August 2024 PI Informational Meeting

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5/15/2024

HEALTH CARE for the HOMELESS

Agenda

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

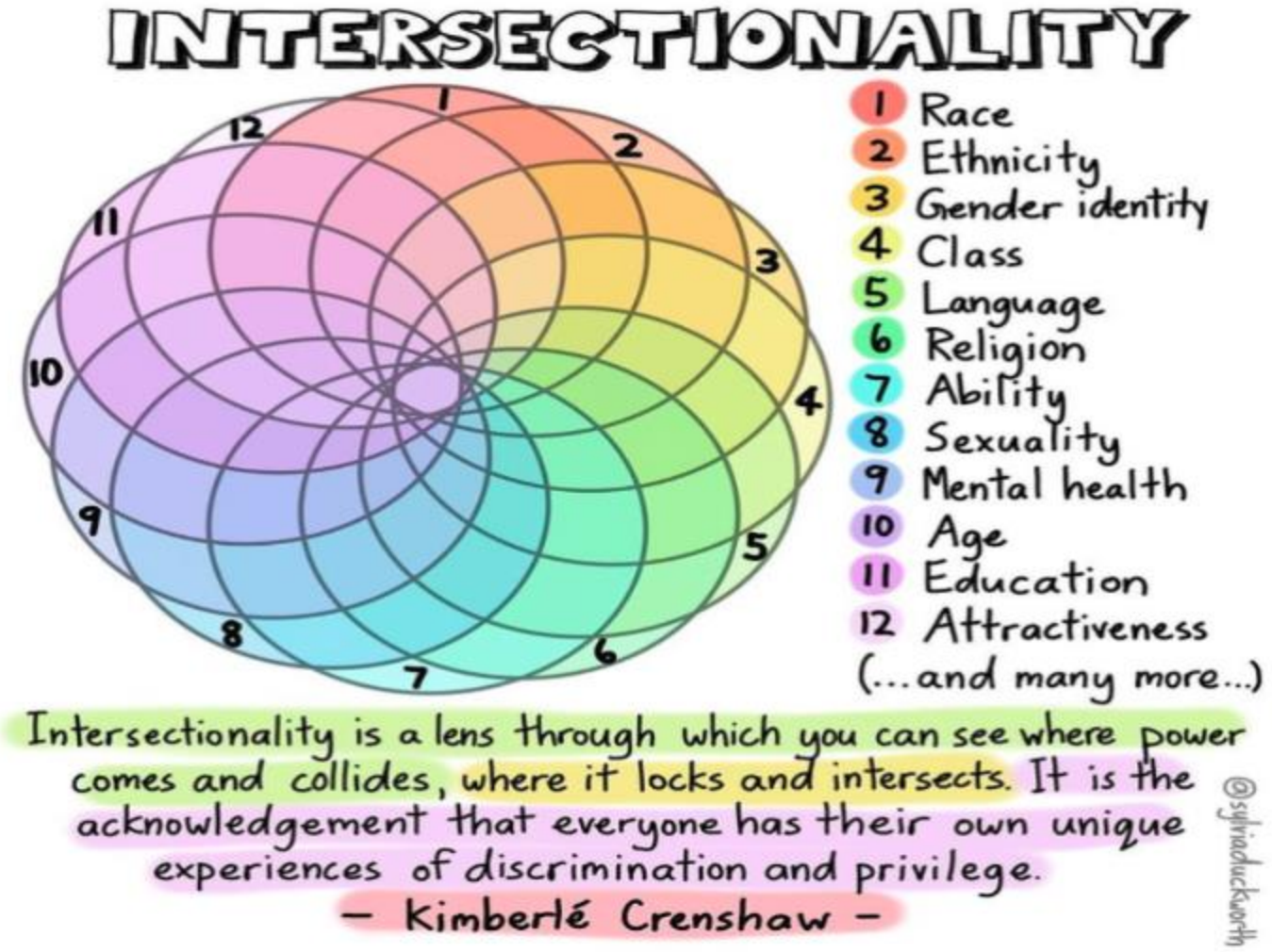
Good morning!

August is Intersectionality Awareness Month!

: the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups

What does intersectionality mean to you?

How do you bring an intersectional lens to your work?



PI Measures

Trailing Year Data

Key
3+ Improvement
1-2+ improvement
Reduction

Disease Management	July	August	2024 Goal
Colorectal Cancer Screening	30%	31%	40%
Controlling high blood pressure	61%	62%	66%
Hypertension Disparities	Black M: 62% Black F: 52% White M: 71% White F: 72% Latino M: 64% Latina F: 67%	Black M: 62% Black F: 52% White M: 73% White F: 63% Latino M: 72% Latina F: 69%	<5% disparity across all races and ethnicities
Childhood Vaccinations	7%	6%	18%
PHQ-9 Questions 1 and 6	Q1 or Q6: 3.96%	Q1 or Q6: 5.06%	5%
Diabetes: HbA1c poor control (>9%) [inverse]	35%	34%	27%
Diabetes and A1c Control (inverse measure)	Black: 32% White: 39% Hispanic/Latinx: 38%	Black: 32% White: 37% Hispanic/Latinx: 36%	31% Hispanic/Latinx clients

Key
3+ Improvement
1-2+ improvement
Reduction

Disease Management	July	August	2024 Goal
Clients receiving PrEP	44 clients	41 clients	36 clients
Prenatal Early Entry to Care	63%	65%	70%
Appointment Access	Med Urgent: 75% Med Routine: 85% BH Urgent: 100% BH Routine: 100% Dental Urgent: 100% Dental Routine: 100%	Med Urgent: 84% Med Routine: 89% BH Urgent: 71% 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	pending	16%	<20%
Closing the Referral Loop	23%	23%	40%
Current Medication Documentation	86%	87%	90%

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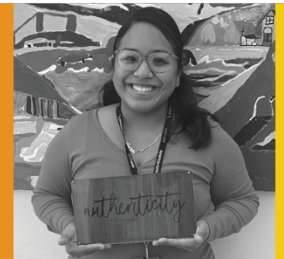


2024 PI Plan

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

Sustainability plan made!

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

Sustainability plan made!

4

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

Dates: March - Aug

2 PDSAs 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 made it!

2 PDSAs in!

6

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

Dates: April - Sept

2 PDSAs in!

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

1 PDSA in!

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**

RCA done!

