Performance Improvement Committee

February 17, 2021

HEALTH CARE for the HOMELESS

February Agenda

Project Updates:

- January PI Launches:
  - Referrals Completion
  - Food/Transportation Access
- February PI Launches
  - Diabetes Control
  - Depression Remission

IHI Forum

- 5 minute video
- De-brief

Project Updates

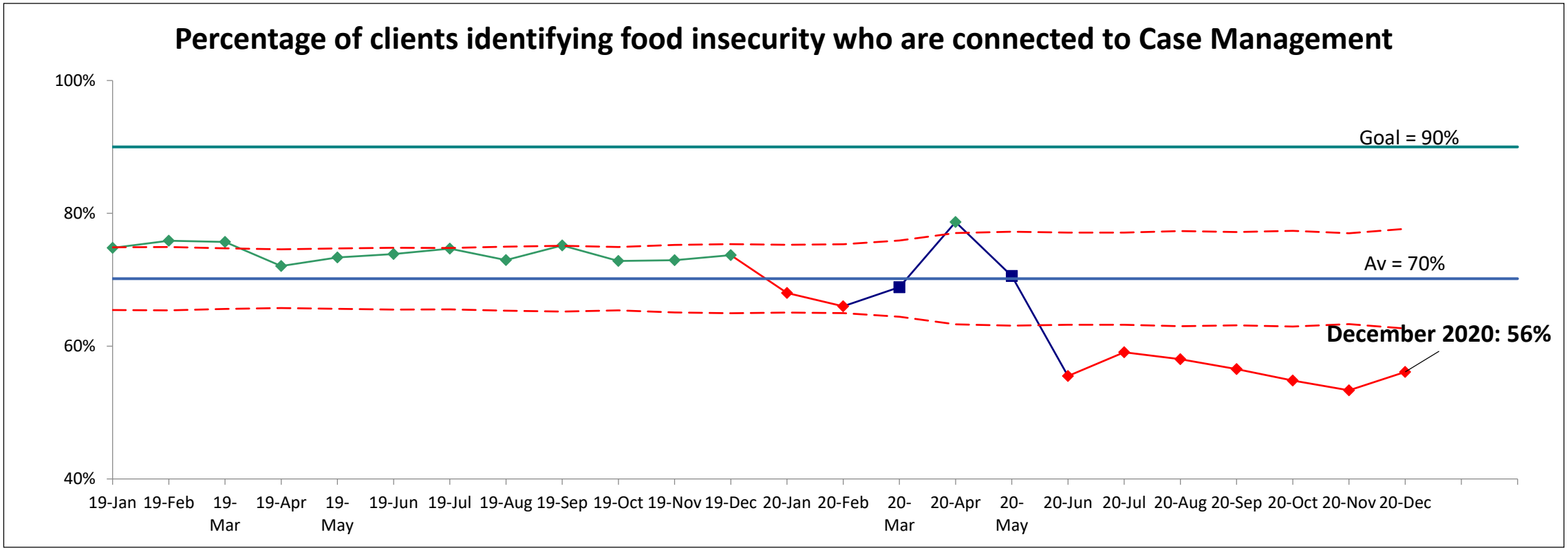
Social Determinants - January

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



Transportation data – January 2021: 58.8%

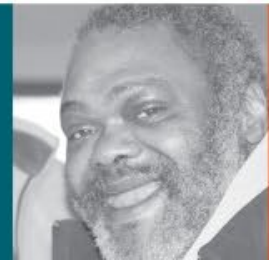
Since we last met…

- Subcommittee has:
  - Identified root causes for low SDH ask rates
  - Identified root causes for poor connection of clients to CMs/CHWs
  - Identified potential change ideas

- Key Change Ideas:
  - **Front end**: SDH Questionnaire
    - Revamping SDH questions and workflow to make easier for staff to use + act on
    - Some questions need to be asked for reporting purposes but not useful for providers to review
  - **Back end**: Connecting clients to CM/CHW + CM/CHW interventions
    - Ensuring that the SDH measure (food insecurity/transportation challenges) is being checked + addressed by providers + staff aware of referral process.
    - Ensure CM/CHW are documenting interventions

