July 2024 PI Informational Meeting

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5/15/2024

Agenda

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

Good morning!

It’s National Minority Mental Health Awareness Month!

It’s Disability Pride Month!

What do you do for self-care?

PI Measures

Trailing Year Data

Key
3+ Improvement
1-2+ improvement
Reduction

Disease Management	May	June	2024 Goal
Colorectal Cancer Screening	30%	30%	40%
Controlling high blood pressure	61%	61%	66%
Hypertension Disparities	Black M: 62% Black F: 54% White M: 74% White F: 69% Latino M: 63% Latina F: 64%	Black M: 62% Black F: 52% White M: 71% White F: 72% Latino M: 64% Latina F: 67%	<5% disparity across all races and ethnicities
Childhood Vaccinations	9%	7%	18%
PHQ-9 Questions 1 and 6	Q1 or Q6: 1.99%	Q1 or Q6: 3.96%	5%
Diabetes: HbA1c poor control (>9%) [inverse]	36%	35%	27%
Diabetes and A1c Control (inverse measure)	Black: 33% White: 37% Hispanic/Latinx: 40%	Black: 32% White: 39% Hispanic/Latinx: 38%	31% Hispanic/Latinx clients

Key
3+ Improvement
1-2+ improvement
Reduction

Disease Management	May	June	2024 Goal
Clients receiving PrEP	44 clients	44 clients	36 clients
Prenatal Early Entry to Care	pending	66%	70%
Appointment Access	Med Urgent: 66% Med Routine: 80% BH Urgent: 88% BH Routine: 100% Dental Urgent: 100% Dental Routine: 100%	Med Urgent: 75% Med Routine: 85% BH Urgent: 100% 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	19%	pending	<20%
Closing the Referral Loop	23%	23%	40%
Current Medication Documentation	86%	86%	90%

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

3 PDSAs in!

4

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

Dates: March - Aug

2 PDSAs in!

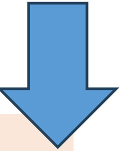
5

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

1 PDSA 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

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**

Scheduling soon!

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

RCA done!

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!*

HTN goal 66%

Race and Ethnicity	% Controlled BP
Hispanic/Latina F:	67%
Hispanic/Latino M:	64%
White F:	72%
White M:	71%
Black F:	52%
Black M:	62%