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

1 PDSA in!

10

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

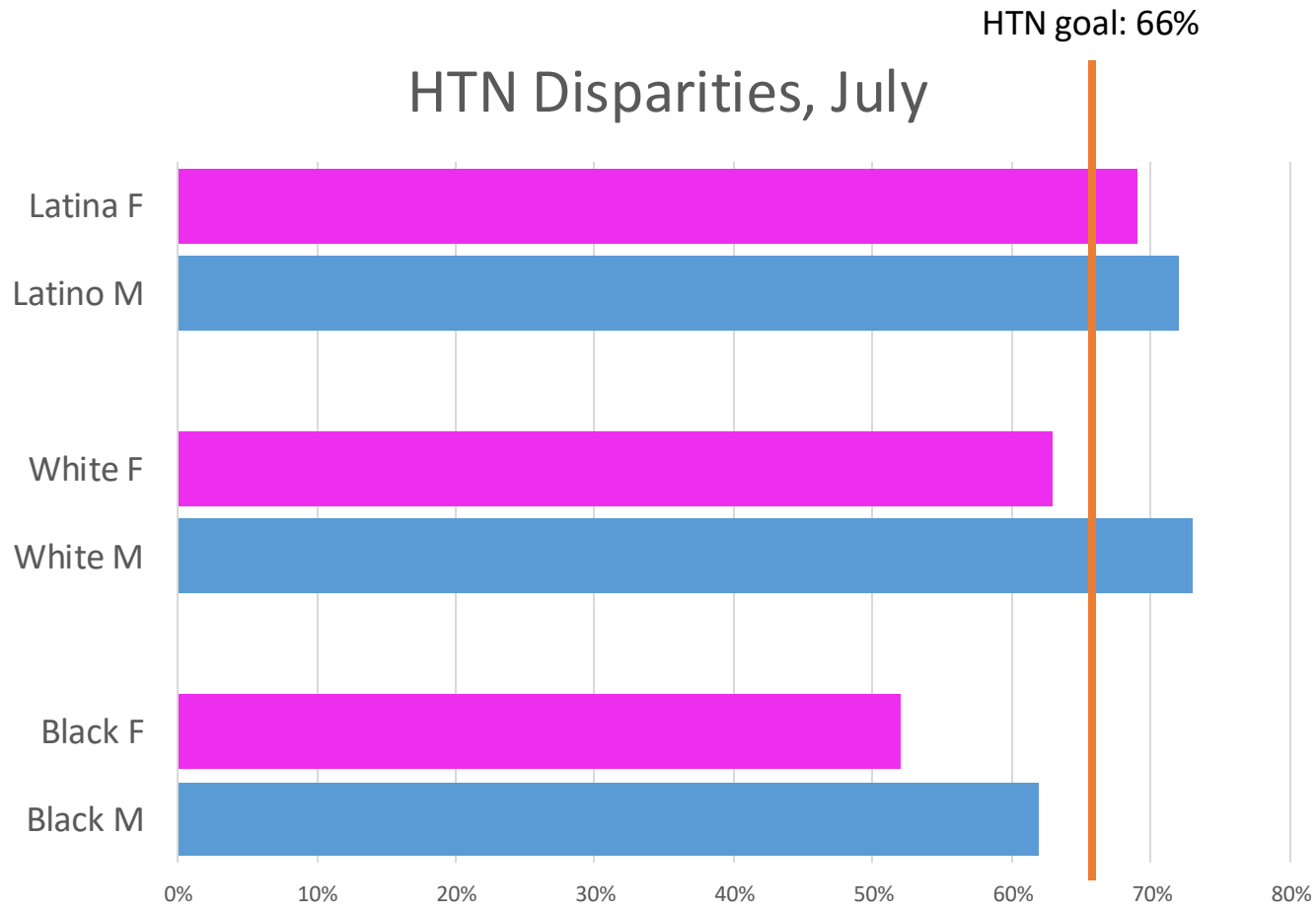
Dates: July - Dec

PI Subcommittee Updates

Hypertension Disparity 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%.

Subcommittee: Iris Leviner, Catherine Fowler, Elizabeth Zurek, Tracy Russell - *a few staff on the committee left the Agency, looking for others to join!*



Hypertension Disparity PDSA Summary

PDSA #1

Change idea: After visit summary sheets to guide clients in check out process (lab, meds, scheduling next appointment)

Result: Did not impact control for sample of clients tracked; but anecdotally, useful to clients and staff in ensuring thorough check out process

Sustainability: Med department maintains; well-integrated in medical space and utilized more widely across all appointment types

PDSA #2

Change idea: care team scorecards – friendly competition to motivate teams in improving race and gender disparities

Result: several teams saw improvement in care team level disparity data

Sustainability: final results shared, sustainability plan discussions upcoming

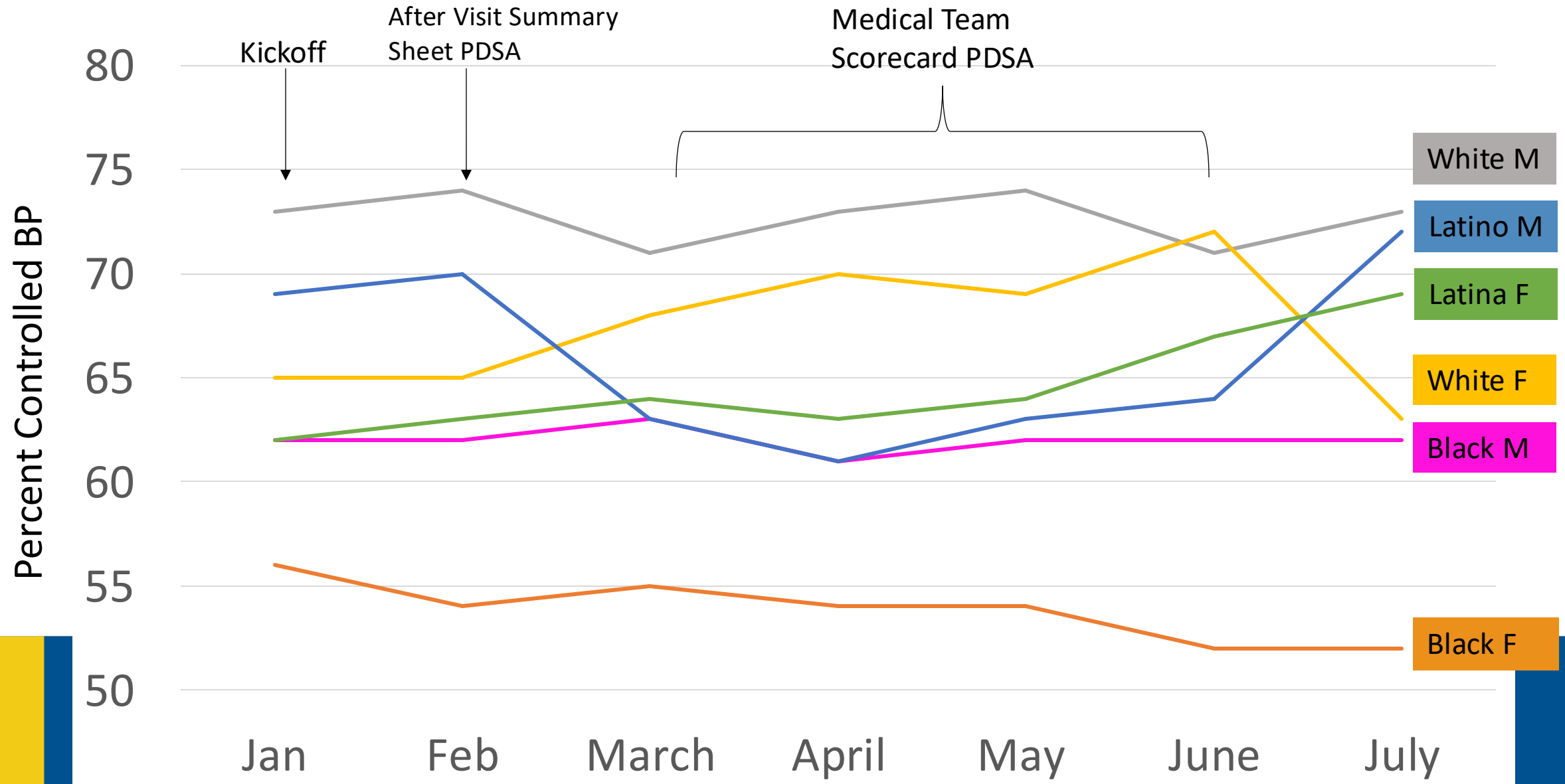
PDSA #3

Change idea: care team use of Azara registry data for outreach to uncontrolled clients

Result: saw 1% improvement in BP control for Hispanic/Latina clients

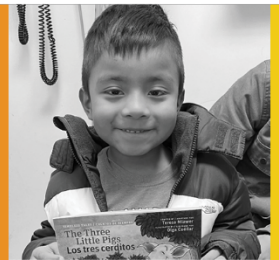
Sustainability: final results shared, sustainability plan discussions upcoming

