Performance Improvement Committee

September 16, 2020

HEALTH CARE for the HOMELESS

September PI Committee Agenda

Monthly Dashboard

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

Improvement Updates – Progress and Challenges

- Flu Campaign 2020

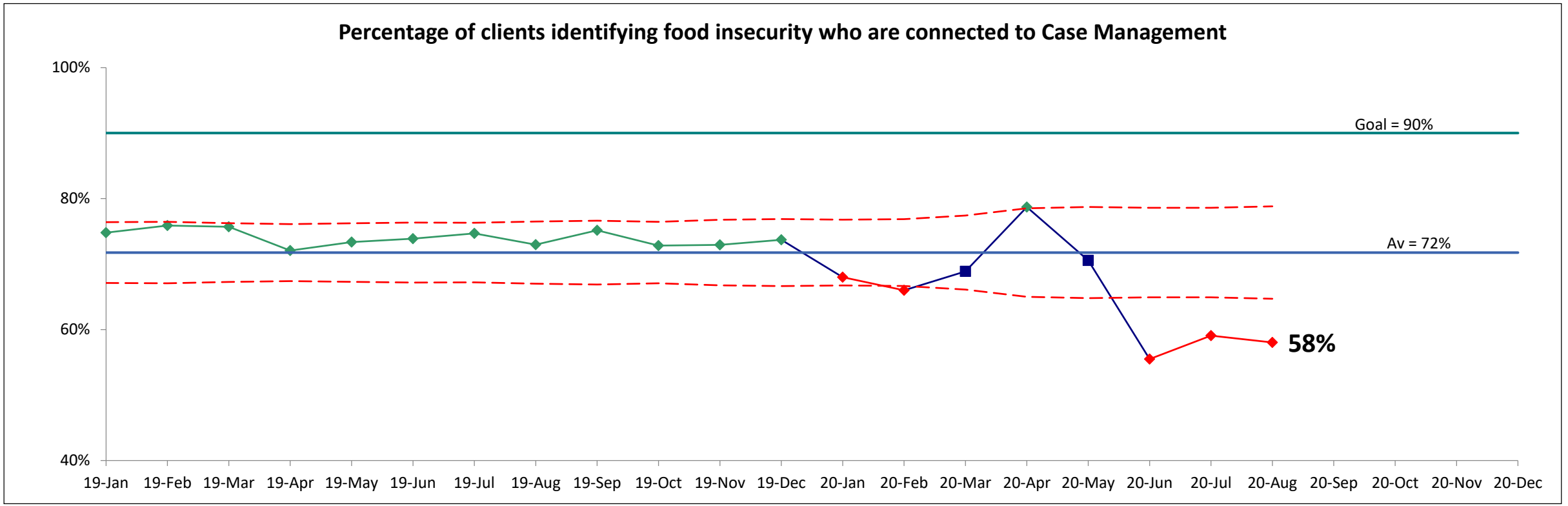
Population Health Updates