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

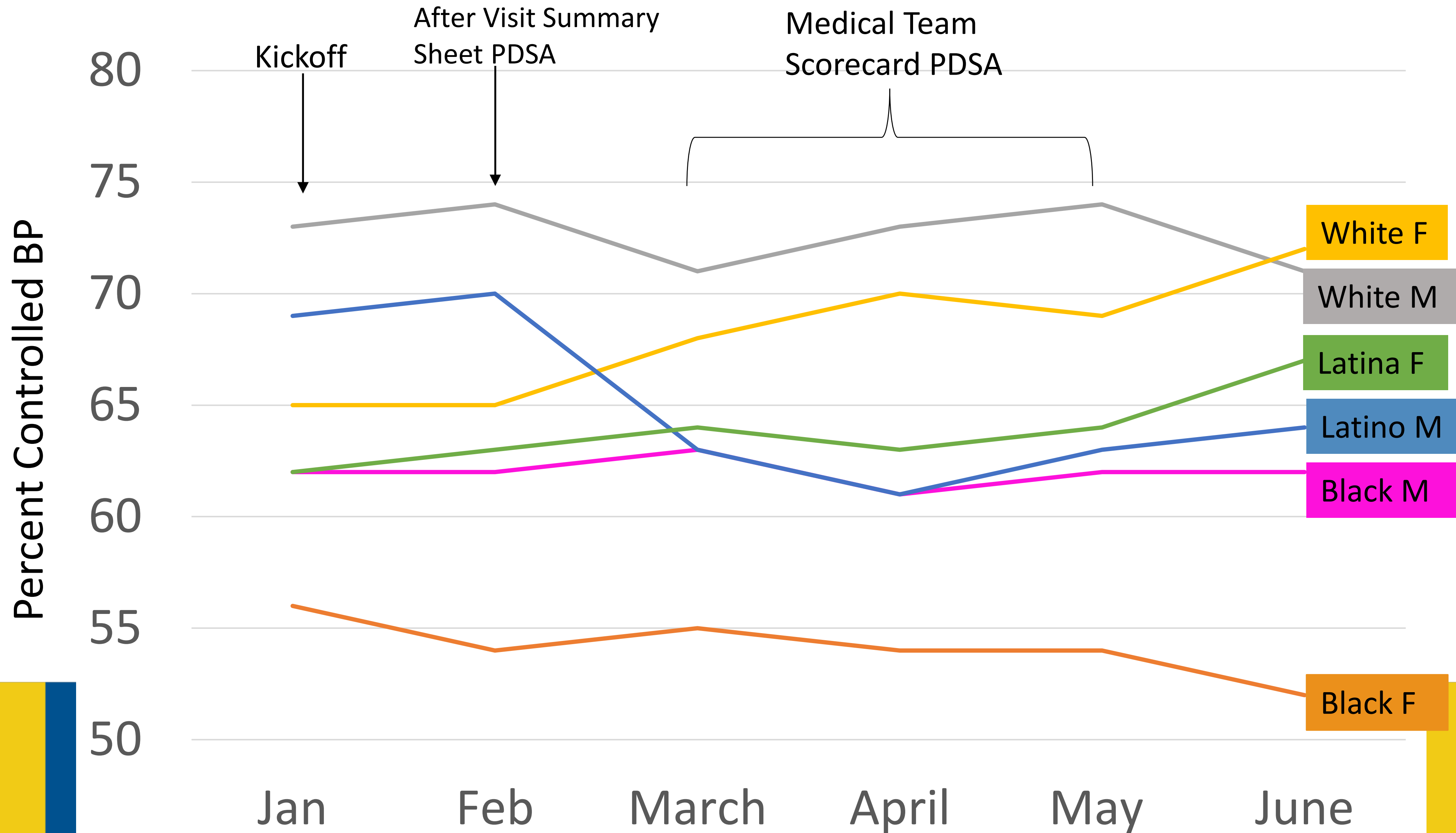
PDSA #3

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



What’s next with the Hypertension Disparity Subcommittee?

Disparity deep dive conducted to look at Black/African American women with diagnosis of hypertension and compare factors between controlled and uncontrolled BP populations.

The uncontrolled population tended to be:

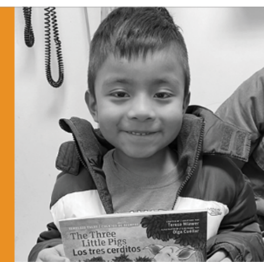
- In frequent care with psychiatry
- More likely to use telehealth
- Slightly less likely to have a recent or upcoming appointment
- May be a fewer years younger on average (did not calculate for statistical sig)
- About 20 points higher systolic BP and 10 points higher diastolic

Factors that are the same across populations:

- Usual provider seen
- Usual site for receiving care
- Nursing utilized for HTN + other chronic conditions

Next steps continued

1. Continuing the work!
   - Notable disparity despite our efforts
   - Recent UDS change to include client at home readings to satisfy the measure
     - Great alignment with our deep dive results e.g. working with group to improve our distribution of automatic BP devices and education on proper measurement technique



PrEP

Double the number of clients receiving PrEP from a baseline of 16 clients.

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

PrEP PDSA Summary

Met goal! Closed out with sustainability plan June 2024!

PDSA #1

Change idea: development of the PrEP dx code and associated order set to improve reporting and tracking

Result: with improved accuracy, increase in number

Sustainability: the report auto-updates monthly and will be used by providers and the HIV/HCV Advocate

PDSA #2

Change idea: increased communications materials (screensavers and pamphlets)

Result: positive feedback from staff; utilization in HIV testing space and waiting rooms

Sustainability: HIV/HCV Advocate upkeep of paper resource; content in screensaver circulation

PDSA #3

Change idea: outreach to PrEP clients without scheduled upcoming appointment

Result: established monthly workflow for outreach with HIV/HCV Advocate; multiple clients reconnected with care

Sustainability: established ongoing workflow and review of success and challenges with supervisor

PrEP

Outreach PDSA

Communications PDSA

Kickoff

PrEP report, dx code, and order set PDSA

50
45
40
35
30
25
20
15
10
5
0

Clients

Jan Feb Mar Apr May Jun

Months

Hospital Readmission

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

During March and April, we remained at 15%, due to changes in CRISP reporting, we are reconfiguring our internal report to accurately reflect this measure data

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

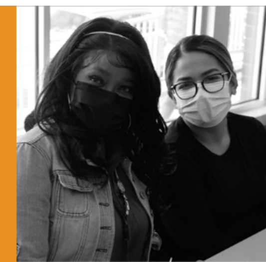
PDSA #3

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

Scheduled with Hopkins discharge team members in July

Other news / what's next

- Met with David Munson from Boston HCH to discuss their strategies
  - They make an effort to be involved at every part of the hospital stay, from admission to after discharge
  - Have a clinic embedded in a local hospital
    - Seen as internal vs. coming from the outside
  - On the Baltimore side, we're creating robust relationships with Hopkins and Mercy now, with possibly other hospital systems to come
    - We're on the right track!



