June 2024 PI Informational Meeting

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Lisa Hoffmann, Director of QI

5/15/2024

HEALTH CARE for the HOMELESS

Agenda

1. Icebreaker
2. PI data snapshot
3. PI updates
4. This month’s PI tool: wishbone diagrams
5. Questions: pop them in the chat or voice them as we go!

Good morning!

Happy Pride! Happy Juneteenth!

Did you go to any events for either?

PI Measures

Trailing Year Data

Key
3+ Improvement
1-2+ improvement
Reduction

Disease Management	Apr	May	2024 Goal
Colorectal Cancer Screening	30%	30%	40%
Controlling high blood pressure	61%	61%	66%
Hypertension Disparities	Black M: 61% Black F: 54% White M: 73% White F: 70% Latino M: 61% Latina F: 63%	Black M: 62% Black F: 54% White M: 74% White F: 69% Latino M: 63% Latina F: 64%	<5% disparity across all races and ethnicities
Childhood Vaccinations	0%	9%*	18%
PHQ-9 Questions 1 and 6	Q1 or Q6: 2.43%	Q1 or Q6: 1.99%	5%
Diabetes: HbA1c poor control (>9%) [inverse]	34%	36%	27%
Diabetes and A1c Control (inverse measure)	Black: 31% White: 36% Hispanic/Latinx: 39%	Black: 33% White: 37% Hispanic/Latinx: 40%	31% Hispanic/Latinx clients

Key
3+ Improvement
1-2+ improvement
Reduction

Disease Management	Apr	May	2024 Goal
Clients receiving PrEP	40 clients	40 clients	36 clients
Prenatal Early Entry to Care	61%	pending	70%
Appointment Access	Med Urgent: 57% Med Routine: 85% BH Urgent: 100% BH Routine: 100% Dental Urgent: 40% Dental Routine: 60%	Med Urgent: 66% Med Routine: 80% BH Urgent: 88% BH Routine: 100% Dental Urgent: 100% Dental Routine: 100%	Med Urgent: 71% Med Routine: 100% BH Urgent: 80% BH Routine: 80% Dental Urgent: 71% Dental Routine: 100%
Hospital Readmission Rate	15%	19%	<20%
Closing the Referral Loop	23%	23%	40%
Current Medication Documentation	85%	86%	90%

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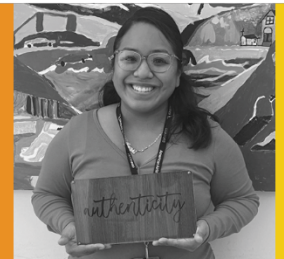


2024 PI Plan

One more thing!

1

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

Dates: Jan – June

3 PDSAs in!

2

Double the number of clients receiving **PrEP**.

Dates: Jan - June

Holding until flu season!

3

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

Dates: March - Aug

2 PDSAs in!

4

Reduce hospital **readmission rate** (hospitalized within 30 days) by 5%.

Dates: March - Aug

1 PDSA in!

5

For clients 12+, improve aggregate score by 5% on the **PHQ-9** for Question 1: little interest or pleasure in doing things and Question 6: feeling bad about yourself; or that you are a failure or have let yourself or family down.

Dates: April - Sept

2024 PI Plan continued

We are here!

2 PDSAs in!

6

Improve percent of adults aged 45–75 years who had appropriate **screening for colorectal cancer** to 40%.

Dates: April - Sept

RCA done!

7

Improve overall score (aggregate of all sites and departments) by 5% that clients reported an **ability to access an appointment when needed.**

Dates: May - Oct

RCA done!

8

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.

Dates: July - **Nov**

9

Monitor and conduct at least one PI project working to improve care coordination based on KPI data (**closing the loop for referrals or current medication documentation**).

Dates: June – Nov

10

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

Dates: July - Dec

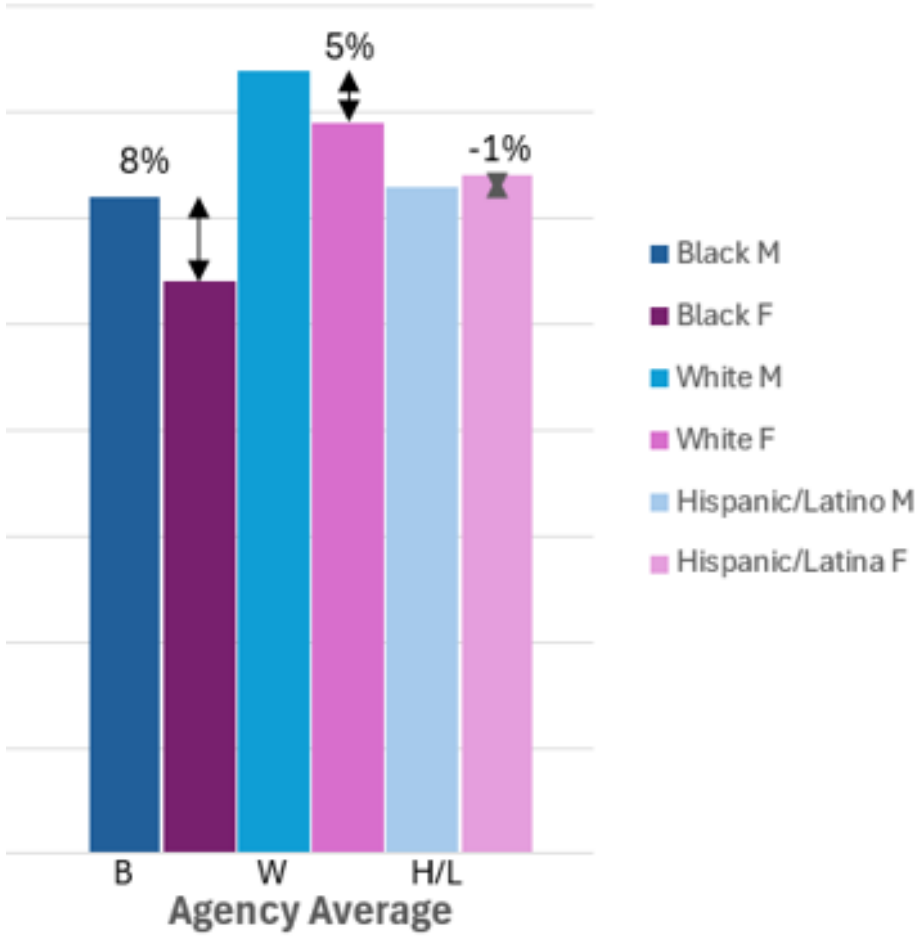
PI Subcommittee Updates

Hypertension Disparity

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

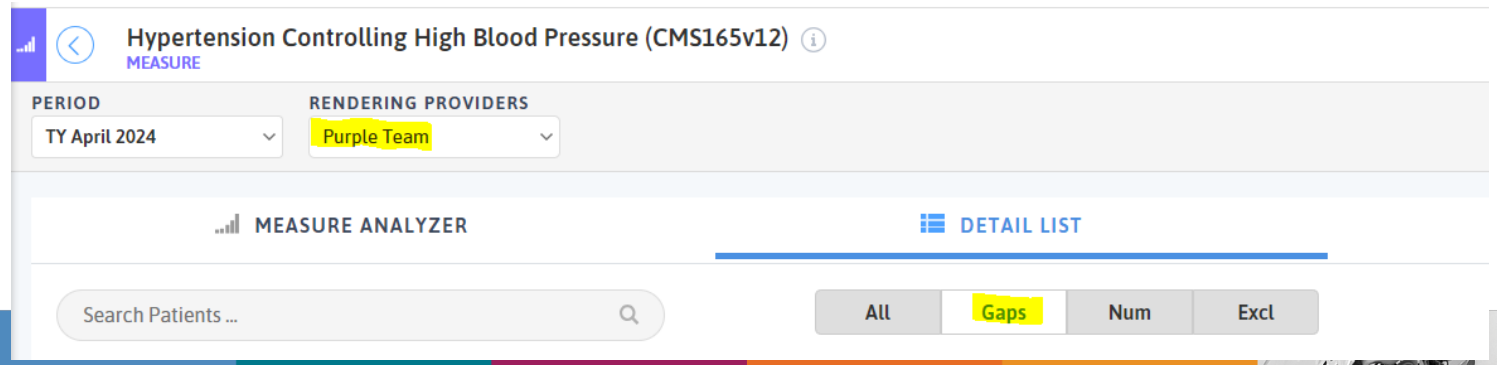
Subcommittee:

Heather Douglas, Iris Leviner, Catherine Fowler, Elizabeth Zurek, Kyler Young, Tracy Russell



The third PDSA: using registries in Azara

- For their PDSA, the **Purple team** has volunteered to use **the Care Gaps report** in Azara
- They will be identifying uncontrolled clients in their care and outreaching for a RN visit
- If you're interested and have Azara access, you can look at your care gaps too!
  - On the measure page, change "Rendering Providers" to you (or whomever you'd like to look at)



And one more thing…?

