## Performance Improvement Committee

November 18, 2020





### **November PI Committee Agenda**

#### Monthly Dashboard

- Medication Errors
- Food Insecurity
- Depression Remission
- Phone Access
- Flu Update

#### PI Discussion

• 2021 PI Plan

#### Population Health Updates

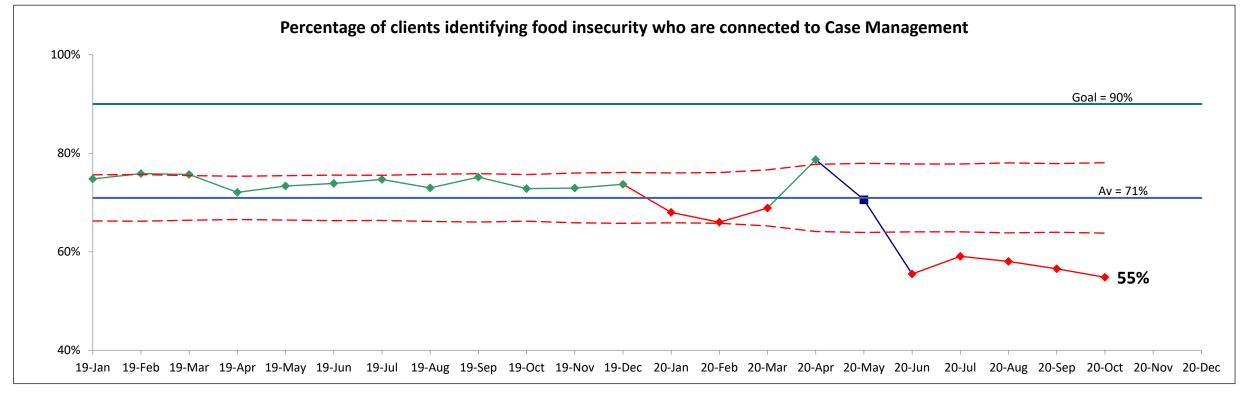
- Cancer Screenings
- Diabetes
- DMEs



## **Monthly PI Dashboard**

#### **Food Insecurity**

**Food Security Goal:** By December 2020, 90% of clients who identify as having food insecurity on the PREPARE tool will be connected to Case Management\*