Colorectal Cancer Screening

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

Since January, we've remained at 30% without fluctuation

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

Sustainability: defining expectations and involvement of trainers in ongoing work

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

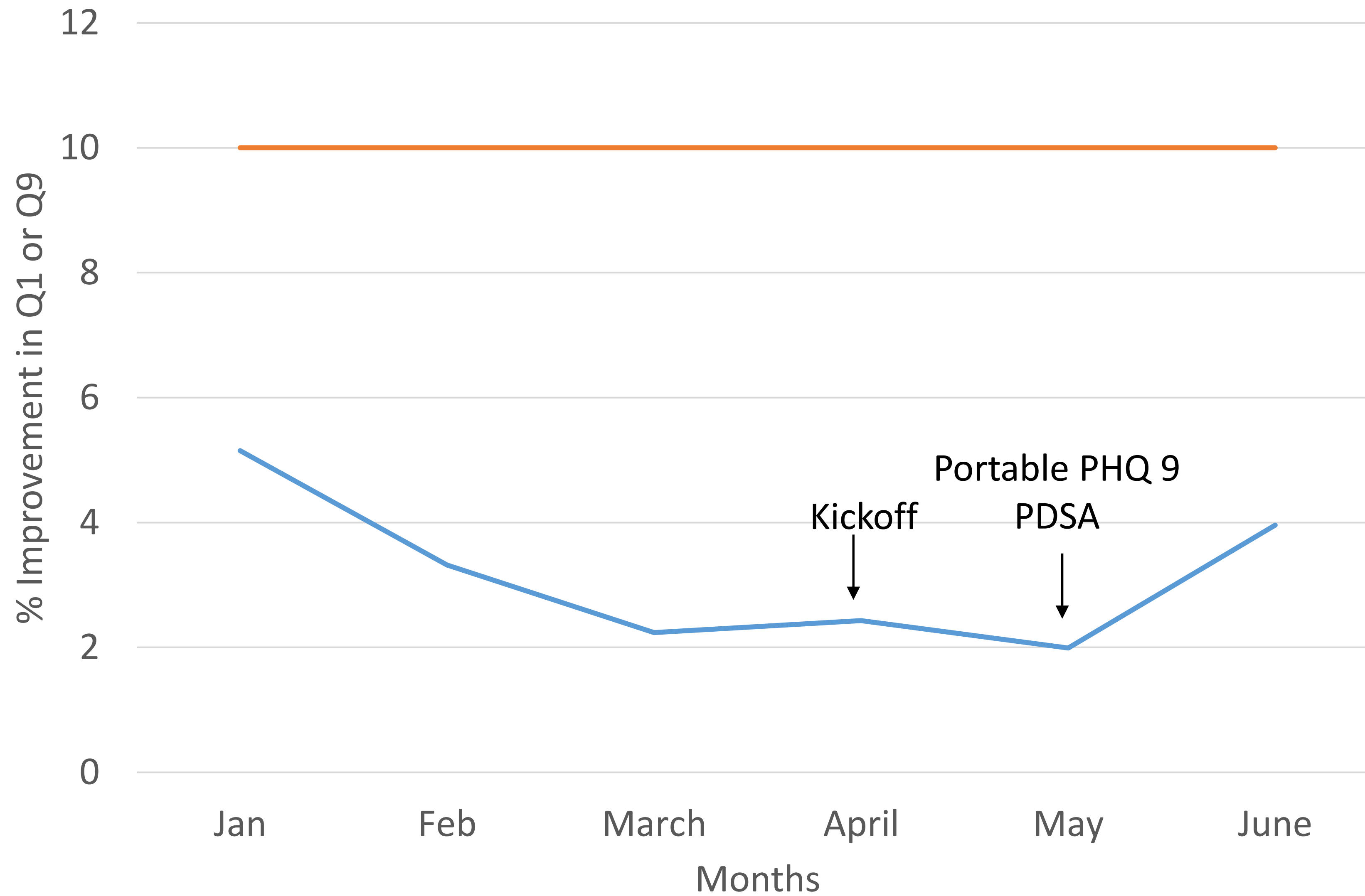
Sustainability: development of additional resources for SH and BH expansion

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)

Currently establishing department specific approaches

PHQ-9 Q1 or Q6



Disparity Data (Depression Remission Measure)

Depression Remission Disparities

	Jan	Feb	Mar	Apr	May	Jun
Black Total Clients		9%	8%	6%		
White Total Clients	5%	6%	6%	6%	5%	6%
Hispanic/Latinx Total Clients	0%	0%	0%	2%	2%	2%
Agency Average	6%	6%	5%	5%	4%	4%
Goal	9%	9%	9%	9%	9%	9%

!

