Performance Improvement Committee

April 21, 2021

April Agenda

Project Updates

- Depression Remission

Project Deep Dive:

- Diabetes Control
- Childhood Immunization
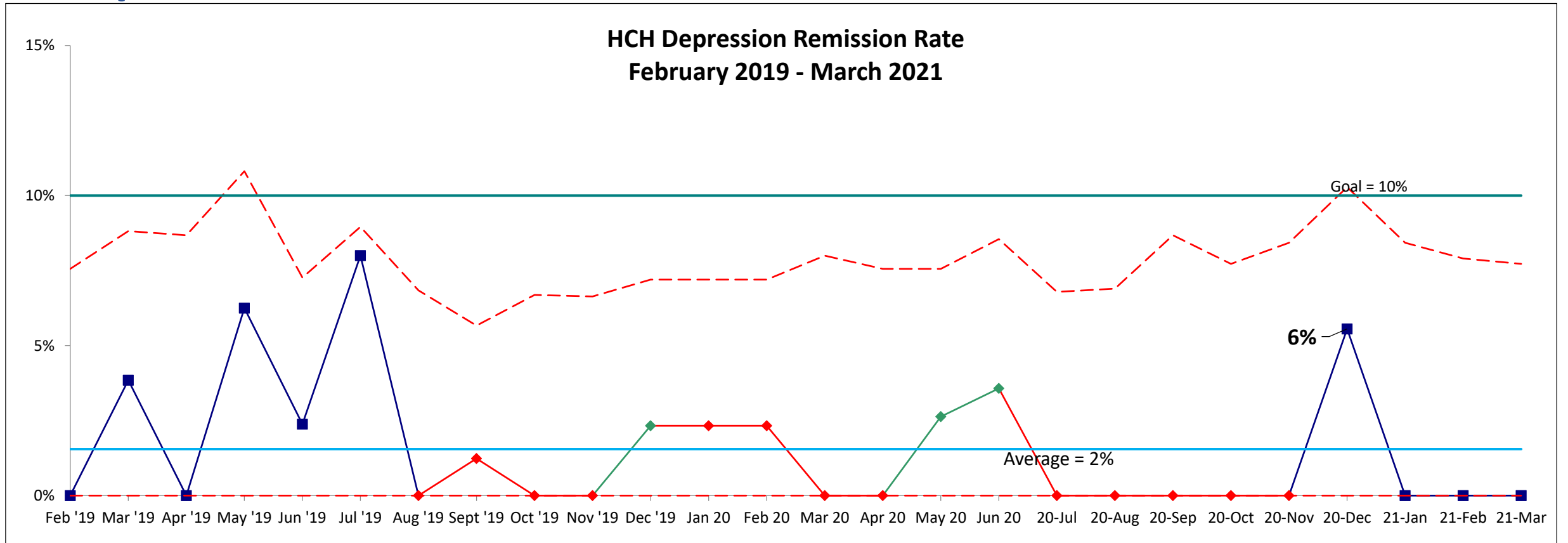- Referral Tracking
- Food/Transportation Access

UDS Debrief:

- UDS Comparison and Updates

Project Updates

Depression Remission

HCH Depression Remission Rate
February 2019 - March 2021

Goal = 10%

6%

Average = 2%

Feb '19 Mar '19 Apr '19 May '19 Jun '19 Jul '19 Aug '19 Sept '19 Oct '19 Nov '19 Dec '19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 20-Jul 20-Aug 20-Sep 20-Oct 20-Nov 20-Dec 21-Jan 21-Feb 21-Mar
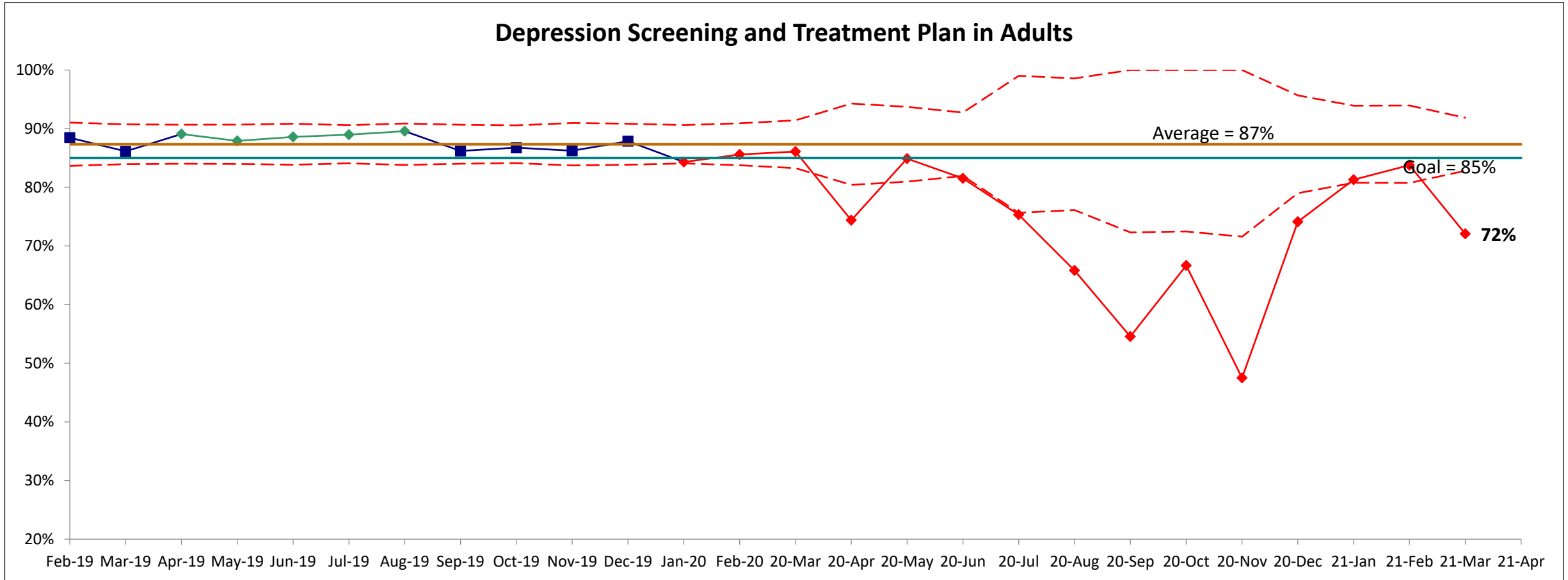
Remission:

10% of adults diagnosed with major depression or dysthymia who scored positively on an initial PHQ9 (>9) will demonstrate remission *between 10-14 months*

Depression Screening

Depression Screening and Treatment Plan in Adults

Average = 87%

Goal = 85%

72%

Screening:

By December 2021, 2021, **85%** of clients who score >9 on a PHQ9 will receive a follow-up screening within 5-7 months.

Data Breakdown

For the Trailing Year (3/1/2020 – 3/1/2021):

- *824 clients scored >9 on the PHQ9*
  - *Of those, 263 also had a depression diagnosis (31%)*
    - *Of those, 178 had at least one BH visit (67%)*
      - *Of those, 142 were due for their follow-up PHQ9 (79%)*
        - *Of those, 41 completed their follow-up PHQ9 (28%)*

- *Of our total 824 clients who scored >9 on the PHQ9, 511 had at least one visit with BH regardless of a depression diagnosis (62%)*
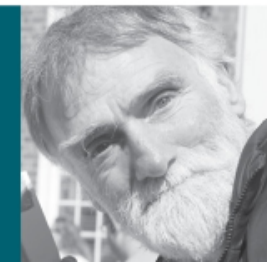
Since we last met…

- Subcommittee has:
  - Finalized all EMR changes to the PHQ-9 form
  - Begun a roll-out plan for trainings on the new form updates

- Key Change Ideas:
  - **Remission**:
    - Reviewing treatment plans and PHQ-9 scores with providers during supervision

  - **Screening**:
  - PHQ-9 form changes – reminder pop-ups, listed historic PHQ-9 scores, client due dates, etc.
  - Provider trainings and practices to improve our PHQ-9 administration rate
    - Registry lists for providers with clients who have upcoming PHQ-9 due dates

Project Deep Dive

Diabetes

A. Reduce the number of clients across the Agency who have an A1C >9 or who were not tested to **25%**
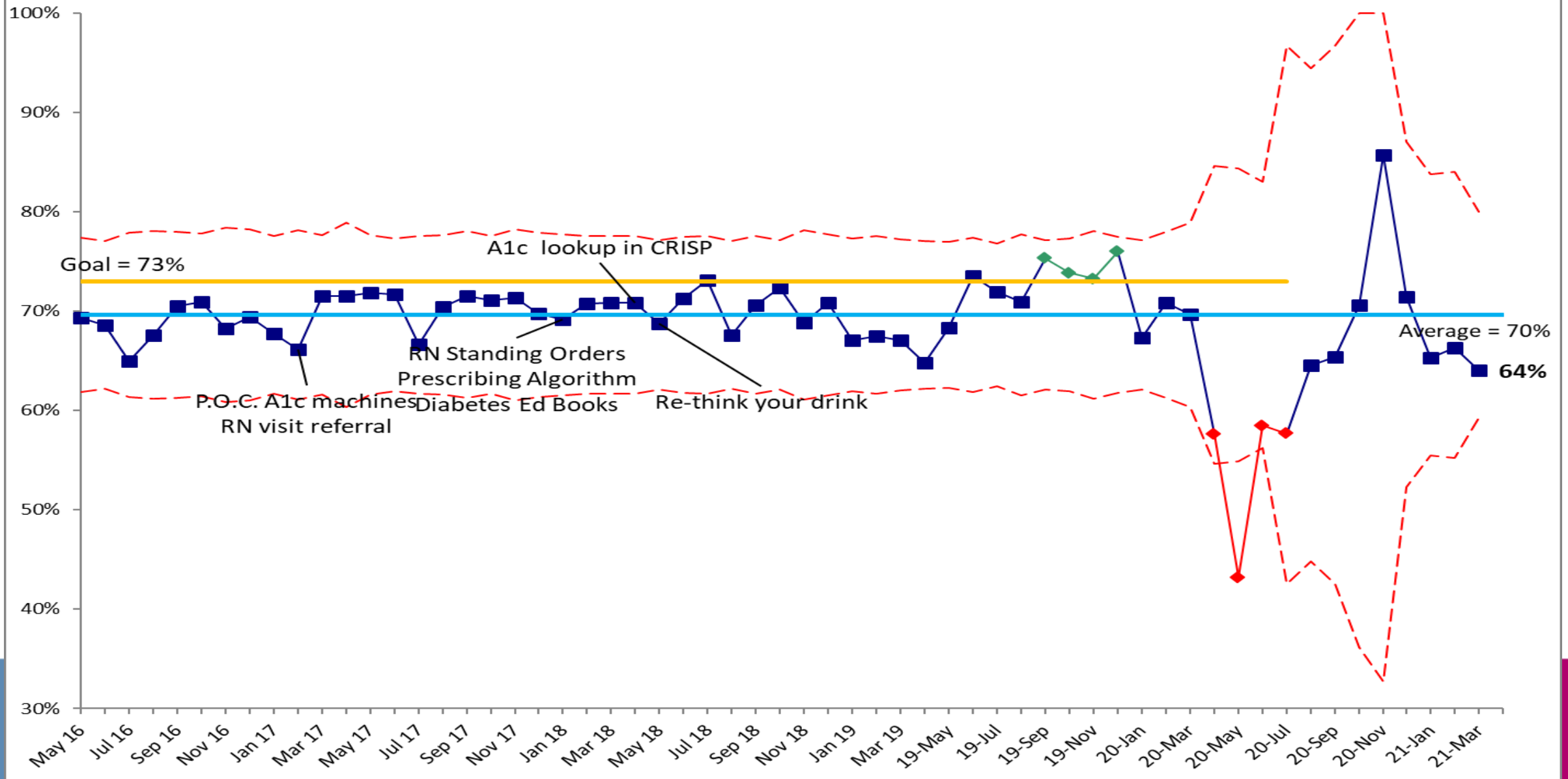
Baseline Data: 44.2%

