Performance Improvement Monthly Meeting

April 2023

HEALTH CARE for the HOMELESS

Presenters:

- Marie Stelmack, Quality Improvement Specialist
- Lisa Hoffmann, Director of Quality Improvement
- Tracy Russell, Director of Population Health and Care Coordination
- Shannon Riley, Population Health Nurse

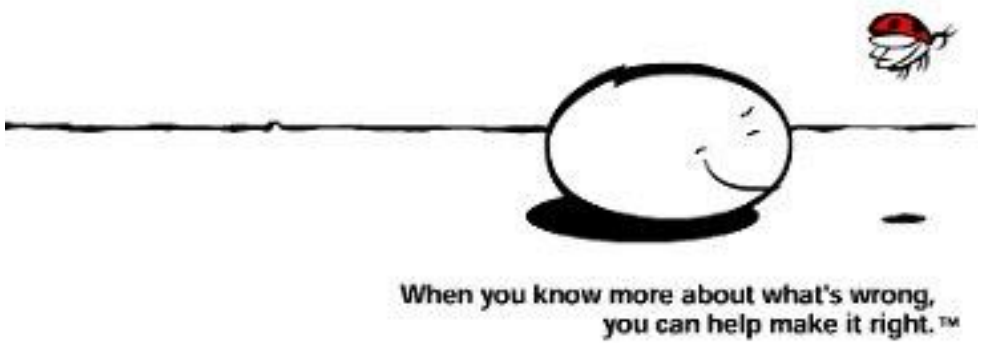
Welcome!

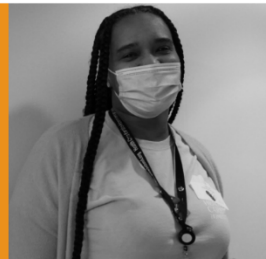
Pick one of these icebreakers to answer!

1. - What’s your favorite form of self-care?
2. -
3. -
4. -
5. -

Depression Remission

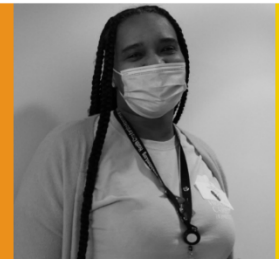
- By December 31, 2023, **11%** of individuals ages 12+ diagnosed with depression will achieve **depression remission**. The Agency will review and stratify data to identify and address disparities identified for housing status, race, ethnicity, sexual orientation, or gender identity.



