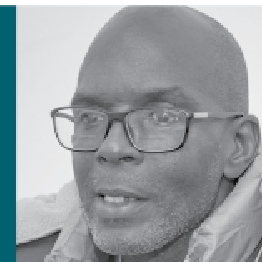
Performance Improvement Committee

March 17, 2021

March Agenda

Project Updates:

- Diabetes Control
- Referrals Completion
- Depression Remission
- Food/Transportation Access



Project Updates

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 – Untested Clients Driver Diagram

Diabetes Testing Driver Diagram			
AIM	*Primary Drivers*	*Secondary Drivers*	*Change Ideas*
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	
		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	

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

Goal = 73%

A1c lookup in CRISP

RN Standing Orders
Prescribing Algorithm
Diabetes Ed Books

P.O.C. A1c machines
RN visit referral

Re-think your drink

Average = 70%

65%

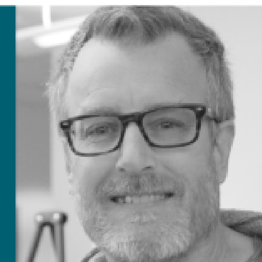
100%
90%
80%
70%
60%
50%
40%

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-…

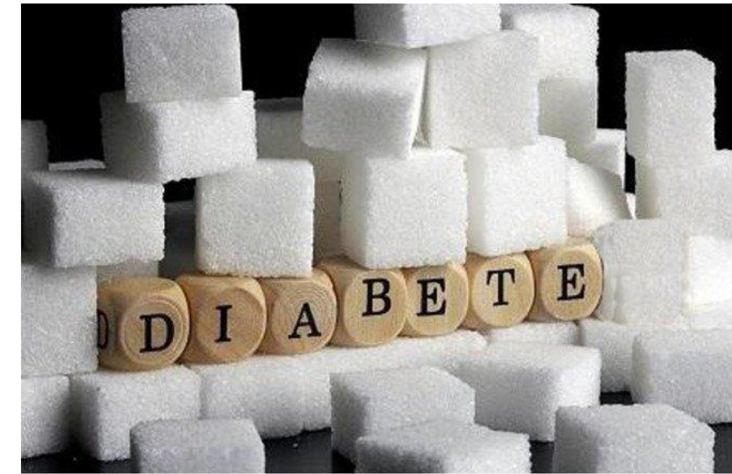
Diabetes

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

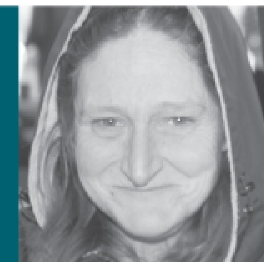
February Launch	Diabetes	
	Champion	**Laura Garcia (Green Team)**
	HIT	**Joseph VerValin + Katie Healy**
	Members	Julia Davis (Green Team)
	REI rep	David Dexter
		Client Representative
		Kiana Johnson
		Lawanda Williams - consult
		Elizabeth Zurek - consult

