Alliance of Independent Academic Medical Centers

The AIAMC National Initiative:

Improving Patient Care through Medical Education

PROCEEDINGS OF NATIONAL INITIATIVE V

National Initiative

March 2017

Amelia Island, FL

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OVERVIEW OF THE AIAMC NATIONAL INITIATIVES

Why a National Initiative?
Both the public and our profession acknowledge that quality and safety efforts are falling short, and many hospitals and healthcare systems are seeking rapid improvements in patient care. Those of us in academic medicine realize that residents play an important role in patient care at teaching institutions; however, residents are generally not visible in safety and quality efforts. The AIAMC recognized that resident quality improvement efforts – shared across multiple programs and systems – had the potential to improve care much more quickly and effectively.

Role of the AIAMC
The Alliance of Independent Academic Medical Centers was founded in 1989 as a national network of large academic medical centers. Membership in the association is unique in that AIAMC members are affiliated with medical schools but are independent of medical school ownership or governance. Approximately 80 major medical centers and health systems across the United States are members, representing more than 750 senior academic leaders.

National Initiative I
In early 2007, the Alliance of Independent Academic Medical Centers (AIAMC) launched *Improving Patient Care through GME: A National Initiative of Independent Academic Medical Centers*. The *National Initiative* (NI) featured five meetings over the course of 18 months which served as touchstones for ongoing quality improvement in 19 AIAMC participating organizations. These meetings, as well as the monthly collaborative calls held in-between, provided structure, discussion and networking opportunities around specific quality improvement initiatives. This 18-month "NI I" was supported by a grant from the foundation of HealthPartners Institute for Medical Education, an AIAMC member institution located in Minneapolis, Minnesota.

As a result of these efforts, we developed initial findings that demonstrated the efficacy of integrating GME into patient safety and quality improvement initiatives. These findings were organized into a series of articles that were published in the December 2009 issue of *Academic Medicine*.

National Initiative II
In 2009, we launched the National Initiative II and expanded participation to 35 AIAMC-member teaching hospitals from Seattle to Maine. Each participating hospital developed a quality improvement team led by a resident or faculty member. These teams met on-site four times and participated in monthly conference calls over an 18-month period. Quality improvement projects focused upon one of the following areas: Communication, Hand Offs, Infection Control, Readmissions and Transitions of Care.

Results from NI II were published in a variety of publications, including the February 2011 issue of the *AAMC Reporter*, and in the May/June 2012 special supplement issue of the *American Journal of Medical Quality*.

National Initiative III

NI III, launched in 2011 with 35 teams, built on the strengths of the first two phases of the AIAMC National Initiative, and moved beyond direct support of local quality improvement teams to the development of teaching leadership and changing organizational culture to support quality improvement initiatives. Graduate medical education *and* continuing medical education were emphasized as platforms for improving patient care. The focus of NI III was faculty/leadership development. We recognized that part of our responsibility as medical educators was to train the next generation of practicing physicians; thus, residents must be considered as junior faculty and were integral in this effort.

Results from NI III were published in a variety of publications, including the Spring 2014 issue of *The Ochsner Journal* and the *Journal of the American College of Surgeons.*

National Initiative IV

NI IV: *Achieving Mastery of CLER*, launched in 2013 with 34 AIAMC-member and – for the first time – non-member teams, focused on navigating the ACGME's Clinical Learning Environment Review (CLER) program. The CLER program was designed to evaluate the level of institutional responsibility for the quality and safety of the learning and patient care environment, and NI IV provided teams the training and guidance necessary that identified strengths and weaknesses across the six focus areas and significantly and measurably advanced the institutional level of preparedness.

Results from NI IV were published in numerous publications, including the *Journal of Graduate Medical Education* and *The Ochsner Journal,* the official publication of the AIAMC National Initiatives.

National Initiative V

National Initiative V: *Improving Community Health and Health Equity through Medical Education* launched in the fall of 2015 with 29 AIAMC-member teams participating and focused on navigating the disparities component of the ACGME's Clinical Learning Environment program. Four on-site learning sessions addressed understanding and engaging with institutional leaders in the Community Health Needs Assessments; GME education in improving health equity, cultural competency and community engagement; and how to better engage the C-Suite. The Initiative concluded in March 2017.

Various writing teams are currently preparing manuscripts for publication.

The AIAMC National Initiative (NI) is the only national and multi-institutional collaborative of its kind in which residents lead multidisciplinary teams in quality improvement projects aligned to their institution's strategic goals. Fifty-eight hospitals and health systems and nearly 700 individuals have participated in the AIAMC National Initiatives since 2007 and have driven change that resulted in meaningful and sustainable outcomes which improved the quality and safety of patient care

For More Information Regarding the AIAMC National Initiatives,
Contact Kimberly Pierce-Boggs, Executive Director, at
kimberly@aiamc.org or 312-836-3712 and
Visit www.aiamc.org

Last Updated March 2017

NI V Participating Institutions

Advocate Illinois Masonic Medical Center Chicago, IL	Kaiser Permanente Northern California Oakland, CA
Advocate Lutheran General Hospital Park Ridge, IL	Main Line Health System – Bryn Mawr Hospital Bryn Mawr, PA
Aurora Health Care Milwaukee, WI	Ochsner Health System New Orleans, LA
Bassett Medical Center Cooperstown, NY	Orlando Health Orlando, FL
Baylor Scott & White Health Central Texas Temple, TX	OSF Saint Francis Medical Center Peoria, IL
Baylor University Medical Center at Dallas Dallas, TX	Our Lady of the Lake Regional Medical Center Baton Rouge, LA
Christiana Care Health System Newark, DE	RWJ Barnabas Health Monmouth Medical Center Longbranch, NJ
Cleveland Clinic Akron General Akron, OH	Saint Francis Hospital and Medical Center Hartford, CT
Crittenton Hospital Medical Center Wayne State University Rochester Hills, MI	Sparrow Hospital Lansing, MI
Florida Hospital Orlando, FL	Swedish Medical Center Seattle, WA
Guthrie – Robert Packer Hospital Sayre, PA	The Christ Hospital Health Network Cincinnati, OH
Hackensack Meridian Health Jersey Shore University Medical Center Neptune, NE	TriHealth Cincinnati, OH
HealthPartners Institute Minneapolis, MN	UnityPoint Health – Des Moines Des Moines, IA
HonorHealth Scottsdale, AZ	Virginia Mason Medical Center Seattle, WA
JPS Health Network Fort Worth, TX	

Community Health Needs Assessment (CHNA): The Need for Resident Physician Engagement

Ranae Antoine, MD, Mohammed Samee MD, RN, Lisa Kritz, MSW, MBA, Barbra White, MHA
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National Initiative

Advocate Illinois Masonic Medical Center

Overall Goal/Abstract

- To include a resident physician in the hospital CHNA process in order to provide a resident's perspective on community needs and interventions to address those needs.
- Compare recommendations of the Community Health Council to the recommendations of resident physicians.

Background

- The Patient Protection and Affordable Care Act of 2010 (ACA) requires tax-exempt hospitals to create a hospital CHNA every three years.
- Since the hospital has been conducting CHNAs, resident physicians have never been a part of the Health Council charged with designing and executing the assessment.
- There has only been one other residency program in the country which has been actively involved in their hospital's CHNA process. The outcome was documented as extremely positive.

Vision Statement

- To engage a resident physician in the CHNA to improve the process of identifying and addressing community health needs.

Materials/Methods

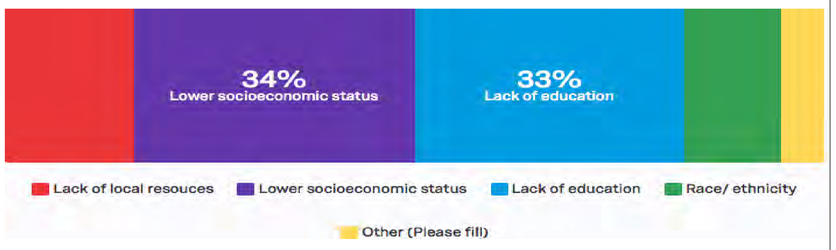
- An Internal Medicine resident was assigned to Advocate Illinois Masonic's Community Health Council.
- A mini-CHNA was conducted with the Internal Medicine residents to mirror the wider CHNA process.
- The top community needs identified by residents were compared to the needs identified by the Council.

Results

- Council priorities matched Resident priorities:

Committee Priorities	Resident Priorities
1) Chronic Diseases (COPD, HTN, heart disease)	1)Chronic Diseases (COPD, HTN, heart disease)
2)Behavioral health, substance abuse	2)Behavioral health, substance abuse
3)Social determinants of health (housing, violence, teen births)	3)Social determinants of health (housing, violence, teen births)

- Residents identified the greatest barriers to healthcare in the community.



- 82% of residents did not have prior knowledge of what a CHNA was.
- 35% of residents feel that they do not have adequate knowledge of community resources.
- If given the opportunity, 84% of residents would participate in a CHNA.

Success Factors and Lessons Learned

- Hospital CHNA priorities reflected needs identified by the residents.
- Resident experience in the CHNA was positive. The resident had enhanced knowledge of community resources.
- Resident stated increased comfort with discussing healthcare barriers in the community.
- Members of the Council valued resident physician input, particularly when prioritizing issues.

Barriers Encountered/Limitations

- Resident was able to attend most, but not all Community Health Council meetings due to patient care obligations.
- As this was a new undertaking, the role of the resident in the committee was not immediately clear.
- The duties of the Council were expansive and the resident was unable to contribute in some areas.
- Limited opportunities for resident physicians to participate in CHNA.