- Racial gaps are **widening**: 14% between Black and white clients, 11% between Hispanic/Latinx and white clients
- Gender gaps are **staying the same**: 8% between Black men and Black women clients
- We are **meeting individually with subcommittee members** to get their ideas on how to alleviate the widening disparities
- A few snippets from the conversations we've had already:
  - Clients may not understand pharmacy well
  - Many female clients also seeing psych, may be an anxiety component – not only to BP but to even showing up in person; may explain reliance on telehealth
  - Many social determinants of health at play with HTN, important to keep working in a multifaceted way to address

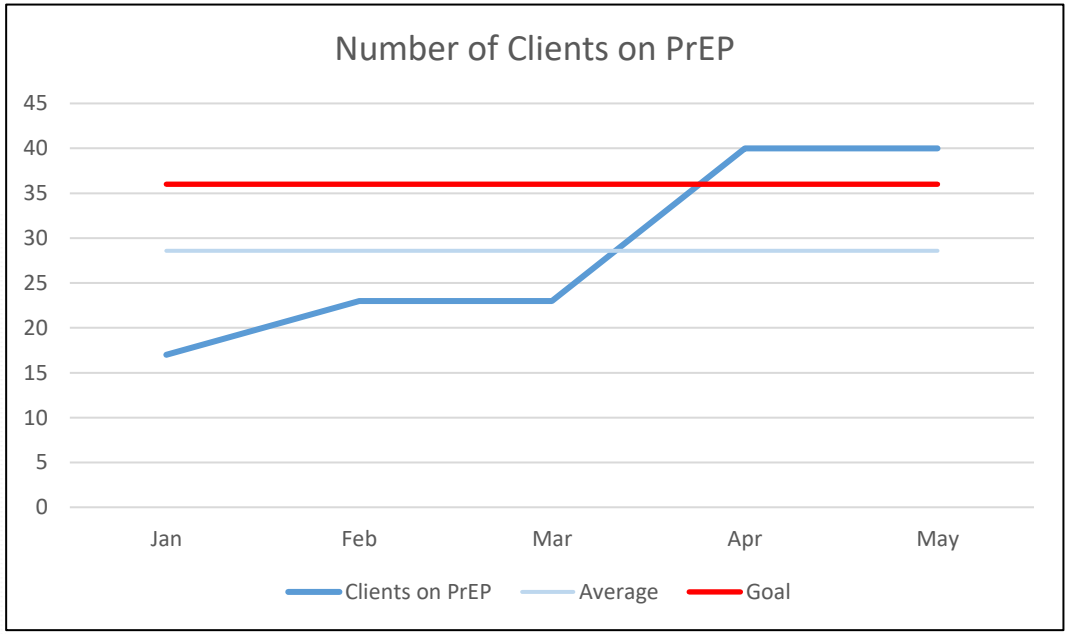
What's next for HTN disparities

- Following care teams through their PDSAs, from idea building to implementation to evaluation
  - Huge kudos to medical for being so receptive and engaged!
- Meeting with individuals from the subcommittee for additional collaboration to try to meet our goal
- Close out meeting with sustainability plan and invite to keep working with us in July

PrEP for HIV

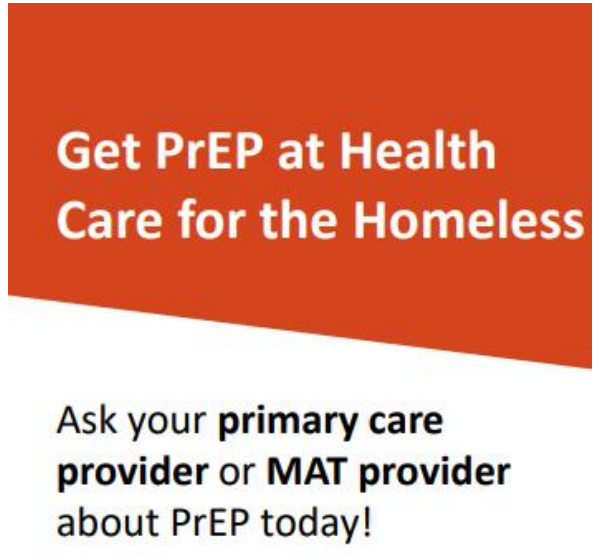
Double the number of clients receiving PrEP.

Subcommittee: Rajen Bajracharya, Meredith Johnston, Nicole Maffia, Catherine Fowler, Julia Felton, Katharine Billipp, Tyler Gray, Tracy Russell, Adrienne Trustman, Sarah Barry, Wynona China



The second PDSA: getting the word out

- You may have noticed a **new PrEP screensaver** in circulation
- You may have also noticed a few new **brochures** in circulation
  - We're trying to keep some in the 2nd floor waiting room and some with Julia Felton
- Let us know in the chat: **have you noticed these?** Have they increased your awareness of PrEP?



