Quality Improvement for Homeless Patients: Infusing a Culture of Quality

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Boston Health Care for the Homeless Program

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Opening Discussion

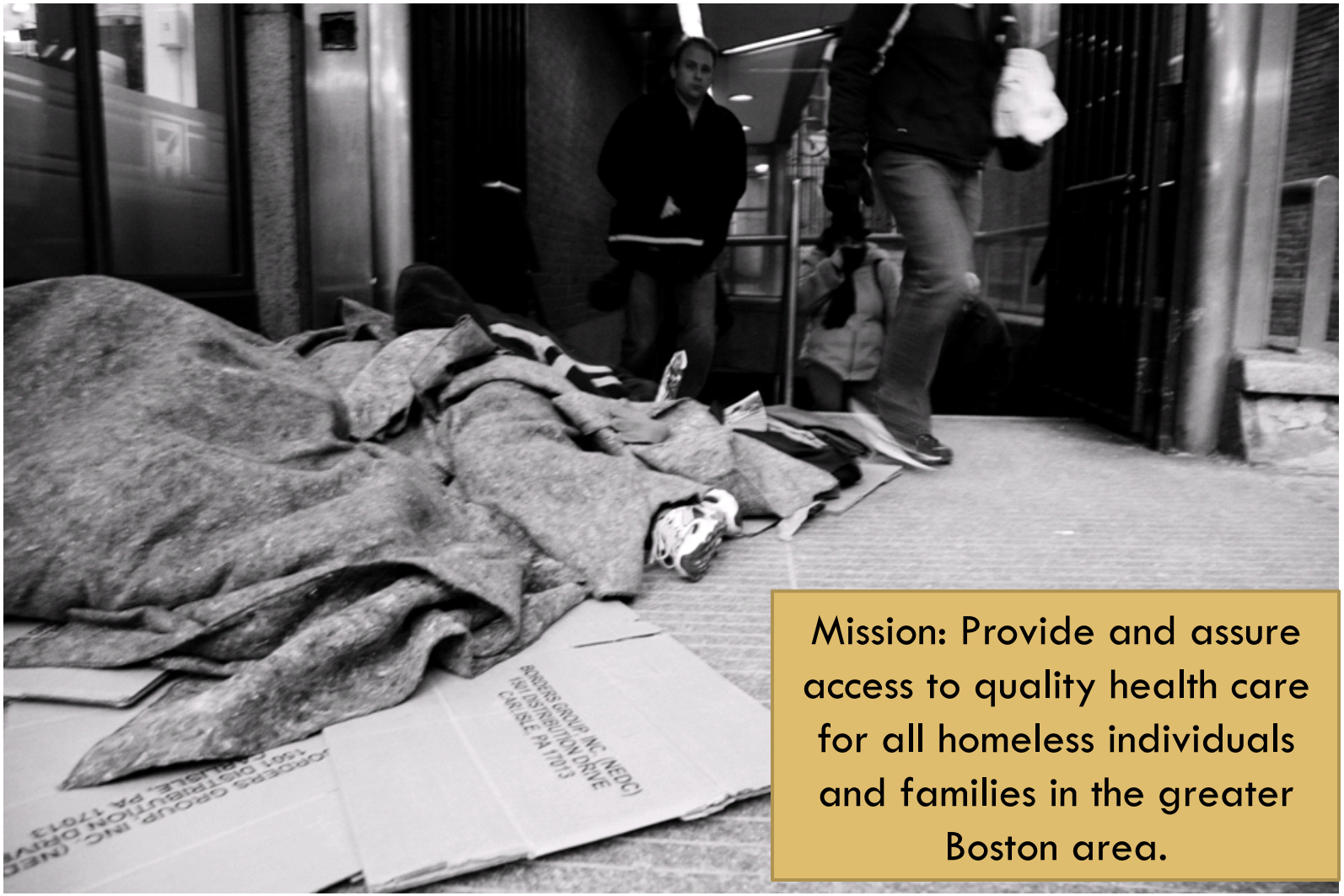
Agenda

- Consider the evolution of the QI program at Boston Health Care for the Homeless Program (BHCHP)
- Describe steps to promote a culture of quality in clinical and administrative settings
- Provide a road map to assist in implementing and maintaining a quality improvement initiative through case examples

Outline

- BHCHP at a Glance
- Our QI Journey
- PCMH Risk Stratification
- PDSA Highlights
- Discussion Throughout

Boston Health Care for the Homeless Program



Mission: Provide and assure access to quality health care for all homeless individuals and families in the greater Boston area.

Care Model

- Person-centered/ comprehensive care
- Team-based/medical home model
- Culturally competent
- Highest quality

Clinical Sites

- Mass General Hospital
- Boston Medical Center
- Bridges, alleys, parks, and doorways
- Barbara McInnis House
- Pine Street Inn
- St. Francis House
- South End Fitness Center
- Casa Esperanza
- Kingston House
- Woods Mullen Shelter
- Shattuck Shelter
- Father Bill's Place
- Rosie's Place
- Women's Lunch Place
- Family Shelters + Hotels
- Dental Clinic
- New England Center for Homeless Veterans
- And more…

Jean Yawkey Place

Boston Medical Center

Massachusetts General Hospital

Pine Street Inn Shelter

Family Team

Suffolk Downs Racetrack

Street Team

Barbara McInnis House

Homeless Health Status

- Increased mortality
- Increased chronic medical illnesses
- Increased mental illness and substance use disorders
- Multitude of barriers to medical care
- Fragmented and crisis-oriented medical care
- Medical follow up is greatly lacking
- No sufficient place to recuperate

Patient Retention

- New: ~ 60% will not come back
- Chronic: ~ 29% will not come back
- What does this imply for:
  - Panels?
  - Required quality measures?
  - Design of service delivery model?

Our QI Journey

QI Initiative

- Collection of data for baseline
- Recognition of need to improve
- Staff champion to take lead
- **Team-based approach to care**
- Motivation and incentives
- Clinical reminders
- Data reporting to individual clinicians
- Road shows

QI Initiative

- “Stall stats”
- Health and Wellness fairs
- CAB participation
- Monthly themes

Program-Wide Quality Measures

Measure	Previous Results TY Sep 2014 %	GOAL 2014-2015 & Healthy People 2020 Target (HP 2020)	Current Results TY Dec 2014 % (N/D)
Cervical Cancer Screening: Percentage of women age 21-64 who received one or more PAP smears in the past three years	50%	HP 2020 - 93% **60%**	51% (1695/3307)
Breast Cancer Screening: Percentage of women age 40-69 who have had a mammogram in the past two years	36%	HP 2020- 81.2% **45%**	37% (670/1835)
Colon Cancer Screening: Percentage of patients age 50 to 75 with appropriate screening for colorectal cancer	34%	HP 2020- 70.5% *40%*	34% (1745/5176)
Hypertension Control: Adult patients with a diagnosis of hypertension, seen at least twice in the last year, with most recent BP < 140/90	58%	HP 2020- 61.1% **61%**	58% (1364/2364)
Diabetes Control: Adults with a diagnosis of diabetes, seen at least twice in the last year with HgbA1C <9%	67%	HP 2020(A1C >9)- 16.1% **70%**	66% (755/1151)
Tobacco Assessment and Intervention: Percentage of patients 18 and older who have been seen for at least 2 medical visits, who were screened for tobacco use one or more times in the past two years AND who received cessation counseling intervention if identified as a tobacco user	97%	HP 2020: Tobacco Screening- 68.6% Cessation Counseling- 21.1% **97%**	97% (5235/5377)

Program-Wide Quality Measures

Measure	Previous Results TY Sep 2014 %	GOAL 2014-2015 & Healthy People 2020 Target (HP 2020)	Current Results TY Dec 2014 % (N/D)
Adult Weight Screening and Follow-Up: Percentage of patients 18 and older who have been seen for at least one medical visit , who had a calculated BMI in the past six months or during most recent visit AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented.	69%	**70%**	72% (6761/9383)
Coronary Artery Disease: Lipid Therapy: Percentage of patients with a diagnosis of CAD prescribed a lipid lowering agent	48%	**80%**	77%* (102/132)
Ischemic Vascular Disease: Aspirin Therapy: Percentage of patients with a diagnosis of IVD or AMI, CABG, or PTCA procedure with aspirin or another antithrombotic therapy	47%	**60%**	44% (191/435)
Asthma Pharmacological Therapy: Percentage of patients aged 5-64 who have been seen for at least one medical visit with an active diagnosis of persistent asthma who were prescribed inhaled corticosteroid or an accepted alternative medication	42%	**50%**	57%** (407/716)
Depression Screening and Follow-up: Percentage of patients aged 12 and older screened for clinical depression using an age appropriate tool AND follow-up plan documented if depressed.	YTD 45%	**60%**	46% (4627/10045)

Team-Specific Quality Measures

Site/Team	Measure
Barbara McInnis House	Medication Error Rate to be less than .75 error/day
HIV Team	Annual PPD Screening for 75% ore more of all eligible HIV patients
HIV Team	To retain 90% or more of patients seen in care
Behavioral Health Team	In 60% or more patients with an initial PHQ9 score of 15 or more, decrease PHQ9 score by 2 or more points or more
Dental Team	50% or more of HIV Team patients with annual dental visits for
Dental Team	55% or more of all dental visits to include Preventive Care
Dental Team	90% ore more of all dental visits to include Oral Cancer screening
Family Team	65% ore more of all children seen with completed immunizations

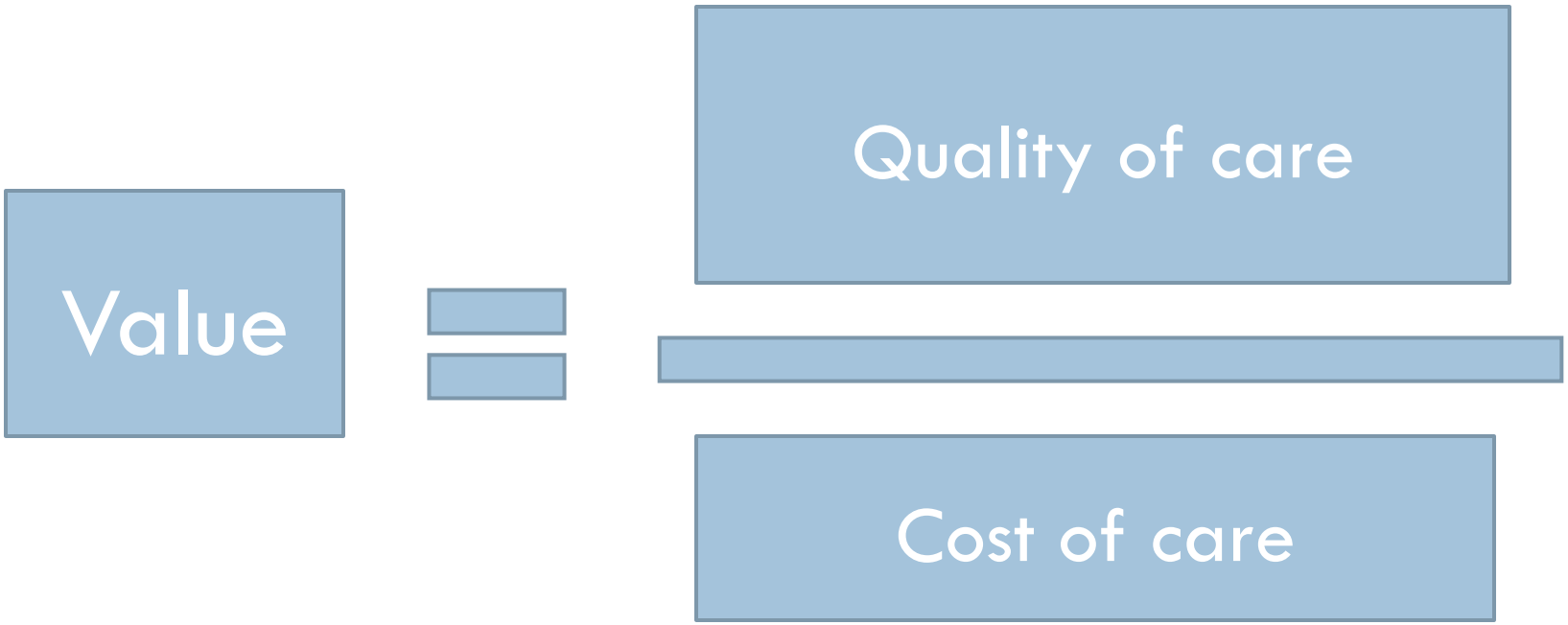
External Quality Reporting?

Quality Measure	Quality Plan	HRSA/ UDS	MA PCPR	BMC Credentialing	HealthNet P4P	MassHealth	NHP	Ryan White	NCQA PCMHI
% Generic Prescriptions						XX			
% New members with first visit						XX			
Adult Pneumococcal Immunization		Proposed							
Annual dental exam in HIV Patients	XX	XX							
Annual Eye Exam for Diabetics					XX	XX			XX
Antiretroviral therapies							XX		
Aspirin or Antithrombotic Therapy for Ischemic Vascular Disease	XX	XX							
Asthma Med Use	XX	XX	XX		XX	XX			XX
BMI Assessment and Weight Counseling	XX	XX	XX						XX
Breast Cancer Screening	XX	Proposed	XX	XX	XX	XX	XX		XX
Cervical Cancer Screening	XX	XX		XX		XX	XX	XX	XX
Childhood Immunizations	XX	XX							
Chlamydia testing in women			XX			XX			
Colorectal Cancer Screening	XX	XX	XX						XX
Continuity of Care with PCP or Team									XX
Depression Screening and Follow-up		XX	XX						XX
Diabetes Control: HgbA1C <9%	XX	XX	XX	XX	XX	XX			XX
Diabetes SMG	XX								XX

Quality Measure	Quality Plan	HRSA/ UDS	MA PCPR	BMC Credentialing	HealthNet P4P	Mass Health	NHP	Ryan White	NCQA PCMHI
Enhanced Care Patients with Integrated Care Plan			XX						XX
ER Utilization			XX		XX	XX			
Flu Vaccine	XX	XX							XX
Hepatitis B Vaccine for HIV+		Proposed						XX	
Hypertension control: BP <140/90	XX	XX	XX		XX				XX
Hypertensives with short-acting Ca blocker meds						XX			
LDL screen in Diabetics			XX	XX	XX	XX			XX
Lipid Therapy for Coronary Artery Disease	XX	XX							
Medication Error Rate	XX								
Microalbumin in diabetics						XX			
Nephropathy screening for diabetics					XX				
Patients with self management goal/ action plan									XX
Post-hospitalization follow-up with 2 days of discharge									XX
Post- hospitalization medication reconciliation			XX						

Quality Measure	Quality Plan	HRSA/ UDS	MA PCPR	BMC Credentialing	HealthNet P4P	Mass Health	NHP	Ryan White	NCQA PCMHI
Potassium check with ACE or ARB						XX			
PPD screening	XX							XX	
Tobacco Assessment and Counseling	XX	XX	XX						XX
Well child visits					XX				
Initiatiation and engagement in alcohol/drug dependence treatement			XX						
Adolescent well visits			XX						
Follow-up after hospitalization for mental illness			xx						
HIV+ Patients with a viral load <200 copies/ mL									XX
HIV+ Patients who had at least one HIV medical visit in each 6 month period with at least 60 days between the visits.									XX
HIV+ Patients who were prescribed ART									XX
HIV viral load (2+ in 12 month period									XX
Comprehensive, Coordinated Primary HIV Medical Care									XX

Value-Based Health Care



Focusing on the Value Argument

- We need to identify where our programs add ***value***:

- What are our strengths?
- How do we best apply these strengths?
- Where do we add value to the health system?

Multidisciplinary Approach

- MD/NP/PA
- RN
- Social worker
- Front desk staff
- Medical assistant
- Case manager
- Community health worker
- Each discipline should be working at their highest level

Multidisciplinary Approach

- Quality plan
- Assign measures to each discipline
- Avoid duplication of responsibilities
- Get feedback from each discipline
- Celebrate and recognize improvements

Multidisciplinary Approach

- FDS: Update PCP
- MA: Vital Signs, BMI
- Clinicians: Pap Smears, Mammograms, Colon Cancer Screening, CAD lipid therapy, Asthma management, BP control, Antibiotic for acute Bronchitis, etc.

