SAN MATEO COUNTY HEALTH
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AGENDA

TOPIC: **HCH/FH Program QI/QA Subcommittee**
DATE: June 13th, 2024
TIME: 12:30pm-2:00pm
PLACE: 455 County Center, Redwood City, CA 94063 (Room COB_402)

Item	Time
1. Welcome	12:30pm
2. Approve Meeting Minutes	12:35 pm
3. Program Updates	12:40 pm
4. HMB Library Feedback	1:00 pm
5. Q1 2024 Performance Measures	1:10 pm
6. QI/QA Plan Amendment	1:30 pm
7. Looking ahead: 2024	1:55 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 March 14th, 2023; 12:30-2:00 PM at 455 County Center, Redwood City, CA 94063 (Room COB_101)
Present: Suzanne Moore, Brian Greenberg, Janet Schmidt, Meron Asfaw, Alejandra Alvarado, Frank Trinh, Jocelyn Vidales

ITEM	DISCUSSION/RECOMMENDATION	ACTION
	Meeting began at 12:30 PM	
Approve Meeting Minutes		Suzanne approved, Janet second All committee members approved.
Program Updates	**2023 UDS Submission** • Annual report has been submitted on February 15th, will revise requested edits and the final report will be submitted by March 31st • This report contains performance data surrounding demographics, finances, and clinical measures for the program • 2023 UDS data will help subcommittee determine which Clinical Quality Measures to prioritize for the 2024 QI Plan **AMI Phones Project** • HCH/FH currently works with AMI Strategies and T-Mobile to provide phones to people experiencing homelessness in San Mateo County • Ongoing project since 2022- extending this project another year (2024-2025) • EPIC has an established telehealth site and portal that can be utilized for this project, will explore this possibility once EPIC is implemented **Death Data** • HCH/FH is working with Public Health Epidemiology to generate homeless mortality report • Public Health Epidemiology gets the death data from Health Service Agency through their database (HMIS)- this is the step we're currently at • Will be asking Public Health Epidemiology manager to come give another update at upcoming board meeting **Smart Watches Project** • HCH/FH will be distributing smart watches to people experiencing homelessness and farmworkers in San Mateo County • Goal: promote health education and get patients accustomed to establishing daily health habits (calories, steps, heart rate, sleep tracker, blood pressure monitoring, etc.)	

	• Training module being created to explain key health features to focus on-attendance required to receive a watch. Follow-up plan will be created to track patient engagement. The committee members expressed interest in the death data project, inquiring about possibilities of increasing the amount of autopsy data we'll receive from the Public Health Epidemiology report. Frank clarified that autopsies have to be requested by the patients families, but we w ill view the patients medical data when we get the HMIS data. This will include cause of death and the medical history that could help up learn more about preventative care. When discussing the Smart Watches Project, Brian recommended including a gift card incentive when following up with patients who received a gift card. In his experience, he stressed that people are more likely to respond if there's an incentive involved; HCH/FH will look into this as a possibility. Subcommittee members also recommended doing a logical follow-up with participant's a few days after watches have been distributed to see if they were able to setup appropriately, and recommended surveying participants at the start of the project and follow-up as well.	
Q3 2023 Tables- Performance Measures	Alejandra presented on the Q4 2023 performance measures, reporting how our program did for our selected outcome measures and highlighting some key performance measures. This data encompasses how HCH/FH performed for the 2023 calendar year, in comparison to SMMC QIP performance for 2023. • FQHC: Federally Qualified Health Centers • This data shows that farmworkers performed better on average than people experiencing homelessness in 2023 in all our priority performance measures except hypertension • This graph also shows that farmworkers performed better than SMMC QIP in four of the metrics that HCH/FH tracks: colorectal cancer screening, breast cancer screening, Adult BMI and follow-up, and Diabetes A1c>9% or missing • There was an improvement in Hypertension for people experiencing homelessness where they improved from 52% to 57% from 2022-2023 • Colorectal cancer screenings saw a significant improvement of over 10% for both farmworkers and people experiencing homelessness	
Trimester Entry into Care Update	• 2022 UDS Trimester Entry into Care- 76 patients o 1st trimester- 63 patients o 2nd trimester- 12 patients o 3rd trimester- 1 patient • 2023 UDS Trimester Entry into Care- 59 patients o 1st trimester- 43 patients o 2nd trimester- 13 patients o 3rd trimester- 3 patient	

	• Prenatal care visits require an ultrasounds, some visits are being coded as ultrasound visits
	  ○ SMMC is doing improvement work to assure that prenatal care visits are coded correctly
	  ○ HCH/FH will continue to follow this work and track quarterly reports to see if visit #'s increase	

IPV & Human Trafficking Update	• 2023 UDS Human Trafficking- 0 patients reported
	• 2023 Intimate Partner Violence
	  ○ PEH: 4 visits, 2 patients
	  ○ FW: 0 patients
	• HCH/FH will be participating in county anti-trafficking meeting to discuss individual cases and working towards labor trafficking campaign
	
	HCH/FH does do report on this for UDS, they are separate metrics although they can do go hand in hand with some of the work that the county is doing and the improvement work were hoping to see within our program. These metrics were added to UDS in 2020, We've always reported 0 for both IPV and Human Trafficking, and a past UDS reviewer did point out that its unusual to report 0 for these since there is a prevalence for these two metrics for our patient population, so there's space for improvement work here. HCH/FH began this work last year through the IPV Safety Cards distribution, and will begin attending an anti-trafficking meeting to discuss active cases.	