Conclusions

- Improved communication and education regarding community resources will improve resident physician's ability to better care for patients.
- The resident physician perspective of health need priorities is enhanced by their front-line experience. The training environment is a reflection of the community we serve.
- Including a resident on the health needs committee greatly benefits both parties.

Bibliography

Community Health Needs Assessment as a Teaching Tool in a Family Medicine Residency: Venis Wilder, MD; Monica Gagnon, MPH; Bamidele Olatunbosun, MD, MBA; Olanrewaju Adedokun, MD; Demetri Blanas, MD, MPH; Guedy Arniella, LCSW; Ayiti-Carmel Maharaj-Best
http://www.stfm.org/FamilyMedicine/Vol48Issue8/Wilder635

Role of Medication Assistance Program in Reducing Readmission Rates at Advocate Illinois Masonic Medical Center

Divya Korpu MD, Beverly C Bohus MSN RN CNCM, Mohammed Samee MD RN, Toi Walker –Smith EdD

Department of Internal Medicine, Advocate Illinois Masonic Medical Center

National Initiative

Advocate Illinois Masonic Medical Center

Overall Goal

- **Objective**: To retrospectively compare the readmission rates one year before and after enrollment in the Medication Assistance Program (MAP) from January 1, 2014 through December 31, 2015.
- **Results**: The average rate of readmissions was decreased by 22.4 % after enrollment in MAP.

Background

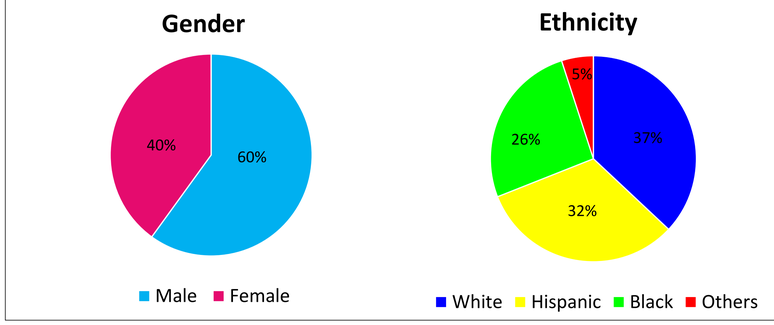
- In 2014, 1 in 8 American adults reported skipping medicines because of difficulty paying for the prescribed medication (1).
- In 2014, MAP was introduced to provide medicines at little or no cost to eligible patients with an objective to reduce readmissions due to lack of medication access and/or adherence.
- From January 1, 2014 through December 31, 2016, MAP provided assistance to 721 patients with drugs worth $3,522,652.

Vision Statement

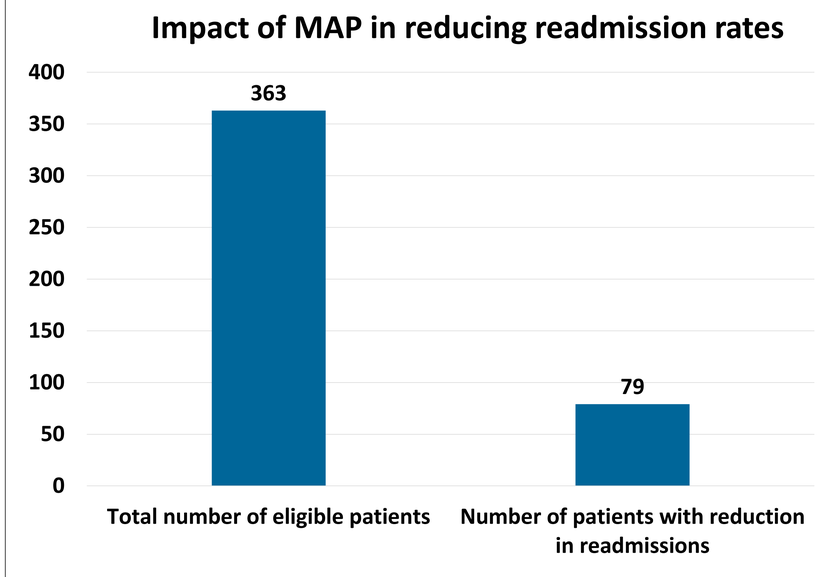
The Medication Assistance Program was introduced to reduce health disparities, promote medication adherence and lower readmissions by providing uninsured and underinsured patients access to prescribed medication.

Materials/Methods

- **Inclusion:** All medical visits to the emergency department, observation and/or inpatient units.
- **Exclusion:** Admissions related to psychiatric illness, trauma and/or pregnancy.
- **Sample size:** 448 patients were identified, 363 patients met the eligibility criteria.
- **Average Enrollee:** 48 years old, single with an average income of $5,546 and $436 in annual medical expenses.



Results



Testimonials

- W.A. – A disabled Medicare patient, reported MAP was a ‘game changer‘, as it helped him with $1,800 for six vials of insulin he needed during the “coverage gap”.
- T.T. – A delivery driver, stated ‘his life has been restored to him’ after MAP helped him with $7,000/month drugs for a newly diagnosed life threatening illness.

Discussion

- A flexible criteria for MAP enrollment allowed us to serve Medicare and Medicaid population when resources were insufficient to support their needs.
- Active partnership with administration and medical staff enabled a robust number of patient referrals.

Limitations

- Few of our patients were lost to follow up even after meticulous documentation.
- First-year residents receive education early in the academic year, limiting retention and referrals to MAP.

Conclusions

- MAP increases indigent patients’ access to unaffordable treatment thus, improves patient compliance, clinical outcomes and quality of lives.
- MAP directly decreases readmissions.

Bibliography

1. Board of Governors of the Federal Reserve System. Report on the economic well-being of U.S. households in 2014. May 2015.

A Second Chance at a First Impression:
Creating an LGBTQ-Friendly Environment

Hilda AG Rock, MD; Andrew M. Guzman, MD; Toi Walker-Smith, EdD; Oscar Zambrano; Jose Elizondo, MD

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National Initiative

Advocate Illinois Masonic Medical Center

Abstract

- Problem:
  - Large LGBTQ population in inpatient and outpatient centers
  - Concerns as to how these patients are cared for and treated
  - Staff comfort/preparedness with LGBTQ patient interactions unclear
- Survey: Outpatient clinic staff/ providers
- Results:
  - LGBTQ patients/staff are a part of the workplace
  - Unsure how to approach LGBTQ patients
  - Inadequate intake form for all patients
- Further growth:
  - Education regarding patient interactions
  - Changes to intake forms

Background

- Advocate Illinois Masonic Medical Center resides in the nation's first municipally recognized LGBTQ neighborhood.
- AIMMC named "Leader in LGBT Healthcare Equality by HRC's Healthcare Equality Index" for the past seven years
- The LGBTQ community is a significant portion of our patient population.
- Health disparities in LGBTQ community
  - Decreased access to health care/insurance
  - Low rates of pap smears and mammograms
  - Higher rates of suicide, depression, substance abuse
- Unknown proportion of LGBTQ patients in practice, which is currently not addressed in intake form

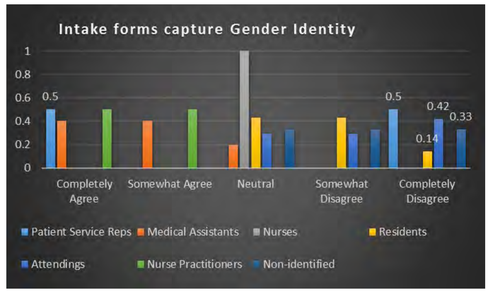
Vision Statement

1. Envision an environment where all patients, regardless of their gender or sexual orientation, have health access and equity,
2. Ensure all providers and staff feel comfortable and confident with each patient encounter,
3. Provide ongoing education for providers and staff on specific population-based healthcare needs.

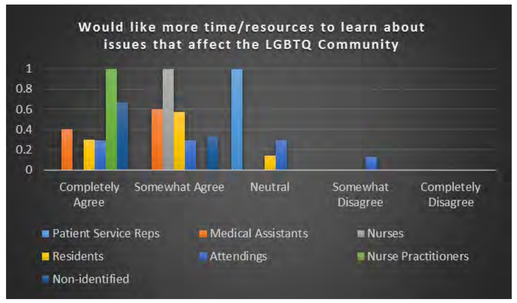
Materials/Methods

- 19 questions assessing a participant's comfort in interacting with LGBTQ patients.
- 27 survey participants: providers and staff at the AIMMC – Ravenswood Family Medicine Clinic.
  - Attending physicians (26%)
  - Resident physicians (26%)
  - Medical assistants – MA (19%)
  - Nurse practitioners – NP (11%)
  - Registered Nurses – RNs (4%)
  - Patient service representatives - PSR (7%)
  - Other office ancillary staff (11%)

Results and Interventions



- Overall, intake forms do not adequately capture gender identity



- Providers and staff show interest in educational opportunities regarding LGBTQ issues

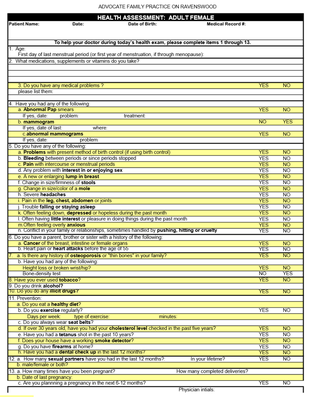
Intervention I: Educational Seminar Topics