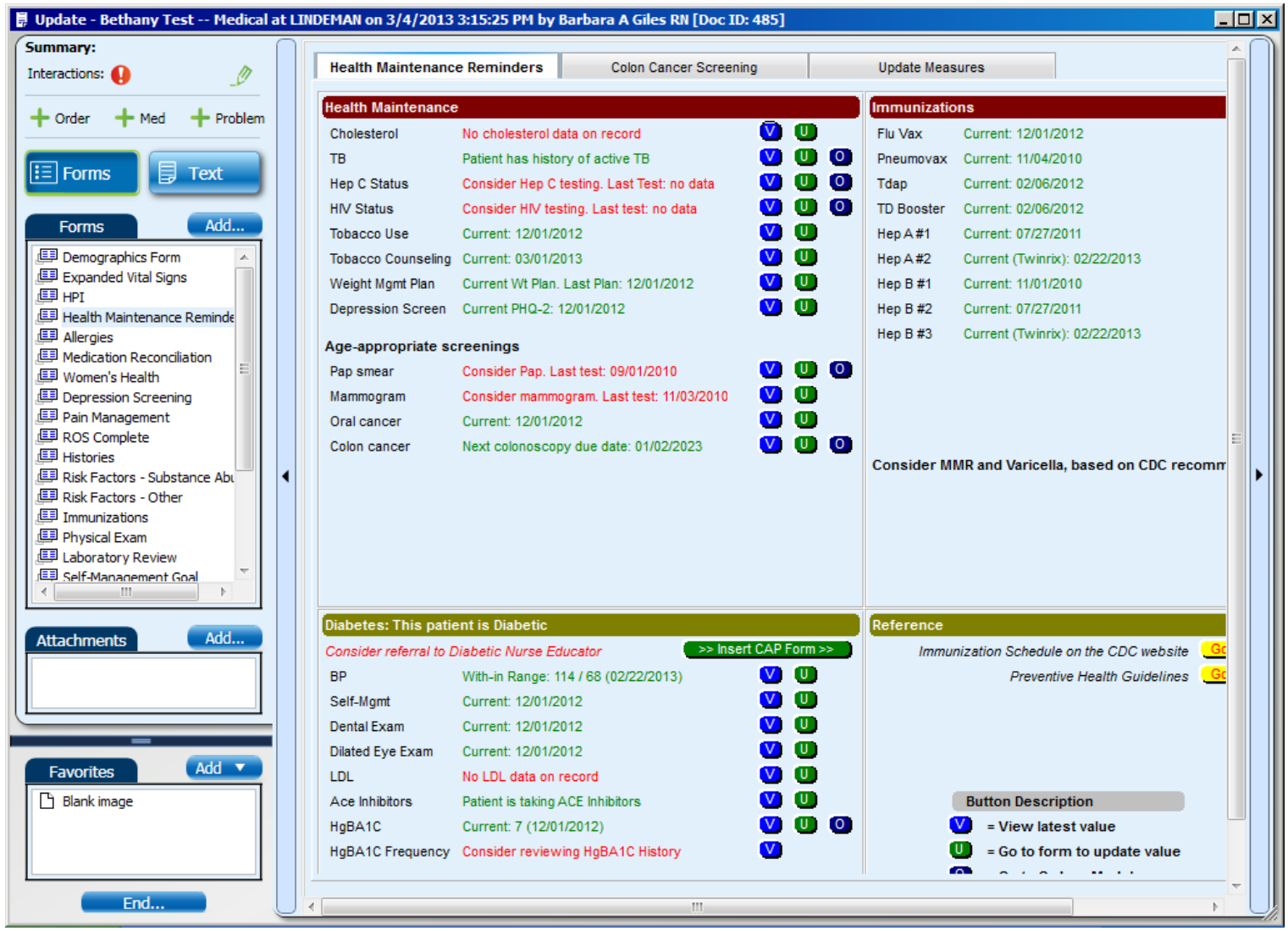
Nursing Practice Standards

- Women's health measures
  - Pap smears, mammograms, FIT kits
- Tobacco screening and counseling
- Diabetes control
  - Finger sticks and HgbA1c

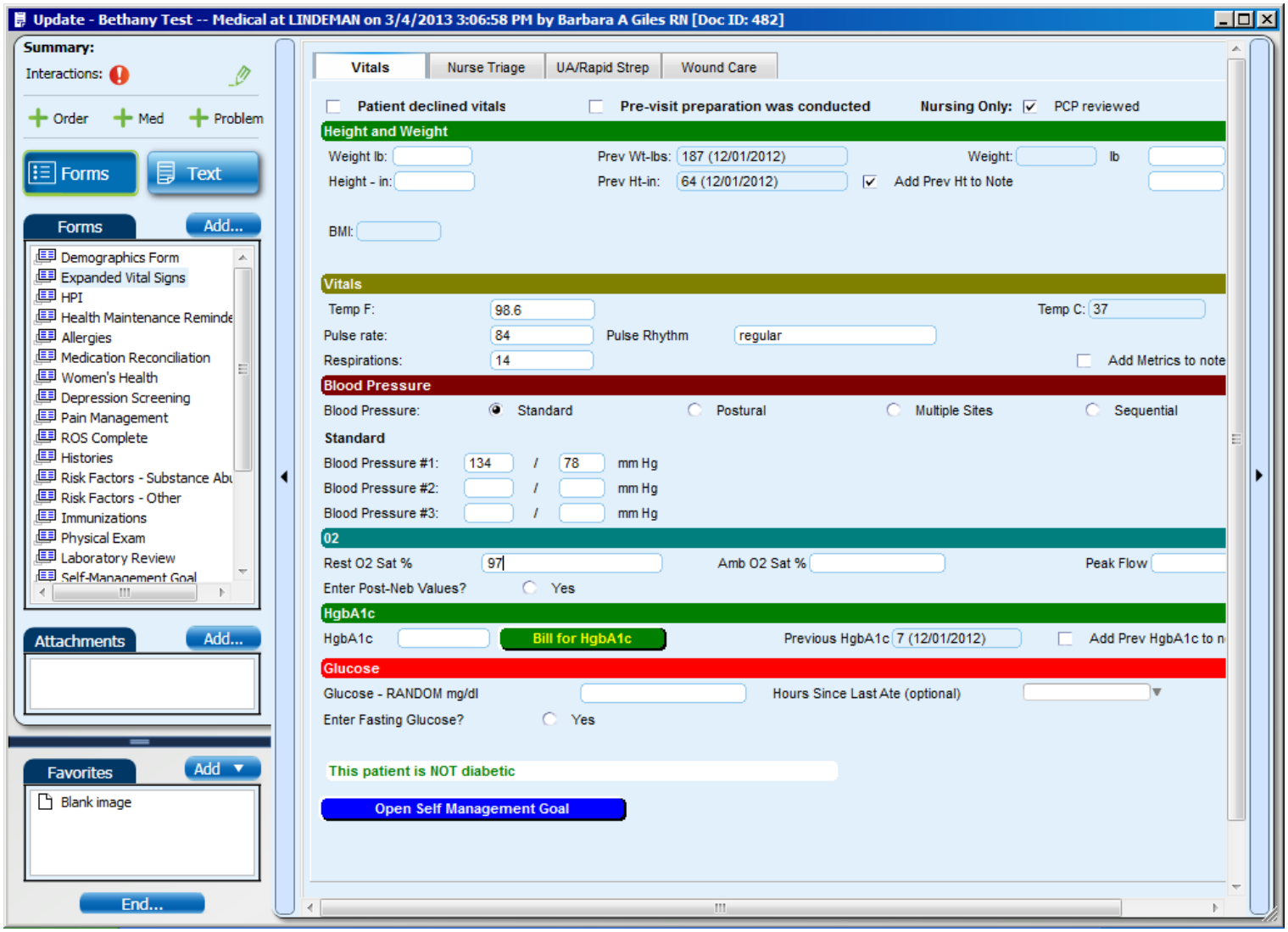
Nursing Practice Standards

- Standing orders for immunizations:
  - Hepatitis A & Hepatitis B
  - Pneumovax
  - Flu
  - TB testing
- Standing orders for OTC's
- Clinical care management for high risk patients