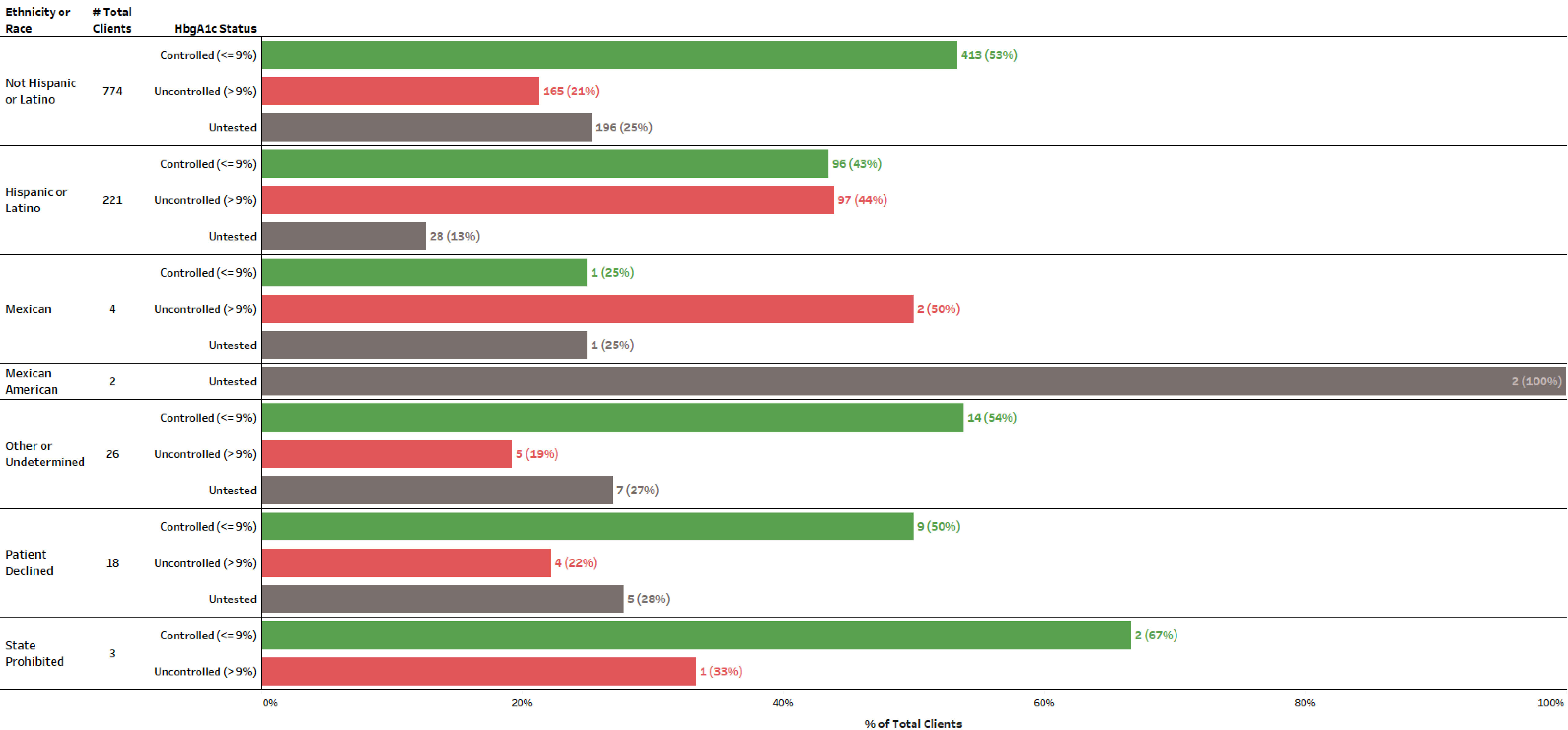


Since we last met…

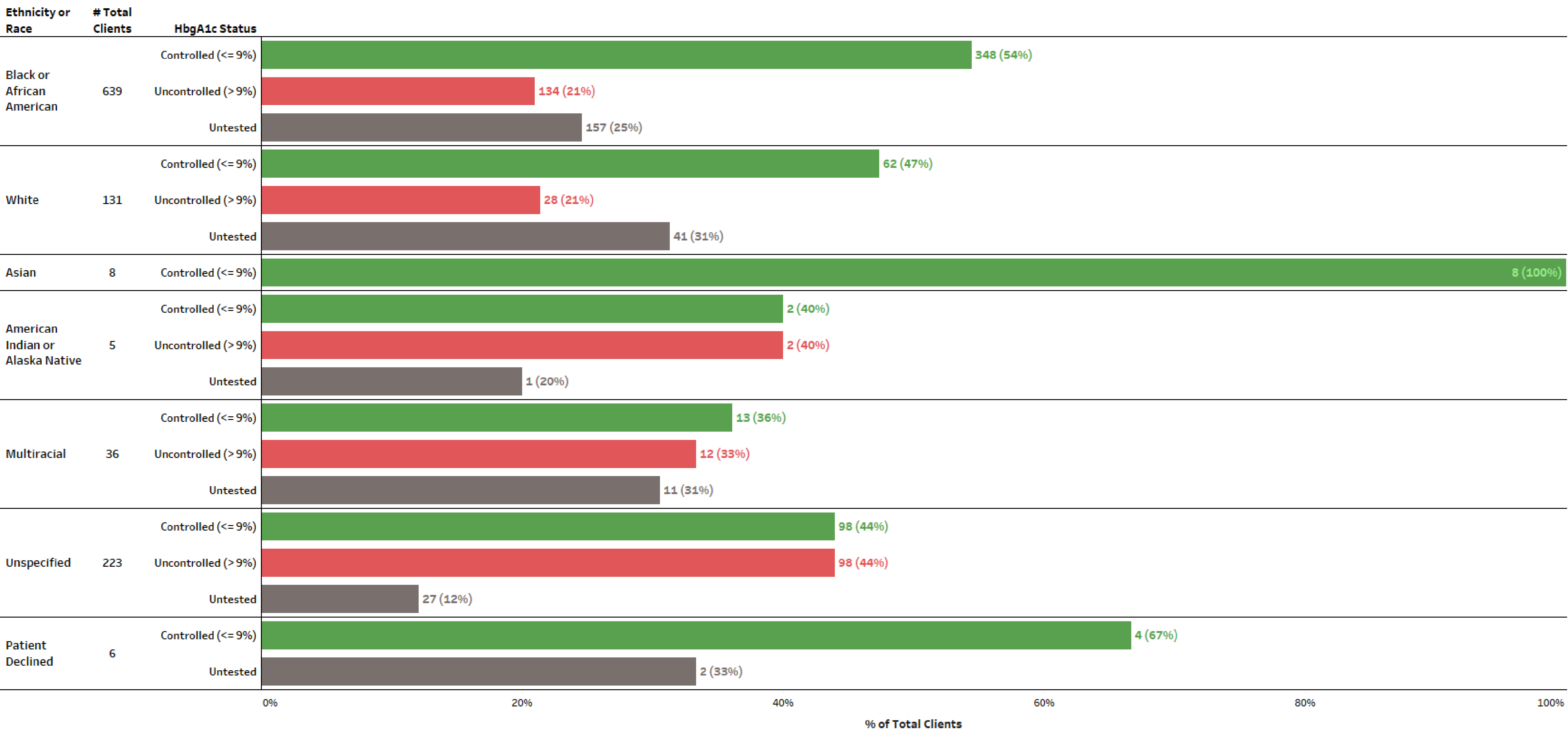


- Developed data for visualizing different demographics, departments, and testing rates for clients
- Explored barriers to consistently testing clients
- Discussed possible tracking methods for our current client call lists





This view shows the distribution of HbgA1c statuses among diabetic clients who completed at least one appointment in the trailing year (3/16/2020 - 3/15/2021) stratified by Ethnicity. HbgÀ1c status was determined based off