Puente Convention Resources	• HCH/FH will be attending the conference and will be providing resources at our booth:
	  ○ IPV Safety Cards
	  ○ HCH/FH Provider Templates- Coast
	  ○ Patient Experience Contact Information
	
	HCH/FH is doing improvement work to educate our contracted partners on the patient feedback process for patients who want to formally document their patient experience during a clinic visit. HCH/FH will continue providing support to partners as they walk through this process.	

Looking Ahead: 2024	• Half Moon Bay library- BP cuff pilot project ending in April
	  ○ Will be reviewing questionnaire data
	  ○ Discussing next steps and project expansion
	• Discuss QI Plan for upcoming year
	  ○ Review UDS comparative data, trends, discuss modifying performance measures
	• Next QI/QA committee meeting: June 2024	

Adjourn	Meeting adjourned at 2:01pm	
Future meeting dates	**TBD**	

Q2 QI/QA Committee Meeting

Healthcare for Homeless &
Farmworker Health Program
Thursday June 13th, 2024

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Approve Meeting Minutes from Q1 2024

Agenda

- Program Updates
- HMB Library Feedback
- Q1 2024- Performance Measures
- QI/QA Plan Amendment
- Looking Ahead: 2024

Program Updates

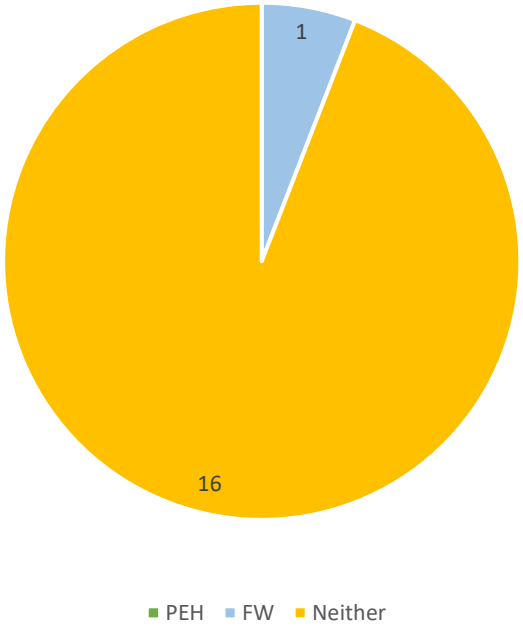
- **Maternal Health Training + Patient Safety Kits**
  - HCH/FH We'll host maternal health training held by provider
  - Training will entail screening education , preventative care, Post Natal guidance
  - Maternal health kits will be distributed Following the training
    - Postpartum Essentials Kit
    - Newborn Supplies Kit
    - Breastfeeding Basics Kit
- **Trimester Entry into Care Data**
  - Currently a monitor only metric- does not track homeless versus farm worker data collection
  - BI (analytics team) request submitted to include homeless and farm worker column in data reports
  - Better able to identify patients and provide targeted resources

Program Updates (cont.)

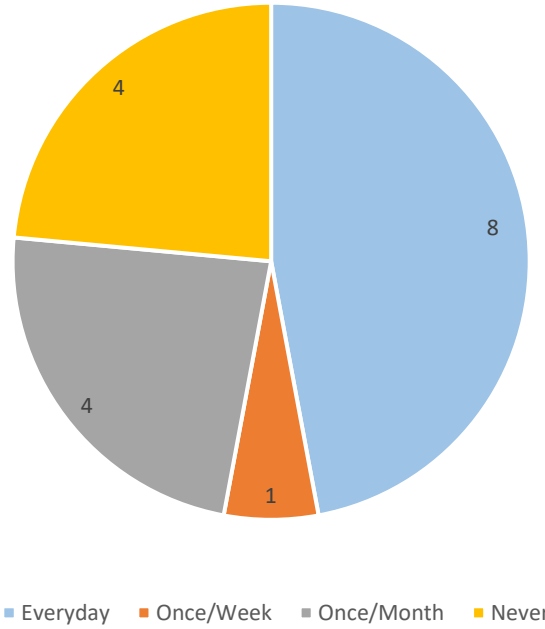
- **Smart Watches Project**
  - HCH/FH will be distributing smart watches to people experiencing homelessness and farmworkers in San Mateo County
  - Goal: increase health education and engagement with watch features (calories, steps, heart rate, sleep tracker, blood pressure monitoring, etc.)
  - Surveys generated, working with team to create distribution list
- **Half Moon Bay Library Expansion**
  - HCH/FH Is expanding its collaboration with the Half Moon Bay library to all libraries in the San Mateo County library system
  - HCH/FH is currently drafting an amended MOU with the library manager
  - Expansion to be implemented in the next few months

HMB Library Feedback

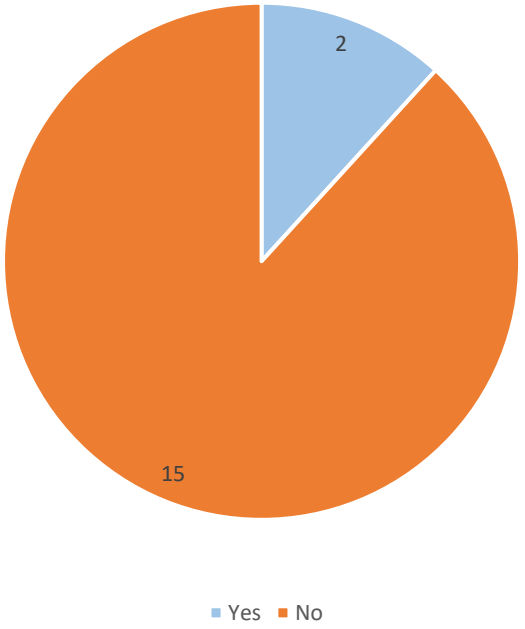
Are you a (check all that apply):



