PI Committee Meeting

December 19, 2018

December 2018 PI Committee Agenda

1. PI Dashboard Review

2. Progress Updates:
   - Colorectal Cancer Screening
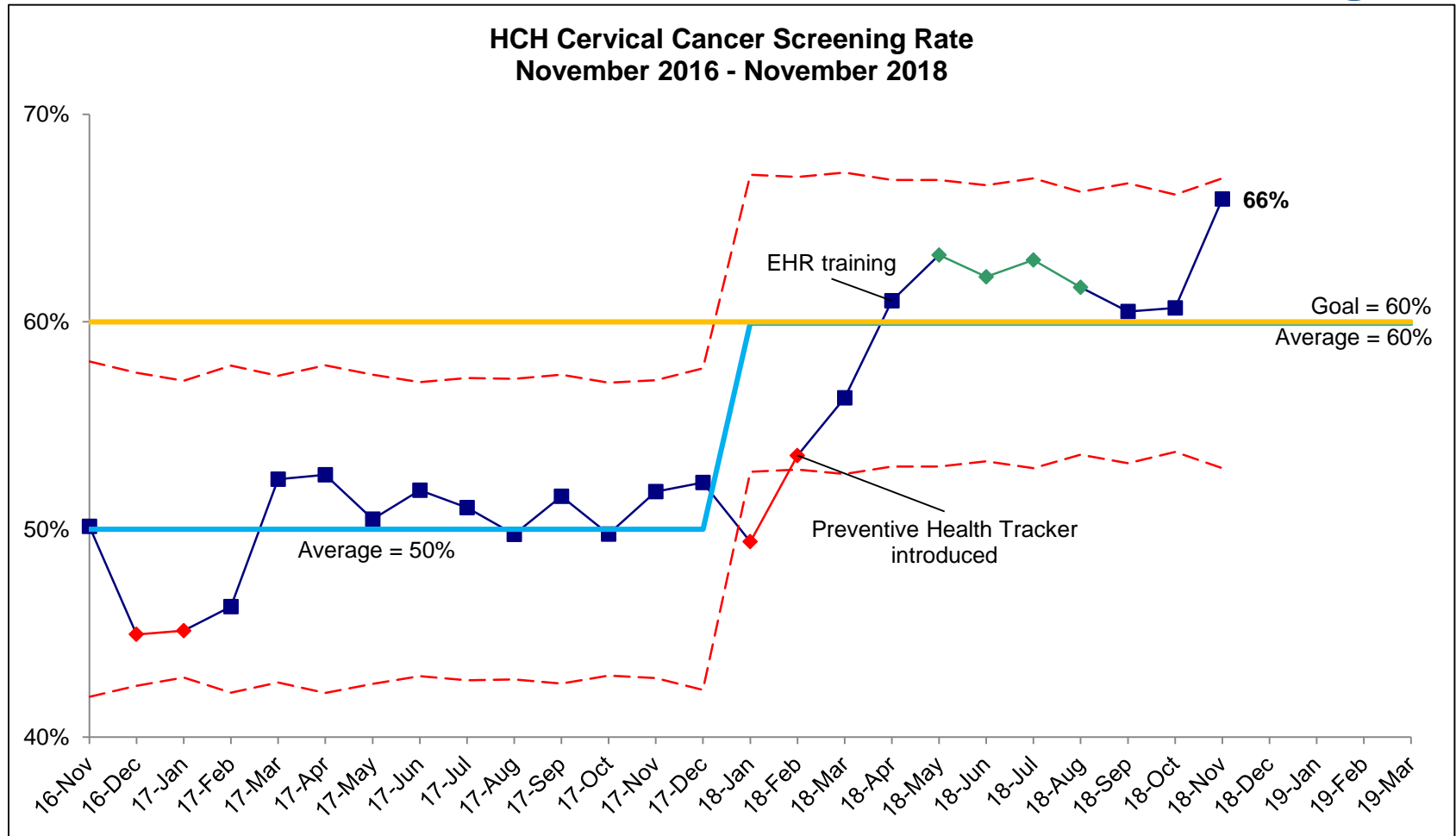   - Missed Appointments

3. Discussion:
   - Client Experience Survey
   - Celebrating the successes
   - IHI Re-cap
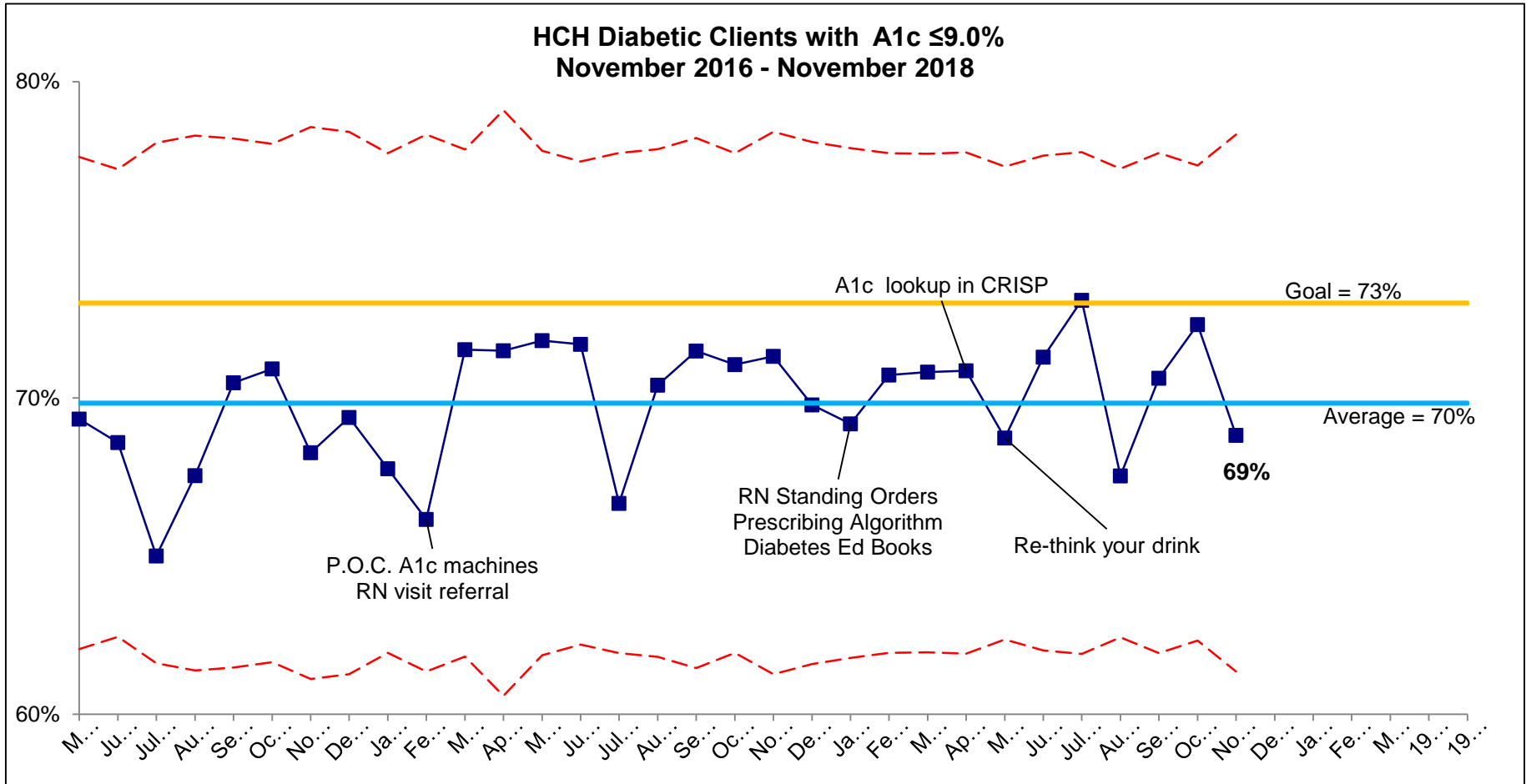   - Reflection on PI in 2018

PI Dashboard: November 2018

November 2018 Dashboard: Cervical Cancer Screening

HCH Cervical Cancer Screening Rate
November 2016 - November 2018

Chart showing cervical cancer screening rate from November 2016 to November 2018, with y-axis ranging from 40% to 70%. Key annotations: Goal = 60%, Average = 60%, Average = 50%, EHR training, Preventive Health Tracker introduced, and final value of 66%.