Targeting Root Causes – Food insecurity/transportation access

Root Cause	Change Idea
Low ask rates for SDH questions	• Revamp the form to make it easier for staff to use • Separate out items needed for reporting purposes vs. actionable items
Low rates of connecting clients with needed services bases on positive SDH responses	• Have CAAs/registration pilot referring clients to needed services within HCH • Train providers to review responses and internally refer clients as appropriate
Lack of clear guidance on how to use form and actionable items	• Streamline workflow for referring clients to CM/CHW (as well as to other departments when needed) • Provide staff training + guidance
Difficulties measuring whether food/transportation are addressed once clt connected with CM/CHW	• Create radio buttons in EMR linked to obs terms for CMs/CHWs to document their interventions



Next steps

- PDSA pilot with 1st Flr. CAAs (2/22-2/26): → refer clients to CM for needed services
  - Plan
  - Do
  - Study
  - Act
- Work to revamp SDH questions, make EMR changes, train staff

Referral Tracking - January

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*

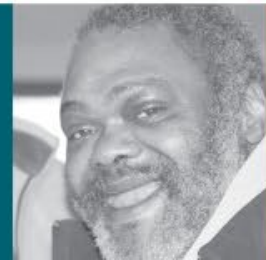
Since we last met…

- Subcommittee has:
  - Identified root causes for low referrals completion rates
  - Identified potential change ideas

- 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

Targeting Root Causes – Referrals completion

Root Cause	Change Idea
Not knowing where a client is in the referrals process	• Training CAAs at 421 in the 30-60-90-day referrals f/u policy and incorporating into their role
High volume of referrals + Lack of processing referrals in real-time upon client discharge	• Lack of CAA – care team alignment → assigning CAAs to care teams and having them process simpler referrals in real-time
Workflow for communicating to clients that referral is processed + ready → not standardized	• Create a standard workflow + reinforce with referrals specialists/CAAs
MCO-specific issues → Of note, lack of UHC PCP alignment with actual PCP	• Pro-actively addressing alignment instead of retroactively



Referrals Completion: Next Steps

- Tolu to transition into role of Referrals PI committee facilitator
- Plan a PDSA for 421 CAAs to try around 30-60-90 day referrals follow-up
- Look into proactive aligning UHC PCP with actual PCP
- Look into a standard workflow for notifying clients when referral has been processed

