Program and Performance Improvement Meeting

Performance Improvement Updates

November 19, 2025

Icebreaker

What is your favorite thing to do right after Thanksgiving dinner?

AGENDA

1. 2025 CQM updates

2. PI goal updates

3. 2026 PI goals (approved by P&PI Committee > going to full Board)

2025 PI Framework

Phase 1 (generally, Q1)

Preparation and Problem Identification

Includes: Qualitative and Quantitative data collection and review (client and staff interviews, chart reviews, observations), process mapping, charters, Pick Charts, design sessions

Phase 2 (generally, Q2/Q3)

Testing via PDSA cycles

Includes: Staff involvement in testing and contributing feedback for iterative cycles

Phase 3 (generally, Q3/Q4)
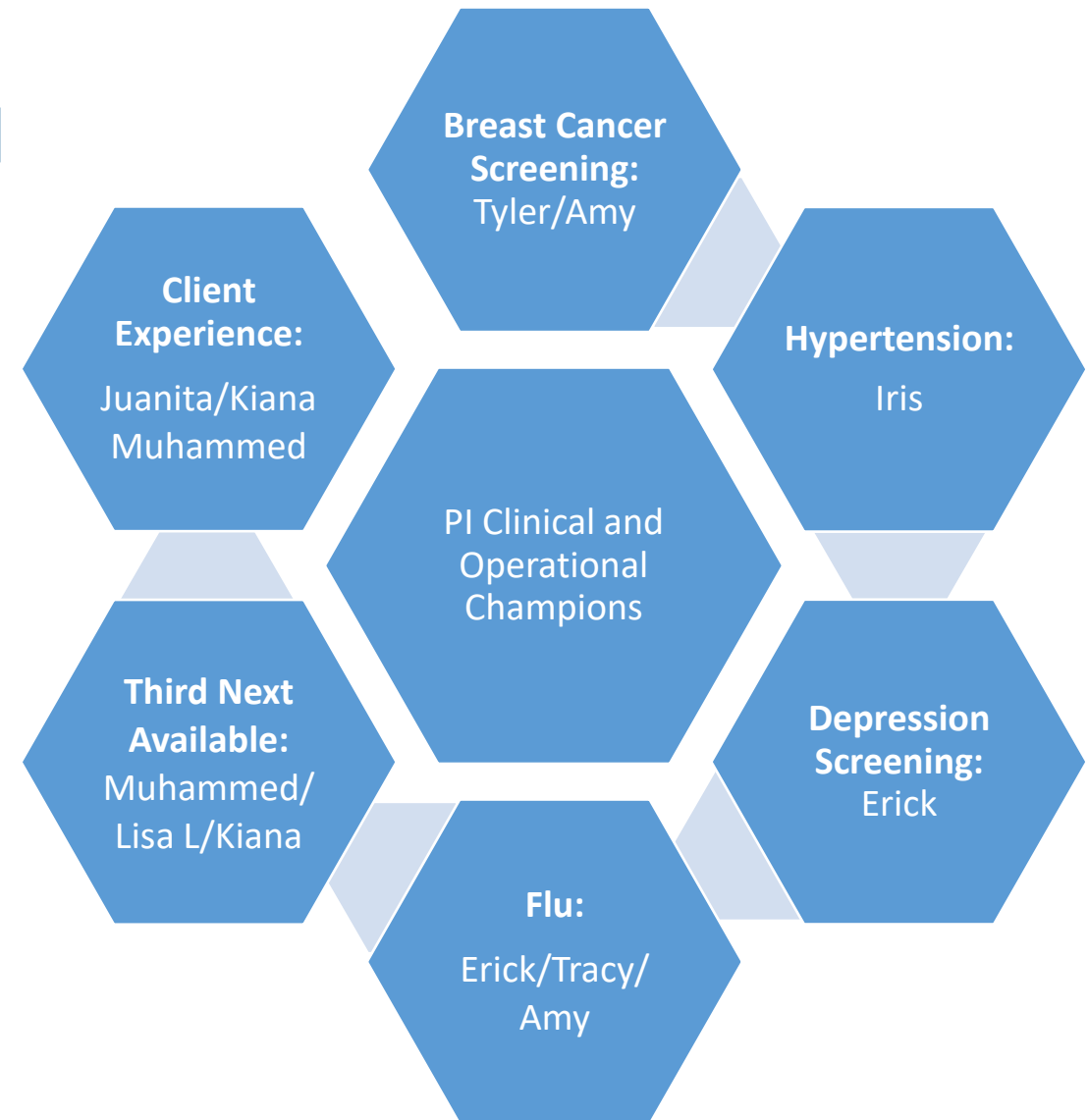
Scale Up and Sustainability

Includes: integrating improvements into workflows and sustaining the gains

2025 PI Framework Continued

Clinical and Operational Champions = department leaders that collaborate on lean team and serve as co-POC for goal work

Staff Champions = collaborate via ad hoc and one-on-one meetings throughout the year, help test changes and provide feedback

Breast Cancer Screening: Tyler/Amy

Client Experience: Juanita/Kiana Muhammed

Hypertension: Iris

PI Clinical and Operational Champions

Third Next Available: Muhammed/ Lisa L/Kiana

Depression Screening: Erick

Flu: Erick/Tracy/ Amy

Quality Measures

2025 YTD

Clinical Quality Measures

Maternal and Child Health	Jan	Sep	Oct	2025 Goal
Childhood Immunization Status	7%	24%	31%	10%; stretch: 26%
Dental Sealants (ages 6 - 9 Years) (YTD)	100%	75%	75%	86%
Early Entry into Prenatal Care	62%	62%	60%	65%
Low Birthweight	7%	11%	13%	5%
Weight Assessment & Counseling for Nutrition & Physical Activity (Peds)	79%	80%	84%	80%; stretch: 82%

Disease Management	Jan	Sep	Oct	2025 Goal
Ischemic Vascular Disease (IVD): Use of Aspirin/Other Antiplatelet	86%	82%	83%	90%
Statin Therapy for Prevention/Treatment of Cardiovascular Disease (CVD)	86%	86%	87%	88%
HIV Linkage to Care	100%	100%	94%	100%
Depression Remission at Twelve Months	4%	2%	1%	7%