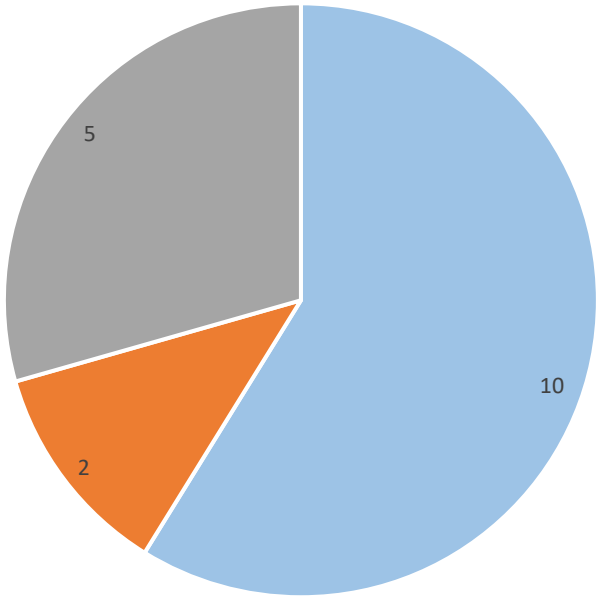
How often do you check your blood pressure:



Spanish? (Y/N)

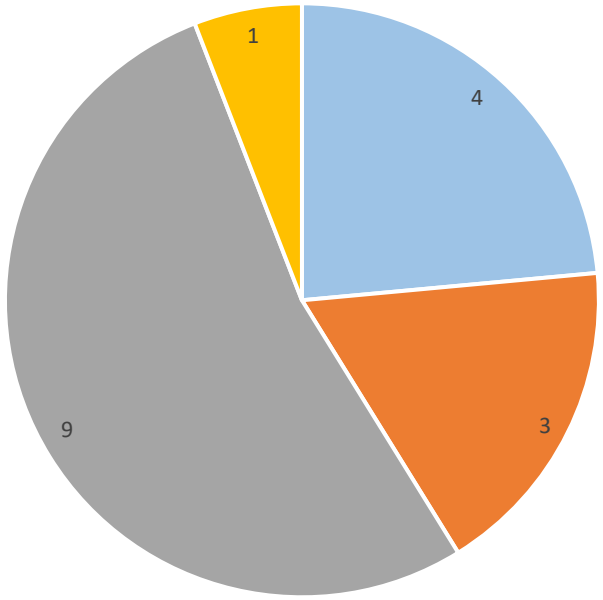


Who will be using the blood pressure kit?



Only you | You + one other family member | You + several other family members

What is your goal for checking your blood pressure?



Maintain a healthier diet | Manage an existing disease/illness | Maintaining my overall health | Other

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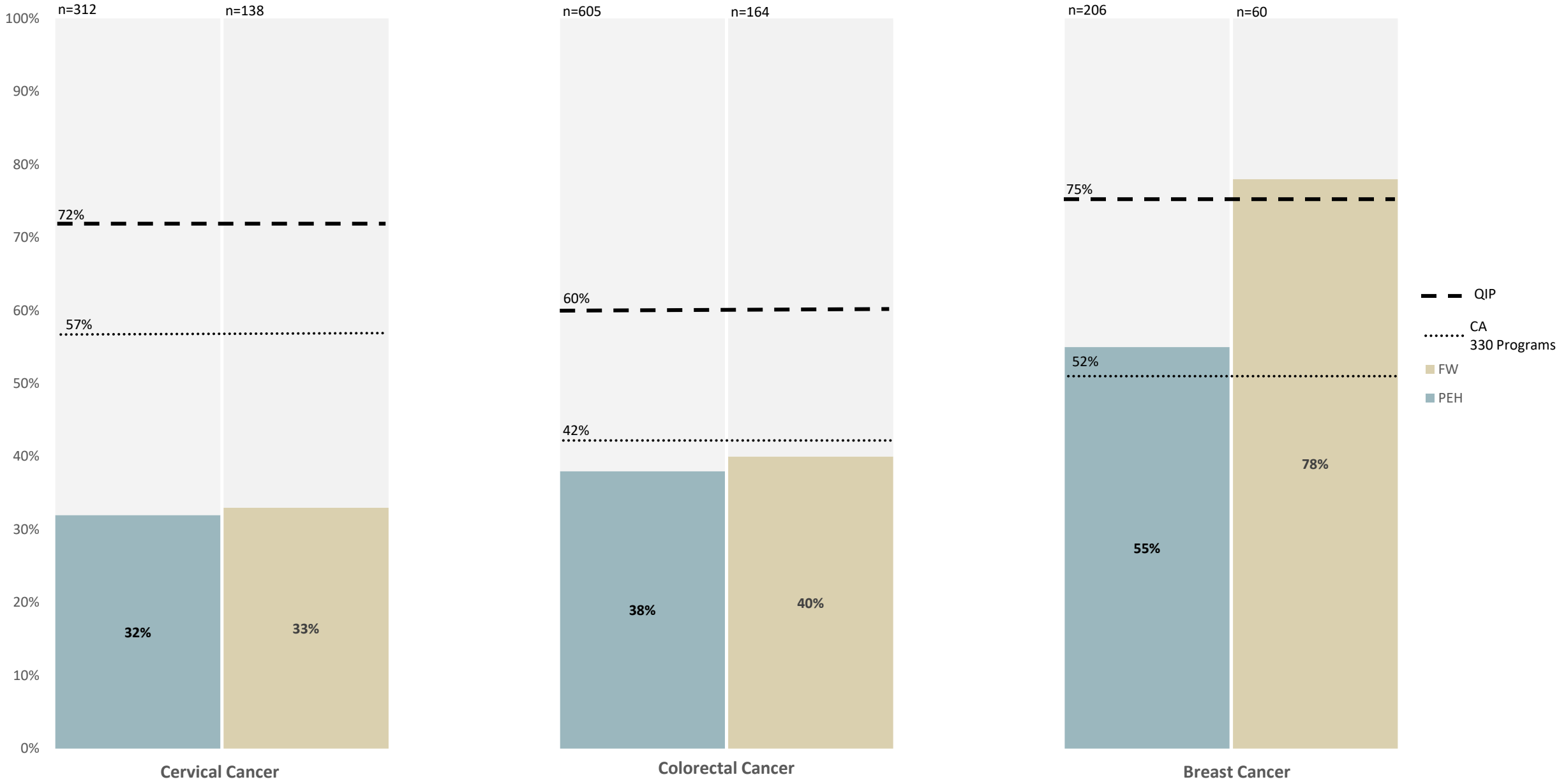
Q1 2024- Performance Measures

