PI Committee Meeting

HEALTH CARE for the HOMELESS

January 17, 2018

January 2018 PI Committee Agenda

Prioritized Goals

- 2017 Wrap-up – Progress & Lessons Learned:
  - *Hep C Treatment*
  - *Universal Screening: HIV & Hep C*
  - *Hospitalization Follow-up*
  - *Housing Documentation*
- 2018 New Goals
  - *Cervical Cancer Screening*
  - *Client Experience: After Hours Phone Access*

November 2017 Client Experience Survey Results

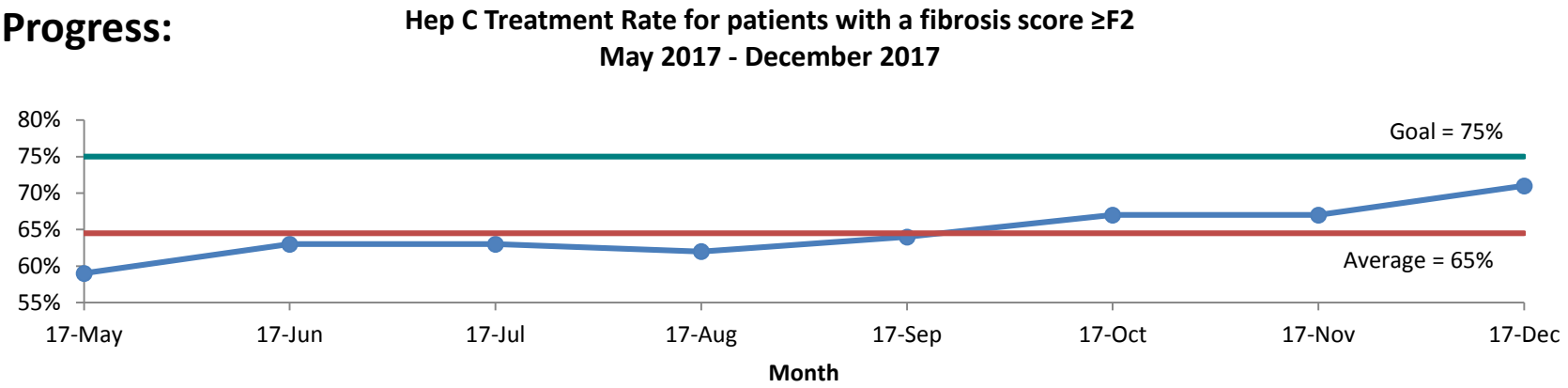
What's new for 2018?

- Project Charters
- PI Committee Format

2017 Prioritized Goal Wrap-Up: Hep C Treatment

Goal: 75% of clients with a Fibrosis Score ≥F2 will begin treatment for Hepatitis C

Progress:



Changes tested:

- Root cause analysis conducted
- RN registry for clients F2 or greater who have not started treatment
- Changed EHR form to track clients receiving treatment elsewhere
- RNs bring lists of registry clients to care teams

Lessons learned:

- RN registry needs to be automated to provide efficiency, optimize RN value to process
- Difficult for RNs to prioritize this work
- Adding clients treated elsewhere did not affect overall rates, despite being #2 in RCA
- Clients lost to care is #1 reason clients don't begin treatment
- High treatment rate possible if payment barrier removed!

2017 Prioritized Goal Wrap-Up: Universal Screenings

Goal: 69% of eligible clients will be tested for HIV & 66% will be tested for Hepatitis C

Progress:

- HIV testing rate, December 2017: 65%
- HCV testing rate, December 2017: 56%

Changes tested:

- Created and refined a workflow for a non-medical department to screen and refer clients for testing.
- Ensured consistent process for screening given variable resources (lack of CTR).

Lessons learned:

- Importance of involving front line staff in improvement projects
- Screening rate improvement require critical mass of referring providers
- Decision to be made about adding departments while on back-up system
- Important to set up improved process in medical as well as in other departments
- West Baltimore clinic significantly higher screening rates – what can be learned?

2017 Prioritized Goal Wrap-Up: Hospitalization Follow-up

Goal: Increase number of hospitalized clients who followed-up with medical and/or psychiatry within 7 days of discharge.

Progress: Baseline rate of 10% established.