- Sharing difficult patient encounters
- Addressing patients at the front desk
- Asking for preferred pronouns
- Developing comfort discussing gender identity
- Taking a complete sexual history

Intervention II: New Intake Forms

Current Form:

- Male and Female Forms- all questions separated by sex
- Does not offer gender pronoun/area for transgender patients
- # Sexual partners = sexual health
- Does not adequately assess risk



ADVOCATE FAMILY PRACTICE ON RAVENSWOOD

HEALTH ASSESSMENT: ADULT FEMALE

Patient Name: Date: Date of Birth: Medical Record #:

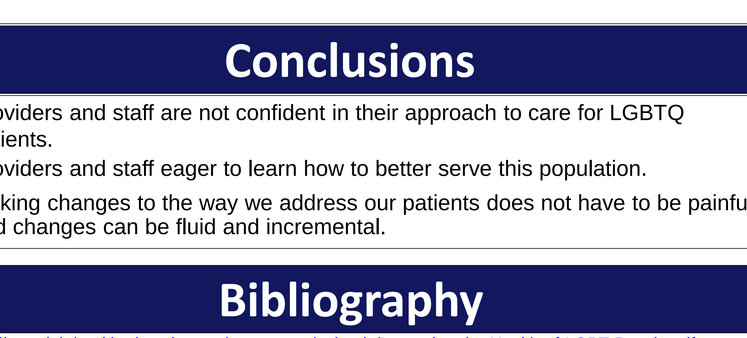
To help your doctor during today's health exam, please complete items 1 through 13.

1. Age:
   First day of last menstrual period (or first year of menstruation, if through menopause):
2. What medications, supplements or vitamins do you take?
3. Do you have any medical problems ? YES NO
   please list them
4. Have you had any of the following:
   a. **Abnormal Pap** smears YES NO
      if yes, date: problems: treatment:
   b. **Sexually transmitted disease** NO YES
      if yes, date of last where:
   c. **abnormal mammograms** YES NO
      if yes, date: problems:
5. Do you have any of the following:
   a. **Problems** with present method of birth control (if using birth control) YES NO
   b. **Bleeding** between periods or since periods stopped YES NO
   c. **Pain** during intercourse YES NO
   d. Lack of enjoyment **interest in or enjoying sex** YES NO
   e. A new or enlarging **lump in breast** YES NO
   f. Change in size/firmness of **stools** YES NO
   g. Change in size/color of a **mole** YES NO
   h. Severe **headaches** YES NO
   i. Pain in the **leg, chest, abdomen** or joints YES NO
   j. Trouble **falling or staying asleep** YES NO
   k. Frequent feelings of **depression** or hopeless during the past month YES NO
   l. Often having **little interest** or pleasure in doing things during the past month YES NO
   m.Often feeling overly **anxious** YES NO
   n. Contact in your family or relationships: sometimes handled by **pushing, hitting or cruelty** YES NO
6. Do you have a parent, brother or sister with a history of the following:
   a. **Cancer** of the breast, intestine or female organs YES NO
   b. Heart pain or **heart attacks** before the age of 55 YES NO
   c. **Osteoporosis** (thinning of the bones) or "thin bones" in your family? YES NO
   d. Have you had any of the following:
      Height loss or broken wrists/hips? YES NO
      Bone density test NO YES
7. Have you ever used **tobacco**? YES NO
8. Do you drink **alcohol**?
9. Did you do any **illicit drugs**? YES NO
10. Prevention:
    a. Do you do a **healthy diet**?
    b. Do you **exercise** regularly? YES NO
       Days per week Type of exercise minutes
    c. Do you always wear **seat belts**?
    d. If over 30 years old, have you had your **cholesterol level** checked in the past five years? YES NO
    e. Have you had a **tetanus** shot in the past 10 years? YES NO
    f. Does your house have a working **smoke detector**? YES NO
    g. Do you have **firearms** at home? YES NO
    h. Have you had a **dental check up** in the last 12 months? YES NO
11. a. How many **sexual partners** have you had in the last 12 months? In your lifetime?
    b. male/female or both?
12. a. How many **sexual partners** have you had in the last 12 months?: In your lifetime?
    b. male/female or both?
13. a. How many times have you been pregnant? How many completed deliveries?
    b. Date of last pregnancy:
    c. Are you planning a pregnancy in the next 6-12 months? YES NO

Physician initials:

Proposed New Intake Form

- Unisex
- Space for name choice and gender pronoun
- Review of systems questions are broad, and can be discussed further with individual providers
- Sexual history question is more relevant to sexual risk behaviors



To help your doctor during today's health exam, please complete items 1 through 13.

1. a What is your preferred name? b. Do you have a preferred gender pronoun? c. If so, what is it?

12. a. Are you sexually active?
    b. Since your last screening for sexually transmitted infections, have you had any new sexual partners?

Discussion

- This was the first step in opening dialogue amongst providers and staff regarding best practices for care of LGBTQ patients.
- Interventions included training on providing an inclusive environment to all patients.
- Developed and presented new intake form on February 17, 2017, pending approval.
- Follow-up meeting and survey to be administered after trial period of new form.

Limitations and Barriers

- Small sample size: some providers and staff unavailable due to clinical duties and other responsibilities.
- Only one clinic sampled. We plan to expand to the Internal Medicine Program.
- Brief Training (only one day). AIMMC partners with Howard Brown to continually educate health care providers and associates on LGBTQ competency. AIMMC Ravenswood FMC is working to make participation mandatory.

Conclusions

- Providers and staff are not confident in their approach to care for LGBTQ patients.
- Providers and staff eager to learn how to better serve this population.
- Making changes to the way we address our patients does not have to be painful, and changes can be fluid and incremental.

Bibliography

1.https://www.lgbthealtheducation.org/wp-content/uploads/Improving-the-Health-of-LGBT-People.pdf

2.Greene, T. (2014), Gay Neighborhoods and the Rights of the Vicarious Citizen. City & Community, 13: 99–118. doi:10.1111/cico.12059

3.http://howardbrown.org/wp/event/mlhs2016/

4.http://www.hrc.org/resources/lgbt-inclusive-intake-forms

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Advocate Illinois Masonic Medical Center **Project Tile: Medication Assistance Program and LGBTQ Community Initiative**

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*The Medication Assistance Program was introduced to reduce health disparities, promote medication adherence and lower readmissions by providing uninsured and underinsured patients access to prescribed medication.* *To engage a resident physician in the CHNA to improve the process of identifying and addressing community health needs.* *Envision an environment where all patients, regardless of their gender or sexual orientation, have health access and equity, ensure all providers and staff feel comfortable and confident with each patient encounter, provide ongoing education for providers and staff on specific population-based healthcare needs.*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	*Objectives:* *To retrospectively compare the readmission rates one year before and after enrollment in the Medication Assistance Program (MAP) from January 1, 2014 through December 31, 2015.* *To include a resident physician in the hospital CHNA process in order to provide a resident's perspective on community needs and interventions to address those needs.* *Compare recommendations of the Community Health Council to the recommendations of resident physicians.* *Educate and engage residents/fellows and other members of the healthcare team about the MAP* *Develop and implement LGBTQ educational program for current and new physicians and associates*

		Identifying opportunities to improve relationships with community agencies that support our LGBTQ community *Collaborate with Patient Access to improve the system to ensure appropriate data fields to support gender identity*
III.	Team Members & Accountability (list of team members and who is accountable for what)	*Name/Credentials* **Barbra G. White, MHA – LGBTQ taskforce member, leadership and member of CHNA, resident advisor for MAP, developing the cultural competency program for LGBTQ, GME Accreditation & Compliance Expert* *Oscar Zambrano, MBA, MPH - developing the cultural competency program for LGBTQ* *Lucy Aquino – V.P. of Hispanocare, member of CHNA* *Lisa Kritz, MSW, MBA - improve relationships with community programs-Community Needs Assessment, guide resident involved in CHNA* *Jerremy Howell, MS, PHR - HR and diversity consultant* *Kim Spencer, PharmD, BCPS, MHA, Director of Pharmacy and Respiratory Services consultant* *Virginia Quiroz, BA – member of CHNA* *Toi Walker Smith, Ed.D – Data analysis, helping to develop and strengthen current initiatives that we have in place, assess and evaluation* **Mohammed Samee, MD – Advocacy and leadership, coordinate analysis of MAP data, provide guidance for resident involved in CHNA* *Ranae Antoine, MD,(PGY I) – actively participate in the CHNA process* *Elsie Lindgren, BSN,RN,CPPS – Patient Safety consultant* *Adrienne Gabriel, PT, DPT, MBA, CPHQ, LSSGB –Regulatory and Quality Improvement consultant* *Catherine Plonka, MD- Advocacy & leadership* *Hilda Rock, MD , PGY-2 – Education in the outpatient arena for the MAP, developing the cultural competency program for LGBTQ* *Drew Guzman, MD, PGY-2 - Education in the outpatient arena for the MAP, developing the cultural competency program for LGBTQ* *Bennish Zulfqar, MD, PGY1- Survey for LGBTQ preferences and physician education*