Diabetes

B. Reduce disparities within racial and ethnic groups by **25%** for clients who have an A1C >9 or who were not tested compared to the agency average

February Launch	Diabetes	
	Champion	**Laura Garcia (Green Team)**
	HIT	**Joseph VerValin + Katie Healy**
	Members	Julia Davis (Green Team)
	REI rep	David Dexter
		Client Representative
		Kiana Johnson
		Lawanda Williams - consult
		Elizabeth Zurek - consult

HCH Diabetic Clients with A1c ≤9.0%
November 2016 - March 2021

Goal = 73%

Average = 70%

64%

A1c lookup in CRISP

RN Standing Orders
Prescribing Algorithm

P.O.C. A1c machines
RN visit referral

Diabetes Ed Books

Re-think your drink

Diabetes – Driver Diagram

AIM	Primary Drivers	Secondary Drivers	Change Ideas
		Diabetes Testing Driver Diagram	
By December 2021, reduce the number of clients across the Agency who have an A1C >9 or who were not tested to 25%	Appointment Access	Clinic Hours don't match lab hours (last 3 slots)	
		No Appointment Availability	
		Staffing shortages (nursing)	
		COVID-19 unable to bring clients in *just* for their test	
		Missed Nursing appointments	
	Clients fall out of care	Lack of empanelment	
		No tracking information for clients on care team lists	
		Clients using telehealth are unable to come in for visit	
		No alert system for medical when client misses appointments and fall out of care	
		No communication between departments to reconnect clients to medical for testing	
	Education for clients	Lack of a standardized structure for handling diabetes clients' education	Develop a curriculum and tool box for nursing staff to educate and easily develop treatment plans with clients
		No formal training on Preventative Health Tracker for all staff	
		No prompt for nurses to check the PHT	
		Not all rooms have printers to create and show clients diabetes information	
		Limited ability to provide take home resources for clients	
	Provider education	Lack of shared knowledge and practices for all providers to treat and manage diabetes	Peer Review opportunity for providers to review each other's work and discuss treatment methods
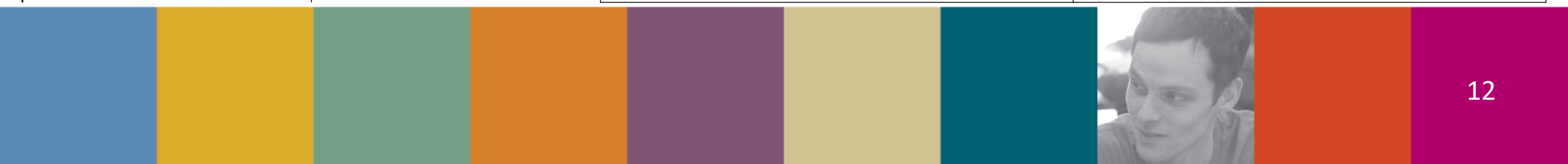
Since we last met...

- Completed a PDSA w/non medical providers asking patients about their HA1c, encouraging scheduling follow up

- Started working on an RN standardized curriculum for DM education, working towards health literacy (Spanish & English) PDSA

- Trial DM focused medical provider peer review
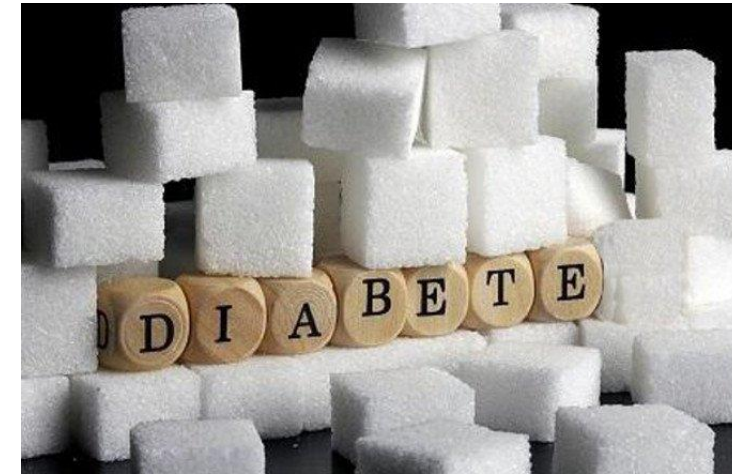
Childhood Immunization

Childhood immunization: By December 31, 2021, 50% of children 2 years of age will have recommended vaccines by their second birthday.