- Cancer Screenings
- Pre-Diabetes

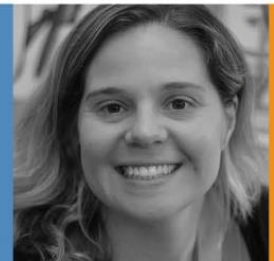
Monthly PI Dashboard

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*

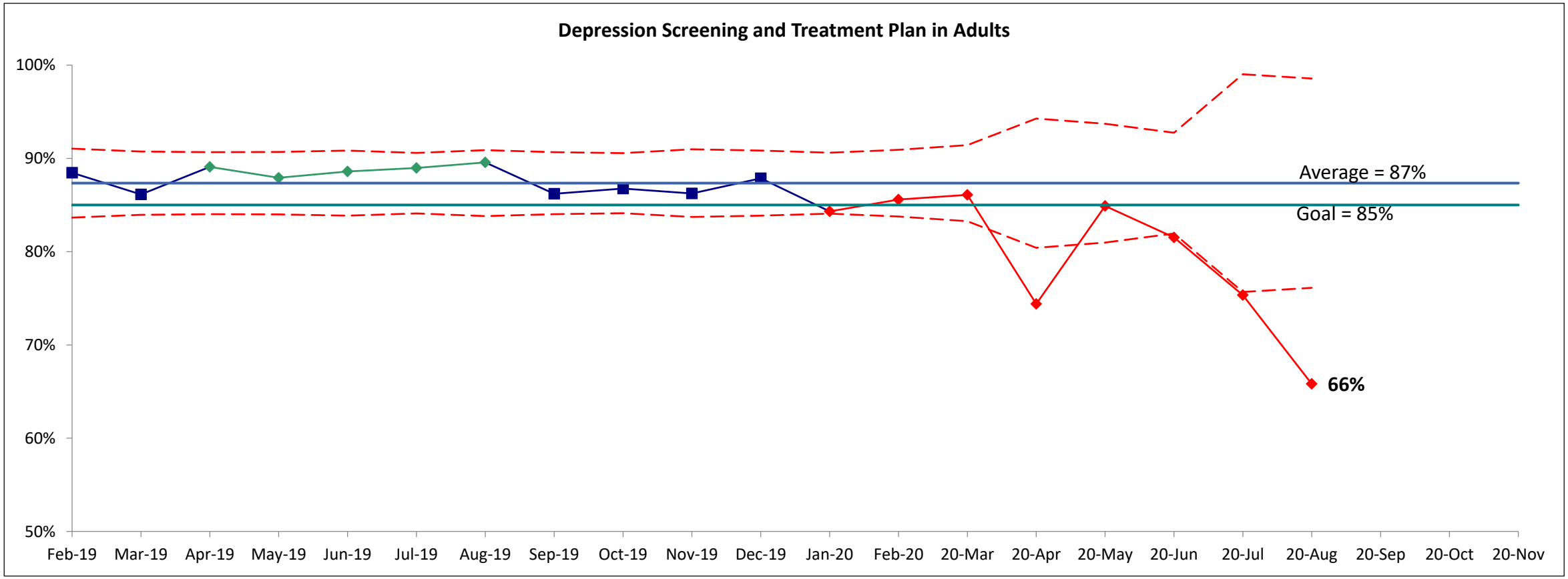


*Includes Community Health Workers



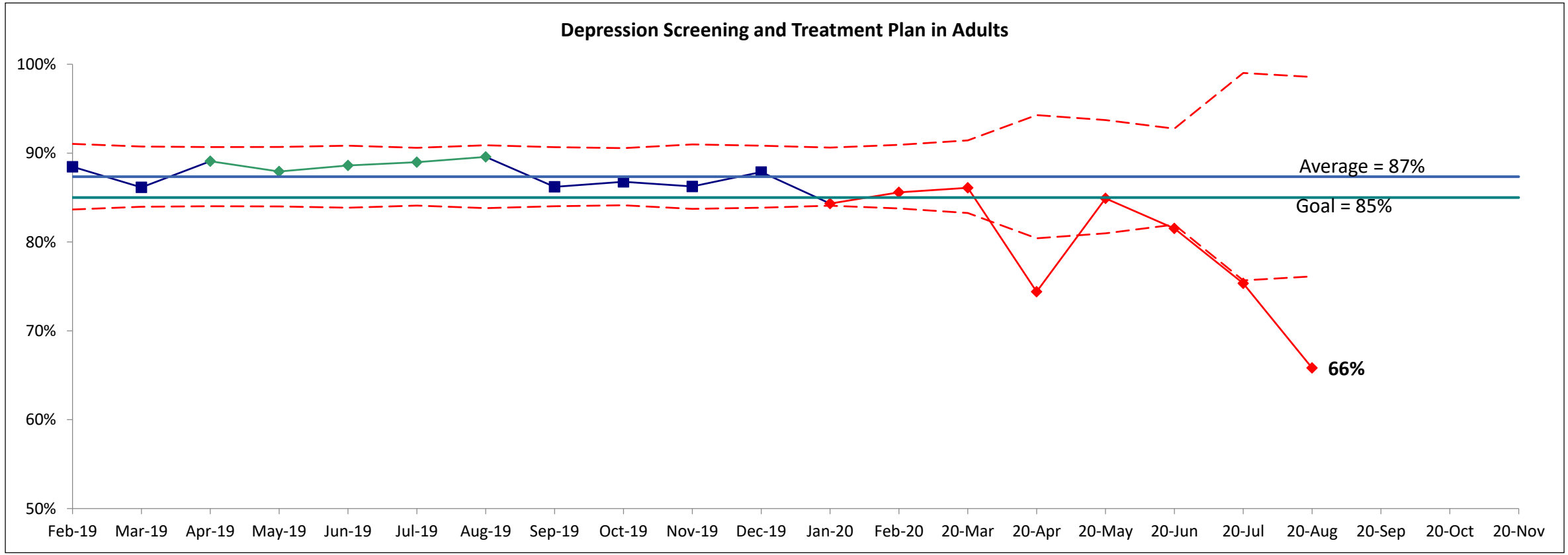
Depression Screening and Treatment - Adults