a client's most recent HbgA1c result collected in the trailing year. Clients with no HbgA1c result in the trailing year were defined as untested.



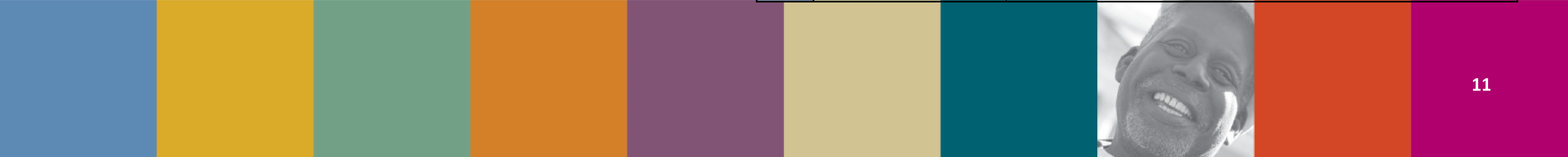
This view shows the distribution of HbgA1c statuses among diabetic clients who completed at least one appointment in the trailing year (3/16/2020 - 3/15/2021) stratified by Race. HbgÀ1c status was determined based off a client's most recent HbgA1c result collected in the trailing year. Clients with no HbgA1c result in the trailing year were defined as untested.