Childhood Immunization	
Champion	Iris Leviner
HIT	Katie Healy
Members	Pam Ford
	Eva Hendrix
	Lilian Amaya
	MaryAnn Rico
	Peds Nurse (once hired)

50 % of two-year old clients will have received **all** age-appropriate vaccines by their second birthday.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos
Hepatitis B (HepB)	1st dose	←—— 2nd dose ——→			←————————————— 3rd dose —————————————→					
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes					
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose			←—— 4th dose ——→		
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes		3rd or 4th dose, See Notes			
Pneumococcal conjugate (PCV13)			1st dose	2nd dose	3rd dose		←—— 4th dose ——→			
Inactivated poliovirus (IPV <18 yrs)			1st dose	2nd dose	←————————————— 3rd dose —————————————→					
Influenza (IIV) — or — **Influenza (LAIV4)**					Annual vaccination 1 or 2 doses					
Measles, mumps, rubella (MMR)					See Notes		←—— 1st dose ——→			
Varicella (VAR)							←—— 1st dose ——→			
Hepatitis A (HepA)					See Notes		2-dose series, See Notes			
Tetanus, diphtheria, acellular										

Children age 4 months through 6 years

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses				
		Dose 1 to Dose 2	Dose 2 to Dose 3		Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B	Birth	4 weeks	**8 weeks and at least 16 weeks after first dose.** Minimum age for the final dose is 24 weeks.			
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	4 weeks	4 weeks Maximum age for final dose is 8 months, 0 days.			
Diphtheria, tetanus, and acellular pertussis	6 weeks	4 weeks	4 weeks		6 months	6 months
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older. **4 weeks** if current age is younger than 12 months *and* first dose was administered at younger than age 7 months *and* at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. **8 weeks and age 12 through 59 months (as final dose)** if current age is younger than 12 months *and* first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months *and* first dose was administered before the 1st birthday *and* second dose was administered at younger than 15 months; OR if both doses were PRP-OMP (PedvaxHIB, Comvax) *and* were administered before the 1st birthday.		**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after.	**No further doses needed** for healthy children if previous dose was administered at age 24 months or older. **4 weeks** if current age is younger than 12 months and previous dose was administered at <7 months old. **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was administered before age 12 months.		**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	4 weeks	**4 weeks** if current age is <4 years. **6 months (as final dose)** if current age is 4 years or older.		**6 months** (minimum age 4 years for final dose).	
Measles, mumps, rubella	12 months	4 weeks				
Varicella	12 months	3 months				
Hepatitis A	12 months	6 months				
Meningococcal ACWY	2 months MenACWY-CRM 9 months MenACWY-D 2 years MenACWY-TT	8 weeks	See Notes		See Notes	

Which vaccines need to be given to count as meeting the measure?

- 4 x DTaP
- 3 x IPV
- 1 x MMR
- 3 or 4 Hib*
- 3 Heb B
- 1 VZV
- 4 PCV
- 1 Hep A
- 2 or 3 Rota**

_____

22 Vaccines Total

- At HCH, we use ActHib (HiB) and Pentacel (combination vaccine). Both require a 4 dose HiB series. If a child receives one of these doses and one of a different HiB vaccine, 4 doses are needed.

** At HCH, we use Rotarix which is a two dose series. If any does is RotaTeq or type is unknown, 3 doses should be given.

Frequently Asked Questions:

1. What if a child presents to HCH AFTER the Rota Vaccine is no longer indicated? Will this client's vaccines count as meeting the measure?

   - No. The client "counts" in the denominator, but will not count as meeting the measure even if all recommended vaccines are given based on the CDC catch- up schedule.

| Rotavirus | 6 weeks
Maximum age for first dose is 14 weeks, 6 days. | **4 weeks** | **4 weeks**
Maximum age for final dose is 8 months, 0 days. |

Frequently Asked Questions

1. What if a child was seen at an outreach site or once for an acute visit and has a primary care provider at another clinic?
   - The measure includes all 2 year olds including those who were only seen for acute care.

2. What if the vaccines were given but are not in our EMR?
   - The vaccines need to be in our medical records to meet the measure.

3. Is cost or insurance coverage an Issue?
   - No. All of the 2 year olds in 2020 qualified for free vaccine from VFC (Vaccines for Children).

Why This Measure?

- Vaccines are the heart of the work we do in pediatrics

- 2019 baseline: HCH: 9%; national: 88%; Maryland: 65-92%

- Challenge assumptions about barriers to meeting the measure

- Focus energy on systems involved in vaccination and vaccine record keeping

- Support more robust population health approach in pediatrics

Why 50% ?

- In 2020, approximately 45% of 2 year-olds completed the Rota Virus vaccine series.

Chart Review

2020 UDS Data

- 32 children across all sites turned two during the measurement period
- 6/32 = 18% met the measure
- The reasons children did not receive all age-appropriate vaccines:
  - Missed opportunity (Not offered at a visit) – 5
  - Missed opportunity (Vaccine not available at a visit) – 2
  - Child received all recommended vaccines but does not meet the measure criteria (Present to care after rotavirus vaccine not recommended) – 4
  - Missing records from abroad –4
  - Lost to follow up –5
  - Outside PCP and records not obtained/downloaded –6
  - Declined vaccine (flu) –1
 - Moved out of state –1

Referral Tracking

40% of referrals will be completed within 3 months of referral initiation.