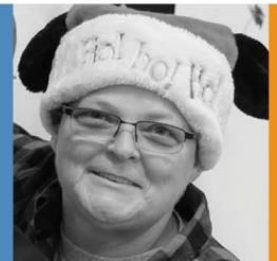
Depression Screening Goal: By August 2020, 85% of clients over 18 years of age will be screened for depression using a validated tool.



Depression Screening and Remission - Adolescents

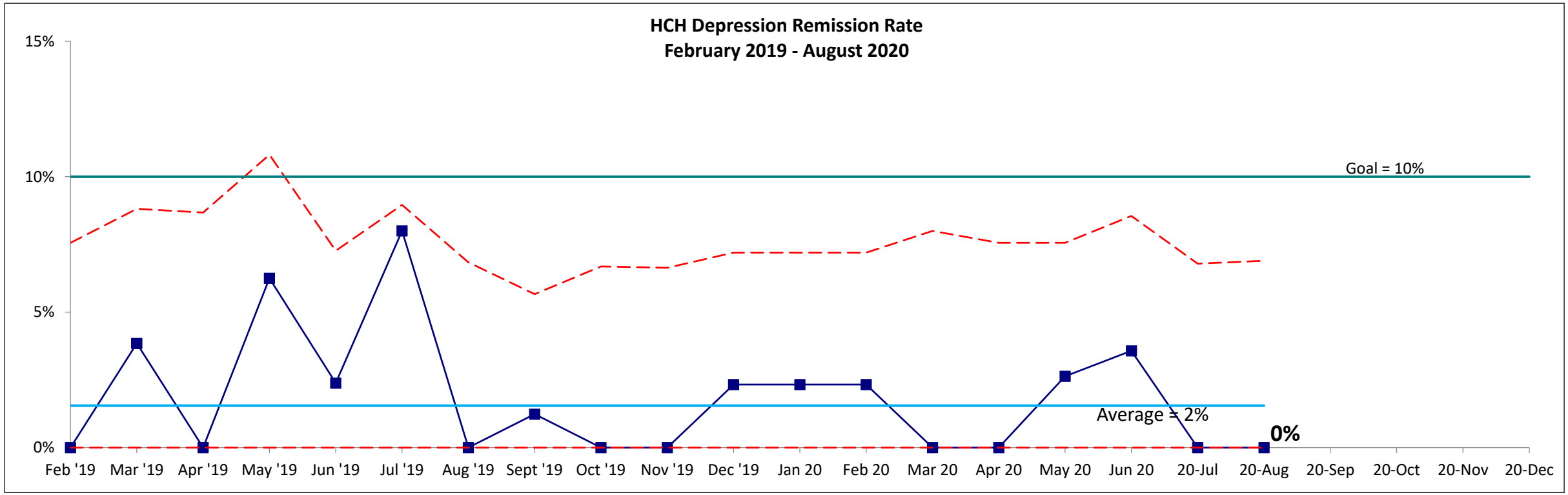
Depression Screening Goal: By August 2020, 85% of clients ages 12-17 will be screened for depression using a validated tool.