		Beverly Bohus, RN, MSN, PCCN - improve relationships with community programs, identifying opportunities within the MAP, patient transitions to prevent readmissions *Divya Korpu – Analyze MAP data* *Robert Zadylak, MD-Advocacy & Leadership*
IV.	Necessary Resources (staff, finances, etc.)	*Data analyst, PDSA Model to measure progress, Community Agency Partnership & Collaboration; human capital to support in form of case management, updated admission categories to enhance demographic data collection, financial support, special speakers, education regarding LGBTQ, outpatient case managers, additional FTE to support the MAP, adjustment of clinical time to participate in initiatives*
V.	Measurement/Data Collection Plan	*Financial Data* *Elements of MAP details: number/type of medications, demographics of patients served (age, gender, insurance status, ethnicity/race; sexual preference), financial statement of support, average SES, , number of times MAP is requested as a resource* *Patient outcome data* *LGBTQ satisfaction data and summary of concerns* *Physician and associate survey pre and post education* *Population health data*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	*Need to identify who will meet with whom?* *Community Partners Meeting– Bohus, Kirtz, Samee, White, Zambrano, Quiroz* *Data Management – Kirtz, Walker-Smith, Samee, White* *Public Relations/Marketing – Zambrano* *Transition of care – Bohus*

VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	*Data (outpatient) , human capital (case management)* *Financial resources* *Time* *Buy-in from associates and physicians* *Change in our structure* *Knowledge* *Resistance*
VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Journal of Quality Improvement* *Journal of Graduate Medical Education* *Alliance for Quality Improvement in Medical Education –Conference* *ACGME-Conference* *AHME-Conference* *AAMC – Quality Improvement Conference* *IMMC –host conference on health disparity* *Society for Teachers in Family Medicine* *Journal of Family Practice* *BMJ Quality Improvement* *Journal of Case Management Association of America* *LGBT Health Link* *Gay and Lesbian Medical Association* *Internal Medicine GME Journals [NEED NAMES]* *Grand Rounds* *Posters* *Repository of educational informational materials*
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*See roadmap*

X.	Success Factors	*The most successful part of our work was having all stakeholders at the table, sufficient lead time to plan, open and honest communication of barriers, data-driven outcomes, and support and commitment from the C-Suite.* *We were inspired by team members' enthusiasm, topic expertise, and level of engagement.*
XI.	Barriers	*The largest barrier encountered was time for resident to work on the project due to patient responsibilities and schedule, and time for leaders to attend the monthly meeting.* *We worked to overcome this by narrowing the scope of the project and resident representation, and having only 1 of the leaders attend the monthly meetings.*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be to have an active partnership with all stakeholders and clearly identify roles.*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish? 8* *1 2 3 4 5 6 7 8 9 10*

60018: Improving Health Equity

J Gravdal, L Kelly, P Hyziak, P Besler, M Stock, S Barrera, R Sanchez,
C Victor, H Graham, S Verma, S Saldana, E. Munoz
Advocate Lutheran General Hospital **Park Ridge, IL**

Overall Goal

- Obtain and review data to understand the needs and resources of our Hispanic population
- Review our Family Medicine Residency Curriculum and curricular literature to improve the learning experience
- Partner with the 60018 Hispanic community, specifically St. Stephen Protomartyr Catholic Church

Background & Context

Diabetes disproportionately impacts the Hispanic community. Zip code 60018, within our primary service area, has twice the Hispanic population of our other PSA zip codes. Partnering with the community will help us better understand and address their needs.

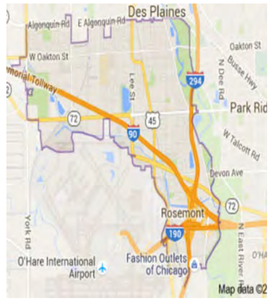
ALGH is committed to population health and works to partner with our diverse populations. This work fits with our CHNA aim - to reduce all health disparities and improve overall community health by providing the safest environment with the best health outcomes while building lifelong partnerships with all stakeholders.

The 60018 initiative allows us to explore our data about diabetes, to partner with the 60018 Hispanic community, and to create a resident curriculum thereby aligning CHNA, population health and GME goals.

Vision Statement

To partner and build trust with our Hispanic community through a holistic approach emphasizing culturally appropriate screening and diabetes education as an immediate step toward preventing and reducing the impact of diabetes

Making the community visible and being visible in the community



Methods

- Obtain and review data
  - CHNA
  - Hospital data
  - Community survey data
  - Literature review
- GME
  - Family Medicine Residency Tour of the community
  - Curricular review: Literature and curricular revision
- Community partnership – Relationship building with St. Stephen Protomartyr Catholic Church. Building trust and offering free screening and diabetes education

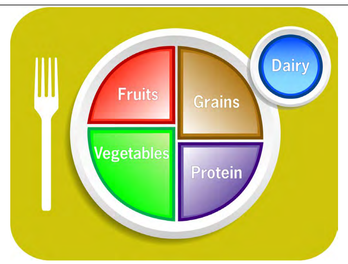
Results

- Relationship with St. Stephen Protomartyr
  - Survey 23 completed surveys
  - Focus Groups 20 in 3 facilitated groups
  - Screening 23 total
    8 with A1c 5.7-6.4
    8 with A1c >6.5 (2 >11)
  - Education sessions (4) 12-15 at each
- The NI V work was incorporated into the new revision of ALGH's CHNA. This validates the importance of and commitment to our work with this community
- Grant money secured to sustain the work and a commitment of long term support by ALGH
- Family Medicine Residency Curriculum changes implemented

Assets Identified to Address Barriers

- **Identification of and Engagement with stakeholders**
  - St. Stephen Protomartyr Catholic Church partnership
    - Success with community members and challenges with community leadership
  - Access Genesis FQHC
    - Shared history and commitment and challenges with their organizational stressors
- **Budget**
  - ALGH Community Health Department
  - ALGHPE Grant for $35,000
- **Time**
  - Regularly scheduled team meetings
  - Schedule that works for the community
    - Their timeline is not our timeline
    - Their perceptions of action, involvement and interest didn't always coincide with our intent
- **Skills gap (culturally sensitive)**
  - Learning from team members, from NI V sessions, from the community
  - Language (Spanish) and Culture (predominantly Mexican)
- **Knowledge/ Literature**
  - Diabetes education for Hispanic communities
- **Trust**
  - Cultural skepticism has a history and takes time to build

Not a Project but a Partnership



Bibliography

1. Alberti PM, Bonham AC, and Kirch DG. Making equity a value in value-based health care. Acad Med. 2013;88(11):1619-24.
2. Cowen JB. Background for implementation of an initiative for addressing pre-diabetes in the Hispanic population in zip code 60018. January 2016
3. Like RC. Educating clinicians about cultural competence and disparities in health and health care. Journal of continuing education in the health professions. 2011;33(3):196-206.
4. Patow C, Bryan D, Johnson G, et. Al. Who's in our neighborhood? Healthcare disparities experiential education for residents. Ochsner Journal. 2016;16:41-44.
5. Stoto MA and Smith CR. Community health needs assessments – aligning the interests of public health and the healthcare delivery system to improve population health. 2014.

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: ALGH Project Tile: "60018" – Improving Health Equity: Collaborating with our Hispanic Population to improve diabetic education, prevention, and care

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*To serve the health needs of the Hispanic community through a holistic approach with an emphasis on education as an immediate step toward preventing and reducing the impact of diabetes.* *Markers of success by March 2017:* *1)Build sustainable partnerships with the 60018 Hispanic community* *2)Increase awareness and understanding of risk factors for and management of DM in the 60018 Hispanic community* *3)Improve education and involvement of residents and attending physicians in understanding disparities and in improving health equity in this population*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	*Zip code 60018 in our primary service area has twice the Hispanic population of our other PSAs. It is well known that diabetes disproportionately impacts the Hispanic community. We first seek to understand the medical and community needs and resources and then to work with them to address their needs.*
III.	Team Members & Accountability (list of team members and who is accountable for what)	*J. Gravdal – Team leader* *L. Kelly – VPMM and DIO* *P. Hyziak – Director, Performance Excellence* *P. Besler – Director, Community and Health Relations*

		M. Stock – FM Residency Faculty *S. Barrera – Administrative Intern* *R. Sanchez – Community Engagement Coordinator, Access Genesis Clinic* *C. Victor – Diabetes Educator* *H. Graham – FM Resident* *S. Verma – FM Resident* *E. Munoz – Community Health Coordinator*
IV.	Necessary Resources (staff, finances, etc.)	*-Funding for meeting attendance – Dr. Kelly and Dr. Gravdal (FM Restricted Funds)* *-ALGH Community Health Department* *-ALGHPE grant*
V.	Measurement/Data Collection Plan	*1- DesPlaines Survey – Jan. 2016 – included two additional questions* *a) Does anyone in your family have DM?* *b) Have you ever been told you have high blood sugar or Diabetes?* *2- Hospital data analysis of Hispanics w/ DM or Glucose intolerance – ED visits, Readm rates, LOS, Discharge disposition 2015* *3-Survey, focus groups and pre-post questionnaires for educational intervention as well as screening results*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	*-Genesis Access FQHC – Ramon Sanchez* *-St. Stephen Protomartyr Catholic Church* *-Advocate – linkage with CHNA, Population Health and our Key Results Areas*

VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	*Time – Regularly scheduled meetings and specific deliverables should alleviate this challenge* *Engagement – currently exists at a high level; will need to work to maintain.* *Budget – needs* *Skills gaps – ongoing identification and involvement of appropriate people/resources*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Population Health Research* *1)Stephanie's Capstone Project* *2)DesPlaines Survey* *Clinical Learning Environment initiatives* *Dr. Kelly's MHA Capstone Project* *Future submissions to AIAMC, STFM, IHI, and AHA are possible*
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*1)Stephanie's Capstone – April 2016* *2)DesPlaines survey – 2016* *3)Community connections and conversations – informal learning* *4)Diabetes education for Hispanic community –* *Survey (Fall 2016)* *Focus Groups (Fall 2016)* *Screening session (October 2016)* *Educational sessions (October 2016)* *Follow-up screening session (March 2017)* *5)GME curriculum on Health care disparities and Population Health*