Baseline Data: 7%

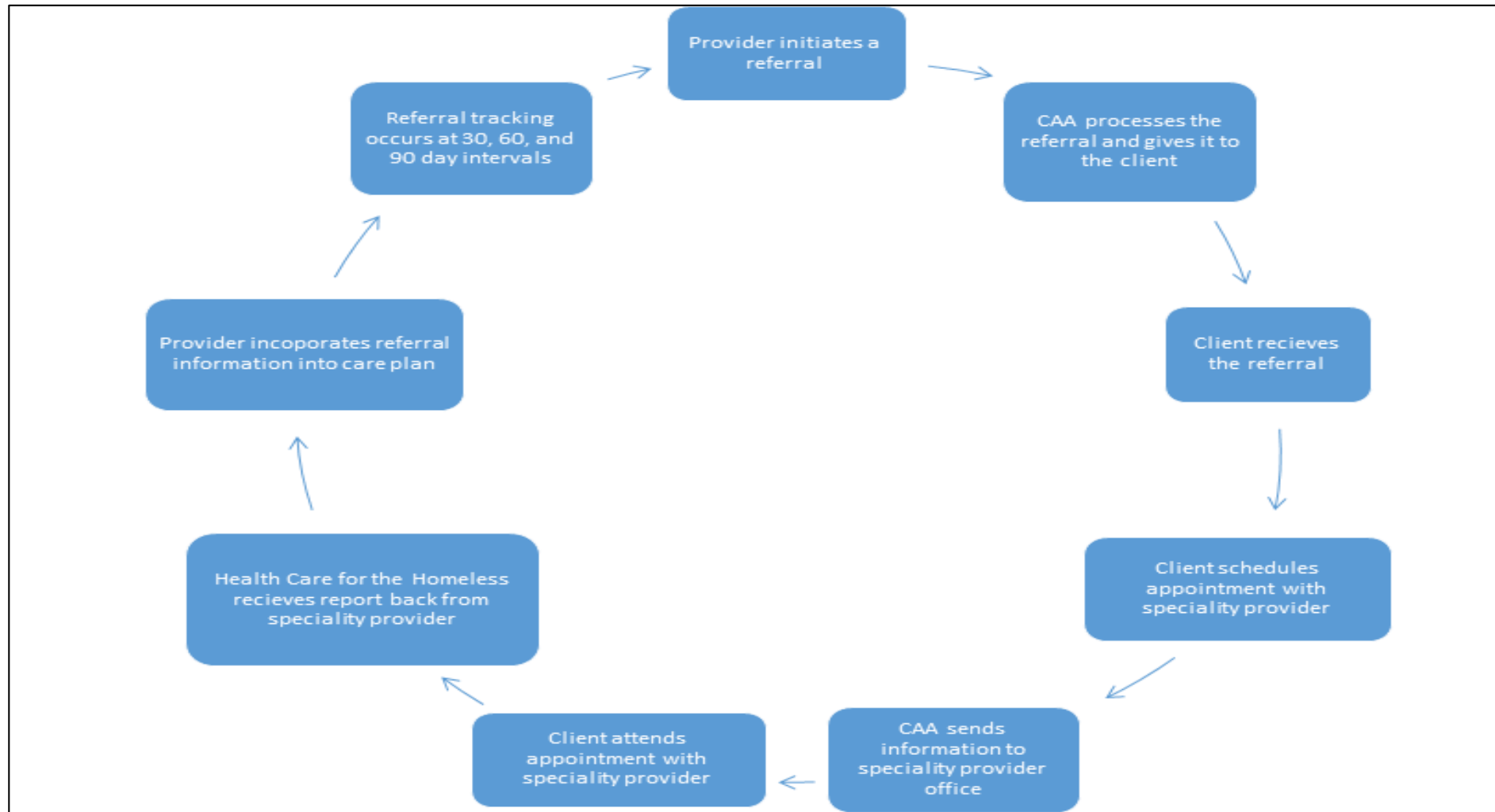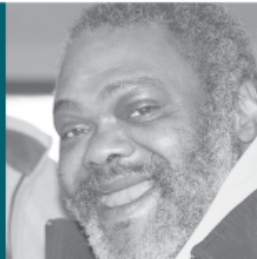| January Launch	Referral Tracking Committee	
	Champion	**Mona Hadley**
	HIT	**Wynona China**
	Members	Greg Myers
		Wanda Hopkins
		Max Romano
		Angela Robinson
		Lawanda Williams
		Adrienne Burgess Bromley
		Lisa Hoffman
		Tolu Thomas
		Eva Hendrix – consult
		Margaret Flanagan - consult
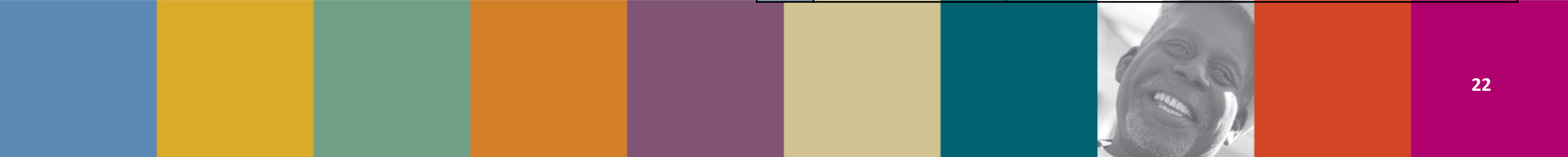
Since we last met…

- Subcommittee has:
  - Identified root causes for low referrals completion rates
  - Developed "ideal" referral workflow
    - Explored barriers to this new workflow
  - Created a PDSA to address real-time referrals

- Key Change Ideas:
  - Implementing better follow-up and tracking of referrals
  - Processing more referrals in real-time
  - Looking at proactively making insurance-related changes rather than retroactively after referrals are ordered

Proposed Workflow

Provider initiates a referral

CAA processes the referral and gives it to the client

Client recieves the referral

Client schedules appointment with speciality provider

CAA sends information to speciality provider office

Client attends appointment with speciality provider

Health Care for the Homeless recieves report back from speciality provider

Provider incoporates referral information into care plan

Referral tracking occurs at 30, 60, and 90 day intervals

Proposed Referral Process		Barriers to Process	Change Ideas
Step 1	Provider Initiates Referral	Providers not checking referral status/ or referral status nomenclature not clear – Creating duplicate referrals	
		Provider notes need to be completed and signed before a referral can be processed (affects Step 3)	
		Provider not putting order details and/or putting in diagnosis - Ex CMA creating GI referrals/ Mammogram referrals (affects Step 3)	
Step 2	CAA prints external Referral and gives to client with Processing timeframe (not currently occurring at Fallsway only community sites) Internal referrals are processed at checkout	External Referrals print out not currently occurring at Fallsway (Community site process)	
		Centricity Matrix list is not accurate – (needs a whole update)	
		unit Clerk Training	
		Referrals done when not in an office/telehealth visit – How do we connect this to a CAA. (who is the CAA?)	
		Internal Referrals - barriers to that not identified	
Step 3	Referral Specialist processes the referral	Client info not up to date	
		Issurance Related Issues - •PCP does not match •Prior authorization •Clients with private insurance •non-clients	
		Provider note not complete/order details not completed	
		Language Barriers	
		System Issues • Centricity is down • PDF – convert referral to PDF and its down • JAI referrals are Paper –CAA @ home an issue • Difficult to fax info through VPN while working from home	
		TAP referrals - must got through case management – Process written out	

