PI Meeting 1/18/23

Friday, January 20, 2023

3:18 PM

**Attendees:** Tracy Russell, Shannon Riley, Arie Hayre-Somuah, La Keesha Arrington-Vega, Wynona China, Tara Dorsey, Lawanda Williams, Andrea Shearer, Sophi Sembajwe, Hala Salih, Malcolm Williams, Hanna Mast, Rebecca Ritter, dmensah, Adrienne Burgess-Bromley, Adedoyin, Margaret Flanagan, Katie Healy, Rosita Harris, Tolu Thomas, Christina Bauer, Adrienne Burgess-Bromley, Jan Ferdous, Tyler Gray, Meredith Johnston

**PI Updates:**

New PI Specialist hired

9 PI Goals are approved

Medstatix surveys will continue – everyone will be surveyed throughout the year/not Dental due to recent Athena migration

Quality/HIT Updates:

Azara access – getting ready to roll out access to all who need it/need to be minful for HIPAA

Revamp SuperUser training (first training is 2/17 at 11 – then every 1st and 3rd Friday)

Getting access- send ticket to HIT (and Cc Wynona)

Building out Portal for access to Training/info will be in Kevin’s teaser

Working on UDS – struggling to get 2022 encounters closed in order to get submitted**/please get encounters closed**

Quality/KPI Dashboard (January YTD)

Increased flu from 16 to 18% (last month to this month)

Struggling with SDH ask rate – 42% were asked questions ONCE in 2022 – please increase/trying to get to 100%

Looking at Jan % -- there is a lot of opportunity for improvement among some measures (see slides for data so far)

2023 – final PI goals:

        1. Conduct eight RCA

        2. Conduct minimum 10 PDSA cycles

        3. Establish equity visualizations and plans for each prioritized measure

        4. Engage with and seek staff input to ID areas for improvement

        5. Partner with clinical dpts

        6. Present monthly goals

        7. Sustainability

**Resource Stewardship**

        1. **Cost Savings**: around antibiotic use/will monitor adults dx with acute bronchitis or URI and reduce the number of antibiotics prescribed for those (share quarterly updates with med providers vis newsletter/starting next month)

        2. **Care Coordination**: by 12/31/2023 - HCH to f/u with 85% of those clients discharged from hospital and ID SDH/racial disparities/reduce readmissions (currently mechanism is to put in a patient case and title: Hospital follow up. HIT asking for some enhancement from Athena to improve tracking). Very important for us to ask clients to ‘opt-in’ for sharing records from hospitalization – the more we are getting clients to opt in, the more likely to get those enhancements (Wynona and Tolu)

        - Community Sites are already doing this work regularly

        - Workgroup meets monthly to determine larger workflow (Fallsway)

        - Kayla/Call Center RN – pulling CRISP ENS list/Understanding capacity for calling clients post-hospitalization (pilot) and documenting procedure

        3. **Preventive**: by 12/31/2023, using HAES, 65% of individuals 18+ who will have ht/wt documented with f/u plan if indicated in the EMR

        -Involving MAT (expanding primary care services to interested MAT clients)

        - Involving Psych Team in this (along with tobacco cessation and f/u measure)

        - Basics of HAES/utility with Arie

        4. **Chronic** – 65% bp controlled/reduce disparity between Black and White individuals by 5%

        -Q1: Begin with Medical Providers to discuss approaches to improving BP control and address disparities

        -Q2: same with Nursing

        5. **BH**- 11% 12+ with depression will achieve remission

        -Root Cause Analysis to understand this measure

        6. **Additional Measures**: ID/measure/improve upon 2 additional clinical measures

        -TBD based on data/hope to set KPIs with Medical

        7. **Access** – reduce time to third next available appt by 5% at all sites

        -By Dept: (BH, CM, Med, Nursing, Psych) for goals r/t third available appt

        8. **Client Experience**: ID measure/improve one area of Client Exp based on feedback/choose a goal aimed at reducing disparities

        9. **Care Management**- 75% of clients at each site have a documented Care Plan

        -Nursing with clients newly or uncontrolled diabetic

        - BH with clients with Depression

        -CMs with clients with housing instabilities or low/no income

**HAES (Health at Every Size) Principles:**

        Weight Inclusivity

        Health Enhancement

        Eating for Well-Being

BMIs are not a good indicator of health/based on small sample, biased for White males, does not include other factors like bone density

        Respectful Care

        Life-Enhancing Movement

**WAIT after the Weight (acronym by Arie)**

**W –** what else to consider?

**A –** acknowledge your biases

**I –** inquire about your patients’ health habits, lifestyle, barriers and facilitators of health

**T –** tailor your follow up plan to patients’ individual needs and circumstances

**Reframing the Conversation**

Set HEALTH GOALS not WEIGHT GOALS

Keep and ear out for stereotype threat

Pay close attention to the language you use

Choose words that don’t perpetuate stigma

Talk with, not AT your patients

Include patients in health goal setting

**(See Slides for More Learning Resources)**

**Pop Health Updates** (see slides)