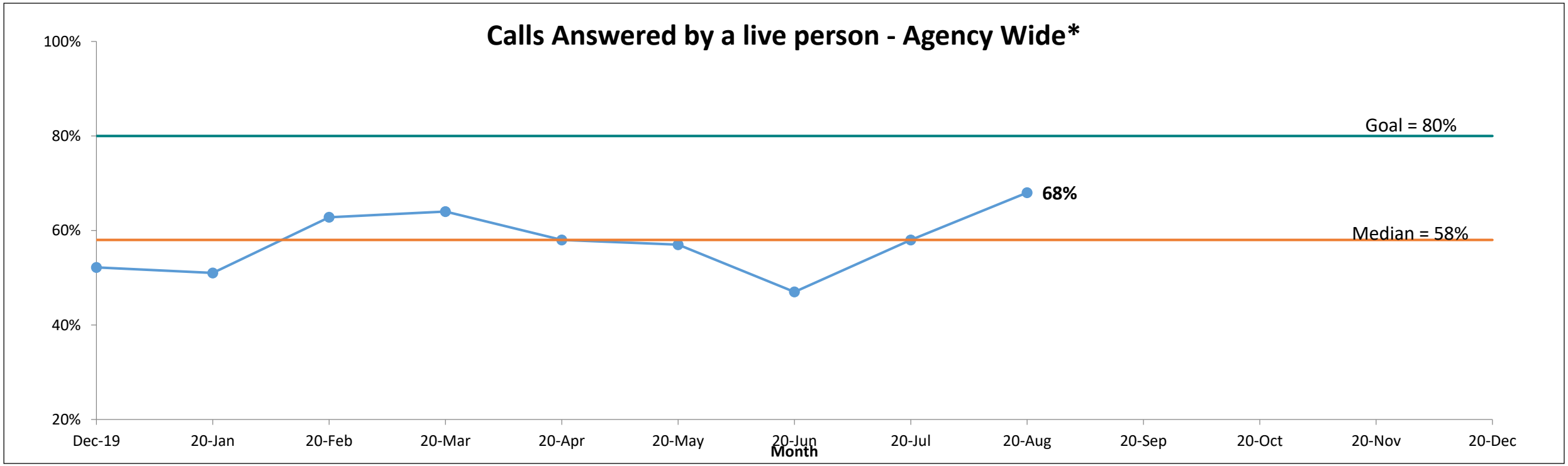
Depression Remission

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)



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

PI Project Updates

Flu Campaign 2020

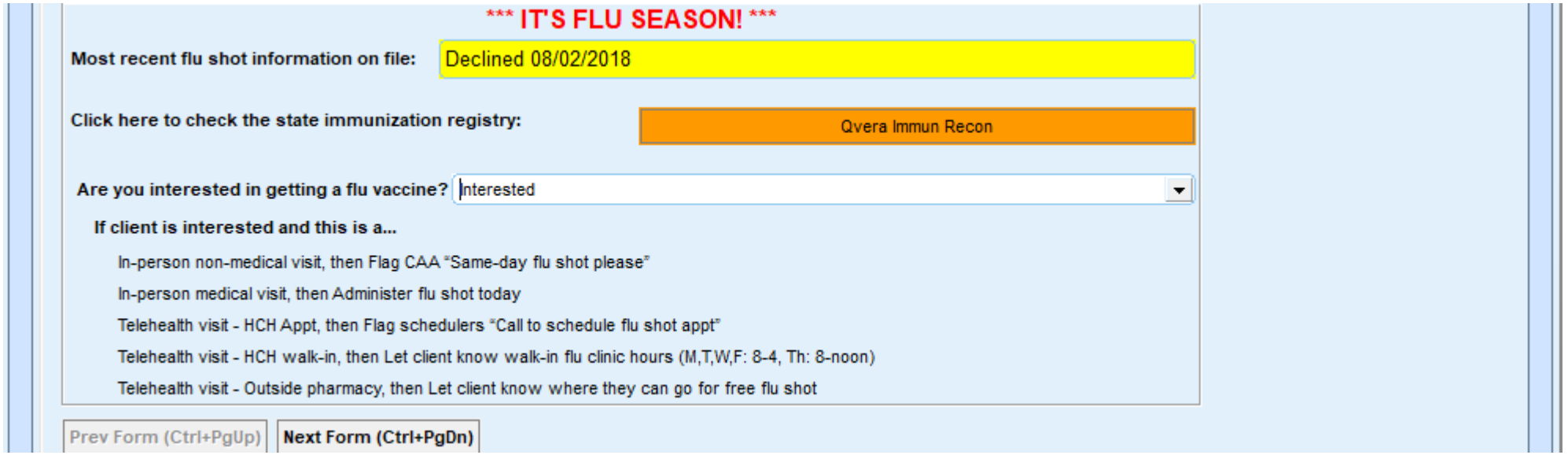
Trainings to go out on Healthcare Source this week

- Trainings specific to different departmental workflows will need to be completed in 1 week

EMR Changes

- Encounter form changes
- Drop down options and guides to accommodate our varying workflows
- Detailed data tracking for each type of visit and their vaccination rates

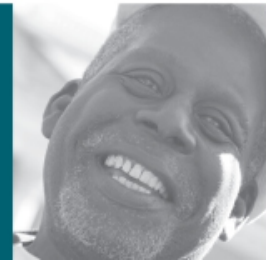
- 2020-2021 Goal = 45% → Our 2019-2020 baseline = 37%



