SAN MATEO COUNTY HEALTH
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AGENDA

TOPIC: **HCH/FH Program QI/QA Subcommittee**
DATE: April 13th, 2023
TIME: 12:30pm-2:00pm
PLACE: County Building Room 101, RWC Address: 455 County Center, Redwood City, CA 94063

Item	Time
1. Welcome	12:30pm
2. Approve Meeting Minutes:	12:35 pm
3. Introduction	12:40 pm
4. Program Updates	12:50 pm
5. UDS Performance measures	1:05 pm
6. QI/QA subcommittee meeting schedule	1:35 pm
7. Looking ahead: 2023	1:45 pm
8. **Adjourn**	2:00 pm

FUTURE MEETING DATES: TBD

*Contact **Frank Trinh** ftrinh@smcgov.org or **Alejandra Alvarado** aalvarado@smcgov.org for additional information regarding the HCH/FH Program Quality Improvement Committee.*

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HCH/FH Program QI Committee
Thursday April 7th, 2022; 9:00-10:00 AM Microsoft Teams, +1 628-212-0105 ; Conference ID: 270 887 568#

Present: Brian Greenberg, Suzanne Moore, Danielle Hull, Amanda Hing-Hernandez, Janet Schmidt, Sofia Recalde

ITEM	DISCUSSION/RECOMMENDATION	ACTION
	Meeting began at 9:00 AM	
Approve Meeting Minutes		Suzanne approved, Janet second
General Updates: 1. SMMC Updates a. Patient Satisfaction Survey b. ACTIVATE Pilot c. Telehealth at Maple Street d. Homeless Death Data Event 2.	1. Patient Satisfaction Survey: Fixed error in homeless and farmworker identification a. NRC Survey flags will now pull identification data from our patient master list rather than per visit status b. Waiting on 2021 Patient Satisfaction Data Report from NRC matching 2021 Patient Master Data Anticipate that efforts in 2022 will focus on how to boost survey participation in patients 2. ACTIVATE Pilot: Coastside Clinic and MITRE have both committed to beginning a telehealth pilot in Summer 2022 a. Setting meeting with Coastside BHRS to gauge interest in participating b. Pilot will follow path of flagship program but will be tailored to SMMC resources and structure; partnership is accompanied by small amount of funding 3. Telehealth at Maple Street: Shelter is ramping up residents a. HCH/FH to visit shelter during house meeting in next few weeks to present about the telehealth station and have short discussion about interest and questions 4. Presented timeline for homeless death data event	
Fair Oaks Food Insecurity Event	Rakhi Singh presented about food insecurity efforts at Fair Oaks Health Center. • The goal of the effort is to connect food insecure patients to community food resources. • Effort begins with accurate identification by asking the validated Hunger Sign food insecurity questions. Responses are tracked in eCW. • A literacy friendly food resource list has been created for South County patients so they know where to access food. QR code for digital access at clinic. • If patients need high need support, they are referred to social work (SMI, child in home, medically complex, 60+) • About 81% of patients at FOHC have been screened • There's hope that CalAIM can support medically tailored food for patients	

	• The Foundation has been providing food boxes since the Facebook sponsored boxes ended	

SMMC Literacy Event	Amanda Hing Hernandez presented about the SMMC Literacy work:
	• The goal of the event is SMMC patients will receive medical information that is easy for them to understand and individualized resources and tools to help them live their healthiest lives
	• The event will establish:
	  ○ Process for assessing for understanding throughout the visit
	  ○ Pathway for front line staff and providers to request updates to existing patient education materials or to create new materials to address all literacy levels
	  ○ System-wide location for easy access to these approved materials (eCW, Sharepoint site, patient portal, external facing site)	

Adult BMI and Follow-up and Depression Screening	Push to next meeting; did not have time to discuss	
Future meeting dates	**September 22, 2022**	
FOLLOW UP- ACTION ITEM		

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QI/QA Committee Meeting Q1

Healthcare for Homeless & Farmworker Health Program

Thursday, April 13th, 2023

Approve Meeting Minutes from 2022 Q2

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Introductions

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Agenda

1. Program updates
2. UDS Performance measures
3. QI/QA subcommittee meeting schedule
4. Looking ahead 2023

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General Updates

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- **ACTIVATE Pilot**
  - Previously discussed with SMMC Materials Management about possibility of developing a MOU with Mitre
  - With MOU requirement, the process to develop agreement would take approx. 2 months
  - Additional time needed to develop MOU might conflict with grant funding timeframe, exploring other opportunities
- **Telehealth at Maple Street Shelter**
  - Equipment being re-allocated from Maple Street Shelter to Navigation Center
  - Once transition of equipment is complete, we will work on process of equipment implementation for patients

