January PI Monthly Meeting

2024 Recap

1/15/2025

HEALTH CARE for the HOMELESS

Agenda

1. Icebreaker
2. Clinical Quality Measure Data
3. 2024 Performance Improvement (PI) Plan recap
4. 2025 PI Plan – Q1 roll out

Icebreaker

What is your favorite style of French Fries?






CQM

Trailing Year

Maternal and Child Health	Nov	Dec	2024 Goal
Dental Sealants (ages 6-9 Years)	81%	81%	95%
Low Birthweight	7%	6%	<5%
Wt assessment & counseling for nutrition & PA (Peds)	78%	78%	83%

Disease Management	Nov	Dec	2024 Goal
IVD: Use of Aspirin/Other Antiplatelet	88%	88%	87% ★
Statin Therapy for Prevention/Treatment of CVD	86%	86%	88%
Depression Remission at Twelve Months	5%	5%	9%

Trailing Year Data

Key
3+ Improvement
1-2+ improvement
Reduction

★ Met goal

CQM

Trailing Year

★ Met goal

Key
3+ Improvement
1-2+ improvement
Reduction

Screening and Preventive Care Measures	Nov	Dec	2024 Goal
Height and Weight Assessment and Health Counseling	44%	44%	50%
Breast Cancer Screening	42%	41%	47%
Cervical Cancer screening	52%	51%	59%
Colorectal Cancer Screening	33%	33%	40%
Depression Screening and Follow-Up Plan	51%	52%	52% ★
HIV Screening	74%	74%	80%
Tobacco use: screening and cessation intervention	72%	72%	75%

Chronic Disease Management	Nov	Dec	2024 Goal
Controlling high blood pressure	61%	62%	66%
Diabetes: HbA1c poor control (>9%) [inverse]	33%	32%	27%

CQM

Trailing Year

Key
3+ Improvement
1-2+ improvement
Reduction

Additional HCH Priorities	Nov	Dec	2024 Goal
Lab Notifications	63%	62%	60% ★
Referral Tracking (% complete)	26%	35%	40%
SDH Ask Rate	35%	29%	70%
FLU: adult vaccination rates	Offer Rate: 58% Admin Rate: 48%	Offer Rate: 57% Admin Rate: 48%	Admin: 40% ★
Suicide assessment follow-up	33%	34%	85%
Prescribing antibiotics for URI and acute bronchitis	99%	-	100%
Hospitalization Follow Up	59%	59%	65%

Summary

PI Goals/Plan End of Year & Sustainability Plans

- **We IMPROVED our performance (from 2023) on 70% (7/10) of our goals**!
  - This includes Colorectal Cancer Screening, Hypertension Disparities, Clients Receiving PrEP, Early Entry into Prenatal Care, Appointment Access, Hospital Readmission, and Closing the Referral Loop
- We MET 30% (3/10) of our goals. This includes hospital re-admission, PrEP, and appointment access

2024: What went well?

1. Staff engagement
2. Subcommittee structure for many goals
3. Integrated client voice into PI goal work
4. Time-limited groups were appropriate for some measures
5. Focus on disparity-specific goals
6. Leadership buy-in

2024: What we learned?

1. Ten is too many goals
2. Time continues to be a challenge when engaging clinical staff
3. Balancing team selecting PDSA with high yield change initiatives
4. Finding the right balance of meeting time, individual approaches
5. Standardized measures are key

PI Measures

Trailing Year Data

Disease Management	November	December	2024 Goal
Colorectal Cancer Screening	33%	33%	40%
Hypertension Disparities	Black M: 60% **Black F: 52%** **White M: 64%** White F: 69% **Latino M: 68%** Latina F: 66%	Black M: 60% Black F: 55% White M: 66% White F: 66% Latino M: 69% Latina F: 69%	<5% disparity among Black, White, and Hispanic/ Latino/a women and men
Childhood Vaccinations	5% YTD	4% YTD	18%
PHQ-9 Questions 1 and 6	3.40%	3.07%	10%
Diabetes and A1c Control (inverse measure)	Agency: 33% H/L: 36%	Agency: 32% H/L: 36%	27% (Hispanic/Latinx clients → 31%)

Key
3+ Improvement
1-2+ improvement
Reduction
Met goal!

Colorectal Cancer Screening

Measure: Increase the percentage of clients who have received colorectal cancer screening to 40%.

