Monthly Performance Improvement Committee

October 2023

HEALTH CARE for the HOMELESS

Presenters:

- Lisa Hoffmann, Director of Quality Improvement
- Marie Stelmack, Quality Improvement Specialist

Agenda

1. Morning chat (5 min)
2. PI updates (35 min)
3. PI learning
4. Questions and discussion (4 min – can also ask along the way!)

Morning!

Today's icebreaker: What's your Halloween costume?

2023 PI Measures

All data is presented as year to date
Green = goal met!

3+ Improvement
1-2+ improvement
No change
Reduction

Disease Management	HCH 2022	Aug	Sept	2023 Goal
Reduce inappropriate antibiotic prescriptions	new	100%	100%	<25%
Hospitalization follow-up	new	83%	31%	65%
Height and Weight Assessment and Health Counseling	26%	45%	45%	65%
Controlling high blood pressure	58%	62%	64%	65%
Depression Remission at Twelve Months	9%	5%	7%	11%
Care management (with care plan)	67%	97%	-	75%
FLU: adult vaccination rates	16%	-	13%	45%
Advance Care Planning	new	2%	3%	5%
Third Next Available		BC: 12 WB: 14 F: 23	BC: 13 WB: 15 F: 23	Reduce by 5%
Client Experience		(C) 92% (S) 93%	(C) 91% (S) 91%	93% (both)

September PI Updates

Goal 1: Antimicrobial Stewardship

Throughout 2023, monitor the percentage of patients with a diagnosis of acute bronchitis or upper respiratory infection (URI) who were not prescribed an antibiotic prescription (Goal >75%). The agency will also review data broken down by race, ethnicity, and SOGI to identify and reduce disparities in prescribing practices.

YTD: 100%

Who is who and what's new

1. **Subcommittee members:** Liz G.; Iris L.; Marie S.; Lisa H.

2. **Recent happenings:**
   - We remain at 100%!
     - Our providers have a good grasp on when antibiotics are and aren't appropriate
     - Thank you, medical providers, for your excellent judgment!

3. **Next steps:**
   - Closing out this measure

Goal 2: Hospitalization Follow Up

By December 31, 2023, the Agency will attempt follow-up within 7 days for 65% of individuals following a hospitalization and identify SDH or racial disparities for client's post-hospitalization.

YTD: 31%

Who is who and what's new

1. **Subcommittee members:** Catherine F; Julia D.; Tara D.; Katie H.; Muhammed M.; Lisa L.; Margaret F.; Tracy R.; Marie S.; Lisa H.

2. **Recent happenings:**
   - Staff outages contributed to an unusually low rate this month
     - Discussions happening around back-up workflow
   - Text pilot: some text messages have failed to send
     - Possibly due to character limit in Ringcentral
3. **Next steps:**
   - For 2024: looking at **30-day readmission rate**