CQM (cont)

Screening and Preventive Care Measures	Jan	Sep	Oct	2025 Goal
Height and Weight Assessment and Health Counseling	46%	48%	48%	50%
Breast Cancer Screening (ages 40 - 74)	41%	43%	43%	46%
Breast Cancer Screening Disparity	B/AA: 35% W: 30% H/L: 61%	B/AA: 32% W: 34% H/L: 60%	B/AA: 32% W: 33% H/L: 60%	Increase 5% for B/AA (goal: 40%) and White (goal: 31%) Female Clients
Cervical Cancer Screening	52%	56%	56%	55%; stretch: 58%
Colorectal Cancer Screening	34%	34%	33%	35%
Depression Screening and Follow-Up Plan	54%	69%	70%	55%; stretch: 60%; double stretch: 65%
HIV Screening	74%	74%	74%	77%
Tobacco Use: Screening and Cessation Intervention	70%	73%	73%	74%

Chronic Disease Management	Jan	Sep	Oct	2025 Goal
Hypertension Controlling High Blood Pressure	60%	62%	62%	65%
Diabetes: HbA1c Poor Control (>9%) [inverse]	32%	33%	32%	31%; stretch: 30%

Additional Priorities

Additional HCH Priorities	Jan	Oct	2025 Goal
Closing the Referral Loop (% Completed Referrals)	39%	54%	40%
SDOH Completion Rate	32%	42%	50%
SDOH Completion Rate By Department	HS: 85% BH: 62% Psych: 55% Medical: 40% SS: 31%	HS: 88% BH: 75% Psych: 71% Medical: 50% SS: 36%	Increase by 10% per department
Suicide Assessment and Safety Plan	30%	35%	85%
Prescribing Antibiotics for Upper Respiratory Infection (URI) and Acute Bronchitis (YTD)	100%	99%	100%
Hospital Readmission	13%	23%	12%

PI updates

2025 PI Goals

2025 Performance Improvement Measures

PI Measures	Sept	Oct	2025 Goal
Breast Cancer Screening (Ages 40 – 74)	43%	43%	**46%**
Depression Screening and Follow-Up Plan	69%	70%	⭐ **55%; stretch: 60%; double stretch: 65%**
Hypertension Disparity (Black/African American Females)	58%	57%	**57%** ⭐
Third Next Available (YTD)	22 days	22 days	**Fallsway Avg: 19 days**
Client Experience (YTD)	4.68	4.69	**4.81**
Flu Vaccinations	Medical Offer Rate: 44% Medical Admin Rate: 24%	Medical Offer Rate: 71% Medical Admin Rate: 50%	**Offer Rate: 75% Admin Rate: 50%** ⭐

Breast Cancer Screening

Women 40-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of year.

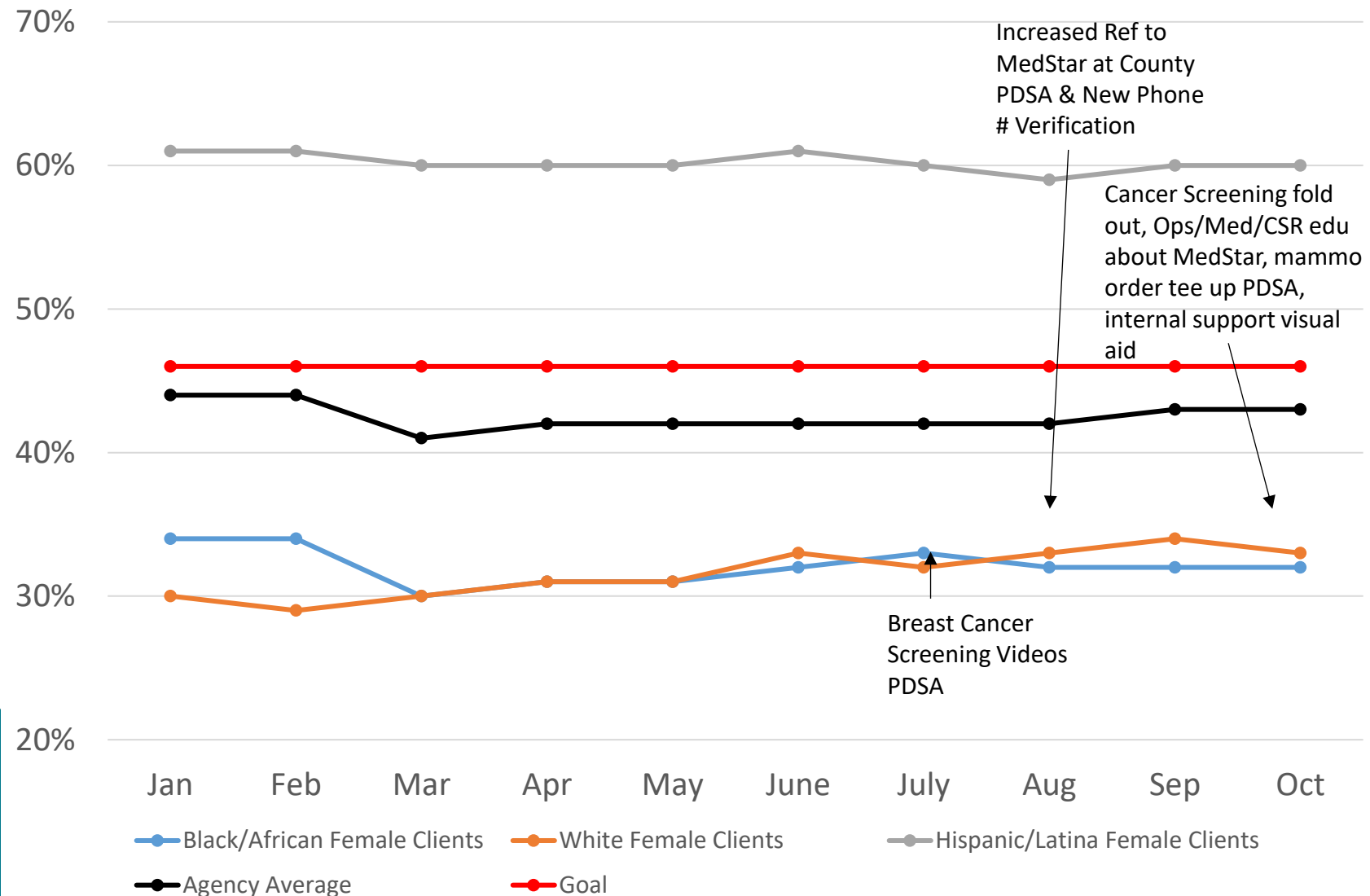**Goal:** 46%

Current: 43%

Disparity Current:

- B/AA: 32% (**goal:** 40%)

- W: 33% (**goal:** 31%, met!)

- H/L: 60%

Breast Cancer Screening Race and Ethnicity Disparity

Increased Ref to MedStar at County PDSA & New Phone # Verification

Cancer Screening fold out, Ops/Med/CSR edu about MedStar, mammo order tee up PDSA, internal support visual aid

Breast Cancer Screening Videos PDSA

Black/African Female Clients   White Female Clients   Hispanic/Latina Female Clients
Agency Average   Goal

Breast Cancer Screening Update

- **Cancer screenings in MAT space** → integrating breast cancer screening for more equitable care across service lines and improved client outcomes for early detection and treatment
  - *Met with leaders in the space who decided to start with cervical cancer screening, initial conversations about cancer screenings are paving the way for breast and other cancer screenings in 2026*

- **October Breast Cancer Awareness Month** activities
  - Mass text campaign messages for those overdue, population health order for provider approval + scheduling support, wear pink day, shared cancer screening fold out, staff led video on the importance of mammograms,

- **MA mammo order tee up** to streamline order for provider to sign with their note
  - Tested with three MAs, qualitative feedback that going well – plan to roll out with more MAs and watch for results in coming months

- Further **expand on utilization of MedStar referrals for uninsured clients**
  - Worked with providers, ops, and referrals to improve visibility and encourage referrals which resulted in additional referrals in the month of October; focus on using Medstar support for applications; diagnostic mammos

Breast Cancer Screening (cont)

Re-education and reminders for providers on **internal referral supports** (CMs, CHWs, Patient Navigation)

- *Met with representatives in the above departments to create visual aid for providers, working to disseminate this month*
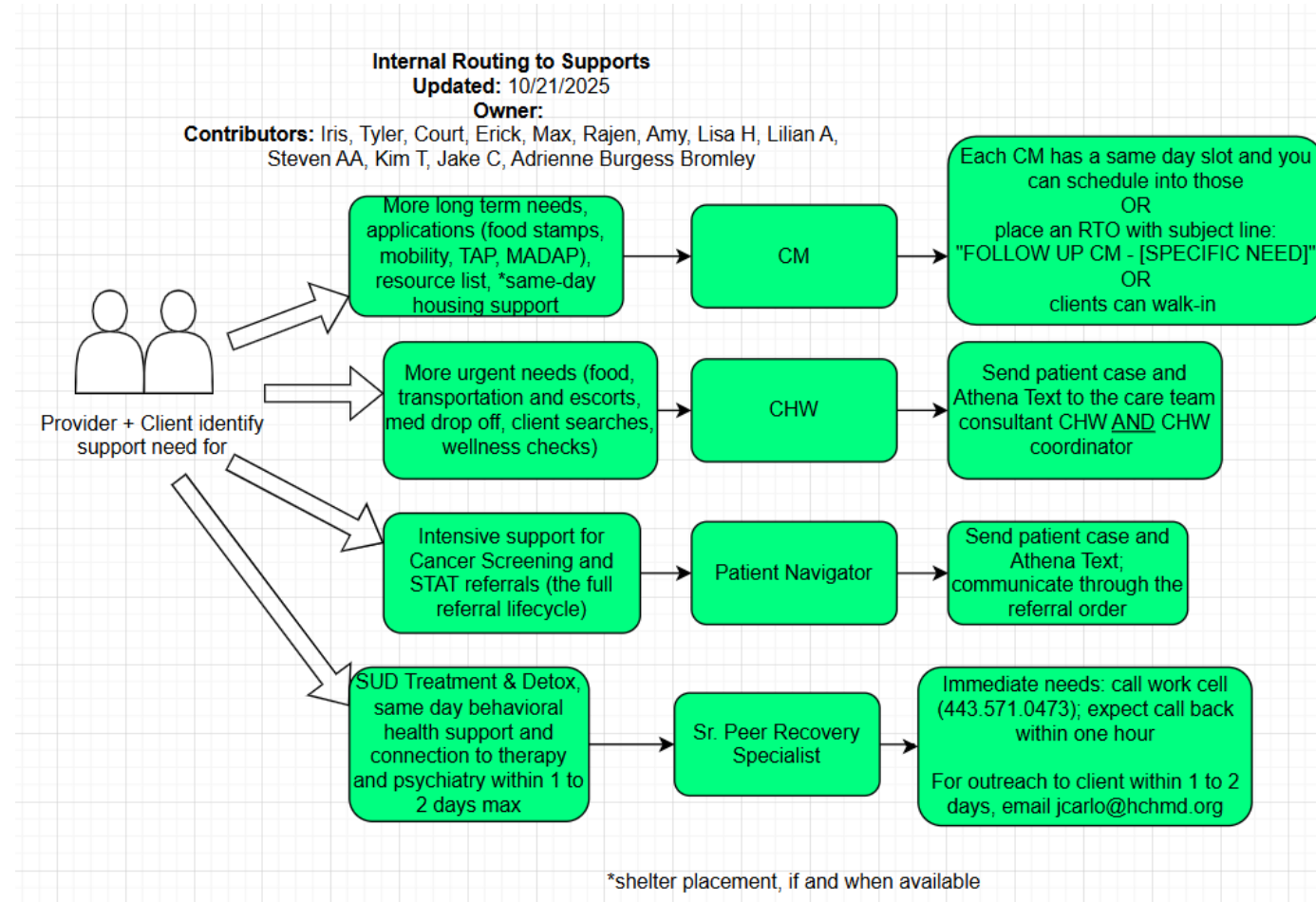
Depression Screening and Follow Up Plan

By December 31, 2025, improve the percentage of **clients 12+ years old screened for depression**, and **if/when positive have a documented follow up plan**, to 55%.

