Performance Improvement Committee

May 20, 2020

HEALTH CARE for the HOMELESS

May Agenda

Monthly Dashboard

- Breast Cancer Screening
- Medication Errors
- Food Insecurity
- Provider Communication

Improvement Updates – Progress and Challenges

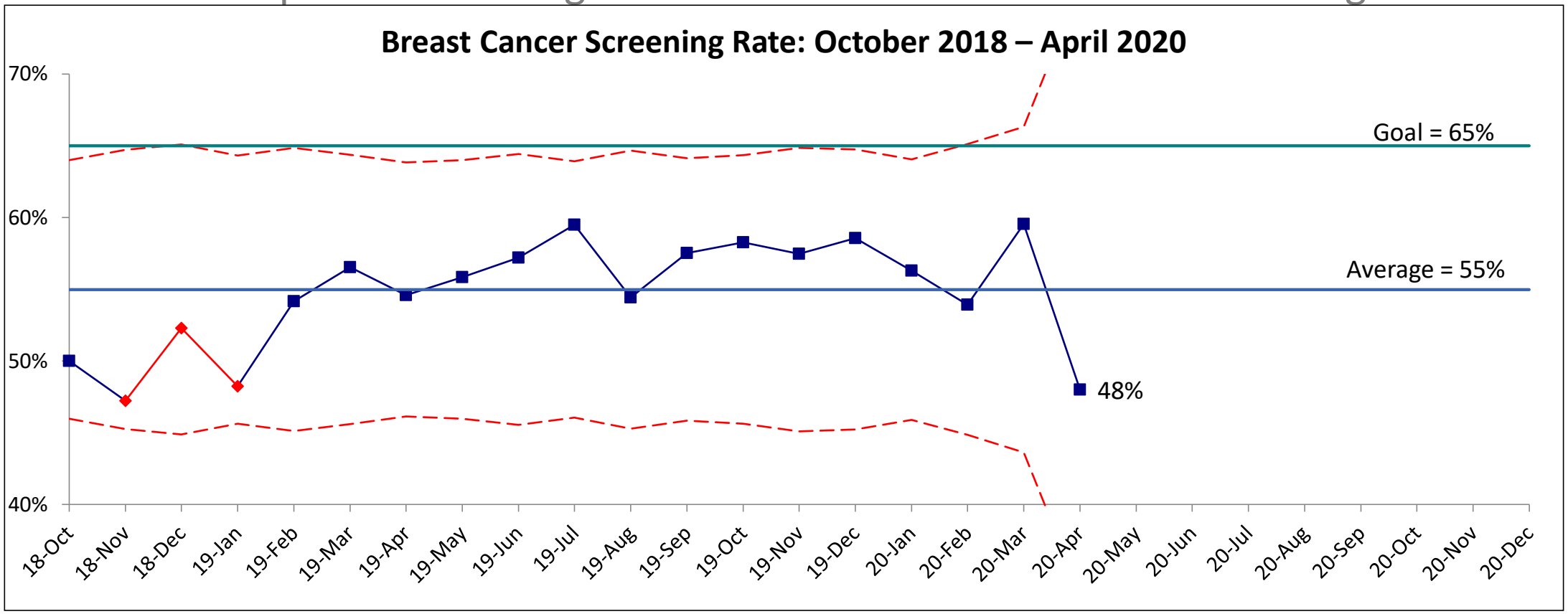
- Depression Remission
- Medication Adherence
- Phone Access
- Joy in Work