Hypertension Disparities



One more thing…

- Knowing that…
  - Black women in our population are more likely to use telehealth
  - Telehealth readings can now satisfy the measure
- **Getting cuffs to Black women with uncontrolled HTN**
  - Utilized a two-time BP group run by Tracy and PH
    - Originally for MDPCP clients, but 8 clients signed up – only 1 was MDPCP
  - Reached out to clients who needed a BP monitor
    - Many of the clients who were called already had monitors!
  - 7 clients expressed interest and were scheduled; none showed
  - **Medical provided a registry of Black/African American women with uncontrolled HTN for care teams to connect clients with BP monitors and educational materials (Catherine and Courtney are leading this effort)**



Hospital Readmission

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

Subcommittee: Wynona China, Jimmy Miller, Tracy Russell, Julie Rich, Tyler Gray, Kayla Walsh, Lilian Amaya, Greg Rogers, Muhammed Mamman, Lisa Lefavore

Hospital Readmission PDSA Summary

PDSA #1

Change idea: Strengthen relationship with Mercy for improved continuity of care (warm hand off process, tour, ongoing touch points, communications resource)

Result: Established client warm hand off connections; addressing challenge of connecting with client post discharge; Mercy and HCH staff seeing promising results

Sustainability: simple process that is manageable and with positive impact; relationship ongoing to address issues

PDSA #2

Change idea: transportation support to clients who otherwise wouldn't be able to make their hospital f/u appointment

Result: did not result in improved appointment access (none of the clients made their appointment)

Sustainability: subcommittee abandoned this idea to focus resources on higher impact change ideas/plan to ask partner hospitals about their resources to help with transport

PDSA #3

Change idea: Expand PDSA #1 to Hopkins, one of top three highest utilized local hospitals by established HCH clients

Met with Hopkins discharge team members; we are rolling our Mercy procedure out to them

Other news / what's next

- Created a sustainability plan
- Meeting with Hopkins and Mercy again in September
- Path forward:
  - Working to connect with University of Maryland as one of top three utilized hospitals
  - Met with MedStar Franklin Square and provided one pager in Spanish and English for staff and clients as well as County number to connect clients to care nearby
    - Working to develop an approach that meets needs of both parties – potential for stronger flagging and coordination on admission between practice manager and the MedStar Team
  - Continuing to meet on a month-to-month basis to develop these relationships

Colorectal Cancer Screening

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

Moved to 31% in July; alone, the month of July was 38%!

Subcommittee: Pandora Bruton, Katharine Billipp, Elizabeth Zurek, Tracy Russell, Kim Taylor, Hanifah Matumla, Jazzmine Jackson, and Tierra Garnett

Colorectal Cancer Screening PDSA Summary

PDSA #1

Change idea: provider communication of documentation for accurate data (certain test not satisfying the measure)

Result: determination that minimal staffing using, but was good reinforcement

Sustainability: incorporated into regular training and reminders in medical spaces

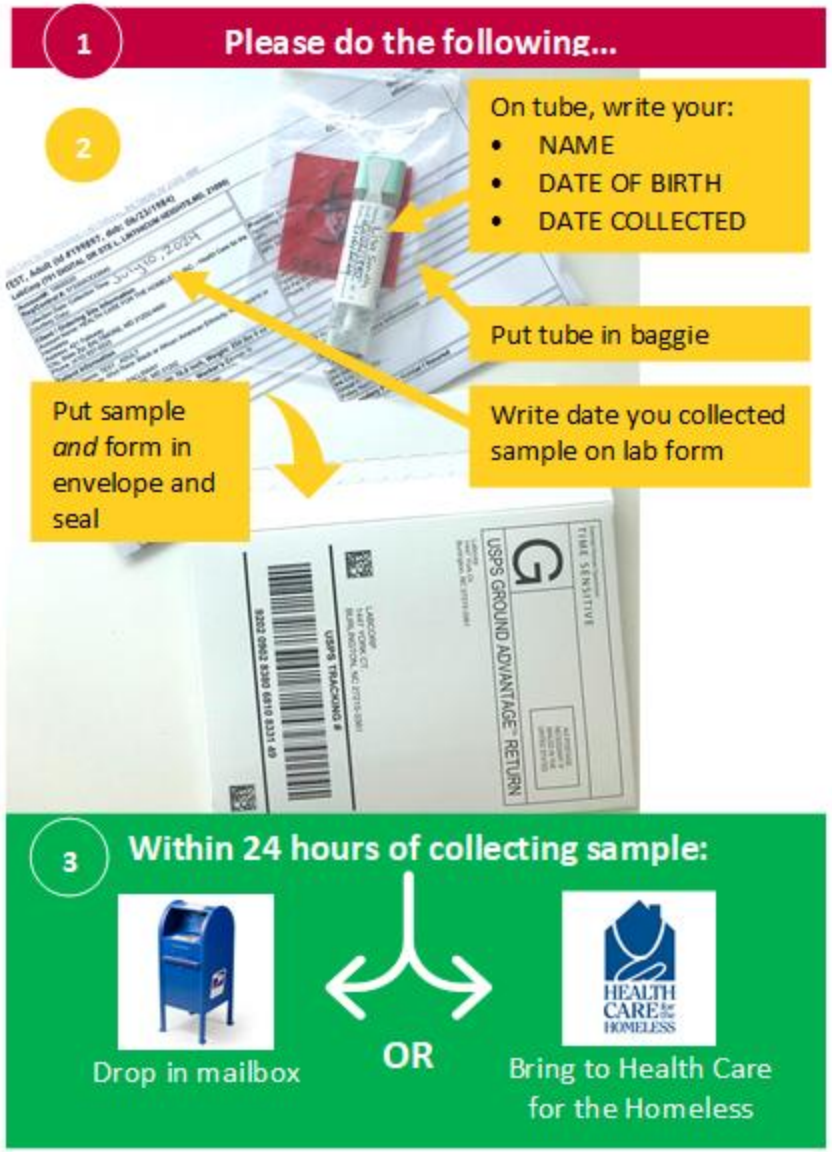
PDSA #2

Change idea: train the trainer; CMA champions as POCs and trainers for their team

Result: currently implementing new visual aids like small toilets to explain to clients how to collect a sample; improved health literacy resources to describe fit kit completion to clients; and gloves for collection kits

Sustainability: defining expectations and involvement of trainers in ongoing work

Next steps



- Designed stickers (at left) to attach to FIT kits
- CMA champions are using the demo toilets now; feedback to come
  - THANK YOU to Jazz, Tierra, and Pandora for all your work developing and implementing this!
- Don’t forget the .crc-screening quicktext!

PHQ-9 Questions 1 or 6

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, Shauna Griffin, Wendy Hrica

PHQ-9 Questions 1 or 6 Summary

PDSA #1

Change idea: equip Therapist Case Managers working in the field with laminated and paper copies of PHQ9 for streamlined access/workflow and visual reminder

Result: Positive feedback from TCMs, desire to expand to full team and include all screenings on a ring

Sustainability: development of additional resources for SH and BH expansion

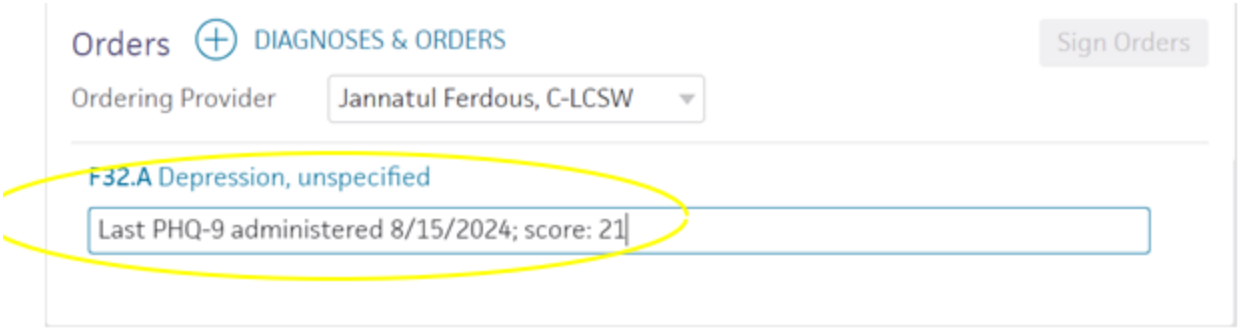
PDSA #2

Change idea: support BH and SH TCM staff in ongoing awareness of last PHQ9 administered to improve on re-screening at appropriate time intervals (i.e. reviewing and inputting last date administered in each note)