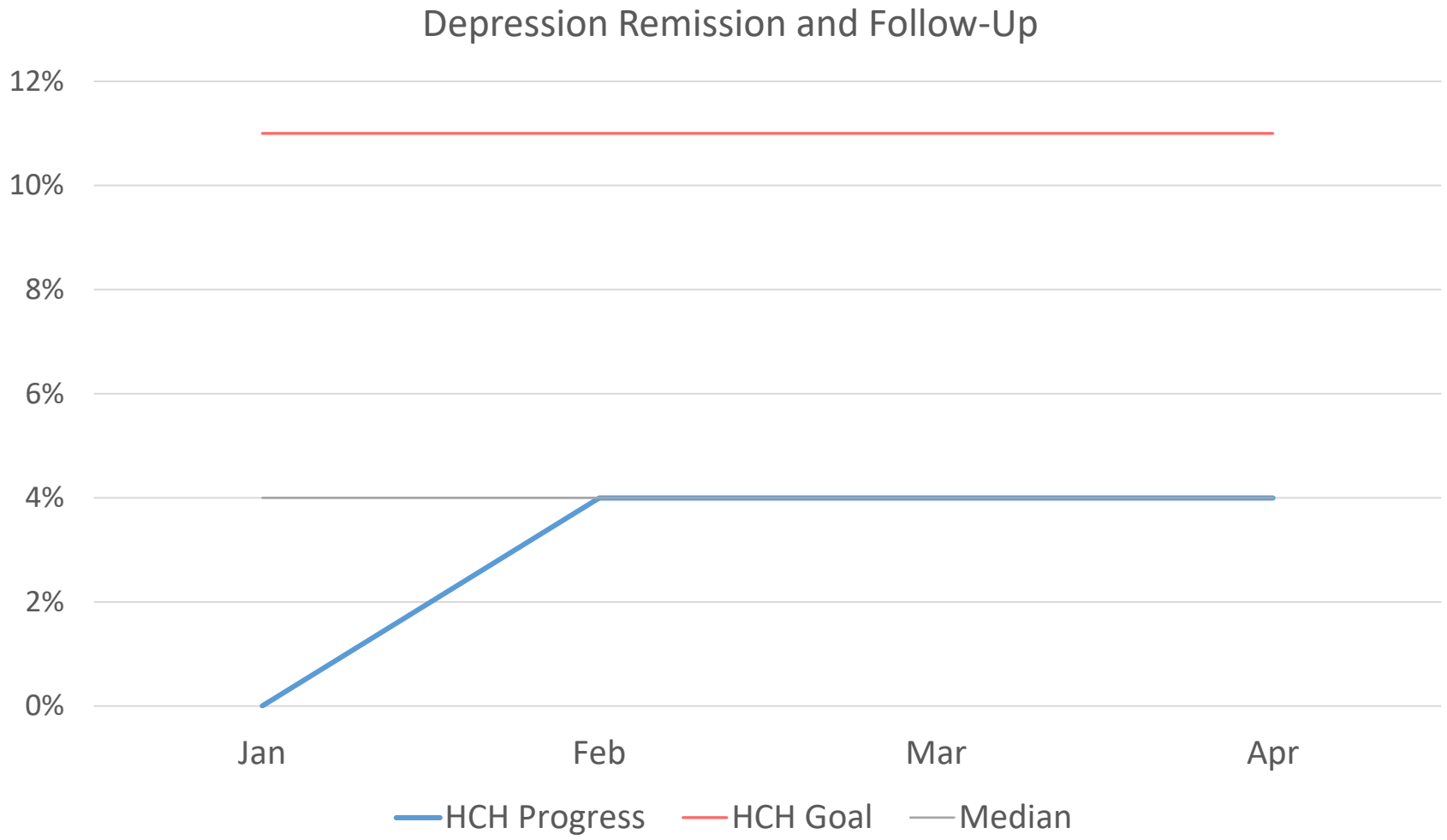


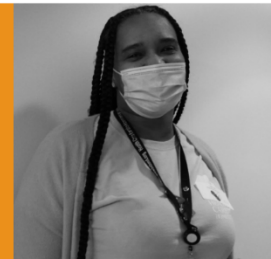
Depression Remission: where are we?

- We know that depression disproportionately affects people experiencing homelessness
  - Alleviating the burden of depression on our patient population would help clients to reach all their other care goals – knock-on effect
- 9% of our clients reached depression remission in 2022
- Conducted a root cause analysis in January 2023
- Completed a pilot of warm hand-offs between other departments (medical, case management) with behavioral health



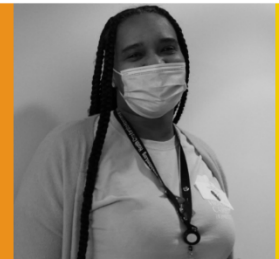
Depression Remission: where are we?





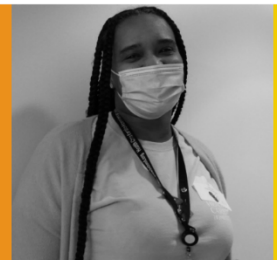
Depression Remission: what's next?

- Meeting this month with BH to create charter and determine next steps
- Potential areas for next steps (based on RCA and pilot results):
  - Our pediatric population has a need for behavioral health care
    - One therapist who can see clients 14+; ages 12-13 need to be referred out
  - With limited access, worth assessing clinician bandwidth and availability
  - Standardize warm handoff process from medical to BH to reduce cognitive burden on staff



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).



Time to Third: where are we?

- Clients' circumstances and schedules can change rapidly; waiting for an appointment is not always plausible
- Community sites are currently testing schedule changes to increase access
  - Assessing which appointments in a schedule are in demand or under-utilized
  - Catching up on scheduling outstanding appointments
  - Ensuring client follow-up where possible

Time to Third: what's next?