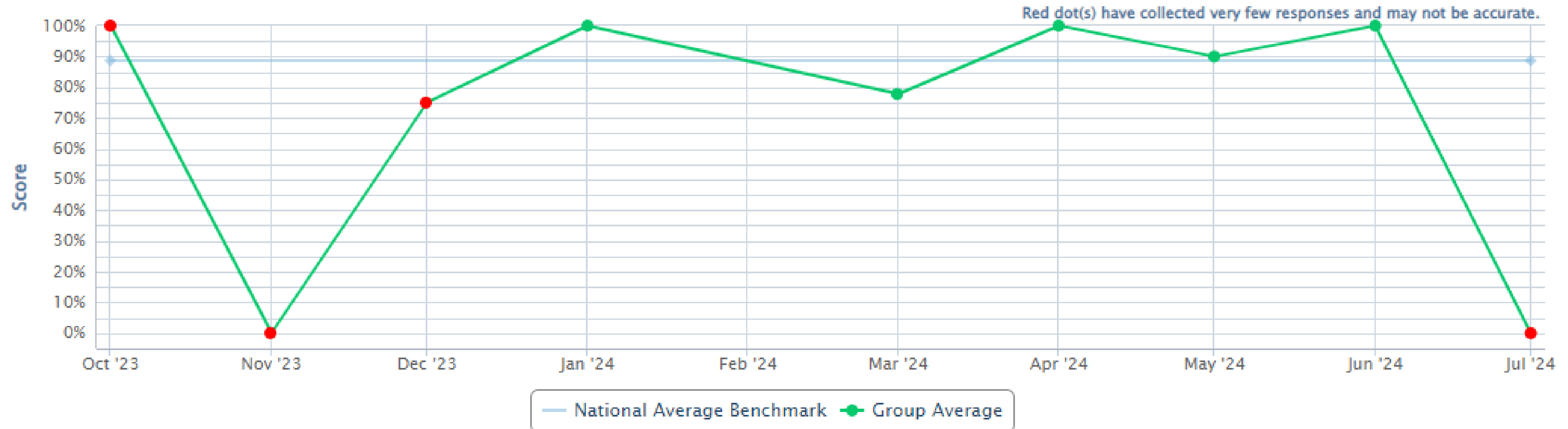
	Q1	Q2
Black Total Clients	8% (9/111)	6% (5/91)
Black Male Clients	6% (3/53)	7% (3/44)
Black Female Clients	11% (6/55)	4% (2/46)
White Total Clients	6% (2/34)	6% (2/34)
White Male Clients	13% (2/16)	11% (2/18)
White Female Clients	0% (0/17)	0% (0/16)
Hispanic/Latinx Total Clients	0% (0/45)	2% (1/45)
Hispanic/Latino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