Goal: 40%

Baseline: 30%

Current: 33%

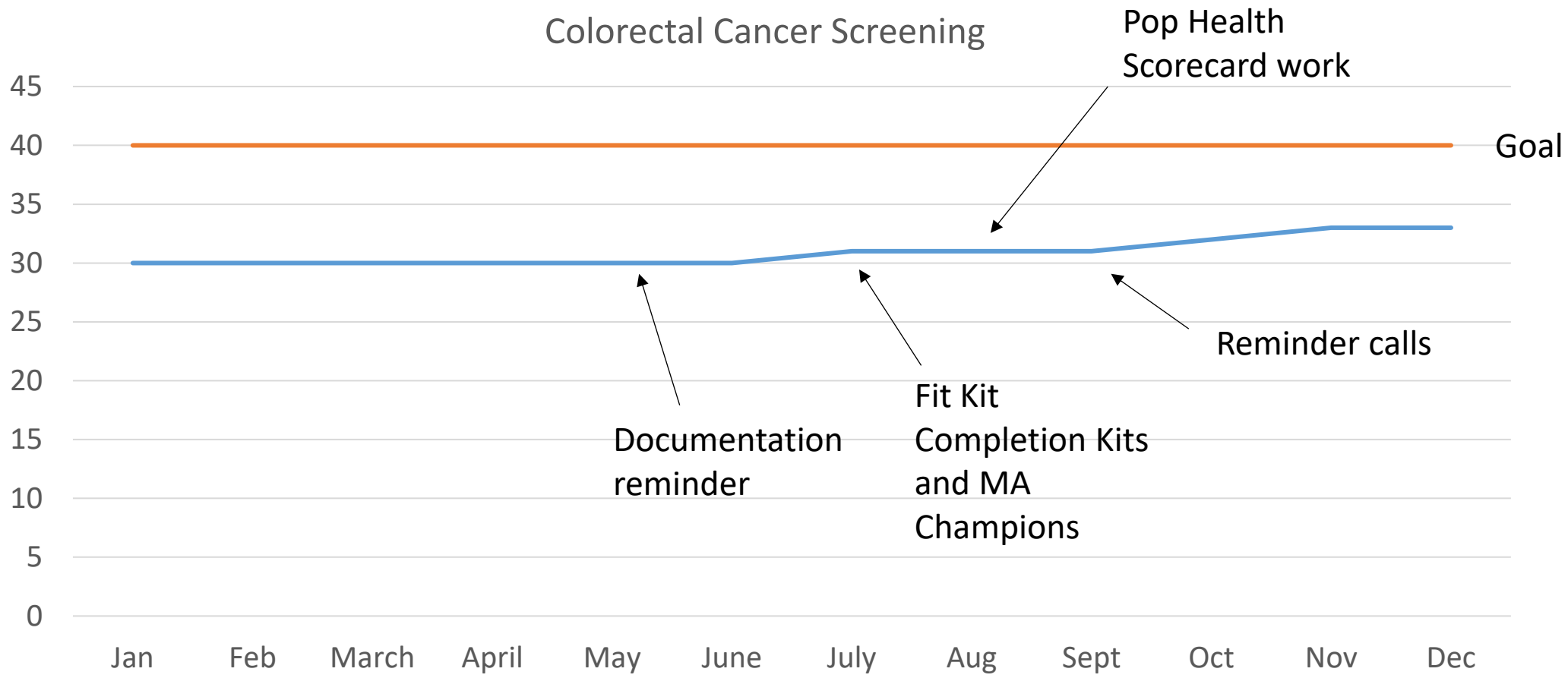
Tests of Change:

1. Documentation Reminder
2. Visual Aid Fit Kit Completion Kits and MA champions
3. Follow up reminder calls

Sustainability:

1. Improved documentation
2. Kits scaled up
3. Pivoted to reminder letters

Colorectal Cancer Screening



Hypertension Disparity

Measure: Reduce the disparity in hypertension control rates (less than 140/90 mmHg) among Black, White, and Hispanic/Latino/a women and men by 5%.

Goal: B/AA F: 61%; White F: 61%; H/L F: 65%

Current: B/AA F: 55%; White F: 66%; H/L F: 69%

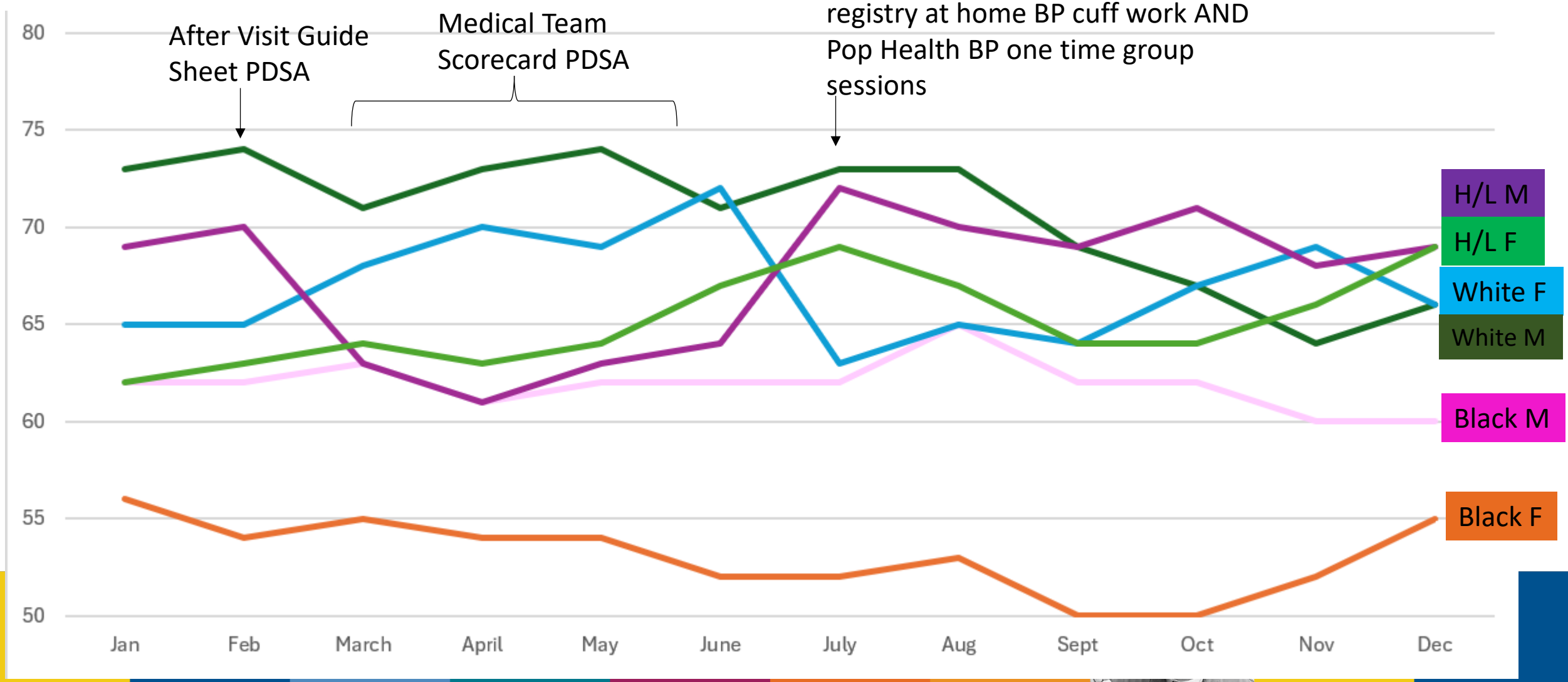
Tests of Change:

1. After Visit Guide Sheets
2. Scorecard Competition
3. BP at home cuffs for B/AA women

Sustainability:

1. After Visit Guide Sheets still in use – expanded to all clients
2. Staff improved focus on disparities in HTN control, some still using interventions including registry data
3. Challenged with maintenance, but promising practice

Hypertension Disparities Review



Childhood Vaccinations

Measure:

Ensure at least 18% of children have all combo 10 vaccinations by age 2

Goal: 18%

Baseline: 10%

Current: 4% YTD

Tests of Change:

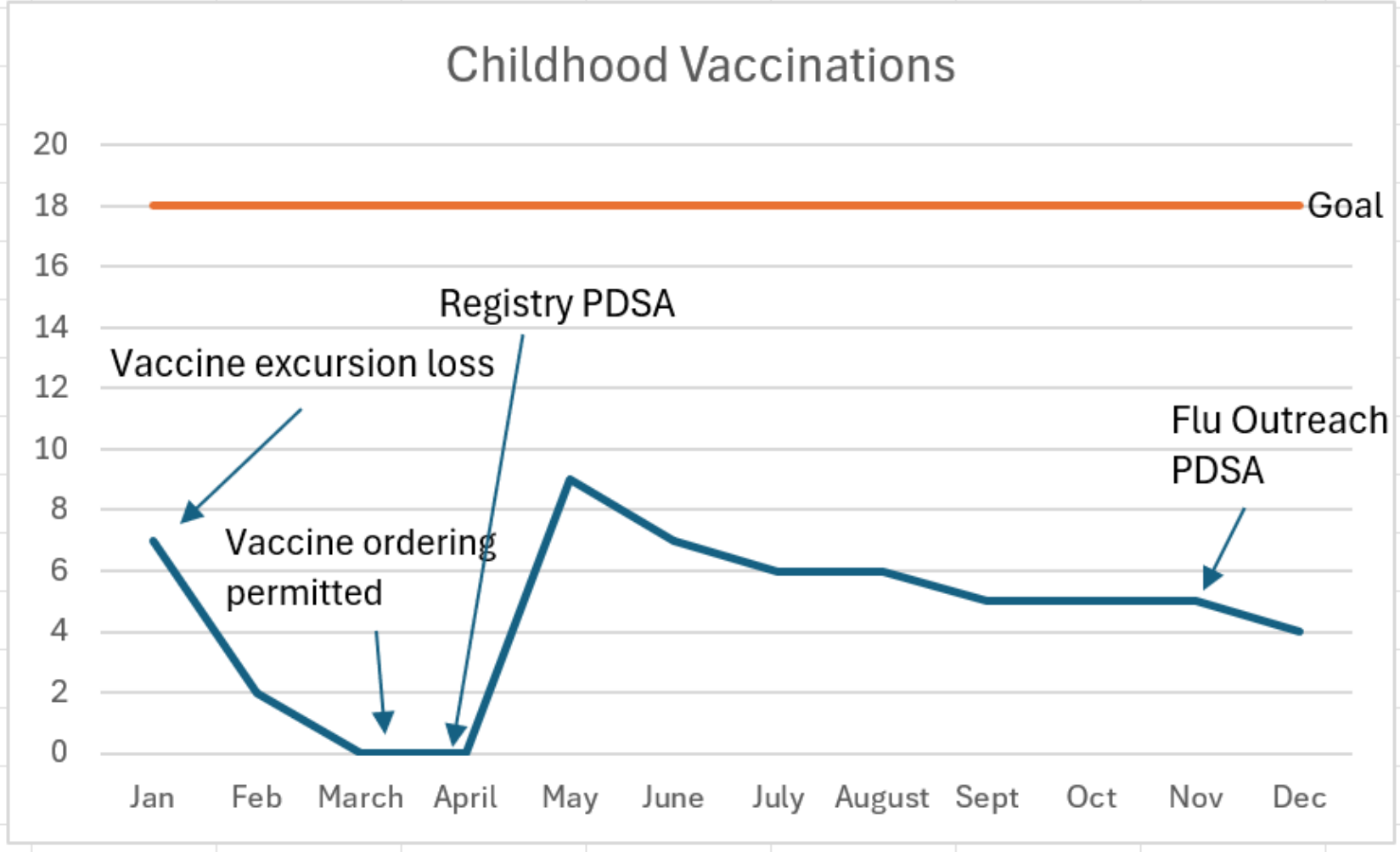
1. Azara registry chart flagging
2. Flu season registry outreach

**wrote letter to NCQA measure stewards about challenges with measure*

Sustainability:

1. Peds Team continuing to use Azara registry approaches to conduct outreach to 2 and under population

Childhood Vaccines Year Review



PHQ-9

Measure: for clients aged 12 and up, improve aggregate score by 5% on the PHQ-9 for Question 1: little interest or pleasure in doing things or Question 6: feeling like you are a failure or you have let yourself or family down.