Population Health Updates

Monthly PI Dashboard

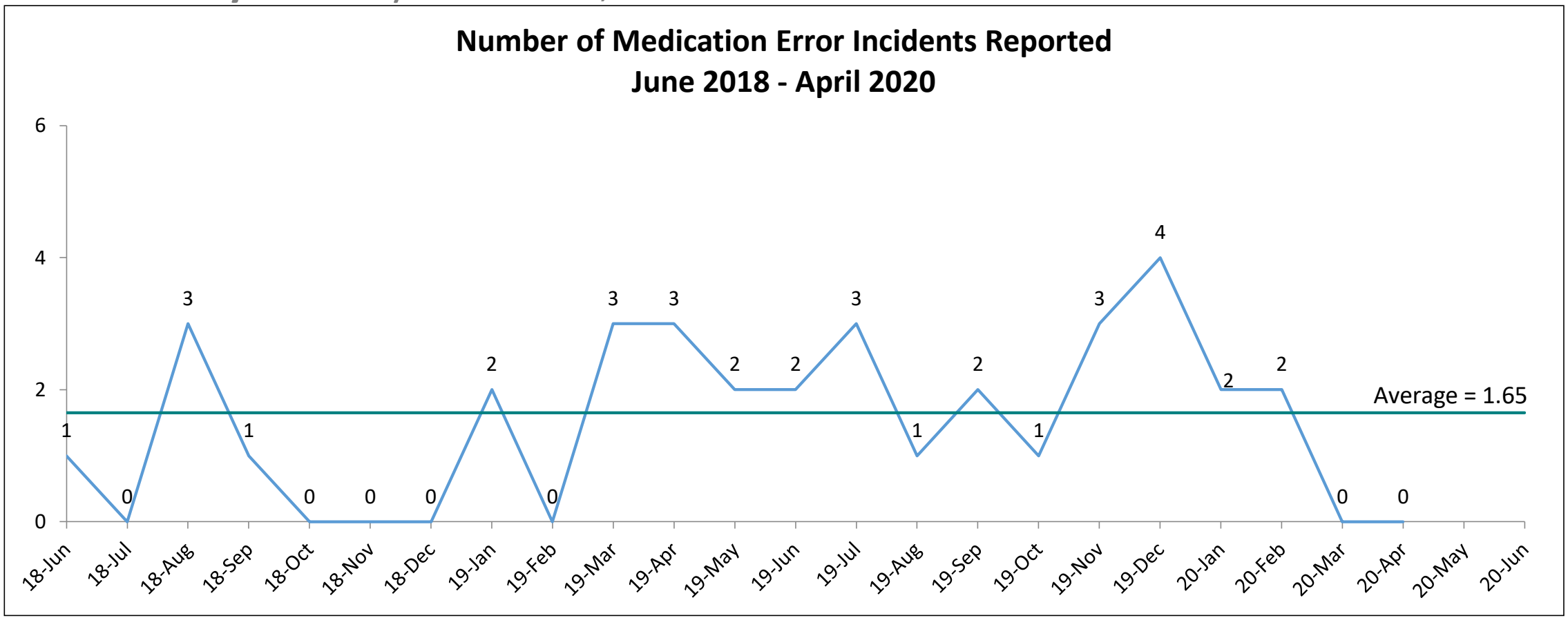
Mammogram Completion

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



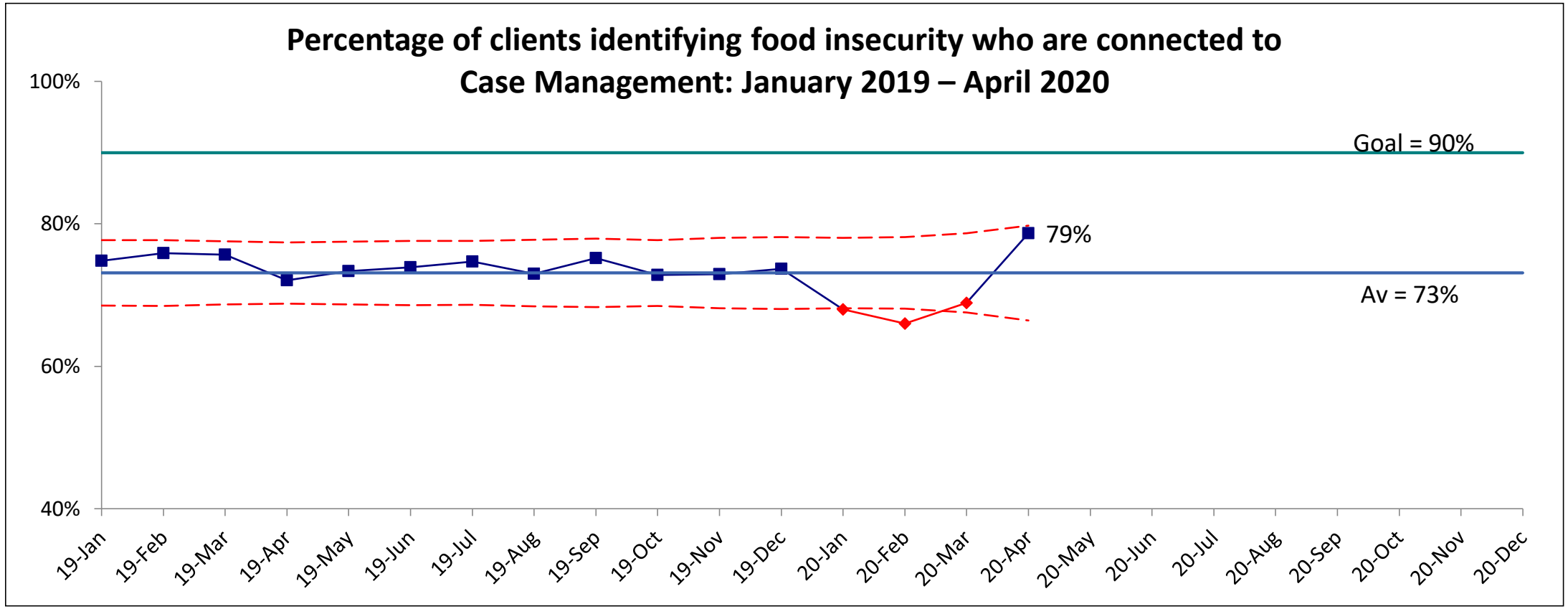
Medication Errors

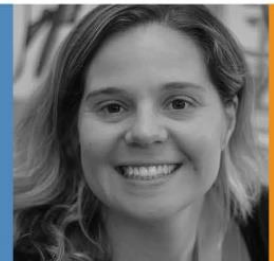
Client Safety Goal: By June 2020, Medication Errors will decrease to 0