Trailing Year (Health Indicators Report): 56%

November 2018 Dashboard: Diabetes

HCH Diabetic Clients with A1c ≤9.0%
November 2016 - November 2018

Goal = 73%

Average = 70%

A1c lookup in CRISP

RN Standing Orders
Prescribing Algorithm
Diabetes Ed Books

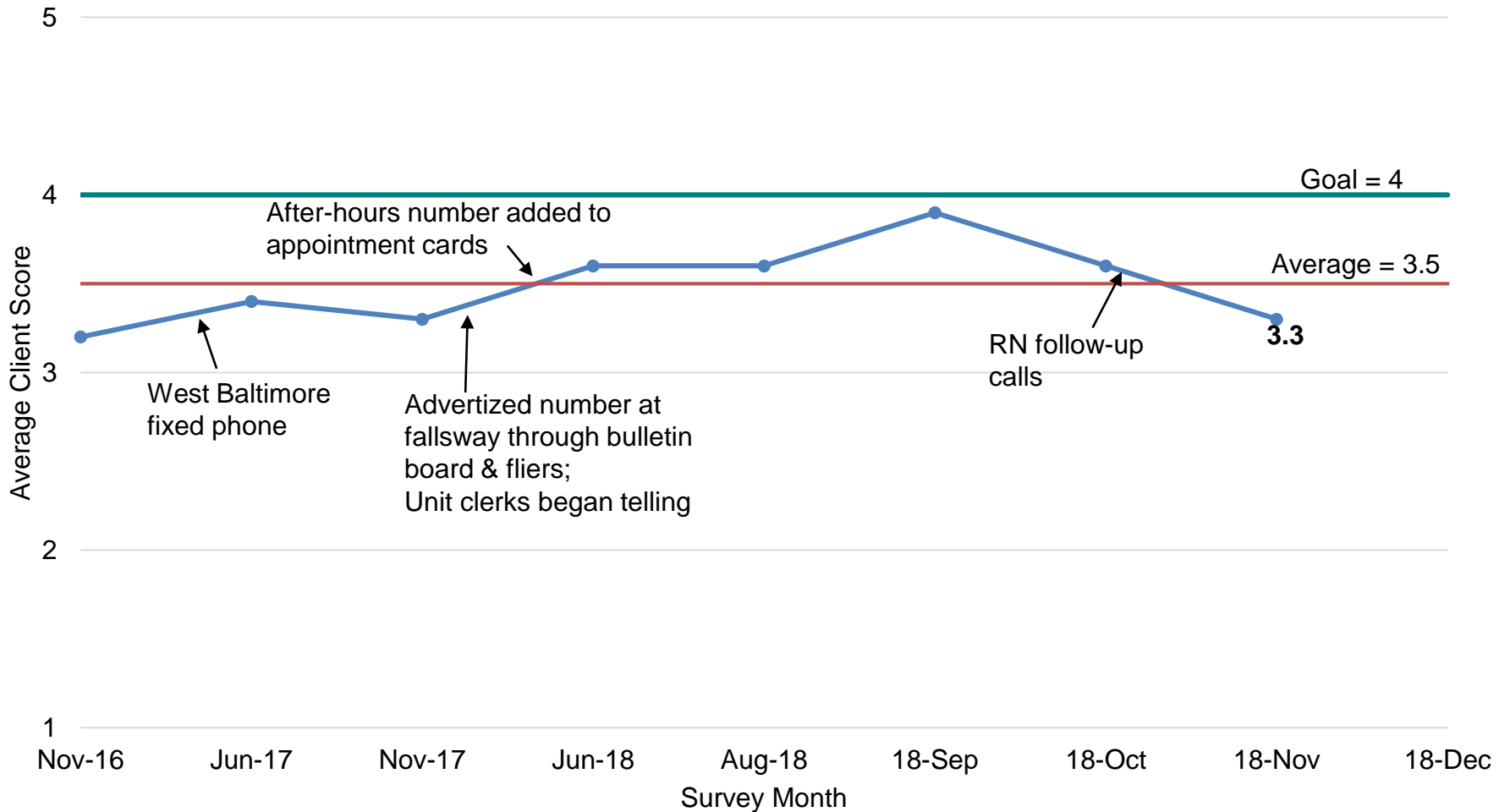Re-think your drink

69%

P.O.C. A1c machines
RN visit referral

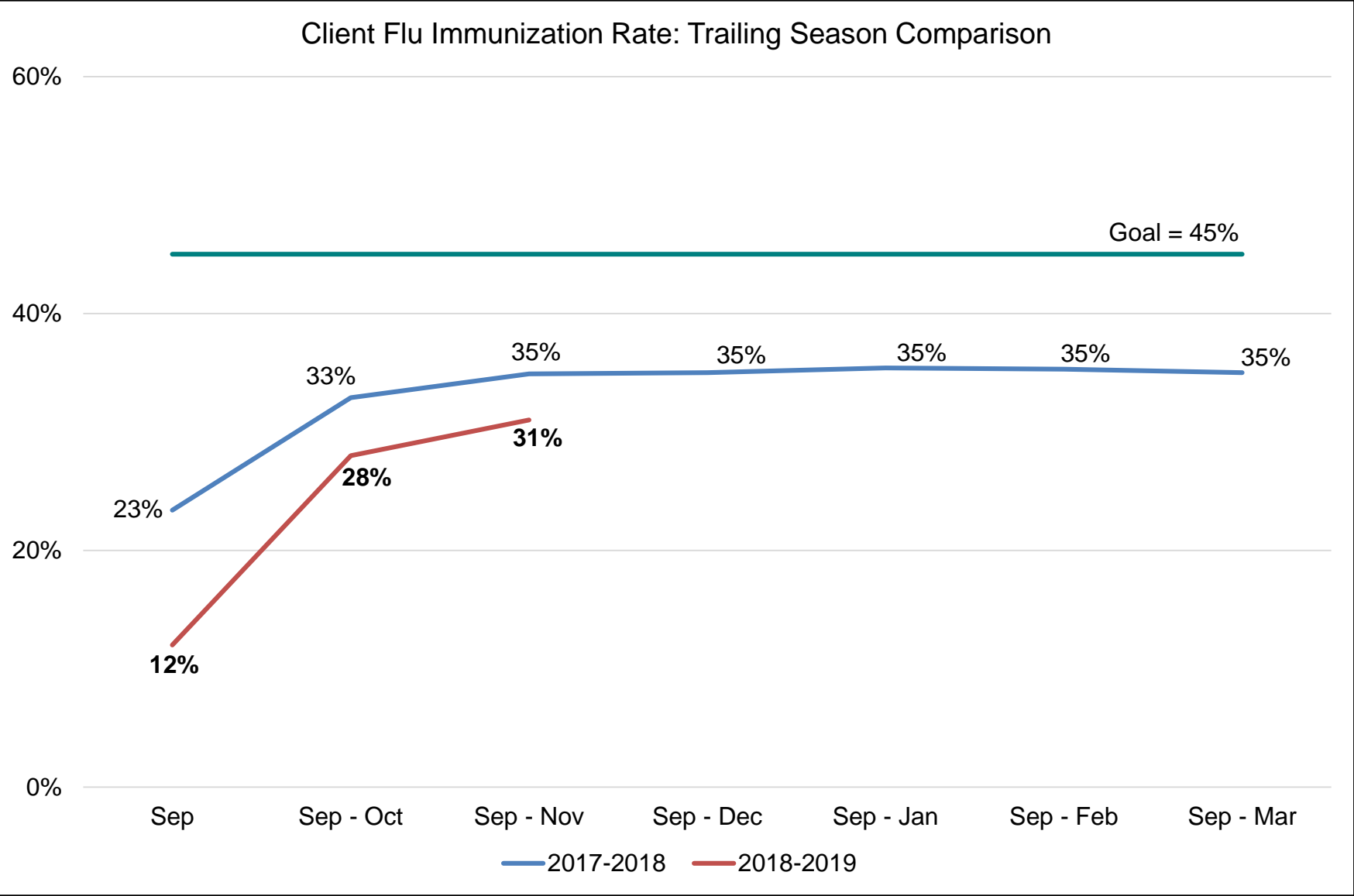Trailing Year (Health Indicators Report): 68%

November 2018 Dashboard: Client Experience

Client experience score for after hours phone access (1-5 scale)