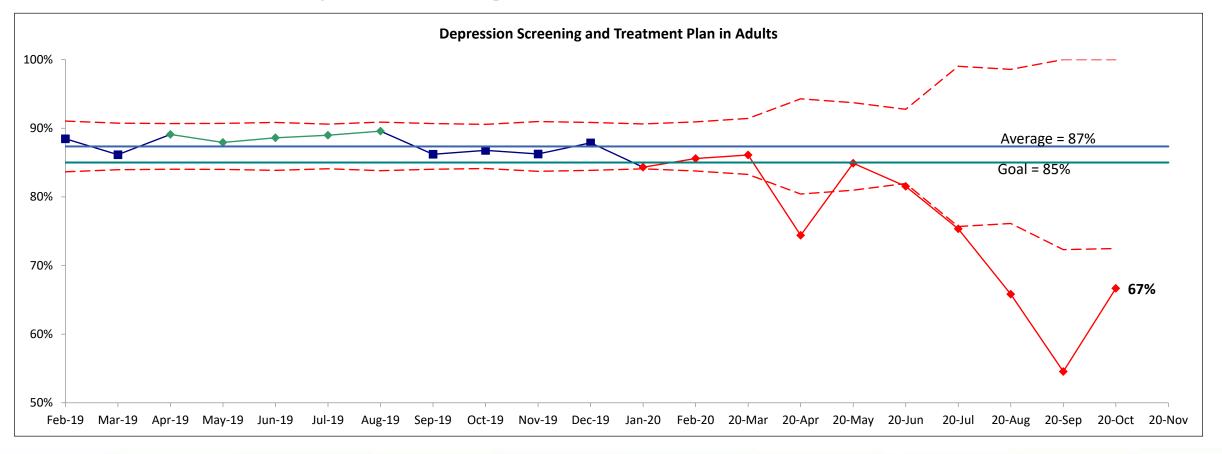


<sup>\*</sup>Includes Community Health Workers



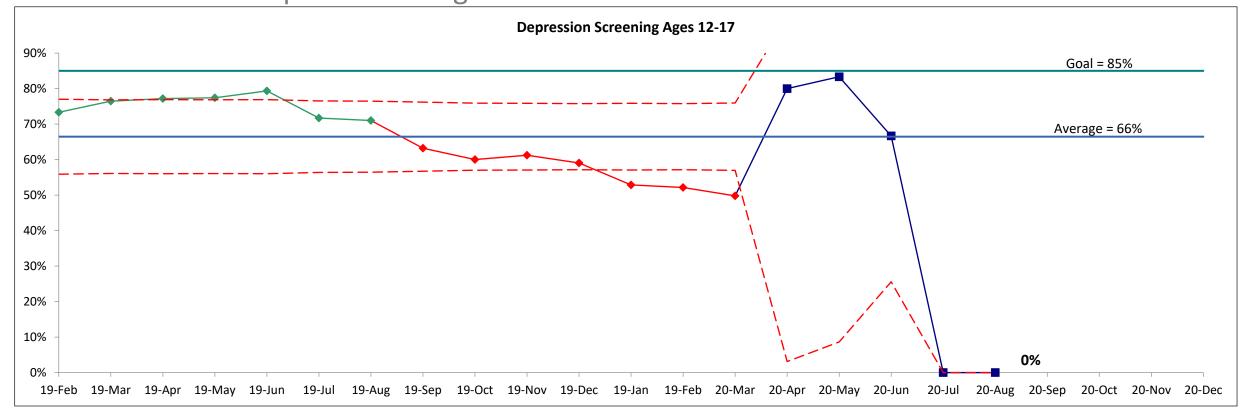
#### **Depression Screening and Treatment - Adults**

**Depression Screening Goal:** By August 2020, 85% of clients over 18 years of age will be screened for depression using a validated tool.



### **Depression Screening and Remission - Adolescents**

**Depression Screening Goal:** By August 2020, 85% of clients ages 12-17 will be screened for depression using a validated tool.

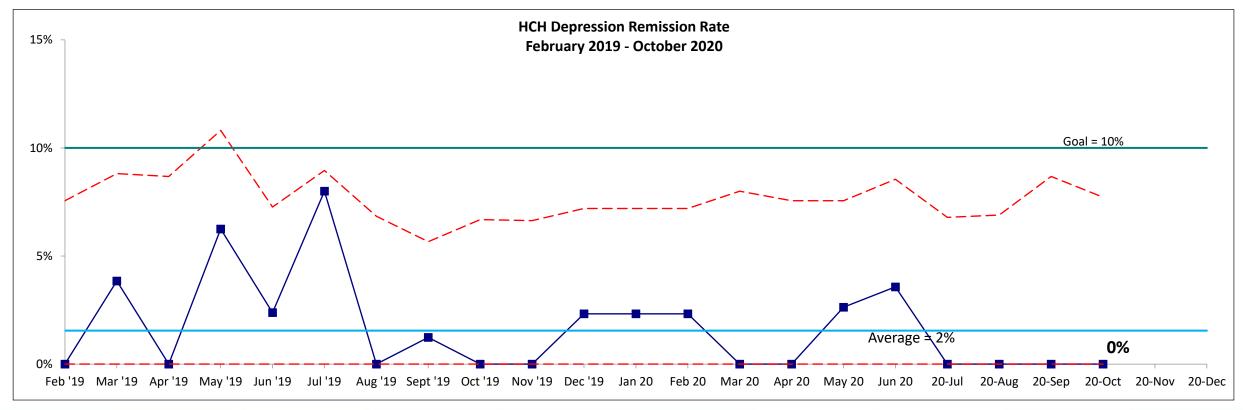


Note: The denominator for September and October is 0.