Food Insecurity

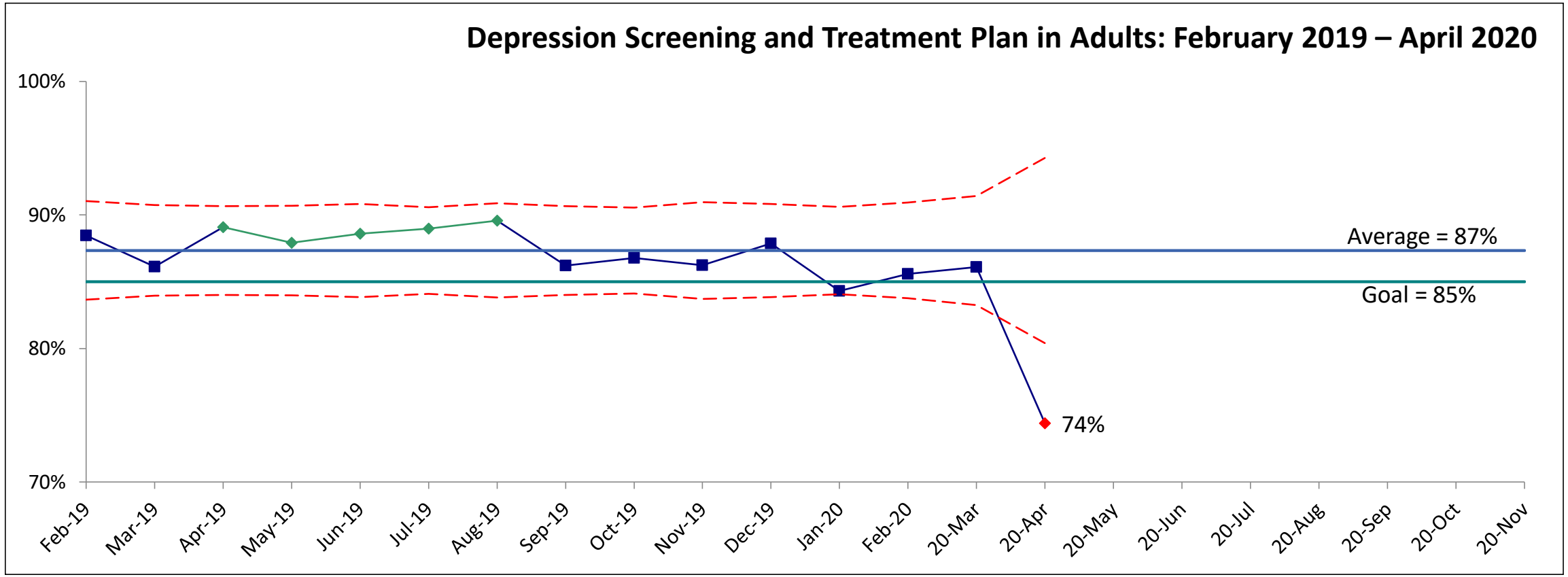
Food Security Goal: By December 2020, 90% of clients who identify as having food insecurity on the PREPARE tool will be connected to Case Management





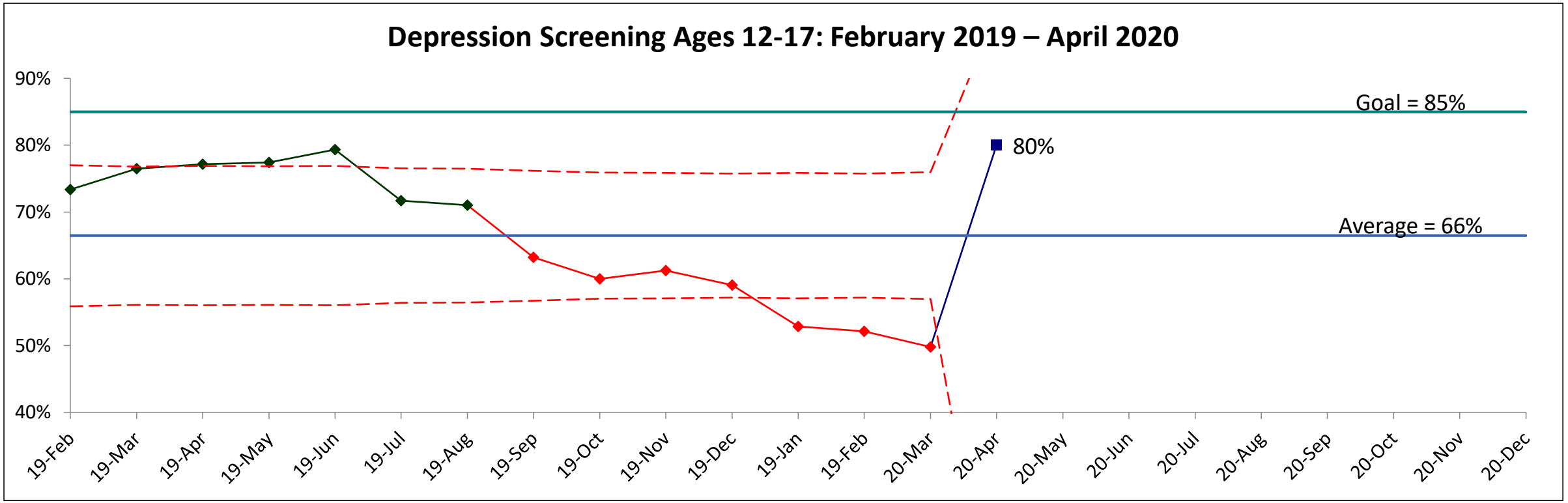
Depression Screening and Treatment - Adults

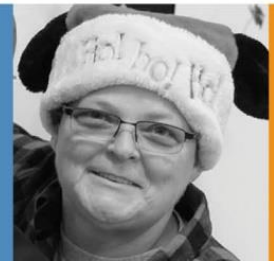
Depression Screening Goal: By August 2020, 85% of clients over 18 years of age will be screened for depression using a validated tool.