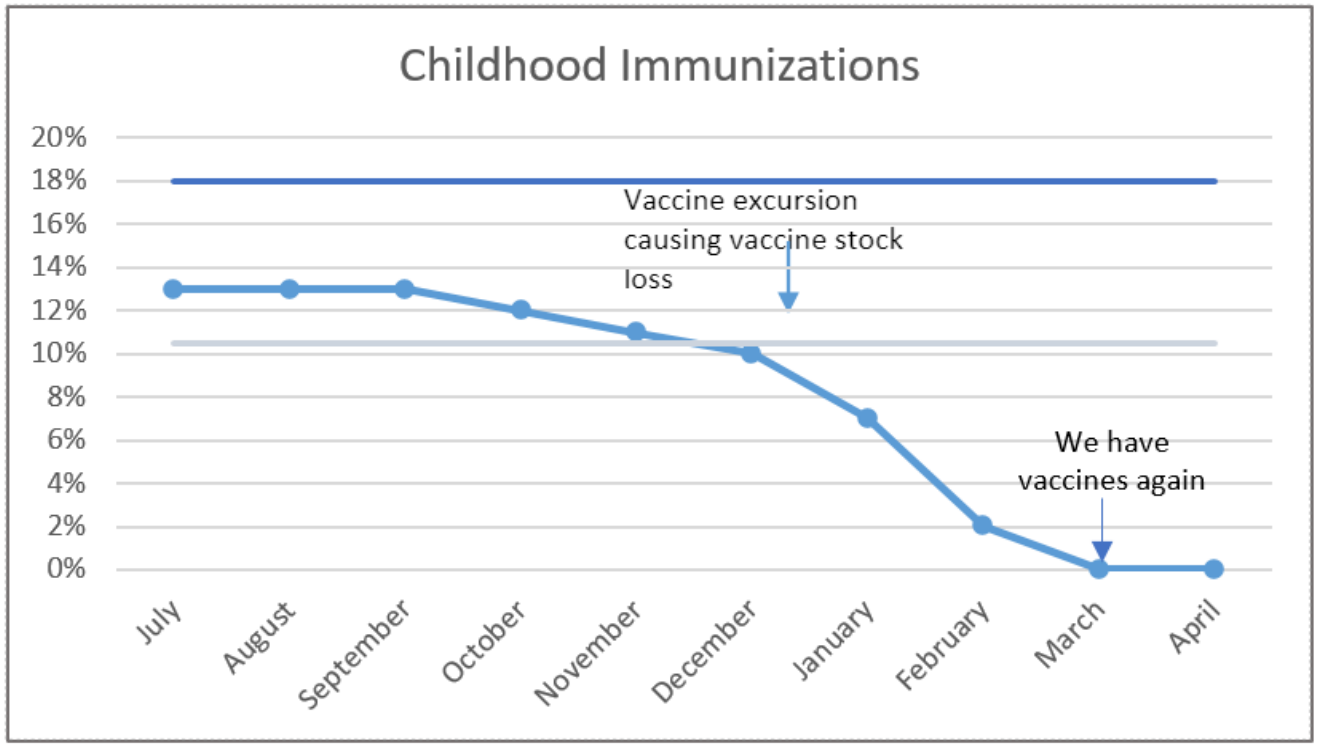
The third PDSA: direct outreach

- For clients who are documented as on PrEP (pre-exposure prophylaxis is in the problem list) but **do not have an upcoming appointment**:
  - Julia Felton will be calling these clients to determine whether they would like to come back into care
  - If they want to come back, she'll make sure they're scheduled
  - If they don't, she'll forward that to the provider and ensure the diagnosis code is removed
- The aim is to keep PrEP clients coming back even if they no-show or don't schedule a follow-up

What's next for PrEP

- Continuing to reinforce proper documentation and order sets throughout the month and beyond
- Brainstorming ways to involve clients in this work
  - Communications is currently working to **interview a client on PrEP** for the newsletter - more to come

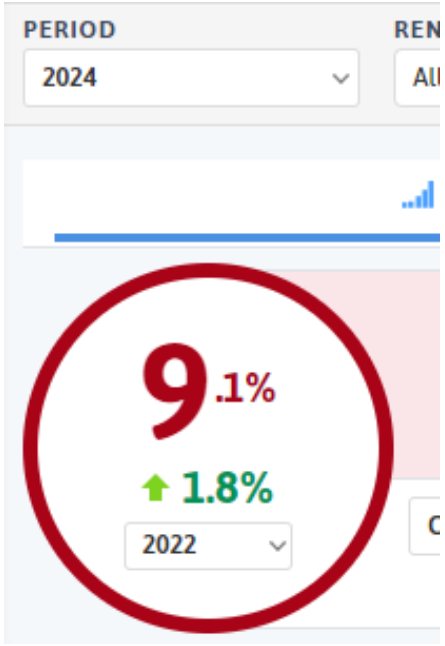
Childhood Vaccinations (Combo 10)



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

Subcommittee: Nicole Maffia, Keri Rojas, Natalia Suc, Ash Lane

Some data notes



- We've been pulling **trailing year** for this measure, like all other measures
- … But looking at who's actually included in this measure, if we pull trailing year, **only** children who have **already turned 2** are included
- Looking at **calendar year** instead, we see all kids who are turning 2 in 2024, which puts us **at 9%!**
  - A few kids have all their shots but haven't quite turned 2 yet
- Moving to calendar year will give us a better perspective on where we'll be at the end of 2024

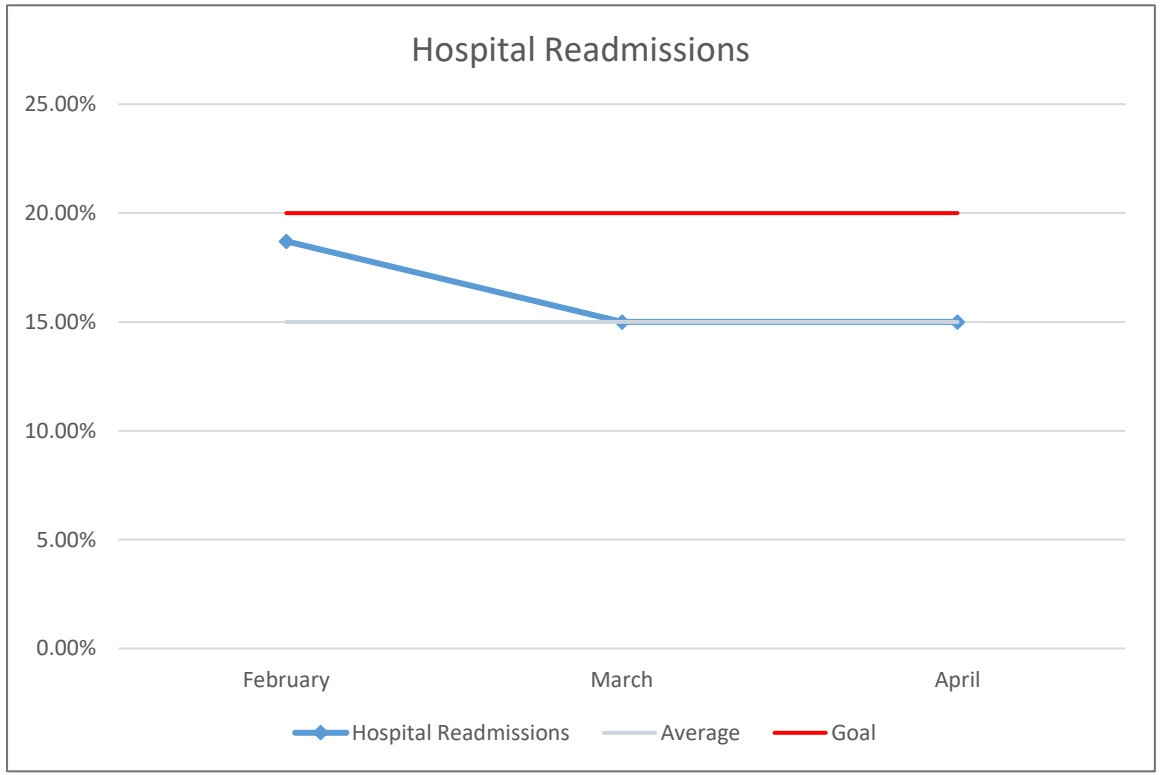
The first PDSA: direct outreach

- As a reminder, Ash, Natalia, and Keri from pediatrics are currently:
  - Performing **direct outreach** from the Azara vaccination registry to clients 12-24 months of age due for vaccines
  - **Flagging charts** with all vaccines needed prior to well visits so that needed vaccines are not missed
- We have now iterated this process **twice**, making minor changes each time
- What have we found?
  - The most commonly missing vaccines are **flu** and **rotavirus**
  - Both are time-limited: you can't get flu outside of flu season, you can't get rotavirus after a certain age window
  - The Pediatrics team is doing *amazingly* with all the others

What's next for childhood immunizations

- As mentioned, there are two sticking points: **flu and rotavirus**
- We are **holding the third PDSA until flu season** so we can target flu
  - Hard to target rotavirus, as it's time-limited: if the child comes into care too late, they just can't get it
  - We're more able to control flu
- Ideas for involving clients in this work
  - Gathering client testimony from OB clients who bring their babies back for care
  - Aim to survey them around the 4-month visit about their experience at HCH
  - *Short* survey will include experiences with prenatal care and vaccines

Hospital Readmission



Reduce hospital **readmission rate** (hospitalized within 30 days of discharge) by 5%.