General Updates

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- **Death Data**
  - HCH/FH collaborating with Public Health Epidemiology to accurately collect county homeless mortality data
    - County data retrieval from previous 10 years in collaboration with HSA using HMIS data
    - Additional data collected- length of homelessness, where they lived when they passed, etc.
    - Public Health Epidemiology's working relationship with the coroners office and Health IT
    - Final report likely to be completed around the Fall (Q3)
- **Hypertension Pilot**
  - BP Cuffs have been distributed, follow-up conducted with SMMC team to assess status of patients
  - Health disparities among Black/African American population evaluated via chart reviews
  - Goal: construct holistic approach to care and preventative screening, targeting patients at younger age
  - Identify PEH and farmworker individuals to track blood pressure and other metrics

2022 UDS Performance Measures

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UDS Measure Description

- Cervical Cancer Screening
  - Percentage of women 23-64 yrs of age who were screened for cervical cancer who 1) had cervical cytology performed within 3 yrs or 2) had HPV testing performed within 5 yrs
- Colorectal Cancer Screening
  - Percentage of patients 50-74 yrs of age who had appropriate screening for colorectal cancer via one of these: 1) Fecal occult blood test (FOBT) 2) Colonoscopy 3) Sigmoidoscopy 4) Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA)
- Breast Cancer Screening
  - Percentage of women 51-73 yrs of age who had a mammogram to screen for breast cancer in the 27 months prior to end of measurement period
- Depression Screening and Follow-Up
  - Percentage of patients 12 yrs of age and older who were 1) screened for depression with a standardized tool and if screening was positive 2) had a follow-up plan documented

UDS Measure Description

- Adult BMI Screening and Follow-Up
  - Percentage of patients 18 yrs of age and older with 1) BMI documented during most recent visit or within previous 12 months to that visit and 2) follow-up plan documented if BMI is outside of normal parameters
- Hypertension
  - Percentage of patients 18-85 yrs of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period
- Diabetes A1c > 9%
  - Percentage of patients 18-75 yrs of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period
- Prenatal Care 1st Trimester
  - Percentage of patients entry into prenatal care having their first visit with the Health Center during their 1st trimester

QI Measures of Focus	2022 UDS	2021 UDS	2021 CA 330 Programs	2021 Adjusted Quartile Ranking	2022 SMMC Performance (Prime/QIP)
Screening and Preventive Care					
Cervical Cancer Screening	28%	55%	55.2%	1	60%
Colorectal Cancer Screening	54%	52%	39.9%	1	60%
Breast Cancer Screening	54%	50%	48.5%	1	70%
Depression Screening and Follow-up	29%	36%	65%	4	46.7%
Adult BMI Screening and Follow-up	40%	29%	58.1%	4	N/A
Chronic Disease Management					
Hypertension	56%	49%	56.9%	3	61%
Diabetes A1c >9%	32%	32%	35.1%	1	28%
Maternal Health					
Prenatal Care 1st Trimester	83%	66%	77.1%	3	N/A

QI Measures of Focus	2022 PEH	2021 PEH	2022 FW	2021 FW
Screening and Preventive Care				
Cervical Cancer Screening	23%	44%	43%	83%
Colorectal Cancer Screening	52%	52%	66%	67%
Breast Cancer Screening	48%	47%	85%	77%
Depression Screening and Follow-up	28%	29%	30%	45%
Adult BMI Screening and Follow-up	37%	21%	46%	21%
Chronic Disease Management				
Hypertension	52%	48%	59%	52%
Diabetes A1c >9%	15%	32%	19%	33%
Maternal Health				
Prenatal Care 1st Trimester				

Areas of Improvement

- Adult BMI Screening and Follow-Up
  - Farmworker Population
    - 2021-155/499 blank with success rate of 21%
    - 2022- 101/514 blank with success rate of 46%
  - People Experiencing Homelessness Population
    - 2021- 1056/2448 blank with success rate of 21%
    - 2022- 752/2429 blank with success rate of 37%
  - BMI autogenerated when weight and height are inputted
    - BMI entry concerns with IT addressed
    - Screening and documentation greatly improved for both populations

Areas of Improvement

- Adult BMI Screening and Follow-Up
  - Dietary Counsel Given Breakdown- 2022:

PEH Subcategories	Dietary Counsel Given (Y)
D- Doubling Up	210
H- Homeless Shelter	54
O- Other	127
S- Street	32
T- Transitional	56
TOTAL	**479**