- Communicating with operations to work out a PI approach
  - How are we measuring this now?
  - How can we measure going forward?
  - How are we ensuring clients make and keep f/u appointments?
- Meeting with community sites to discuss access, their initiatives, and further steps

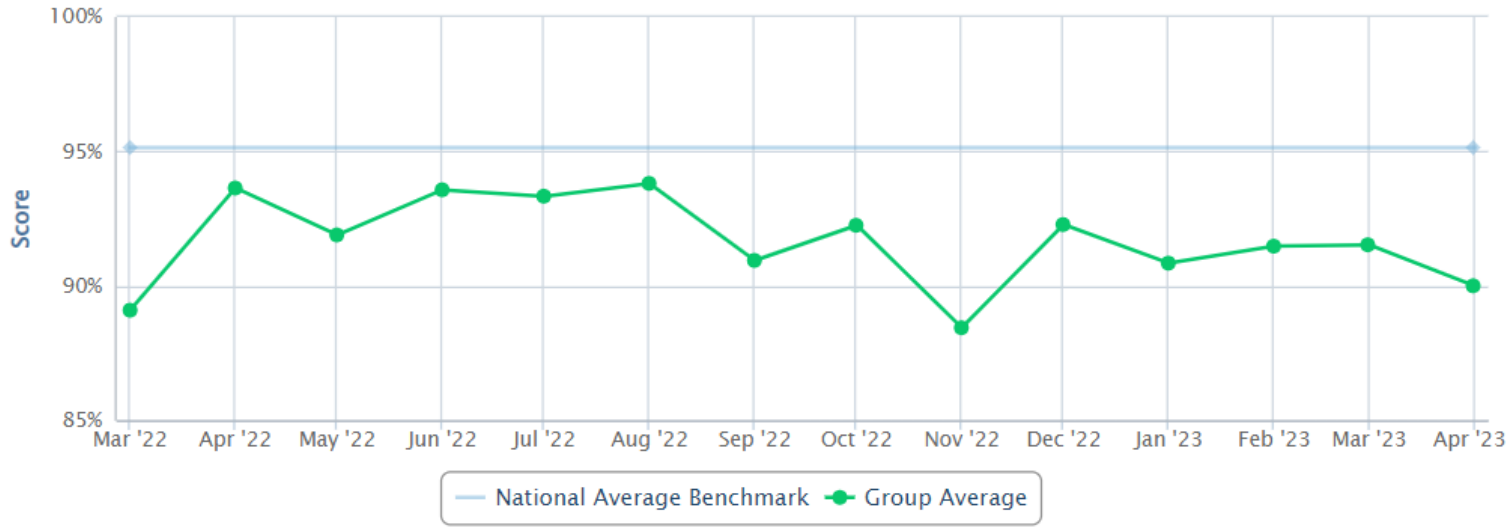
Client Experience

- 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.
- Currently, we are aiming to improve **client experience at scheduling, check-in, and check-out.**

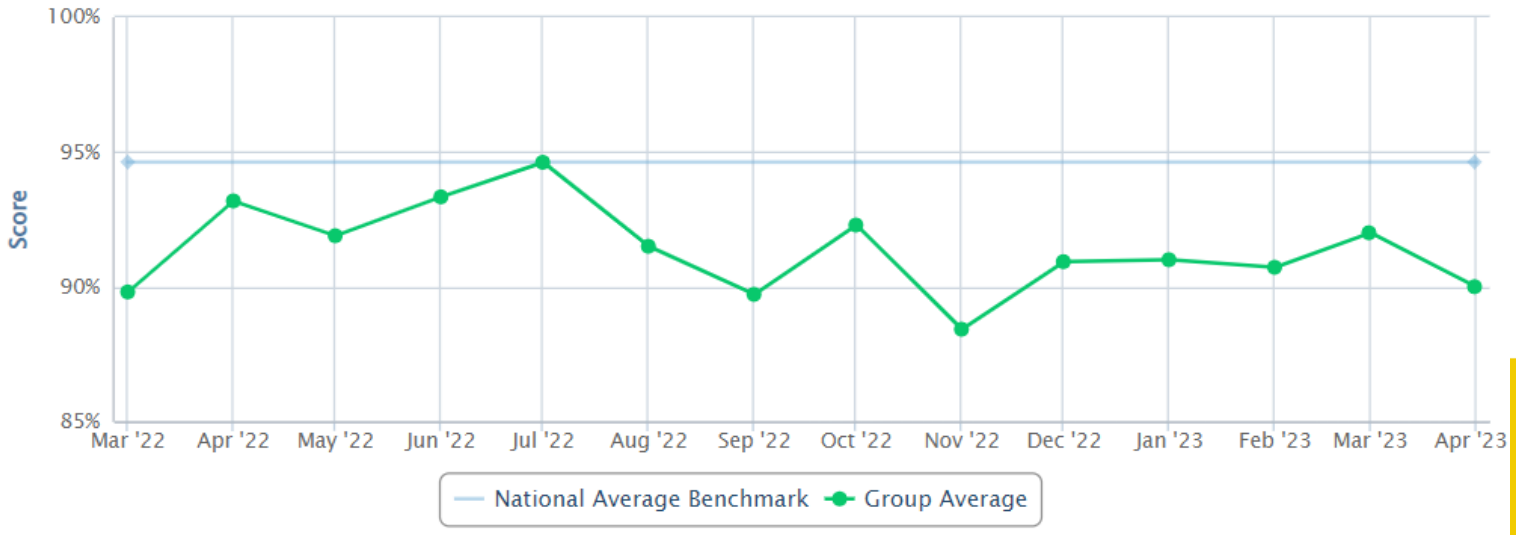
Client Experience: where are we?

