2024 Performance Improvement Goals

Clinical Quality Measures (5)

1. By December 31, 2024, improve percent of adults aged 45–75 years who had appropriate screening for colorectal cancer to 40%.
    1. Baseline: 29%
    2. Goal: 40%
2. By December 31, 2024, reduce the disparity in hypertension control rates (less than 140/90 mmHg) among Black, White, and Hispanic/Latino/a women and men by 5%.

Clients	Baseline (all: 61%)	Current disparity	Goal
Black men	64%	9%	
Black women	55%		61%
White men	71%	15%	
White women	56%		61%
Hispanic/Latino	69%	9%	
Hispanic/Latina	60%		65%

3. By December 31, 2024, ensure at least 18% of children will have all combo 10 vaccinations by age 2.
    1. Baseline: 13%
    2. Goal: 18%
4. By December 31, 2024, 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.
    1. Baseline: n/a
    2. Goal: 5% improvement
5. By December 31, 2024, 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.
    1. Baseline: 34%
    2. Goal: 30%
6. By December 31, 2024, double the number of clients receiving PrEP.
    1. Baseline: 19
    2. Goal: 40

Access (1)

7. By December 31, 2024, ensure at least 70% of pregnant clients have access to and initiate care in the first trimester of pregnancy.
    1. Baseline: 52%
    2. Goal: 70%

Client Experience (1)

8. By December 31, 2024, improve overall score (aggregate of all sites and departments) by 5% that clients reported an ability to access an appointment when needed.
    1. Baseline: n/a
    2. Goal: 5% improvement

Resource Stewardship (2)

9. By December 31, 2024, reduce hospital readmission rate (hospitalized within 30 days) by 5%.
    1. Baseline: 25% (includes readmissions to ED as of 9/7/2023)
10. By December 31, 2024, 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).

In addition to PI goals, the quality department monitors and reports on the following measures.

Maternal and Child Health	Steward
Childhood Immunization Status	UDS
Dental Sealants (ages 6-9 Years)	UDS
Early Entry into Prenatal Care	UDS
Low Birthweight	UDS
Weight assessment & counseling for nutrition & Physical Assessment (Peds)	UDS
Disease Management	
IVD: Use of Aspirin/Other Antiplatelet	UDS
Statin Therapy for Prevention/Treatment of CVD	UDS
HIV Linkage to Care	UDS
Depression Remission at Twelve Months	UDS
Screening and Preventive Care Measures	
Height and Weight Assessment and Health Counseling	UDS
Breast Cancer Screening	UDS
Cervical cancer screening	UDS
Colorectal cancer screening	UDS
Depression Screening and Follow-Up Plan	UDS
HIV Screening	UDS
Tobacco use: screening and cessation intervention	UDS
Chronic Disease Management	
Controlling high blood pressure	UDS
Diabetes: HbA1c poor control (>9%) [inverse]	UDS
Additional HCH priorities	
Advance Care Planning	NCQA
Lab Notifications	KPI
SDH Ask Rate	KPI
FLU: adult vaccination rates	TJC
Suicide assessment follow-up	KPI
Prescribing antibiotics for URI and acute bronchitis	TJC
Hospitalization f/u	KPI
NCQA dashboard	
Closing the Loop (% complete referral tracking)	NCQA
% lab reports received back	NCQA
% in care management with care plan	NCQA
% in care management with care plan with written care plan offered	NCQA
% on time timely clinical advice calls	NCQA
% imaging received back	NCQA
% clients who visited care team/PCP	NCQA
% med reconciliation	NCQA
% up to date med list	NCQA