Goal 3: Height and Weight Assessment and Health Counseling

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

YTD: 45%

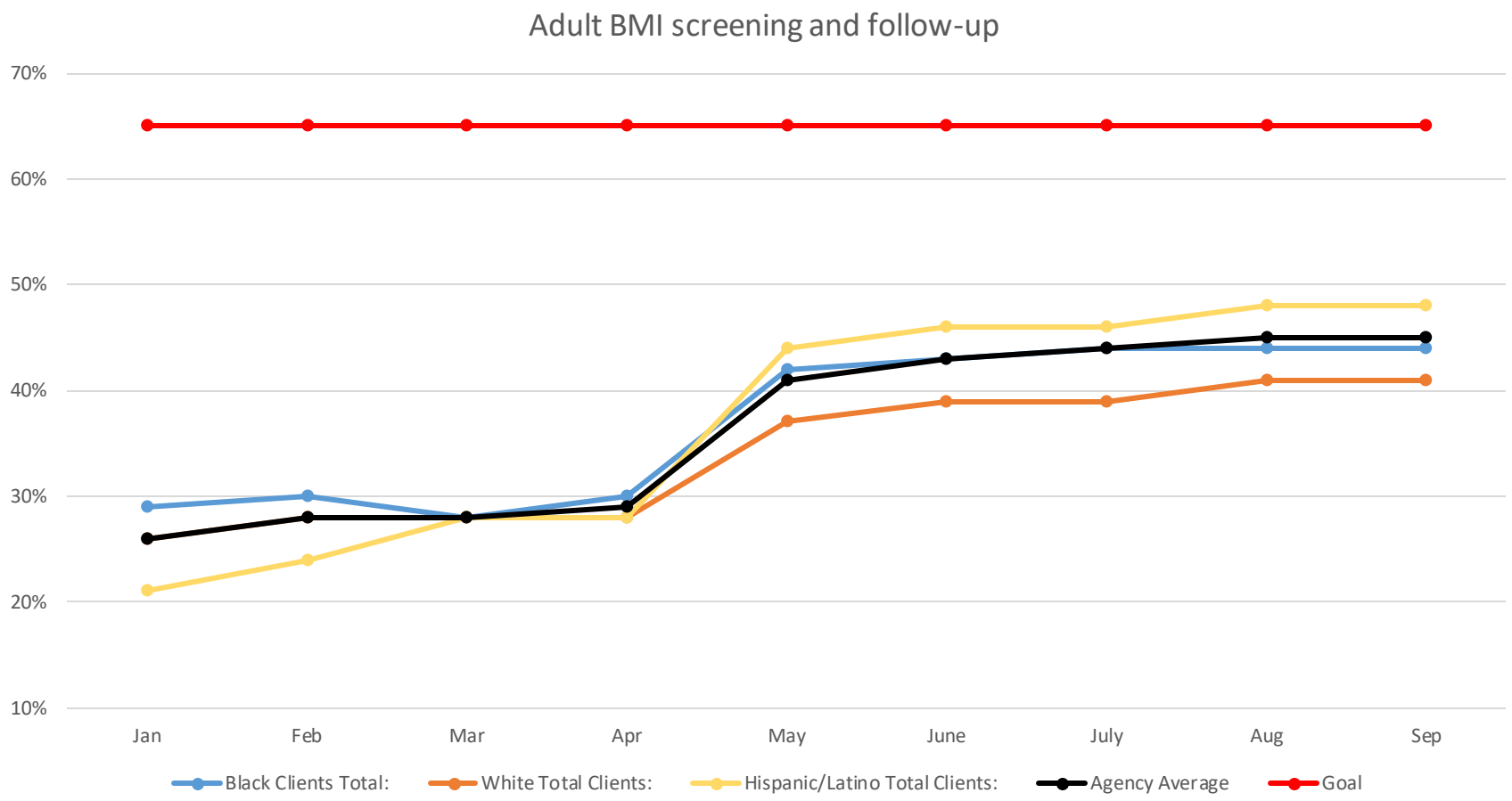
Who is who and what's new

1. **Subcommittee members:** Arie HS.; Amelia J.; Meredith J.; Molly G.; Adrienne T.; Marie S.; Lisa H.

2. **Recent happenings:**
   - The order set "BMI < 18.5 or > 25" is live!
     - Can choose "overweight" or "underweight" as diagnosis code
     - Reworked wording and added more HAES-friendly resources
     - **Please subscribe!**
   - Reminder: education must be provided under the diagnosis code of "underweight," "overweight," or "obese" to count in Athena – this is where the order set helps
   - Reminder: **shrinking begins young** (between the ages of 30-70)! It's worth getting an updated height for a client if you haven't in awhile

3. **Next steps:**
   - Some last reminders for height and weight assessment (must be done 1x per year)
   - Final push!

Disparity Data



	Sept
Black Clients Total	44%
White Client Total	41%
Hispanic/Latino Clients Total	48%
Agency Average	45%
Goal	65%

Goal 4: Blood Pressure Control

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%.