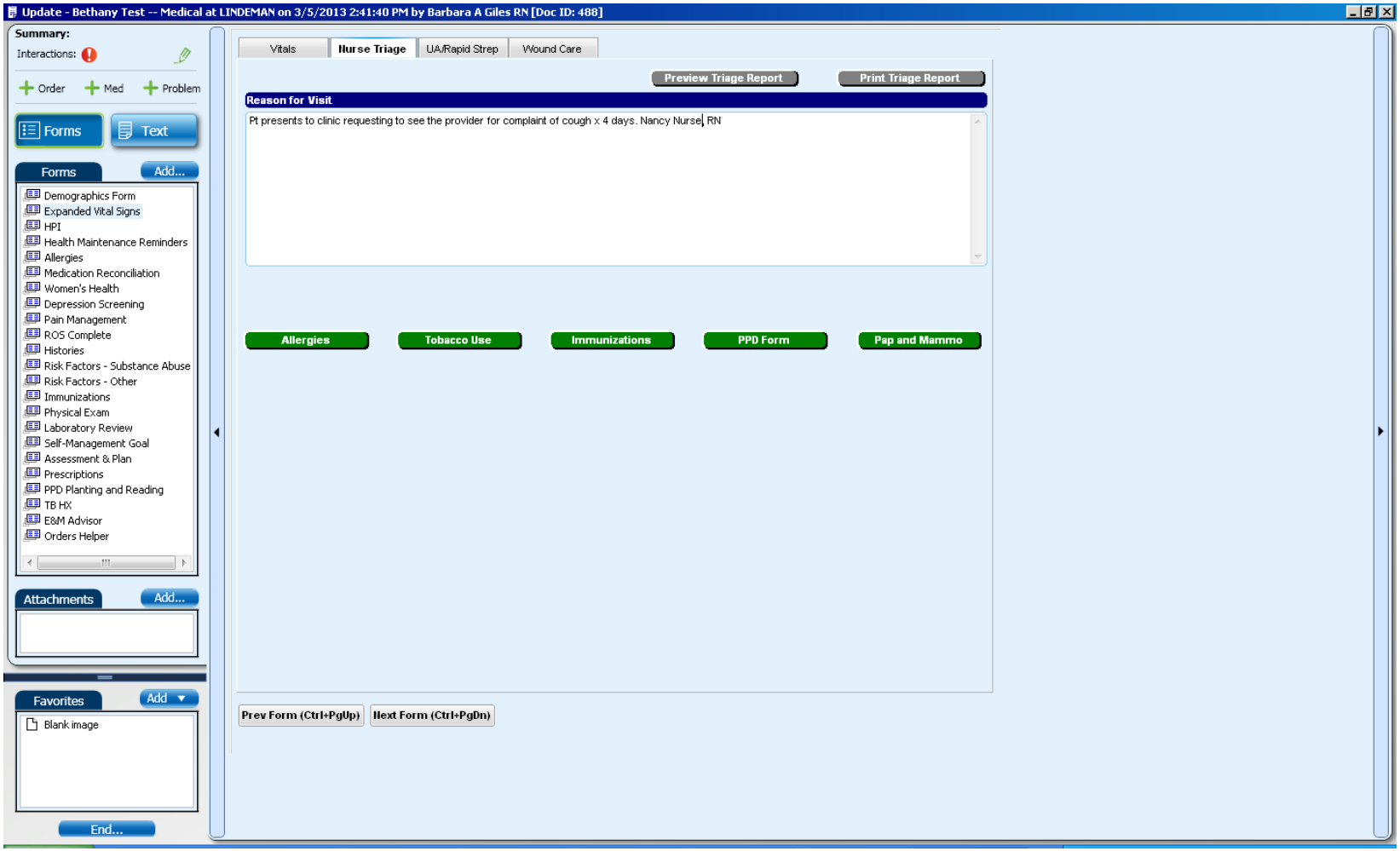
Health Maintenance Reminders



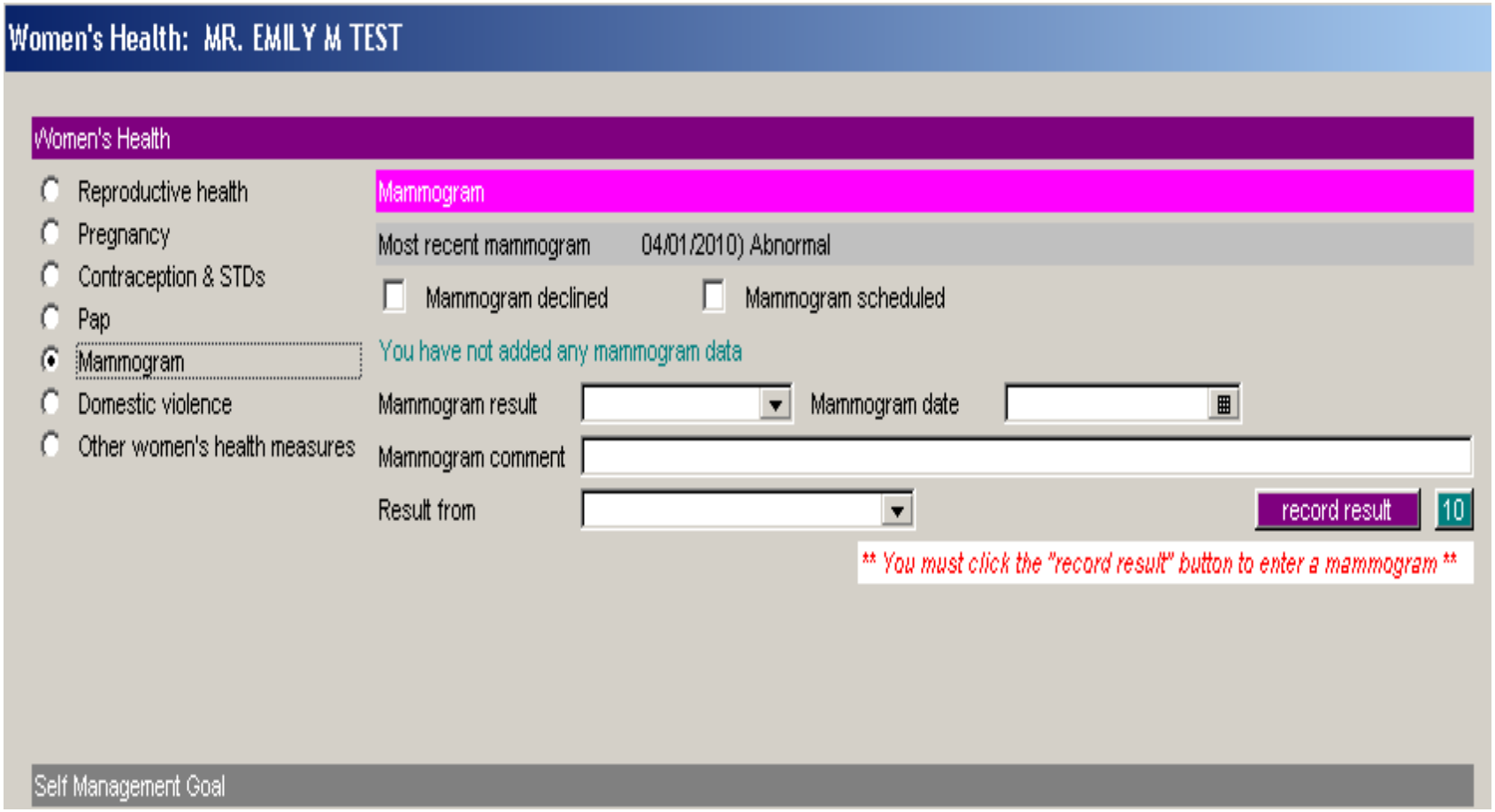
Nurse Triage Form



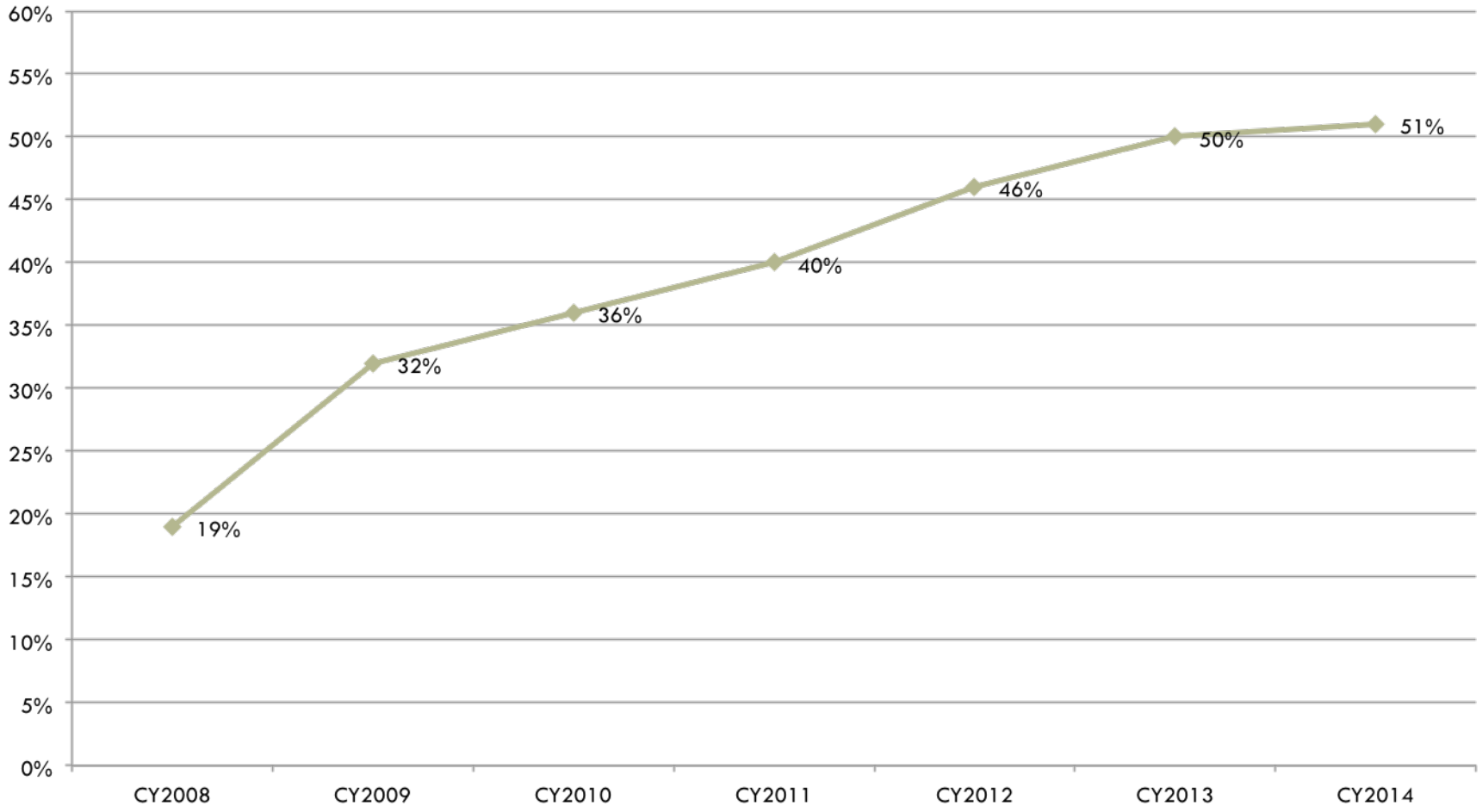
Nurse Triage Form



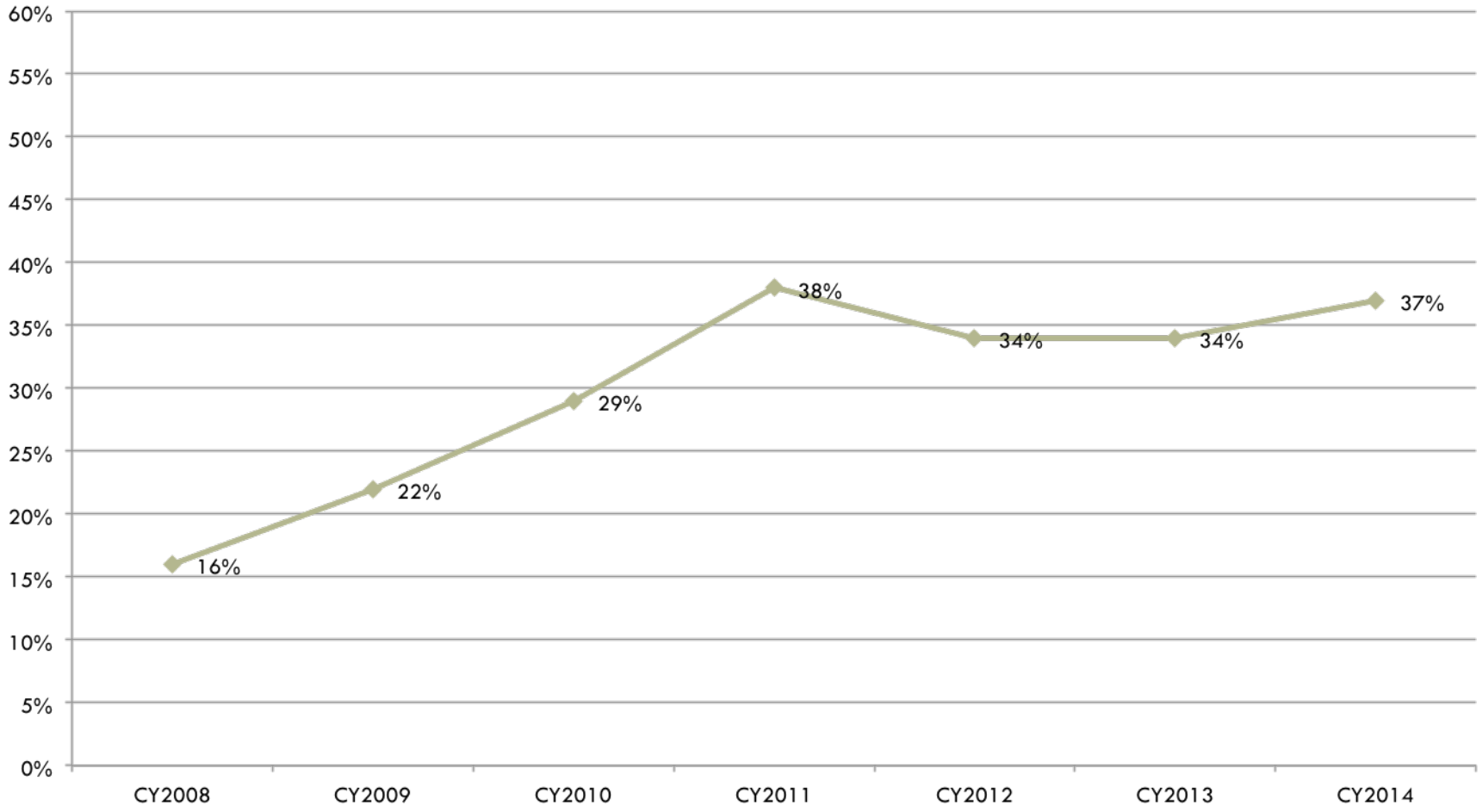
Nurse Triage Form



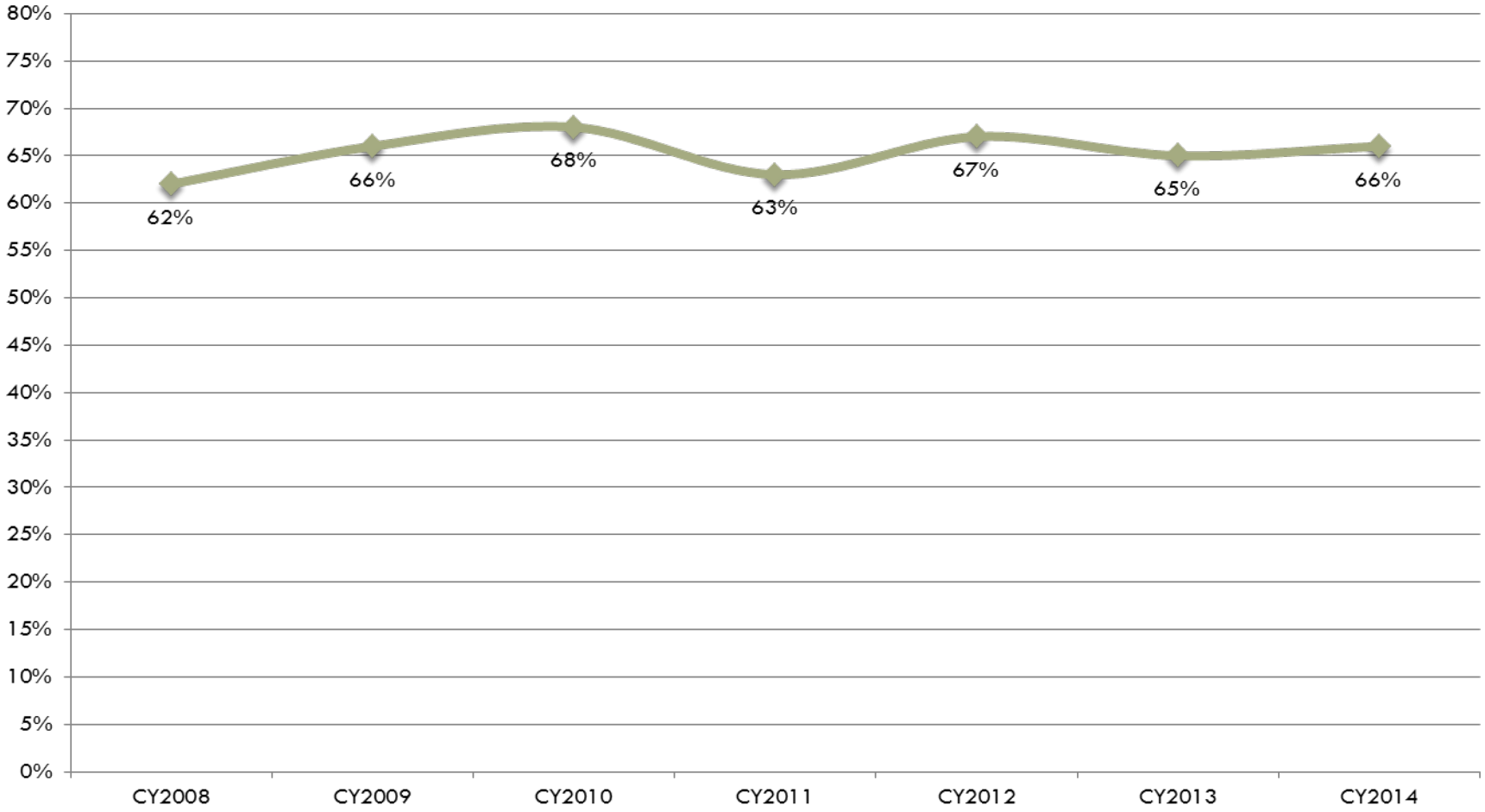
Cervical Cancer Screening: BHCHP



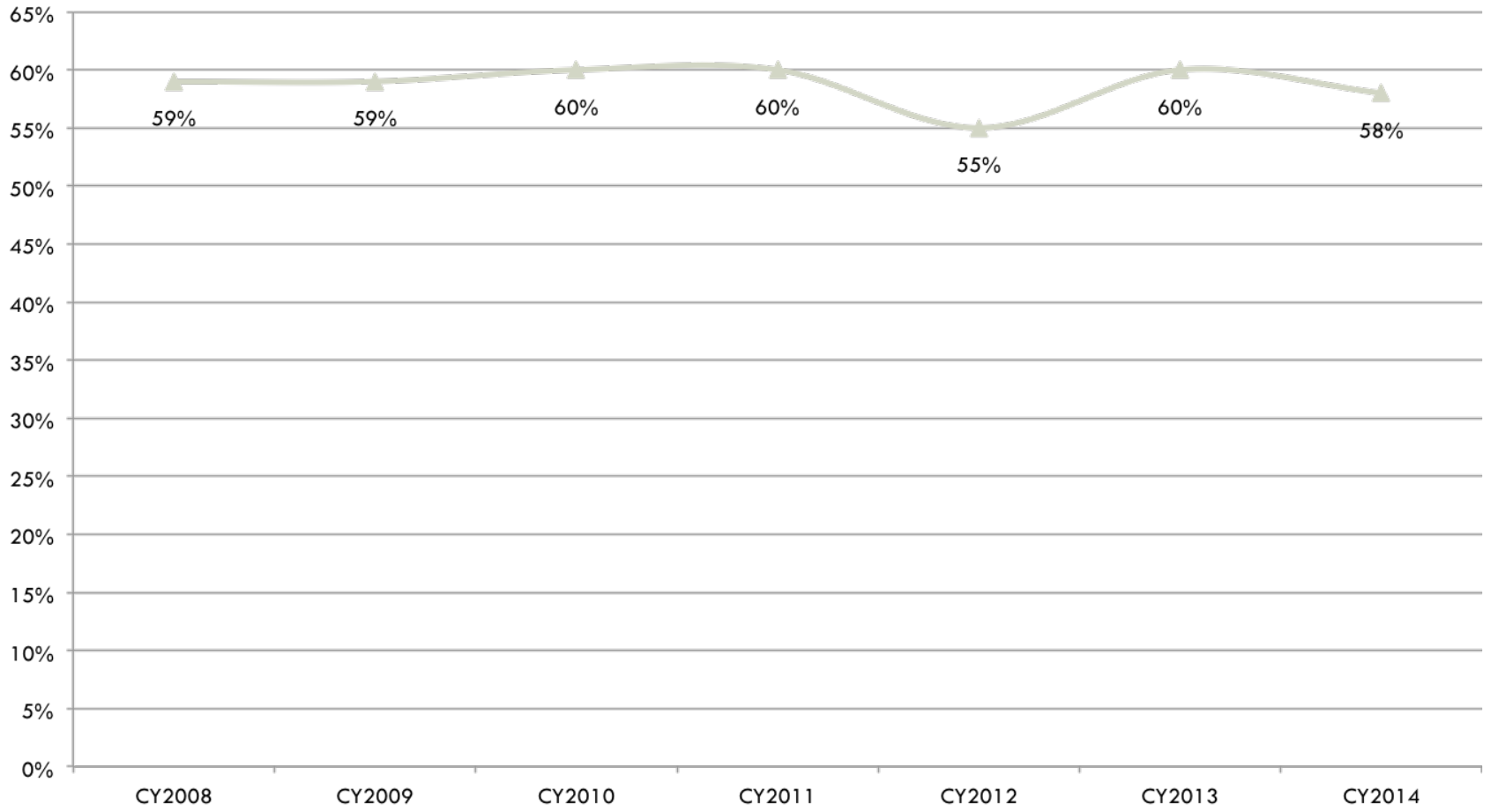
Breast Cancer Screening: BHCHP



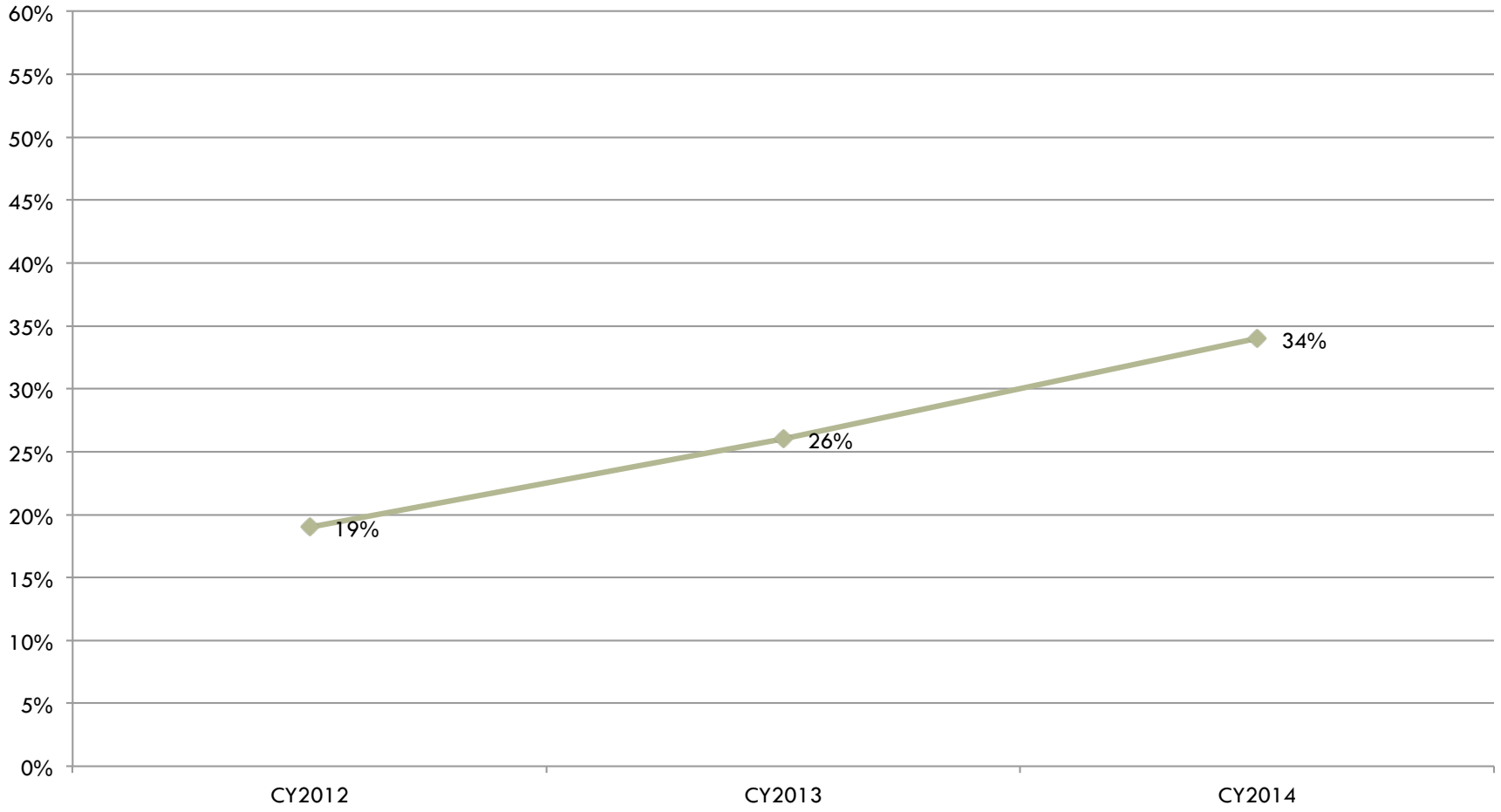
Diabetes Control: BHCHP



Blood Pressure Control: BHCHP



Colon Cancer Screening: BHCHP



Site-Based Reporting

- Quarterly quality measures report (transparent!)
- Action plans

Reporting period: 10/1/2013 to 9/30/2014

Location	Cervical CA Screening Goal -60%				Breast Cancer Screening Goal- 45%				Colon CA Screening Goal- 40%				Adult Weight Screening & Follow-up (updated) Goal-70%				Tobacco Assessment and Intervention(updated) Goal- 97%				Depression Screening and Follow-up(NEW) Goal- 60%			
	Num	Den	%	diff.	Num	Den	%	diff.	Num	Den	%	diff.	Num	Den	%	diff.	Num	Den	%		Num	Den	%	
[redacted]	85	176	48%	-6%	31	115	27%	-3%	97	302	32%	-2%	373	652	57%	n/a	461	479	96%	n/a	319	759	42%	n/a
[redacted]	464	752	62%	-3%	329	573	57%	0%	919	1,594	58%	1%	2682	3088	87%	n/a	2511	2524	99%	n/a	1682	2835	59%	n/a
[redacted]	368	485	76%	-3%	31	81	38%	-1%	6	27	22%	-12%	542	694	78%	n/a	267	280	95%	n/a	288	588	49%	n/a
[redacted]	50	98	51%	-6%	36	77	47%	3%	76	164	46%	-2%	213	318	67%	n/a	142	142	100%	n/a	151	272	56%	n/a
H[redacted]	47	81	58%	2%	50	80	63%	6%	180	285	63%	0%	263	368	71%	n/a	310	319	97%	n/a	188	340	55%	n/a
[redacted]	177	359	49%	-4%	68	173	39%	1%	124	422	29%	-2%	1080	1393	78%	n/a	840	846	99%	n/a	866	1128	77%	n/a
[redacted]	51	91	56%	2%	44	86	51%	2%	158	279	57%	1%	270	420	64%	n/a	367	371	99%	n/a	184	396	46%	n/a
[redacted]e	154	291	53%	-7%	123	228	54%	-1%	388	813	48%	-1%	1040	1428	73%	n/a	1379	1400	99%	n/a	742	1319	56%	n/a
[redacted]	228	490	47%	-2%	123	323	38%	-3%	389	1,099	35%	-1%	1679	2406	70%	n/a	1324	1332	99%	n/a	767	2046	37%	n/a
R[redacted]	62	134	46%	-3%	45	120	38%	-3%	26	88	30%	-4%	87	151	58%	n/a	75	80	94%	n/a	31	108	29%	n/a
[redacted]	39	70	56%	3%	22	44	50%	8%	105	247	43%	2%	377	636	59%	n/a	302	333	91%	n/a	147	510	29%	n/a
[redacted]	114	231	49%	-5%	54	141	38%	2%	195	491	40%	1%	1025	1275	80%	n/a	793	796	100%	n/a	520	1212	43%	n/a
[redacted]	25	39	64%	2%	23	34	68%	2%	43	86	50%	3%	86	131	66%	n/a	93	98	95%	n/a	10	116	9%	n/a
[redacted]	81	155	52%	-3%	13	35	37%	1%	12	67	18%	-3%	399	587	68%	n/a	258	260	99%	n/a	430	465	92%	n/a
[redacted]	16	47	34%	7%	5	30	17%	10%	62	478	13%	3%	515	783	66%	n/a	221	222	100%	n/a	353	651	54%	n/a
[redacted]	84	163	52%	-2%	47	104	45%	2%	60	213	28%	-2%	391	472	83%	n/a	327	330	99%	n/a	216	370	58%	n/a

Location	Diabetics with A1C<9% Goal- 70%				Hypertensive Pts. BP<140/90 Goal- 61%				Asthmatics on Appropriate Meds. (updated) Goal- 50%				CAD: Lipid Therapy Goal- 80%				IVD: Aspirin or Antithrombotic Therapy Goal- 60%			
	Num	Den	%	diff.	Num	Den	%	diff.	Num	Den	%	diff.	Num	Den	%	diff.	Num	Den	%	diff.
[redacted]	38	66	58%	33%	98	157	62%	0%	37	77	48%	n/a	4	13	31%	-26%	32	61	52%	4%
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[redacted]	1	15	7%	-18%	21	46	46%	-3%	7	46	15%	n/a	0	1	n/a	n/a	1	1	100%	50%
[redacted]	25	33	76%	0%	33	73	45%	-5%	5	14	36%	n/a	7	11	64%	-11%	11	21	52%	2%
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[redacted]	33	56	59%	-3%	97	158	61%	2%	22	40	55%	n/a	8	11	73%	-5%	24	43	56%	5%
[redacted]e	206	322	64%	-1%	360	541	67%	3%	84	149	56%	n/a	17	36	47%	-4%	70	138	51%	1%
[redacted]	199	274	73%	2%	377	628	60%	5%	78	181	43%	n/a	18	41	44%	-8%	52	116	45%	-4%
[redacted]	4	5	80%	18%	19	48	40%	-11%	11	24	46%	n/a	2	3	67%	-33%	2	4	50%	10%
S[redacted]	47	67	70%	4%	77	132	58%	-6%	13	44	30%	n/a	4	9	44%	28%	8	21	38%	-10%
[redacted]	100	132	76%	3%	205	337	61%	3%	58	121	48%	n/a	6	14	43%	3%	24	52	46%	-2%
[redacted]	11	15	73%	17%	26	40	65%	4%	4	6	67%	n/a	1	2	50%	17%	2	9	22%	-3%
[redacted]	10	14	71%	9%	23	41	56%	-9%	5	28	18%	n/a	1	3	33%	33%	1	4	25%	25%
[redacted]	44	79	56%	-1%	111	179	62%	4%	13	34	38%	n/a	4	13	31%	-16%	10	19	53%	9%
[redacted]	38	45	84%	8%	81	129	63%	2%	29	53	55%	n/a	4	9	44%	11%	15	31	48%	-5%

Index

- Exceeds goal
- Meets goal
- Goal w/in 5%
- Below goal

SITE/TEAM QUALITY SUMMARY SHEET AND ACTION PLAN

[redacted] Clinic Quarterly Report- TY Sep 2014

Action Plan for QI from last quality meeting	Result/Feedback?
PAP days with Stacy/ sign up patients for PAPs	
Fun PAP appointment cards and reminders on pts. pillows	

TY Sep 2014 Data Comparison to TY Jun 2014

Gains of more than 2%:	Losses of more than 2%:
• Diabetics with A1C>9 went from 76% to 84% (n<50) • CAD with Lipid Therapy went from 33% to 44% (n<10)	• IVD with Aspirin Therapy went from 54% to 48% (n< 30)

Your site is at goal or exceeding program-wide goals in the following measures:
1. Breast Cancer Screening
2. Adult Weight Screening and Follow-Up
3. Tobacco Assessment and Intervention
4. Diabetics with A1C<9
5. Hypertensive pts with BP<140/90
6. Asthmatics on Appropriate Meds
Your site is within 5% of the program-wide goal in:
1. Depression Screening and Follow-up

Areas for Potential Improvement:

1. Cervical Cancer Screening
2. Colon Cancer Screening
3. CAD: Lipid Therapy
4. IVD: Aspirin Therapy

Action plan or areas of focus in quality improvement for upcoming quarter/year:
1. Stock pap supplies at clinic.
2. Have ready to use pap trays.
3. Get specula with built in light.
4. Use FIT to increase colon cancer screening rate.