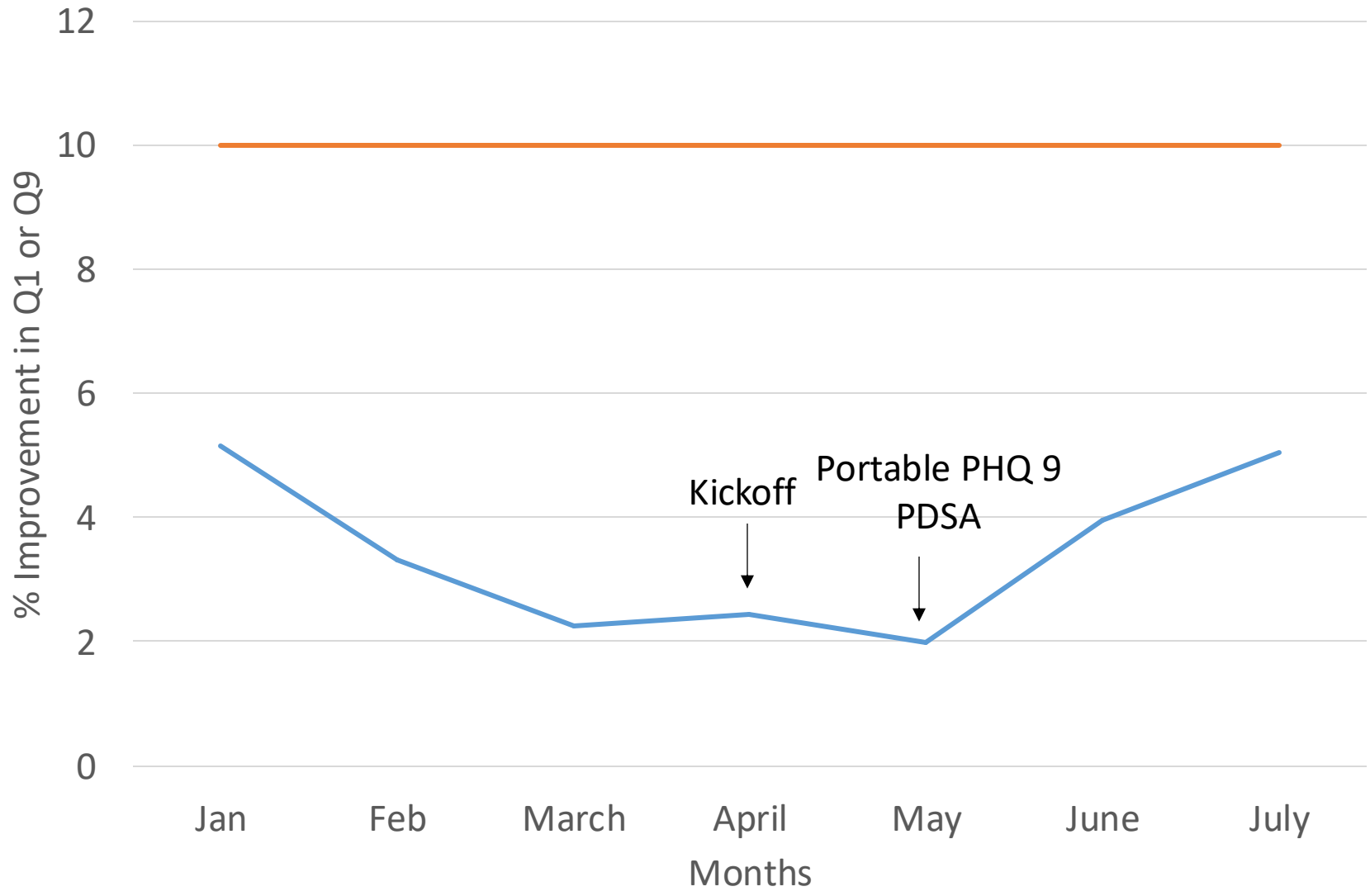
2 BH therapists and 2 TCMs to use the Assessment and Plan portion of the chart to document last PHQ9 date and score; will continue to carry over until updated

Documentation of last PHQ-9

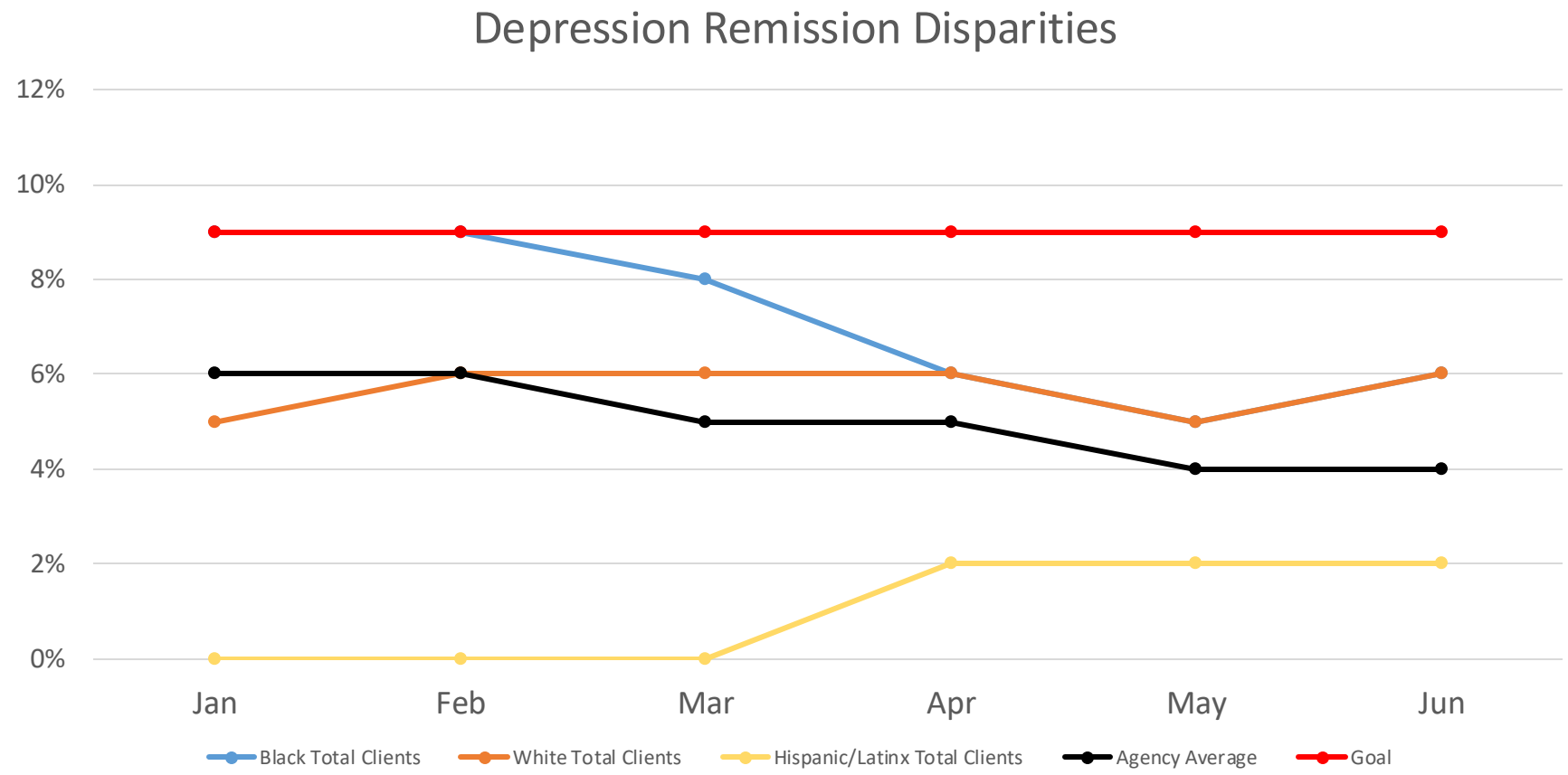
- A team of TCMs and BH therapists will trial documenting the last PHQ-9 under the diagnosis, as below:



PHQ-9 Q1 or Q6


12
10
8
6
4
2
0
% Improvement in Q1 or Q9
Kickoff
Portable PHQ 9
PDSA
Jan
Feb
March
April
May
June
July
Months

Disparity Data (Depression Remission Measure)



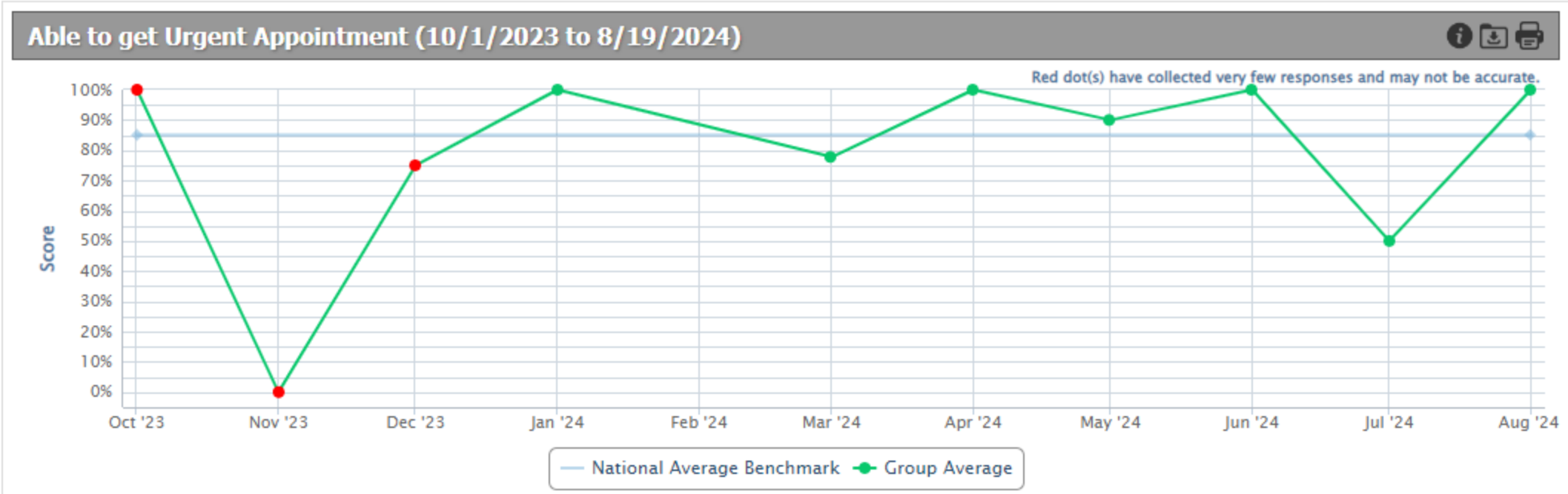
	Q1	Q2
Black Total Clients	8% (9/111)	6% (5/91)
Black Male Clients	6% (3/53)	7% (3/44)
Black Female Clients	11% (6/55)	4% (2/46)
White Total Clients	6% (2/34)	6% (2/34)
White Male Clients	13% (2/16)	11% (2/18)
White Female Clients	0% (0/17)	0% (0/16)
Hispanic/Latinx Total Clients	0% (0/45)	2% (1/45)
Hispanic/Latino Male Clients	0% (0/6)	0% (0/6)
Hispanic/Latina Female Clients	0% (0/38)	3% (1/37)

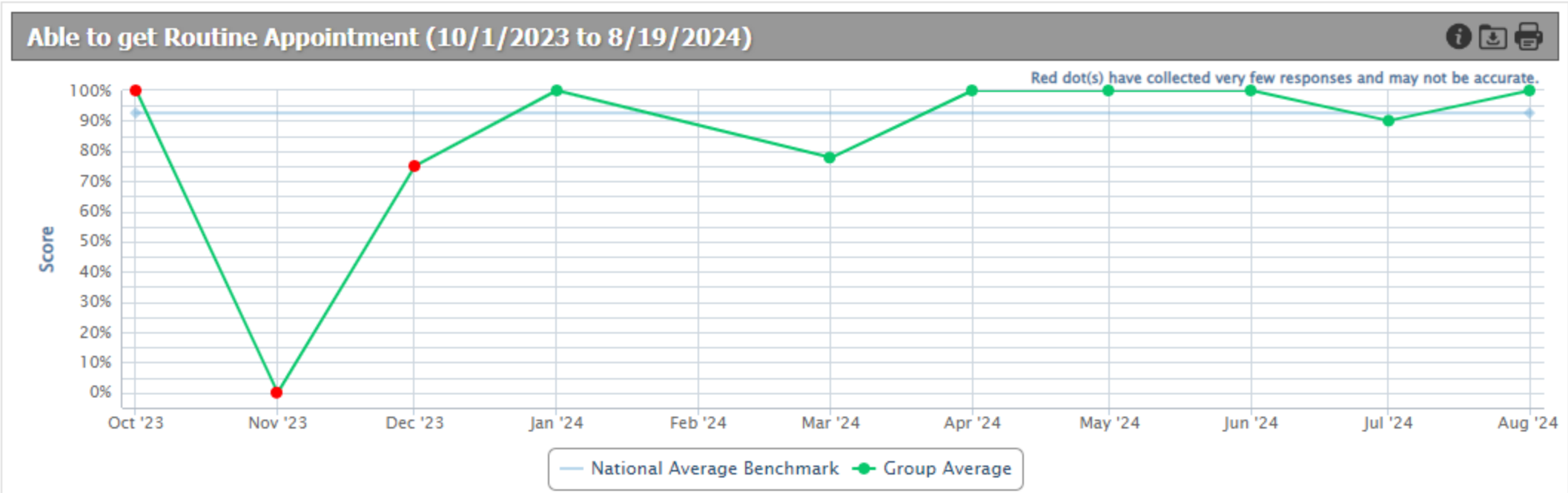
Appointment Access

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

BH


Able to get Urgent Appointment (10/1/2023 to 8/19/2024)
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
Jun '24
Jul '24
Aug '24
National Average Benchmark
Group Average