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was…..Obtaining Executive Leader Sponsorship and grant dollars to sustain and expand the work of our NI V team* *We were inspired by…..The people in the community who enthusiastically participated in the screening and educational sessions*
XI.	Barriers	*The largest barrier encountered was…..Unrecognized challenges within our partner church* *We worked to overcome this by…..Being patiently and respectfully persistent as well as flexible in developing a Community Health Worker position when the church was unable to commit to a Faith Community Nurse.*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be…..Be prepared to listen to both the words and the nonverbal with an open and flexible mind*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5 6 7* **8** *9 10*

Disparities in Colorectal Cancer Screening

Jonathan Blaza MD, Jasmine Wiley MD, Wilhelm Lehmann MD, Jeffrey Stearns MD, Deborah Simpson PhD

Aurora Family Medicine Residency Program, Milwaukee, Wisconsin

Overall Goal/Abstract

Objectives:

- To identify REAL-G disparities (race, ethnicity, age, preferred language and gender) and insurance in care to patients ≥ 50 who are eligible for colorectal cancer (CRC) screening in two family medicine residency clinics
- To develop and implement a targeted intervention to increase CRC screening in the disparate group
- To evaluate progress in addressing identified disparity gap by clinic to support continuous improvement

Background: CRC Screening

- CRC is a national health care priority
- CRC is an Aurora Health Care (AHC) Quality Metric and a care gap per AHC's Community Health Needs Assessment (CHNA)
  - Our residency clinics face challenges associated with urban underserved populations
  - Clinics currently < goal for the CRC screening quality metric
- Studies have identified disparities in CRC screening with screening less prevalent among patients who are:[A, B, C]
  - Uninsured and/or lower socioeconomic status
  - African American/Black, Asian;
  - Non-English speaking Hispanic patients
  - Local variations do exist /deviate from national experiences
- Age related disparities in CRC screening rates among eligible patients is limited/not reported in literature

Vision Statement

Vision

- To improve the health and equality of our community by identifying and addressing disparities in colorectal cancer screening rates

Mission

- To identify and address disparities in CRC screening in our resident clinics based on REAL-G data (race, ethnicity, age, preferred language) and insurance

Bibliography/References

A. Baker, DW, Liss DT. Understanding current racial/ethnic disparities in colorectal cancer screening in the United States: the contribution of socioeconomic status and access to care. *American Journal of Preventative Medicine* 2014; 46(3):228-36.

B. Beyer KM, Malecki KM, Hoorman KA, Szabo A, Nattinger AB. Perceived neighborhood quality and cancer screening behavior: evidence from the survey of the health of Wisconsin. *J Community Health 2015*.

C. May FP, Almario CV, Ponce N, Spiegel BM. Racial minorities are more likely than whites to report lack of provider recommendation for colon cancer screening. *American Journal of Gastroenterology* 2015; 110(10):1388-94.

D. Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

Materials/Methods

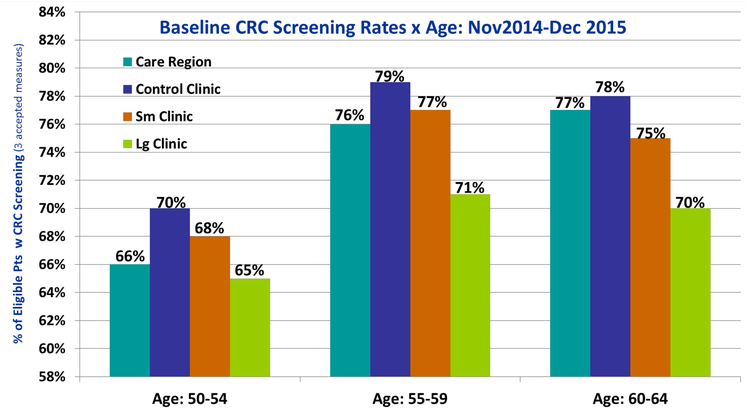
IHI Improvement Model

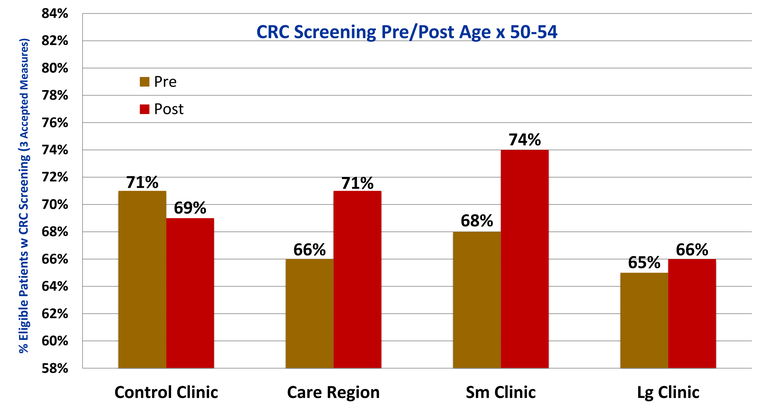
- A team of residents/faculty framed our approach using the IHI Model's for Improvement [D]
- Providers at 2 family medicine clinics identified barriers to CRC screening using a fishbone approach to engage them in the improvement process

Population Data

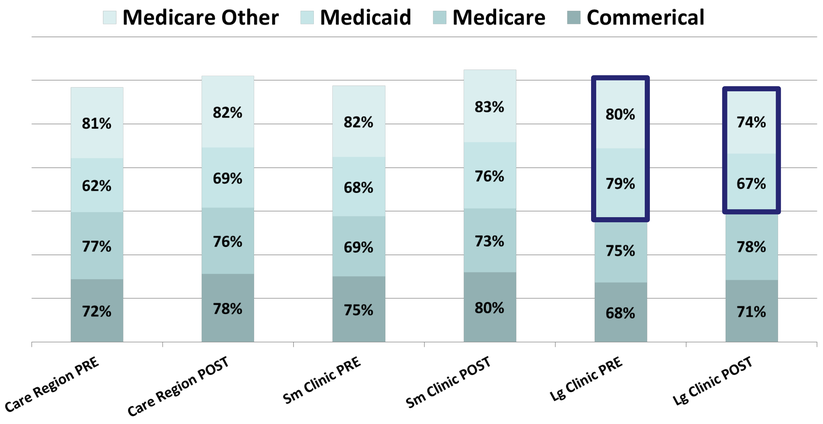
- A retrospective analysis of all patients eligible for CRC screening at 2 targeted clinics , a control clinic (residency clinic in same zip code), and our care region during a 12 month period (Dec-Nov 2015) was completed in collaboration with AHC quality improvement specialists
  - % patients achieving CRC screening metric was reported by REAL-G & insurance
  - Categories with an N < 25 were omitted
  - Criterion for disparity within a category was identified as > 10%
  - Analysis was repeated in Jan 2017 for intervention period (Jan-Dec 2016)

Results: CRC Screening x Age Disparity





Results: CRC Screening Pre/Post x Insurance



Success Factors and Lessons Learned

- Identifying a specific disparity group provided a focus for improvement (beyond the monthly quality metrics received by each clinic)
- Increased CRC screening rates appears to be influenced by:
  - Improved CRC ordering workflows
  - Clinic provider/staff education
  - Staff champions who are CRC advocates and implement changes
- Project created dialogue about CRC screening rates in several Aurora-wide groups, which may have encouraged change in our care region

Barriers Encountered/Limitations

- *Wisconsin Collaborative for Healthcare Quality* ranks Aurora Health Care as 8 / 20 systems in Wisconsin (77.6% Q3 2014Q2 2015) for CRC screening
- Age 50-54 as a disparity group was an atypical "frame" potentially limiting provider/staff engagement and buy in
- CRC screening rates may be influenced by clinic size
- Need to investigate differences in insurers' coverage of CRC and clinic specific perceptions re: coverage; identify/implement strategies to address

Conclusions

- Analyzing local population data REAL-G categories provides new insights re how to reduce health disparity gaps and further our progress toward achieving best in our state care for all patients

DIABETES- IMPROVED SERVICE EFFICIENCY IMPROVES RACIAL DISPAIRTY

Abel Irena MD MSc, Kushal Patel MD, David B Thompson MD, Abiy Gesese MD,
Gregory J. Schleis, MD, Richard J Battiola, MD
Internal Medicine Residency Program – Aurora Health Care - Milwaukee, Wisconsin

Overall Goal/Abstract

GOAL:
Improving the health outcomes of patients with diabetes mellitus

PURPOSE:
Improving racial disparity in diabetes outcome indicators among diabetic patients being treated at Aurora Sinai Internal Medicine Ambulatory Clinic.