Individual-Level Reporting

- Quarterly quality measures report (transparent!)
- Included in individual annual evaluations

Individual Provider Quality Indicators

Outcomes for patients by providers for a medical visit from 7/1/2012 to 6/30/2013

Provider Name	Goal- 60% PAP Smear Done			Goal- 45% Mammogram Done			Goal- 65% Blood Pressure Control			Goal- 70% Diabetes Control			Goal 40% Colon CA Screening		
	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
A	70	114	**61%**	40	81	**49%**	134	215	**62%**	58	94	**62%**	111	268	**42%**
B	16	19	**84%**	6	10	**60%**	13	25	**52%**	1	1	**100%**	17	39	**44%**
C	31	41	**76%**	26	37	**70%**	77	114	**68%**	16	24	**67%**	73	161	**46%**
D	40	75	**53%**	29	62	**47%**	71	121	**59%**	13	22	**59%**	92	251	**37%**
E	13	39	**33%**	7	33	**21%**	19	29	**66%**	11	20	**55%**	11	58	**19%**
F	31	44	**70%**	22	33	**67%**	59	80	**74%**	1	4	**25%**	42	113	**38%**
G	37	42	**88%**	24	35	**69%**	67	99	**68%**	9	14	**64%**	63	140	**45%**
H	71	88	**81%**	33	66	**50%**	88	119	**74%**	6	9	**67%**	70	154	**53%**
I															
J															
K															
L															
M															
N															
O															
P															
Q															
R															
S															
T															
U															
V	25	41	**61%**	13	30	**43%**	88	150	**59%**	17	25	**68%**	46	224	**21%**
W	19	27	**70%**	8	21	**38%**	40	66	**61%**	5	8	**63%**	29	93	**31%**
X	26	38	**68%**	17	33	**52%**	64	97	**66%**	2	5	**40%**	47	135	**35%**
Y	56	82	**68%**	34	63	**54%**	78	122	**64%**	21	37	**57%**	65	150	**43%**
Z	64	96	**67%**	43	82	**52%**	144	215	**67%**	34	52	**65%**	123	288	**43%**
AA	26	43	**60%**	23	37	**62%**	60	76	**79%**	24	29	**83%**	41	107	**39%**
AB	73	125	**58%**	8	15	**53%**	4	12	**33%**	0	2	**0%**	1	9	**11%**
AC	46	75	**61%**	34	55	**62%**	118	177	**67%**	33	63	**52%**	79	214	**37%**
AD	71	100	**71%**	43	82	**52%**	111	165	**67%**	29	55	**53%**	69	206	**33%**
AE	44	77	**57%**	29	59	**49%**	110	169	**65%**	43	69	**62%**	84	239	**35%**
AF	35	39	**90%**	14	29	**48%**	39	54	**72%**	6	7	**86%**	42	60	**70%**
AG	20	33	**61%**	7	20	**35%**	42	61	**69%**	6	9	**67%**	14	59	**24%**
AH	75	129	**58%**	26	65	**40%**	110	172	**64%**	20	35	**57%**	53	273	**19%**
AI	67	106	**63%**	36	82	**44%**	62	114	**54%**	9	14	**64%**	62	172	**36%**
AJ	109	161	**68%**	78	127	**61%**	166	253	**66%**	52	75	**69%**	157	348	**46%**
AK	46	82	**56%**	32	73	**44%**	109	162	**67%**	10	16	**63%**	85	239	**36%**
AL	73	128	**57%**	58	114	**51%**	115	170	**68%**	32	50	**64%**	95	250	**38%**

Individual Provider Quality Indicators

Outcomes for patients by providers for a medical visit from 7/1/2012 to 6/30/2013

Provider Name	Goal- 60% PAP Smear Done			Goal- 45% Mammogram Done			Goal- 65% Blood Pressure Control			Goal- 70% Diabetes Control			Goal 40% Colon CA Screening		
	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
A	70	114	**61%**	40	81	**49%**	134	215	**62%**	58	94	**62%**	111	268	**42%**
B	16	19	**84%**	6	10	**60%**	13	25	**52%**	1	1	**100%**	17	39	**44%**

Other Quality Initiatives

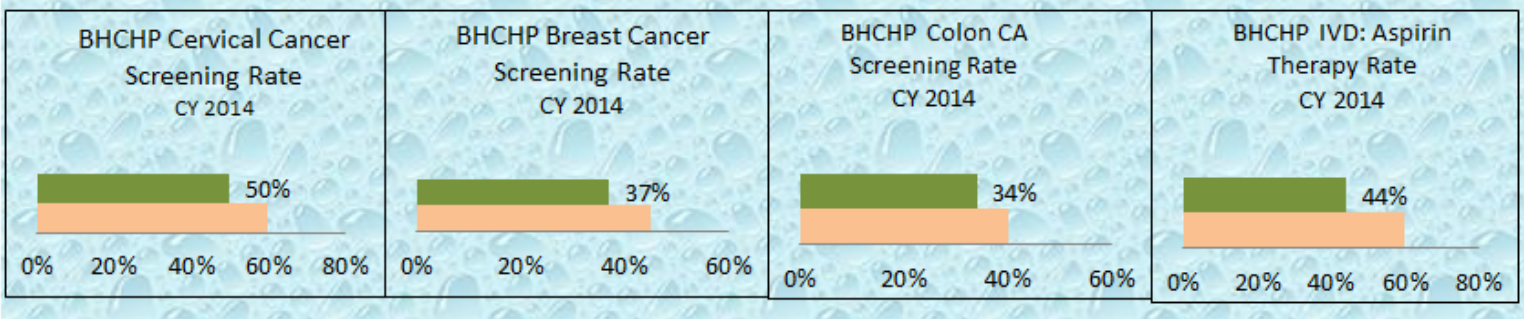
Stall Stats

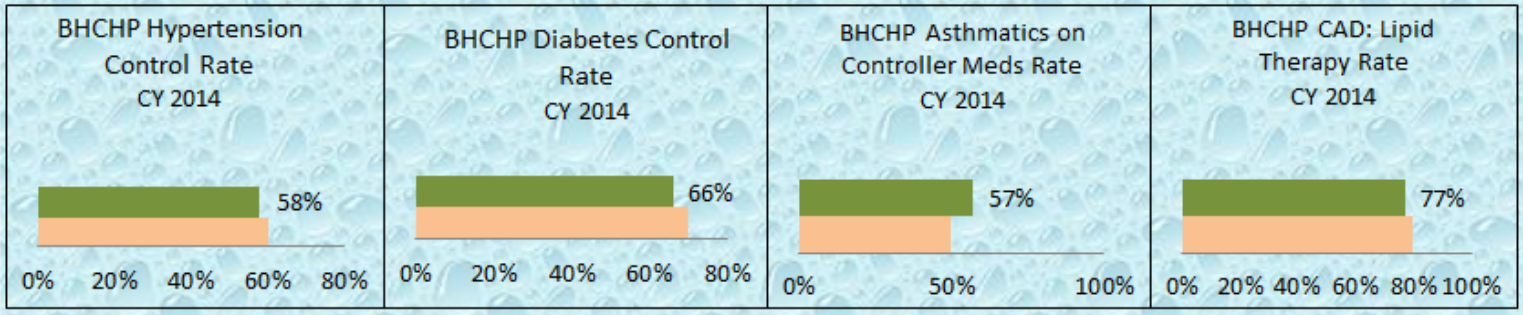
BOSTON HEALTH CARE *for the* HOMELESS PROGRAM
SINCE 1985

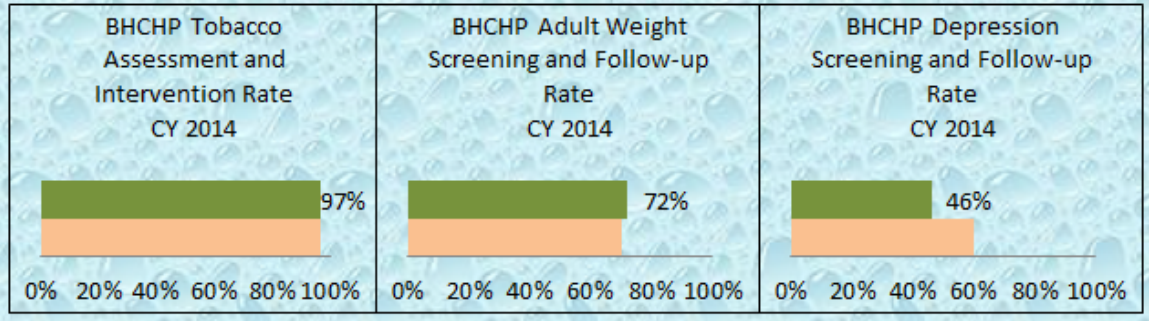
Our Mission:
To provide or assure access to the highest quality health care for all homeless men, women and children in the greater Boston area.

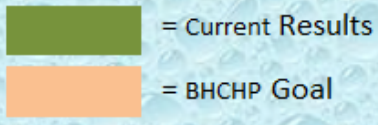
We would love to hear from all our staff about our continuous quality improvement efforts here at BHCHP and welcome any suggestions or feedback.

For More Information Contact:
Monica Bharel MD, MPH; Chief Medical Officer
mbharel@bhchp.org





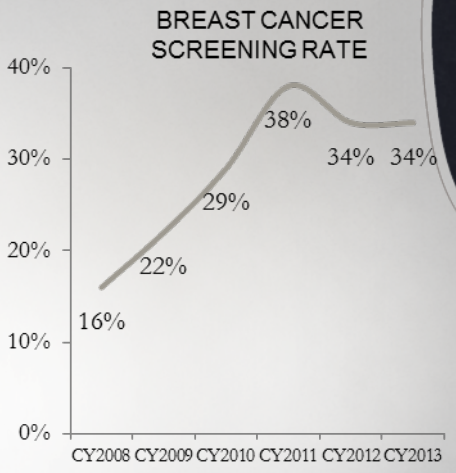


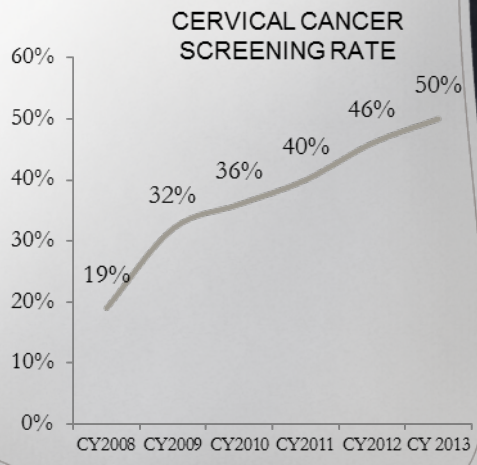


Updated: January 2015

STALL STORY: WOMEN'S HEALTH SCREENINGS

- A 43 year old uninsured female patient with two children was seen at a family shelter by the BHCHP family team
- Case management helped her and her two children get health insurance and connect to primary care
- She had her first mammogram at a BHCHP screening fair showing abnormal results
- With support from BHCHP she had additional imaging, a biopsy showing atypical ductal hyperplasia, and surgery confirming the diagnosis
- She will follow-up for repeat mammogram in 6 months
- Patient had had an abnormal pap in 2012 in another state and was supposed to have colposcopy but was not able to follow up
- Repeat pap done by BHCHP showed persistent abnormality so she was referred for colposcopy
- She is a single parent and is very happy to be getting appropriate cancer screening so she can stay healthy and raise her two boys



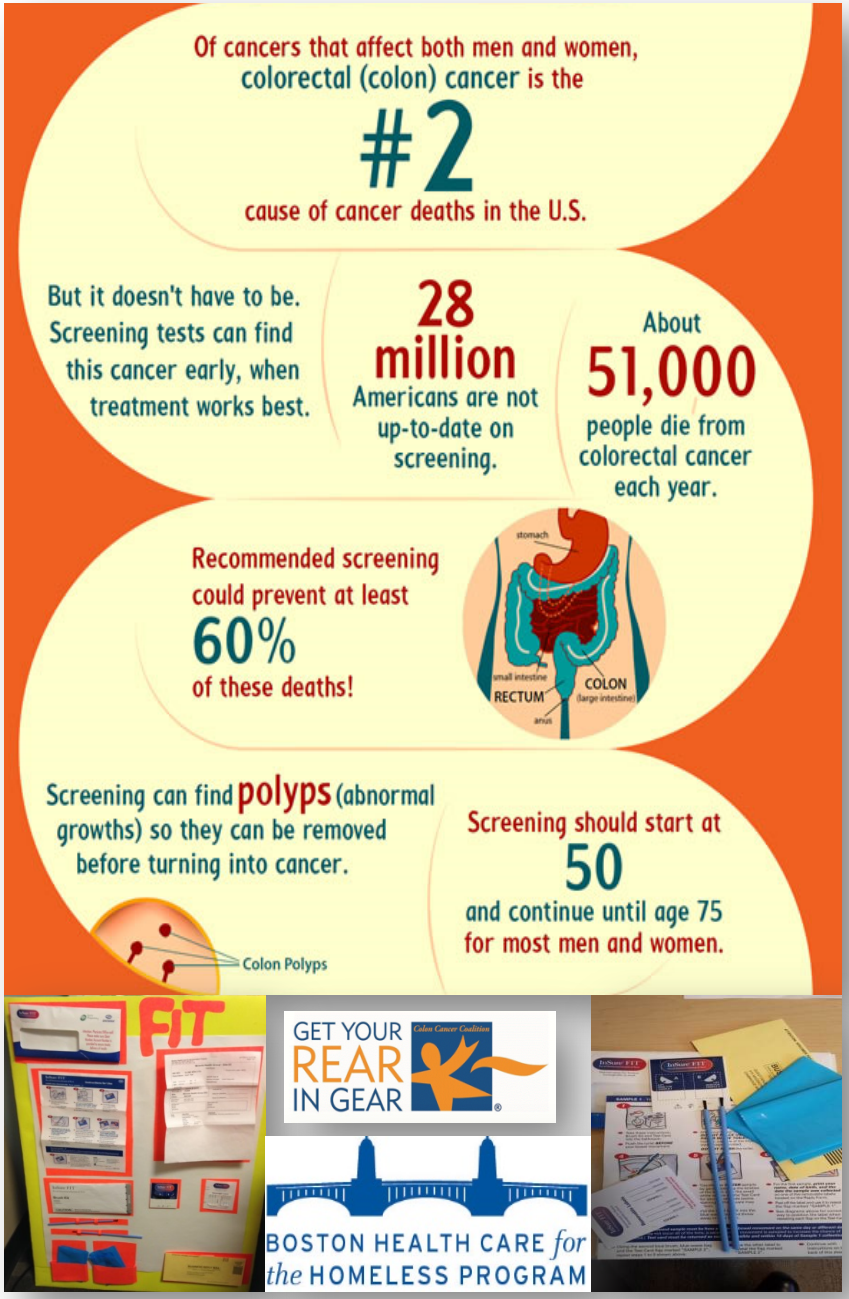


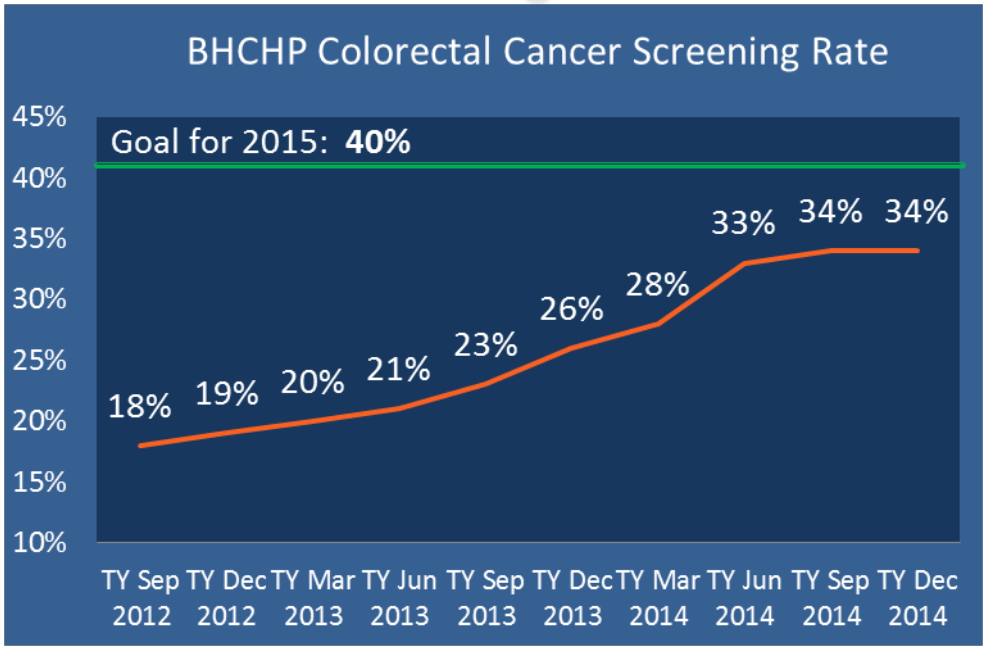
Please email us your success stories and let us know what has been working for you. We love to hear from all of you!