Depression Screening and Remission - Adolescents

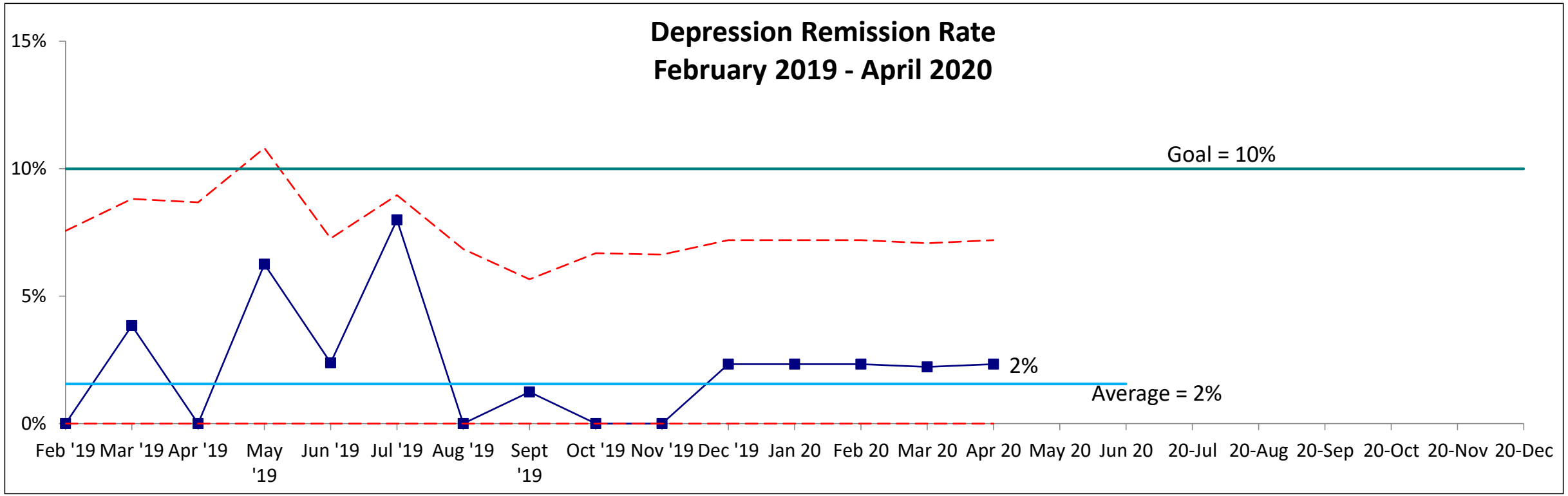
Depression Screening Goal: By August 2020, 85% of clients ages 12-17 will be screened for depression using a validated tool.





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 Screening and Remission

Depression Screening + Follow up Strategies:

- Focus on repeated PHQ-9 administration at 5-7 months
  - Improving the PHQ-9 form in the EHR
- 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
- Exploring clinical approaches to achieving remission
  - Survey results from providers

Depression Screening and Remission

Clinical Approaches to Achieving Depression Remission

- Surveying BHTs on what clinical approaches they have taken that has led to symptom improvement in their clients
- Discerning if housing, medical, addictions recovery, or mended relationships were main drivers of symptom improvement
- Allows for providers to have a platform to discuss their approaches; crowdsource our information to the broader discipline

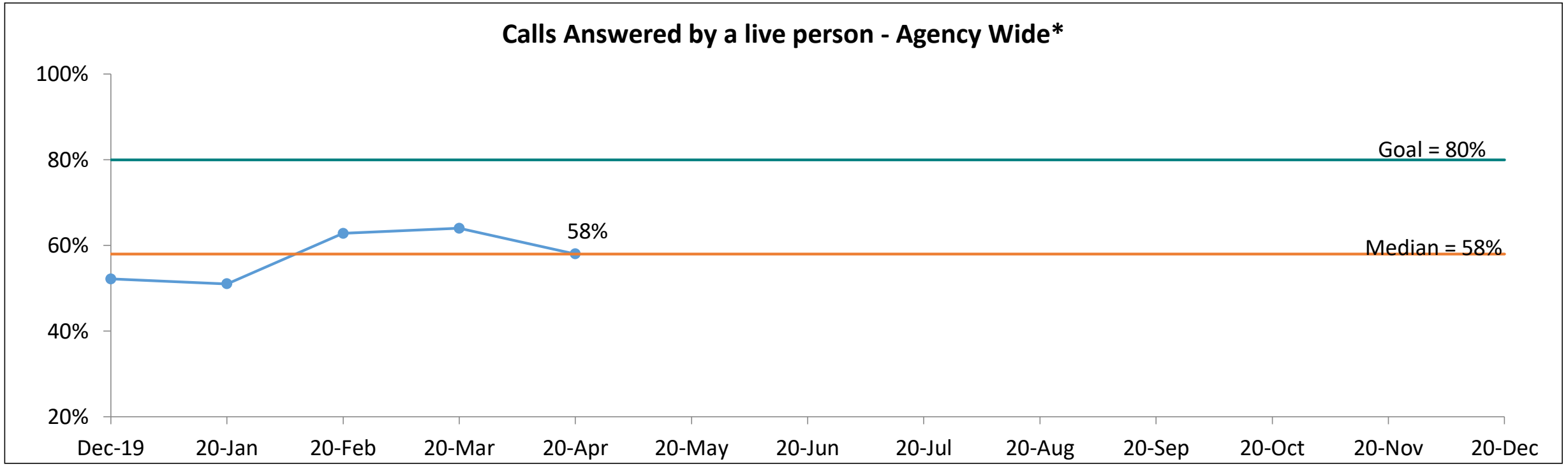
Medication Adherence

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

- We await the completion of the ASK-12 tool which we will then begin testing
- **Only** clients with the following disease states will count towards the measure:
  - Hypertension
  - HIV
  - Diabetes
  - Depression
  - Hep C
- We will be meeting with department representatives to develop workflows that will ensure sustainable success

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.