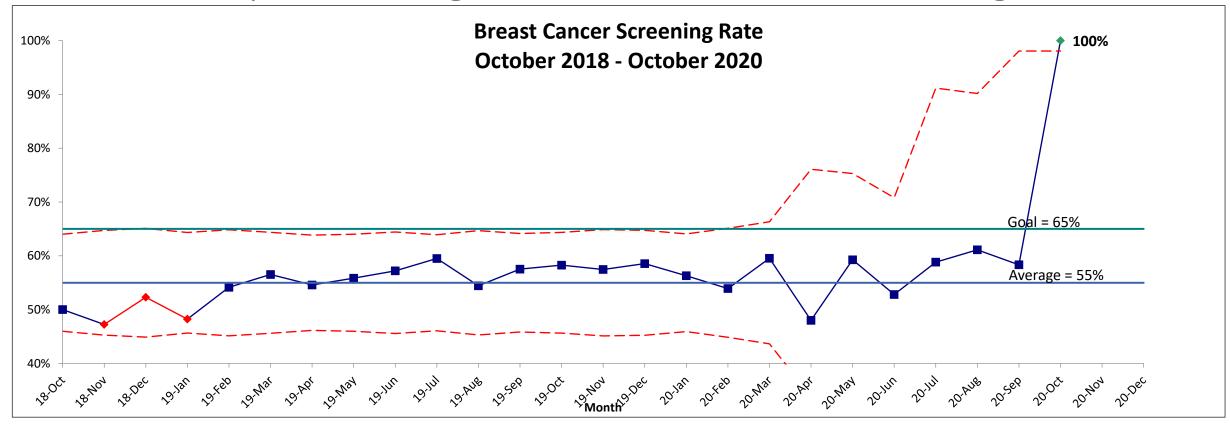
### **Depression Remission**

**Depression Treatment Goal:** By December 2020, 10% of adults diagnosed with major depression or dysthymia who scored positively on an initial PHQ-9 (>9) will demonstrate remission at 6 months (PHQ <5)



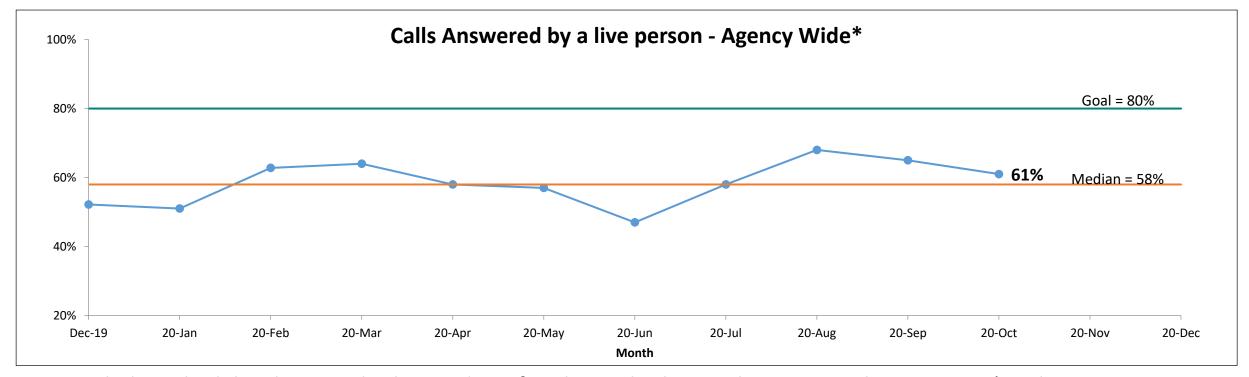
#### **Breast Cancer Screening**

Mammogram Completion Goal: By December 2020, 65% of women recommended to have a completed mammogram will have documentation of screening



#### **Phone System Access**

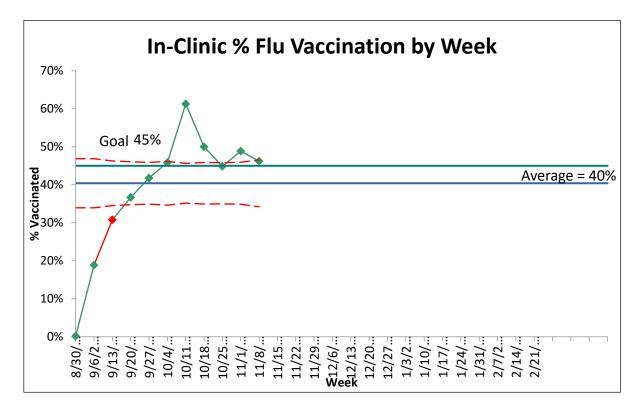
Client Phone Access Goals: By December 2020, 80% of calls will be answered by a human and 80% of voicemails will be returned within 1 business day.