Kickoff Meeting:

- Subcommittee: Wynona China, Jimmy Miller, Julie Rich, Tyler Gray, Heather Douglas, Lillian Amaya, Greg Rogers, Tracy Russell, Kayla Zabkowski
- Included staff from medical and health IT
- Decided to focus primarily on medical – CRISP is hard to parse with co-occurring conditions and reason for hospitalization, but more effective to focus on one line of service

The first PDSA: streamlining link between Mercy and HCH

- Met with Mercy to establish a connection, discuss barriers
- Our call center RN, Kayla, is now taking calls **directly from Mercy's transitional care team** about established clients
  - Mercy to call into call center and ask for "Discharge"
    - Not a specific name: if someone's covering, we want them to be able to help
  - Will provide name, DOB, location of discharge (shelter? WHRC? street?), phone number
  - Clients who are being discharged to WHRC will follow a different pathway
- Mercy **toured Fallsway** earlier in the month and was impressed

The second PDSA: transportation

- Attempting to increase show rates at hospital follow-up appointments by assessing transportation needs and referring to CHW
- Kayla is asking clients who need a follow-up appointment: **Is transportation a barrier to making this appointment?**
  - If we simply ask “do you want transportation?,” everyone would say yes: we’re trying to assess for whom it is a deal-breaker
- If so, will email CHWs, who will call back and assess for transportation assistance

What's next for hospital readmission

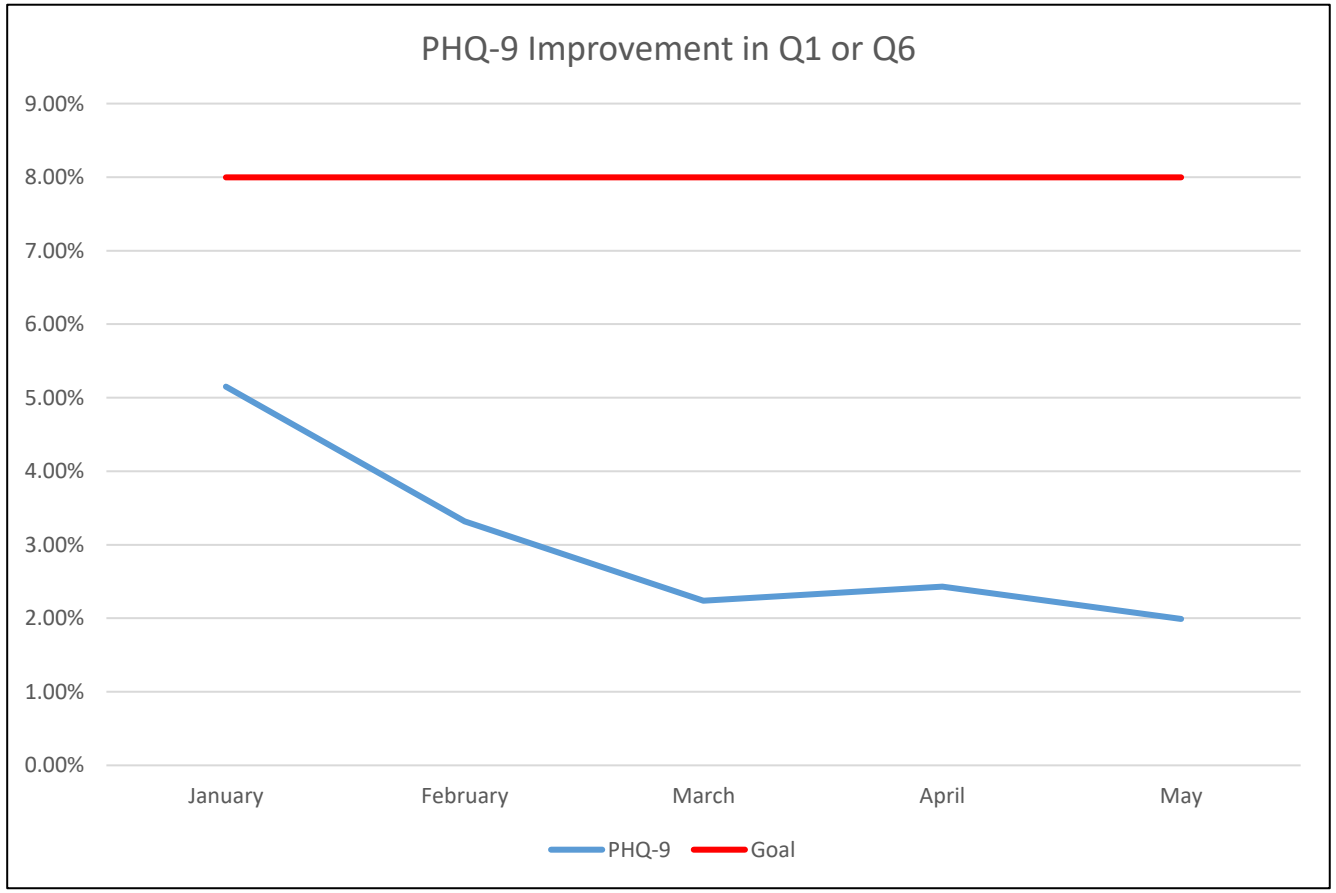
- Strengthening our link with Mercy
- Looking into establishing links with other hospital systems in the area
  - Hopkins and UMD are also in top three most utilized hospitals by our clients
- Ways to involve clients in our work for this measure
  - Involve frequent hospital utilizers?
  - Open to any input!

Depression Remission

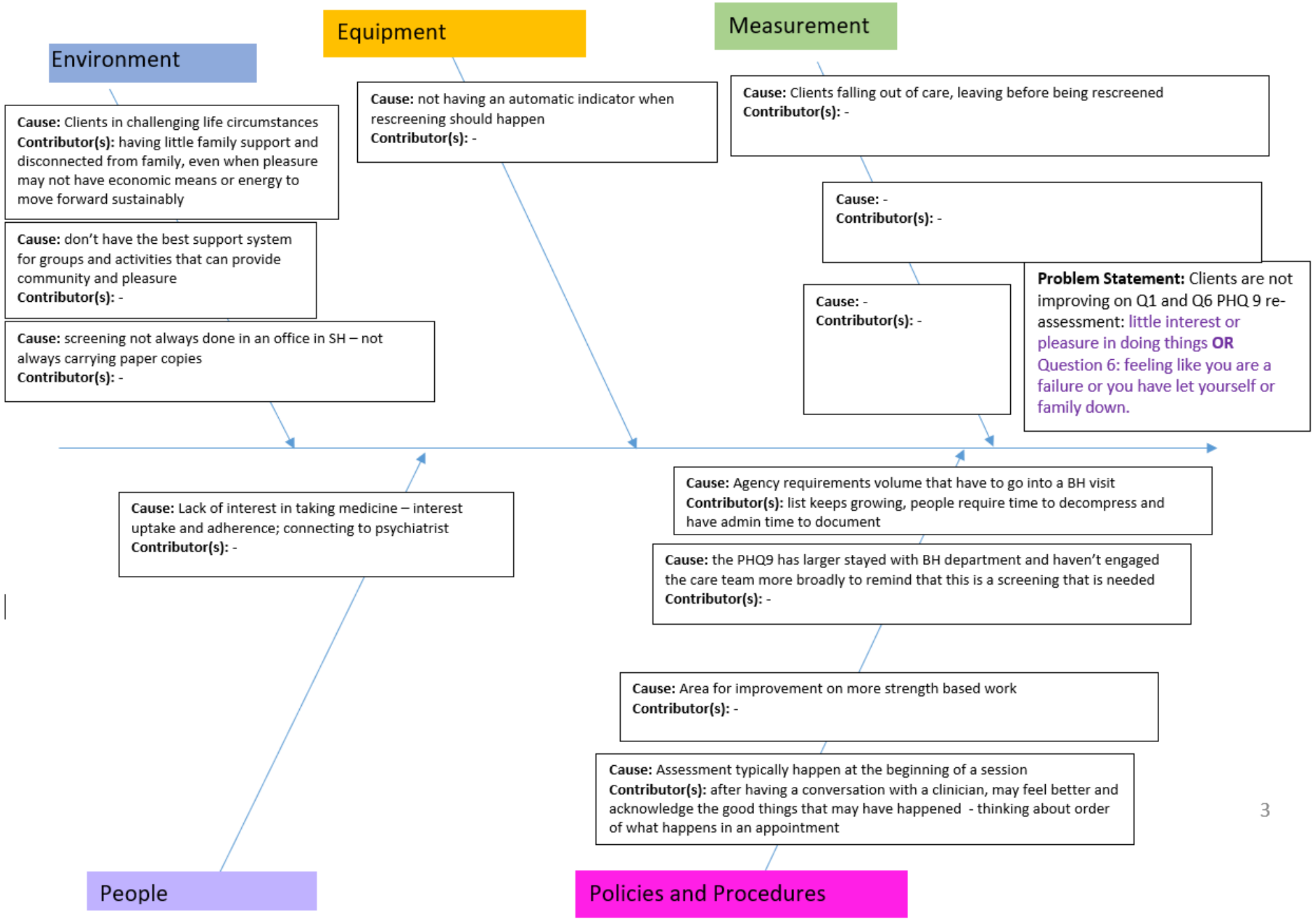
By December 31, 2024, for clients aged 12 and up, improve aggregate score by 5% on the PHQ-9 for Question 1: little interest or pleasure in doing things or Question 6: feeling like you are a failure or you have let yourself or family down.