Diabetes - February

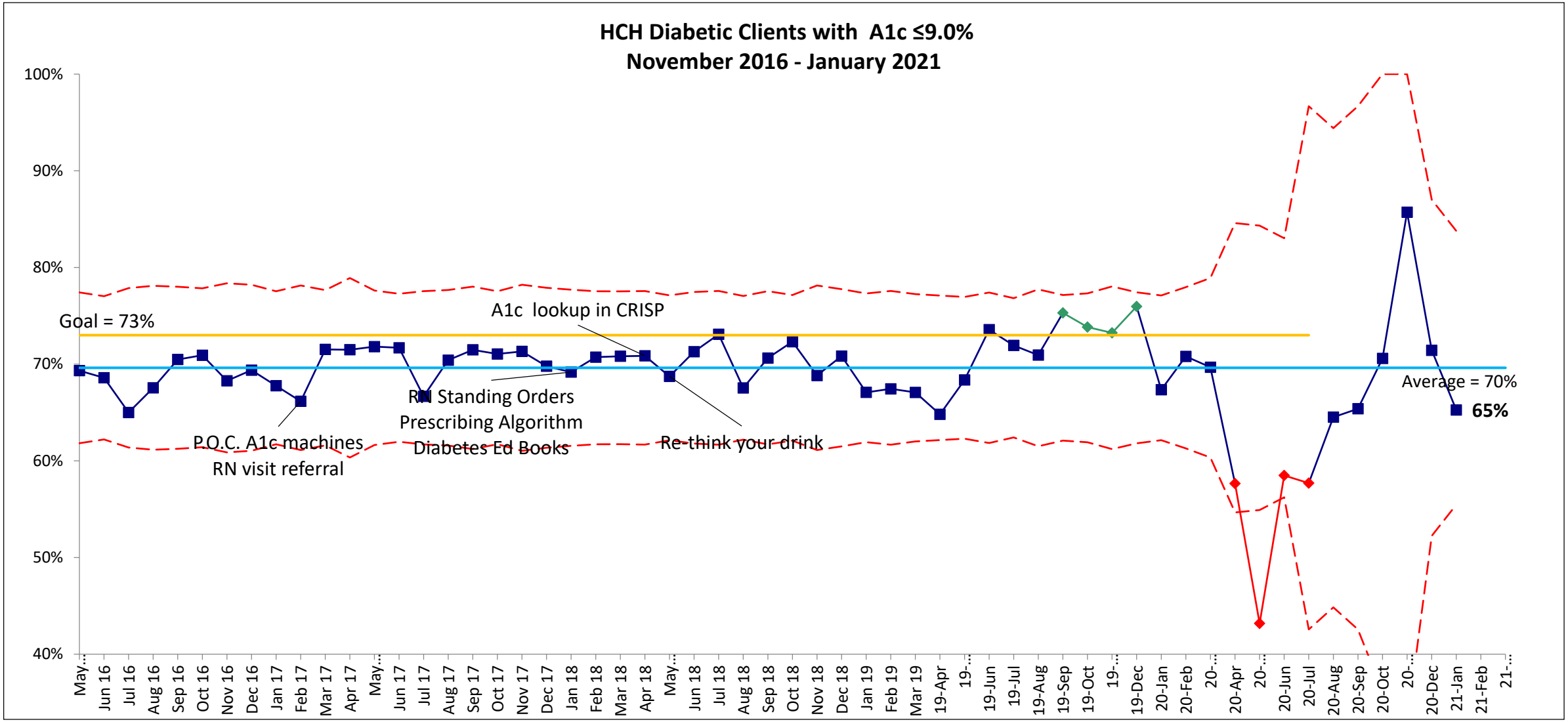
A. Reduce the number of clients across the Agency who have an A1C >9 or who were not tested to **25%**

Baseline Data: 44.2%

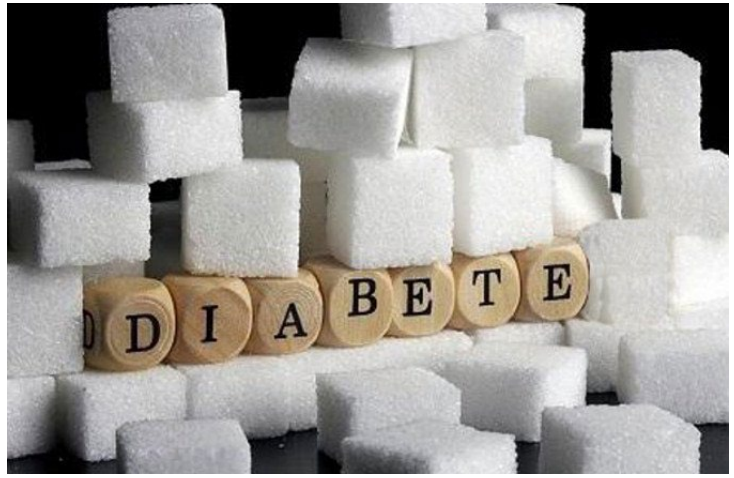
Diabetes

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

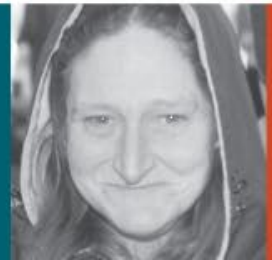
	Diabetes	
February Launch	**Champion**	**Laura Garcia (Green Team)**
	HIT	**Joseph VerValin + Katie Healy**
	Members REI rep	Julia Davis (Green Team) David Dexter Client Representative Kiana Johnson *Lawanda Williams - consult* *Elizabeth Zurek - consult*