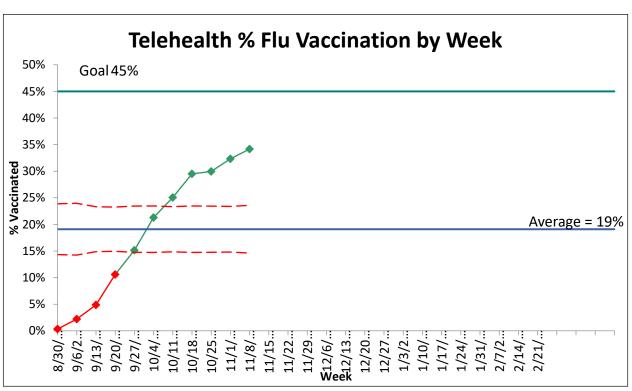


Data includes Scheduling line, Medical Records, Referrals, Medical Triage line, West Baltimore Main\*, Baltimore County Main\*, & Fallsway Front Desk. Data excludes weekends



#### Flu Vaccine Rates\*



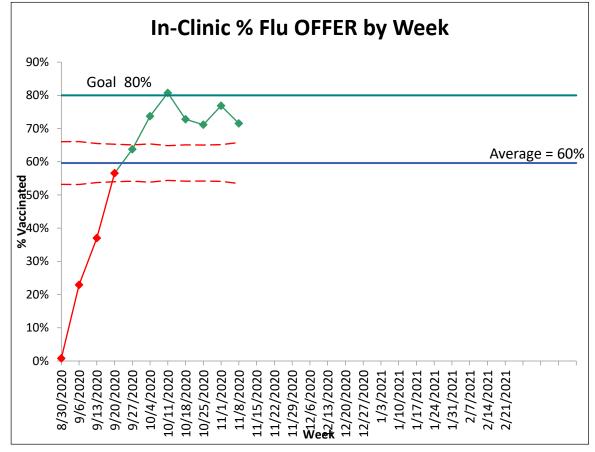


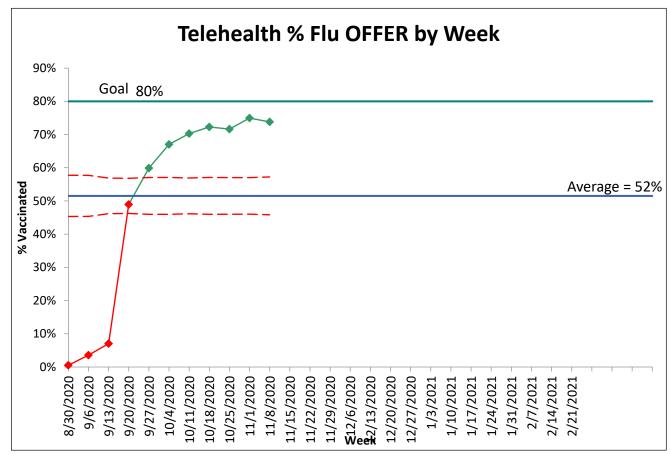
\*Includes anyone seen during a particular week who was vaccinated this flu season (in-house or outside)



#### Flu Vaccine Offer Rates\*

\*Anyone offered the flu vaccine at all this flu season (could be counted in both in-clinic and telehealth if the client had both appointment types)





### # Flu Vaccines Administered by Week

- The most vaccines were administered/documented the week of the coat drive!
- Total of 4,448 vaccines administered total this flu season thus far!