Abstract

NI-V PROJECT FOCUS: DIABETES MONITORING

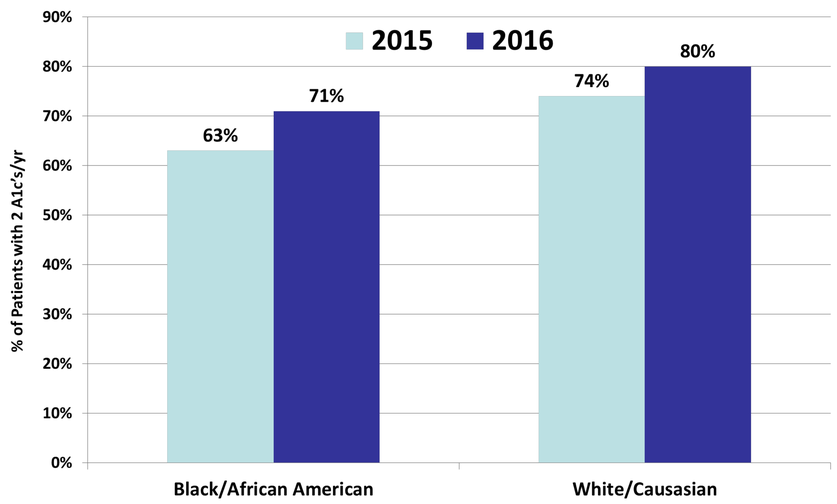
- Disparities seen in diabetes management with poor outcomes in Black/ African American patients as compared to white race[1]
- Two of the four diabetic indicators showed racial disparity:
  - Glycohemoglobin (A1C) check at least 2/year
  - Blood pressure control to goal (<140/90) in Diabetics
- Known strategies to reduce racial disparities in diabetes include:[2,3]
  - Community engagement, patient empowerment
  - Increasing access, improving care coordination
  - Improving quality of care
- Data collected through staff interview, group discussion, review of work flow identified key barriers: on-time A1C ordering; patient's staying for lab work; timely availability of lab results; resident/staff workload

Materials/Methods

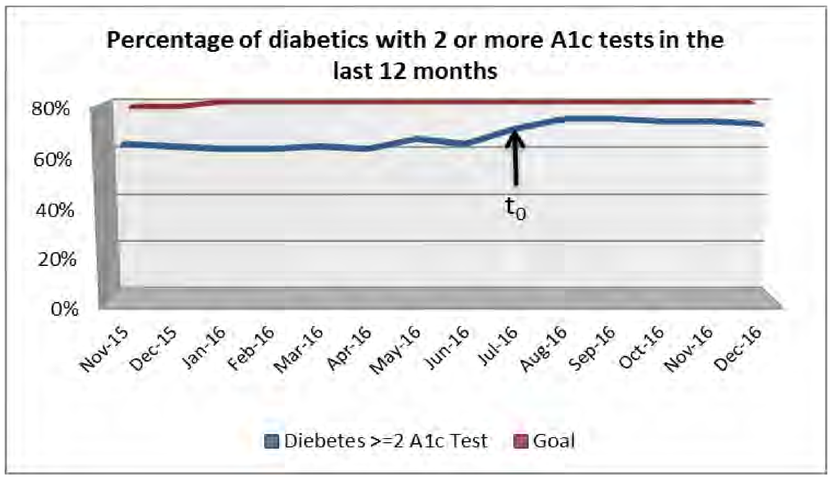
- Clinical patient disparities in Diabetes for Internal Medicine residency clinic identified using REAL-G categories (race, ethnicity, age, language preferred - gender) from EPIC analyses
- Provider, staff and patient perceptions were obtained
- Optimal interventions identified and prioritized for DM targeted REAL-G disparity, via literature, clinic's health care team perceptions cognizant of available resources
- A1C testing machine purchased, streamlined clinic workflow for point of care/day of patient appointment access
  - Resident, faculty, staff orientation / training
  - Resident and Faculty Clinic champions / each day of workweek
  - Numerous PDSA cycles were conducted with the leadership of the clinic staff to improve the workflow related to point of care/day of A1C access

Results

% of Diabetic Patients with 2/yr A1C Checks
by African American/Black and White/Caucasian for
Pre (2015) and Intervention (2016) in IM Residency Clinic



IM Clinic showed overall increase in DM measures from 2015 to 2016
- A1C 2/yr = 9% increase
- BP <140/90 = 2% increase



- Full implementation of intervention began July 2016 - at "t_o"
- Clinic "no show" rate remains static at approximately 30% , challenging further improvement at this time

Barriers Encountered/Limitations

- Resident/faculty schedules conflicts and duty hours limit opportunities for team meetings
- Unable to impact some socioeconomic factors surrounding care outside of clinic as below:
  - Lack of resource to improve lifestyle and dietary habits
  - Lack of ability to provide financial support for medications
  - Inability to influence social/cultural norms surrounding diabetic care

Lessons Learned (Discussion)

- Improve diabetes care for all patients by improving access to point of care/same day A1C testing with streamlined work flow
- Seek to increase team's access data in format that supports analysis clinic/system level to more agilely answer emerging questions
- Team based approach essential
  - Continuous project engagement difficult as clinical obligations shift
  - Active involvement, ownership of the clinic staff/leaders
  - Formalize and publicize team's time needs (e.g., protected/block time)

Conclusions

- Racial disparities exist in clinic setting where African American are the predominant customers
- May be associated with overall service quality
- Can be improved by implementing interventions that improve service for all patients
- Sustaining project is increased through active involvement of clinic staff/leaders at project inception

Bibliography

REFERENCES:

1. Heidemann DL, Joseph NA, Kuchipudi A, Perkins DW, Drake S. Racial and Economic Disparities in Diabetes in a Large Primary Care Patient Population. Ethnicity & Disease. 2016;26(1):85-90.
2. Betancourt JR, Duong JV, Bondaryk MR. Strategies to reduce diabetes disparities: an update. Curr Diab Rep. 2012;12(6):762-8.
3. Lewis MA, Williams PA, Fitzgerald TM, et al. Improving the implementation of diabetes self-management: findings from the Alliance to Reduce Disparities in Diabetes. Health Promot Pract. 2014;15(2 Suppl):83S-91S.

ACKNOWLEDGEMENTS: AHC Offices of Clinical Quality, Graduate Medical Education, Academic Affairs - Deborah Simpson, PhD & Jeffrey Stearns, MD

Preventing Postpartum Readmissions for Hypertension

Molly K Lepic DO, Sara M O'Meara DO, Carla J Kelly DO, Rebecca Eberhardt RN
Deborah Simpson PhD, Jeffrey Stearns MD,
Aurora Health Care – OBGYN Residency Program
Department of Obstetrics and Gynecology, Milwaukee, Wisconsin

Overall Goal

Goal:

- Identify risk factors in our community and reduce postpartum readmission for hypertension within our hospital system
- To better educate patients prior to discharge on their diagnosis and provide easy to understand written and verbal information
  - Ensure patient understanding and recognition of symptoms
  - Create easier access to follow up with scheduled appointments and access to medications prior to discharge

Purpose:

- Improve discharge process and follow up for patients at risk for postpartum hypertension among all obstetrical patients treated at Aurora Sinai

Background

NI-V Project Focus: Readmissions for Postpartum Hypertension

- Preventable readmissions regarding hypertension has been flagged as an area for improvement in OBGYN at Aurora Health Care
- Hospital readmission rates is a Centers for Medicare & Medicaid Services focus
  - In 2009, 27% of all obstetric readmissions nationally were due to hypertensive disease,[1] however our readmission numbers seemed relatively higher
  - Chronic disease (hypertension) and health literacy are improvement targets per Milwaukee County Community Health Needs Assessment
- System opportunity to improve health care quality and patient education in order to reduce preventable readmissions using ACOG updated recommendations for treatment of hypertension in pregnancy[2]
  - ACOG recommendations slowly incorporated through our multidisciplinary team of attending physicians, residents, midwives, and nursing staff
  - Traditionally, discharge planning, follow-up, BP checks, and education on postpartum preeclampsia, was at discretion of individual providers

Vision Statement

- To reduce postpartum readmissions for hypertension
- To better educate patients prior to discharge on their diagnosis and provide easy to understand written and verbal information
  - Ensure patient understanding and recognition of symptoms
  - Create easier access to follow up with scheduled appointments and access to medications prior to discharge

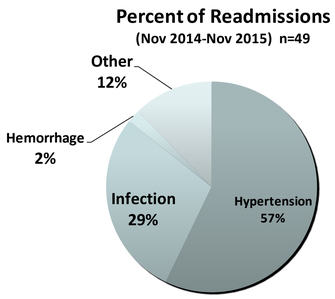
Bibliography

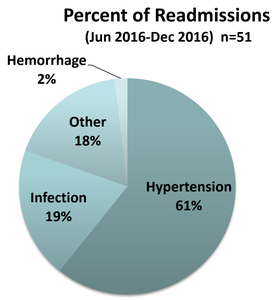
1. Muri JH, Crawford N, Connors Jellen B; American Hospital Association. Reducing avoidable obstetrical and neonatal readmissions. Accessed Feb. 3, 2016 http://www.aha.org/content/11/PerinatalReadmissionscall1.pdf.
2. American College of Obstetricians and Gynecologists. Hypertension in Pregnancy. 2013. Accessed 3.1.2017. https://www.acog.org/~/media/Task%20Force%20and%20Work%20Group%20Reports/public/HypertensioninPregnancy.pdf
3. O'Meara S, Lepic M. What clinical interventions have been implemented to prevent or reduce postpartum hypertension readmissions? A Clin-IQ. J Patient Cent Res Rev. 2016;3:150-2. doi: 10.17294/2330-0698.1264