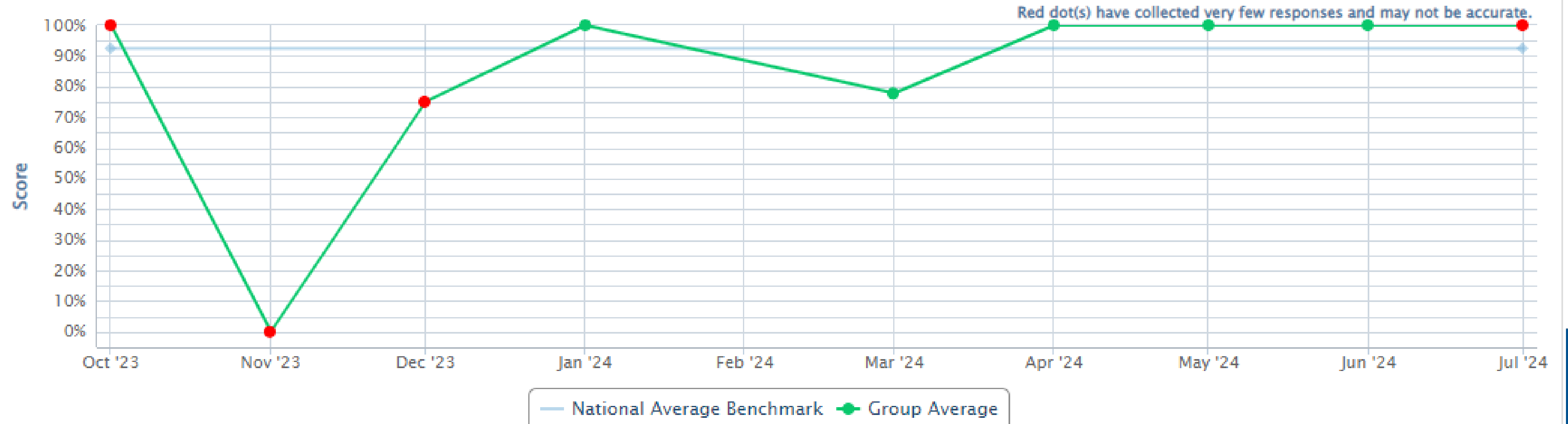
Appointment Access

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

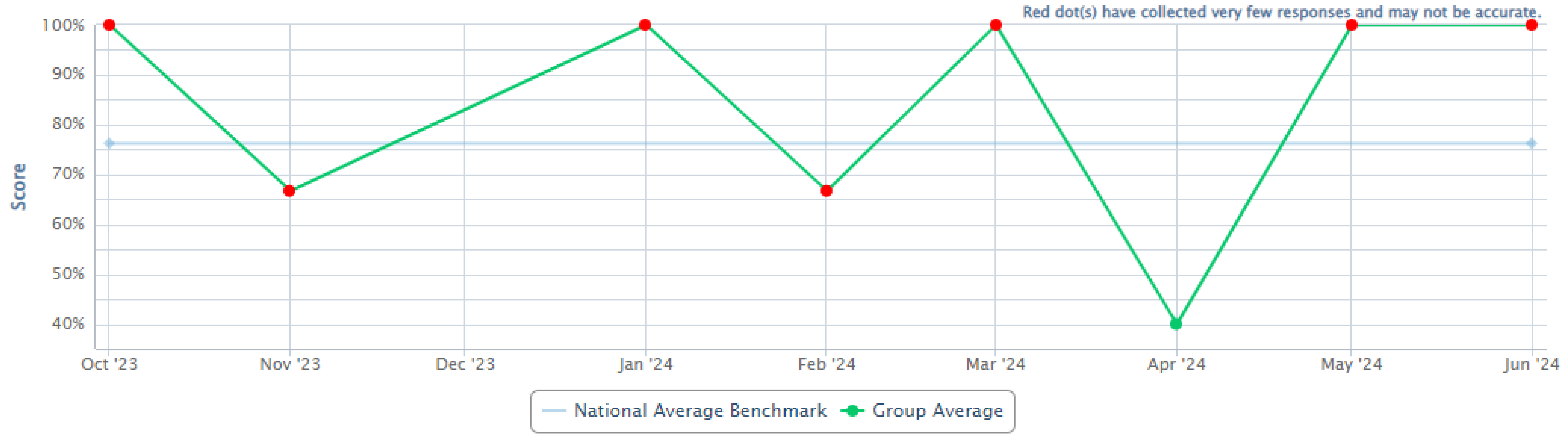
Subcommittee: Lisa Lefavore, Liz Goldberg, Muhammed Mamman, John Lane, Alkema Jackson, Juanita Peterson, Wynona China, Janel Taylor, Jan Ferdous, Deborah Hart

