Minutes

BOARD OF DIRECTORS
PROGRAM & PERFORMANCE IMPROVEMENT COMMITTEE MEETING
September 10, 2024

HEALTH CARE for the HOMELESS

PARTICIPANTS:

☒ Stuart Levine, Co-Chair
☐ Debony Hughes, Co-Chair
☐ Chelsea King Arthur
☒ Athena Haniotis
☐ Crista Taylor
☒ Jannae White

Staff:

☒ Tolu Thomas
☐ Laura Garcia
☒ Margaret Flanagan
☐ Lisa Hoffmann
☒ Lawanda Williams
☐ Other

I. Review and Approval of Minutes (S. Levine)

ACTION ITEM: Committee members reviewed the May and July meeting minutes. Follow-Up Topics: none. **By unanimous vote, both sets of minutes were approved by the committee members in attendance.**

II. Privileging Requests (L. Williams)

A. Initial Privileging recommended by L. Williams: **Lindsey Weller, LCSW-C**
B. Initial Privileging recommended by L. Williams: **Edna Green, LMSW**
C. 1st Reprivileging recommended by L. Williams**: Merina Elahi, DDS**

ACTION ITEM: Committee members reviewed the three candidates. Follow-Up Topics: none. **By unanimous vote, the three candidates were approved for requested privileges by the committee members in attendance.**

II. HRSA New Access Point Grant (NAP) Discussion (M. Flanagan)

(see meeting materials for full summary)

A. **Background:** NAP is a funding stream that provides support for opening new sites or expanding current health center sites. HRSA expects to award a total of $50M with approximately 77 applicants, so it is highly competitive. NAP are not issued frequently; we opened our West

Baltimore, Baltimore County and Mobile Clinic sites with NAP funding. If we are awarded a NAP grant, then we are expected to open an accessible, 40-hour/week site that serves new patients within 120 days. If we successfully complete a one-year performance period, then the clinic is approved to be part of our scope in subsequent years.

B. We would like to submit a NAP proposal to add a **second mobile clinic** for $650,000. The clinic would provide **street medicine**, going to encampments and other areas where people congregate. It would offer medical, behavioral health and enabling services.

C. **Committee Discussion**

   i. *How do current hiring challenges impact this growth plan?* Lately the agency has had better success when recruiting for therapist case manager roles (as opposed to behavioral health therapist roles). TCMs have also greatly improved their billing practices. The 1 FTE TCM role in this proposal is likely to be an attractive position based on what candidates have been telling us because it offers greater flexibility in their daily work and the ability to be out in the community (rather than behind a desk). Community health workers have not been difficult to hire.

   ii. *What is the plan for sustainability in the coming years, particularly since we decreased the staffing and hours of the West Baltimore and Baltimore County clinics at the close of 2023?* We decreased our programs at West Baltimore and Baltimore County in response to lower demand at those brick-and-mortar sites and now we are trying to increase capacity in the places where clients are and where the demand is high. Our current mobile clinic program has surpassed capacity this year. As with our first mobile clinic, the funding for the second mobile clinic will roll into our HRSA base funding and continue every year. We will likely need to raise one-time capital funds to purchase a second mobile clinic, which may run between $150k-$350k. This Mobile/Street Medicine program expansion would not be pursued without the HRSA NAP grant funding.

D. This proposed program expansion will also go to the Finance and Facilities Committee prior to moving to the full Board for discussion and vote.

ACTION ITEM: Committee members reviewed and discussed the proposed mobile/street medicine program expansion. Follow-Up Topics: none. **By unanimous vote, the committee approved the program expansion,**

contingent on a favorable financial evaluation by the Finance & Facilities committee.

III. **2025 Draft Performance Improvement Goals (M. Flanagan)**
(See meeting materials for full summary)

A. **Background**
This draft was created by a committee composed of staff from Quality, Health Informatics, Performance Improvement, Health Equity and Consumer Relations. It is also informed by a staff survey. 2025 goals will be fewer in number (7) than the 2024 goals and more directly connected to standardized measures such as ECQM and HEDIS measures.

B. **Clinical Quality Measures (4)**

i. Preventative: Increase Breast Cancer Screenings by 5% and decrease the disparity between Black/African American and White women by 5%. Discussion ensued about reasons why these numbers are low:

a. Many clients come to us for services other than primary care and preventative care (for example, MAT and 24-hour follow-up)
b. Some clients hesitate to get the screenings because they are easy to complete
c. A lack of insurance coverage leads to a limited number of external referral providers

Discussion ensued about whether to further refine the goal to isolate clients who come for primary care visits or to better measure "apples to apples".

ii. Chronic or Acute: Decrease the hypertension control rate disparity between Black/African American women and the Agency average by 5%.

iii. Behavioral Health: Increase the depression screening rate (and, if the screening is positive, rate of documented follow up plans) for 12+ year olds by 9%. This is a particularly ambitious goal because we believe that it may primarily be due to fixable EMR documentation and workflow issues around positive PHQ-9. (Rates were higher prior to the agency's switch to athenaOne.)

iv. Immunizations: Increase flu vaccination offer rate by 12% (to 40%) and the flu vaccination administration rate by 5% (to 32%). Discussion ensued about reasons why the goal is not to reach a 95%+ offer rate:

a. The low baseline of 28% offer rate may reflect providers/Mas documenting the offer in two separate places within the EMR, so

that the baseline data is not accurate. Now that we have identified this issue and are resolving it, we may see a significantly positive jump in the 2025 percentage.

b. The committee suggested that an asterisk be added noting this issue because the numbers are so low.

c. The committee also suggested combining HIV testing in the waiting room with offering flu vaccinations if it does not have negative impacts on workflow and can increase ease of client access to the vaccination.

C. **Access**

i. The goal will be to reduce the median wait time from the end of check-in to the start of being seen.

ii. The baseline is in development and a goal will be brought to the committee in November.

D. **Client Experience**

The agency is exploring a new client experience vendor and would like to get baseline data by June 2025 and then set a goal to act upon by December 31, 2025.

E. **Resource Stewardship: Care Coordination**

Continuing our work on increasing the referral completion rate (receipt of a consult note from the specialist) by 5% to 28%.

F. **Next Step:** A second draft of the PI Goals will be brought for further consideration at the next Committee meeting.

Next Meeting: November 12, 2024 at 5:30 pm