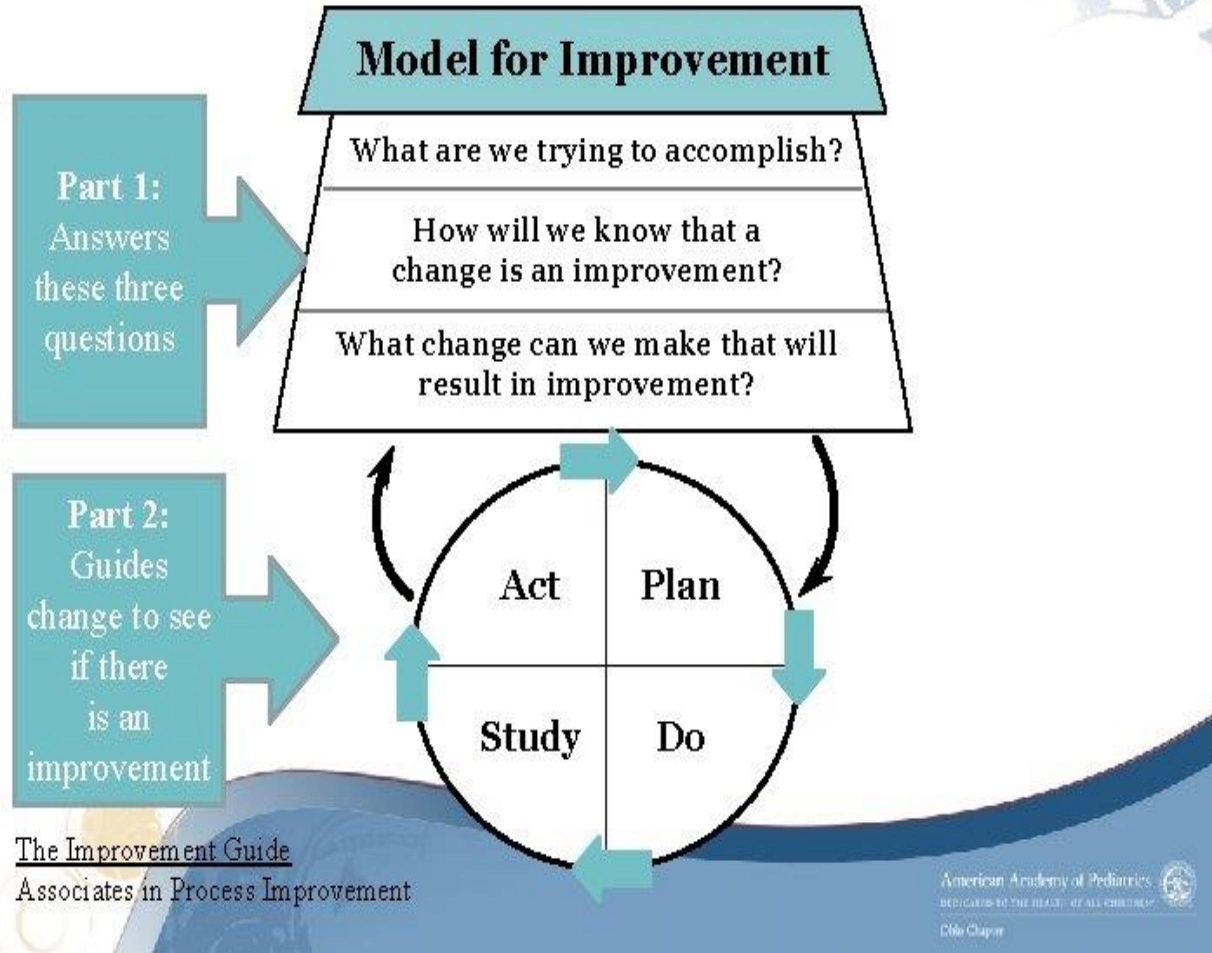
PLAN –Do- Study- Act (PDSA)

CLINICAL QUALITY MANAGEMENT COMMITTEE (CQM COMMITTEE) MEETING

PREPARED BY BEHAVIORAL SCIENCE RESEARCH
JUNE 17, 2022

Objective

Review the Plan step in the PDSA cycle to test a change idea.