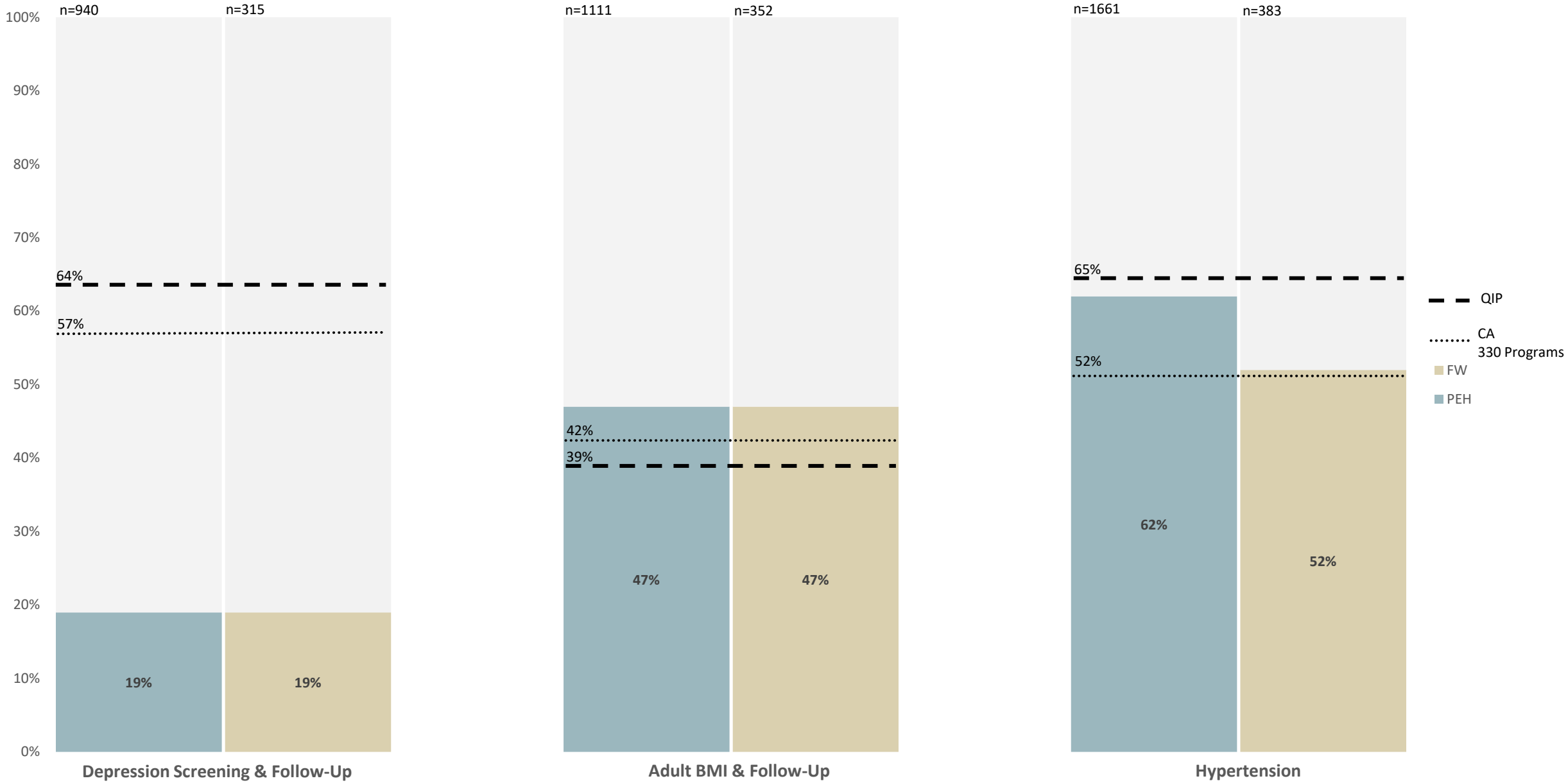
	QI Measures of Focus	Q1 2023	Q1 2024	2022 Adjusted Quartile Ranking
Screening & Preventative Care	Cervical Cancer Screening	43%	45%	4
		23%	28%	
	Colorectal Cancer Screening	38%	40%	1
		52%	55%	
	Breast Cancer Screening	82%	78%	1
		48%	55%	
	Depression Screening & Follow-Up	19%	19%	4
		19%	19%	
	Adult BMI & Follow-Up	45%	47%	4
		45%	47%	
Chronic Disease Management	Hypertension	45%	52%	3
		45%	62%	
	Diabetes A1c > 9% or Missing	53%	35%	1
		55%	48%	