For more information contact: Monica Bharel MD, MPH, Chief Medical Officer; mbharel@bhchp.org

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM
SINCE 1985

March is Colorectal Cancer Screening Month





BHCHP Initiatives

FIT as a screening tool for patients	Patient incentive	FluFIT program
Patient and staff education	Health fairs	Collaborations and grants
Process improvement initiatives	Population management	Colonoscopy prep support

HEALTH FAIRS

Health Fair Planning Form

Task	Point person	Details/Comments
Flyer		
Invitations/Mailings/ Event Promotion		
Engage site managers		
Engage clinical staff		
Engage CAB		
Transportation		
IT support		
Refreshments/snacks		
Decorations		
Space Set-up needed (Facilities)		
Incentives/Goodie bags		

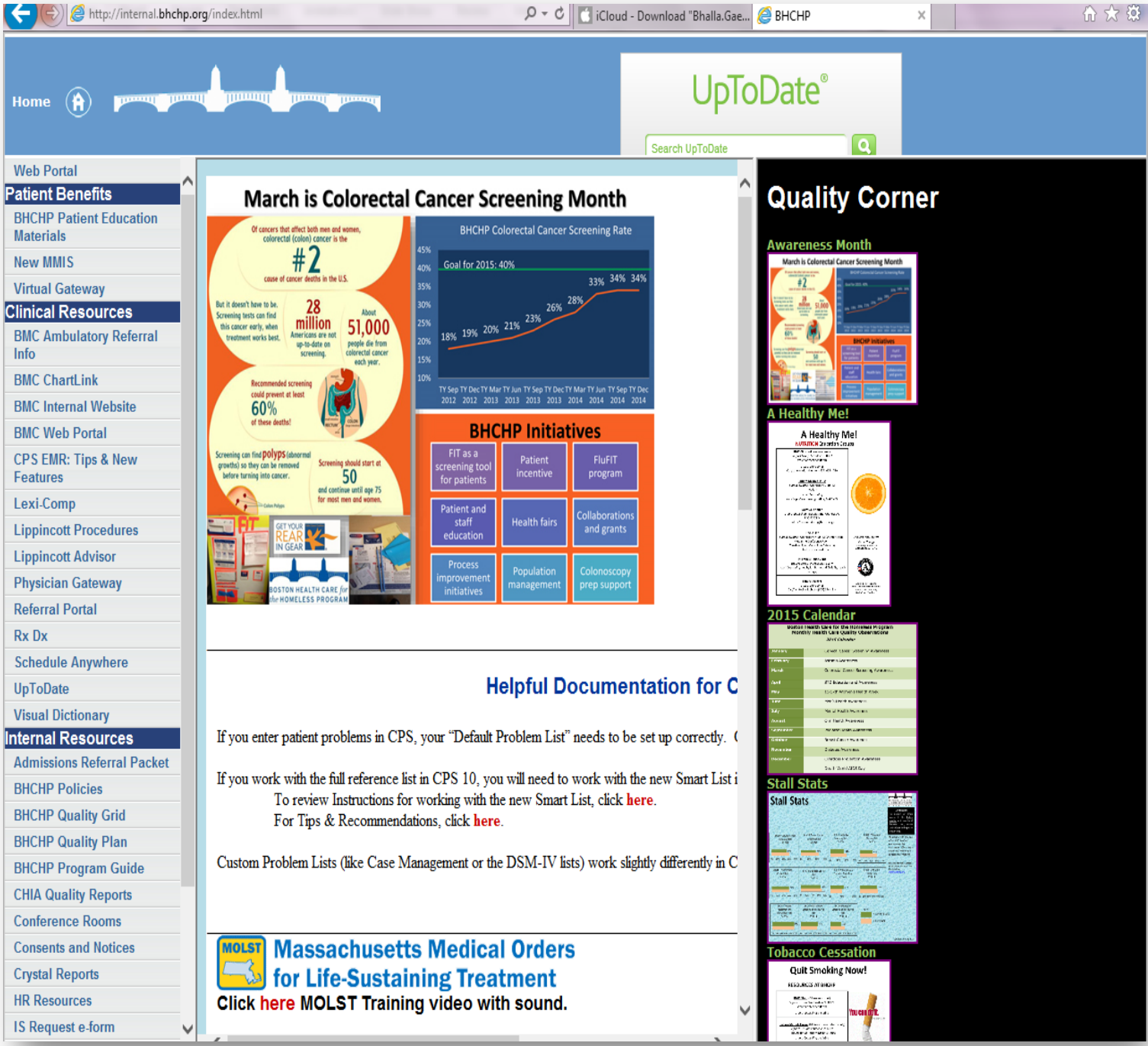
Table	Point person	Details/Comments
Naloxone/Addictions		
Behavioral Health		
Oral Health		
Benefits		
Tobacco		
Healthy Eating/Exercise		
Vaccine		
Check-in/Raffle/Goodie bags		
Community partners?		
Pap/Mammo education		
Colon Cancer screening education/FIT		

Same day services	Point person	Details/Comments
Pap		
Mammo		
FIT		
BP check		
Massage? Yoga? Zumba?		

MONTHLY QUALITY OBSERVATIONS

Boston Health Care for the Homeless Program Monthly Health Care Quality Observations (2015 Calendar)			
Month	**Quality Observation**	**Point Person/ Team**	**Event/Activity**
January	Cervical Cancer Screening	Sanju Forgione	Information on Intranet Site-based Challenge
February	Asthma Awareness	Sanju Forgione	Infographic on intranet
March	Colorectal Cancer Screening	Colleen Wiggins & Kathleen Saunders	Colon CA Screening event at Respite
April	STD Education and Awareness	HIV Testing and Counseling Team	
May	11-17th Women's Health Week	Pine Street Inn Women's Health- AmeriCorps	
June	Men's Health	South End Fitness Center Team	
July	Mental Health	Behavioral Health Team	
August	Oral Health	Dental Team	
September	Pediatric Health/ Back to School Activities	Family Team	
October	Breast Cancer Awareness	Melinda and Sanju	Mammo Day and Women's Health Fair
November	Diabetes Awareness		
December	Overdose Prevention		

USING THE HOMEPAGE TO PROMOTE QUALITY



PCMH

Risk Stratification

And

Enhanced Care

PCMH

- What is “Enhanced Care?”
  - The clinical model
- Who receives Enhanced Care?
  - Risk stratification
- Impact on quality

What is "Enhanced Care?"

- More intensive services for patients at highest risk
- Clinical model includes:
  - Clinical Care Management by team nurses
  - Additional case management
  - Outreach capacity
  - Case conferencing
  - More involvement in care transitions
  - Integrated care plans (in progress)
  - Opt-out for behavioral health (future)
  - Prioritization for medical respite (future)

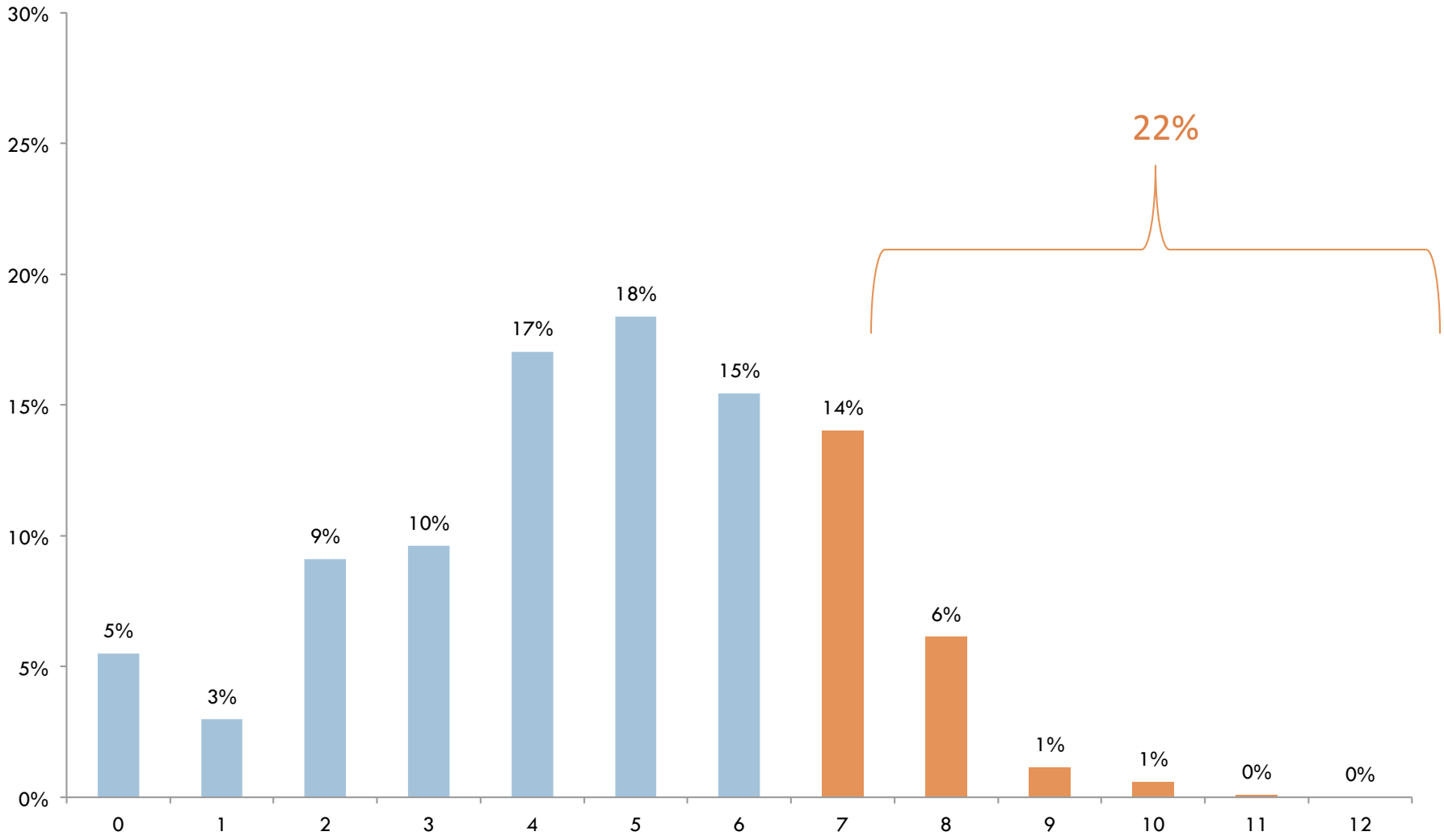
Who receives Enhanced Care?

- High risk is defined in either of two ways:
  - Identified by insurer as high risk or high cost, as part of two Medicaid payment reform programs:
    - Primary Care Payment Reform
    - Duals demonstration project
  - High score on home-grown risk stratification tool

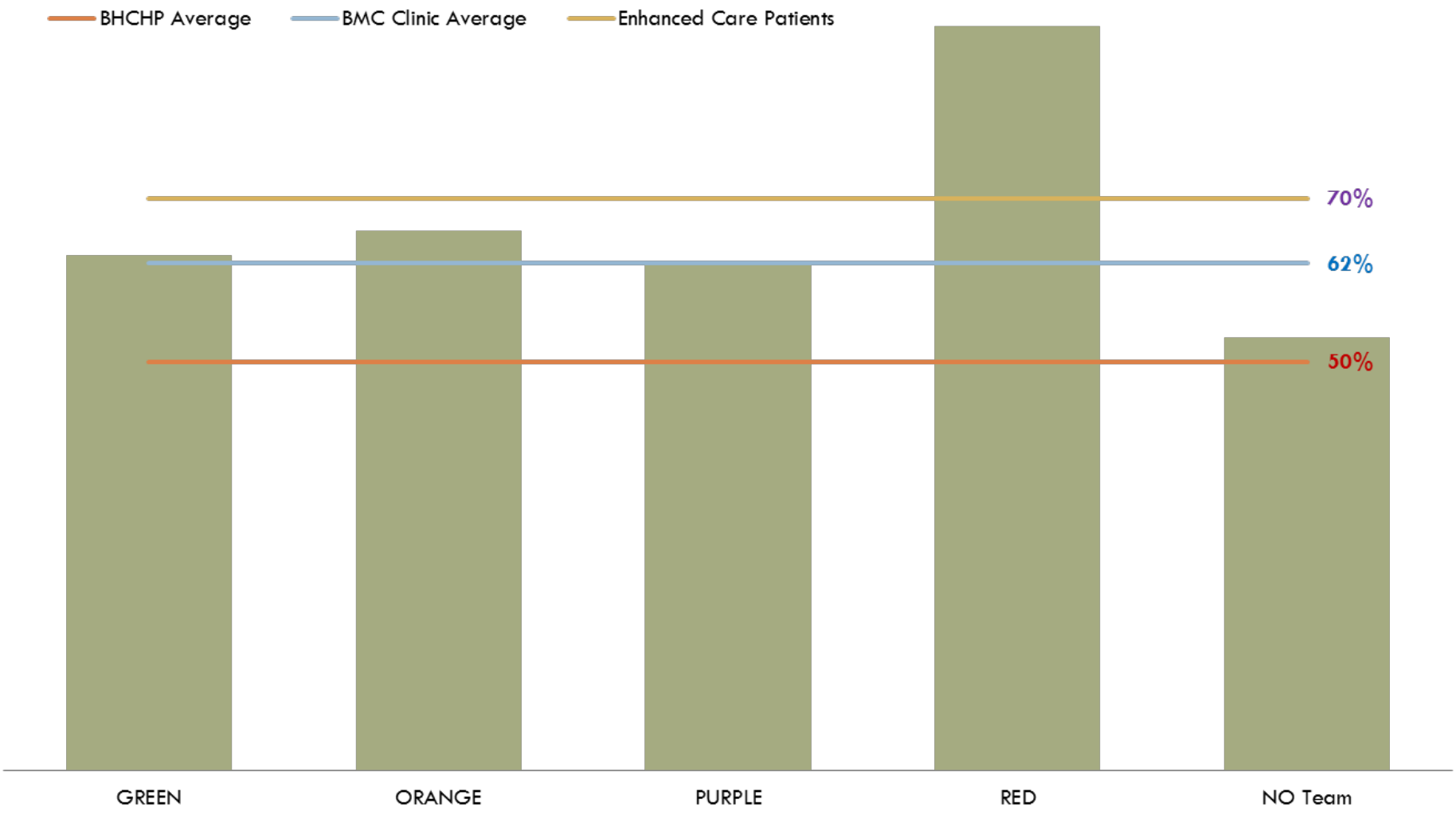
Home Grown Risk Stratification Tool

Risk Category	Factors Included	Points possible	Point values
Medical Burden	Elixhauser minus Substance abuse and mental health diagnoses	3	0 – 0 diagnoses 1- 1 diagnosis 2- 2 diagnoses 3- 3+ diagnoses
Substance Use Disorders	Problem List, Drug Use History Form, Risk Factor Form, History of an overdose	3	2- Substance Use Disorder 3- History of an OD
Mental Health diagnosis	Anxiety, PTSD, depression, psychosis, dementia, cognitive impairment, personality disorder, adjustment disorder as documented by ICD9 codes	2	0 – no diagnoses 2 – one or more diagnosis
Utilization	Designation as High ED Utilizer	2	0 – Not a high ED utilizer 2- High ED utilizer
Exposure	Immersion foot	1	0 - no exposure diagnosis
	Hypothermia		1 - any exposure diagnosis
	Frostbite		
Disability	Dual eligible	1	0 no 1 yes
	Total Possible Points	12	