Week	# of Vaccines Administered
8/30/2020	3
9/6/2020	111
9/13/2020	231
9/20/2020	334
9/27/2020	413
10/4/2020	455
10/11/2020	680
10/18/2020	577
10/25/2020	552
11/1/2020	593
11/8/2020	499



### **Discussion**

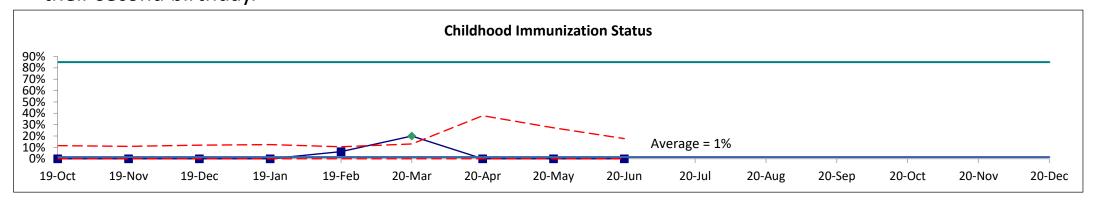
#### **2021** PI Plan: Behavioral Health Goals

**Depression Remission**: By December 2021, 10% of adults diagnosed with major depression or dysthymia who scored positively on an initial PHQ9 (>9) will demonstrate remission between 5-7 months (PHQ <5)

- **a. Follow-up Screening:** By December 2021, 2021, 85% of clients who score >9 on a PHQ9 will receive a follow-up screening within 5-7 months.
- **b. Remission:** By December 2021, 10% of adults diagnosed with major depression or dysthymia who scored positively on an initial PHQ9 (>9) will demonstrate remission between 5-7 months (PHQ <5)

#### 2021 PI Plan: Population Health & SDOH Goals

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

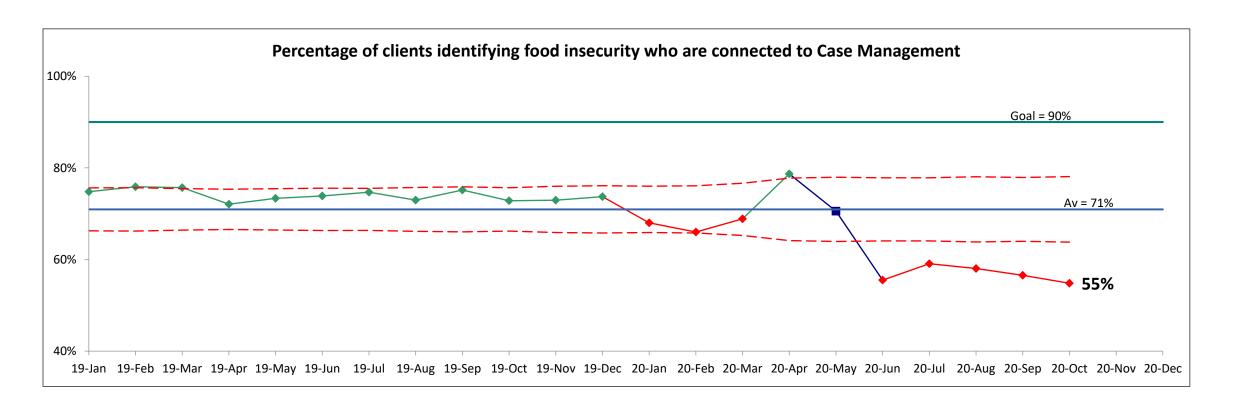


**Chronic Disease/Diabetes**: By December 2021, reduce disparities within racial and ethnic groups by 25% for clients with an A1C >9 or who were not tested in the measurement period compared to the Agency average.

- a. By December 2021, reduce the number of clients across the Agency who have an A1C >9 or who were not tested to 25%
- b. By December 2021, 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

### **2021** PI Plan: Population Health & SDOH Goals

**Social Determinants**: By December 2021, 90% of clients who answer yes to experiencing food insecurity <u>OR</u> transportation challenges on the PRAPARE tool will be connected to Case Management or Community Health Workers.



