**7/19/23 Monthly Performance Improvement**

**Attendees:** Lisa Hoffmann, Marie Stelmack, Malcolm Williams, Hala Salih, Margaret Flanagan, Tracy Russell, Andrea Shearer, Christina Bauer, Lisa Lefavore, Rebecca Ritter, Tolu Thomas, Wynona China, Tara Dorsey, Hanna Mast, Shannon Riley, Tyler Gray, Maonry Leonzo, Kat Acosta, Adrienne Burgess-Bromley, Arie Hayre-Somuah, Katie Healy

**Led by Lisa Hoffmann and Marie Stelmack**

* **Morning chat** (What was your favorite childhood toy or game?)
* **2023 PI measures**
  + Green = goal met 🡪reduce inappropriate antibx prescriptions, hospitalization f/u, care management (with care plan)
  + Changed name of BMI measure to ht and wt assessment and health counseling (based on HAES approach, we should use new terminology so renamed) with recommendation of P&PI Board Committee
  + Improving: ht and wt assmt, controlling HBP, ACP
  + Maintained: depression remission at 12 mos
  + Mixed: third next available (reduce by 5% is the goal)
  + Dip: client experience survey
* **Goal 1: Antimicrobial Stewardship**
  + Not prescribing antibx for viral reasons which lead to antibx resistance
  + Status = 100%!
  + Seeking to hold these gains
  + Liz G. Iris L are medical providers engaged in this work
  + 7/6 🡪 azara training provided to medical providers, empowering provider to review own data
  + Marie will make a recording of the azara training to share with incoming providers
  + Committee will reconvene in October for flu season when URIs may be more prevalent
* **Goal 2: Hospitalization follow-up**
  + f/u with clients discharged from hospital within 7 days (goal = 65%)
  + Currently at 70%
  + Refining the monthly report with HIT
  + Denominator doubled in June from about 40 to 80 clients on the list per week
  + Marie put together a proposal for automation which is moving to leadership
* **Goal 3: height and weight assessment and health counseling**
  + At 43% (up slightly from last month)
  + Seeing some disparities (White clients lower than Black and Hispanic/Latino/a clients)
  + Arie did a HAES training (Med, psych, BH trained)
  + Arie will be working to get this training to CM and CHWs, as well as HS – goal to get everyone in org trained on HAES, anti-wt bias can trickle into everything
    - Getting info to everyone clinical first and then shifting to rest of organization as well
  + Working to get equipment accessible and convenient in all depts – with consideration for privacy, too
  + Next steps: Developing order sets with resource recs and guidance in conversations to target the f/u intervention
    - Recommending list of handouts for clt education that are in line with HAES principles and keep in mind challenges around food insecurity
    - For clients underweight per BMI scale, also looking at resources for boxes of fruits and vegetables if clients are interested, resource for soup kitchens, as well
* **Goal 4: blood pressure control (goal = 65%)**
  + YTD 59%
  + Also want to reduce disparities between race/ethnicities and genders
  + Clients who are White above agency average. Black clients lagging by 9%. Hispanic/Latino/a clients lagging by 6%.
    - Want to target these communities and reduce disparities
    - Also disparities by women across all races/ethnicities noted and behind men
  + Recent happenings: hang tags on VS machines with standards for measuring BP (clients are noticing these as well), sticky notes for clients on monotherapy (but who should be on 2 or more per EBP) – will have a better idea of impact toward end of the month, lit review and health equity training about disparities in HTN control (community power building, connecting with HCH program that participated in past CMS program Million Hearts)
  + Next steps: addressing disparities
* **Goal 5: depression remission (Goal = 11%)**
  + YTD: 4%
  + Disparity data – all over the place right now. Looking more at interventions we can do as a whole right now.
  + Challenging goal due to our client population
  + Lawanda reaching out to different HCH programs about successes thus far – no feedback thus far or suggestions
  + Looking at modifying the quality tab view for BHTs and TCMs and re-training on quality ab usage for depression remission
  + Looking into prescribing practices as an intervention
  + Next steps: review literature on interventions to address disparities
* **Goal 6: Time to Third Next Available (Goal by 5% across sites)**
  + Agency average = 22 days
  + Reviewing 24-hr follow-up appointments and ensuring being used properly
    - Want to reserve these better instead of scheduling so far out
* **Goal 7: Client Experience**
  + Respected by check in and check out staff and respected by scheduling staff at or over 93% x 3 mos (goal)
  + Recent happenings: many aspects of service delivery to consider such as ensuring communications are well delivered and well received, not yelling over each other, knowing where in agency to go for services
    - Line and check-in process: fair amount of yelling due to 6 different desks and 1 line, plexiglass also poses challenge
      * Pilot: signs that are brightly color to signal to clients, corresponding colored signs for desk numbers, signage and line, clarifying line for appts vs. walk-ins changes (with help from Comms)
    - In County organizing huddles to proactively meet client needs at check-in
  + Next Steps: change ideas with scheduling
* **Goal 8: Care Management (Goal 75% of clients enrolled have care plans across sites)**
  + YTD: 96%
  + Recent happenings: looking to refine workflows, Drafting Monday Minute videos to spotlight champions and best practices across 3 departments, working toward 75% offer rate for printing, simplified paper handout
  + Next steps: creating and disseminating videos and paper handouts
* **Goal 9: Flu vaccination rate (goal = 45%)**
  + Last year ended at 20%
  + Kickoff meetings, identifying medical workflows at 421 – will be added to CMA schedule
  + Next steps: running an RCA, meeting with Comms to identify flu campaign strategies, kickoff meeting for flu and coat drive event on 7/20, identify workflow @ community sites
    - Traditionally had a separate flu clinic in the past but not a lot of uptake so want to take a different approach this year
* **Goal 10: Advance Care Planning (goal = 5%)**
  + YTD = 2% (up 1% over past month!)
  + Recent happenings: medical provider training up (7/20)
    - First planning meeting for lunch and learn 7/18 – will be in September and will be a hybrid event
    - Working with comms team to promote event
* **Let’s get a refresher on PDSAs! video** 🡪 deferring to another time due to time constraints
* **Pop Health Updates (with Shannon Riley)**
  + Athena Mass Messaging Campaign for Breast Cancer for those past-due – to go out sometime in July
    - First contact through athena
    - Clients encouraged to contact HCH for appt/referral
    - Call center will direct clients to Shannon Riley via Patient Case
    - Team will divvy up call back work, order, coordinate navigation (second contact)
  + End of June had HIV/PrEP event
    - Had front porch campaign (45 clients were targeted)
    - PrEP/HIV testing event in 3rd floor group rooms = 6 clients received education around PrEP, HIV testing
    - Incentives have been so important to the work of client engagement
* **PI meeting survey**: <https://www.surveymonkey.com/r/WTSWMD8> - please take!