- We are lagging behind national averages in the following questions:
  1. *Check-in and check-out staff were respectful and courteous*
  2. *Phone and scheduling staff were respectful and courteous*

Respected by Check-in/Check-out Staff (3/1/2022 to 4/14/2023)

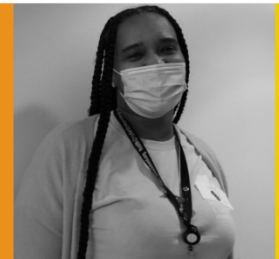


Respected by Scheduling Staff (3/1/2022 to 4/14/2023)



Client Experience: what's next?

- Met yesterday with PI, operations, and management staff to create charter and determine next steps
- Trauma-informed care training for the entire team (building off of Ops lead AIDET customer service training done)
- Improved communication with Spanish-speaking patients
  - Consistent usage of interpreter service or a Spanish-speaking staff member to communicate with clients at all levels
  - Ops lead Q2 priority to build language line training and begin to measure usage



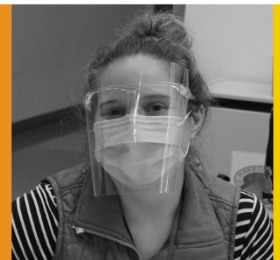
Antimicrobial Stewardship

Throughout 2023, monitor the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis or upper respiratory infection (URI) who were prescribed an antibiotic prescription (Goal = <25%).

The agency will also review data broken down by race, ethnicity, and SOGI to identify and reduce disparities in prescribing practices.

Antimicrobial Stewardship: where are we?

- Forming a clinical group to work with!
- Awaiting our first report
- Thinking through change ideas

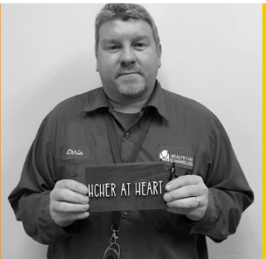


Antimicrobial Stewardship: what's next?

1. Meet with subcommittee
   - Develop charter
     - Think through change ideas

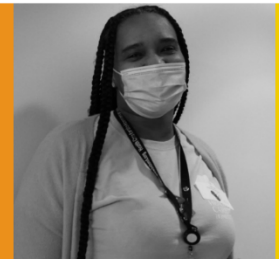
Health at Every Size

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



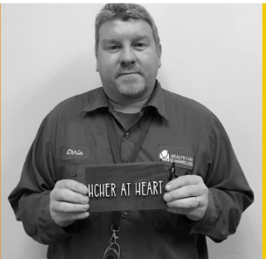
Health At Every Size: where are we?

1. Training complete on HAES and WAIT with medical and psych teams
2. Hardcopy resource cards for exam room ringlets ready for “doing” part of the PDSA process
3. Language drafted for communication with staff on how to use
4. Developing a post-training survey to assess success of training as intervention



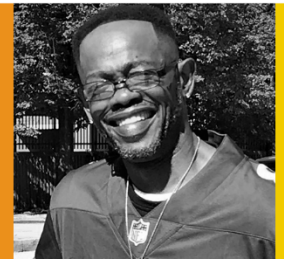
Health At Every Size (HAES): what's next?