#### 2021 PI Plan: Patient Safety and Quality Goal

**Referral Tracking**: By December 2021, 40% of referrals will be completed within 3 months of referral initiation.

#### **2021** Pl Plan: Clinical Operations Goal

**Phone Access:** By December 2021, the Agency will reduce disparities across departments and for clients with limited English proficiency to achieve an answer rate of 85%.

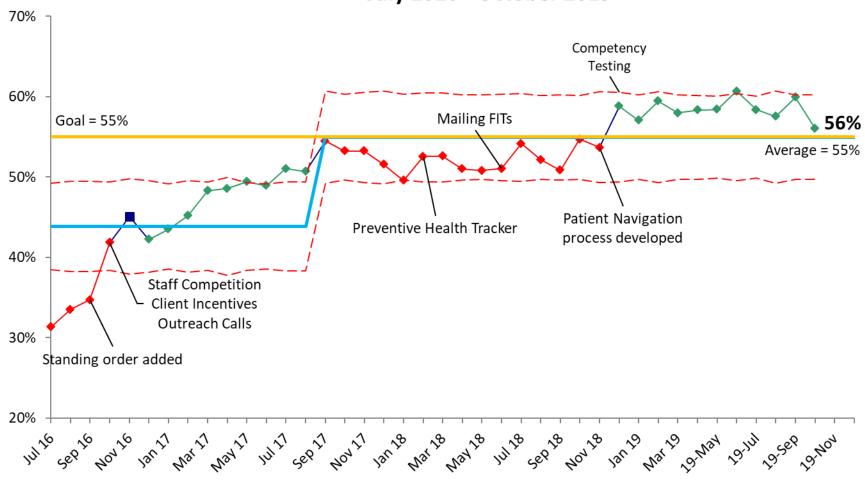
## Population Health Updates November 2020

Cancer screenings

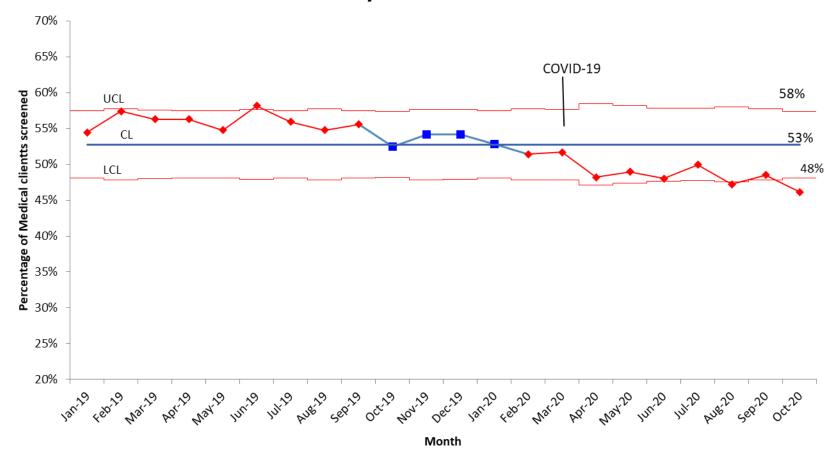
**Diabetes** 

**DME** 

# HCH Colorectal Cancer Screening Rate July 2016 - October 2019



#### HCH Colorectal Cancer Screening Rates January 2019 - October 2020





## FIT mailings!

• The best test is the one that gets done!



#### **Diabetes**

- CMAs have re-started A1C Calls to clients past due
- Steel Team continuing to pilot discussion of clients with uncontrolled diabetes
  - Initially started out discussing clients out of care not effective use of care team time since discussion centered around CHW work
  - Now discussing clients engaged in care difficult due to lack of team alignment
  - Other ideas to promote good care team discussion and better client care?



### **Food insecurity**

- Large food donation from Calvert Hall College Campus Ministries yesterday!
- Workgroup to come up with a proposal for in-house food pantry
- Space group figuring out if we have space for things like food storage
- We have funds from a donor that could be used to stock a food pantry

### **Durable Medical Equipment (DME)**

- Pilot with home BP cuffs and scales went well!
- Criteria for client engagement with medical team members was achieved
- Given out all 25 BP cuffs and most of scales
- Placing a bulk order of more supplies soon