Discussion

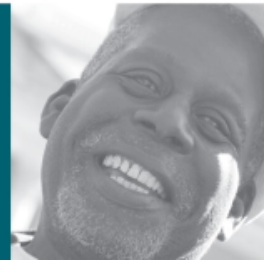
2021 PI Plan

- 2020 PI Goals affected by COVID-19:
  - Mammogram completion
  - Medication Errors
  - Medication Adherence
  - Joy in Work



2021 PI Plan

- Opportunities for improvement in 2021:
  - Cardiovascular disease prevention and tx (83%)
  - Depression screening (76%)
  - Depression Remission (2%)
  - Childhood Vaccination (13.9%)
  - Food insecurity screening and connection (72%)
  - Transportation access (N/A)
  - Provider communication (79%)
  - Referral completions (7%)
  - Phone access (78%)



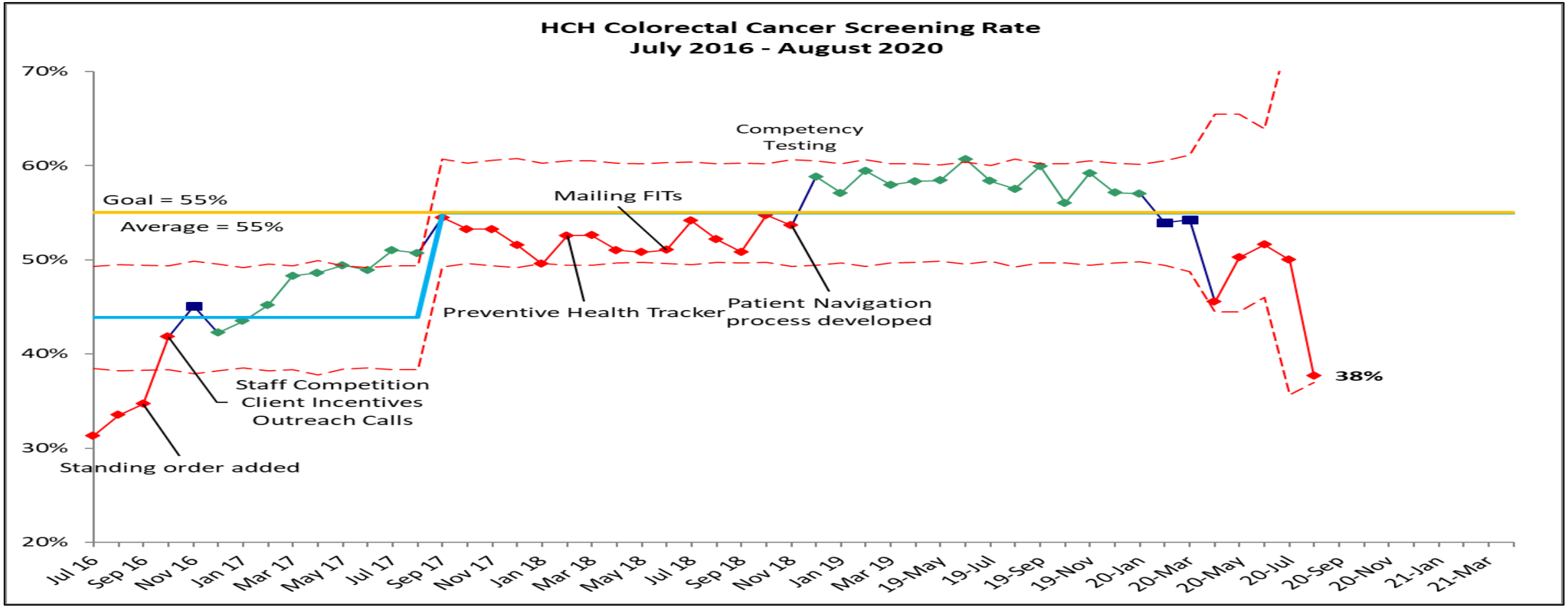