Subcommittee:

Lawanda Williams, Jan Ferdous, Wynona China, Lydia Santiago, Shauna Griffin, Wendy Hrica

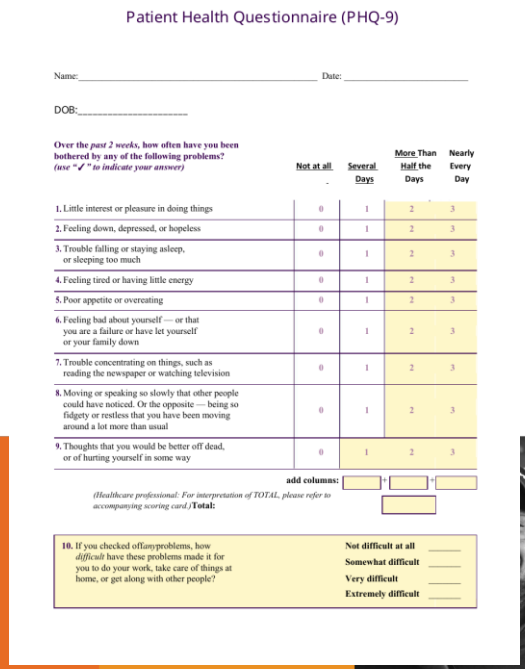


Depression Remission RCA



The first PDSA: PHQ-9 in the field

- Much of the problem comes from **rescreening –** clients are not getting consistently re-screened
- Two representatives from Housing Services – Shauna and one other – will be **administering PHQ-9s in the field**
  - They have a laminated PHQ-9 sheet and a dry-erase marker for ease of use



Patient Health Questionnaire (PHQ-9)

Name:_____ Date: _____

DOB:_____

Over the *past 2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
		add columns:	+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **Total:**				

10. If you checked off any problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all _____
	Somewhat difficult _____
	Very difficult _____
	Extremely difficult _____

What’s next for depression remission

- Focusing on disparities
  - Hispanic/Latinx clients seem to achieve depression remission much less often – were consistently at 0% throughout 2023 and early 2024
  - A chart review from 2023 indicates these clients may not always be rescreened

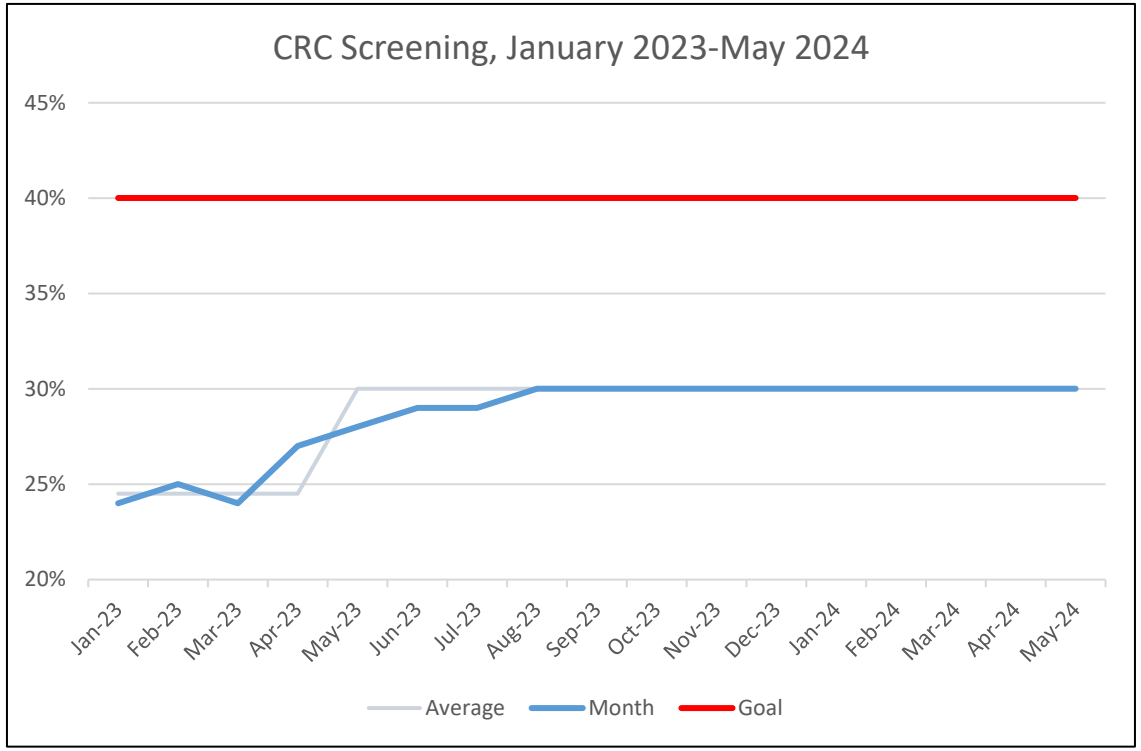
Colorectal Cancer Screening

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

Subcommittee: Pandora Bruton, Katharine Billipp, Elizabeth Zurek, Tracy Russell, Kim Taylor, Hanifah Matumla

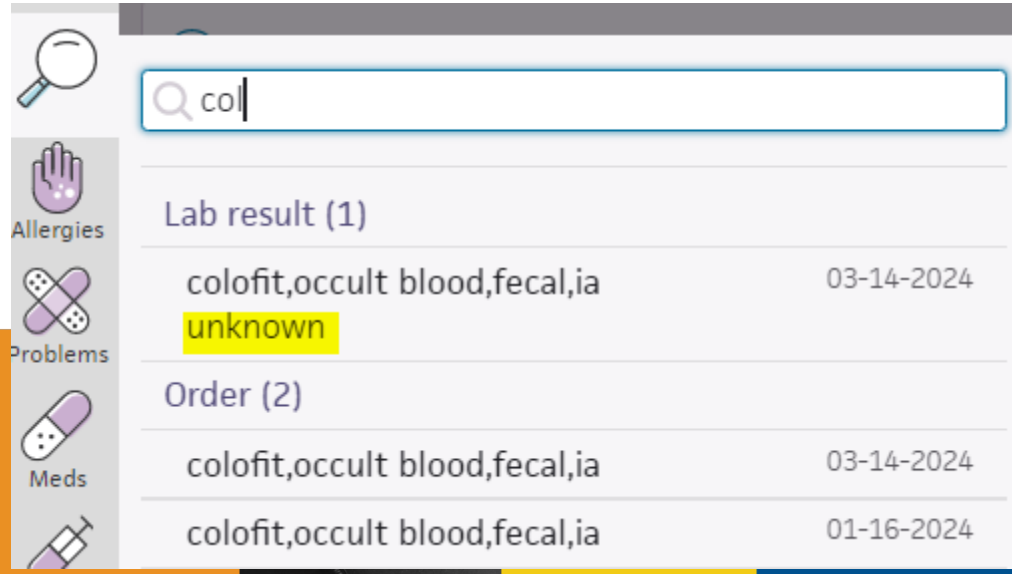
Enlisting the care team triad at West Baltimore as part of the subcommittee

- We're trying to trial small tests of change with just this care team triad



The first PDSA: documenting correctly

- A few providers were using an incorrect FIT order that did not satisfy the UDS measure
- Disseminated **info on the correct FIT orders:**
  - Colofit, occult blood, fecal, ia (the most commonly used)
  - Home colofit, fecal, ia
- Disseminated info on the **incorrect FIT order:**
  - Fecal occult blood, stool
- Low-yield, but we know how to document now!