Goal: 10%

Baseline: 5%

Current: 3.07%

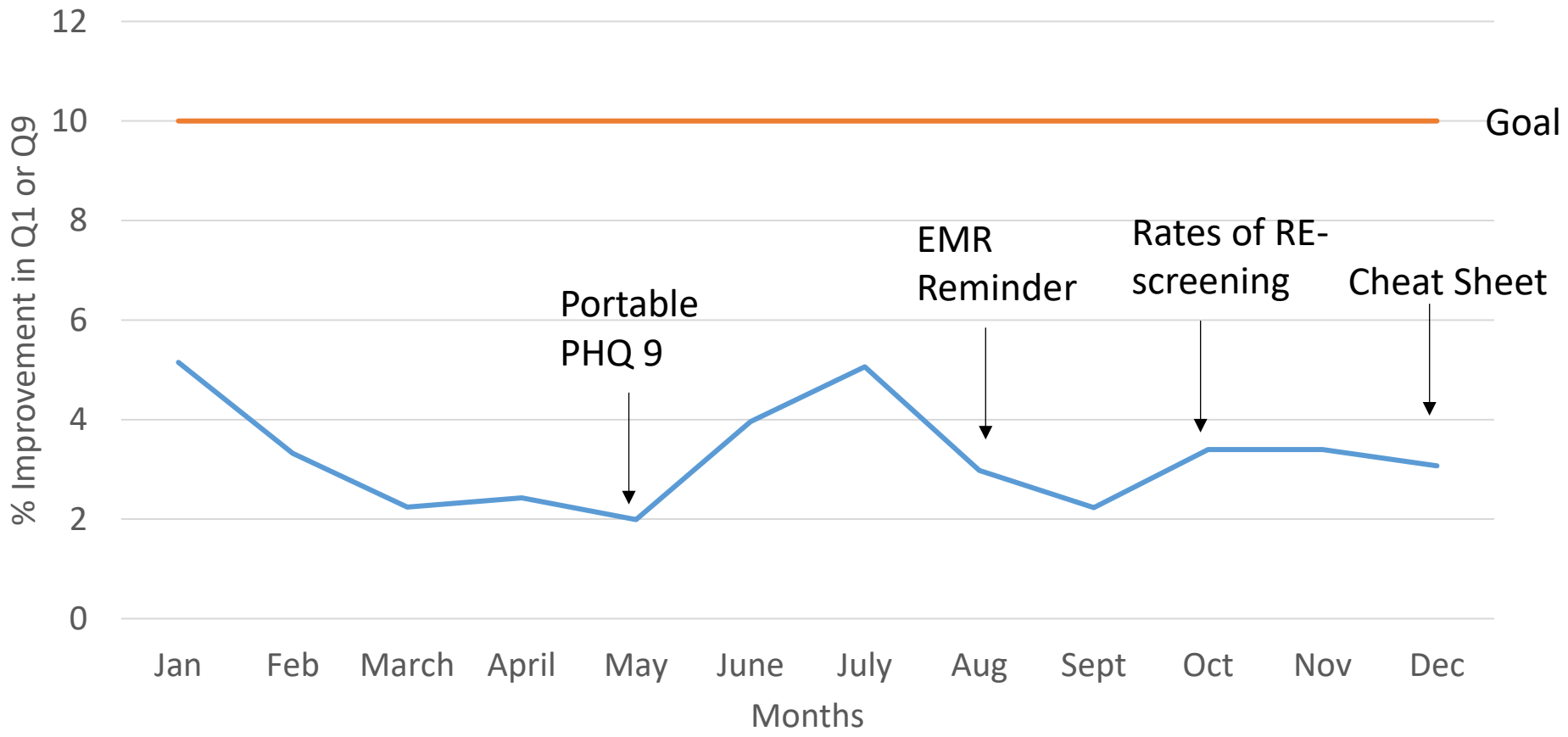
Tests of Change:

1. Portable PHQ9s
2. EMR reminders
3. Rates of re-screening per provider
4. Cheat Sheet

Sustainability:

1. Portable PHQ9s in use
2. Retired EMR reminders
3. Pivoted away from data sharing
4. Distributed recently!

PHQ9 Review


12
10
8
6
4
2
0
% Improvement in Q1 or Q9
Goal
Portable PHQ 9
EMR Reminder
Rates of RE-screening
Cheat Sheet
Jan
Feb
March
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Months


DIGNITY

Diabetes

Measure: Reduce the percent of clients aged 18–75 years with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent to 30% and reduce the racial/ethnic gap by 5% for Hispanic/Latino clients.

Goal: 27% (Agencywide);

31% (Hispanic/Latinx)

Baseline: 30%; 36% H/L

Current: 32%; 36% H/L

Tests of Change:

1. Provided registries to nurses managing Diabetes care for review of uncontrolled and untested in their care team panel

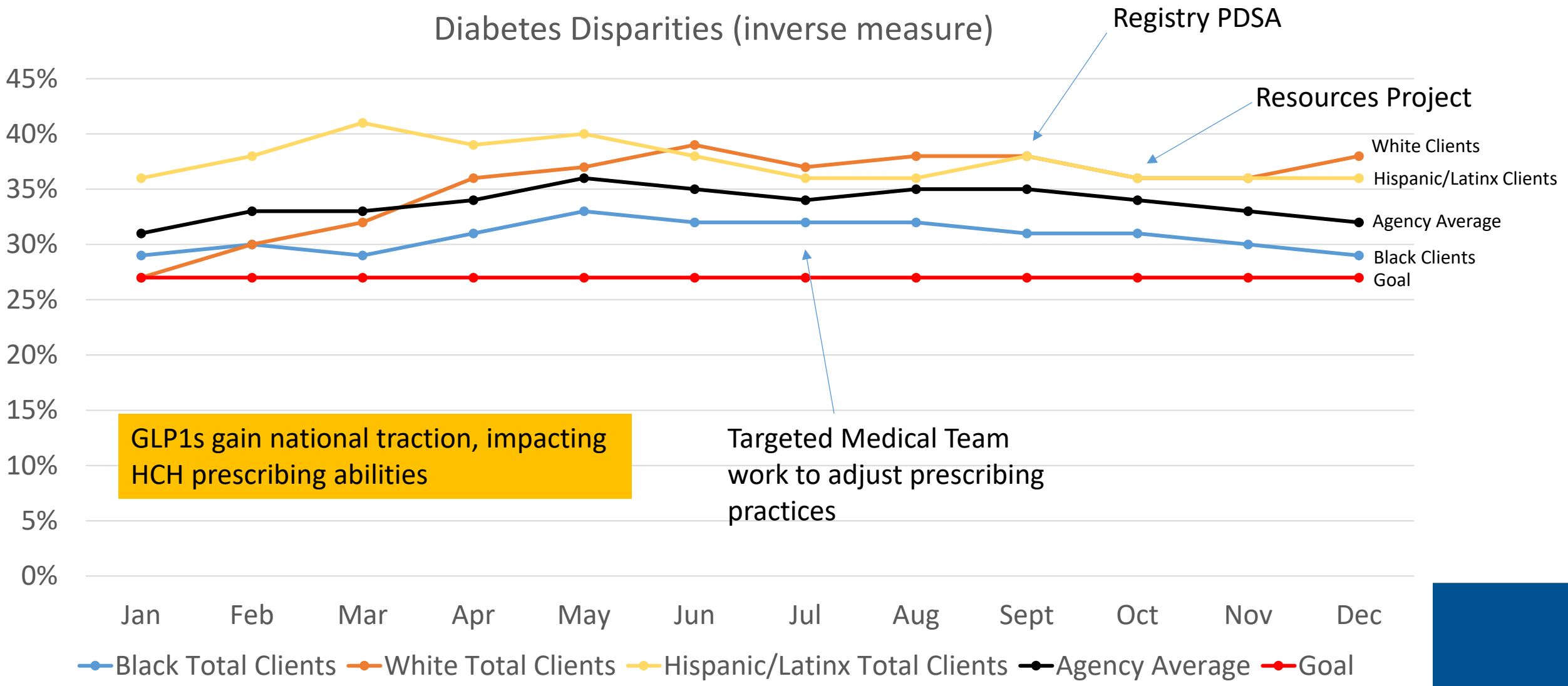
2. PrevMed Student Project: client and staff resources (disease information, medications, scheduling follow up based on control)

Sustainability:

Working to develop a streamlined system to send/access filtered registries in Azara

Student completing resource project

Diabetes Year Review



PI Measures (cont.)

Disease Management	November	December	2024 Goal
Clients receiving PrEP	37 clients	35 clients	36 clients ★
Early Entry into Prenatal Care	63%	62%	70%
Appointment Access		Retired question and rolled out new client experience survey!	Med Urgent: 71% Med Routine: 100% ★ BH Urgent: 80% BH Routine: 80% Dental Urgent: 71% Dental Routine: 100%
Hospital Readmission Rate	14%	14%	≤15% ★
Closing the Referral Loop	26%	35%	40%

Key
3+ Improvement
1-2+ improvement
Reduction
★ Met goal!