Population Health Updates

September 2020

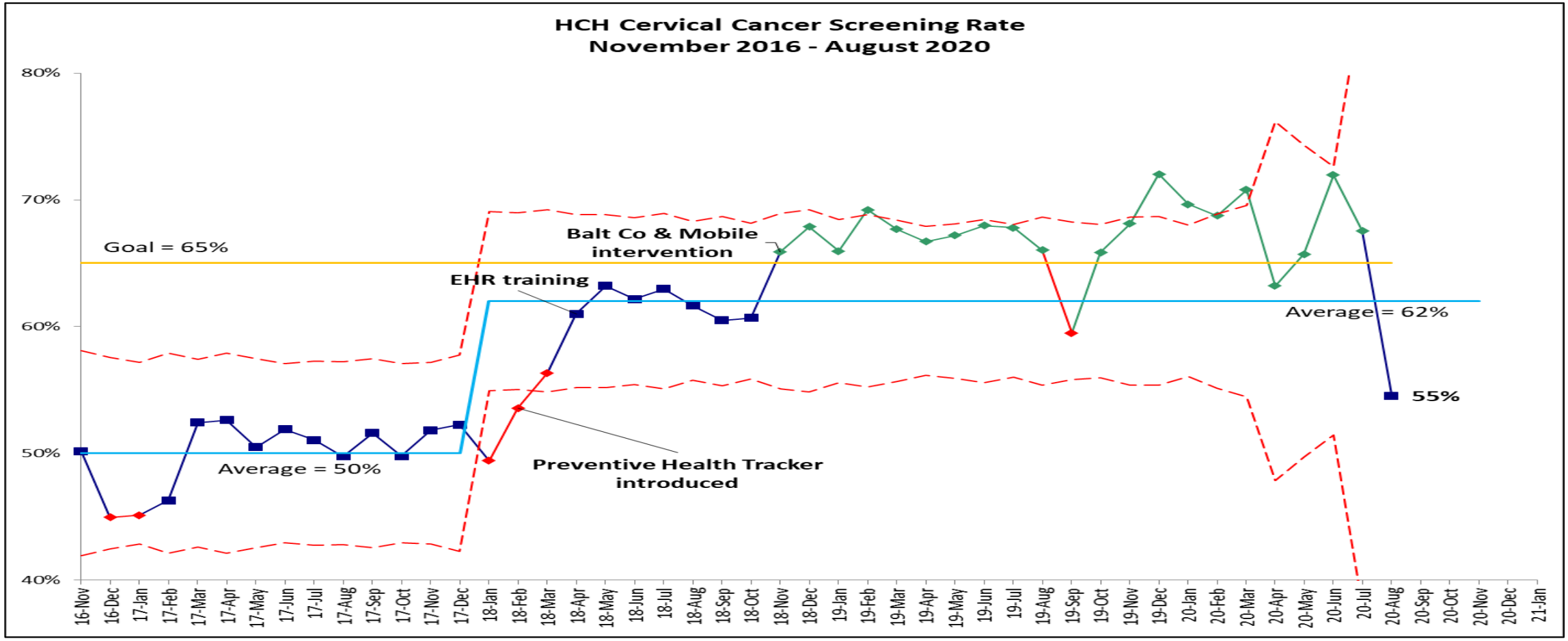
Cancer Screenings

- **Colorectal cancer screenings**: Called and mailed out FIT kits. This effort is continuing during telehealth visits but need to remind/reinforce with medical team members.
- **Cervical Cancer Screenings**: Our ability to tackle this is somewhat limited and inconsistent across providers during COVID.
- **Breast Cancer Screenings**: We almost completed a breast cancer screening campaign, placing orders for clients who are past due and contacting clients via phone/mailings.