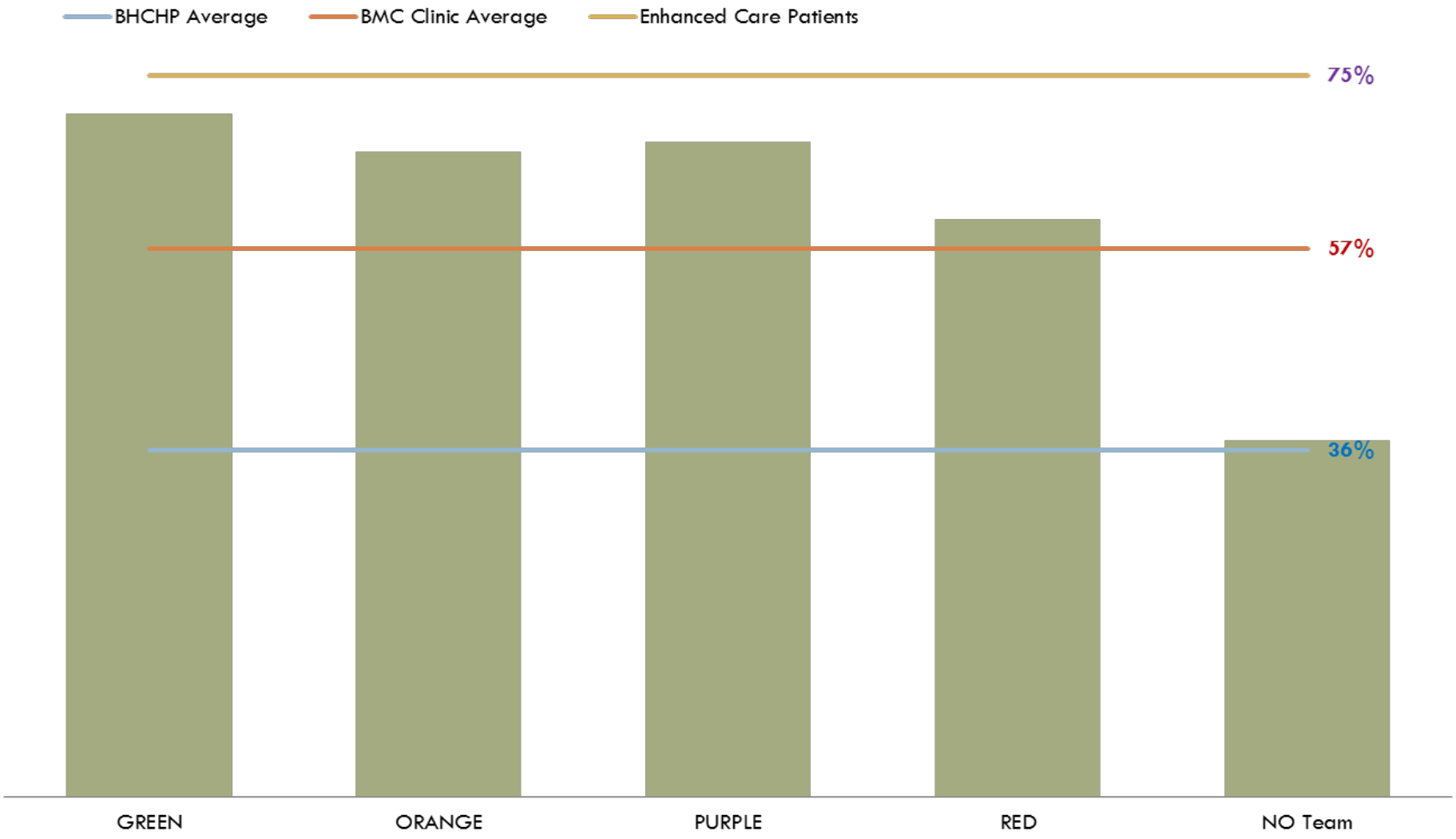
Point Distribution



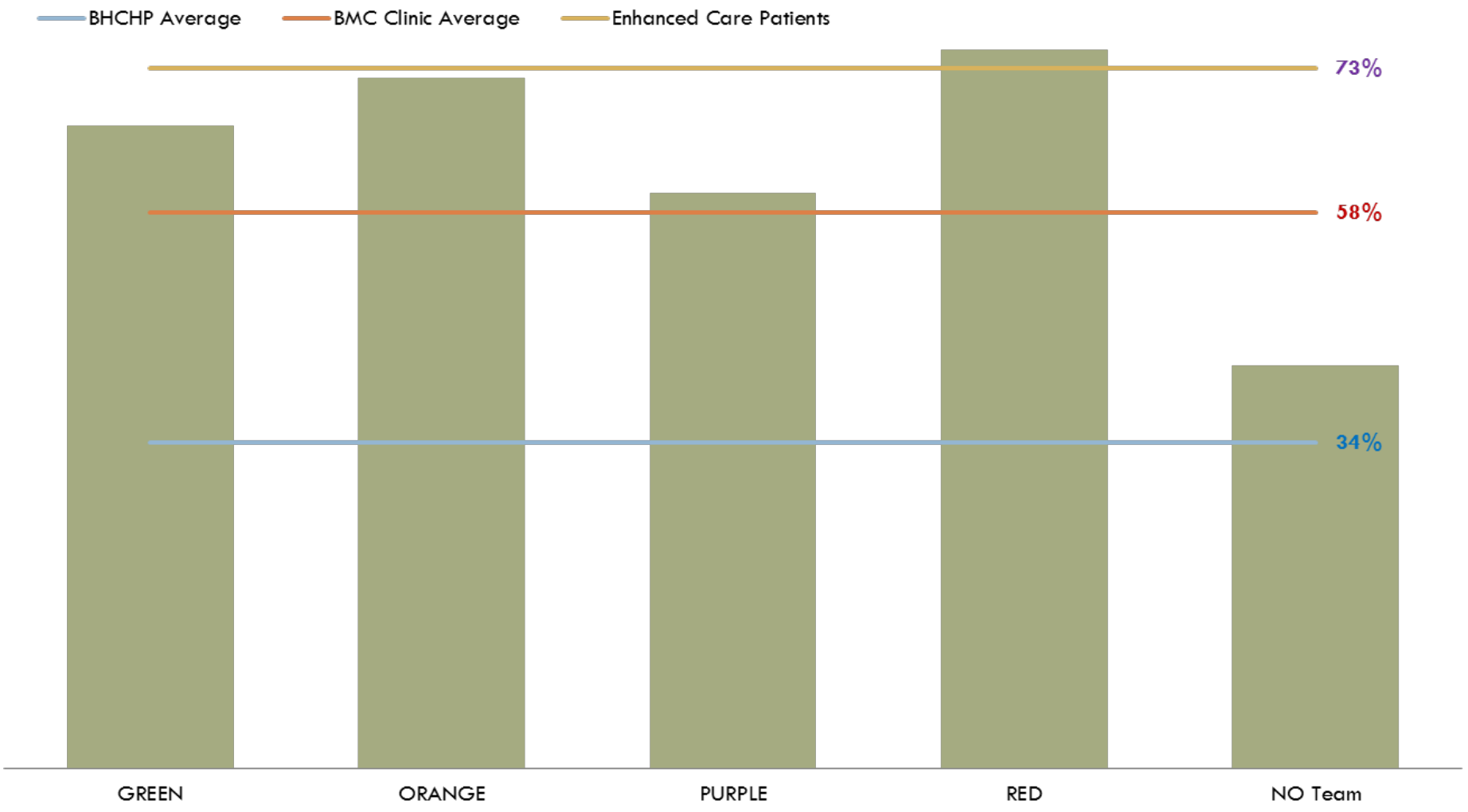
BHCHP Cervical Cancer Screening Rate
(TY Sep 2014)



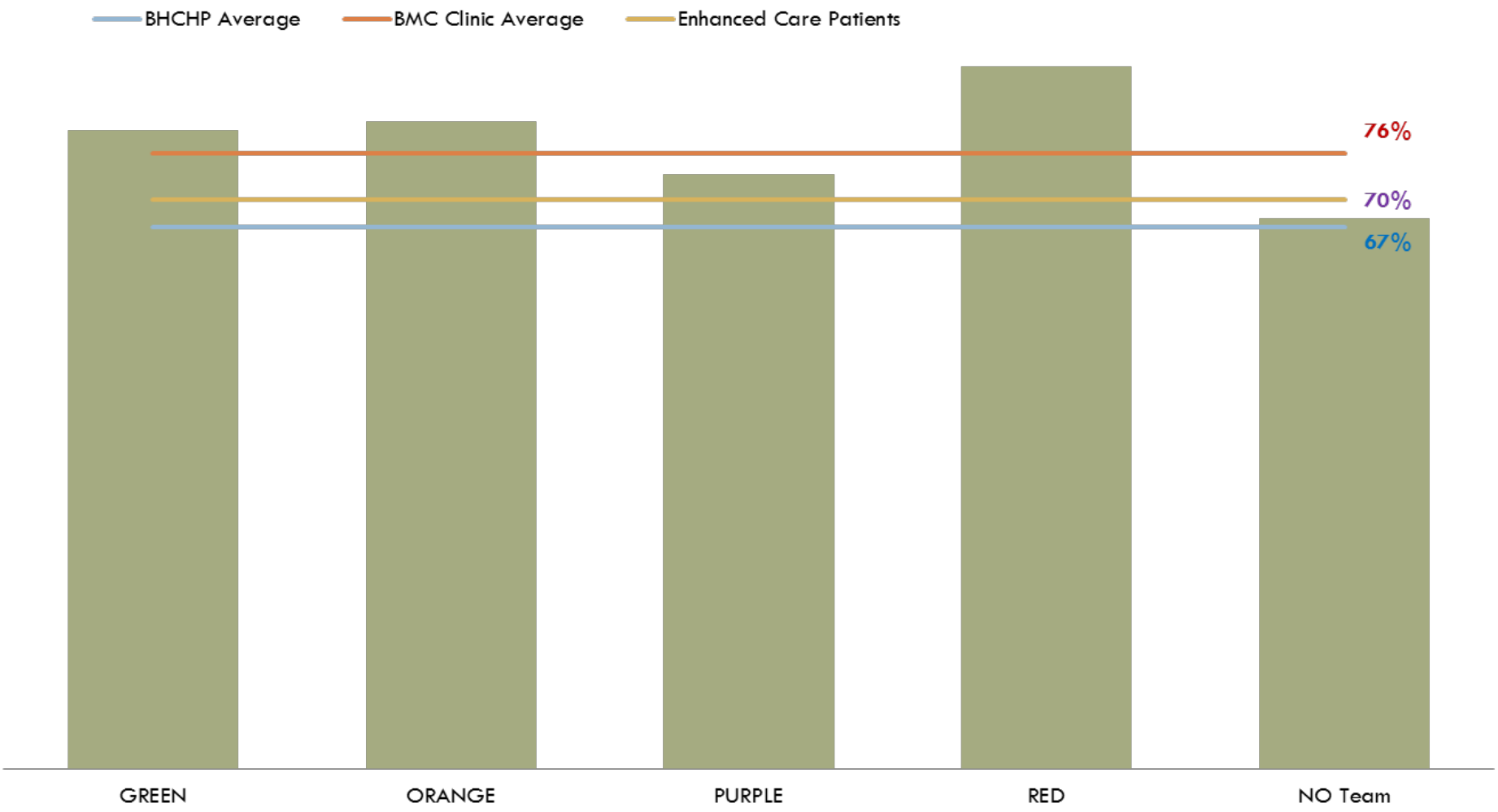
BHCHP Breast Cancer Screening Rate
(TY Sep 2014)



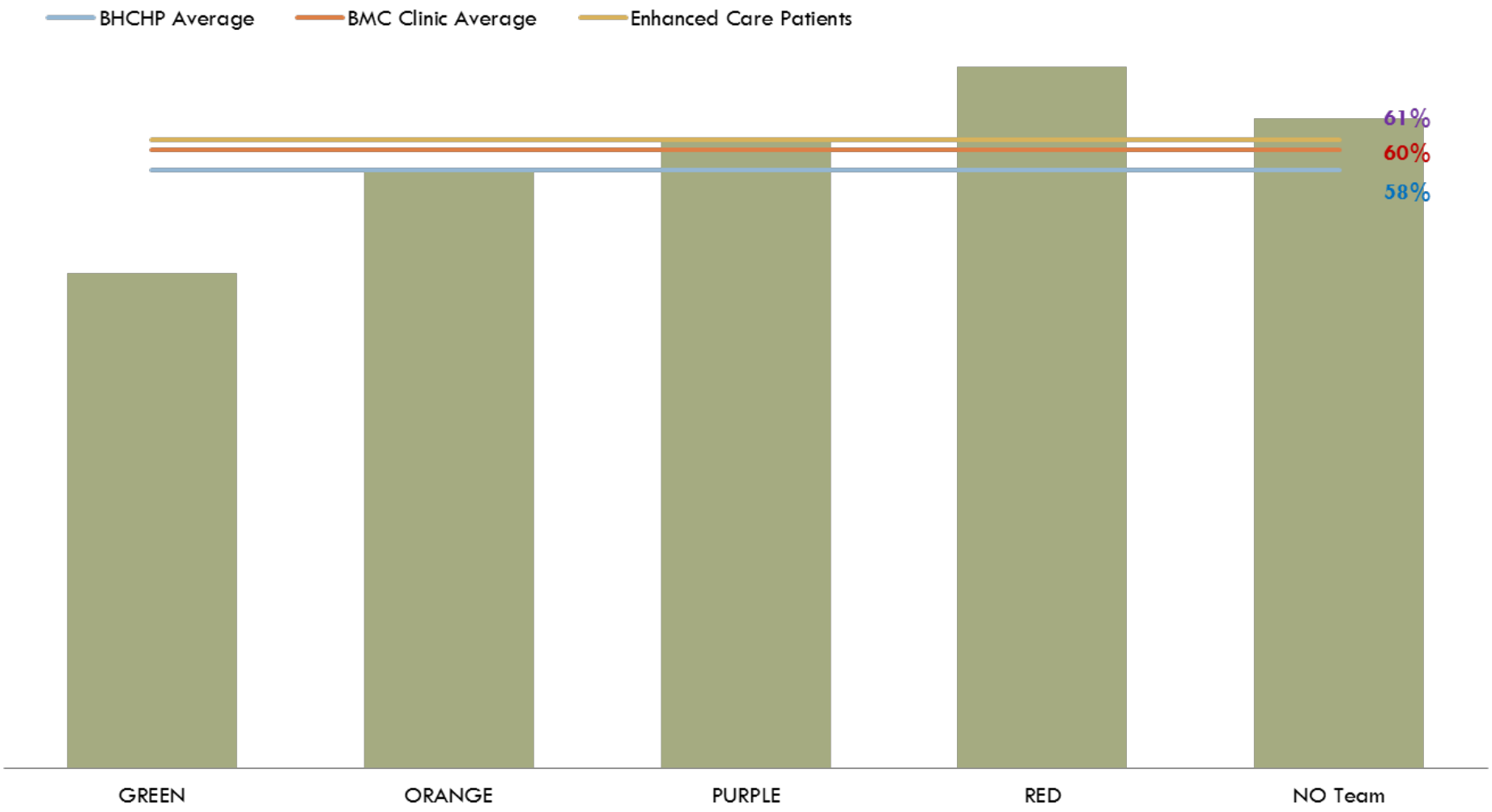
BHCHP Colon Cancer Screening Rate
(TY Sep 2014)



BHCHP Diabetics with A1C<=9
(TY Sep 2014)



BHCHP Hypertensive Pts with BP<=140/90
(TY Sep 2014)



PDSA Highlights

PDSA Samples

1. Fecal Immunochemical Testing (FIT) for colon cancer screening
2. Oral health front desk process improvement
3. Pap project at BMC Clinic
4. Improving the BMH patient admission process
5. Family Team “rock the doc” project
6. Care Innovation and Transformation (ongoing)

TRANSITIONING FROM GUAIAC- BASED FECAL OCCULT BLOOD TEST (GFOBT) TO FECAL IMMUNOCHEMICAL TEST (FIT)

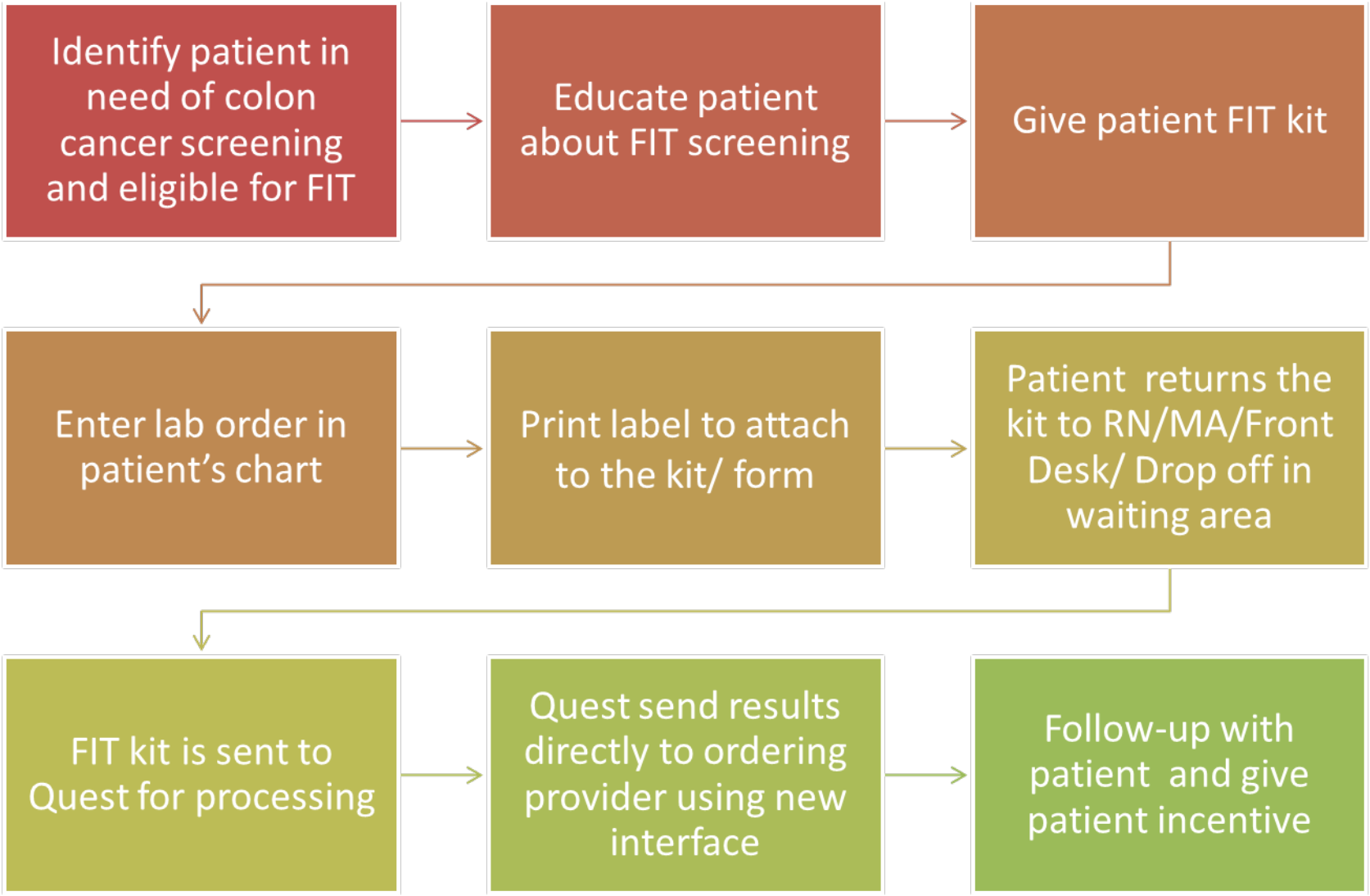
Setting the Stage

- Acquired a grant to improve colorectal cancer (CRC) screening
- Formed multidisciplinary work group
- Reviewed baseline data
- Proceeded to change our screening option from guaiac-based FOBT (gFOBT) to Fecal Immunochemical Test (FIT)