The second PDSA: “training the trainer”

- CMAs and RNs play a pivotal role in getting CRC screening done
  - Doing the initial risk assessment, entering the order, physically giving the FIT kits…
- Looking for **CMA champion** to help educate
  - How do you screen? How do the tests work? How do you order, put the FIT together, instruct the patient to return?
- Also some helpful scaffolding from Tracy in Pop Health:
  - A text macro .crcscreening that helps CMAs and RNs to know risk factors, serve as a reminder of the workflow
  - A demonstration competency – CMAs and RNs, check your email to sign up for this

What's next for CRC screening

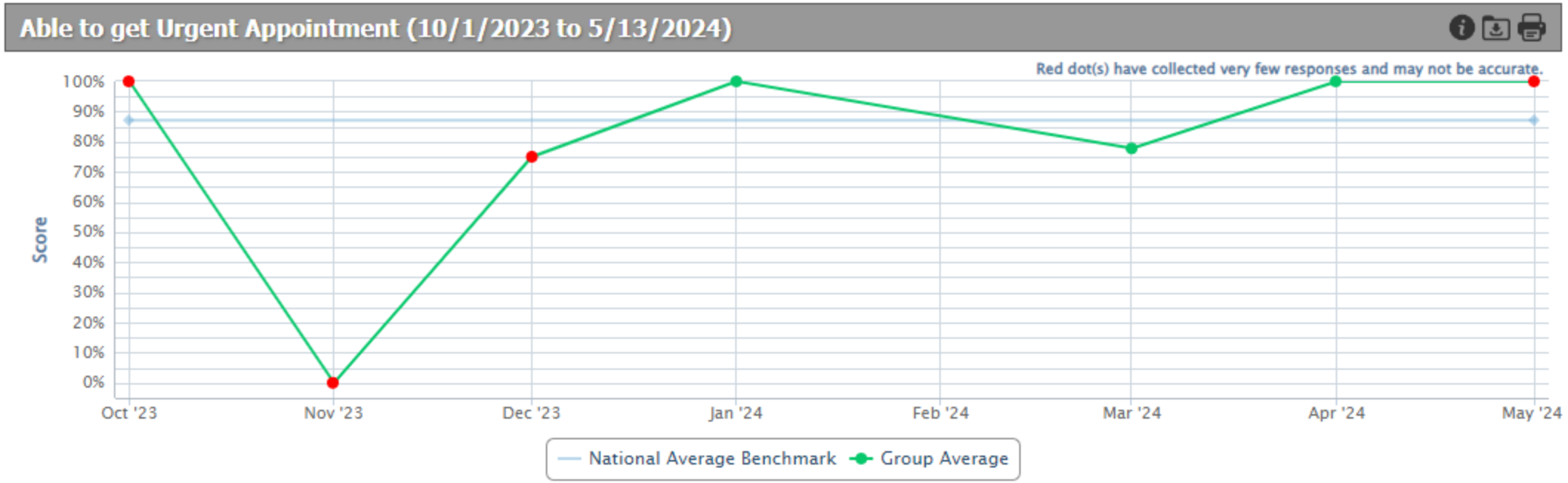
- Figuring out ways to be smart about how we send back FIT kits
  - Losing some FIT kits to labeling, no name/DOB on tube, sent back in incorrect envelope, etc
  - Ordered fine-tip sharpies for the clinic at Fallsway so clinic staff can label tubes
- Ways to involve clients in this work
  - Front porch campaign(s)?
  - Client testimonies about what their CRC screening was like (attempt to reduce fear)?

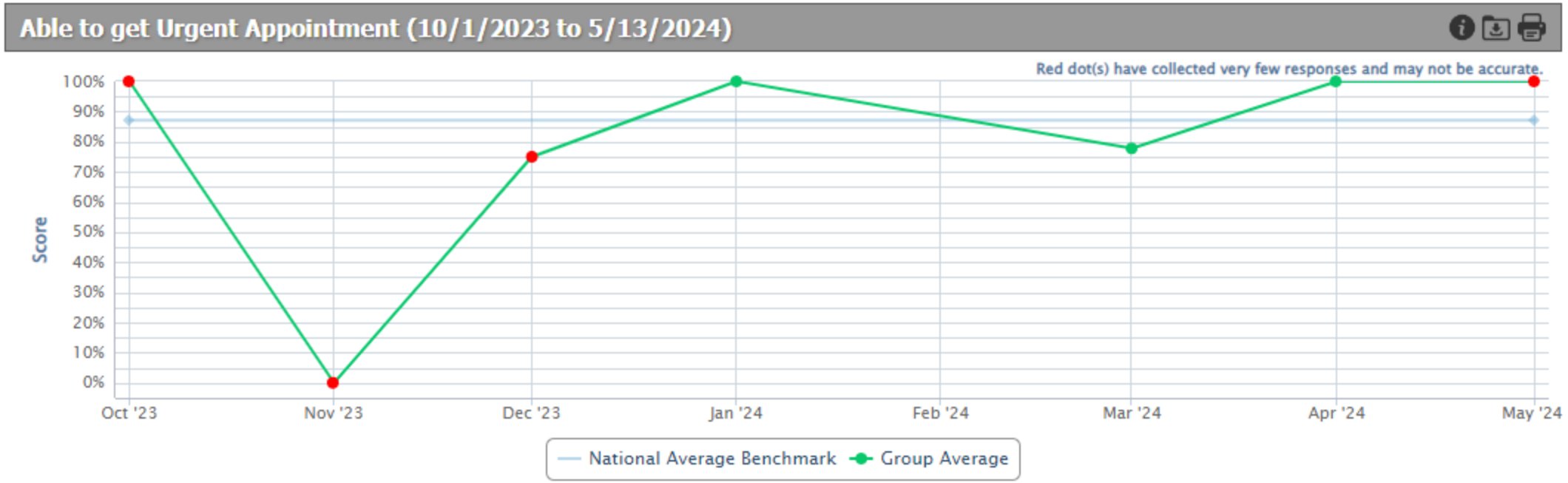
Appointment Access

Improve overall score (aggregate of all sites and departments) by 5% that clients reported an **ability to access an appointment when needed.**

Subcommittee: Lisa Lefavore, Liz Goldberg, Muhammed Mamman, John Lane, Alkema Jackson, Juanita Peterson, Wynona China, Janel Taylor, Jan Ferdous, Deborah Hart, Eman Boyer