What are we trying to accomplish?

By July 31, 2022, after six months beginning February 1, 2022, we will decrease the percentage of clients with missed mental health visits among the 18 unsuppressed Hispanic females from 100% to 50%.

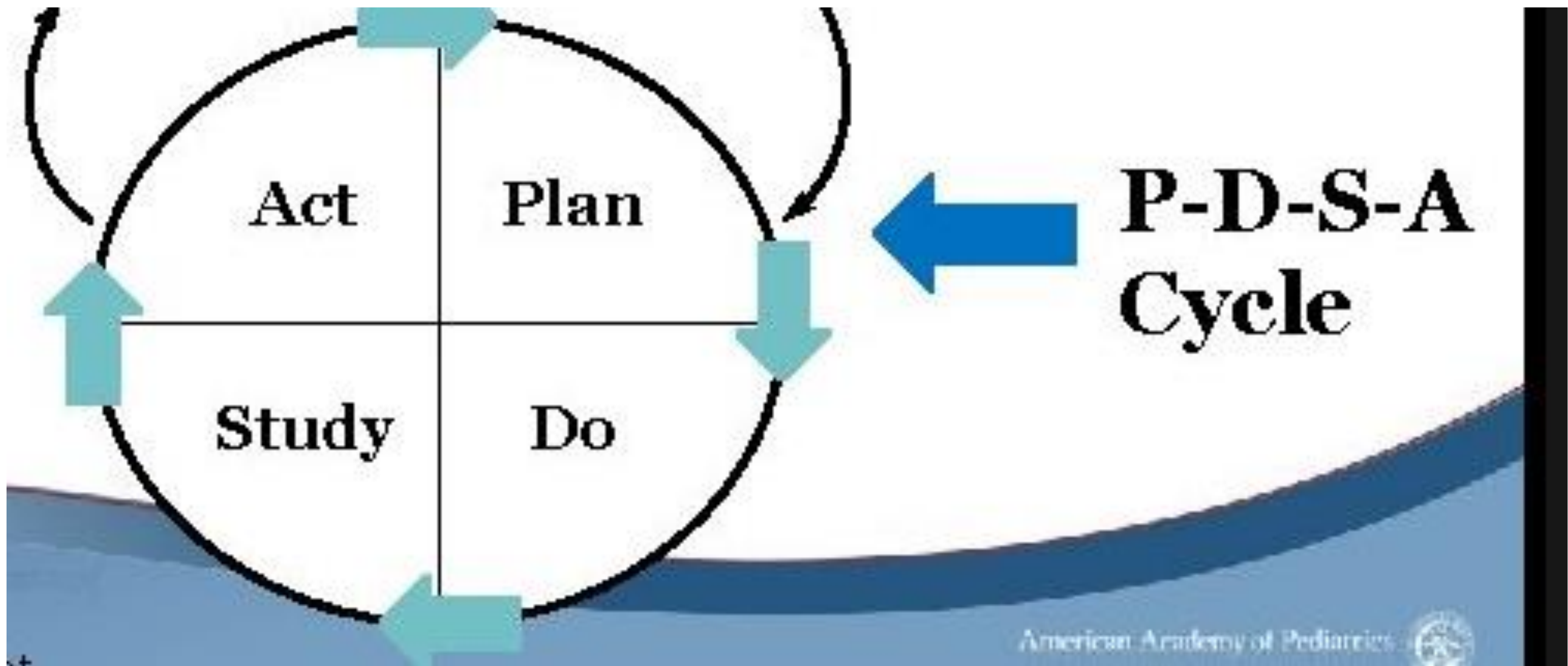
How will we know that a change is an improvement?