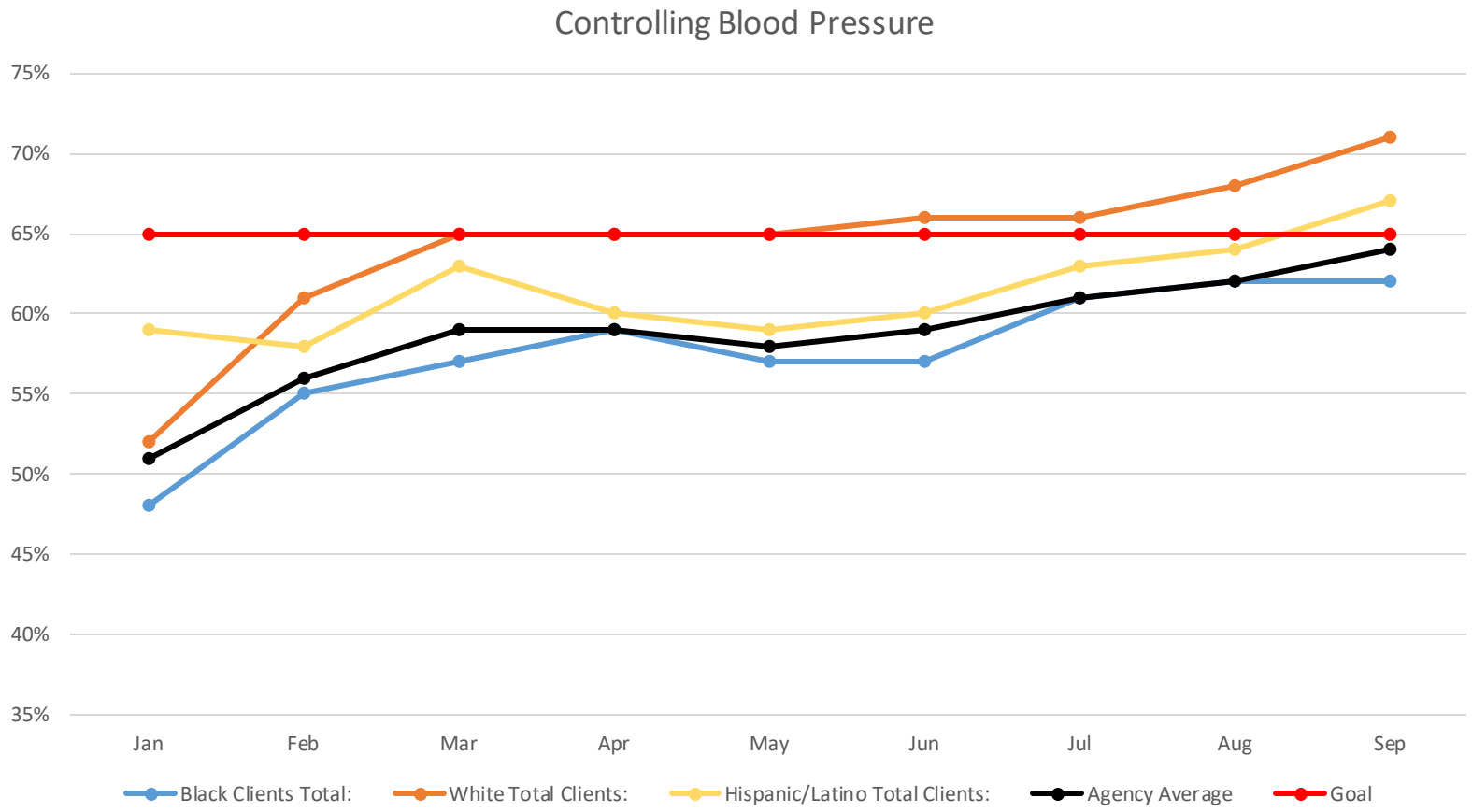
YTD: 64%

Who is who and what's new

1. **Subcommittee members:** Tyler G.; Faith T.; Julia D.; Marie S.; Tracy R.; Lisa H.