Data includes Scheduling line, Medical Records, Referrals, CMA line, West Baltimore Main*, & Baltimore County Main*
Data excludes weekends

Phone System Access

Recent Changes:

- Phone Tree adjustments
- Impact of telework on answer rate, wait time data

Current Work:

- Fully understand system configuration, queue options
- Exploring voicemail traffic and set-up including outgoing message

Joy in Work

Staff Experience Goal: By December 2020, the agency's level of Joy in Work will improve by 20%.

IHI Framework :

Critical Components of a Joyful, Engaged Workforce:

- **Physical & Psychological Safety**
- **Meaning & Purpose**
- **Choice & Autonomy**
- **Recognition & Reward**
- **Participative Management**
- **Camaraderie & Teamwork**
- **Daily Improvement**
- **Wellness & Resilience**
- **Real-time Measurement**

Joy in Work

Staff Experience Goal: By December 2020, the agency's level of Joy in Work will improve by 20%.

- Took a baseline measurement in February, but paused both the work and the measurement due to COVID-19.

- Questions:
  - What does this work look like moving forward?
  - When do we resume measurement?

Population Health Updates
Review of 2020 Goals

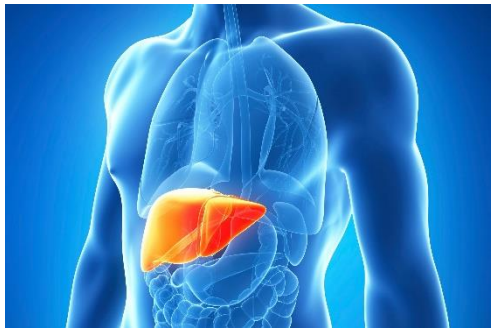
Hepatitis C

- Raise lifetime Hep C screening rates of adult clients with HCH visits to 70% monthly by the end of 2020
- COVID-19 impact: significantly decreased testing (17 thus far this month)

Committee: Tyler Gray, Catherine Fowler, Julia Felton, Laramie Libertini, Tracy Russell

Adult Clients Ever Tested for Hepatitis C by Month of Visit

	# Clients Seen	# Clients Scre..	Screening Rate
Mar 2019	3,182	1,894	60%
Apr 2019	3,284	2,002	61%
May 2019	3,279	1,998	61%
Jun 2019	3,116	1,877	60%
Jul 2019	3,321	1,985	60%
Aug 2019	3,229	1,897	59%
Sep 2019	3,178	1,949	61%
Oct 2019	3,460	2,069	60%
Nov 2019	2,948	1,835	62%
Dec 2019	2,941	1,847	63%
Jan 2020	3,218	2,034	63%
Feb 2020	2,974	1,874	63%
Mar 2020	2,791	1,812	65%
Apr 2020	2,062	1,373	67%
May 2020	1,719	1,169	68%



Actions

- HIT added lifetime Hep C screening alert into Azara

Plan

- Pilot EMR change: Adding lifetime screening status of HIV/Hep C into SA notes used by addictions team so they can id and refer high-risk clients for rapid testing
- Ultimately add this screening into universal screenings (like the flu vaccine)