Proposed Referral Process		Barriers to Process	Change Ideas
Step 4	Referral specialist sends information to specialty provider office	System • Fax not working • Matrix not updated have the wrong information	
Step 5	Extrenal referral provider should be calling and scheduling ? or do we call ?	Falls way – if we do not print the initial referral with processing time info - patients are not always contacted -	
		Providers goes around the step and refers to case management to ensure clients are getting scheduled – process to close the loop for the referral process	
Step 6	Client Schedules appointment with specialty provider	Lack of transportation to external appointment	
		Clients refuses appointment	
		Language barriers	
		No appointments for Specialty care provider	
Step 7	Client attends appointment with specialty provider	View up/ similar barriers listed in Step 6	
Step 8	HCH Receives report	No partnership relationships	

Other Barriers Identified	No shared understanding of "completed"; "in-process" tracking labels	
	Ways things are documented in Centricity makes the report for 30, 60,90 days are not accurate. Documentation is not standard across the board	
	A lot of referrals in the system; being able to identify which is an internal/external/ (referral clean up needed in the system)	
	Expired referrals – what do we do with that?	
	If client declines – what is the policy – (notification to the provider and provider can cancel) – how do we document and tracking it appropriately	
	Referral processed in 30, 60, 90 days and redoing referrals completely and never scheduled. – creating processes for processed referral and how to create a new referral.	Notifying provider within a certain timeframe 90 day of status?
	How do we identify referrals that are due to expire? Patient sheet – Utilizing the system to help us guide the processes	
	Referral Tracking - Process written out and clear as to how we track and steps we take.	
	Differences in Imaging vs. Speciality care workflows are not deliniated	
	Referral manual created but whereabouts are unknown	

Referrals Completion: PDSA

- PDSA Plan:
  - Have unit clerks identify locations for the referred specialist utilizing the paper matrix and giving clients information about expectation of the referral process
  - Focus only on Max's Adult referrals for the PDSA
  - Include both In-person and Telehealth
  - 4 – 5 half days per week
  - Expected # of referrals is 20 – 30 referrals
  - Includes x-rays and mammograms

Referrals Completion: Next Steps

- Continue to develop and explore change ideas
- Conduct the unit Clerk CAA
- Look into a standard workflow for notifying clients when referral has been processed

Social Determinants – Food Insecurity and Transportation Challenges

90% of clients who answer "yes" to food insecurity **OR** transportation challenges will be connected to a Case Manager or Community Health Worker

Baseline Data: 71% (2020 PI plan data)

| January Launch	Food Insecurity and Transportation Committee	
	Champion	**Kim Carroll**
	HIT	**Irina Gayesky + Maia Gibbons**
	Members	Lilian Amaya
		Kiana Johnson
		Kim Carroll
		LaVeda Bacetti
		Lawanda Williams
		Adrienne Burgess Bromley
		Tyler Gray - consult
		Meredith Johnston - consult
		Margaret Flanagan - consult
		Client Representative

Food Insecurity

Percentage of clients identifying food insecurity who are connected to Case Management
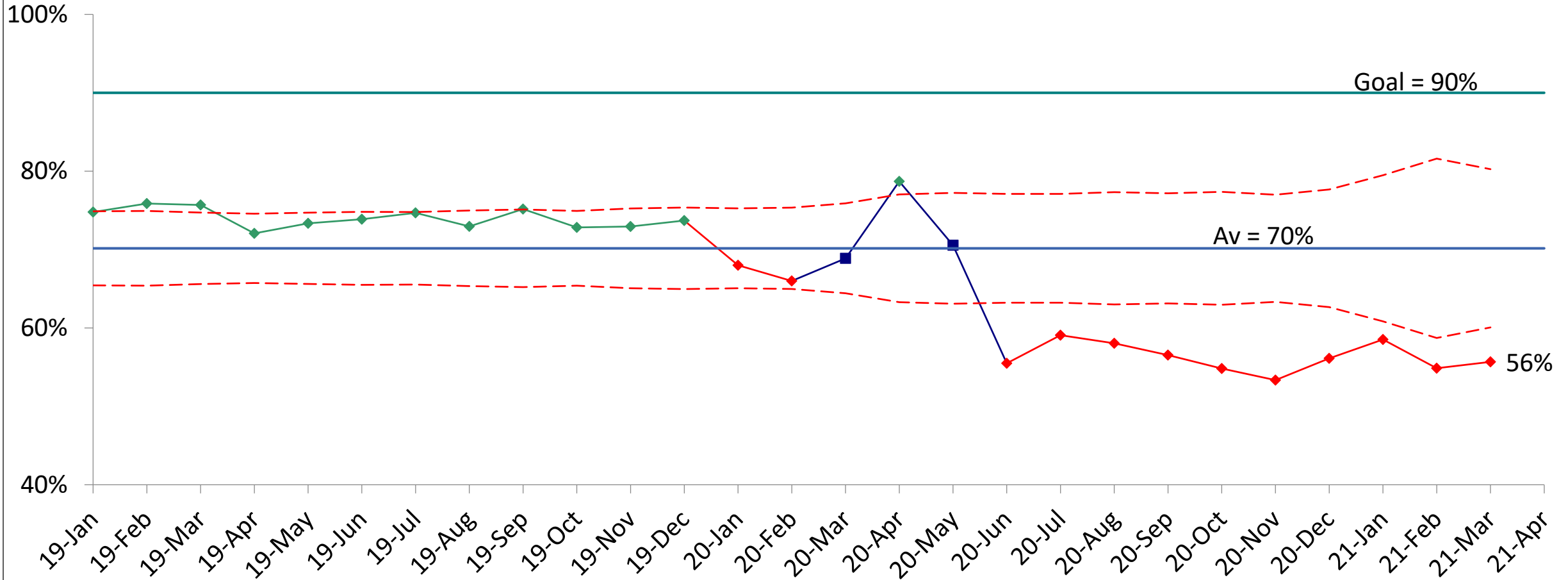
Transportation Challenges