November PI Dashboard: Flu Immunization

Client Flu Immunization Rate: Trailing Season Comparison

Goal = 45%

2017-2018: 23%, 33%, 35%, 35%, 35%, 35%, 35%

2018-2019: **12%**, **28%**, **31%**

Sep | Sep - Oct | Sep - Nov | Sep - Dec | Sep - Jan | Sep - Feb | Sep - Mar

— 2017-2018 — 2018-2019
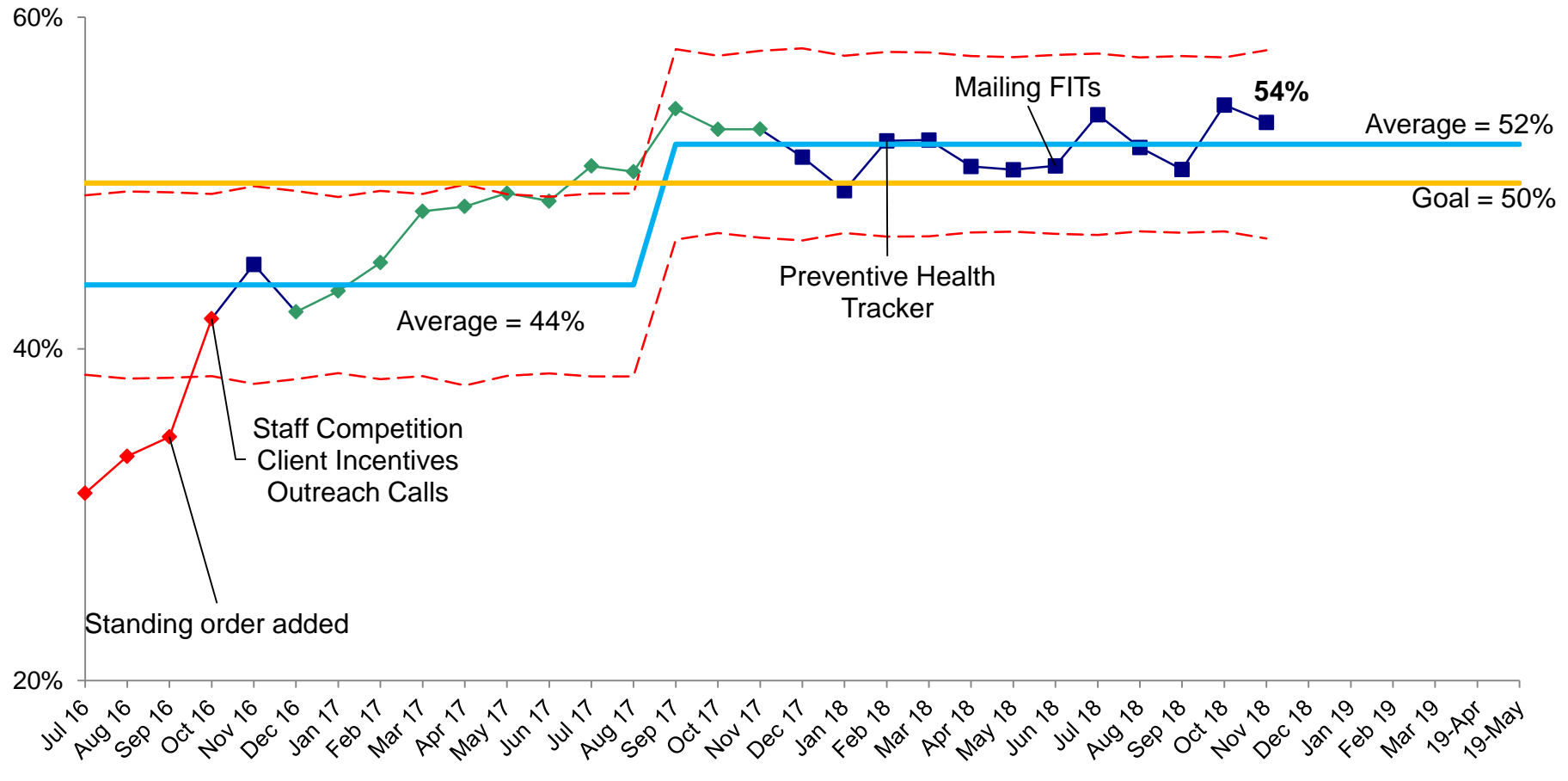
Subcommittee Updates

Colorectal Cancer Screening

Goal: By December 2018, **50%** of eligible medical clients will have an up-to-date colorectal cancer screening