1. Meeting with the full subcommittee with added clinical team members
2. HAES Training for Behavioral Health Department (June 2023)
3. Assess training success
4. Roll out of exam room educational materials

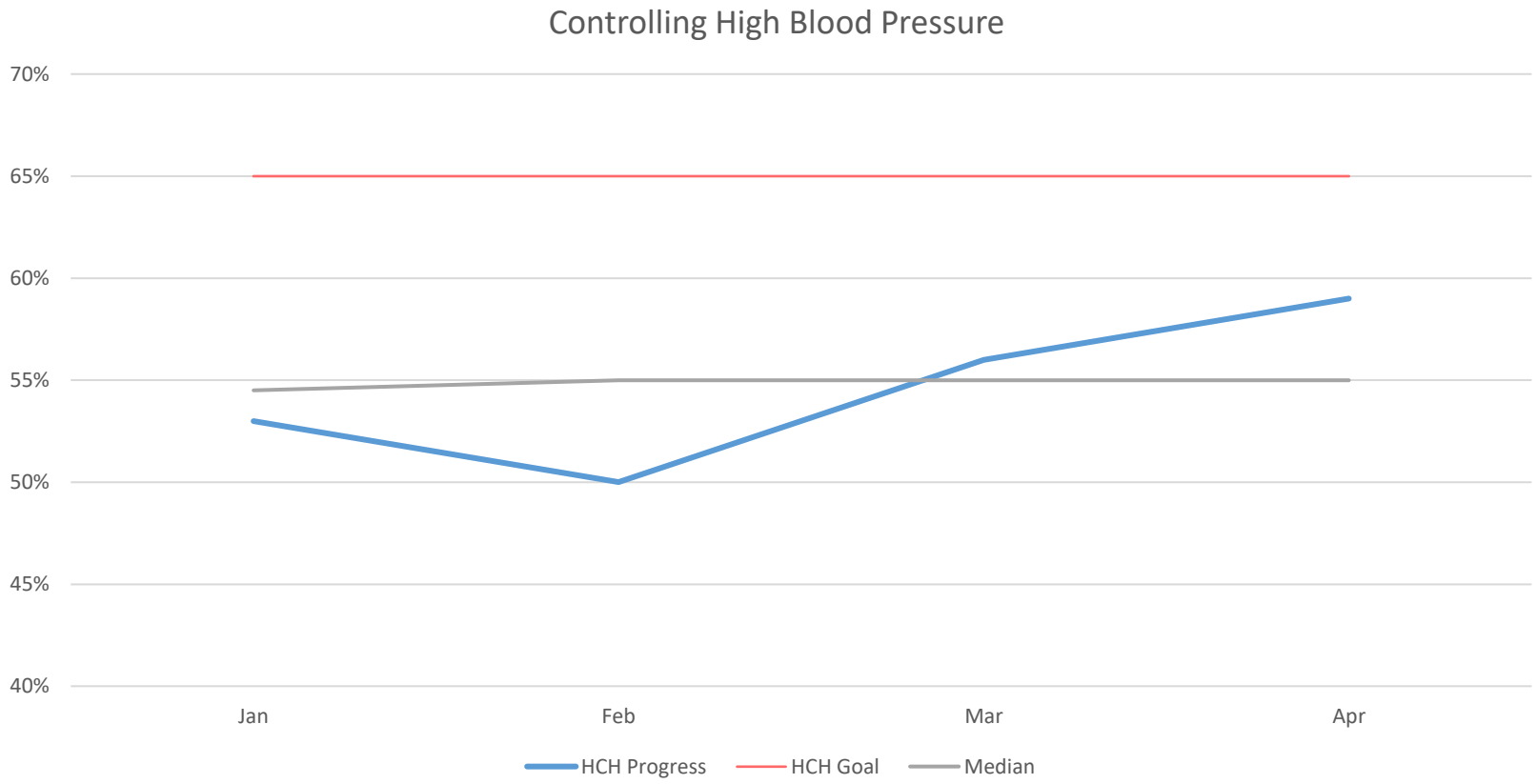


BP

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%.



Blood Pressure Control: where are we?



Blood Pressure Control: what's next?

Hospitalization Follow-Up

By December 31, 2023, the Agency will attempt **follow-up with 85%** of individuals following a hospitalization and identify SDH or racial disparities for clients post-hospitalization.