Able to get Routine Appointment (10/1/2023 to 8/19/2024)
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
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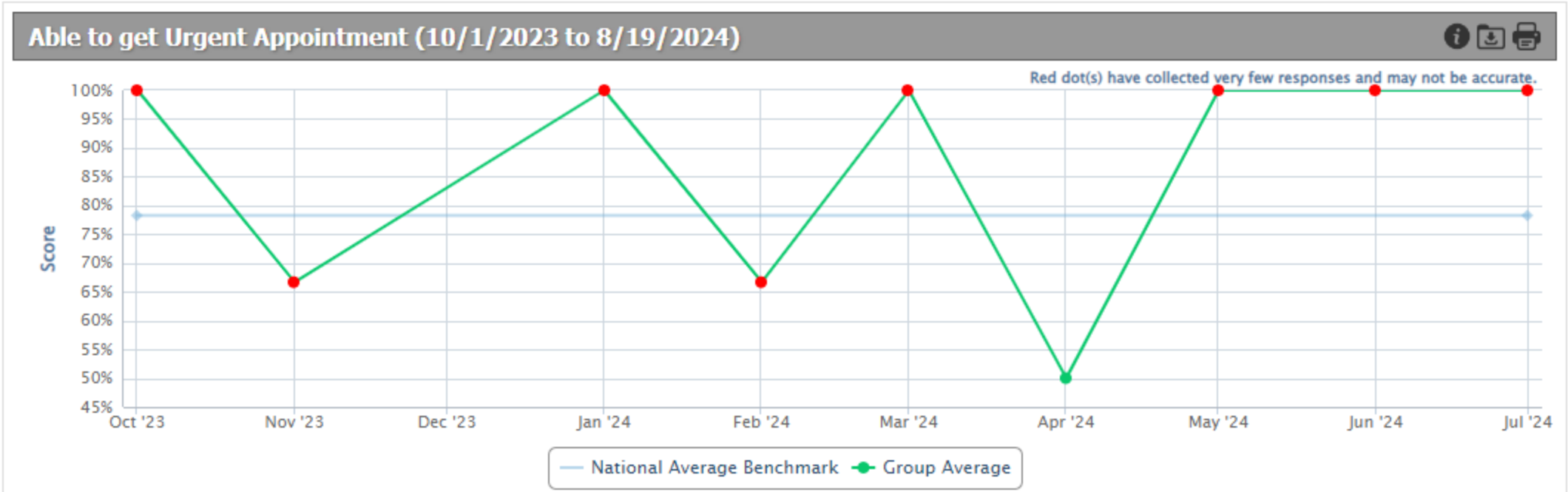
Apr '24
May '24
Jun '24
Jul '24
Aug '24
National Average Benchmark
Group Average

Dental


Able to get Urgent Appointment (10/1/2023 to 8/19/2024)
Red dot(s) have collected very few responses and may not be accurate.
Score
100%
95%
90%
85%
80%
75%
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60%
55%
50%
45%
Oct '23
Nov '23
Dec '23
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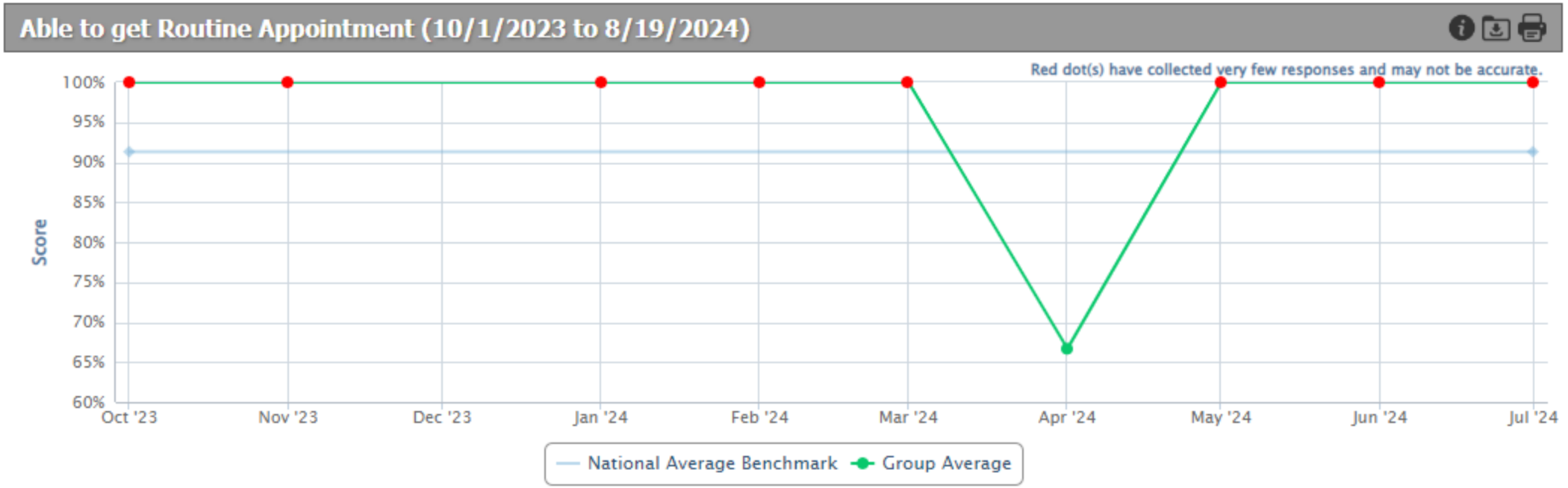
Jun '24
Jul '24
National Average Benchmark
Group Average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Score
100%
95%
90%
85%
80%
75%
70%
65%
60%
Oct '23
Nov '23
Dec '23
Jan '24
Feb '24
Mar '24
Apr '24
May '24
Jun '24
Jul '24
National Average Benchmark
Group Average

PDSA #1

Client idea!

Change idea: clients are restricted on coming in by transportation; creating a paper resource of all known available transportation assistance

Results: working with Communications to refine into a good-looking, readable resource

Sustainability: still determining review cadence and responsibility

PDSA #2

Client idea!

Change idea: retention and burnout are issues; create a “shout-out jar” so employees can show appreciation to coworkers

Results: two departments volunteered: **looking for more to try this out!**

Sustainability: boxes will be maintained by a representative of each department

Shout-Out Boxes

For when passing the light quarterly isn't enough…

Shout-out boxes: you can pass the light right when you feel it!

- Please **place in an area your team congregates** (shared workspace, etc.)
- Please also **designate one person** to check it regularly
  - Could be a supervisor or a designated champion
- It's your team's choice how you **share the compliments**
  - At your team's regular meetings
  - Via email
  - Via mass Teams message

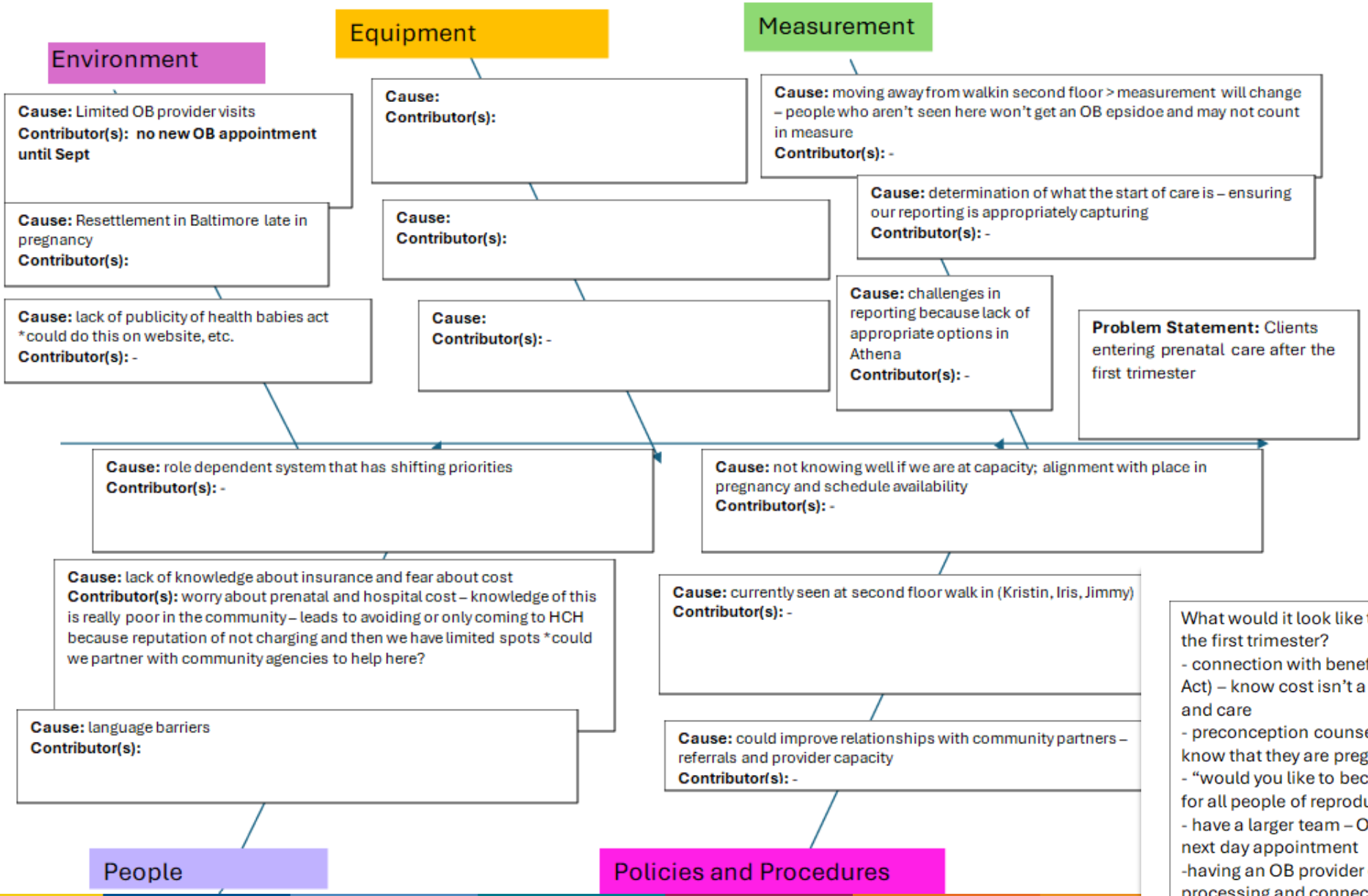
We have two more boxes that we'd love other departments to try!
Please contact us if interested!