- Baseline: 46% (July 2024 TY)

- Current: 70% (met goal!)

- **Goal: 55%; stretch goal: 60%; double stretch: 65%**

PHQ Challenge and Bulletin in BH space

Intake Packet
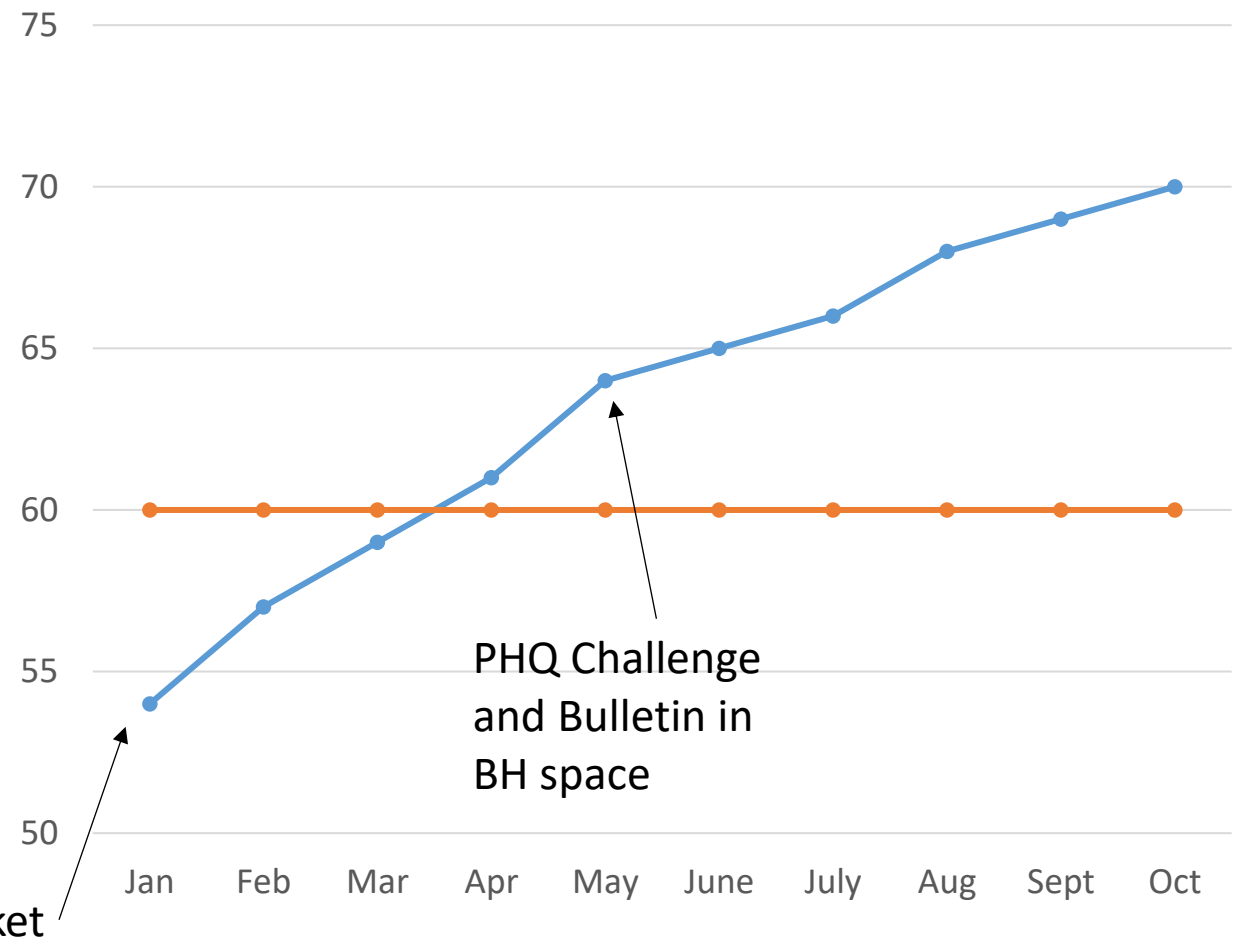
Depression Screening and Follow Up Plan Update

- Pivoting to **follow up plan** with medical providers (how to ensure documentation and work satisfies the measure)
  - *Enhancing educational document and re-educating providers*

- Continued **sustainability** planning
  - *Continuing with efforts on universal screening in the medical space as well as regularly scheduled PHQ9 screening in the BH space*