Hepatitis C

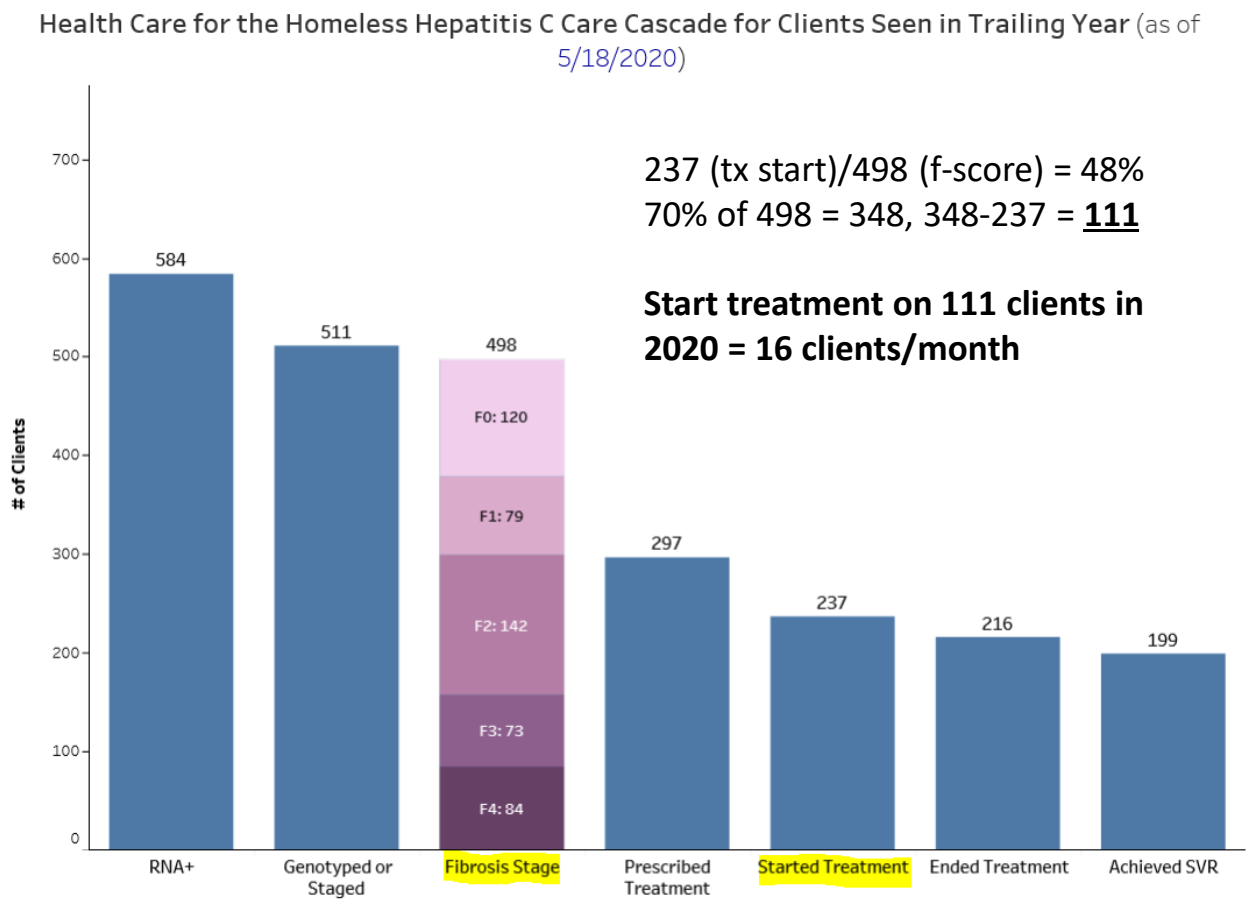
- Increase rate of treatment starts for chronic hep c clients seen in the trailing year to 70% by end of 2020

Actions

- Opened dedicated nurse Hep C schedules, Tyler provider medical provider training, ALL medical providers are certified Hep c providers, EMR changes (flowsheet), removed PA barriers, encouraged pt assistance program for uninsurable clients, MVP delivering meds during pandemic

Plan

- Support medical providers with Hep C PAs, provide care team lists of hep c clients, continue EMR form changes to make the work easier for staff, continue advocating for reduced PA barriers



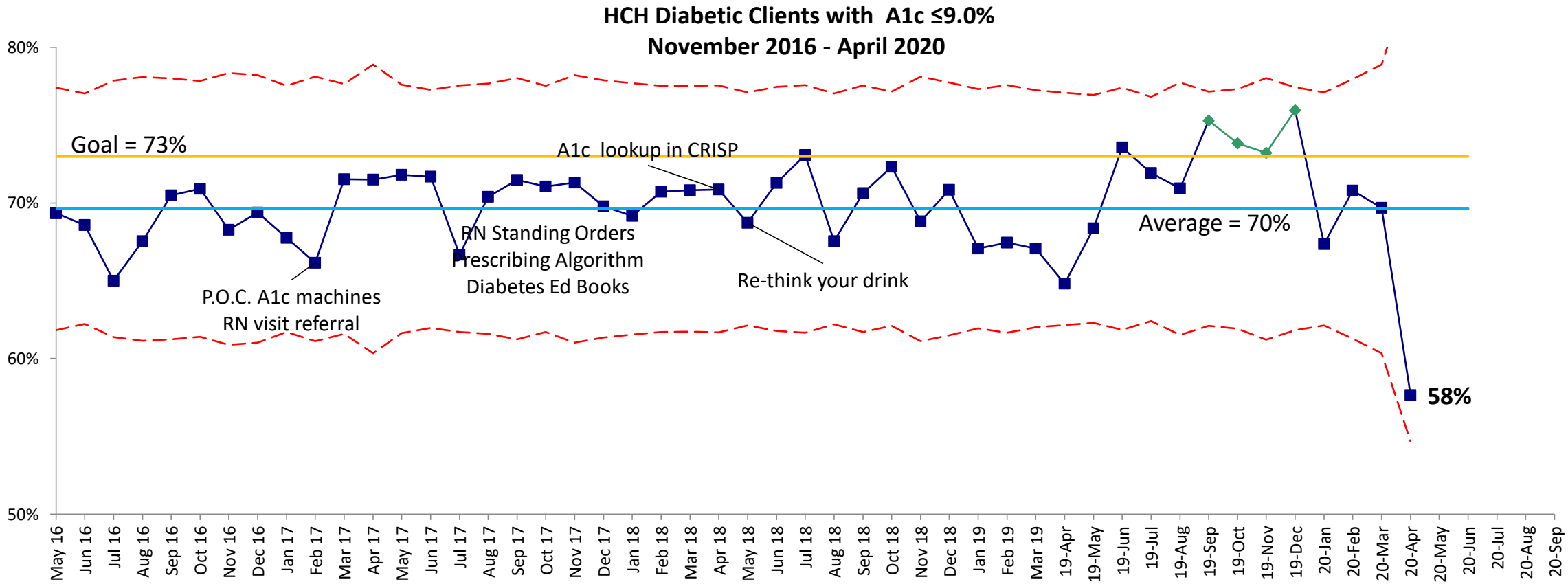
Increase rates of cancer screenings at Community Sites – ON HOLD