2. **Recent happenings and next steps:**
   - We're almost there organizationally!
   - Ordered footstools to get more accurate BP in exam rooms
   - Disparity interventions
     - Women continue to have lower rates of controlled BP than men across all racial/ethnic demographics
     - Disparity between Black/African-American clients and White/Hispanic/Latinx clients is *growing*
     - Looking into a hypertension group for next year

Disparity Data



	Sept
Black Clients Total	62%
White Clients Total	71%
Hispanic/Latino Clients Total	67%
Agency Average	64%
Goal	65%

Goal 5: Depression Remission

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

YTD: 7%

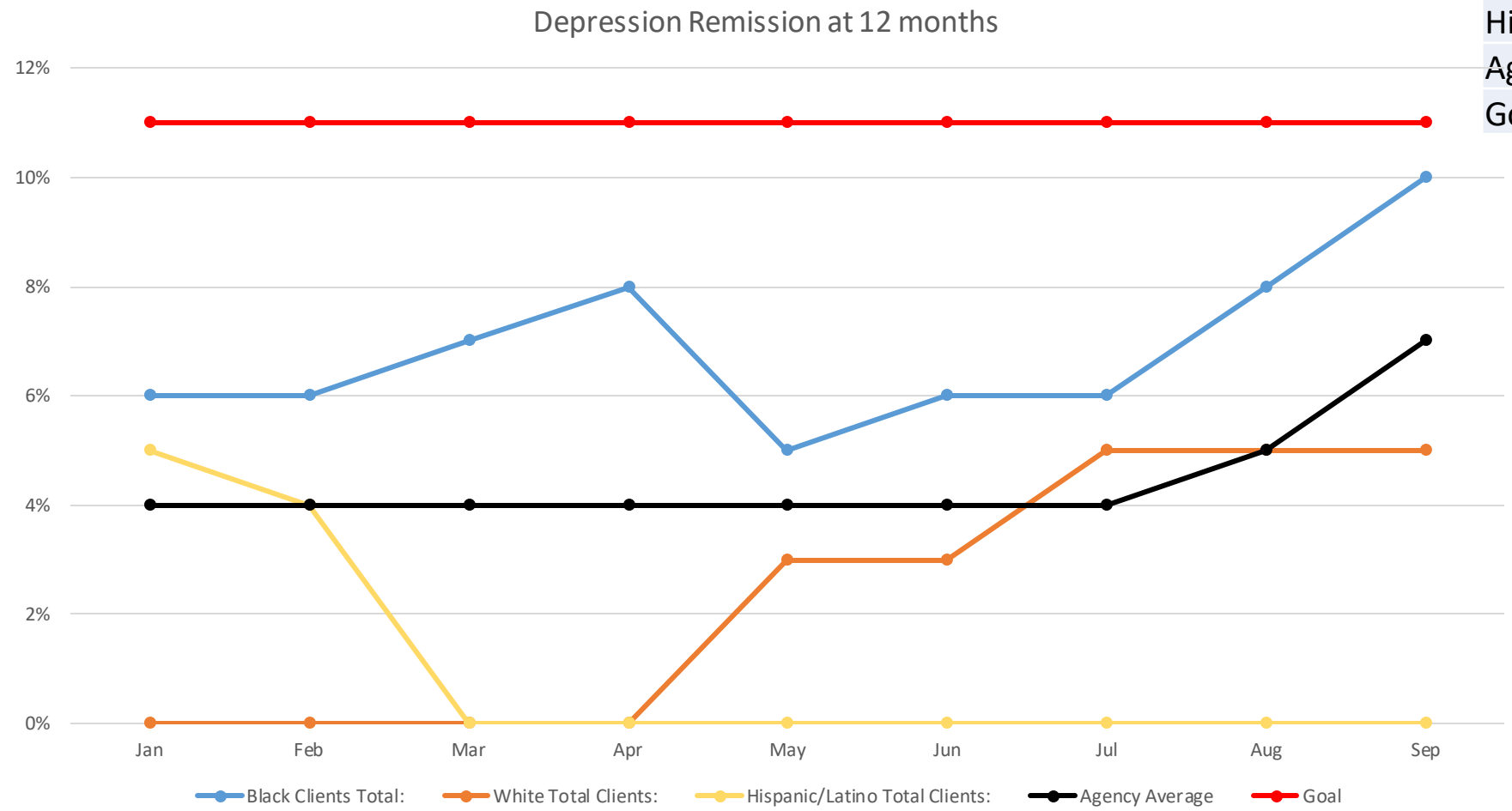
Who is who and what's new

1. **Subcommittee members:** Jan F.; Arianne J.; Kellie D.; Lawanda W.; Taavon B.; Marie S.; Lisa H.

2. **Recent happenings:**
   - Quality Tab improvements to make it easier to tell when a client should be rescreened
   - New **Spanish-speaking** BH intern
3. **Next steps:**
   - For 2024: monitoring *specific questions* on the PHQ-9 for improvement
     - **Questions 1 (little interest/pleasure in doing things) and 6 (feeling bad about yourself, or that you are a failure or have let your family down)**
     - Remission may not be an achievable goal for much of our population; look at the questions with most impact on their daily living and safety
   - Monthly registry to identify clients due for rescreening

Disparity Data

	Sept
Black Clients Total	10%
White Clients Total	5%
Hispanic/Latino Clients Total	0%
Agency Average	7%
Goal	11%



Goal 6: 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).

YTD: **County: 13**

WB: 15

Fallsway: 23

Who is who and what's new

1. **Recent happenings:**
   - Looked at clients booked past 30-35 days out in 24-hour or provider f/u slots