Hypertension Disparity

By December 31, 2025, **improve hypertension control rates (less than 140/90 mmHg) for Black/African American women to 57%** to more equitably align with the Agency's other racial, ethnic, and gendered populations.
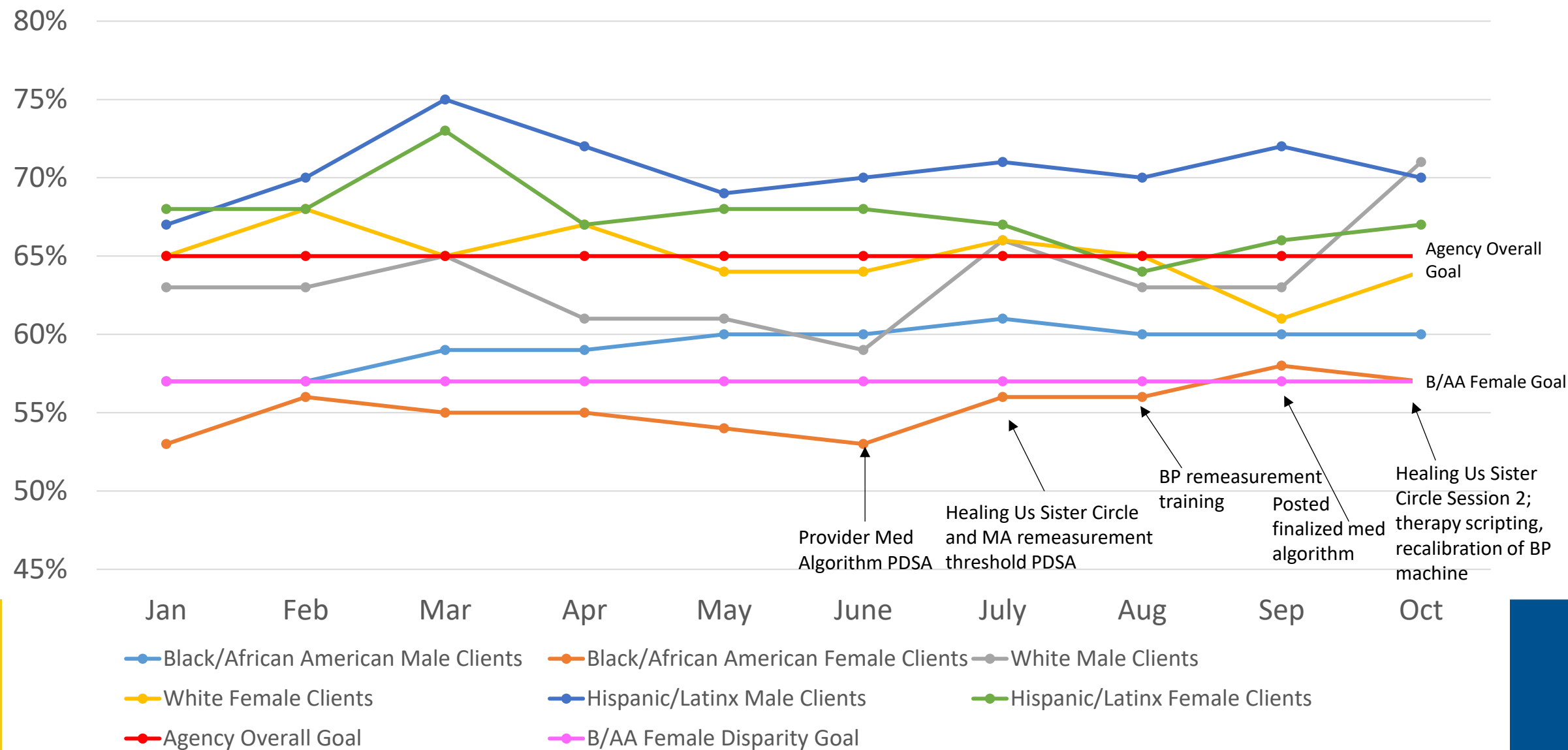
- Baseline: 52% (July 2024 TY)

- **Goal: 57%**

- **Current: 57% (met goal!)**

| Race/Ethnicity/Gender	Baseline Comparison (July 2024 TY)
Agency Average	**62%**
Black/African American men	62%
Black/African American women	52%
White men	73%
White women	63%
Hispanic/Latino men	72%
Hispanic/Latina women	69%

Hypertension Disparity

Hypertension Race, Ethnicity, and Gender Disparity
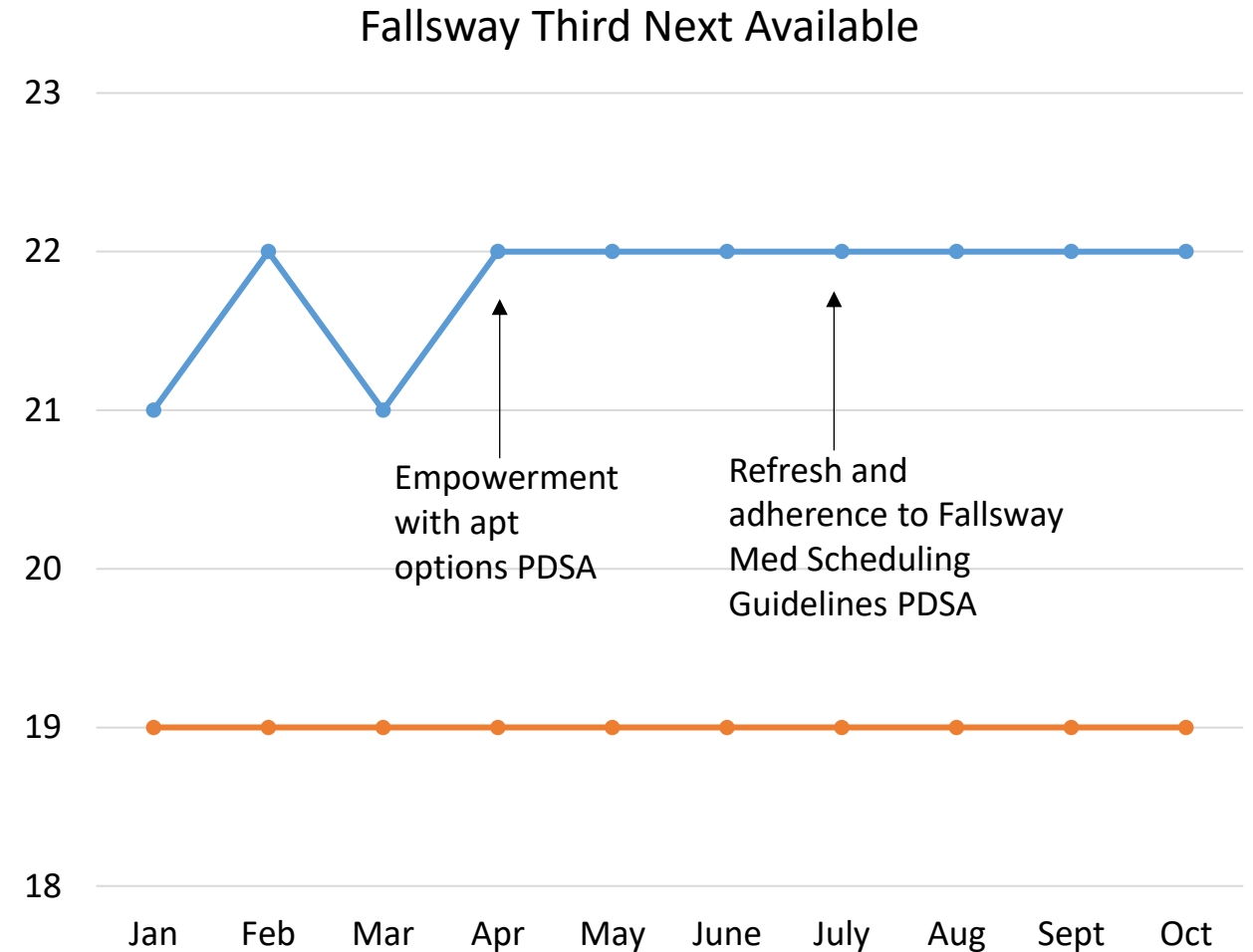
Hypertension Disparity Update