Steps Taken

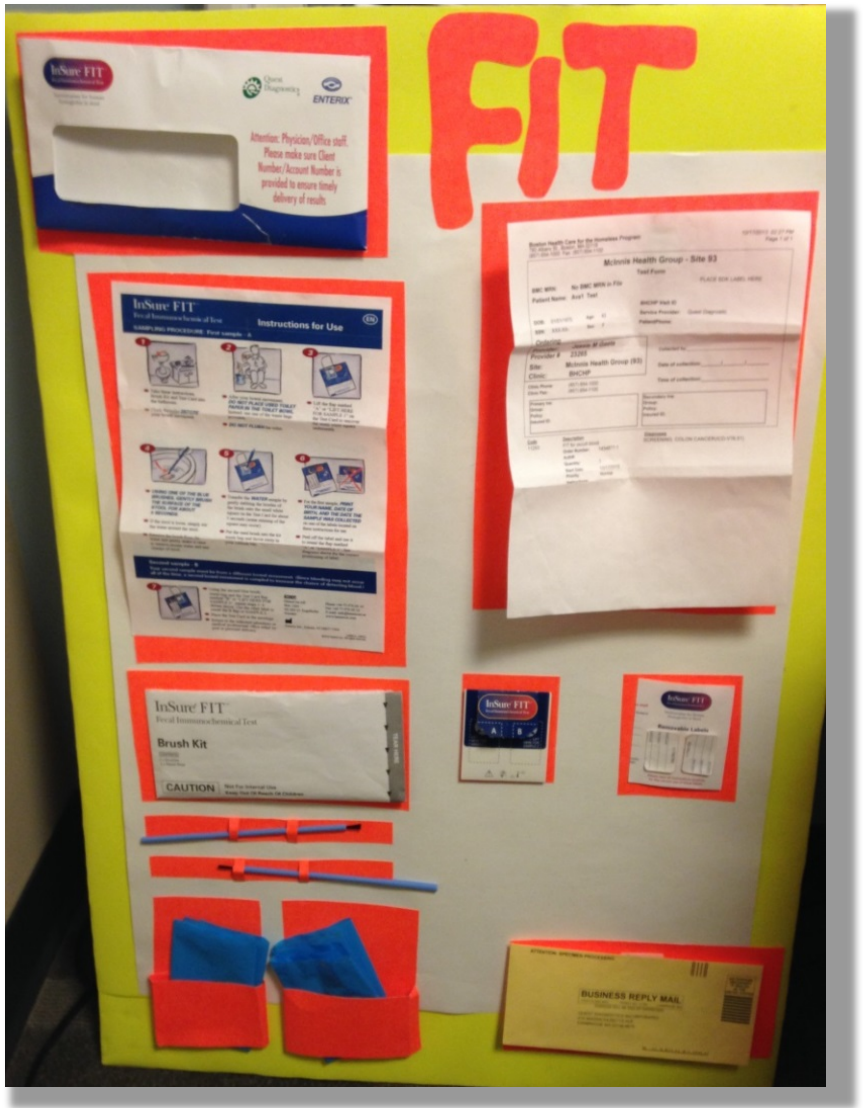
- Workflow evaluation including process mapping
- Updated policies and procedures
- Modified EMR to adapt to FIT
- Mailings/outreach to subset of patients
- Health Fairs
- Education! Education! Education!
  - Patient Education
  - Clinician Education
  - Site/Team Education

Process Mapping

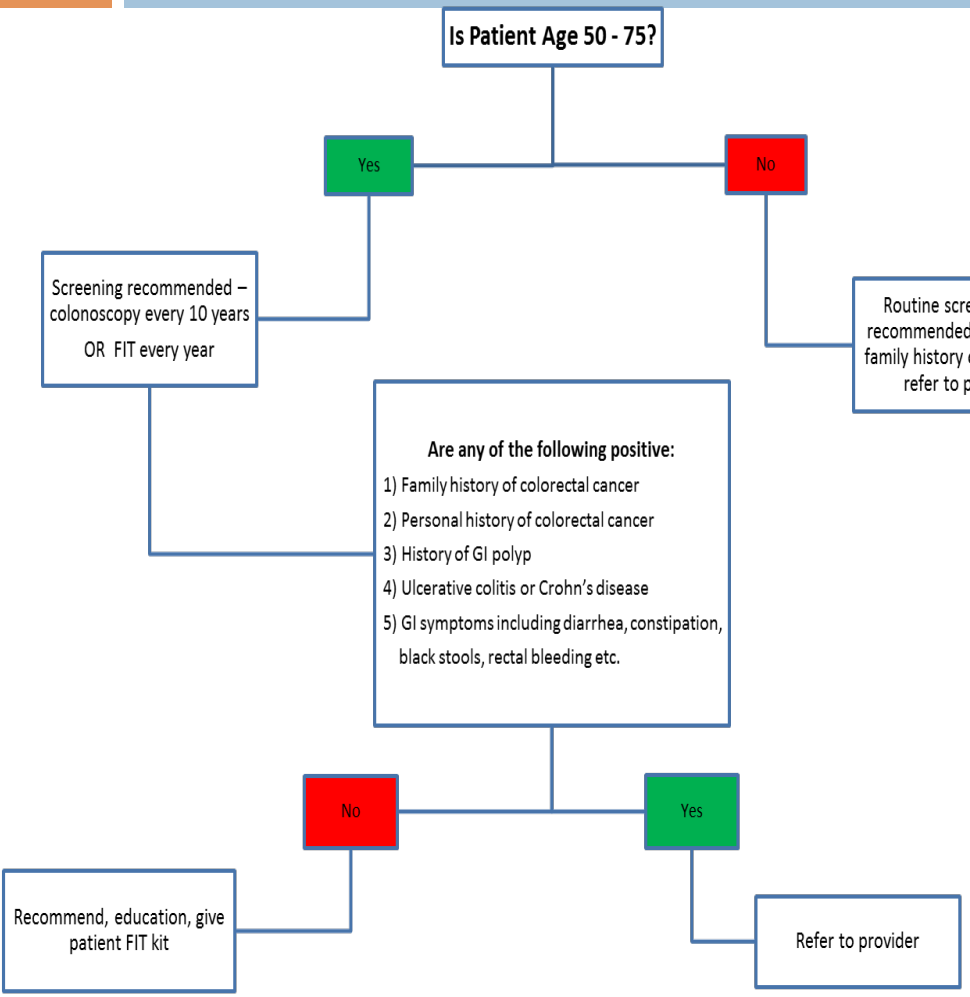


Patient Education

- Interactive presentations at patient groups about CRC screening and FIT
- Design and distribution of culturally appropriate brochures and posters in multiple languages
- Patient incentives to complete test
- Tailored FIT instructional insert to simplify language/ bilingual



Clinician Education

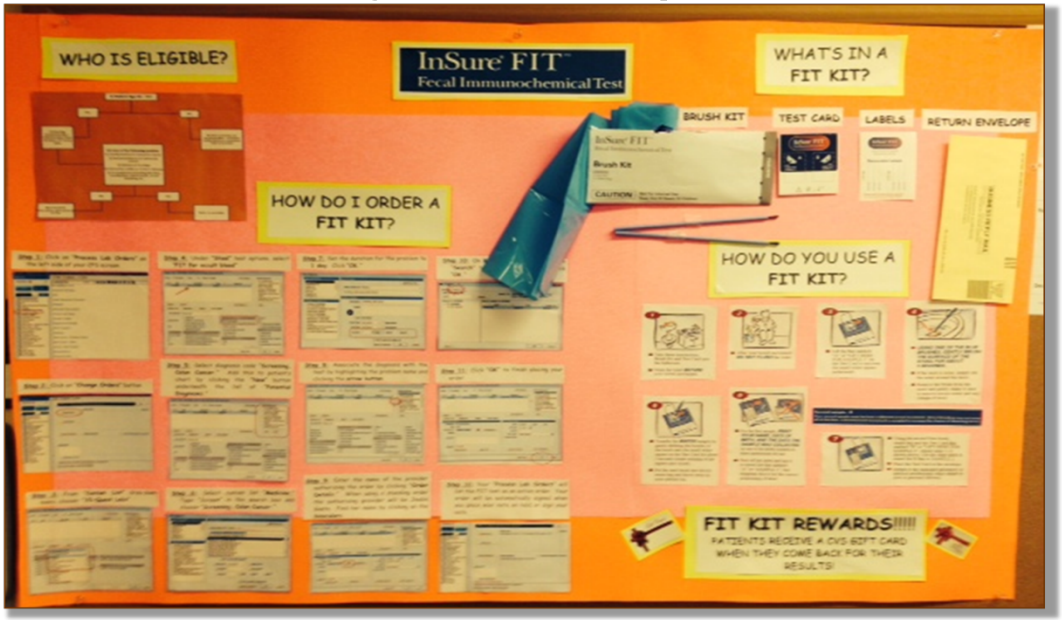


Who can get a FIT kit?

- Frequent educational bulletins via emails to clinicians
- Education on screening options and ordering FIT in EMR
- Program-wide Grand Rounds on CRC

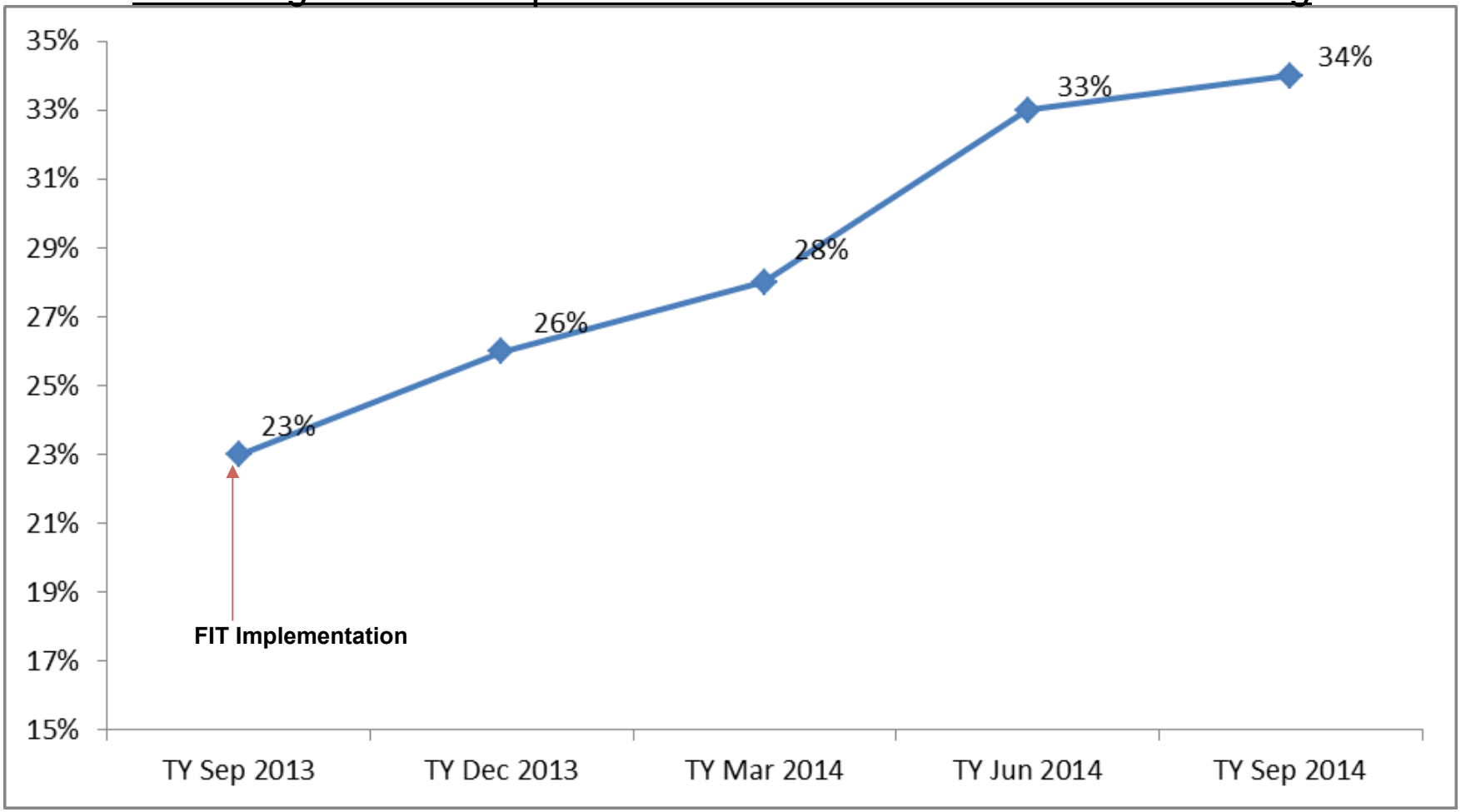
Site/Team Education

- CRC work group members met with sites/teams
- Implementation through process improvement techniques
- Educational bulletin boards in high traffic areas
- Facilitated sharing of best practices



Monitoring Progress

Percentage of BHCHP patients 50-75 with Colon Cancer Screening



Lessons Learned

- Communication
- Staff involvement and accountability
- Track progress
- Reminders and follow-up
- Celebrate success

ORAL HEALTH FRONT DESK PROCESS IMPROVEMENT PROJECT

Project Charter for: Boston Health Care for the Homeless Program

Problem Statement:
- Patients and staff have decreased satisfaction with delays/confusion at the front desk. Staff are responsible for multiple processes at one time and are frequently interrupted.

Aim Statement:
- Our aim is to increase patient and staff satisfaction by improving efficiency and removing redundancies at the front desk.

Measures of Success:
- Improved scores on Customer / Staff satisfaction survey
- Reduced staff waste time
- Better distribution of front desk tasks over staff/time

Scope:
- All patient types, at JYP site, focused on front office processes.

Boundaries:
- FTE neutral, no capital expenses > $500

Start Date: 2/26/14
Planned End Date: 6/11/14

Sponsor:
- Monica Bharel

Facilitator(s) / Practitioner(s):
- Bessy Wrights
- Moselande Joseph
- Dana Thompson
- Colleen Anderson

Coach:
- Antonia Blinn

Team Members:
- Indira Goranovic - DA
- Maria Alves – DA
- Tom Ricci, DDS
- Al Filzer, DDS

Sponsor Approval & Date

Sponsor Approval & Date

Sponsor Approval & Date

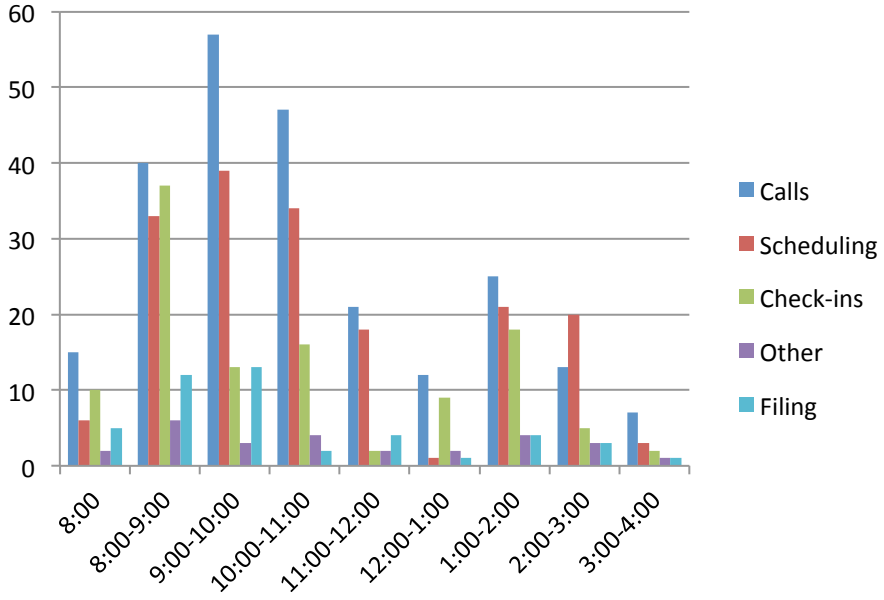
Measure and Analyze: BHCHP

- **Hypothesis:**
  - **All staff are responsible for same tasks, and have to do multiple tasks at the same time.**

- **To understand possible root causes of the problem we:**
  - Conducted staff and patient surveys
  - Completed 5 days of telephone logs
  - Completed 8 days of observation

- **Findings:**
  - Staff have mixed responses to ease/stress of tasks
  - Patient are largely satisfied, and unaware of staff frustrations
  - Tasks all peak at the same time

Results of analysis:



Root causes identified:

- Heavy appointment schedule at that time
- Patient traffic heaviest in CHC at that time
- Lack of task division between staff members
- Lack of protocols for dealing with common situations

Massachusetts League of Community Health Centers

Survey Results

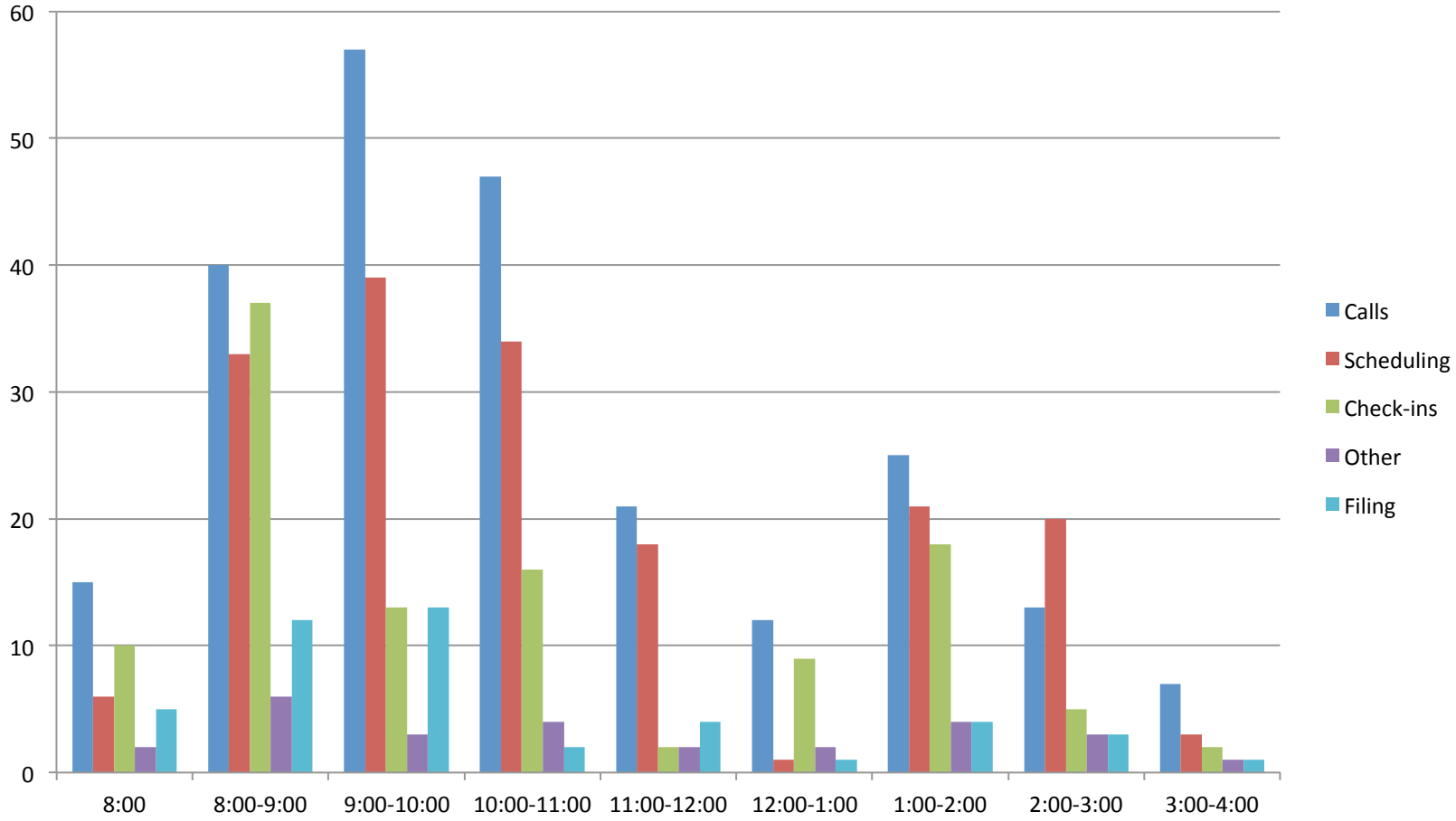
Staff:

- Mixed satisfaction, tends to dissatisfaction
- Find lack of protocols challenging
- Sometimes lack needed information
- Often/sometimes use work-arounds
- Report mild level of stress

Patients:

- Overall satisfied
- Most schedule in person
- Find staff courteous and helpful

Everything Peaks at the Same Time!