Team: Laura Garcia, Tracy Russell, Catherine Fowler, Veronica Dennis, Leonid Suarez, Lillian Amaya, Caitlin Synovec
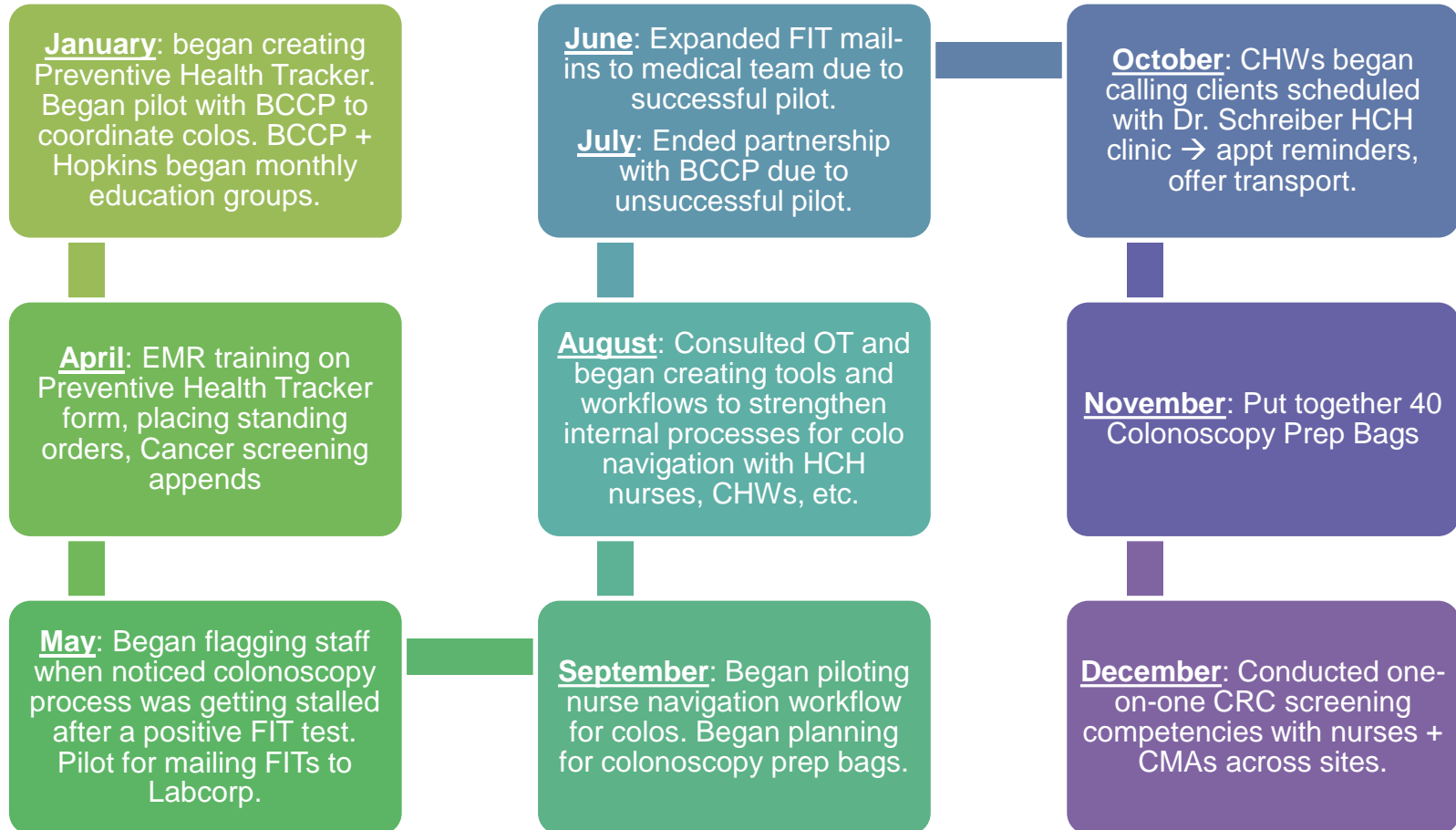

Progress:

HCH Colorectal Cancer Screening Rate
July 2016 - November 2018

Mailing FITs

54%

Average = 52%

Goal = 50%

Preventive Health Tracker

Average = 44%

Staff Competition
Client Incentives
Outreach Calls

Standing order added

Trailing Year (Health Indicators Report): 45%

Colorectal Cancer Screening: 2018 in Review

Interventions:

January: began creating Preventive Health Tracker. Began pilot with BCCP to coordinate colos. BCCP + Hopkins began monthly education groups.

April: EMR training on Preventive Health Tracker form, placing standing orders, Cancer screening appends

May: Began flagging staff when noticed colonoscopy process was getting stalled after a positive FIT test. Pilot for mailing FITs to Labcorp.

June: Expanded FIT mail-ins to medical team due to successful pilot.