Follow up on abnormal cancer screenings

- Increase the rates of ob/gyn appt completion following abnormal pap smears in 2020 to 70% by the end of 2020.
  - Current rate of ob/gyn appt completion 2 out of 12 = 17%
- Increase the rate of colonoscopy completion in follow-up to abnormal FIT results in 2020 to 70% by the end of 2020
  - # of positive FIT test since November 1st, 2019 requiring colo f/u = 17
  - Current # completed = 1 out of 17 (6%)

- **Action**
  - Send prompts/flags to staff members who play a role in next steps
- **Plan**
  - Prioritize f/u visits for these clients with specialists once clinics re-open
  - High Risk pap report that CHWs can own and bring to care teams
  - Find out if certain MMC OB/GYN clinics can better accommodate HCH clients

Diabetes (2018 PI Goal: Clients with A1C <9 and tested 73%)



Committee: Mara Schneider, Katie Healy, Tracy Russell

Diabetes control

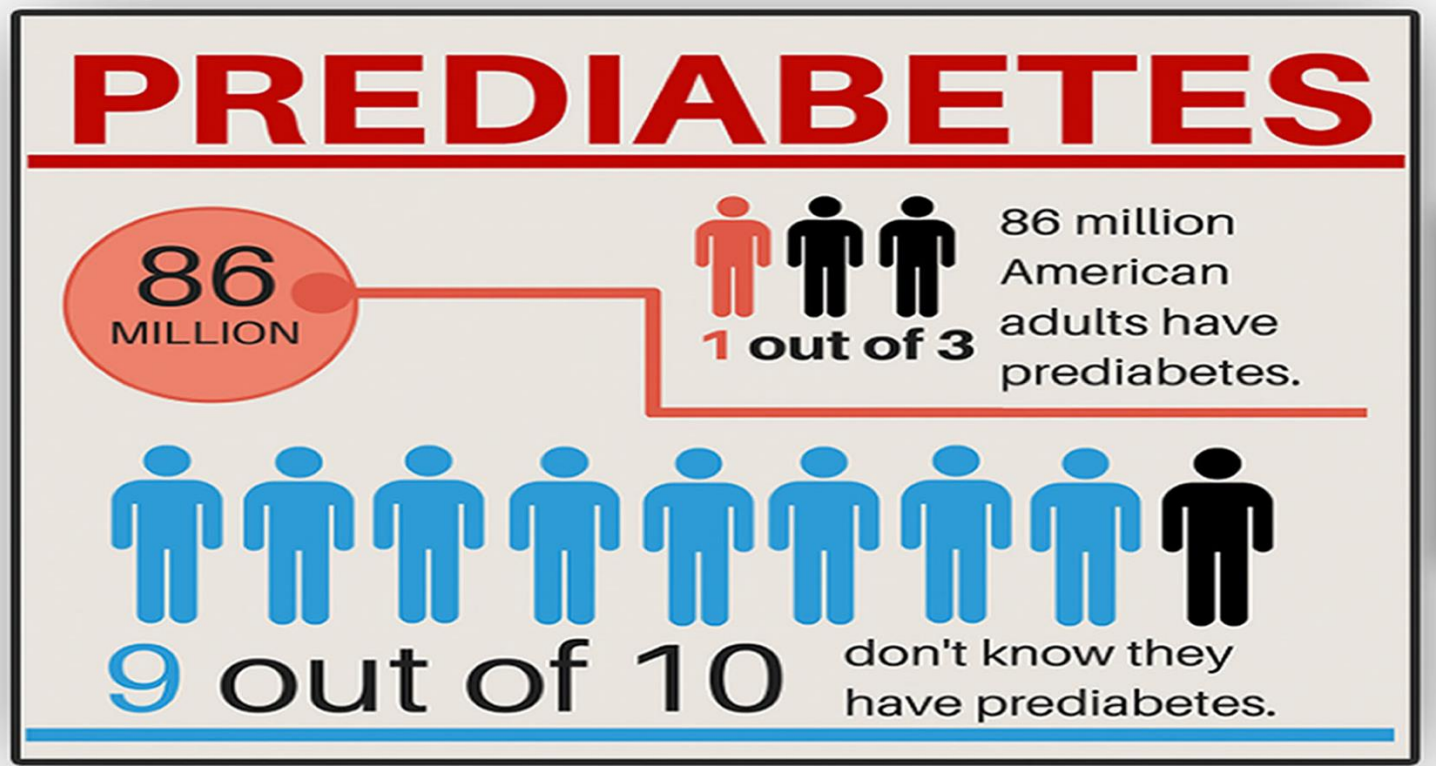
Actions:

- Continue to have clients with uncontrolled diabetes meet with nursing.
  - Nurses have a registry of clients with A1C >9 who have not been seen in TY

Plan:

- Comms helping to get education ringlets together for the exam rooms as visual teaching tools for healthier eating.
- **Prediabetes Project**
  - Several HCH staff participated in a four-session DM Learning Collaborative (NHCHC) on Nutrition + Diabetes
  - Building staff awareness of prediabetes and how to have discipline-specific conversations with clients around healthy dietary changes + campaign to increase testing amongst high-risk clients

Prediabetes



Clients with "Prediabetes" in their problem list:

880 since 2018

HCH Baltimore

Issue & Need

Problem Statement

We have many clients with pre-diabetes, but do not equip well with resources, support, & guidance around preventing/delaying diabetes through healthy lifestyle changes. Many clients may have prediabetes but not be aware

Target Population

Clients already pinpointed as having prediabetes, clients with high risk factors for prediabetes/diabetes who have not yet been screened

Contributing Factors

Many clients do not know they have prediabetes, may not know how to eat healthier or lack the knowledge and resources (i.e. lack of income, lack transportation, do not know how to cook, lack of appliances, do not know how to read a nutrition label). Many staff do not have prediabetes on their radar and do not address healthy lifestyle changes and/or are not well equipped to do so.