Improve

Ideas tested:

- Designated specific check-in and scheduling stations at front desk
- Divided tasks between two front desk staff
- Visual Management: Added signs and stanchion to guide patients
- Decreased missing information by enforcing existing protocol for providers

Patient feedback:

- Some confusion about desk designations at first, but otherwise positive

Results from tests:

Staff feedback:

•Overall positive

•Some report it helps them focus; they like not feeling responsible for "everything"; feel more relaxed.

•Staff became more comfortable over time, feedback has become more positive

•Noted it is easier to see deviation from or lack of protocols

Developed designated tasks (multiple iterations)

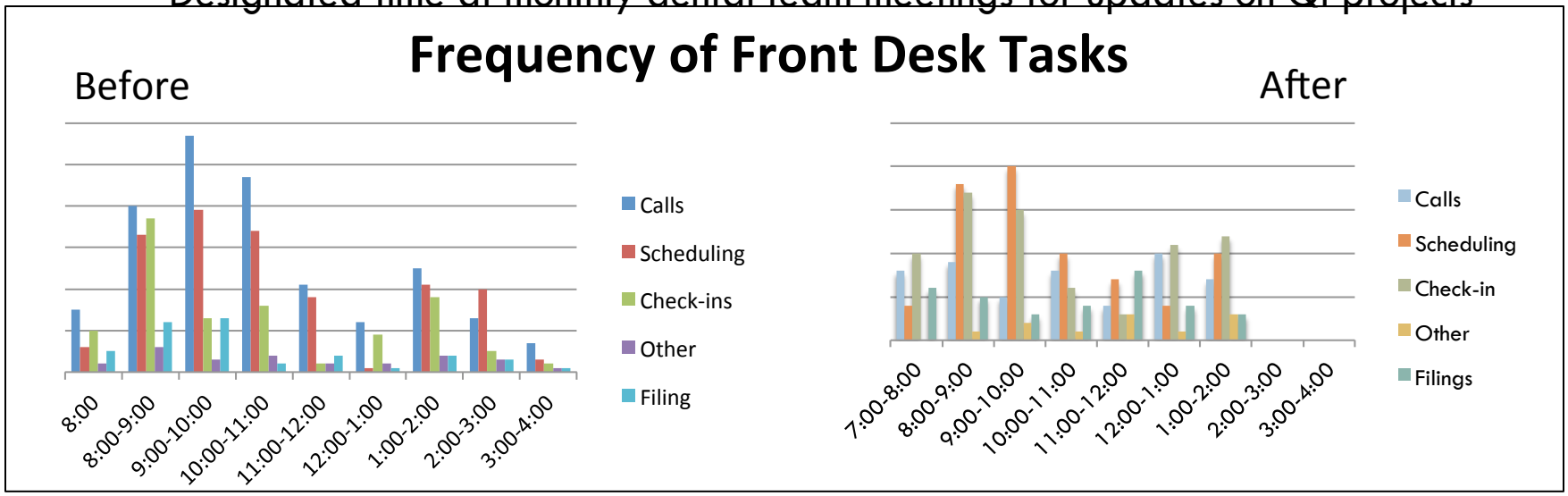
Developed more specific processes (ie: contact information)

Completed limited observations of time/ frequency of tasks to assess for better distribution.

Desk Divisions and Visual Management

Sustain

- **Our plan to sustain changes includes:**
  - Weekly huddle of assistants to touch base and address issues as they arise
  - Periodic observations of front desk administration to monitor progress
  - Periodic staff survey to evaluate satisfaction
  - Designated time at monthly dental team meetings for updates on QI projects



Key Learning and Future Work

Key learning from this work:

- It's important to not jump to solutions (this is hard to stop).
- Taking time to analyze problems leads to better solutions that are sustainable.
- Looking at things systematically allows us to focus on one area at a time.
- Communication with stakeholders is really important. Next time, we will devote more time early in the process to engaging the whole team.

Plans for future projects:

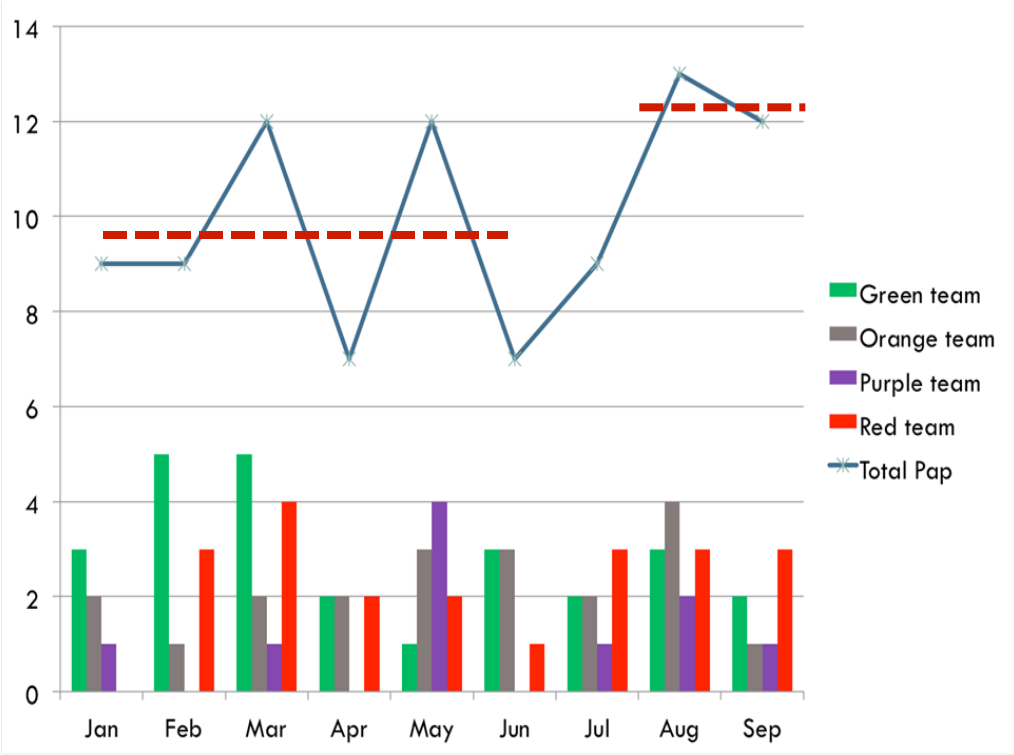
- Continue to standardize our front desk protocols.
- Evaluate other clinical operations for task division/standardization.

Pap Project at BMC Clinic

- 1/3 of women not up to date with cervical cancer screening
- Team based PAP competition conducted from Aug 14th to Sep 30th
- The team with the most paps won:
  - Bragging rights
  - Pizza case conference
- Result:

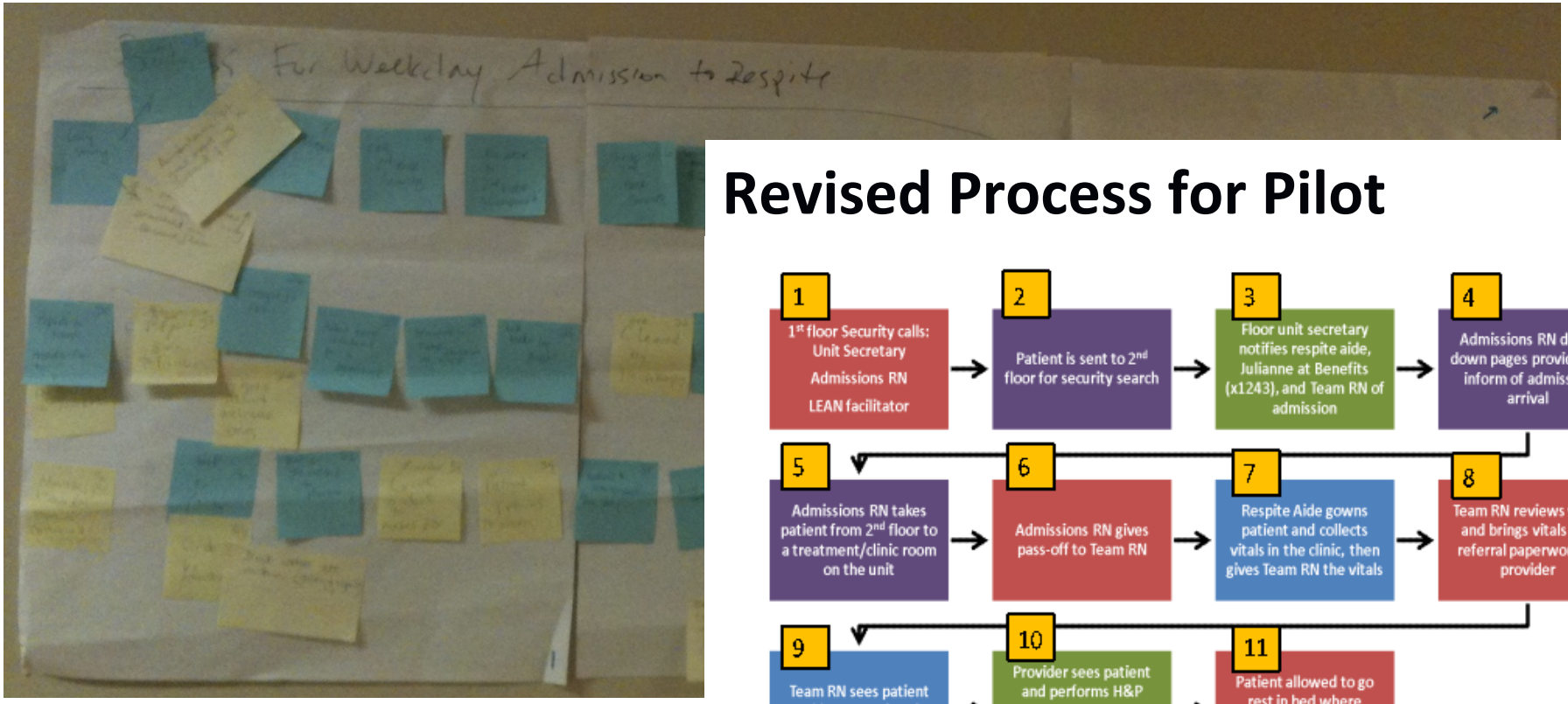
	Jan 1 – Aug 13	Aug 14 – Sept 30
Pap rate	**16%**	**21%***

***Chi squared p value: 0.16%**



Improving the Barbara McInnis House Patient Admission Process

Original Process for Admissions



Revised Process for Pilot

PDSAs and Results

Ideas tested:

- Bring patient to unit floor immediately (no waiting on 2nd floor)
- Decrease the steps in the admission process

Patient feedback: (n=5)

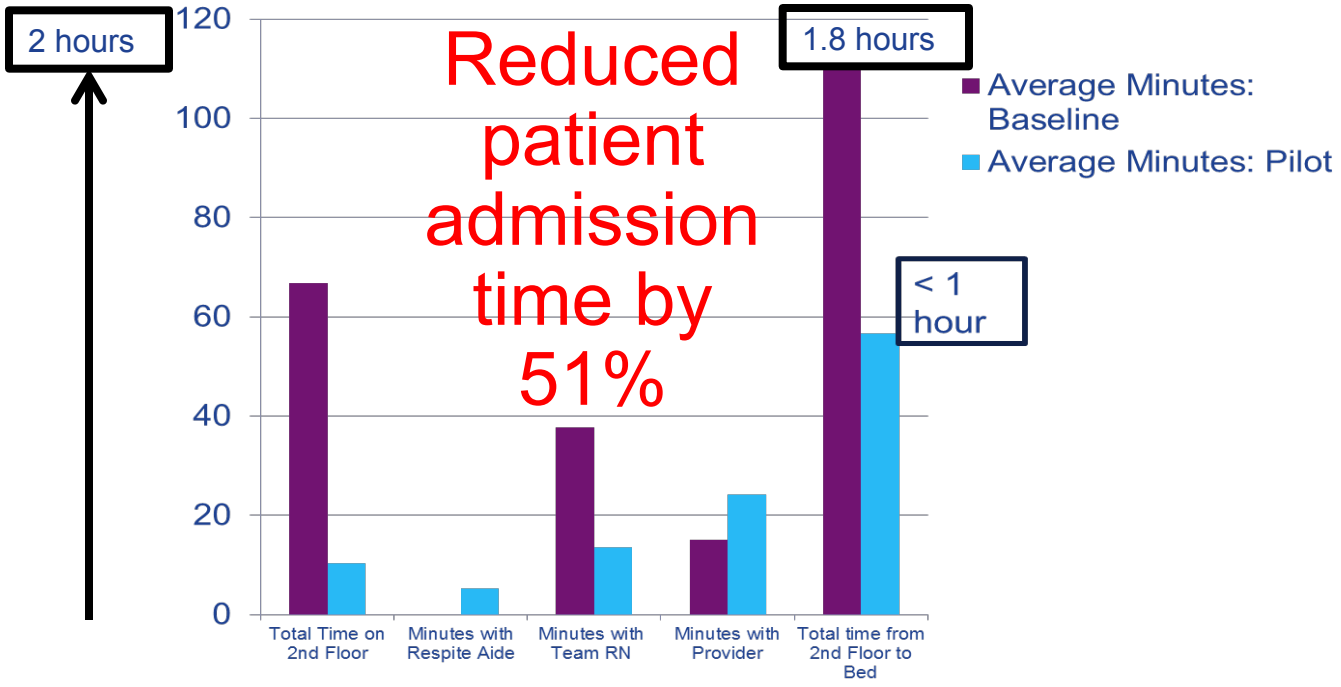
☑"I prefer this admission process as I felt I was monitored the entire time."

☑"I think this way was more efficient"

☑"There was no waiting - period"

☑"Everything was efficient"

Results from tests: 15 patient flow observations



Family Team- Rock the Doc Project / DocSmart

Goal: Improve programmatic data collection and reduce time between opening and completing notes in EMR.

Ideas tested:

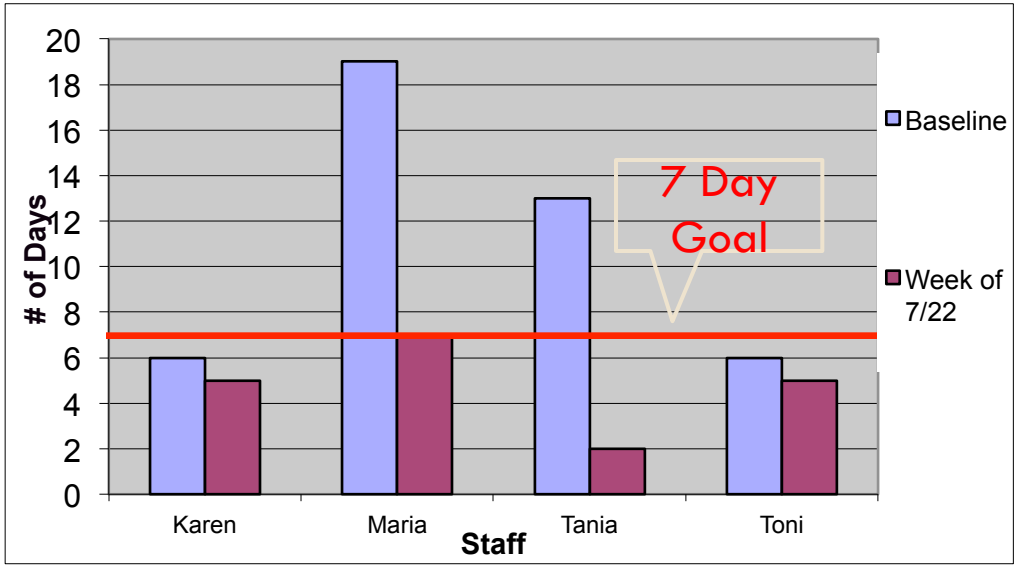
- Creating, use and revise standardized form for clinical staff
- Use of a planner/organizer for documentation
- Carve out of time for documentation
- Wear headphones when documenting in the office

Results from tests:

- A **structure** helps keep everything in the same place and makes documentation easier
- Blocking time is good, but it is not enough
- Some are feeling more organized and others are nervous about the loose papers
- Rest of staff is so excited to start using these new tools

Key learning from this work:

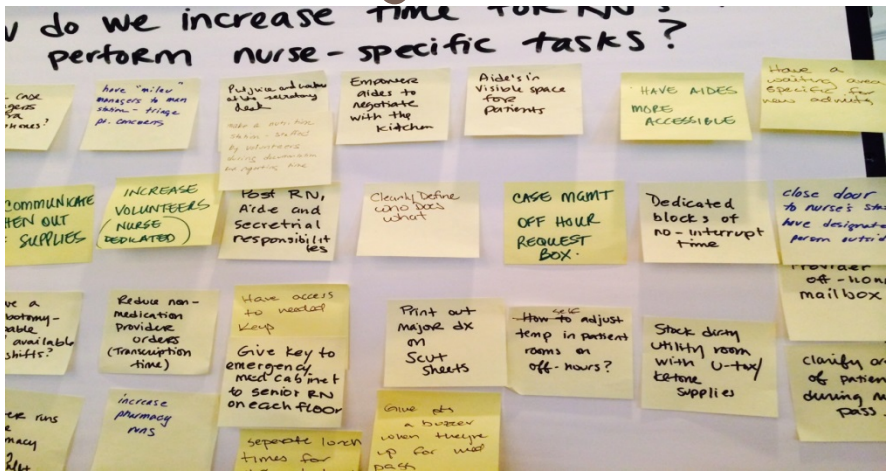
- Technology was not the solution!!
- Need for more practice structure and guides even in autonomous roles
- Working **together** helped the team find efficiencies and increased staff satisfaction
- Being pro-active and not reactive empowered staff



Care Innovation and Transformation

Frontline teams generate new ideas

Brainstorming



BMH first Initiatives

- Introducing hard copy of vital signs for morning and evening vitals
- Respite Aide empowerment to make diet changes
- Admissions Huddles
- Chart Debulking

Low hanging fruit- Chose tests of change which we have high chance of succeeding first

- Clarifies the problems and identifies other problems that need to be solved first
- Provides further impetus for change
- Provides positive feedback – further builds morale and motivation
- Lessons learned help in planning the next goal
- Creates greater difficulty for resisters to block further change
- Provides leadership with evidence of success
- Builds momentum – helps draw the neutral or reluctant supporters

Thank You