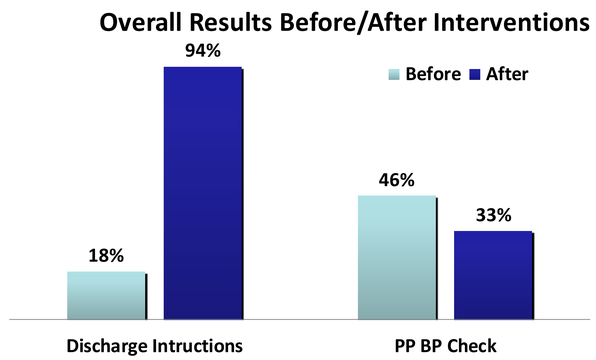
Materials/Methods

1. **Retrospective chart review from November 2014-2015**
   - Collected demographic, comorbidities, information regarding hospitalization and readmission
   - Identified 28 readmissions for postpartum hypertension, representing 57% of our obstetric readmissions
   - Discharge instructions and decreased interval to blood pressure reassessment were two areas of improvement[3]
     - Average days to readmission = 6 days postpartum (mode 2-3 days postpartum)
     - 18% had printed instructions regarding postpartum hypertension
2. **Provider and Nursing Education**
   - Multi-disciplinary discussion raising awareness of HTN readmissions
   - Increased surveillance for postpartum vitals for at risk patients (every 4 hours, daily weights, I/O)
   - Discharge instructions → appropriate verbal and written precautions for signs and symptoms of de novo or worsening disease
3. **Access to Care**[3]
   - Schedule BP checks within 72 hours of discharge
   - Utilize Aurora at Home for BP checks
   - Improved outpatient management when appropriate

Results







Results (Continued)

- Significant improvement in written discharge instructions regarding postpartum hypertension
- After "intervention" average days to readmission was 8 days
- 4 of 31 patients (13%) had VNA services on discharge
  - May not account for patients who had VNA services but did not require readmission

Success Factors and Lessons Learned

- Improved Patient Care and Patient Education can occur with small changes
- Difficult to work quickly for a large scope problem, but engaging more people helps with engagement and compliance
- Nursing Educators and multi-disciplinary view of a common problem (fishbone diagram) can help identify areas for intervention and correct missed opportunities

Barriers Encountered/Limitations

- Residency duties and primary obligations can limit dedication to quality improvement opportunities
- Data analysis
  - Dependent on time consuming chart review
  - Pulling data for VNA services was difficult to obtain in a meaningful way
- Scope of Control
  - Cannot control discharge planning for all patients
    - Consider including midwifery and private attendings in the improvement
    - Limited by consistent resident and nursing involvement
  - Compliance with interventions cannot be forced on patients
- Increasing attempts at VNA services may have decreased primary attempts at BP appointments in the goal period

Conclusions

- Engaging nursing assistance and providing education for comprehensive discharge planning helps with consistency
- Improvement in discharge instructions for patient did not decrease overall admission for postpartum hypertension
- Cost Analysis would be beneficial to see further economic impact
- Large projects, driven by administrative priorities, are best addressed with a multi-disciplinary approach

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Aurora Health Care Project Tile: From Population Data to Patient: Analyzing Clinical Quality Data Using REAL-G categories to Design Clinical Unit based strategies for Intervention

<table>
<tr><td>I.</td><td>Vision Statement
(markers of success by March 2017; refer to Toolkit #5)</td><td>Aurora Health Care aspires to provide ALL people better health care than they can get anywhere else.

Vision: Improving health care through engaging residents and faculty in identifying and addressing disparities in clinical quality metrics creating a win-win for patients and providers.</td></tr>
<tr><td>II.</td><td>Team Objectives
('needs statement,'
project requirements, project assumptions, stakeholders, etc.)</td><td>1. Utilize existing clinical quality data to identify health care disparities using REAL-G (Race, Ethnicity, Age, Language-Gender) categories,
2. Design and implement evidence-based strategies to address disparity gaps in targeted clinical settings (resident clinic and postpartum OB) through partnerships amongst residents, faculty, caregivers, Aurora data management individuals, patients, and communities.
3. Share our processes and outcomes within AHC community to sustain /spread our initiatives.</td></tr>
<tr><td>III.</td><td>Team Members & Accountability
(list of team members and who is accountable for what)</td><td>
<table>
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		^ Simpson & *Stearns advisory/consulting team members		
IV.	Necessary Resources (staff, finances, etc.)	*Engagement of key stakeholders:* • Residents and faculty in three Aurora residencies and their clinic staff/leaders, including pharmD's in two resident clinics, and postpartum nursing/social service in OBG; • Clinical Practice Committee (AUWMG-CPC), Aurora Care Management and Quality Leaders for operations and data to support (e.g., accessing broad Aurora data sets, and categorizing them into REAL-G groupings); • Aurora leadership in the areas of Government and Community Relations, Social Responsibility, Diversity and Inclusion, Research; Faculty and program directors.		

		• AHC GME Synergy Committee to engage hospital/clinical leaders
V.	Measurement/Data Collection Plan	• Baseline data: data analysis for 12 months prior to NI V intervention to provide baseline data for targeted clinical quality metrics in two resident clinics and our postpartum OB units, arrayed across the REAL-G categories. • Use baseline data to identify disparity gaps and inform intervention design along with literature. • Monitor monthly clinical quality reports (2 projects) to track overall progress. • Post Intervention Data: Post the 6 month intervention time period, analyze quality data using the same REAL-G categories to assess improvement in health care disparities.
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	• Monthly meetings with stakeholder groups to apprise them of progress and engage them in discussion regarding process/challenges. • Each residency group will meet 1-2 times per month to identify disparity gap and then design/implement strategy with on-going review of challenges and metrics to support continuous improvement. • CMO, Hospital and GME Leadership through quarterly CLER Synergy meetings. • GME through GMEC (GME leaders), Residency Council and GME-wide share noon conferences. • AUWMG Newsletter updates – for all caregivers affiliated with GME; distributed to key stakeholders • Presentations at AHC sponsored forums including Scientific Day, Quality Round Table
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc.)	• Time is the biggest challenge per previous NI projects (e.g., the ongoing time commitment of busy residents and their prioritization of tasks). • Implementation in real time clinical environments requires engagement and active involvement of clinical staff/caregivers (e.g., significant buy-in from those persons to effect changes in clinical processes). • Partnering with the site specific clinical quality/care management leaders to sustain project.

VIII.	Opportunities for Scholarly Activity (Potential publications, conference presentations, etc.)	Seek opportunities to submit to peer reviewed forums within AHC (system wide venues) and extramurally to disseminate work in peer review forums. o AHC Scientific Day o AHC Quality Roundtable o Clin-IQ in Journal of Patient-Centered Research and Reviews o AIAMC meetings/posters/publications o Specialty specific regional/national venues (APGO/CREOG; STFM; ACP)
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	We continue to made steady progress and hit all marker in our NI V Roadmap including: o Attendance at all NI V meetings (with at least one resident/faculty in attendance) and conference calls o All project teams have implemented evidence-based approach to address targeted clinical disparity o Submission of abstracts and accepted presentations at AIAMC annual meeting, Wisconsin-American Congress of Obstetricians & Gynecologists (ACOG) Annual Conference, Aurora Scientific Day, Aurora Quality Roundtable.

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was…..* #1: Addressed clinically hospital/clinic performance needs (e.g., postpartum HTN readmission) important #2: Framing disparities as REAL-G - Made disparities clinically relevant providers who work on a daily basis with underserved and to quality / care management leaders #3: Amongst the earliest adopters of REAL-G data analysis to inform quality improvement initiatives for patients served by our residency programs. Served as "pilots" for system partners to explore "how to analyze" REAL-G data, educating physicians on Diversity and Inclusion, etc. *#4:* Demonstrate the value of integrating residents with their respective health care teams to actively engage in process improvement resulting in better care. *We were inspired by…* #1: Collaborating with residents, faculty and clinic/hospital staff to implement change to improve care

		for our target disparity population (and in all eligible patients as a whole) – "we moved a metric that had been static for years" #2: Passion and commitment of their health care team members (e.g., patient education from RN, Mas associated with post-partum readmission, CRC screening) #3: Power of "teamwork" and bridging gap between "resident "and clinic staff… "It's as close as we've gotten of bridging our patient care and resident education – and impact" *#4:* Great projects and passion of all the projects presented by other teams at the AIAMC meetings and the passion all the teams had for making a difference - "it was really cool".
XI.	Barriers	• **Paradigm Shift:** With each project residents, faculty and staff come to the realization that a new engagement between residency education and clinical change is needed. We are shifting the paradigm to recognize that the knowledge and skills for process change are critical to improving care of patients and populations. " • **Protected Time:** o Need to formalize time involved in the project with acceptance by faculty/attendings (e.g., protected/block time) o Be firmer with team's time commitments and timelines • **Increase clinic engagement:** o Push harder to engage larger group with clear delineation of roles expectations and accountabilities o Increase involvement of core team to draw on residents/faculty and clinic staff (e.g., operations who were actually at the pilot clinic (e.g., clinic medical director, supervisor of clinical operations) • **Education**: Increase the curricular emphasis/formal education for resident with ongoing "re-education" • **Data:** Increase ability to access data in format that supports analysis at system level with data analyst support to more agilely answer emerging questions
XII.	Lessons Learned	*The largest barrier encountered was…* #1: The use of REAL-G data to frame our work – from engaging data analyst and teams to implementation – added time and complexity to normal change processes. *We worked to overcome this by…..*

		#1: Patience, persistence, strong and visible C-Suite support for project, new partnership, expanding involvement of the clinical care/project team(s) and humor.
XIII	Project Director's Key Driver	*Educational outcomes have to equate with health care systems outcomes. You are not doing good medical education if you are NOT affecting good health care outcomes.*
XIV	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5 6 7 8 9 10*

Partnerships for Developing Strategy and Curriculum in Disparities

James Dalton, MD, Edward Bischof, MD, Sue van der Sommen, Kara Travis, Sarah Mader, D.O

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Overall Goal/Abstract

The goal of Bassett Medical Center's NI V project was twofold – with a charter from the CEO, to develop an institutional strategy for addressing the diverse population of people Bassett serves in central New York and to develop a curriculum in disparities for our GME programs. A broadly representative central steering committee guided the development of these two processes with subgroups working at the granular level.