Percentage of clients identifying Transportation Challenges who are connected to Case Management

Goal = 90%

Av = 61%

57%
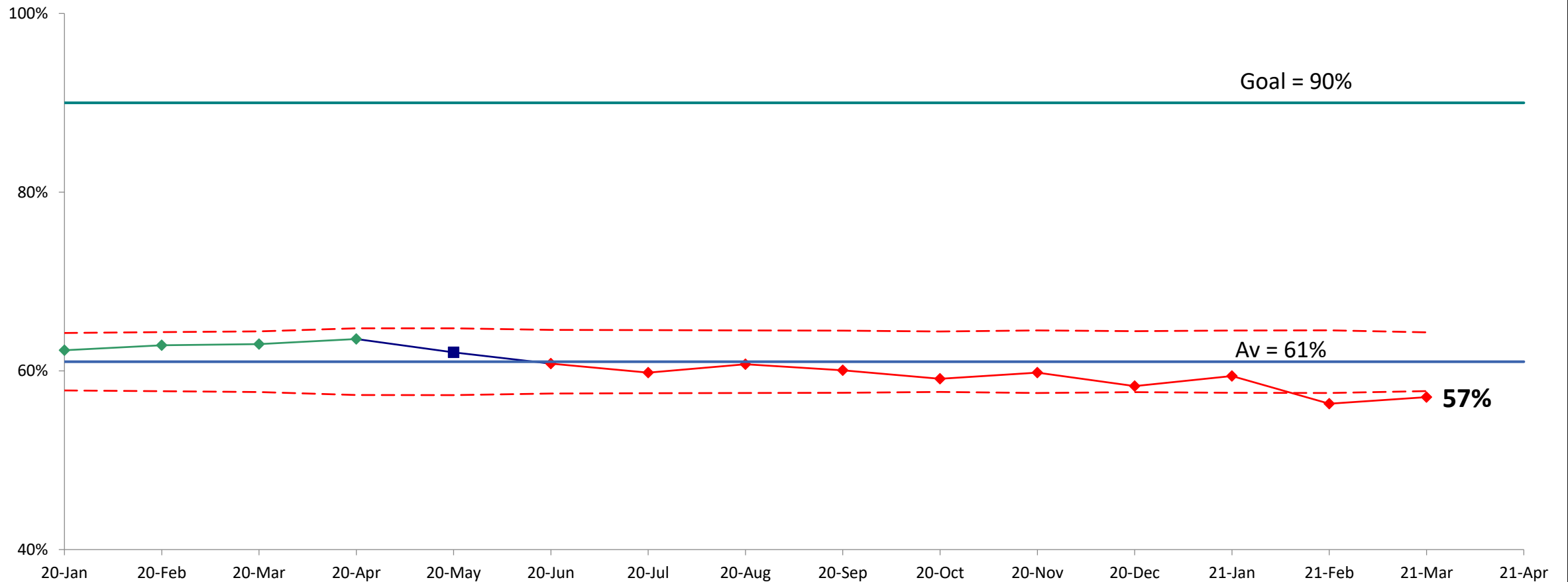
Since we last met…

- Subcommittee has:
  - Discussed current workflow challenges that affect our ask-rate
  - Planned a new PDSA cycle to address our ask rate

- PDSA Plan:
  - Use the CAA reminder calls as an opportunity to ask clients the SDH questions
  - Pull a registry list of clients with upcoming appointments <u>and</u> who are overdue
  - CAAs will call clients ahead of their appointment and ask their food and transportation questions
  - CAAs will document:
    - How many clients were reached
    - How many clients answered the questions
    - How many clients refused to answer the questions
    - How much of an added burden was this change in workflow
  - Prediction:
    - Some added time per call
    - Increase in our ask rate for clients
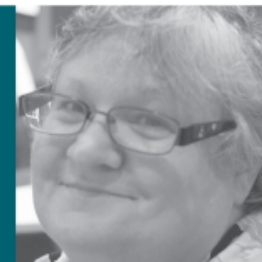   - Potential documentation challenges
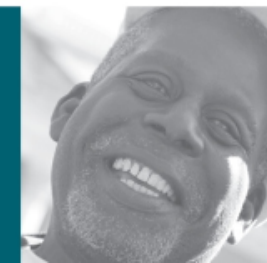
Question to providers

1. How do you use the answers to the SDH questions in your practice?

Next steps

- Conduct our PDSA:
  - Meeting with CAA team to discuss results
- Continue to test other change ideas
  - Address ask rate
  - Address connection to CM when a client expresses a food or transportation need

Discussion

2020 UDS Debrief

What is the UDS?

1. The Uniform Data System (UDS) Report is a required annual report submitted to the Health Resources and Services Administration (HRSA).

2. Each year, all health center grantees report on their performance using the measures defined in the UDS.

3. This standardized reporting system provides consistent information about health centers.

How is this data useful?

1. UDS is the primary means that we can compare ourselves to other health centers, those that also serve primarily individuals experiencing homelessness and 'general population' community health centers.