July: Ended partnership with BCCP due to unsuccessful pilot.

August: Consulted OT and began creating tools and workflows to strengthen internal processes for colo navigation with HCH nurses, CHWs, etc.

September: Began piloting nurse navigation workflow for colos. Began planning for colonoscopy prep bags.

October: CHWs began calling clients scheduled with Dr. Schreiber HCH clinic → appt reminders, offer transport.

November: Put together 40 Colonoscopy Prep Bags

December: Conducted one-on-one CRC screening competencies with nurses + CMAs across sites.

Colorectal Cancer Screening: 2018 in Review

Lessons Learned:

❖ Pilots that involved the entire medical team were not effective. We learned the value of sticking with one mini care team at a time.

❖ Using external partners for complex care coordination needs (i.e. colonoscopies) was less effective than using internal resources. However, external partners were helpful in supporting simple efforts (i.e. group education).

❖ Implementing new workflows across sites is very challenging, and required more proactive, intentional efforts.

❖ One-time trainings often are insufficient. CRC screenings required multiple training attempts, including some more intensive one-on-one efforts.

Colorectal Cancer Screening: 2018 in Review

Next Steps:

In 2019 Population Health seeks to maintain/improve CRC screening rates while also tackling other issues this PI project has brought to light (particularly the lack of timely and regular follow-up to abnormal CRC screenings).

- **Objectives for CRC for 2019**:
  - Increase the percentage of eligible clients screened for CRC to **>55%.**
  - Increase the percentage of clients with positive FIT result whose medical provider reviews the lab result and orders a diagnostic colonoscopy within 14 days of receipt of lab result to >**95%.**
  - Increase the percentage of clients with a positive FIT result in 2019 who complete a diagnostic colonoscopy within 12 weeks in 2019 to >**50%.**
- **Deliverables for CRC for 2019:**
  - Solidify nurse/CHW navigator role + finalize workflow for clients needing support to complete the colonoscopy process. Train all applicable nurses and CHWs in this role.
  - Finalize implementation + workflow (supported by EMR) that addresses timely f/u of abnormal CRC screenings.

Colorectal Cancer Screening: 2018 in Review

Quiz Time!!!!

Q: Who is eligible for the CRC screening?

A: Men and women aged 50-75

Q: What two types of CRC screenings does HCH offer, how often does each test get completed, and what incentive does the client receive for completing a screening?

A: FIT test (annually) and screening colonoscopy (every 10 years) if results are normal. The client receives a $7.50 subway gift card for completing either screening.

Q: Name at least two risk factors for colorectal cancer.