- **Healing Us Sister Circle** → group ended and working on another group with expanded access starting in October for 8 weeks
  - *Group 2 session started, increased participation*

- **Therapy scripting** to share benefits of therapy for stress reduction and impact on BP
  - *Met with seasoned therapist and crafted scripting*

- **Recalibration of blood pressure machines**
  - *Worked with facilities to ensure proper recalibration of machines on regular cadence for accurate blood pressure measurement*

- Posted **medication algorithm** and surveyed providers on utilization
  - *Providers shared satisfaction with the algorithm and note they've reviewed and consider in prescribing*
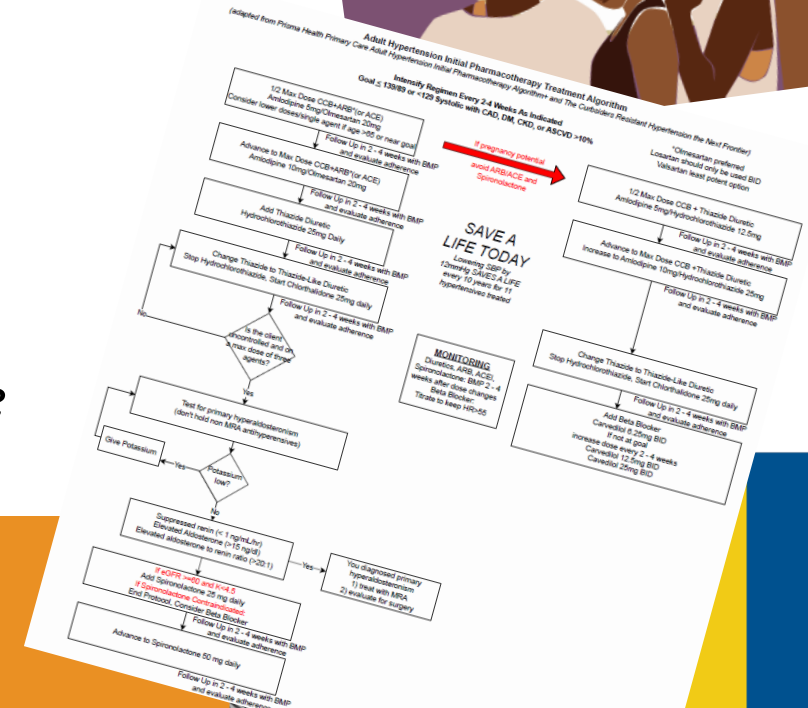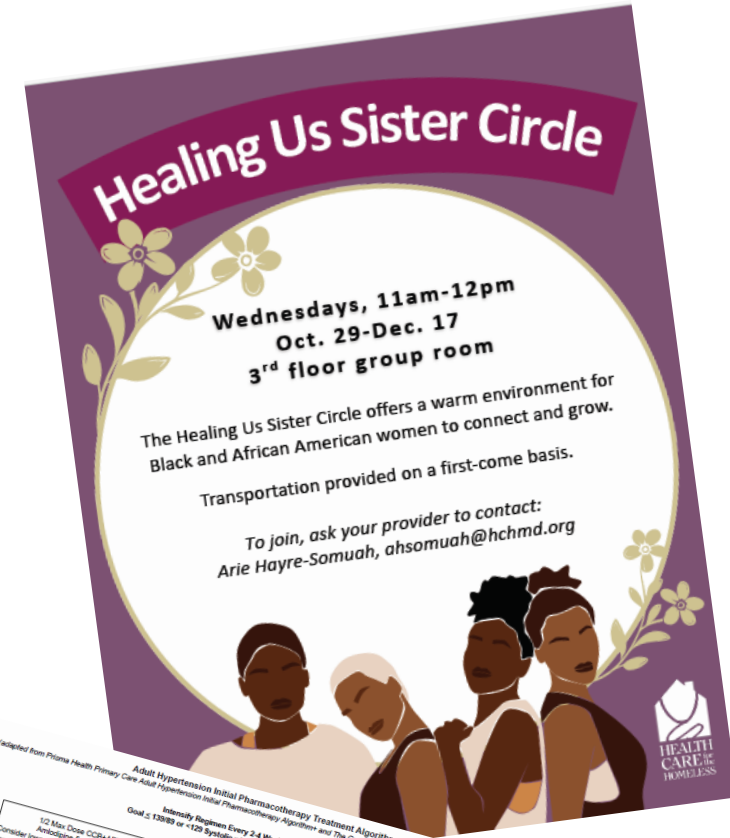
Third Next Available

By December 31, 2025, improve the **Fallsway location time to third next available appointment to an average of 19 days** (includes Behavioral Health, Case Management, Medical, Nursing, and Psychiatry departments).