Referral Tracking

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

Baseline Data: 7%

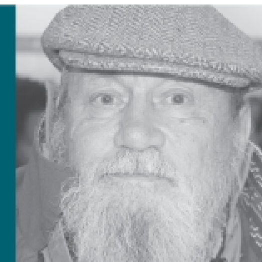
January Launch	Referral Tracking Committee	
	Champion	**Mona Hadley**
	HIT	**Wynona China**
	Members	Greg Myers Wanda Hopkins Max Romano Angela Robinson Lawanda Williams Adrienne Burgess Bromley Lisa Hoffman Tolu Thomas *Eva Hendrix – consult* *Margaret Flanagan - consult*



Since we last met…

- Subcommittee has:
  - Identified root causes for low referrals completion rates
  - Developed "ideal" referral workflow
    - Explored barriers to this new workflow

- 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	
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: Next Steps

- Continue to develop and explore change ideas
- 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

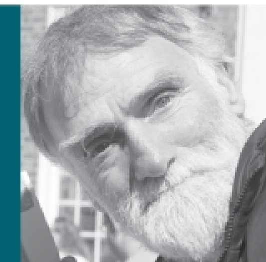
Depression Remission

A. 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***

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*



Depression Remission

HCH Depression Remission Rate
February 2019 - February 2020

15%
10%
5%
0%

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

Depression Remission

B. Screening:

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

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*

Since we last met…

- Subcommittee has:
  - Changed the measure to accurately reflect realistic treatment plans
  - Nearly finalized the updates 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.
    - Registry lists for providers with clients who have upcoming PHQ-9 due dates

Social Determinants

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

100%
80%
60%
40%

Goal = 90%

Av = 70%

December 2020: 56%

19-Jan 19-Feb 19-Mar 19-Apr 19-May 19-Jun 19-Jul 19-Aug 19-Sep 19-Oct 19-Nov 19-Dec 20-Jan 20-Feb 20-Mar 20-Apr 20-May 20-Jun 20-Jul 20-Aug 20-Sep 20-Oct 20-Nov 20-Dec

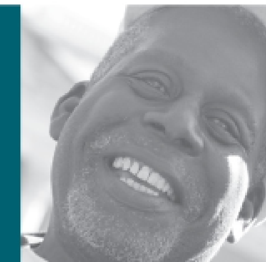
Transportation data – February 2021: 56.8%

Since we last met…

- Subcommittee has:
  - Conducted a PDSA to test CAAs sending clients to CM from front desk
  - Planned for follow up PDSA cycle
  - Shifted our focus to screening and connection to CM

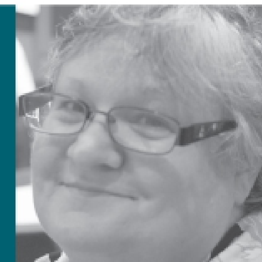
- PDSA Update:
  - **PDSA Parameters:**
    - Screened clients using Baseline form who stated they have potential CM needs
    - Scheduled them for same day/walk-in CM visit
    - Clients then went to their main appointment then to CM

  - **Results**:
  - CAAs successfully connected some clients to CM
  - However, in many instances the CMs were simply identifying a different need than clients stated at front desk
  - CMs had to then refer the clients to another department
  - Some capacity challenges for CAAs to complete the Baseline form in real time



Next steps

- PDSA repeat with new parameters:
  - Meeting with CAA team and CM reps to discuss cross training
  - Develop and test optimal multi-appointment visit workflow
    - CM → Medical; Medical → CM; BH → CM; etc
- Continue to test other change ideas



Questions?