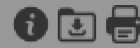
BH

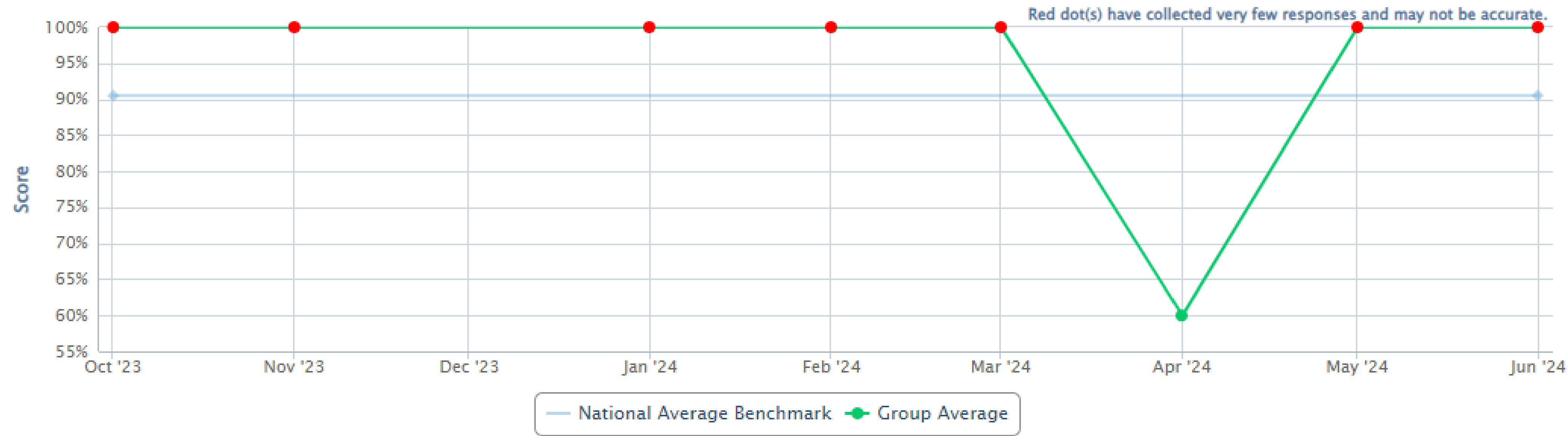




Dental







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

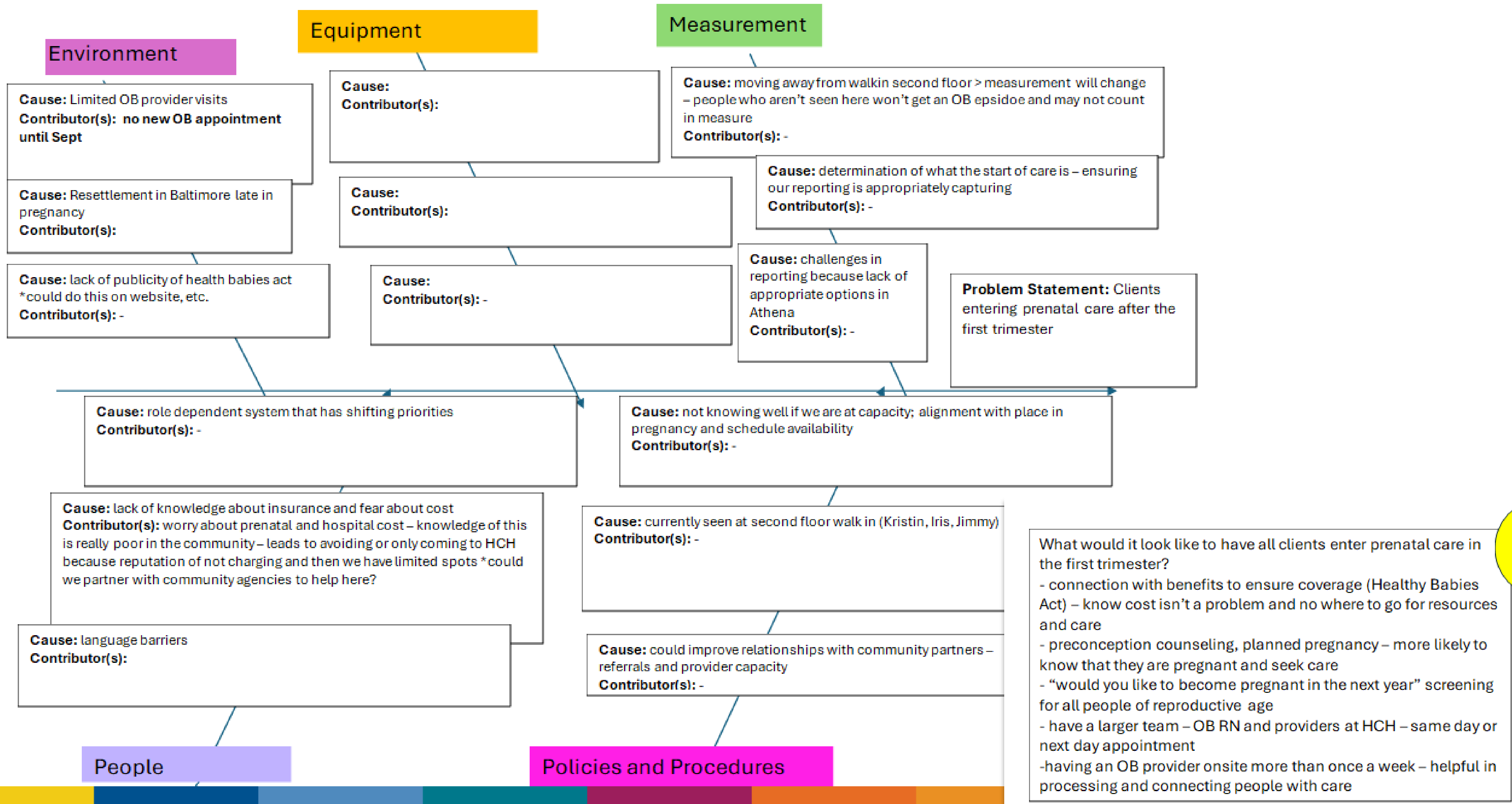
Sustainability: still determining review cadence and responsibility