HCH Diabetic Clients with A1c ≤9.0%
November 2016 - January 2021
100%
90%
80%
70%
60%
50%
40%
Goal = 73%
Average = 70%
65%
A1c lookup in CRISP
RN Standing Orders
Prescribing Algorithm
Diabetes Ed Books
P.O.C. A1c machines
RN visit referral
Re-think your drink
May...
Jun 16
Jul 16
Aug 16
Sep 16
Oct 16
Nov 16
Dec 16
Jan 17
Feb 17
Mar 17
Apr 17
May...
Jun 17
Jul 17
Aug 17
Sep 17
Oct 17
Nov 17
Dec 17
Jan 18
Feb 18
Mar 18
Apr 18
May...
Jun 18
Jul 18
Aug 18
Sep 18
Oct 18
Nov 18
Dec 18
Jan 19
Feb 19
Mar 19
19-Apr
19-...
19-Jun
19-Jul
19-Aug
19-Sep
19-Oct
19-...
19-Dec
20-Jan
20-Feb
20-...
20-Apr
20-...
20-Jun
20-Jul
20-Aug
20-Sep
20-Oct
20-...
20-Dec
21-Jan
21-Feb
21-...

Current Diabetes Work



- **CMAs** calling clients >6 mos since last A1C
- **Referrals to nursing** for clients with A1C > 9
- **Steel Team Pilot**
  - CHWs re-engaged clients (40% success)
  - Housing staff to consult at Care Team meetings
  - Focus on clients with upcoming appts
- **Now ALL Care Teams discussing clients with uncontrolled diabetes**



Depression Remission

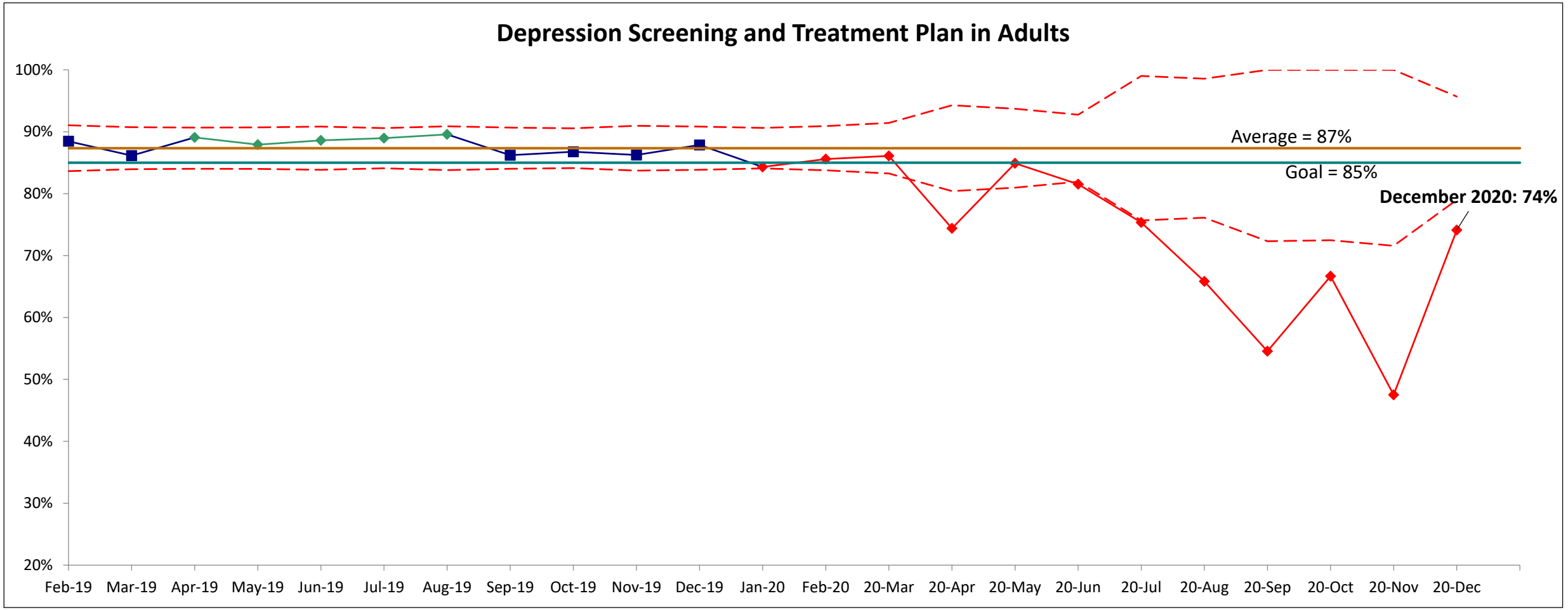
B. Remission:

10% of adults diagnosed with major depression or dysthymia who scored positively on an initial PHQ9 (>9) will demonstrate remission between 5-7 months

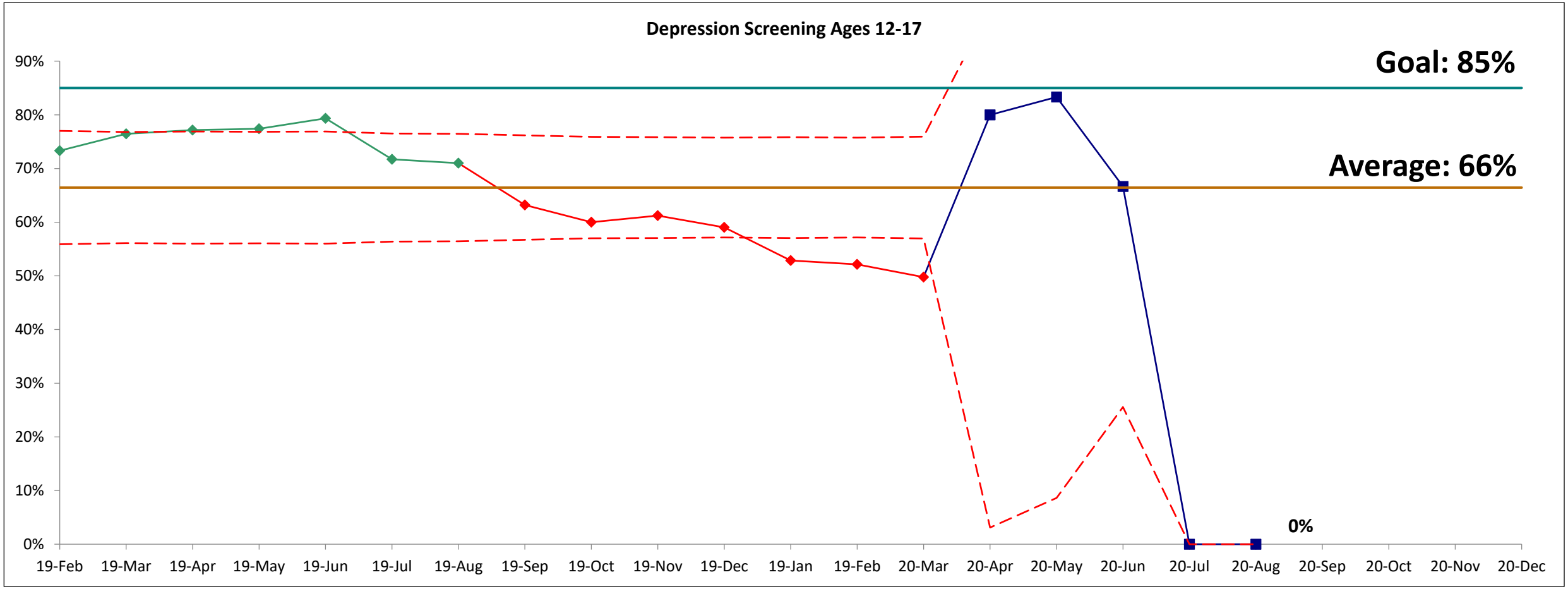
Baseline Data: 2.3% (2020 anticipated UDS)