     - Not all of these clients were scheduled appropriately – some had urgent needs
     - Difficult to tell why clients were scheduled in these slots from documentation in chart / appt notes
     - Long-term solution is to hire providers, but can look at immediate mitigating solutions
2. **Next steps:**
   - Look at chronic no-shows and cancellations
     - What can we do to help this population? Where is our human touchpoint with them?
     - If they can't make their appts, keep them frozen for 24-hr and provider follow-ups

Goal 7: Client Experience

By December 31, 2023, the Agency will achieve three consecutive months in which both "Respected by check-in and check-out staff" and "Respected by scheduling staff" rate at or over 93%

YTD: Check-in and out: 91%; Scheduling 91%

Who is who and what's new

1. **Subcommittee members:** Juanita P.; Muhammed M.; Gia J.; Lisa L.; Hala S.; Tara D.; Malcolm W.; Maonry L.; La Keesha AV.; Mona H.; Lisa H.
2. **Recent happenings:**
   - Discussing how departments communicate internally and with each other
     - Ineffective communication with clients and internally can lead to clients feeling forgotten; effective communication leads to clients feeling respected
     - We used a whiteboard to brainstorm: more on this later
3. **Next steps:**
   - For 2024, monitoring **ability to access an appointment when needed**

Goal 8: 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.

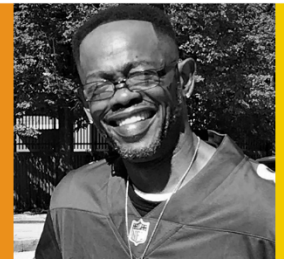
YTD: 96%

Category	Dx	% Care Plans
Behavioral Health	Depression Care Mgmt	Pending
Case Management	Psychosocial Analysis Mgmt	Pending
Nursing care management session	Nursing Care Mgmt	Pending

Who is who and what's new

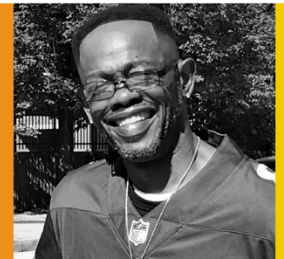
1. **Subcommittee members:** Tracy R.; Marie S.; Lisa H.