PrEP

Measure: Double the number of clients receiving PrEP

Goal: 36

Baseline: 18

Current: 35

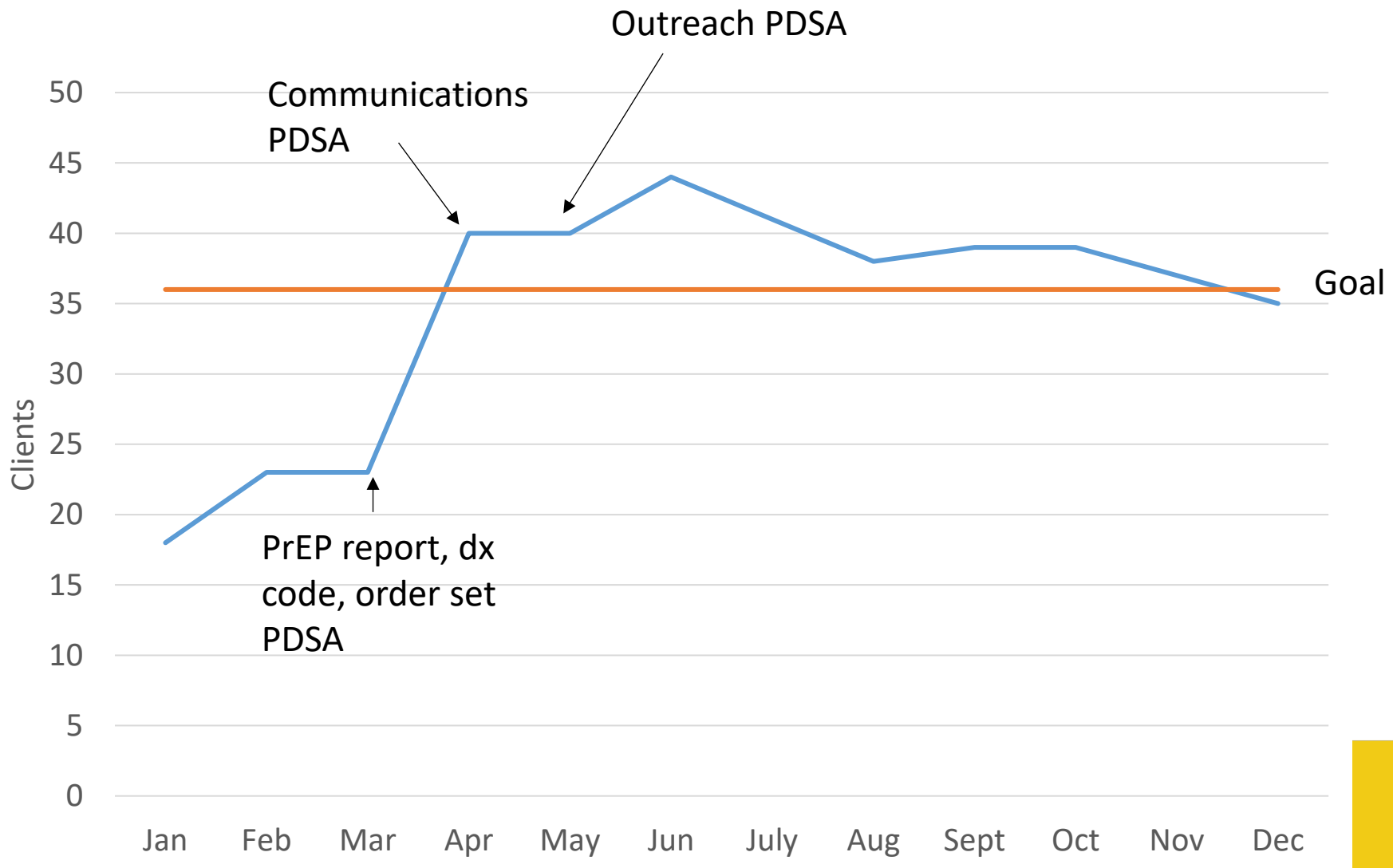
Tests of Change:

1. Data enhancements
2. Increased communications materials
3. Outreach workflow to clients without upcoming apt on PrEP

Sustainability:

1. Well developed report for provider use
2. Ongoing maintenance of simple client pamphlet on PrEP
3. Continued outreach workflow

PrEP Review


Outreach PDSA
Communications PDSA
50
45
40
35
30
25
20
15
10
5
0
Clients
Goal
PrEP report, dx code, order set PDSA
Jan
Feb
Mar
Apr
May
Jun
July
Aug
Sept
Oct
Nov
Dec

Early Entry into Prenatal Care

Measure: Ensure at least 70% of pregnant clients have access to and initiate care in the first trimester of pregnancy.

Goal: 70%

Baseline: 58%

Current: 62%

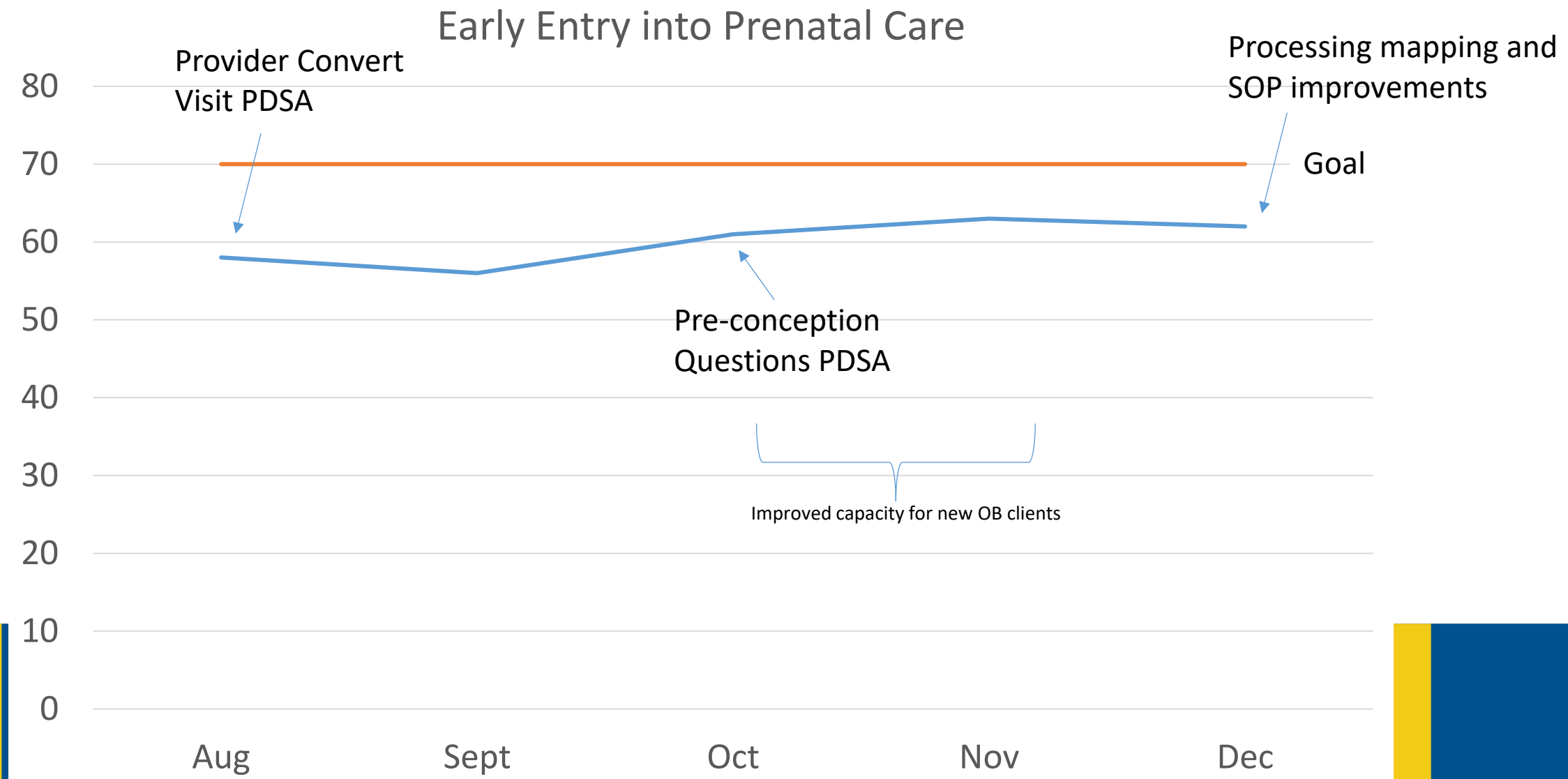
Tests of Change:

1. OB Provider Convert Visits
2. Pre-conception Questions in Postnatal visits
3. Process mapping and SOP improvements for OB entry into care process

Sustainability:

1. OB Convert Visits successful, but high demand for services did not allow for continued testing (return at later date)
2. Pre-conception questions moved to general practice
3. Wrapping up

Early Entry into Prenatal Care Review



Appointment Access

Measure: Improve department scores by 5% that clients reported an ability to access an urgent or routine appointment when needed.

Goal:

Med Urgent: 71%
Med Routine: 100%
BH Urgent: 80%
BH Routine: 80%
Dental Urgent: 71%
Dental Routine: 100%

Current: retired in Sept; met all but Med Routine (6% from goal)

Tests of Change:

1. Transportation Resource
2. Shout out boxes
3. Portal Information Session

Sustainability:

1. Transportation Resource part of Case Management resources
2. Shout out boxes still in pilot spaces, but retired
3. Low yield portal information session

Closing the Referral Loop

Measure: increase closing the loop (percentage of referrals marked as Completed, with receipt of the consult note from the specialist) to 40%.

Goal: 40%

Baseline: 26%

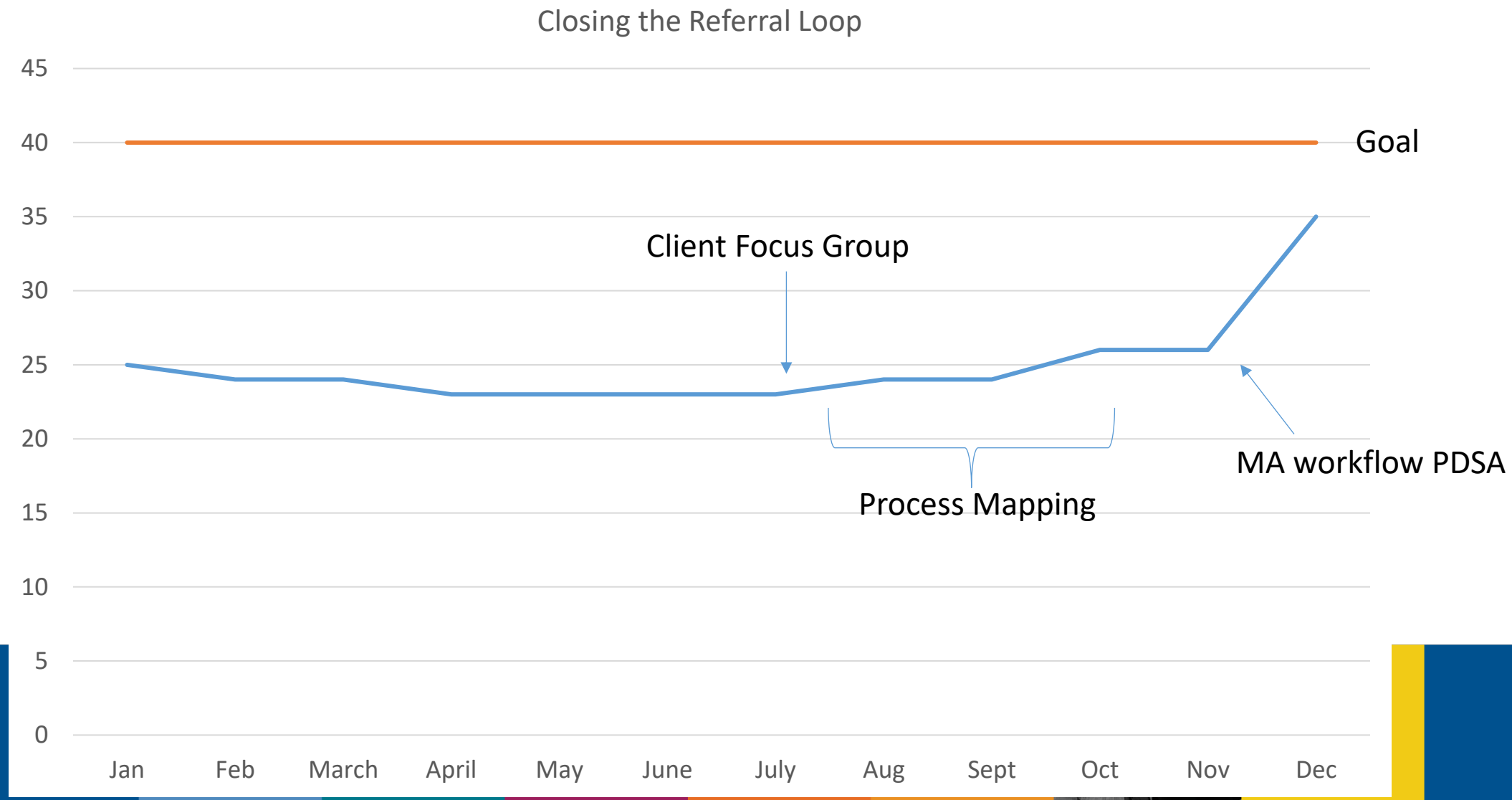
Current: 35%

Tests of Change:

1. Process mapping
2. New workflow for CMA follow up

Sustainability: Two MAs piloted the new workflow, seeing feasibility and success, this is moving to a Risk Management Goal to be rolled out the full MA team

Closing the Referral Loop Review



Care Coordination: Hospital Readmission

Measure: Reduce medical hospital readmission rate (hospitalized within 30 days of discharge) to 15%.

Goal: 15%

Baseline: 20%

Current: 14%

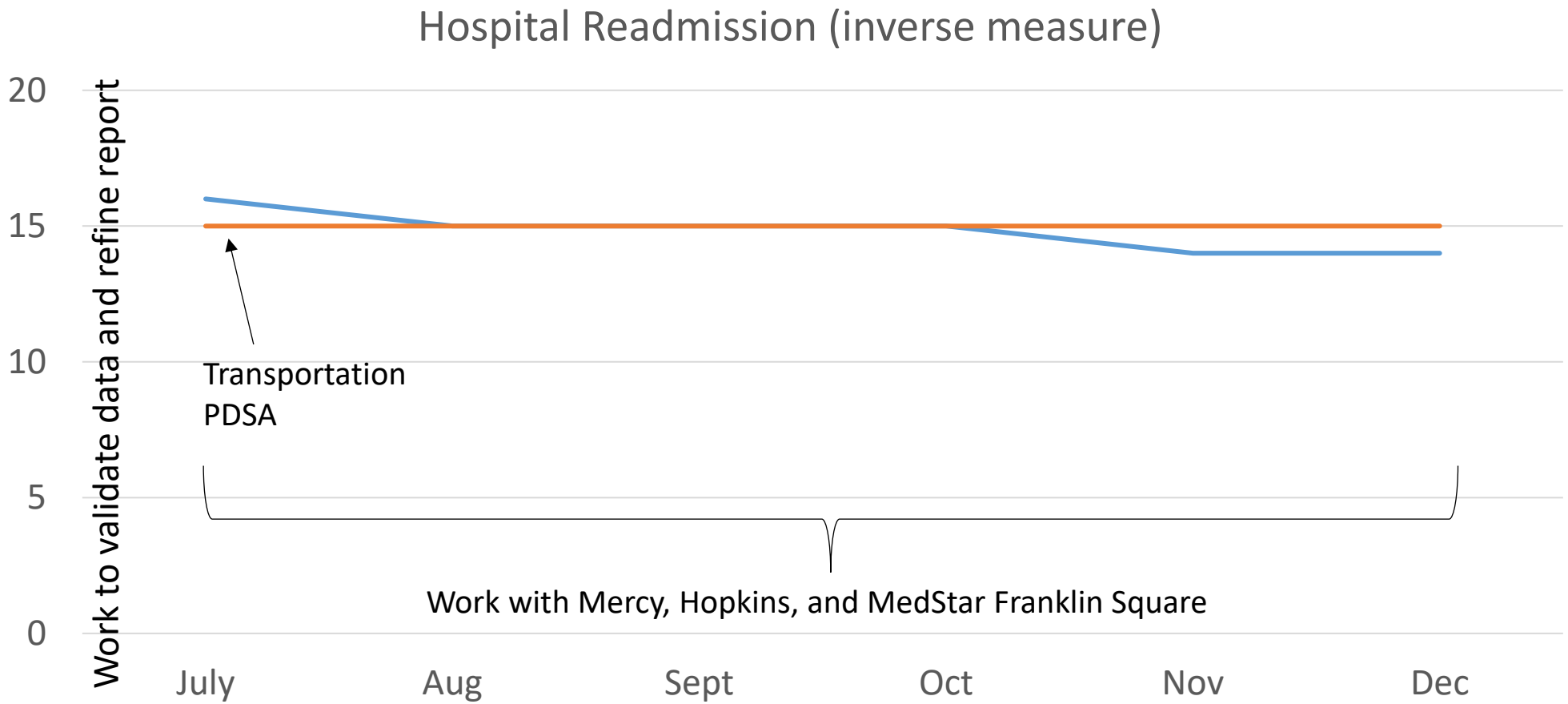
Tests of Change:

1. Strengthen relationships with top utilized inpatient hospitals to better coordinate hospital follow up appointments
2. CHW transportation support

Sustainability:

1. Work continues with Mercy and MedStar Franklin Square
2. Retired CHW transportation support because not successful

Hospital Readmission Review



2025 PI goals

1. Breast Cancer (disparities)
2. Hypertension (disparities)
3. Depression Screening
4. Flu
5. Access
6. Client Experience

Q1 Plan

1. Identify clinical representative
2. Complete analysis of measure. Includes process mapping, client and staff interviews, lit reviews, analyzing internal data and more!
3. Identify interventions and PDSA cycles and prepare for improvement work

Questions or Thoughts?

Thanks!

HEALTH CARE for the HOMELESS