A: Any of the following: personal/family history of colorectal cancer or colonic polyps, having irritable bowel disease, having a genetic predisposition (FAP or Lynch syndrome), having abdominal pain, bloody stools, or unexplainable weight loss.
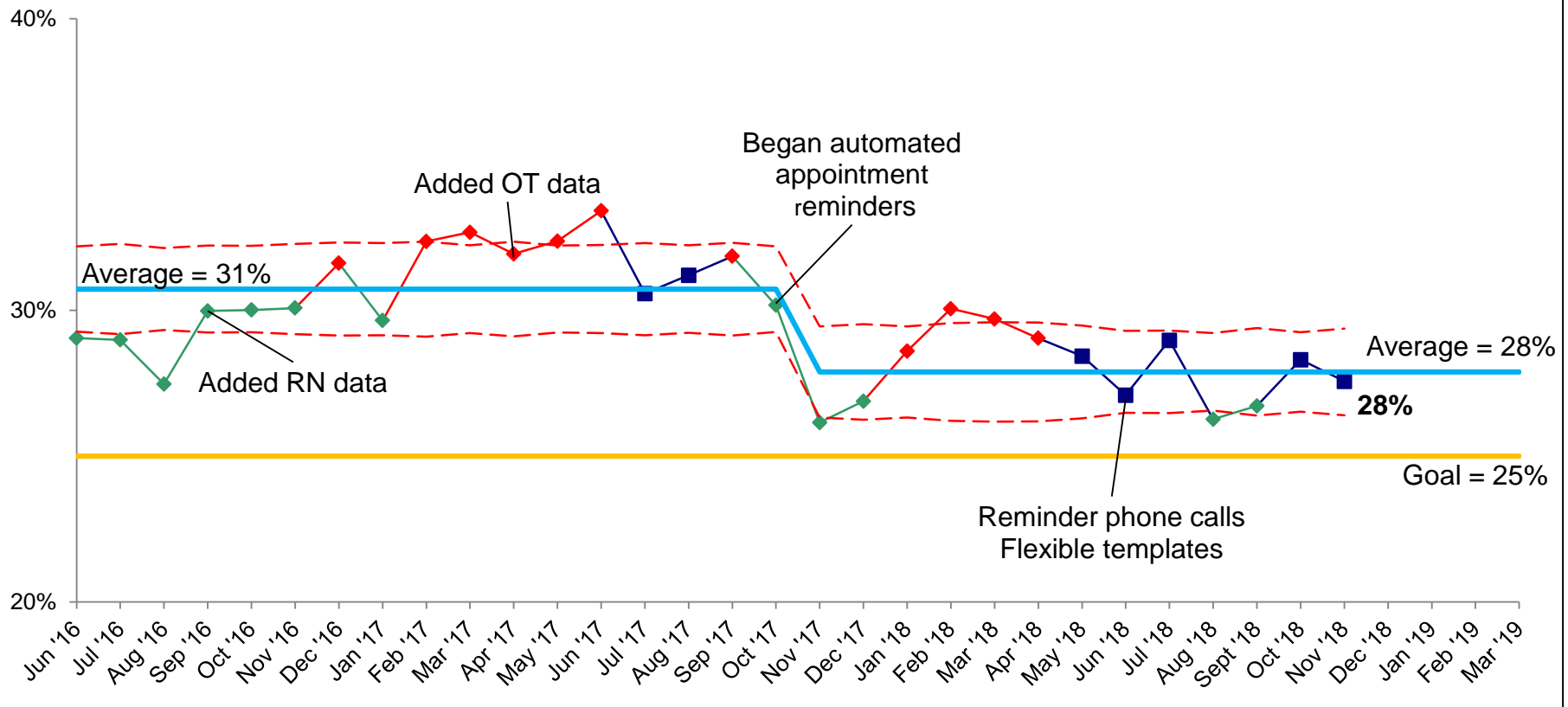
Missed Appointments

Goal: By December 2018, the organization will have a missed appointment rate at or below **25%**
Team: Aisha Darby, LaVeda Bacetti, Mona Hadley

Progress:

HCH Missed Appointment Rate
June 2016 - November 2018

Missed Appointments: 2018 in Review

Questions explored with tests of change:

❖ Is Televox an effective way of reminding clients of their appointment?

❖ Would we see better results if we leveraged our client/provider relationship for reminding clients of their appointments? If so, what is needed to support that workflow?

❖ Will a transportation guide for clients reduce missed appointments at Baltimore County?

❖ Will creating more flexible schedule templates increase same-day access and reduce the missed appointment rate?

❖ What interventions could we do to address the high amount of repeated missed appointments from certain clients?

Missed Appointments: 2018 in Review

Lessons Learned:

❖ Use of Televox resulted in a 3% reduction in Missed Appointments. A multi-pronged approach is needed to see a further decrease.

❖ Provider phone calls proved effective as a small test, but there needs to be a sustainable workflow for pulling the list and implementing it as part of daily tasks

❖ Changing the schedule templates did not have an appreciable effect on missed appointment rate

Missed Appointments: 2018 in Review

Lessons Learned (cont.):

❖ The Baltimore County transportation guide PDSA cycle was inconclusive, but is perhaps a starting point for creating follow-up interventions for the SDH questions

❖ There is tension in the need to accommodate our clients while understanding and addressing our missed appointment rate that should be acknowledged and balanced

❖ Many clients have an extreme amount of appointments with a multitude of providers

Missed Appointments: 2018 in Review

Plan for 2019:

❖ Expand group to provide clinical staff and perspectives

❖ Explore the multi-pronged approach to reminding clients of their appointments

❖ Define "frequent" for clients missing appointments, and consider interventions for clients driving the Missed Appointment rate.

❖ Dive into person-centered care from a scheduling perspective

Discussions

Discussion: Year-end Reflection

- *What did you learn this year?*

- *What went well?*

- *What didn't go well or still confuses you?*

- *What do you want to see in 2019?*

Next Month: January 16, 2019

Dashboard Updates:
- Colorectal Cancer Screening
- Missed Appointment Rate
- Flu

Presentations:
- Diabetes
- Cervical Cancer Screening
- Client Experience: After-Hours

HEALTH
CARE for the
HOMELESS