2. **Recent happenings and next steps:**
   - Pending data for September
     - Tableau to PowerBI transition
   - Interviews with department champions
     - Minute Mondays – short videos with best practices shared out via email
     - Interviews with Courtney Hunt and Ebony Hicks shared out to teams and in teasers



Monday Minutes

1. **Ebony from Behavioral Health**
   - Discussed implementing SMART goals for clients
     - Care plans help to establish goals for a session and keep clients on track
     - Clients feel good about themselves when they achieve goals, so keeping them achievable is important
2. **Courtney from Nursing**
   - Discussed care plans for clients with diabetes
     - Important to get into and rely on the workflow of updating care plan at each visit
     - Again, achievable goals -



Goal 9: Flu Vaccination Rate

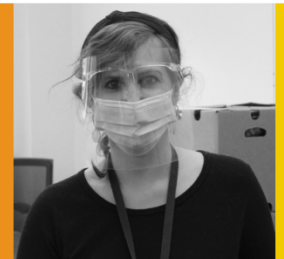
Forty-five percent (45%) of eligible clients have documentation of an influenza vaccination in the electronic health record.

YTD: 13%

Who's who and what's new

1. **Subcommittee members:** Tracy Russell, Catherine Fowler, Marie Stelmack, Lisa Hoffmann, and our flu champions

2. **Recent happenings and next steps**
   - Gave flu quick-guides to all client-facing staff
     - Education on where flu shots are being given and how to refer
     - Ask Marie or your flu champion if you don't have one
   - Completed root cause analysis around flu shot uptake
     - Due to staffing, same-day access is not always available
     - Ensuring that our CMAs, especially newer CMAs, understand the process
     - Brief shortage that is now resolved

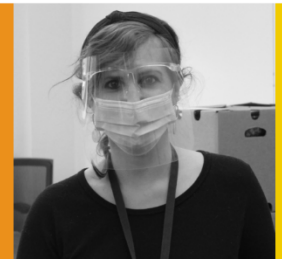


Flu Season

Flu champions identified for each department: ask your flu champion for help!

Sarah Gillman	Psych
Karen Ross Taylor Lydia Santiago	BH
Amelia Jackson	County
DeBorah Jackson	West
Adrienne Burgess-Bromley	CM
Monica Martin	Dental
Ryan Frederick	CCP

Justine Wright	Mobile
Lilian Amaya	CHW
Molly Greenberg	MAT
Courtney Hunt Heather Douglas	Medical
Adam Pfeifer	Supportive Housing
Erick Torres	Peds



Flu and Coat Drive

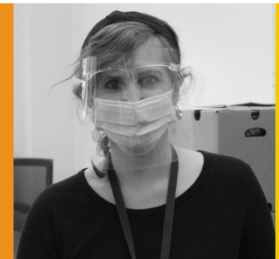
THIS WEEK!

0830-1200 daily

First floor (Adult and Pediatric)

Encourage clients to bring proof of vaccine

Academic Institutions: Morgan State University and Johns Hopkins



Goal 10: Advance Care Planning

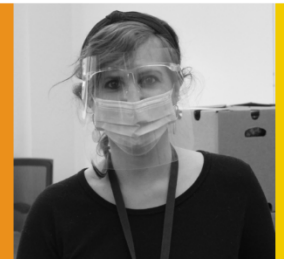
Improve the percentage of adults 66 years and older who had an advance care planning discussion completed or documented in the medical record by 5% and create one SOP.