- Baseline: 21 days (December 2024 YTD)

- **Goal: 19 days**

- **Current: 22 days**

Fallsway Third Next Available

Empowerment with apt options PDSA

Refresh and adherence to Fallsway Med Scheduling Guidelines PDSA

Jan Feb Mar Apr May June July Aug Sept Oct

Third Next Available Update

- **Re-establish and enforce scheduling guidelines in Fallsway Medical** space → determined accuracy of slot utilization and identified specific appointment types that are most frequently mis-scheduled (Short Term Follow Up and Provider Follow Up)
  - *Further discussed potential change ideas, but determined will test in 2026*
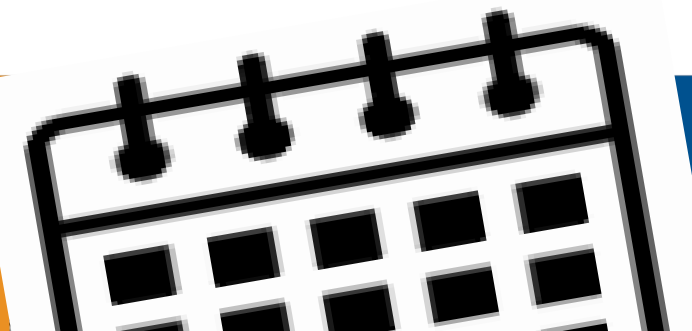
Flu Vaccination

By the end of the 2025/2026 flu season, improve Agency percentage who were offered an influenza vaccine to 75% and administered to 38%.

Baseline: Offer Rate: 28%; Administered Rate: 27% (2023/2024 Flu Season)

Goal: Offer Rate: 75%; Administered Rate: 50%

Current: Offer Rate: 71%; Administered Rate: 50%

Influenza Vaccination Update

- **Flu Vaccine Rounds** → Quality Team navigating building with cart to provide resources and reminders about flu vaccine workflows
  - *Continued through September and into October and helped to answer questions, troubleshoot in real time, and enhance resources*

- **Flu Vaccine Mass Text Campaign** → improvements to last year in staggering messages

- **Flu vaccine door decorating competition** → building on "everyone is a flu champion" and further engaging staff to promote vaccination to clients
  - *12 doors creatively decorated encouraging vaccination*

- **Flu and Coat Drive Event** → annual event that draws many (299 vaccinations + 500+ coats!)

- **Medical Offer Rate Competition** with monthly prizes for incremental improvements
  - *Saw substantial improvement and met admin goal – provided cookie prize*

- **Continuous communications reminders**
  - *Hang tags for computers, tv screens, screensavers, tear tags in offices and around clinic*
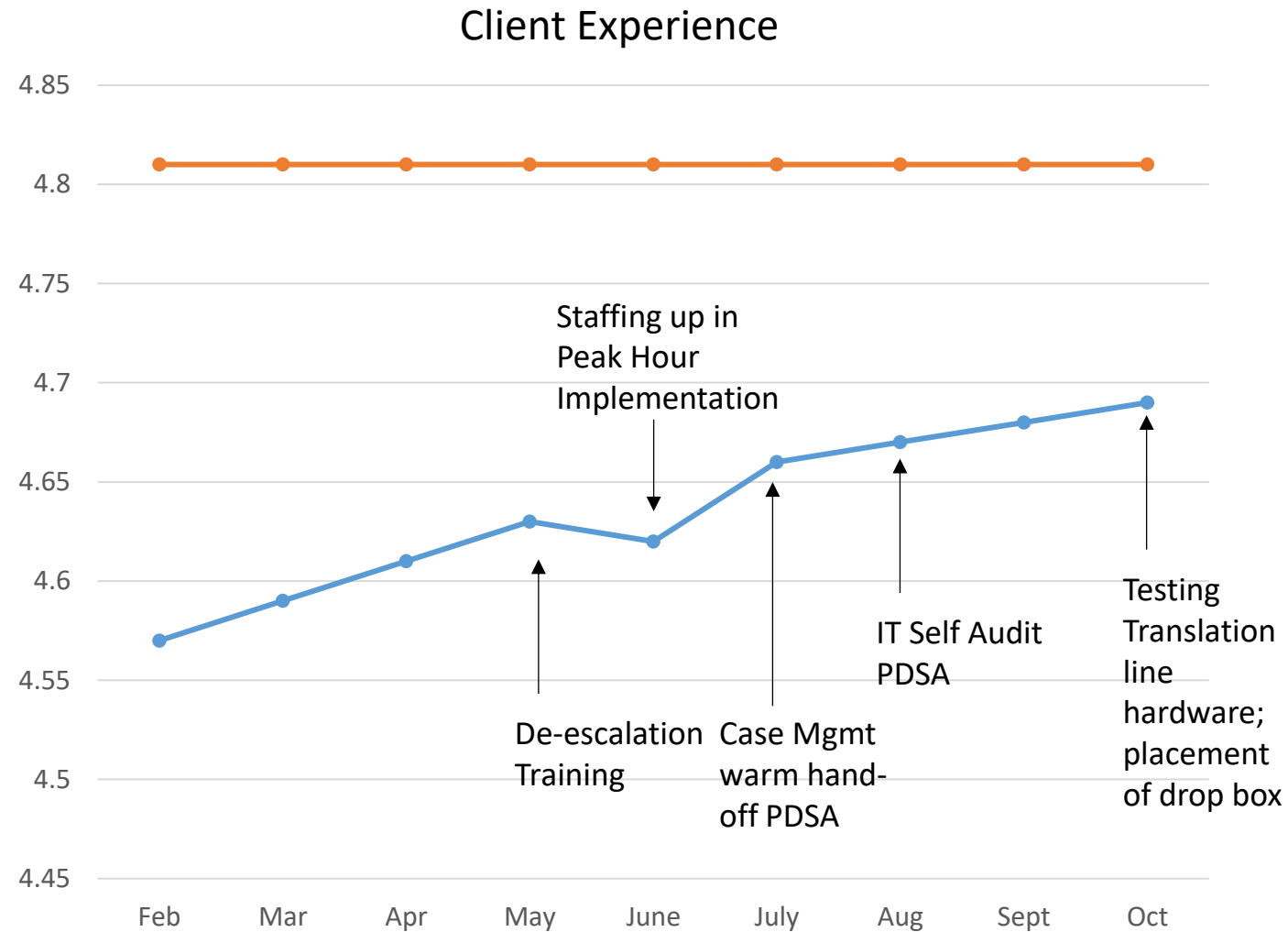
Client Experience

By December 31, 2025, improve the average level of client satisfaction survey for **"rate your level of satisfaction during your recent visit of the person who you assisted during the check-in process" to 4.81** (scale of 1 to 5, 5 being the highest).