2. Allows the comparison of national and state averages to our health center.

3. HRSA uses to determine 'quality awards' and other funding opportunities.

…With that being said

1. Primary Care Providers have A LOT to cover and are held accountable for many different measures and standards.

2. The UDS is only a snapshot of some, and is not only driving force of a quality program.

3. We are able to still choose our own quality indicators that we want to prioritize.

2020 Demographics details

1. Saw 8694 'patients' this year
   - Represents 682 person drop (9374 in 2019)
   - How HRSA defines 'patient' is different than all clients who present to health center, which is why you hear different numbers

2. No marked change in percent of men seen (56%) vs. women (44%) from 2019. We have seen an increase in women seen over the past 3-5 years

3. Saw a slight increase in individuals who identify as Hispanic/Latinx (28% compared to 25% in 2019). Have seen marked increase (10-15%) over the past 3-5 years

4. Saw a slight decrease in Black/African American served (52% compared to 56% in 2019). Have seen a decrease (-10%) over the past 3-5 years

Visit data

1. **Medical:** Saw an **increase** in clients seen by medical (7008 compared to 6998); but fewer visits (~2000 with virtual visits)

2. **Mental Health:** Saw an **increase** in patients (2651 in 2020 compared to 2230 in 2019), but fewer visits (~3000 with virtual visits)

3. **Substance use:** Saw an **increase** in patients (2065 in 2020 compared to 1241 in 2019), but fewer visits (~4000 with virtual visits)

4. **Case Management:** Saw a **decrease** in case management clients (300 fewer), but we did see MORE encounters in 2020, when combining in-person to virtual visits.

5. **Dental**: Saw a 50% reduction in clients and visits

What's going well?

1. In 2020, in a pandemic and shift to telehealth, we saw MORE clients across three major service lines.

2. Seeing an increase in uninsured clients, and meeting a need in the Hispanic/Latinx community

3. Vast majority of clients are extremely low-income (below 100% FPL)

Areas of improvement?

1. Missing key data points that we are required to report out on income and other demographic sections

2. Seeing more clients (~14,000)

Some caveats to 2020 data

1. Several of our measures that saw a large drop required an in-person visit:
   - BMI screening and follow-up plan (kids and adults)
   - Childhood immunizations
   - Dental sealants

2. Others rely on screenings that may not have been the focus or prioritized during the pandemic and the switch to virtual visits:
   - Tobacco screening and cessation
   - Depression screening and follow-up plan

3. Low numerator and denominators impact some of the measures large shifts:
   - Dental Sealants
   - Childhood immunizations

Health Care for the Homeless year-by-year Comparison

Measure	2018 Result	18-19 Change	2019 Result	19-20 Change	2020 Result
Cervical Cancer Screening	57.4%	2.2%	59.6%	-2%	58%
Child Weight Screening / BMI / Nutritional /Physical Activity Counseling	54.2%	6.4%	60.6%	-19%	42%
Tobacco Use: Screening and Cessation (NQF 0028)	81.6%	3.4%	85.0%	-21%	64%
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	79.9%	5.0%	84.9%	-1%	84%
IVD Aspirin Use	85.6%	-6.4%	79.2%	2%	81%
Colorectal Cancer Screening	46.7%	0.5%	47.2%	-10%	37%
Screening for Depression and Follow-Up Plan	75.8%	5.8%	81.6%	-4%	78%
Hypertension Controlling High Blood Pressure	57.4%	-1.6%	55.8%	3%	59%
Diabetes A1c > 9 or Untested	31.8%	-2.2%	29.6%	6%	36%
BMI Screening and Follow-Up 18+ Years	75.8%	1.6%	77.4%	-25%	52%
Childhood Immunization Status	20.0%	-15.3%	4.7%	16%	21%
HIV linkage to care	100.0%	0.0%	100.0%	0%	100%
Dental Sealants	n/a	n/a	100.0%	-50%	50%
Breast Cancer Screening	new	new	new	n/a	84%
HIV Screening	new	new	new	n/a	78%
Depression Remission at 12 months	new	new	new	n/a	2%

HCH Comparison to National Averages

Measure	2020 Result	Natl Average	% difference
Cervical Cancer Screening (NQF 0032)	58%	56%	+2%
Child Weight Screening / BMI / Nutritional /Physical Activity Counseling (NQF 0024 modified)	42%	69%	- 27%
Tobacco Use: Screening and Cessation (NQF 0028)	64%	88%	- 24%
IVD Aspirin Use (NQF 0068)	81%	81%	
Colorectal Cancer Screening (NQF 0034)	37%	44%	- 7%
Screening for Depression and Follow-Up Plan (NQF 0418)	78%	71%	+ 6%
Hypertension Controlling High Blood Pressure (NQF 0018)	59%	63%	- 4%
Diabetes A1c > 9 or Untested (NQF 0059)	36%	33%	- 3%
BMI Screening and Follow-Up 18+ Years (NQF 0421/eCQM 69v7)	52%	70%	- 18%
Childhood Immunization Status (NQF 0038)	21%	39%	- 18%
HIV linkage to care	100%	86%	+ 14%
Dental Sealants	50%	53%	- 3%

What going well?

1. While we saw a slight decrease, the following measures maintained previous years quality metrics:
   - Cervical cancer screening, Statin treatment, and Depression screening

2. We saw improvements in: (improvements in a pandemic = huge win!)
   - hypertension control
   - IVD treatment
   - Childhood immunizations

   Of note, these three measures saw declines from 18-19, with then improvements from 19-20!

3. Saw strong performance in two new measures – breast cancer and HIV screening

Areas for Improvement

1. Three UDS measures that have areas for improvement were prioritized on this year's PI plan
   - Childhood immunization (3 years below national average performance)
   - Diabetes (2 years declining performance)
   - Depression Remission (new measure, but very low percentage. We are using a different definition than UDS)
2. Colorectal, cervical, and breast cancer screening are Pop Health priorities
3. Restoration of in-person services will improve many of these measures
4. Hopeful EMR changes and improvements in documentation will improve our prenatal reporting

Questions?