Intervention

Development of agency resources for providers to address clients with pre-diabetes specific to each discipline , or for all: Information on community supports, places to find low cost healthy foods, etc.).
Development of a Campaign to raise awareness of prediabetes and to encourage clients (particularly those with high risk factors) to know their status.

Culturally Appropriate

We would want to be sure to cater our resources to clients with culturally different diets and food preferences, and ask our clients if we are meeting their specific needs.

Overall Goal

Goal

To promote healthier behaviors amongst our clients with pre-diabetes to prevent/ delay diabetes, starting with healthier eating habits.

Timeline

Ideally we will move quickly through each activity (completing the project in 3-6 months). However, COVID makes it difficult to set a concrete timeline.

Activities & Phases

-IDing resources for each discipline involved
-IDing champions from each discipline to help implement this project
-Determining if resources for all disciplines will be developed simultaneously or if there are providers that need resources first
-Information / sources for the resources – such as: Evidence-based information to develop educational materials, Time to review and identify what is applicable and useful for clients, Development of hand-outs or resources – such as a shared drive, Engagement with communications team, Review by providers, Piloting use of tools for feedback, Final review, Identifying work flow to ID who has pre-diabetes and process for getting information to providers so they know resources would be useful

Staff Buy-in

Not clear yet. As more of a preventive measure and one that we aren't being held responsible for, there are many competing interests amongst staff and leadership.

Partnerships

Externally, partnering amongst learning collaborative participants, learning from others who have done similar work, partnering with other agencies that could help equip clients toward healthier eating habits. Internally, working with our new training coordinator, working with staff members on creating resources and workflows, working with champions regularly to disseminate info to teams.

Resources

Leadership buy-in (executive + director level to support time for planning, resources, wide-scale training + support), staff buy-in and champions/reps from each discipline to provide their expertise and encourage engagement in and application of discipline-specific interventions, funding + materials for campaign, efficient workflow for testing clients for prediabetes and incorporating focus on prediabetes in routine visit with client (particularly with non-medical staff), training for staff education/workflows

Tracking Progress

Developing a timeline with steps for each discipline that will receive resources, then checking off when each step is complete for each discipline.

Data

-Number of clients with pre-diabetes
-How clients with pre-diabetes are identified
-What currently happens when someone is diagnosed with pre-diabetes
-Information on best practices and relevant practices for individuals with pre-diabetes
-How often are the resources being used in staff discussions with clients
-Eating habits (to compare pre-post intervention) and pre- and post- A1C

Define Success

Sustain & Scale

Coming soon to a bulletin board near you!

HEALTH CARE for the HOMELESS

HOW TO READ NUTRITION LABELS
CÓMO LEER LAS ETIQUETAS DE NUTRICIÓN

Nutrition Facts

24 servings per container

Serving size **1 cookie (30g)**

Amount per serving	
Calories	**160**
	% Daily Value*
Total Fat 8g	**10%**
Saturated Fat 5g	**24%**
Trans Fat 0g	
Cholesterol 30mg	**9%**
Sodium 75mg	**3%**
Total Carbohydrate 20g	**7%**
Dietary Fiber 0g	**1%**
Total Sugars 9g	
Includes 9g Added Sugars	**19%**
Protein 2g	**4%**
Vitamin D 0mcg	0%
Calcium 20mg	2%
Iron 0mg	4%
Potassium 20mg	0%

* The % Daily Value (DV) tells you how much a nutrient in a serving of food contributes to a daily diet. 2,000 calories a day is used for general nutrition advice.

1. **LOOK AT SERVING SIZE | *MIRE EL TAMAÑO DE LA PORCIÓN***
   One package may contain multiple servings!
2. **CHECK CALORIES | *CONTROLE LAS CALORÍAS***
   If you aren't active, calories are stored as fat.
3. **LIMIT THESE NUTRIENTS | *LIMITE ESTOS NUTRIENTES***
   They cause high blood pressure, weight gain and heart problems.
4. **EAT FIBER & PROTEIN | *CONSUMA FIBRA Y PROTEÍNAS***
   They help you feel full and eat less.
5. **GET TO 100% | *LLEGUE AL 100%***
   Vitamins and minerals keep you healthy.
6. **NOTICE DAILY VALUE | *OBSERVE EL VALOR DIARIO***
   Aim for: 5% or less — fat, cholesterol, sodium, sugar; 20% or more — fiber, protein, vitamins

Supporting Self-Management during a time of social distancing

At home

- Home blood pressure monitoring
- Encourage clients to get labs drawn at local labcorp and continue telehealth visits
- Mailings to provide tools for clients (and better info for staff): weekly pillboxes, scales and/ weight logs, education handouts, food/blood sugar diaries, chart summaries
- MCOs providing any special resources to clients at home?

In-person

- Use of tools like maptician to consider different environmental layouts to support groups safely?
- Create/call lists of priority clients that ideally should be seen in-person (DM, HTN)