Early Entry to Prenatal Care

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

Subcommittee: Tyler Gray, Sharon Hooper, Hanifah Matumla, Ash Lane, and the Pediatrics and OB teams

Root Cause Analysis



PDSA #1

Change idea: OB provider convert visits – Ash performing intake and sending clients directly to Tyler Gray and Dr. Dole for provider assessment and initiation of care (is best practice and fulfills requirements of the UDS measure!)

Result: meeting at end of August to build out PDSA and next steps

Other notes on early entry

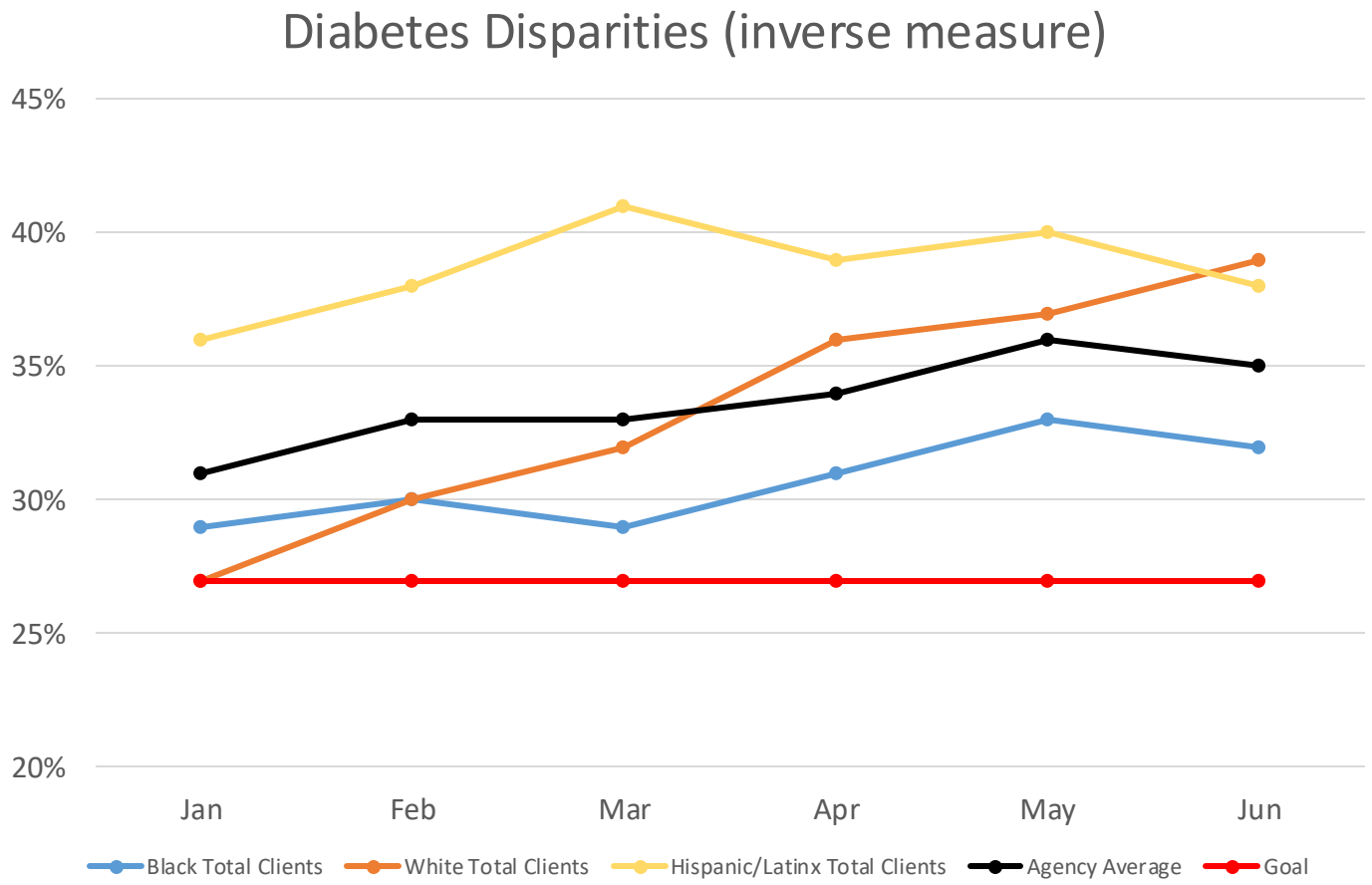
- Health IT has created an excellent report that includes prenatal early entry and OB outcomes
- Developing a brief feedback questionnaire for OB clients who bring their babies back for care
  - 4-5 questions
  - Includes questions about prenatal care, ease of scheduling child, and vaccines
  - To be given at the 6-month visit

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, Margaret Flanagan, Arie Hayre-Somuah

Disparity Data (DM Disparities)



	Q1 (34%)	Q2 (35%)
Black Total Clients	29% (162/554)	32% (176/543)
Black Male Clients	28% (92/330)	33% (108/330)
Black Female Clients	31% (66/215)	31% (65/207)
White Total Clients	32% (53/165)	39% (71/183)
White Male Clients	36% (34/94)	38% (39/104)
White Female Clients	28% (19/69)	40% (31/78)
Hispanic/Latinx Total Clients	41% (181/445)	38% (175/466)
Hispanic/Latino Male Clients	49% (93/189)	44% (88/202)
Hispanic/Latina Female Clients	34% (84/250)	33% (87/263)

PDSA #1

In the works!

The Spanish-speaking resources we found are already in use

Pivoting to another intervention (or set of interventions) in collaboration with nurses

PI and the nursing team will continue to collaborate in the weekly huddle space

Next steps and other ideas: diabetes

- We have some clients who are **untested**: have no A1c on file for the past year, but have a DM diagnosis
  - 21% of uncontrolled clients at HCH were untested as of May 2024
  - How do we get these clients in for their test?