Q1 2024 Cancer Screenings

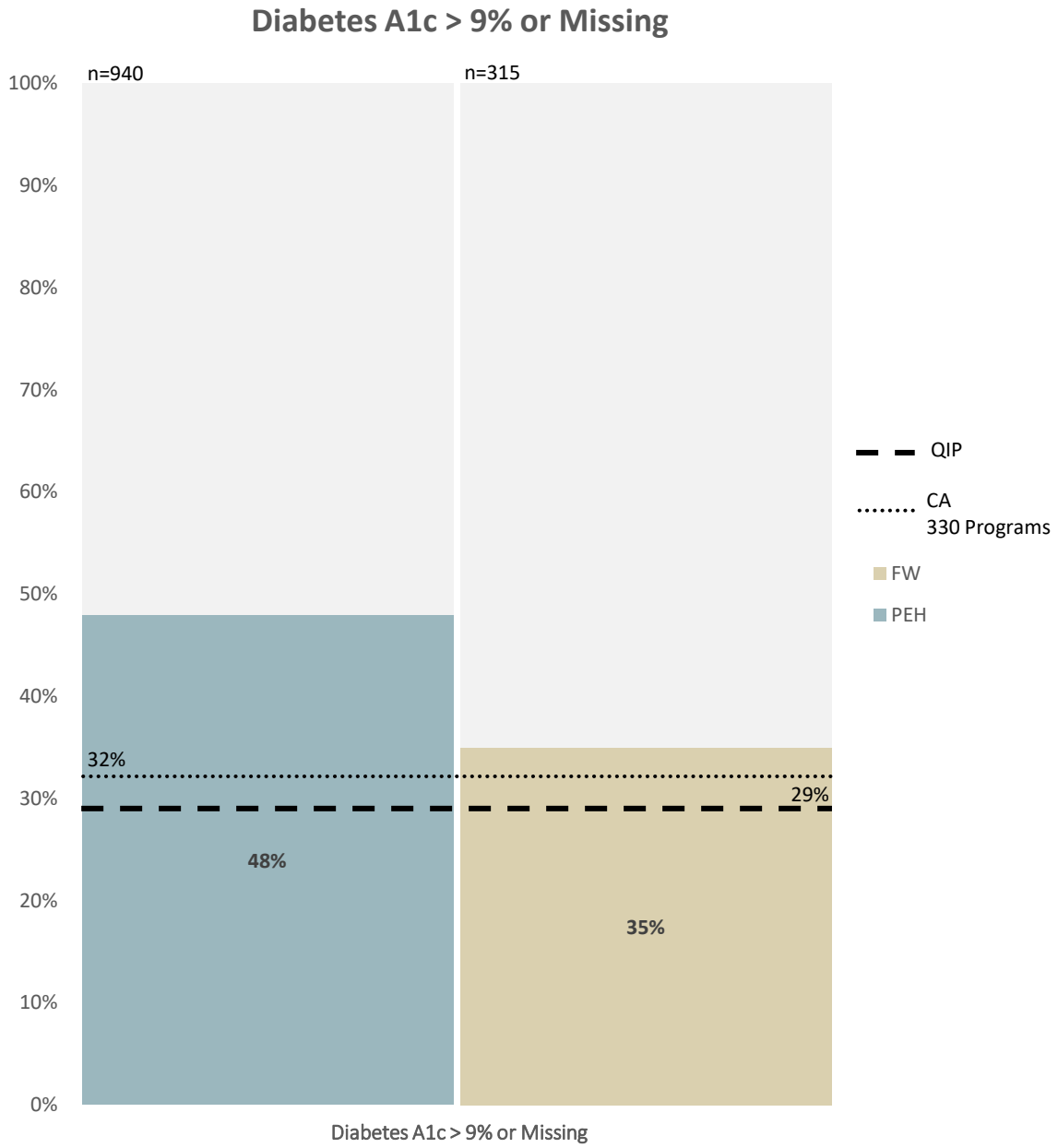


Definitions:
Cervical Cancer Screening: Percentage of women 24-64 years of age who were screened for cervical cancer
Colorectal Cancer Screening: Percentage of adults 45–75 years of age who had appropriate screening for colorectal cancer*
Breast Cancer Screening: Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer in the last 27 months*