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



Other notes on early entry

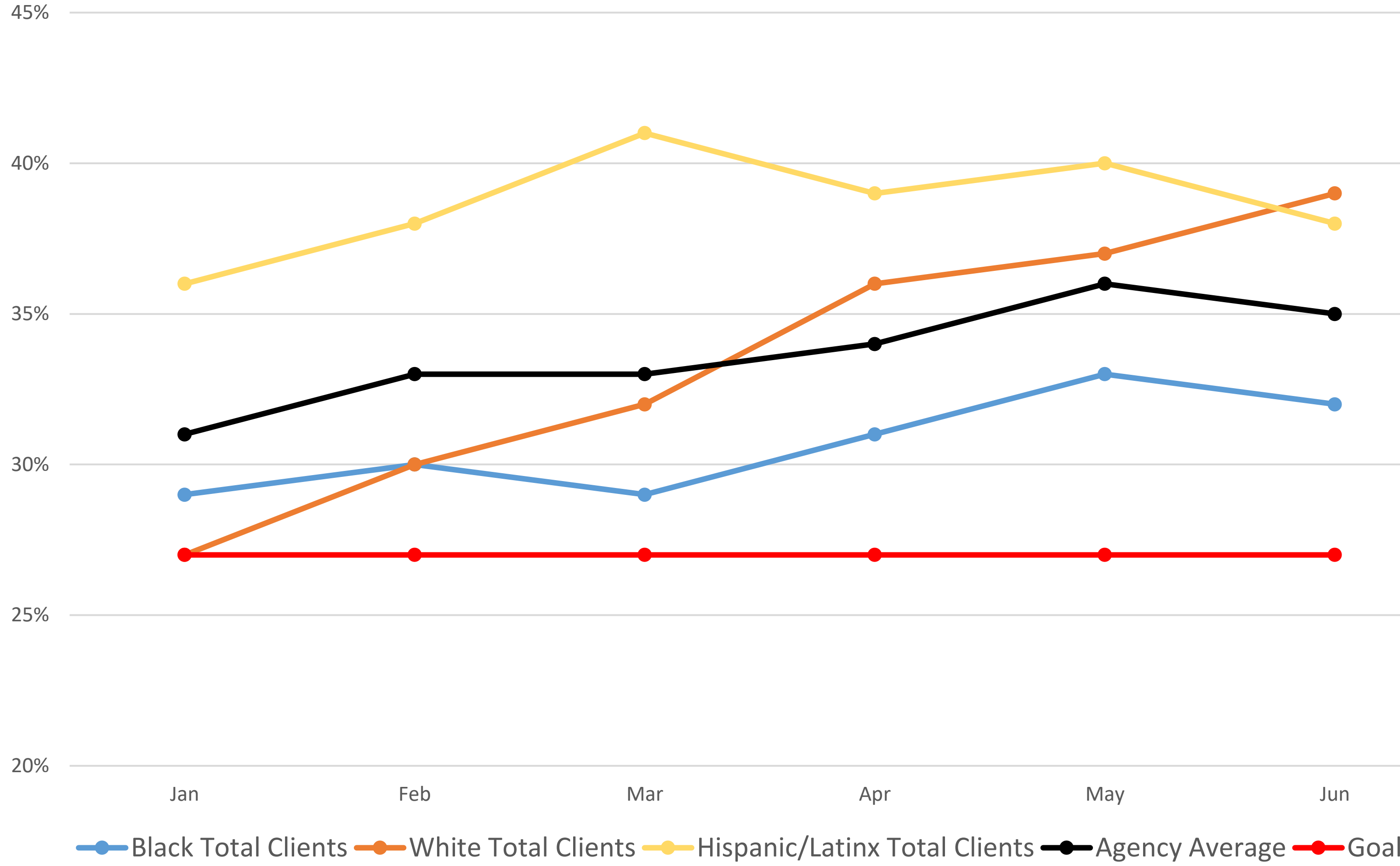
- Health IT has created an excellent report that includes prenatal early entry and OB outcomes
- Developing a brief feedback questionnaire for OB clients who bring their babies back for care
  - 4-5 questions
  - Includes questions about prenatal care, ease of scheduling child, and vaccines
  - To be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