An increase in viral suppression among the 18 Hispanic females from 0% to 50%.

An increase in the mental health kept appointment visit rate from 0%-50%.

What change can we make that will result in improvement?

Sunny Community Health Center plans to schedule a mental health visit the same day as the medical visit for the 18 Hispanic unsuppressed females with mental health disorders.



Testing your Change Idea

Video Clip

Why is planning such an important part of a PDSA cycle?

https://youtu.be/S49qCzv9KuI

PLAN STEP

What change are you testing?

What do you predict will happen? Why?

Who will be involved?

What resources are needed?

What is the time period for the test?

What are the action steps and who is responsible for each step?

What data will be collected and how?

What change are you testing?

Sunny Community Health Center plans to schedule a mental health visit the same day as the medical visit for the **18** Hispanic unsuppressed females with mental health disorders.

Goal: We are seeking fifty percent of the 18 Hispanic females with mental health disorders to receive a mental health visit on the same day as the medical visit by July 31, 2022.

What do you predict will happen? Why?

It is predicted that the Hispanic females with mental health disorders who receive an integrated primary care and mental health visit will have decreased no-show rates and increased viral load suppression rates.

Provide details on the test:

- Who will be involved?
- What resources are needed?
- What should be the time periods for the test?
- What are the details and action steps needed, and who is responsible for each?

Sunny CHC Example:

Who will be involved:

- Peer educator
- Front desk specialist
- Clinical Quality Management Director or assignee
- Program administrator
- Medical case manager (MCM)

What resources are needed:

- Electronic Health Record (EHR) to create an appointment panel that includes appointment slots for the integrated mental health and primary care provider care visits.
- Provide Enterprise Miami to generate various reports.

What is the time period for the test?

Fifty percent of the 18 Hispanic females with mental health disorders will receive the mental health visit and the medical visit on the same day for the period (February 1, 2022-July 31, 2022).

What are the details on action steps?

The clinical quality director will create a dual appointment panel that includes slots for both the mental health visit and the primary visit during the same visit.

The MCM and or Peer will schedule the mental health visit and primary visit using the dual appointment panel.

The clinical quality director will collect the mental health and primary care visit no-show rate data weekly. This will be done for the next six months (January 2022 – June 2022).

The MCM will ensure the VL data is collected in January, March, and June 2022.

The data will be reviewed/analyzed during the monthly team meeting that includes the team (Peer educator, front desk specialist, Clinical Quality Management Director or assignee, Program administrator and MCM).

What data will you collect?

- The VL lab results will be collected from Provide Enterprise Miami.
- The mental health visits no show rate report will be collected from the EHR.
- The primary visits no show rate report will be collected from the EHR.

Questions

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Answers

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PHT/PET Center Quality Improvement Project

Question 1: What are we trying to accomplish?

- By June 30, 2022, we will increase the percentage of PET center MCM clients without an OHC billed visit in the last 12 months (among 18 Hispanic MMSC) from 0% to 50%.

Question 2: How will we know that change is an improvement?

- An increase in scheduled OHC appointments among the SFAN Clients (specifically Hispanic MMSCs).
- An increase in the number of billed clients who received an OHC service in the last 12 months (among 18 Hispanic MMSC) from 0%-50%.
- Tracking the number of OHC clients scheduled and seen for a service on a weekly basis:
    a. 7 clients have been seen
    b. 7 clients are confirmed for future appointments
    c. 1 client canceled their scheduled appointment
    d. 2 clients remaining to be scheduled
    e. 1 client now prefers to be seen at JMH-Main

Question 3: What change can we make that will result in an improvement?

