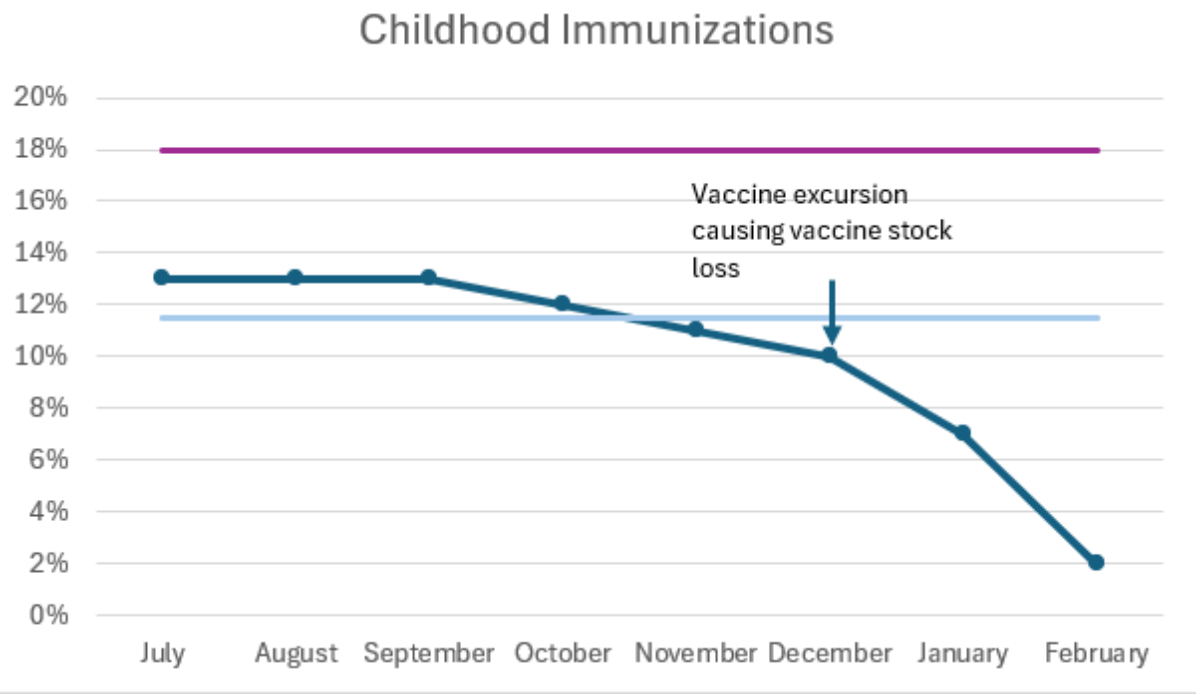
# Up Next!

- March kickoff meeting for:
  - Hospital Readmission
- April kickoff meeting for:
  - Colorectal Cancer Screening
  - Appointment Access

# This month's PI tool: run charts

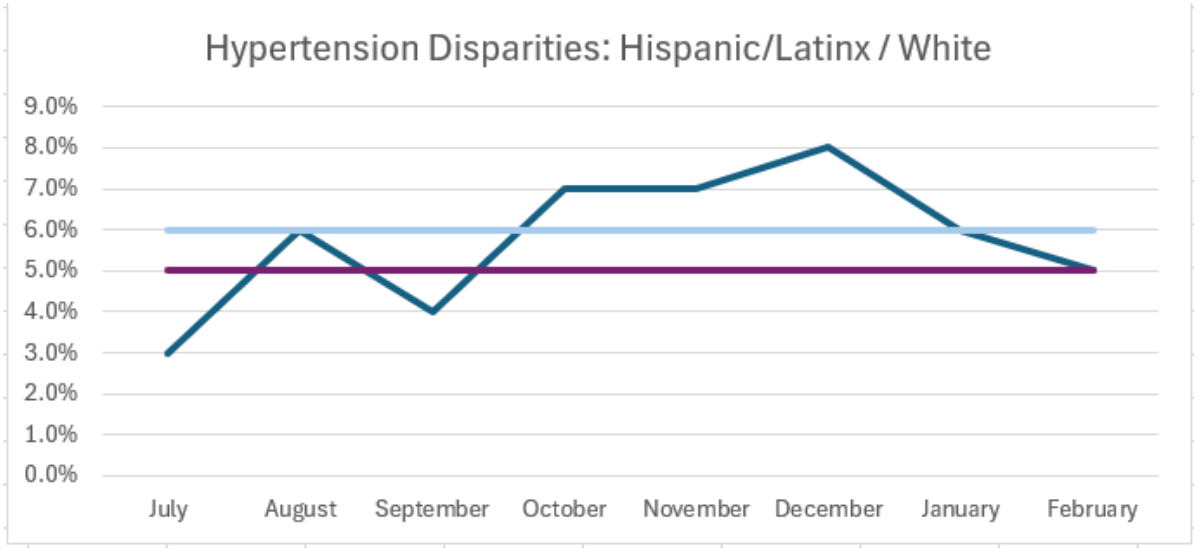
- You've seen some charts with *extra lines* through this presentation
- These are **run charts:**
  - The middle line represents the **median** (middle point of all the data)
  - The rest of the chart is like a normal line chart: we're plotting PI measure data by month
  - We use these to assess **variation** in our processes
    - Is the variation due to something we already know (hopefully a cool process change)? We'll try to annotate it on the chart
  - We assess this through seeing *trends* (a series of 6+ points that trends one way) and *shifts* (a series of 7+ points above or below the median)
  - If we see a significant change due to a certain cause, then we can plot a new median

# What can we take away from this run chart?




- Steady decline: not jumping around on either side of the median, not terribly subject to *common-cause variation*
  - *Trend* of 6 decreasing data points – *special-cause variation?*
- The vaccine loss clearly caused a marked effect on immunization rates…
- But they were declining before that

# What can we take away from this run chart?




- No shifts, no trends
- A reasonable amount of *runs* (stretches of points above or below the median in a row): not too few or too many
- There is no evidence for *special-cause variation*
- That said, the median is still above the goal, so we have work to do ☺

# Thanks!