Changes tested:

- Tried to establish partnership with Mercy to be contacted prior to hospital discharge.
- Tried to identify recently hospitalized clients through internal resources: tried asking at the front desk, at triage, walk-in providers, and all case management.
- Added 7-day follow-up appointment availability
- RN follow-up calls at West Baltimore
- Community Health Workers doing CRISP list outreach – calls and trying to find in the community

Lessons learned:

- Importance of having baseline measure (and measurement strategy) prior to goal setting
- Hospital partnership efforts met with limited success
- Opportunities exist internally to screen clients for recent hospitalization (case management)
- Same-day appointments didn't sufficiently meet post-hospitalization scheduling needs
- Standardized hospital follow-up visit workflow needed
- Clients with inpatient stays at Bon Secours do not necessarily belong with the West Baltimore Clinic
- CHWs refined workflow to maximize value of their efforts (phone calls vs community visits)

2017 Prioritized Goal Wrap-Up: Housing Documentation

Goal: Standardize housing data collection across teams

Progress: Baseline established – chart review in March 2017:

- 58% of clients had different housing status recorded in same day of visiting HCH
- 47% of clients had correctly defined housing status

Changes tested:

- PRAPARE evaluated for usefulness

Lessons learned:

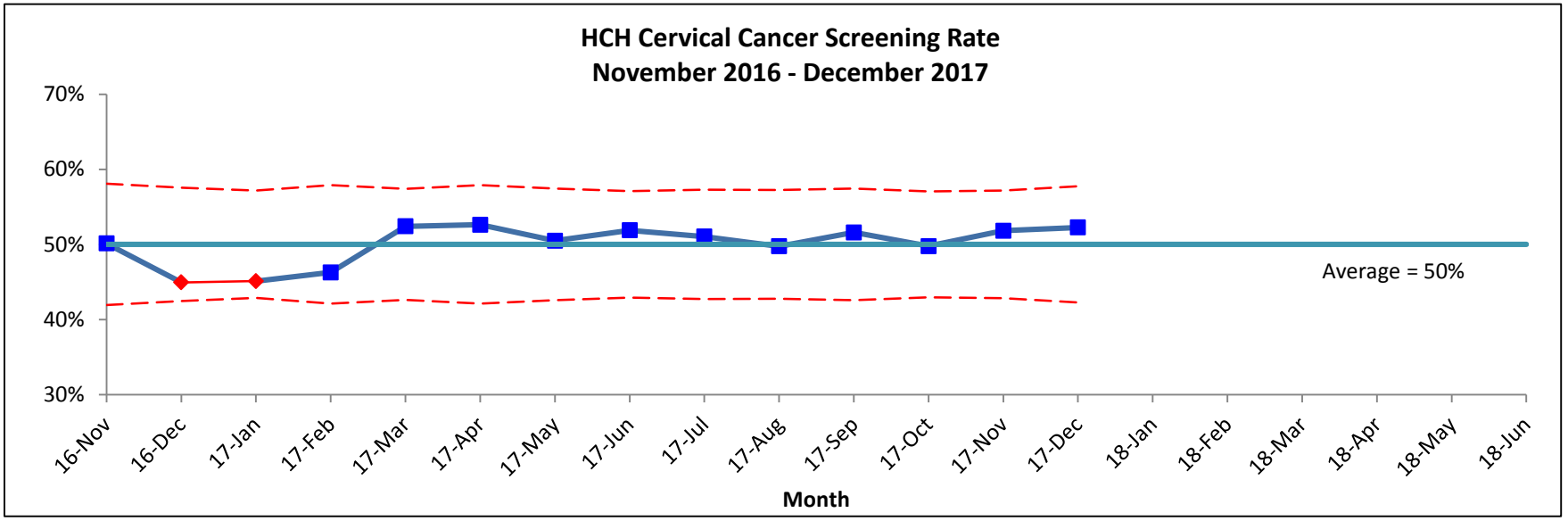
- Importance of having baseline measure (and measurement strategy) prior to goal setting
- Differentiated process & content for screening vs assessment
- Standardized tools allow for broader possibilities with collected data(using PRAPARE vs homegrown screening)
- Project ultimately duplicative with other work around the agency (PRAPARE and Housing Assessment Group)

2017 Prioritized Goals

What are your “lessons learned”?