YTD: 3%

Who is who and what's new

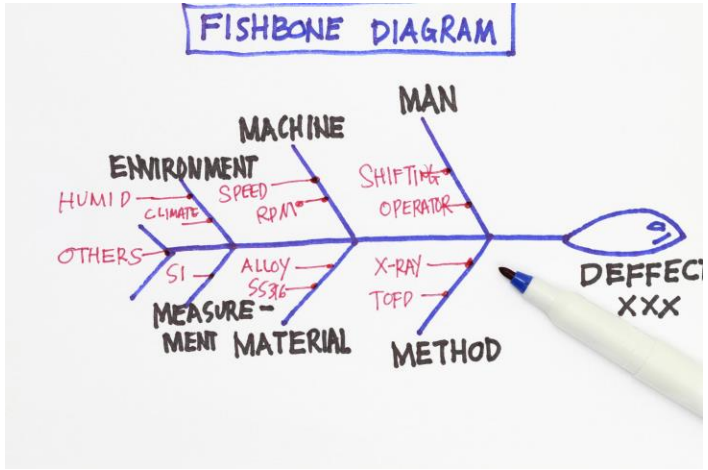
1. **Subcommittee members:** Tyler G.; Iris L.; Tracy R.; Marie S.; Lisa H.

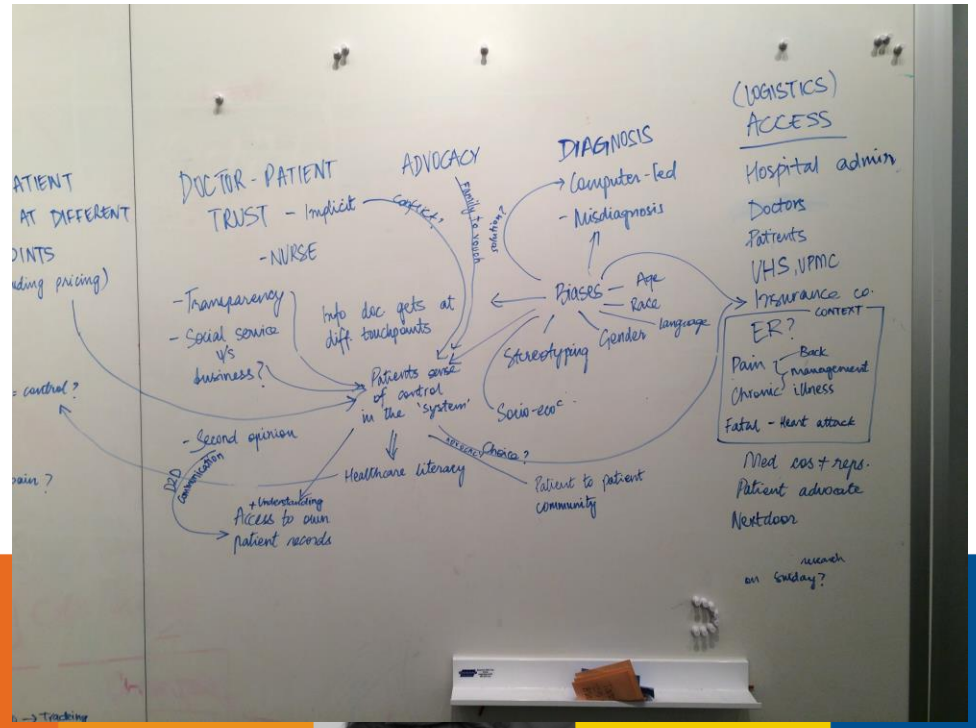
2. **Recent happenings and next steps:**
   - If every medical provider has 5 more conversations, we can make the 5% goal
   - CMs encouraged to initiate conversations independent of medical referral
   - Giving advance care planning lunch and learn presentation to BH team in early November



Let's talk about whiteboards!

- Whiteboards or jamboards are a way to collaborate in real time with your team, hands-on
- Can be physical or digital
- Any paper PI tool can be whiteboarded
  - Root cause analyses
  - Brainstorming
  - Flowcharts and PDSA diagrams
  - No, really, anything





You can digitally whiteboard too!

whiteboard.office.com

You can log in with your HCH account

Let me show you an example…

Interested in any of these goals or have questions? Reach out to

Director of QI, Lisa Hoffmann or

QI Specialist, Marie Stelmack.

HEALTH CARE for the HOMELESS