February Launch	Depression Remission	
	Champion	**Jan Ferdous**
	HIT	**Maia Gibbons**
	Members	Arianne Jennings
		Karen Ross-Taylor
		Meredith Johnston
		Tyler Gray
		Edith Augustson
		Rosita Harris - consult

Adult Depression Screening and Treatment

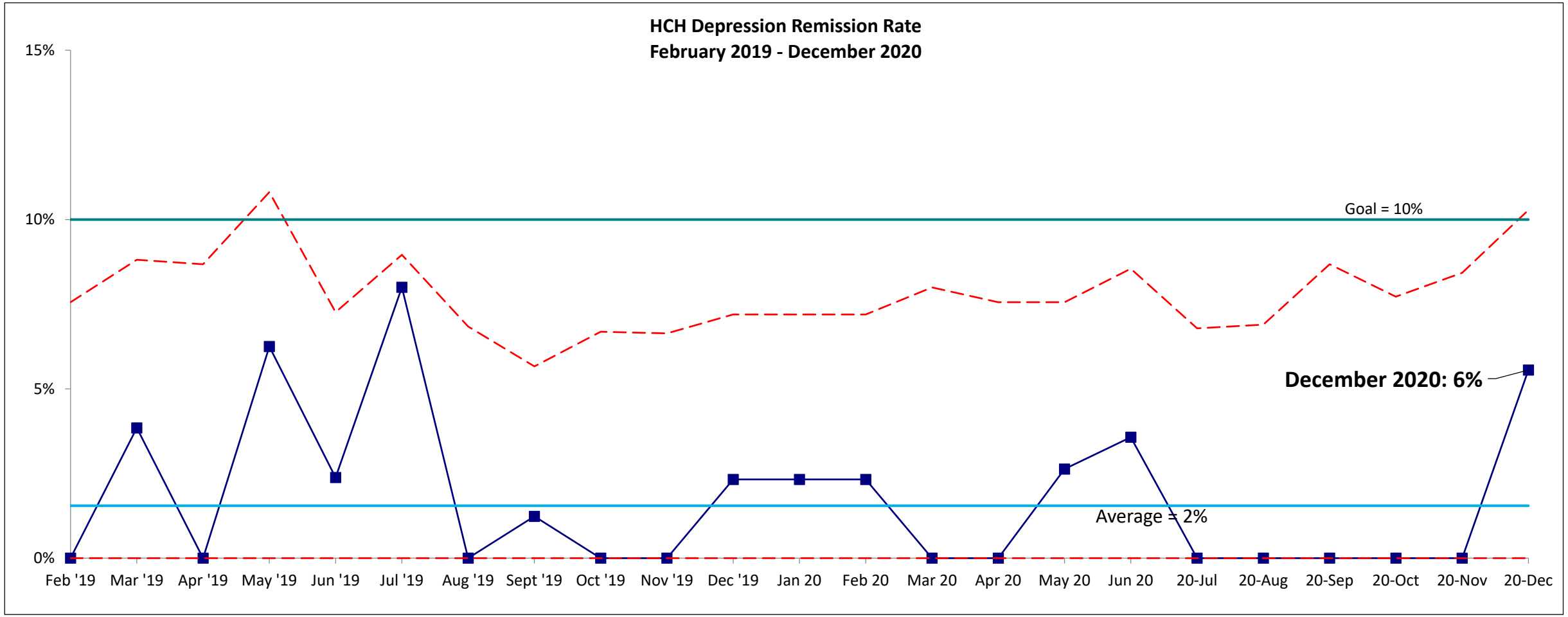


Depression Screening – Adolescents



Note: The denominator for September – December is 0.

Depression Remission



Discussion

Let’s watch a quick video from the IHI Conference

Keynote Speaker: Kedar Mate

YOU can improve care at the agency!

- **Attend monthly PI meetings**
  - 3rd Wednesdays at 8:15 a.m.
- Coming soon to the **PI page on the portal**:
  - **PI Tools**
  - **IHI Conference materials**
- **Be a change agent**
  - Consult PI Department for projects/PDSAs when you see a problem or have a change idea