2018 New PI Goals: Cervical Cancer Screening

Goal: By December 2018, 50% of eligible medical clients will have an up-to-date cervical cancer screening (Baseline, September 2017 =37%)



2016 Cervical Cancer Screening Criteria:

- Cervical Cytology testing every 3 years

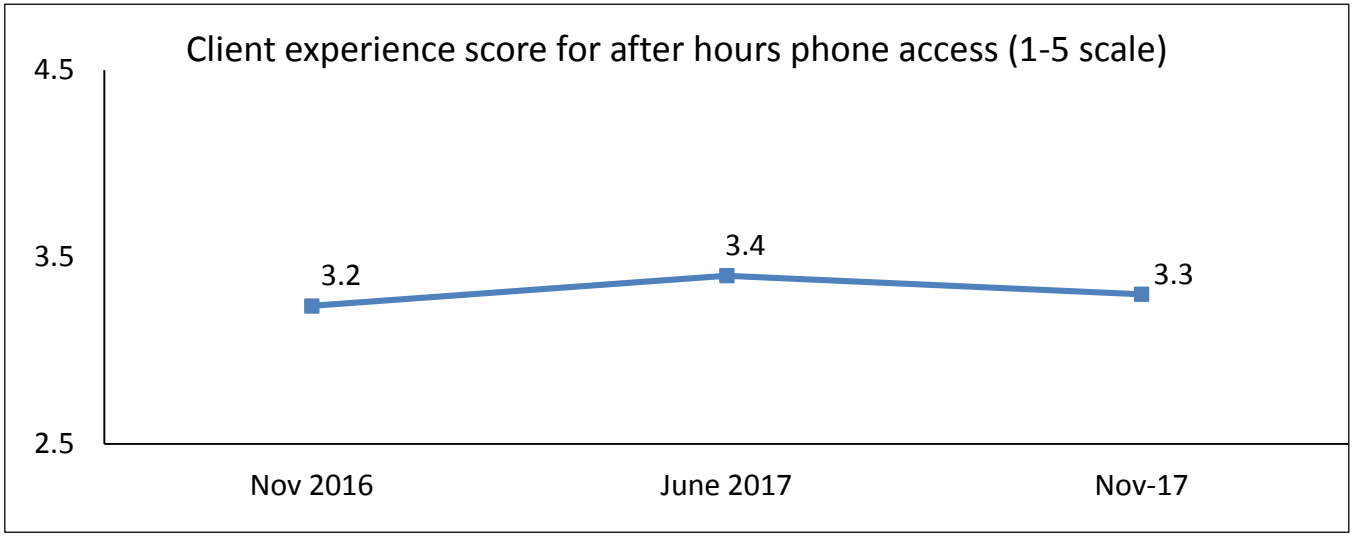
2017 Cervical Cancer Screening Criteria:

- Cervical Cytology testing every 3 years

AND

- Cervical Cytology/HPV co-testing every 5 years after age 30

2018 New PI Goals: Client Experience Score: After Hours Phone Access



2017 Changes tested:

- Held focus group with clients
- Tested functionality
- Posted number in Fallsway Lobby
- Fliers for clients
- Informing providers about number
- Unit clerks circle number on client blue card
- Added number to the website

2018 Areas of focus:

- More advertising of number, purpose
- Advertising at all sites
- Continued tracking of balancing measure

Client Experience Survey: November 2017

- Annual surveys with after-action plans
- Conducted by staff and/or volunteers
- Variable questions/format
- In-clinic only
- Conducted using paper copy

Changed content to standardized CAHPS survey with 4 custom questions

2007 2015 2016 2017 2018

- Client Survey 2x year
- Volunteers for survey administration, but professional survey analysis
- iPads introduced for survey collection
- Calls made to clients in addition to in-clinic surveys
- In-house survey design
- West Baltimore & Baltimore County sites added

Client Experience Survey: November 2017

CAHPS Results: National Comparison

- Scored significantly lower on all standard CAHPS questions
- Scored significantly better on Patient-Centered Medical Home Add-on questions

Custom Question Results: 6 month comparisons

- Remained the same across all 4 questions

Welcome to 2018!

PI Committee Format:

1. **Each subcommittee will have a charter that documents the following:**
   - Aspirational Goal
   - Specific Aim (PI Goal)
   - Team Members/team lead/PI facilitator
   - Root cause analysis or driver diagram
   - “Big dot” measure
   - List of changes tested
2. **Tests of change communicated through weekly email updates**
3. **PI Committee –** Opportunity to learn from each other! Each month discuss observations, breakthroughs, failures, lessons learned from tests of change and current barriers.

Next Month: February 21, 2017

Prioritized Goals (Chronic Disease & Flu):

- Diabetes
- Behavioral Health
- Flu Vaccine

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