Q1 2024 Priority Measures



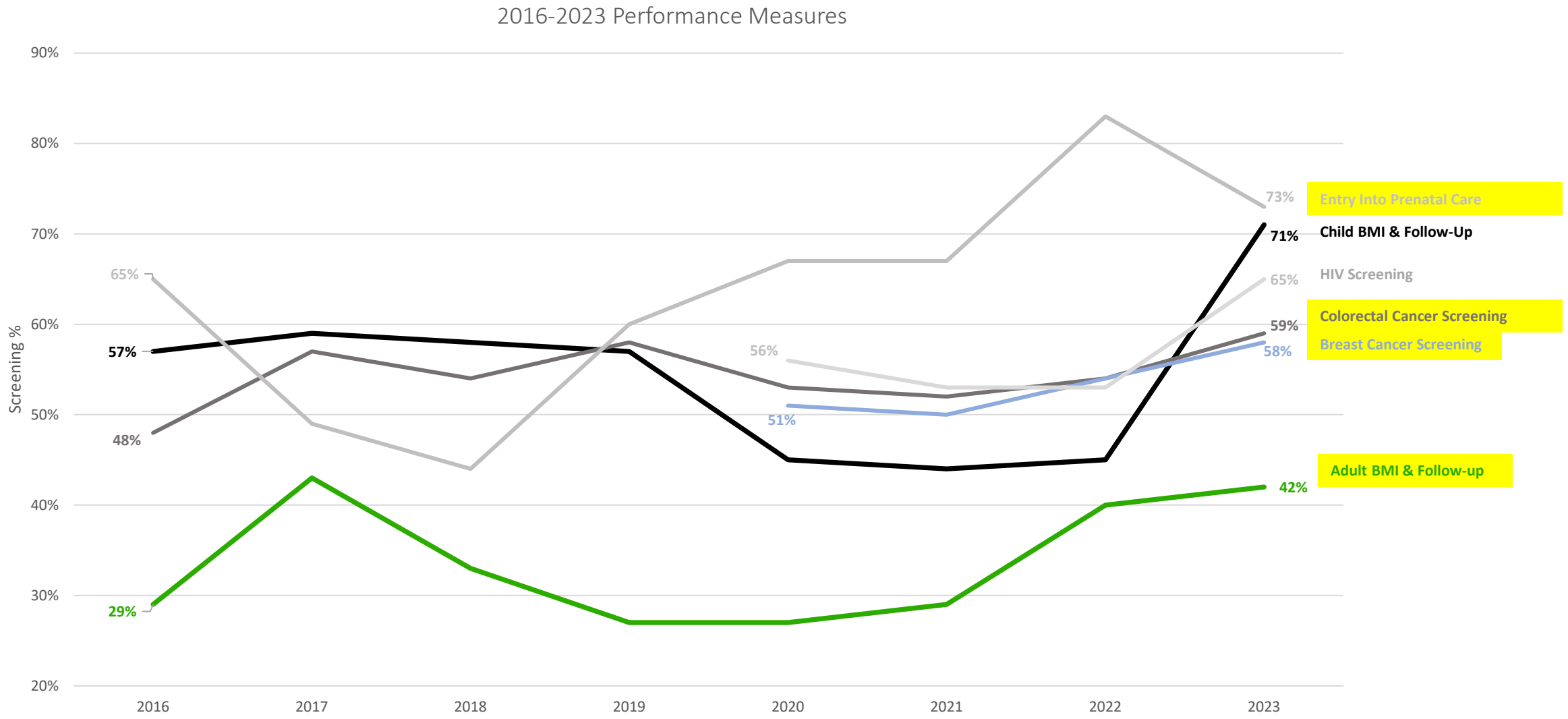
Definitions:
Depression Screening & Follow-Up: Patients aged 12+ yrs screened for depression and, if positive, a follow-up plan is documented on the date of or up to two days after the visit
Adult BMI & Follow-Up: Patients 19+ yrs of age with BMI documented during a medical visit, & who received nutrition counseling if outside of normal parameters
Hypertension: Patients 18–85 years of age diagnosed with hypertension, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the year



Definition:
Diabetes A1c > 9% or missing: Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