BH


Able to get Urgent Appointment (10/1/2023 to 5/13/2024)
Red dot(s) have collected very few responses and may not be accurate.
Score
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Oct '23
Nov '23
Dec '23
Jan '24
Feb '24
Mar '24
Apr '24
May '24
National Average Benchmark
Group Average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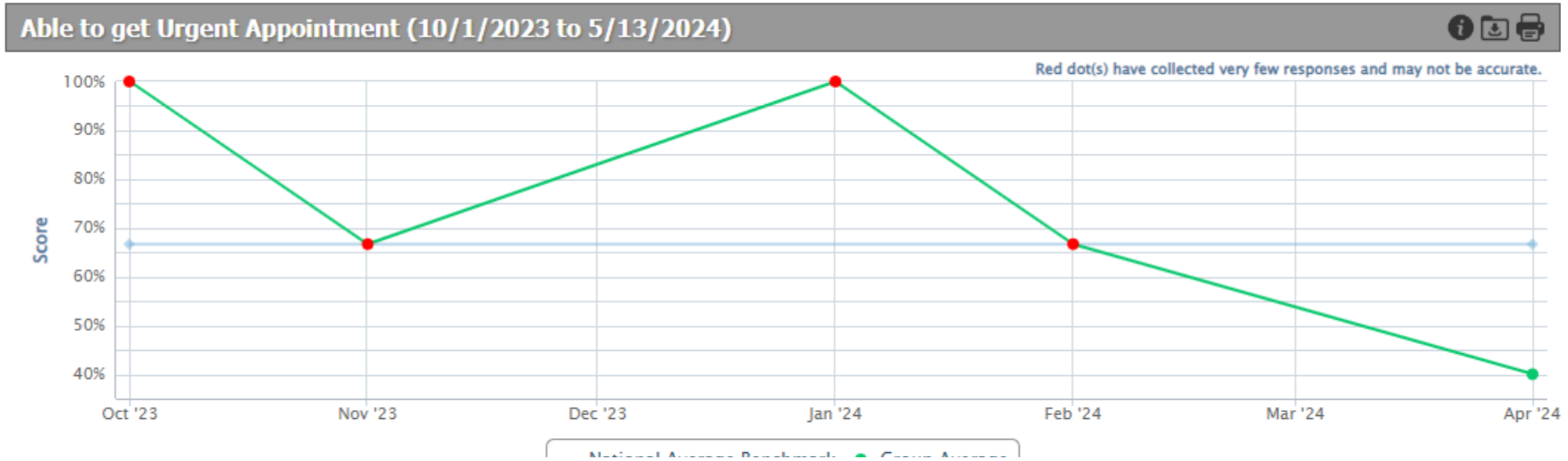
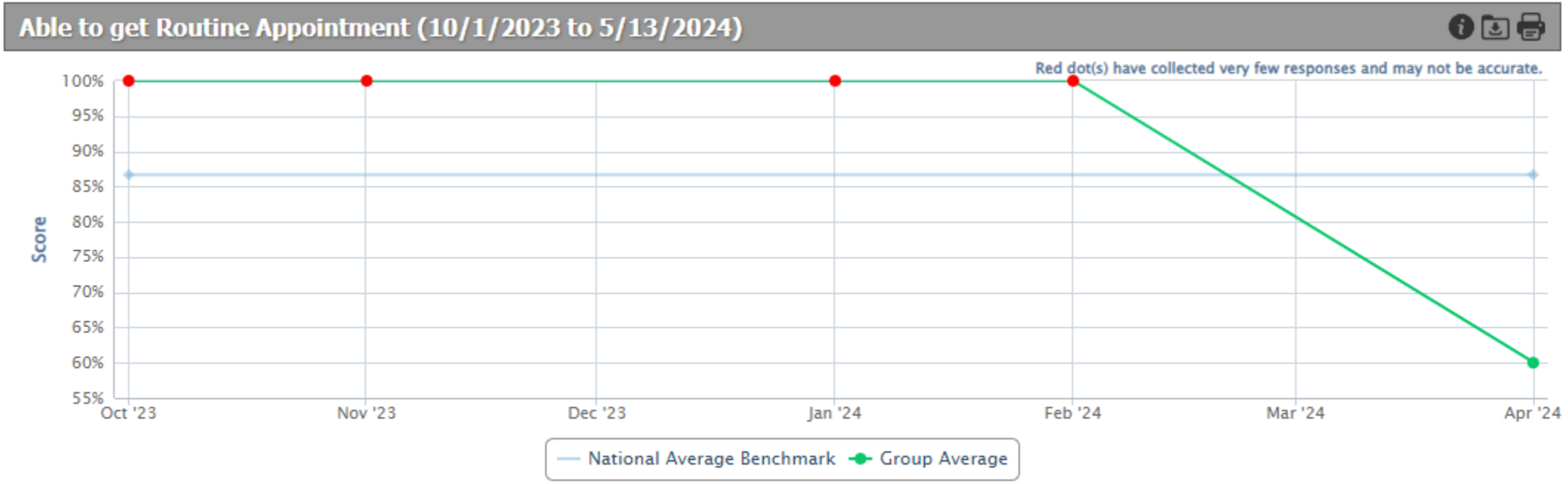
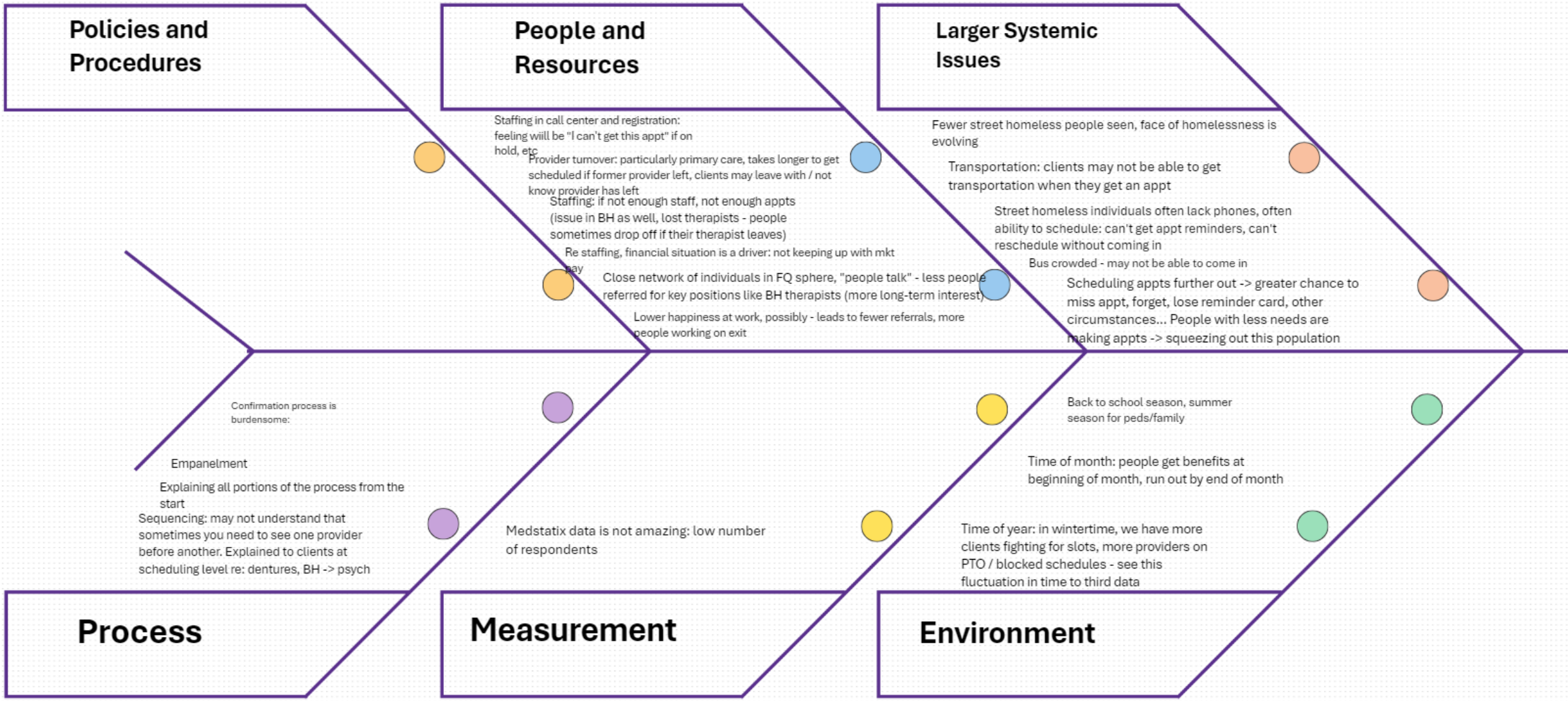
40%
30%
20%
10%
0%
Oct '23
Nov '23
Dec '23
Jan '24
Feb '24
Mar '24
Apr '24
May '24
National Average Benchmark
Group Average

Dental


Able to get Urgent Appointment (10/1/2023 to 5/13/2024)
Red dot(s) have collected very few responses and may not be accurate.
Score
100%
90%
80%
70%
60%
50%
40%
Oct '23
Nov '23
Dec '23
Jan '24
Feb '24
Mar '24
Apr '24


Able to get Routine Appointment (10/1/2023 to 5/13/2024)
Red dot(s) have collected very few responses and may not be accurate.
Score
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
Oct '23
Nov '23
Dec '23
Jan '24
Feb '24
Mar '24
Apr '24
National Average Benchmark
Group Average

Root Cause Analysis



Next steps for appointment access

- **We have a client for this subcommittee!**
- Met with Janel from HR to discuss turnover and its impact on client access
- Meeting in late July to discuss our first PDSA

A1c and Diabetes Disparities

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.