	Mar (34%)	Jun (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

Change idea: culturally-tailored DM education, such as recipes and Spanish-language handouts

Result: 2-3 RNs are currently deploying these resources with Hispanic/Latinx clients with diabetes

Sustainability: resources found will be relevant far into the future

Other notes on diabetes

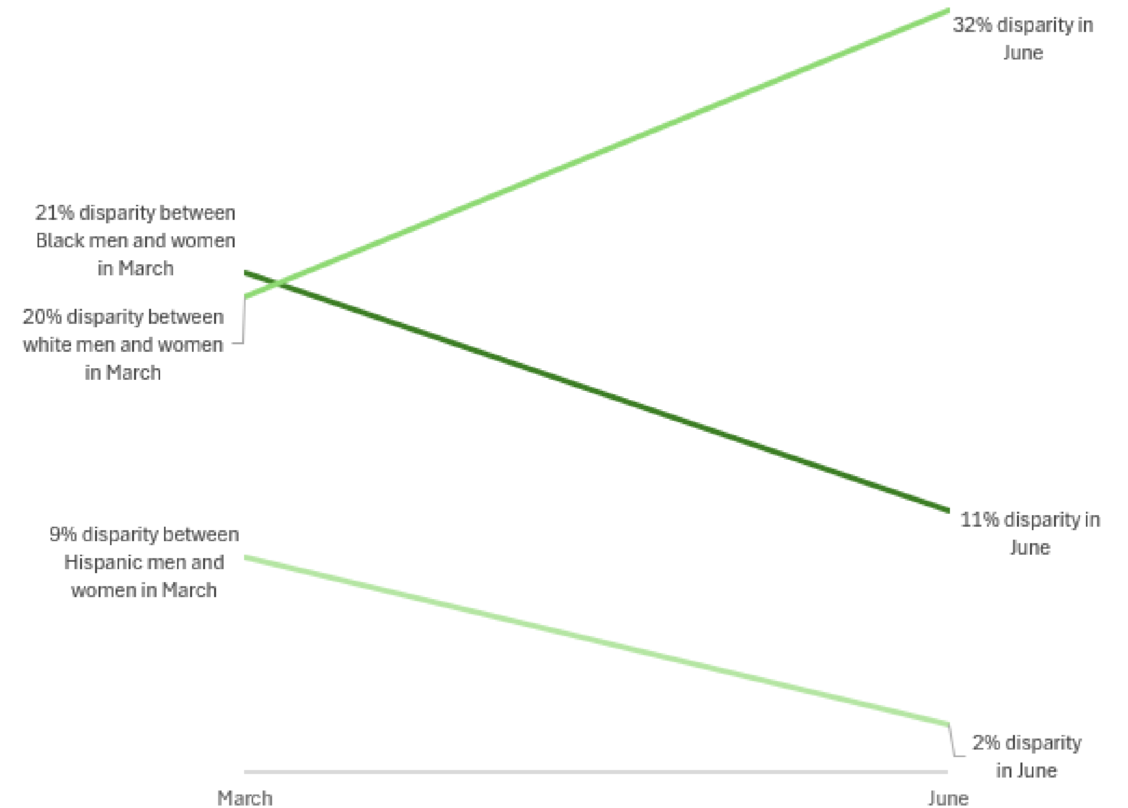
- Some insight from Laura Garcia:
  - HCH history: our diabetes control rates improved significantly when we began prescribing modern diabetes meds e.g. GLP-1 inhibitors
  - However, these drugs are going up in price massively and facing widespread shortages
  - We’ve had to go back to prescribing older, less effective drugs as a result

Next measures coming up

- Working on scheduling for the care coordination measure: **closing the referral loop**
- Looking forward to the end of the year
  - Data party…? Stay tuned
  - Quality and Safety Celebration!

PI tool: slope charts

- What if you want to show change for multiple groups over a time period, but showing the fluctuation in-between is just too much data?
  - We've learned in past months that variation can be typical in processes
  - Maybe we don't want people to get lost in analyzing those fluctuations
- Enter the **slope chart**
  - Simplest possible line chart: two points
  - Plotting multiple slopes can show changes in ranking, the magnitude and speed of total change over time, or the differences between two categories



Resources

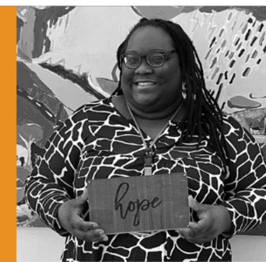
As a reminder, our PI tools and templates are available for use:

(And a shout-out to Kaoru Ishikawa, the creator of the fishbone diagram, who would have turned 109 on the 13th!)

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:

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