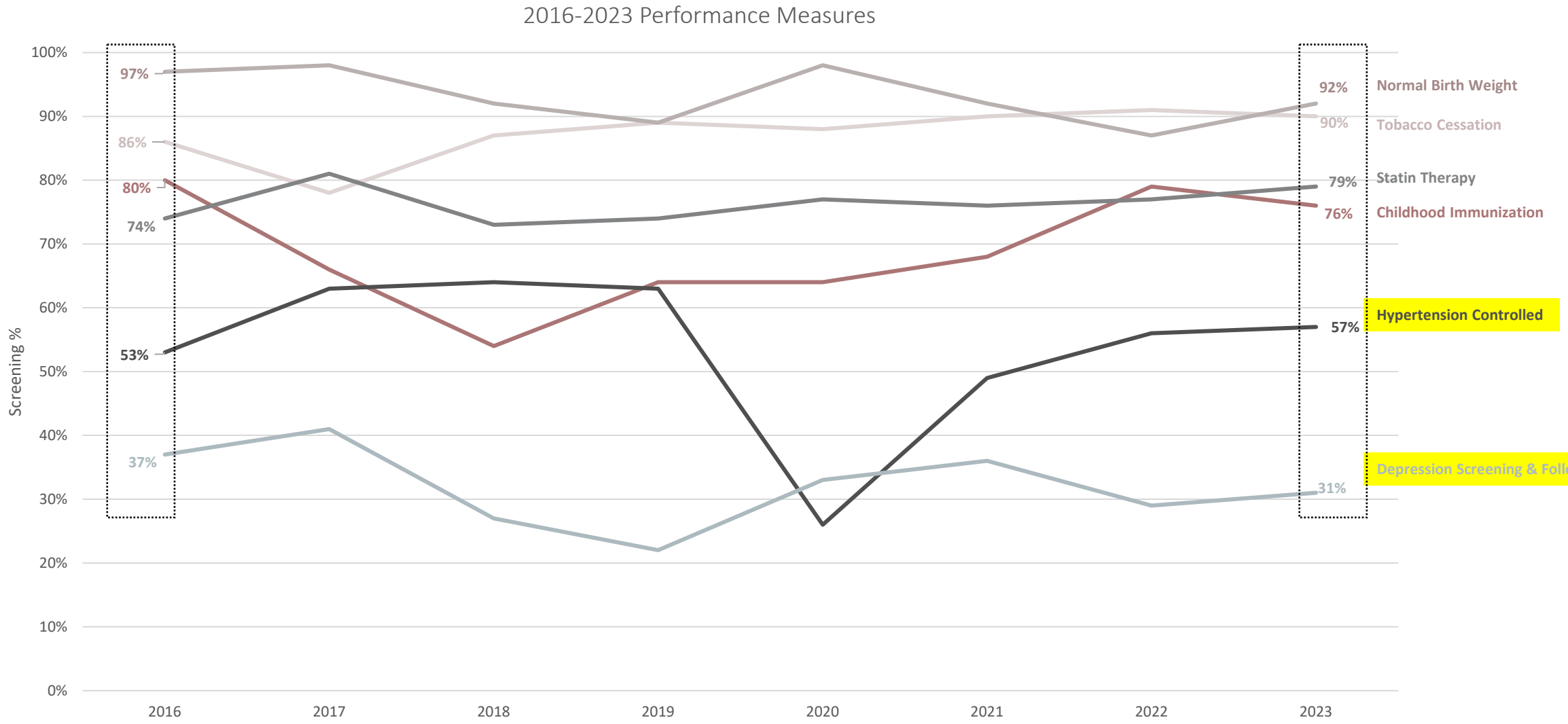
QI/QA Plan Amendment

Best Performing Measures



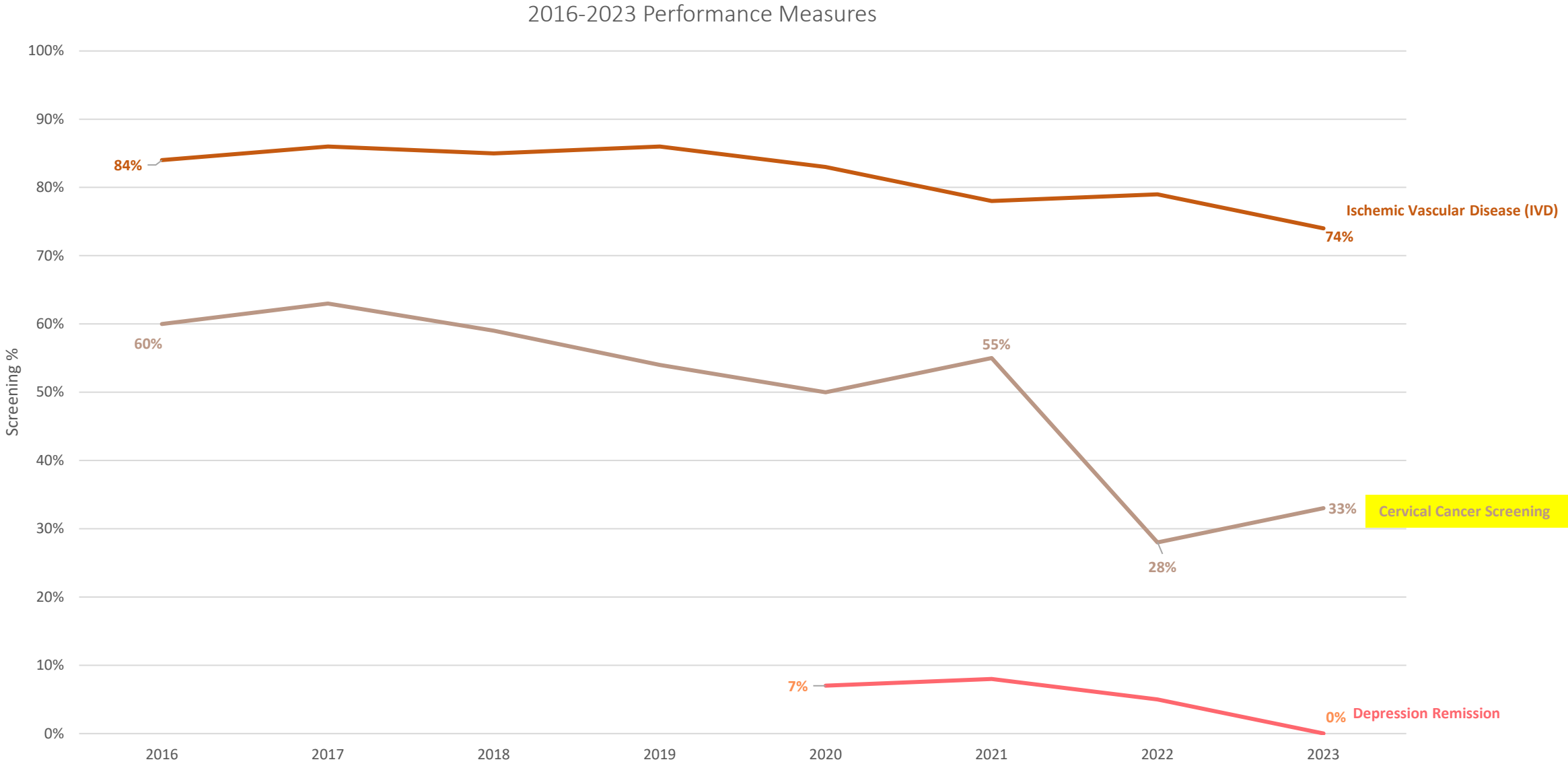
Definitions:
Entry into Prenatal Care: Percentage of prenatal care patients who entered prenatal care during their first trimester
Child BMI & Follow-Up: Patients 3–17 yrs of age with BMI documented during a medical visit, & who received nutrition counseling if outside of normal parameters
HIV Screening: Percentage of patients aged 15–65 at the start of the measurement period who were between 15–65 years old when tested for HIV
Colorectal Cancer Screening: Percentage of adults 45–75 years of age who had appropriate screening for colorectal cancer*
Breast Cancer Screening: Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer in the last 27 months*
Adult BMI & Follow-Up: Patients 19+ yrs of age with BMI documented during a medical visit, & who received nutrition counseling if outside of normal parameters