Subcommittee: Sharon Hooper, Tracy Russell, Courtney Hunt, Katie Healy, Kyler Young, Erin Levitt, Karen Bisson, Arie Hayre-Somuah

Environment

Cause: diet; cultural components that may be contributing; food insecurity
Contributor(s): zip code inequities (lack of grocery stores, one grocery store that is very expensive)

Cause: lack of educational resources
Contributor(s): -

Cause: lower health literacy levels
Contributor(s): -

Cause: jobs that limit time or limit energy to shop or prepare foods or lack of employment that may contribute to not having enough food
Contributor(s): -

Equipment

Cause: portability of glucometer (hard to use in every day settings)
Contributor(s): clients ask about subq monitors but very expense

Cause: cost of medications
Contributor(s): ensuring everyone who has access to insurance, gets insurance (under 21 have more options)

Measurement

Cause: this measure includes clients who missed measurement (about 11% Hispanic/Latinx didn't have a measurement)
Contributor(s): -

Cause: -
Contributor(s): -

Cause:
Contributor(s): -

Problem Statement: Clients have uncontrolled diabetes

Problem Statement: Hispanic/Latinx clients are disproportionately uncontrolled from racial and ethnic counterparts

Cause: lack of a support system (may forgot how to manage their diabetes or pre-diabetes)

Contributor(s): particularly immigrant clients may not have had access to healthcare in 2-3 yrs (but have been diagnosed previously) due to moving

Cause: lack of standardized way to evaluate health literacy (coming soon!)
Contributor(s): -

Cause: med adherence

Contributor(s): side effects of medication (GI side effects), shelter restrictions, pharmacy wait can be upwards of 2 hours for medication

Cause: transportation for appointments

Contributor(s): some clients travel great distances for appointments, as far as near DC

Cause: prep of healthy foods
Contributor(s): -

Cause: lack of affordable gym memberships
Contributor(s): people may not realize that they can do exercise if have restrictions on mobility too

People

Policies and Procedures

What would it look like to have everyone's Diabetes controlled?
- fewer hospitalizations, fewer complications and co-morbidities
- people with functioning organs
- people feeling more empowered when have control over diagnosis – ability to manage own condition – accomplishment, empowerment and wellbeing
- when people see results, it can be really motivating

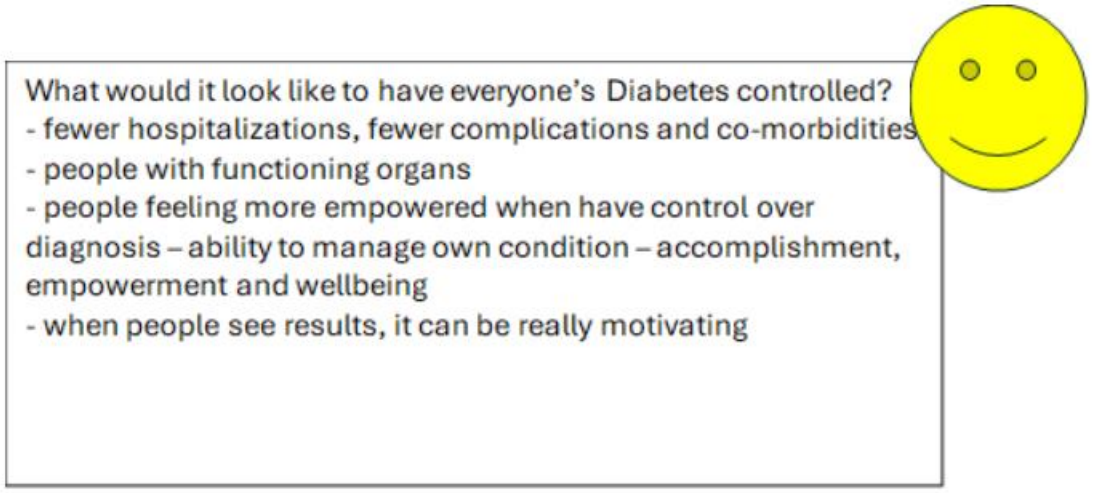
What's next for diabetes control

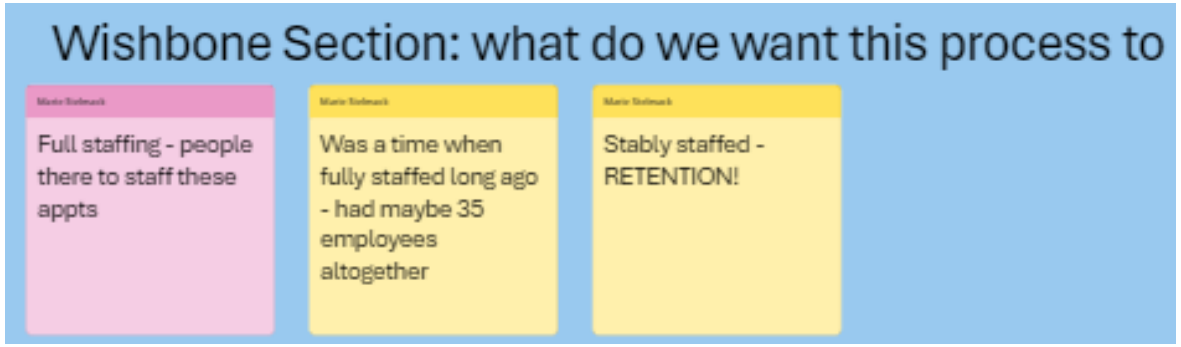
- Met with Erin Levitt to discuss both diabetes and hypertension disparities; some takeaways:
  - Hispanic/Latinx population has trouble with accessing healthcare: many were diagnosed in their home country but saw lapses in care due to immigration
  - There's a Spanish-only pharmacy text line and Saturday hours that clients can utilize, but many clients do not know about these
  - Pharmacy waits up to 2 hours are an issue
- Developing our first PDSA

Next measures coming up

- Care coordination and prenatal early entry to care are coming up quickly
  - For our care coordination flex goal, we will be focusing on **closing the referral loop**
- Looking forward to the end of the year
  - Data party…? Stay tuned

PI tool: fishbone vs. *wishbone*





- We know what a fishbone is: a tool to determine root causes of a problem
- How do we move that into a more positive-thinking paradigm? How do we imagine a better future, not just look at the problems?
- Enter the **wishbone**
  - A section to discuss what your "ideal world" would be
  - Not coming up with solutions just yet, but setting goals for what environment those solutions will create

Resources

As a reminder, our PI tools and templates are available for use!

(The fishbone template has a wishbone section, too!)

These are stored on our PI Communal OneNote page, linked here:

PI Communal OneNote: Templates Tab

Give them a try next time you want to solve a problem!

Thank you, and happy Thursday!

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HEALTH CARE for the HOMELESS