- The client's primary visit scheduled on the same day as the OHC appointment
- Client reminder calls the day prior to the OHC visit
- The MCM, Peer, PCP and OHC provider educating clients on the importance of maintaining OHC appointments
- Providing an incentive (Partnership merchandise) as a thank you to the clients who kept their OHC appointment

Jessie Trice CHS QI Project
55+ Populations not RiMC
Model for Improvement & PDSA Stages

PROBLEM STATEMENT

As of February 2022, a disproportionate number of Jessie Trice's 55+ participants were not RiMC. This project is important because this age group is at high-risk for COVID-19. As COVID continues to mutate, participants must learn how to navigate Telehealth and agency COVID protocols. Additionally, affected 55+ participants often have limited access to technology in addition to difficulties using remote software.

Through this project, Jessie Trice will aim to educate 55+ participants on how to navigate Telehealth and understand agency COVID protocols

BACKGROUND

As of February 2022, Jessie Trice served 151 Miami-Dade RWP MCM clients in one location is South Florida. A total of 41 clients were classified as not RiMC. Out of these 41 not RiMC participants, a total of 24 or 59%, were in the age group 55+. Within this 24-participant subset, 17 participants were ages 55-64 and 7 were age 65+. Their ethnicity grouping was as follows: 16 African American, 7 Haitian, 1 Hispanic.

PRIORITY POPULATION IDENTIFIED:

NOT RiMC						
Age Group	18-24	25-34	35-44	45-54	55-64	65+
Female						
Hetero			2	2	8	4
Male						
Hetero		2	2	1	8	2
MSM	3	2	3			1
Unknown/unreported					1	
Grand Total	3	4	7	3	17	7

Total # of Clients	41
55-65+	24
% of Clients	59%

Ethnicity	55+	% of 55+
BAA NHNH	16	67%
Haitian NH	7	29%
Hispanic	1	4%

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55+ Populations not RiMC
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THREE QUESTIONS FOR IMPROVEMENT

1. WHAT ARE YOU TRYING TO ACCOMPLISH?

By:	**July 31, 2022**
We will:	**Decrease**
The:	**Number of clients not RiMC**
Among:	**55+ clients**
From:	**24 Clients**
To:	**10 Clients**

ROOT CAUSE ANALYSIS TOOL: 5 WHY'S

PROBLEMS: 55 POPULATION NOT RIMC

5 Whys	Question:	Answer:
1	Why is the 55+ population not RiMC?	Pandemic
2	Why is the pandemic causing participants not RiMC	Fear of covid exposure
3	Why is this fear exposure preventing them from RiMC	This population may not realize that Telehealth is a safer option for seeing their HIV provider.
4	Why isn't this population aware of Telehealth as an option for care at JTCHS?	This population may not understand the concept of Telehealth.
5	Why doesn't this population understand the concept of Telehealth?	JTCHS encountered communication barriers with participants due to their limited access to computers, internet, and ability to navigate remote software.
ROOT	Communication Failure	JTCHS will educate 55+ participants on how to navigate Telehealth (remote software) and agency COVID protocols.

Jessie Trice CHS QI Project
55+ Populations not RiMC
Model for Improvement & PDSA Stages

AIM STATEMENT

By July 31, 2022, after six months beginning February 1, 2022, Jessie Trice will aim to decrease the number of 55+ patients Not RiMC from 24 to 10. This aggressive goal aims at reducing the number of 55+ not RIMC by 60%.

2. HOW WILL YOU KNOW THAT A CHANGE IS AN IMPROVEMENT?

Jessie Trice will aim to increase the number of 55+ RiMC by proactively educating participants on how to navigate Telehealth and increasing their understanding of agency COVID protocols.

3. WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN AN IMPROVEMENT?

THE JESSIE TRICE PROPOSED CHANGE IDEAS:

Jessie Trice CHS will aim to increase the number of 55+ participants by implementing the following interventions:

- Case Managers will educate 55+ participants on how to navigate Telehealth and COVID protocols.
- Case Managers will educate participants on how Telehealth calls are established and conducted.
- Case Managers will ensure follow-up phone calls are made prior to scheduled appointments.
- Nursing staff will reach out to 55+ participants on a monthly visit to discuss COVID related concerns.