Hospitalization Follow-Up: where are we?

- High rates of follow-up occurring based on Call Center RN tracking data
- CCRNs began including community site clients into their hospital f/u work starting in April (to centralize the process)
- Number of clients on the weekly CRISP list has decreased since most recent panel upload to CRISP (80+ clients --> 40s)
- Reached a relatively stable workflow after many months
  - Thanks to the hard work and flexibility of many team members (Call Center Nurses: Kayla and Steph, Call Center Specialists, BHTs, Care team nurses, MAT)
  - Feedback that current process based on current #s is sustainable and going well, still often difficult to make contact with clients through calls

Hospitalization Follow-Up: what's next?

- Continue on with current workflow
- Draft an SOP and accompanying visio diagram of the workflow
- Potentially test out pilot text messaging clients post-hospitalization through Ring Central (limited to call center nurses)
  - Assist with sustainability and making successful contact
- Coming soon: Tableau report with data on follow-up rates

Flu Vaccines

By the close of the 2023-2024 flu season, **45%** of clients 18+ will have completed their seasonal flu vaccine.

Flu Vaccines: where we are

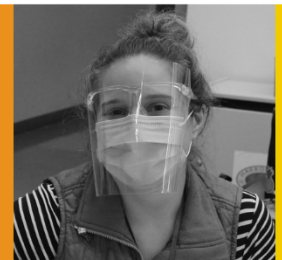
- Ended the 2022-2023 flu season at **20% completion rate (adults)**

What went well	Potential areas for improvement
Successful Flu and Coat Drive • High # attendees, drove rates up that week Flu Clinic • Dedicated flu clinic early on in the flu season - increased access to non-medical clients	• Lack of standard flu clinic hours and workflow over duration of flu season • Limited referrals for flu vaccine from non-medical staff to medical • Lack of proactive outreach to clients past due • Vaccine reconciliation: outside vaccines not captured automatically in Athena

- Next Flu season kick-off meeting: June 22

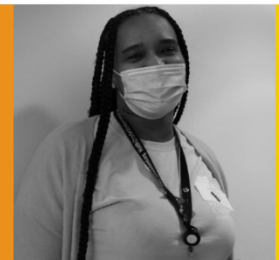
Care Management

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



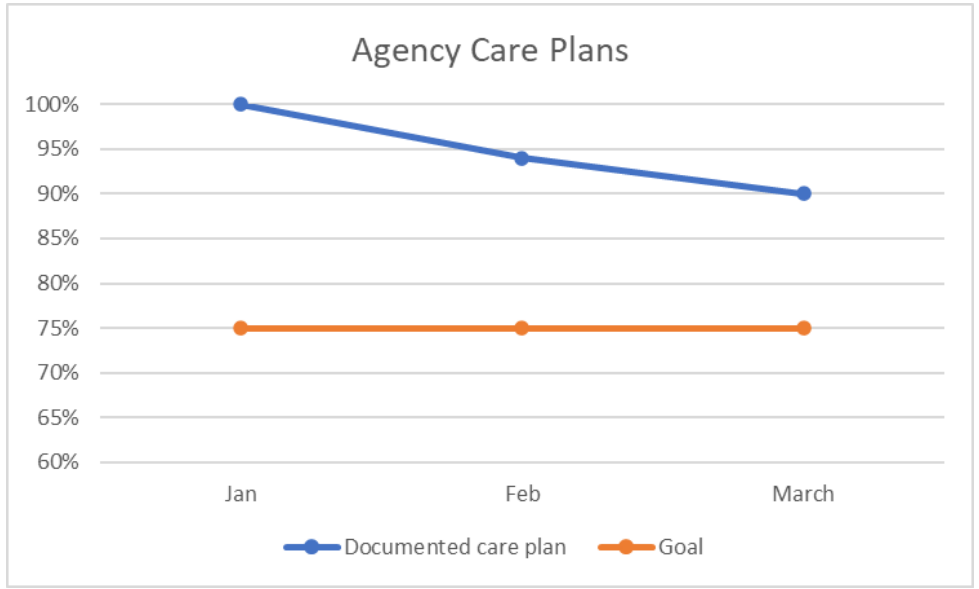
Care Management: where are we?