Closing the Referral Loop

Conduct at least one PI project on care coordination: **closing the referral loop.**

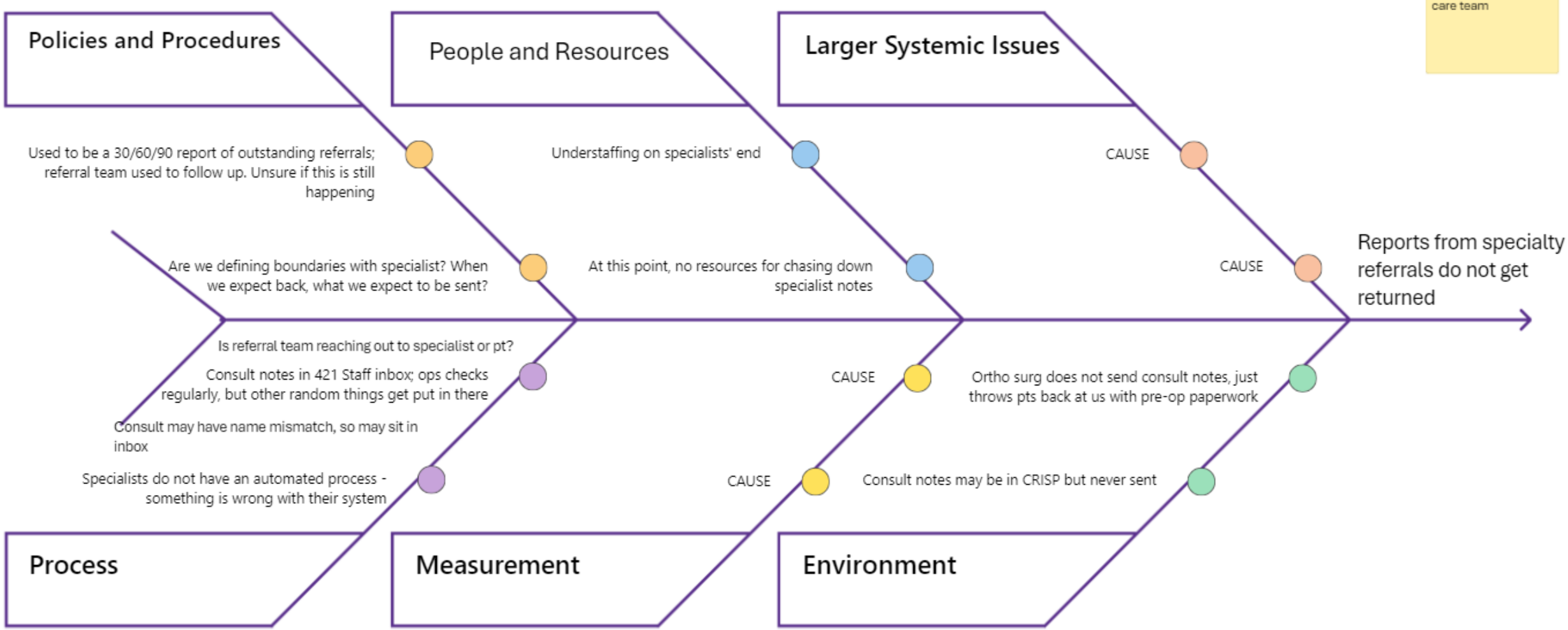
Subcommittee: Catherine Denver, Cecelia Lane, Wynona China, Kristin McCurnin, Gabi Hiciano, Adrienne Burgess-Bromley, Charmaine Johnson

Root Cause Analysis

Reaching out directly to specialists to discuss issue - how would they prefer to transmit?

Azara PVP module has referrals widget

Referral coordinator assigned to each care team



Client focus group: Referrals

- Conducted a focus group of **4 clients**
  - 3 had experience with our referral system, 1 did not

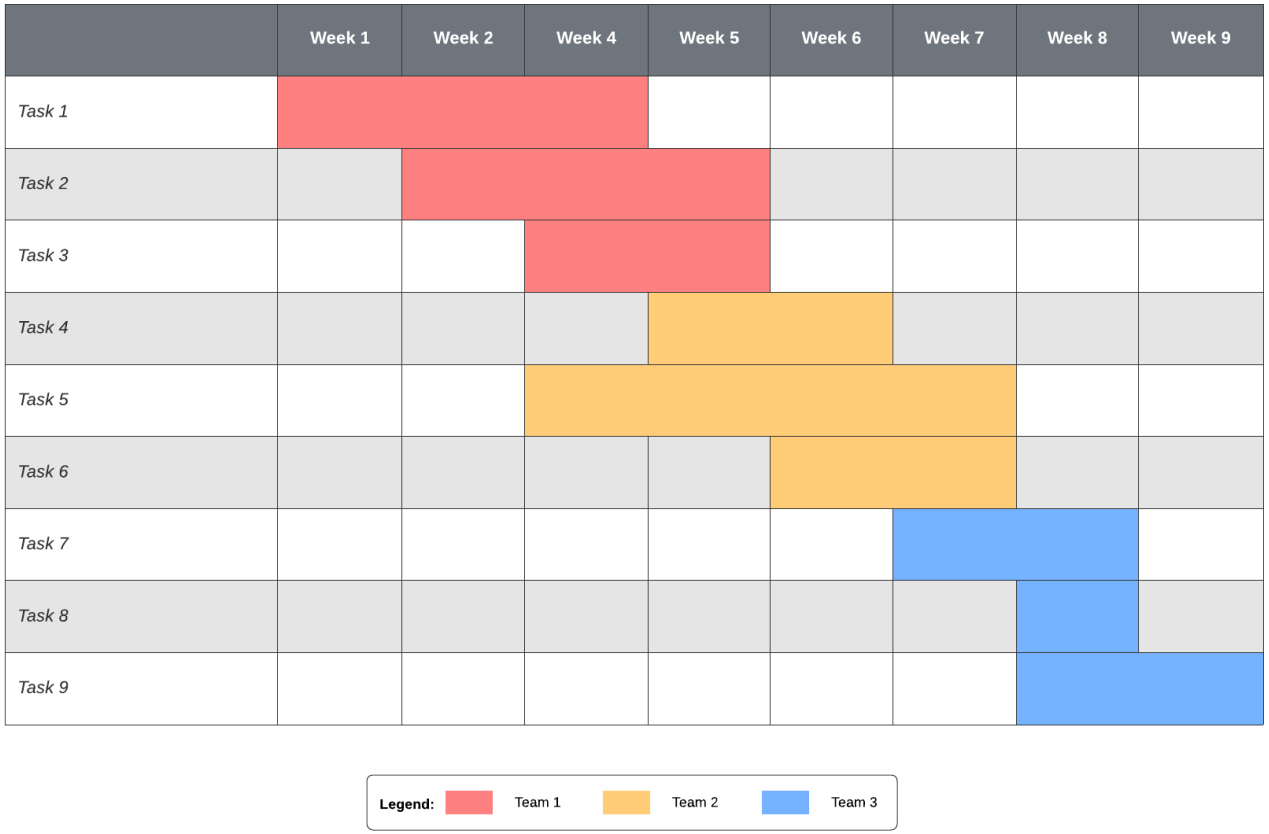
Contributors to Successful Referrals	Contributors to Unsuccessful Referrals
Peer support to alleviate anxiety	Anxiety about the appt, procedure, or recovery
Clear instructions	Expired referrals
Timing and location of appt: must be accessible	Traveling to referrals: scattered across city, far from home
Portal enrollment	Lack of bus fare or accessible transportation
Communication between PCP and specialist	Unknown provider change that was not communicated to client
Provider offering help with communication	

Next measures coming up

- Choosing PI goals for next year
- Looking forward to the end of the year
  - Data Party in October!
  - Quality and Safety Celebration in November!

PI tool: Gantt charts

- PI usually has multiple things going on at once
  - Multiple subcommittees
  - Multiple tasks for each subcommittee
  - Different teams working on all of it
- Other departments do too! So how do you look at or plan all this work at a bird's-eye view?
- Enter the **Gantt chart**
  - A bar chart that illustrates a project schedule
  - Shows the time allotted for different tasks or phases of a project



Resources

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

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 Wednesday!

For any questions, email:

mstelmack@hchmd.org

lhoffmann@hchmd.org

HEALTH CARE for the HOMELESS