Neutral Performing Measures



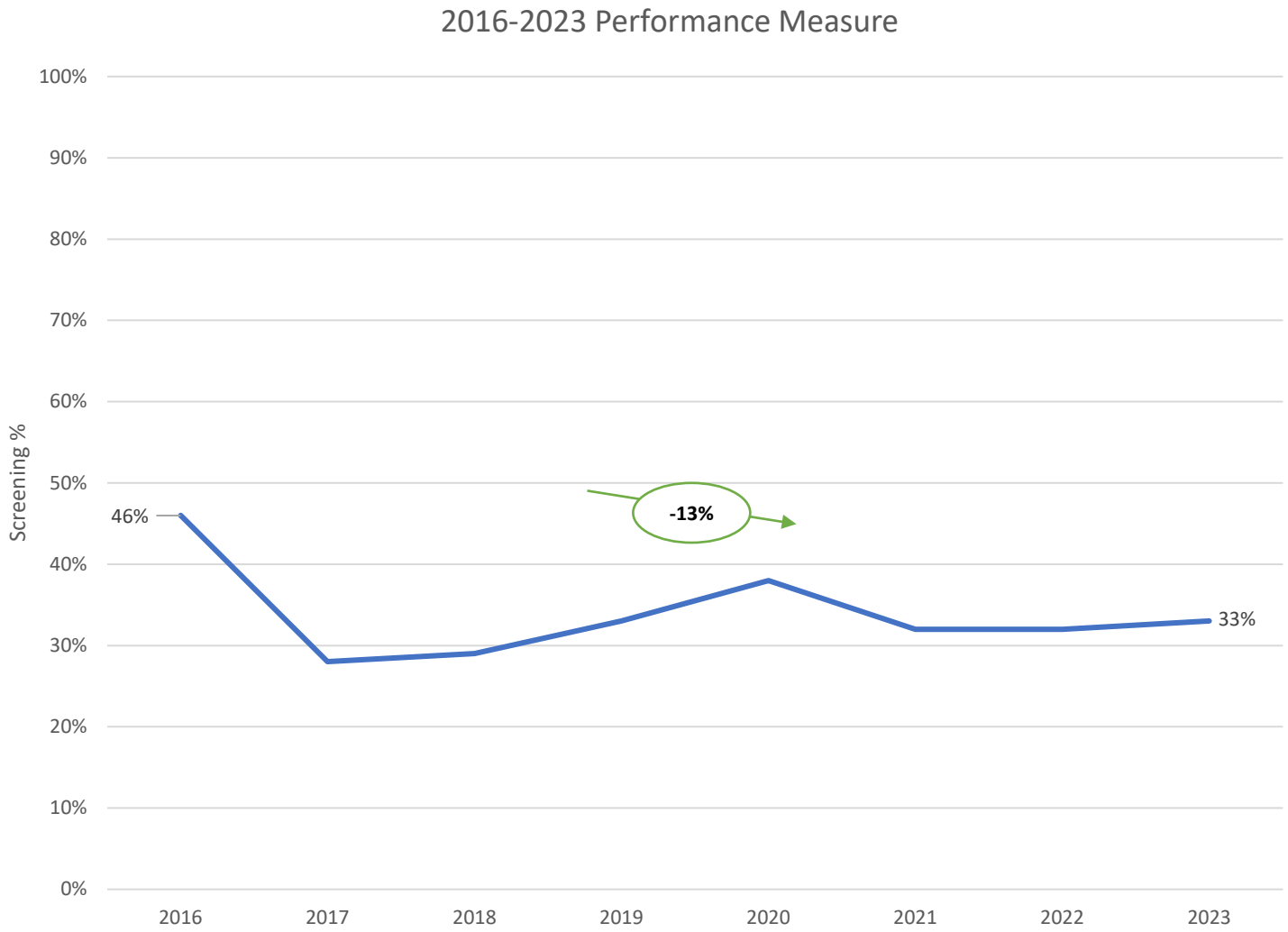
Definitions:
Normal Birth Weight: Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams)
Tobacco Cessation: Percentage of patients 18+ yrs screened for tobacco use one or more times during the year, & who received tobacco cessation intervention if identified as a tobacco user
Statin Therapy: Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the year
Childhood Immunization: Percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday
Hypertension Patients 18–85 years of age diagnosed with hypertension, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the year
Depression Screening & Follow-Up: Patients aged 12+ yrs screened for depression and, if positive, a follow-up plan is documented on the date of or up to two days after the visit

Underperforming Measures



Definitions:
IVD: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet
Cervical Cancer Screening: Percentage of women 24-64 years of age who were screened for cervical cancer
Depression Remission: Percentage of patients 12 years of age and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event

Diabetes A1c > 9% or Missing



Definition:
Diabetes A1c > 9% or missing: Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

Looking Ahead: 2024

- HCH/FH team continuing working on RFP cycle
- Cancer data set draft
- Review QI Plan revisions for upcoming year- add discussed changes
- Next QI/QA committee meeting: September 2024

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