August 2022 Monthly PI Meeting Minutes

Attendees: Tracy Russell, Shannon Riley, Andrea Shearer, Wynona China, Sean Morrissey, Joanna Diamond, Kim Carroll, Malcolm Williams, Meredith Johnston, Arie Hayre-Somuah, Barbara DiPietro, Tolu Thomas, Tyler Gray, Rebecca Ritter, Adedoyin Eisape, Laura Garcia, Adrienne Burgess-Bromley, Julia Davis

Agency Clinical Departments - Weekly Encounters (Tolu)

Goal for keeping appts is 80% for the agency. Several are already past this goal and many departments are seeing improvement.

Team Highlight - Mobile Clinic - they are counting their engagement/encounters by zip code (also new encounters)

On the Portal - can find where Mobile Clinic Schedule so can direct clients there if easier for them (also on HCH Instagram/Twitter)

Upcoming Flu Season (Tracy)
Stand alone flu vaccine from 08:30-2:30 (Th 08:30-12:00) 9/1-10/31
Starting in November, there will still be a clinic but less frequently/anticipating less need
Trainings coming up for Medical, Non Medical, CSRs to complete prior to 9/1.
Will have some dedicated staff vaccine clinic as well as joint client/staff clinic (staff starting around 9/9)
Check HealthCare Source for trainings.

10/17-10/21 -- Flu and Coat Drive (will include adult and pediatric)

Healthy Babies Equity Act Update (Joanna)
Law passed in July that extended Medicaid coverage to pregnant women regardless of immigration status.
We have been in touch with Medicaid about implementation of this. There are substantial barriers.
Maryland Medicaid doesn't anticipate implementing the law until about July of 2023. We continue to advocate for this.
Retroactive payment? This doesn't typically happen, but in this case they are not saying "no". They are asking CMS for this.

Also - will be a stand alone CHIP program - this will be processed through Maryland Health Connection.

Data -- Quality KPIs (2022 month to month) (Tracy)

Medical is moving a lot of this work forward.
Congratulations to Medical for their work on steadily increasing our % completion of the many measures.

- *Measures to continue to improve*:

BMI screening and follow up for adults
Depression screening and follow up

HIV lifetime screening
Weight assessment and counseling for peds

Final 3 clinical quality measures KPI

1. Lab tracking Notification Rate
2. SDH Ask Rates - ask once/year - for past year: Fallsway 39%, West Baltimore 90%, Baltimore County 85%. Please note whether client has had SDH questions in 2022 and if note, please ask and connect to CM, etc as indicated.
3. Referrals Completion Rate

Consults, Imaging, Procedures and Surgery - about 18-27% completion rates

<u>Health Disparities Dashboard</u>

Highlighting a few priority areas:

Diabetes (inverse measure- doing well!)
Hypertension - disparities - seeing less control among Black clients, but improvement across Black, Latino and White populations.
Cervical Cancer Screenings- steadily improving across the board
Colorectal Cancer Screenings - White population lowest completion rate/Latino highest (includes FIT)

<u>Current priorities:</u>
Pap Champions - spearheading/pilot of Pap Only visits
Have agreed to stay on as PI Champions (Max Romano, Mykia Gerow and Faith Timothy)
5 clients Pap Only, All completed, Providers did not find burdensome.
Tyler Cornell also to pilot pap only visits

Next priority - CRC screening

HIV screenings - Testing week and awareness month concluded/ongoing
Depression Screening and manually satisfy the follow up plan
Depression Remission - BH team getting a monthly list of those who are due. If they are due, require a full PHQ-9 screening
HTN control (medical doing a lot of work on this)
Deprescribing aspirin -HIT working to help get this data accurate

Hypertension Work continued (Tyler G)
Noting significant racial disparity
Both at HCH and Nationally, see high rates of uncontrolled HTN among Black population. Using equity lens to focus our work around ensuring following most up to date guidelines
Clinical inertia (being okay with seeing high bp, need to be more inclined to improve/update meds based on what bps are - such as starting 2 meds at the same time, prescribing meds faster, diagnose it earlier, lifestyle interventions and close f/u with Nursing). Home blood pressure readings -- evidence that they are actually good/reliable. Try to get more bp cuffs out/teach clients how to check their own bp at home and record it. Informs providers better about med management/increased engagement involving client in monitoring their own bps - Wynona to see if something in Athena to help clients to track. There are also free apps we may be able to direct clients to.

Data shows we are already doing better Disparity between White and Black populations not improved but generally doing better!

For 2023, how do we roll Health Equity into our PI Plans? Overall? For each KPI?

Client feedback -- for July had about 24% completion rate of client satisfaction.
Majority of comments are complimentary. 2 negative which were put into GRC as incident reports.