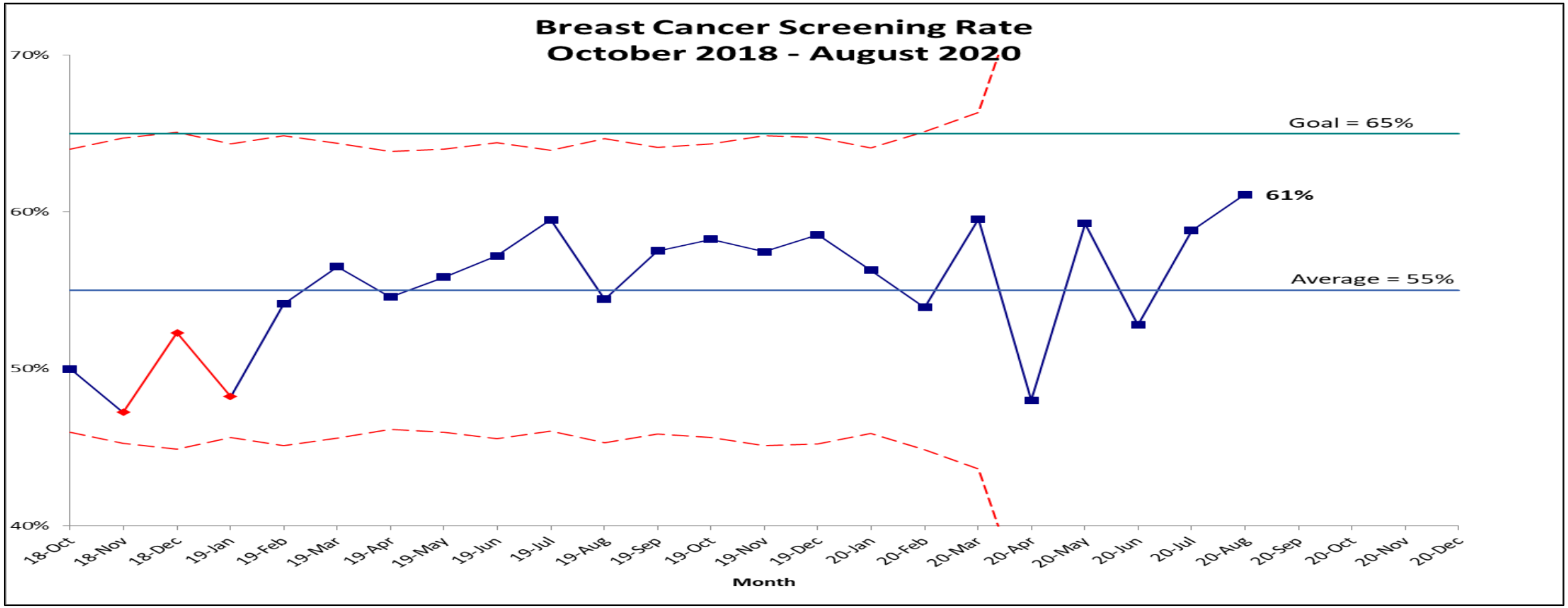
Colorectal Cancer Screening Rates



Cervical Cancer Screening Rates



Breast Cancer Screenings

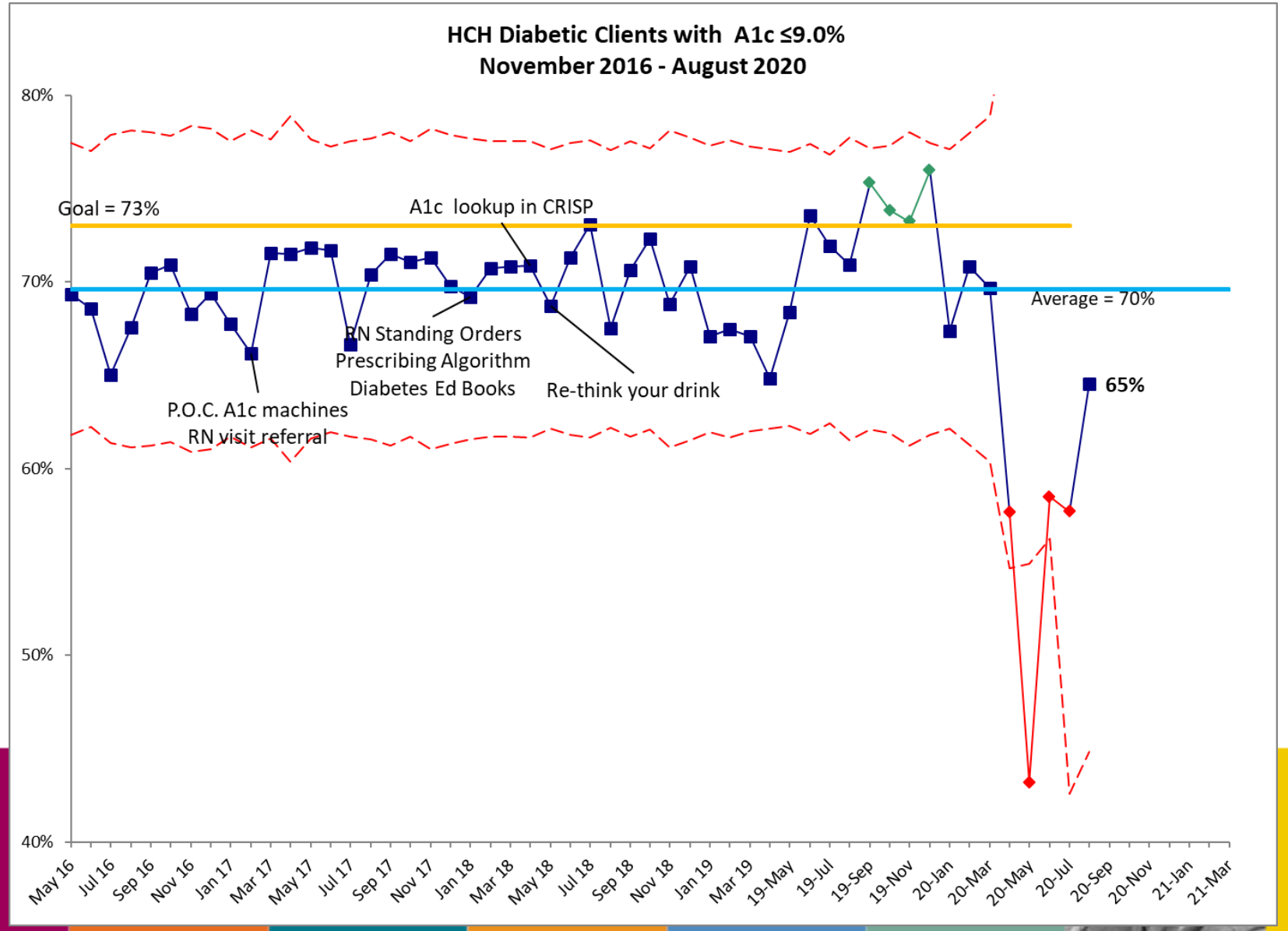


Follow-up to Abnormal Cancer Screenings

Webex call with Practice Mgr. and Sr. Director of Operations at the Institute of Gynecologic Care at MMC (Julia Morrison & Dawn Bullins)

- Promising!
- They will review registry of high-risk clients (#20) who have had referrals sent to MMC and get back to us
- IGC will allow appointments to be scheduled in real time with CM + client, which should improve access to these services
- They designated a point person (Fiama Romero) for us to contact to coordinate care and requested our referrals contact info
- 2 month f/u call scheduled

Diabetes


HCH Diabetic Clients with A1c ≤9.0%
November 2016 - August 2020
80%
70%
60%
50%
40%
Goal = 73%
A1c lookup in CRISP
Average = 70%
RN Standing Orders
Prescribing Algorithm
Diabetes Ed Books
Re-think your drink
P.O.C. A1c machines
RN visit referral
65%
May 16
Jul 16
Sep 16
Nov 16
Jan 17
Mar 17
May 17
Jul 17
Sep 17
Nov 17
Jan 18
Mar 18
May 18
Jul 18
Sep 18
Nov 18
Jan 19
Mar 19
19-May
19-Jul
19-Sep
19-Nov
20-Jan
20-Mar
20-May
20-Jul
20-Sep
20-Nov
21-Jan
21-Mar

Diabetes (uncontrolled and untested)

- Bring care team lists to care team facilitators and propose a pilot with one care team