Areas of Improvement

- Prenatal Care 1st Trimester
  - 2021 UDS- out of 86 total patients **57** sought prenatal care during 1st trimester
    - 2nd trimester- 17 at Health Center, 1 patient with another provider
    - 3rd trimester- 11 patients
  - 2022 UDS- out of 76 total patients, **63** sought prenatal care during 1st trimester
    - 2nd trimester- 12 patients
    - 3rd trimester- 1 patient

Areas of Concern

- Cervical Cancer Screening

2021 UDS	2021 PEH	2021 FW	2022 UDS	2022 PEH	2022 FW
55%	44%	83%	28%	23%	43%

- Screening decreased by almost half for total screenings and for both populations
- Majority of screenings done in clinic- not screening in mobile vans
- PEH breakdown by year:

2021

PEH Subcategories	Screened (Y)
D- Doubling Up	153
H- Homeless Shelter	32
O- Other	65
S- Street	12
T- Transitional	23
TOTAL	**285**

2022

PEH Subcategories	Screened (Y)
D- Doubling Up	62
H- Homeless Shelter	21
O- Other	44
S- Street	9
T- Transitional	25
TOTAL	**161**

Areas of Concern

- Depression Screening and Follow-Up

2021 UDS	2021 PEH	2021 FW	2022 UDS	2022 PEH	2022 FW
36%	29%	45%	29%	28%	30%

  - Mental health access in street medicine
    - Psychiatrist access via BHRS
  - Mobile clinic has limited mental health services
  - PCP clinics embedded with BHRS referral services- faster patient connections to providers
  - 2022 Farmworker clinic breakdown:
    - Coastside- Adult: 46%
    - Coastside- Pediatrics: 23%
    - Public Health San Mateo: 6%
    - Puente Services: 4%

Areas of Concern

- Depression Screening and Follow-Up
  - 2022 Farmworker ethnicity breakdown:
    - Hispanic (Y) – 91%
    - Hispanic (N) – 0.5%
    - Declined – 0.5%
    - Unknown – 8%
  - 2022 PEH ethnicity breakdown:
    - Hispanic (Y) – 56%
    - Hispanic (N) – 38%
    - Unknown – 7%
    - Declined – 0.4%

Areas of Concern

- Depression Screening and Follow-Up
  - 2022 PEH Race Breakdown:

PEH Race Breakdown	Patients Screened
White	407
Other	199
Asian	87
Unknown/Declined	84
Black	36
Pacific Islander	21
Native American	4
TOTAL	**838**

Areas of Concern

- Diabetes A1c > 9%
  - Farmworker population rate- 19% screened
    - Percentage of A1c not collected- 7%
  - Homeless Population rate- 15% screened
    - Percentage of A1c not collected- 18%
  - 2022 PEH ethnicity breakdown:
    - Hispanic (Y) - 57%
    - Hispanic (N) - 37%
    - Unknown - 6%

Areas of Concern

- 2022 Diabetes PEH breakdown:

Race Breakdown	Screened Patients with A1c >9%
White	36
Unknown	9
Other	8
Native Hawaiian/Pacific Islander	4
Black/African American	4
Asian	4
TOTAL	**65**

PEH Subcategory	Screened Patients with A1c >9%
D- Doubling Up	18
H- Homeless Shelter	13
O- Other	21
S- Street	9
T- Transitional	4
TOTAL	**65**

Updated HRSA Health Center Data 2021

- Adjusted Quartile Ranking
  - 330 program performance data not released for 2022 yet
  - Adjusted quartile: ordering of health centers' clinical performance compared to other health centers reported to the UDS annually.
- Clinical performance for each clinical quality measure (CQM) measure is ranked from quartile 1 (highest 25% of reporting health centers) to quartile 4 (lowest 25% of reporting health centers).
- Our program changed quartile rankings for the following metrics:

Metric	2020 Adjusted Quartile Ranking	2021 Adjusted Quartile Ranking	Positive/Negative Change
Early Entry into Prenatal Care (1st Trimester)	4	3	Positive
Hypertension	4	3	Positive
Diabetes A1c >9%	2	1	Positive

QI/QA Committee Meeting Schedule

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Looking Ahead: 2023

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- Current administrative building is getting torn down, office relocation in April 2023
- Collect committee members general availability to plan for time/location of future meetings
- New project initiatives
  - Pap-test update- waiting for FDA approval
  - HMB library update- BP cuff installation initiative
  - AMI Phones- contract renewal
- HCH/FH committee member goals, vision, limitations
  - What goals are you excited for the HCH/FH program to accomplish this year?
  - What aspects are you looking for the HCH/FH program to focus on?
    - Are there any limitations that concern you?
    - Any additional visions or questions?