- Staff trainings on enrolling clients into care management and documenting care plans in Q4 2022
  - BHTs: clients with depression or other mood disorder
  - CMs: clients with unstable housing or no/low income
  - Nurses: clients with newly diagnosed/uncontrolled diabetes
- Teams really began enrollment into care management and documentation of care plans in Q4 2022 and Q1 2023
- Recently created/disseminated quick-guides to reference
  - documenting enrollment into care management, declination of care management, initiating/maintaining care plan, terminating care management
  - Friendly reminder: need to document that a written care plan was offered
    - Global text macro "**.cp**"



Care Management: where are we?

- Month-by-month data (above goal)



- YTD data by role

Category	DIAGNOSIS	Cohort	CarePlans	% Care Plans Completed
Behavioral Health	Depression care management	82	82	100%
Case Management	Psychosocial analysis management	94	88	94%
Nursing	Nursing care management session	39	33	85%

Care Management: what's next

- Bringing some of data to PI and to Agency Ops on 4/25
  - Best use of tableau report
  - Large variation in # of clients care managed by staff member
    - RNs: 3-23
    - BHTs: 1-41
    - CMs: 0-29
  - Determine what is a reasonable target (care management caseload for each individual staff member)
  - Opportunities to utilize staff champions (adapted to enrolling and managing larger case load), reinforce training around care management
  - Discuss & identify next steps for moving work forward

Advance Care Planning – Care of Older Adults

By December 31st, **5%** of older adults aged 66+ will meet this measure through provider discussion and/or completion of an advance care plan.

What is advance care planning?

Advance care planning involves voluntarily discussing and preparing for future decisions about your medical care if you become seriously ill or unable to communicate your wishes.

Advance Care Planning: where are we?

- **YTD: 1% completion (20/1640 clients)**
- Updated & finalized Advance Care Plan procedure
- Tyler Gray created draft of Advance Care Plan SOP
- Lawanda leading Case Management team training on how to have the advance care planning discussion with clients on 4/20 (will be recorded)
  - Agency will use the STATE OF MARYLAND OFFICE OF THE ATTORNEY GENERAL advance directive form: adirective.pdf (marylandattorneygeneral.gov)

Advance Care Planning: what's next?

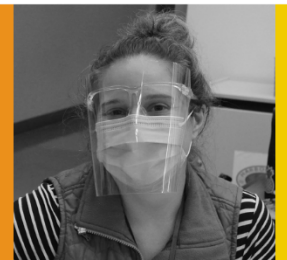
- Finalize ACP SOP by 4/26
- Come up with a plan for & implement a training around ACP for Medical
- Monitor data to see if ACP is being addressed and ensuring the work is sustained over time
  - Reminder: 60-minute appointment due to length of time required for this task

Colorectal Cancer Awareness Month Efforts

Kick Off

Front Porch Campaign

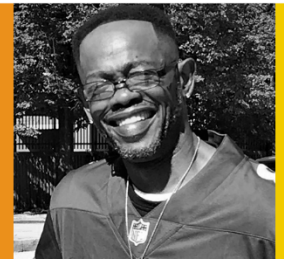
Awareness Items



Colorectal Cancer Screening Effort/Status

	Baseline	Goal	Q1	Q2	Q3	Q4	YTD
Colorectal Cancer Screenings (improve by 5%; reduce disparities by 5%)	30%	37%	24%				24%

- Mass Text sent on March 6 to all HCH clients seen at HCH in trailing year past due for CRC screening
- Excellent client response to mass text
- Pop Health opened sessions to assist with increased flow r/t crc (8 total with 30 min visits)
- Total patients seen via in-person/telehealth: 35



Themes of 35 CRC client visits by Pop Health- Mar 2023

FIT ordered (15)

- in person: 7
- mailed: 8
- completed: 7 (combo in person/mail)

GI referral ordered (9)

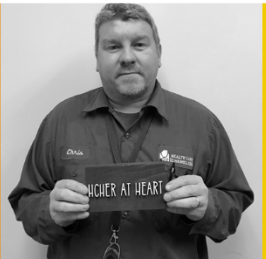
- in progress (various)

Other (11)

-already complete/update Quality: 3

-navigation/appt assistance: 4

-already ordered/other: 4



Women's Health Day

It's BACK!

May 18 @ 12-2pm

2nd floor walk-in area

- Education
- Stress-redux activities
- Story-sharing
- Healthy food and gifts