**6/21/23 Monthly PI Committee Meeting**

**Attendees:** Lisa Hoffmann, Laura Garcia, Tyler Gray, Christina Bauer, Tara Dorsey, Keiren Havens, Hala Salih, Margaret Flanagan, Christina Bauer, Andrea Shearer, Iris Leviner, La Keesha Arrington-Vega, Maddy Horan, Malcolm Williams, Maonry Leonzo, Rebecca Ritter, Arie Hayre-Somuah, Tracy Russell

**Presenter: Lisa Hoffmann**

* **Pet icebreaker** - show us your pets!
* **Data updates:** Azara will be our "source of truth" moving forward - Marie can provide a walk-through at July 6th provider meeting, make sure azara accounts are active before then
* **Goal 1: Antimicrobial stewardship**
	+ Waiting on disparity data still
	+ At 100%! - Marie has done some great review on the data
	+ Looking at ways to sustain this measure - empowering providers to look at their own data and prescribing practices through azara
* **Goal 2: Hospitalization follow-up**
	+ Calculated rate based on text macro associated with the patient within 7 days of discharge over the # on the CRISP list
	+ SOP is now finalized
	+ HIT developing a power BI report to see if client is engaged in care at HCH
* **Goal 3: BMI & HAES**
	+ Looking at follow-up discussion for clients outside of 18.5-25 BMI range
	+ Disparities data: all have trended upwards this month - not exactly sure if this is due to --> excited for next change ideas
	+ Current happenings
		- HAES training for BH team took place this last week
		- Marie reviewed pt education handouts in athena to find those which do not mention weight loss
		- HAES education cards present in exam rooms with WAIT acronym and HAES principles - also in MAT and with Psych, working to get to community sites as well
	+ Next steps: food insecurity resources, ensuring scales are available in comfortable private locations in clinic, evaluating effectiveness of training through survey, text macros and other order groups (sharing best practices in pt ed handouts)
		- Two good handouts identified: "learning about food insecurity" that can be paired with local food resources, "eating healthy foods: care instructions" (add healthier choices rather than subtracting)
* **Goal 4: Controlling Blood Pressure**
	+ Goal 65%
	+ White clients trending along the goal
	+ Downward trend for Hispanic/Latino/a and AA/Black populations
	+ Reminder cards of gold standard BP measurement on vitals machines
	+ Next steps:
		- June medical team meeting presenting BP mgmt with survey and evaluate impact
		- Race and gender disparities remain stark; discuss opportunities for targeted outreach
* **Goal 5: Depression Remission**
	+ At 4% (goal 11%)
	+ Disparity data: White population trending upwards, black/AA trending downward this month, Latino/a/Hispanic population remaining constant
	+ Particularly challenging measure due to our client population
		- Reaching out to other HCHs to see what successes others have had to move the needle forward on this particular measure
	+ Next steps: Modifying the quality tab view for BHTs and TCMs; re-training on usage for depression remission
* **Goal 6: Time to third next available** (working to improve by 5%)
	+ Agency average = 22 days
	+ Breakdown by site:
		- Balt County = 9 days (goal 12)
		- West = 13 (goal 19)
		- Fallsway = 23 (goal 23)
	+ Recent happenings - discussing how to manage provider PTO to level patient access across week/month/year
	+ Next steps: Joining fallsway access meetings to learn about work already being done
* **Goal 7: Client experience**
	+ Goal at or over 93% x 3 consecutive months for responses around "respected by check-in and check-out staff" - took a dip this past month
	+ Large subcommittee consisting of a lot of staff
	+ Recently: completed observations of call center and front desk
		- Seeing RCA observations in practice and prioritizing
		- Discussed with Community site successes and best practices
	+ Next steps
		- Marie and Malcolm looking at line configuration on first floor at fallsway
		- Flagging system (seeing when a CSR is available is challenging)
			* Visual solution for this - being considered
		- La Keesha plans to Reschedule county huddle for after patient hours @ County site (to reduce feeling of clients coming in and having to wait to access care)
	+ RCA - highlighted items:
		- Environment: line configuration - delay in check-in (calls up scheduling)
		- Client/staff factors: Challenges with communication b/w other departments - causes delays and lack of coordinate care
		- SDOH/systemic issues: access - client wants to be seen tomorrow and can't fit in/triage fills up fast; can't get a hold of a dept or provider
	+ Other RCA items:
		- Baselines often taken with client to be completed at later time when they need to get to appt - want to look into tracking system so they don't go missing as much
		- Scanning workflow is challenging - finding way to work through workflow
		- Desire for more guidance docs (scheduling)
* **Goal 8: Care management**
	+ 96% currently (meeting goal)
	+ BH @ 100%, CM @ 97@, Nursing @ 88%
	+ Recent happenings - discussions with champions on best practices - benefits, challenges and workflow design
	+ Next steps
		- Providing monthly reports to departmental supervisors
		- Leadership to communicate with teams to maintain visibility
		- Disseminating best practices
			* Integration of SMARTIE goals
			* Supervisor review ad highlights - provides feedback to team members which has really improved quality of the care plans overall
			* Communicating goals and successes with clients through the course of care
* **Goal 9: Flu vaccination rate** (goal of 45%)
	+ Past flu season is over (20% the past flu season)
	+ Preliminary planning
		- Exploring if we can capture offer rate (in addition to capture completion rates)
		- Consider best workflows for non-medical client who are interested in flu vaccine
		- Youtube video on desktop for quick facts (dispel myths)
* **Goal 10: Advance care planning**
	+ At 1% (goal 5%)
	+ SOP is finalized
	+ Next steps:
		- Lunch and learn session for staff on Advanced directives (guided session for completing their own AD) - sometime in September - learn how to complete these, best practices
		- Medical provider training in June/July (led by Iris and Tyler Gray)
* **Questions/Comments from meeting participants**
	+ Question from Keiren: what was the N for the depression remission #s (May rate = 7/190)
	+ Comment from Laura: mentioned that she has seen the difference in action that the hospitalization follow-up work has made in practice
	+ Pop health Announcement: HIV testing and PrEP informational event taking place on June 30th @ 9, 10 and 11 AM in 3rd floor group rooms