Baseline: 4.57

Current: 4.69

Goal: 4.81 (50th percentile)

Client Experience

Staffing up in Peak Hour Implementation

De-escalation Training

Case Mgmt warm hand-off PDSA

IT Self Audit PDSA

Testing Translation line hardware; placement of drop box

Client Experience Update

- **IT improvements** in check-in/check-out spaces through self audit → identified key challenge areas from trends in malfunctioning equipment and analyzing more reliable IT set ups for translation device set up
  - *Tested two solutions and found one that exceeds our expectations, working on proposal for purchase now*

- Developing **audio-visual method to support clients with completing paperwork during registration**
  - *Developed and actively testing with baseline paperwork in first floor registration at Fallsway*

- Designing **space to return paperwork**
  - *Facilities installed a drop box for paperwork to decrease confusion and interruption during check-in processing*

2026 Goal Finalization

Approach

1. Select evidence-based goals that are benchmarked nationally and locally (e.g. UDS measures) and that meet regulatory or grant requirements (e.g. NCQA requirements to "act and improve")

2. Prioritize goals with a large impact on client populations or have a substantial health impact on a specific population

3. Promote buy-in through direct staff feedback on goal selection and subsequent engagement in improvement initiatives

4. Select goals that show room for improvement in performance trends or experience challenges in meeting a previous target

Choosing Goal Percentages

1. **Review Trends:** Compare last year and the current year's performance to see how the Agency is trending, using benchmarks for reference.

2. **Assess Current Work:** Look at ongoing clinical and operational initiatives and identify priority areas for improvement. Reflect on last year's Performance Improvement (PI) focus areas and current interventions that show positive results.

3. **Use Comparison Data:** Analyze available data (e.g., UDS reports or national averages) to gauge performance. Set goals to meet or exceed national benchmarks.

4. **Consider Influencing Factors:** Consider client population characteristics and other factors that may affect performance rates.

5. **Set Realistic Improvement Targets:**
    - Aim for a 3–5% improvement within a year, depending on the measure.
    - For challenging outcome measures, set realistic, attainable goals.
    - For process measures or those with potential "quick fixes" (e.g., documentation issues), set stretch goals for greater improvement

Preventive Care

By December 31, 2026, increase the percentage of individuals age 21 – 64 who were screened for cervical cancer to 60%.

Current Baseline: 56% (July 2025 TY)
Goal: 60%
Goal Rationale: HCH's 2024 UDS-reported rate was **52%**, with a **4% increase** observed by July 2025. This improvement occurred without a dedicated Performance Improvement (PI) focus, suggesting that a 4% annual increase is both feasible and sustainable. Achieving this target would bring the Agency closer to the top-performing local health center (BMS at 61%) and position us above the national average. In 2025, the Agency also launched a population health project focused on cervical cancer screening. Insights from this initiative have guided new quality and medical team collaborations, including efforts to expand cancer screening access in non-traditional medical settings and to introduce HPV self-collection kits.

Chronic or Acute Clinical

By December 31, 2026, improve hypertension control rates (less than 140/90 mmHg) for clients 18 – 85 years of age to 67%.

Baseline: 63% (July 2025 TY)

Goal: 67%

Goal Rationale: The Agency achieved a **1% increase** from the 2024 UDS-reported rate, with an additional **3% improvement year-to-date in 2025**. By year-end, the goal is to narrow the disparity gap by raising hypertension control rates among Black or African American women from 53% to 57%—a 4% increase. With current initiatives underway, promising new strategies to be piloted, and strong engagement from the medical team, this target is considered realistic and attainable. Reaching this goal would align the Agency's performance with the 2024 UDS national average and position it competitively with BMS by 2026.

Behavioral Health

By December 31, 2026, increase the percentage of clients 13+ years of age who initiated and engaged in ongoing treatment of substance use disorder to 35%.

Baseline: 24% (July 2025 TY)

Goal: 35%

Goal Rationale: In 2023, the **national average across payers was 40.8%**; excluding the highest-scoring payer, the average drops to **36%.** Although there is no current UDS or FQHC benchmark for this measure, the Agency's goal is to align more closely with national averages. As this is a new measure, it is anticipated that initial improvements in documentation practices will lead to early gains in reported rates, establishing a strong foundation for broader, system-wide improvements in the future.

Care Coordination

By December 31, 2026, increase the percentage of clients age 18+ years of age with a documented list of current medications in their electronic health record to 90%.

Baseline: 88% (July 2025 TY)

Goal: 90%

Goal Rationale: Ensuring accurate documentation of current medications is a key indicator of safe and coordinated care. According to Azara user data, the top-performing center reports a rate of 88%, which aligns with the Agency's current performance. Continuing to strengthen efforts in this area to reach the NCQA target of 90% will further enhance workflow efficiency and reinforce the Agency's commitment to high-quality, safe care.

Client Experience

By December 31, 2026, improve client reported perception of their care team's care coordination efforts by X% (final % here based on baseline).

Baseline: TBD (December 2025; trailing 2 months)

Goal: TBD

Goal Rationale: In alignment with The Joint Commission's standard requiring organizations to collect data on patient perceptions of care coordination and continuity, this goal focuses on acting upon findings from the client experience survey. Building on ongoing efforts to strengthen care team coordination in 2025, the Agency will formally evaluate care team interventions and use this measure to guide continued improvements in care coordination. The target percentage for improvement will be determined based on the foundational work completed in 2025 and the promising practices under consideration for 2026.