- Work with the care team to re-engage clients in need of A1C testing (+ other labs), PCP visit and other care team members as needed (RN, BH, CM, CHW, etc.)
- Ultimately see this registry used with ALL care teams on a rotating basis

The Prediabetes Project

- MI training with Kim Riopelle completed, positive feedback
- 1 staff member + 1 student intern working to move this project forward
- 3 helpful resources listed across all disciplines:
  - Easy, healthy recipes
  - Affordable, healthy grocery List
  - Healthy snacks (7-eleven, Dunkin' Donuts, etc.)
- Next Steps:
  1. Create the 3 resources above (tying the first two resources together) to make available to everyone.
  2. Send to the champions for feedback + edits.
  3. Work with champions on more department-specific resources

Other projects

- Health Ed Ringlets (Diabetes, Chronic Diseases, Infectious Diseases, Nutrition/Wellness)
  - Should have gotten to all Directors at 421
  - Will go up in exam rooms shortly
- DME: Pilot using home blood pressure cuffs (25) and scales (10) as a way to manage chronic diseases during COVID
- Hep C:
  - Nurse training to submit Hep C Prior Auths went well
  - Tyler Gray shared that in NY, PAs for Hep C tx no longer required!
  - Julia Felton, HIV/Hep C Advocate, is back in clinic in the AMs

Questions or Comments?

Next Meeting:
Wednesday, October 21st

HEALTH CARE for the HOMELESS