In November of 2016 a draft institutional strategy was given to the CEO and is under review by the CEO and then to the Board of Trustees.

In June of 2016, an initial curriculum in disparities was introduced in the Internal Medicine residency. Concurrently, the Steering Committee worked alongside others in the institution to develop a curriculum in cultural competency for the entire organization.

Background

Bassett's first CLER visit, in February of 2015, demonstrated that, while we had a number of programs which were dedicated to helping underserved segments of our population in rural, upstate New York, we did not have an overall strategy to assess the healthcare delivery to diverse parts of our population..We also did not have an educational program within our GME programs to expose resident physicians to the diverse segments of our population.

Rural New York state, unlike most urban settings in the U.S., does not have significant racial diversity. Its disparities lie mostly in the socioeconomic and geographic realms. But, there are significant cultural subgroups within our population that access healthcare (or not) in different ways.. In order to better understand this dynamic, we invited people from a wide range of populations and healthcare perspectives to serve on the steering committee for this project.

Vision Statement

Bassett Healthcare will have a strategy for understanding the health care needs of the population it serves. This strategy will include partnerships with external health and wellness organizations and a plan for education in disparities.

Materials/Methods

A Steering Committee was convened in September 2015, composed of leaders from within Bassett Healthcare and from other organizations in the community.. The composition of the committee expanded as more stakeholders were identified.

The Committee met every six weeks to monitor progress and to give input to work groups in the two main areas – institutional strategy and curriculum development..

The Committee included leaders from clinical areas both in Bassett and in the private practice community, public health, administration, research, quality improvement, outreach, mental health, and medical education. The CEO of Bassett was a frequent participant in the Steering Committee.

Results (data gathered both quant & qual.)

Institutional Strategy (Draft at CEO desk, undergoing review and revision)

Tie the elimination of healthcare disparities to the Mission/Vision/Values

Use IT and Research to better understand the demographics of our region

Create dashboards for our disparate populations for preventive care, cancer and heart care

Cultural competency training across the institution

Achieve a high Health Equity Index

Target interventions understanding cost and impact

Continue and enhance collaboration with community

Leadership engagement at Board level

Internal Medicine Disparities Curriculum

Experiential blocks in Gender Wellness Center and independent, grant-funded free clinic.

Experiential blocks under development in Farm Health Outreach, School-Based Health, and two regional facilities serving developmentally disabled people.

Didactic curriculum to support the experiential learning. Residents have their own "core curriculum" and they participate in the institutional cultural competency curriculum.

Institutional Cultural Competency Curriculum

In partnership with DSRIP (a New York state program designed to reduce healthcare disparities among Medicaid enrollees) and Leatherstocking Collaborative Health Partners, a curriculum in cultural competency has been developed with the intention of rollout through the entire organization and its partners. The first workshop in the curriculum was held in November, 2016, and focused on the healthcare needs of the LGBTQ community, eldercare, and opiate dependent individuals.

Current Research Project

Creating a dashboard for health maintenance in the Gender Wellness Center.

Success Factors and Lessons Learned(Discussion)

The most successful aspect of this project has been the collaborative efforts among all of the stakeholders. Inclusion of DSRIP and the Leatherstocking Collaborative Partners expanded the scope of the project, but also enabled the resident learners to be part of the entire institutional effort. This is one of the points that CLER has made apparent to us – that residents should be an organic part of the institution, not merely "visitors".

Another success as a result of this collaboration has been better recognition when two or more groups are working on a similar project. In the past (and still, in many instances), the groups would be duplicating efforts. The Disparities Steering Committee and workgroups have helped link groups who were working toward the same end and – hopefully – have helped with efficiency.

Barriers Encountered/Limitations-

Competing curricular demands for the IM residents was and continues to be a significant barrier to giving the disparities curriculum the right emphasis.

Competing demands for the CEO, Board of Trustees, and IT have made the revision and adoption of the institutional strategy a slower than hoped for process.

Conclusions

The partnership of internal and external stakeholders at Bassett Healthcare and its surrounding communities has successfully developed a draft of an institutional strategy for addressing healthcare disparities in our region.

A residency curriculum has been initiated in the IM residency at Bassett.

A curriculum in cultural competency has begun for the entire organization and its partners.

Multiple research opportunities have been created because of the development of these curricula.

This is a good start.

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Bassett Medical Center
Project Title: Development of an Institutional Strategy for Disparities of Care and an Institutional Curriculum in Disparities

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*Bassett Medical Center will have a strategy for understanding the health care needs of the population it serves. This strategy will include partnerships with external health and wellness organizations and a plan for education in disparities.*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	*Our first CLER visit in February 2015 demonstrated that, while we had a number of programs which were dedicated to helping underserved segments of our population in rural, central New York state, we had no overall strategy for assessing our populations. We also did not have an educational program within our GME programs to expose residents to the diversity within our population. So the overall objective of the project was to remedy these gaps.* *Our assumptions differ from many of our colleagues. Rural New York state (and rural America*

		outside the South) does not have the racial diversity of the rest of the country. Our disparities lie mostly in the socioeconomic and geographic realm. But, there are significant cultural subgroups within our population that access healthcare (or not) in different ways. In order to better understand this dynamic, we invited people from a wide array of populations and health care perspectives to serve on the steering committee for this project.
III.	Team Members & Accountability (list of team members and who is accountable for what)	***Diversity and Disparities Workgroup*** *Sarah Mader, D.O. IM Resident* *Satish Boddhula, M.B.B.S. IM Resident* *Susan van der Sommen, Director, DSRIP Program* *Kara Travis, DSRIP* *Charlotte Hoag, Administrative Director, Medical Education* *Edward Bischof, M.D., Program Director, IM Residency* *Chris Kjolhede, M.D., Director, School-Based Health Clinics* *Henry Weil, M.D., Assistant Dean, Columbia-Bassett Medical Campus*

		Julie Sorensen, PhD, Director, New York Center for Ag Medicine and Health(NYCAMH) *John May, M.D., Director of Research and Founder, NYCAMH* *David Strogatz, PhD, Director, PHIP program* *Ben Friedell, M.D., Director, Oneonta Community Health Center* *Carolyn Wolf-Gould, M.D., Director, Gender Wellness Center* *Anna Gaeta, R.N., Performance Improvement* *Heidi Bond, R.N., Director, Otsego County Public Health Department* *Vance Brown, M.D., CEO, Bassett Healthcare Network* *James Dalton, M.D., Director of Medical Education and DIO, Chair and Coordinator*
IV.	Necessary Resources (staff, finances, etc.)	*Steering Committee needed to meet every six weeks with reports from subgroups working on curriculum and strategies. As curriculum was developed, finances were needed to fund workshops for the institution and community. Curriculum for the residencies has evolved slowly, with elective rotations initially offered in the IM residency.*
V.	Measurement/Data Collection Plan	*Measurements to date have included participation in workshops. Studies involving individual groups in the population are being developed currently.*

VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	*Communication flows from the regular meetings and correspondence between meetings through the leadership represented in the group to their divisions.*
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	*One of the largest challenges will be collecting accurate demographic information that goes beyond race, gender, and ethnicity, so that we can measure outcomes in diverse segments of our population. This will require an IT investment (in the midst of several other large projects) and a cultural shift that will take time. We do not anticipate that that will be accomplished in the time frame of NI V, but that the journey will have begun.* *Budget is always an issue when we discuss spending scarce resources. Our budget, similar to most non-profit healthcare institutions in New York state, runs on essentially a "break-even" budget. One goal of this project is to develop the strategy so that a price tag can be assigned to every project that is built around disparities. This way, the institution can decide which projects to tackle in any given year, weighing the cost against the impact on the community.* *The initial engagement has been heartening. We do not anticipate any lack of interest on the part of any of the stakeholders. Curriculum delivery, particularly as it relates to residency curriculum, will be challenging, given the many requirements for residency training.*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	1. *A descriptive paper outlining the process of pulling together groups within and outside of the institution to develop strategy. Challenges and benefits.* 2. *Assessment of healthcare equity in some of our (presumed) underserved populations, followed by interventions (either in a QI/PI format or a scientific controlled intervention). Some of the groups include farmers and farm workers, transgender patients (we have a disproportionately large population of transgender people cared for in our region), and the uninsured population.*
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	1. *Engagement and discussion by stakeholders on the Steering Committee regarding priorities for a strategic plan for disparities. Discussion to include barriers and ways to overcome them. September 2015 through September 2016.* 2. *Presentation of a draft strategic plan for disparities of care to the CEO. September 2016.* 3. *Development of a curriculum in Disparities for the Internal Medicine residency. September 2015 to July 2016.* 4. *Collaboration with DSRIP (New York Medicaid grant to improve disparities of care to Medicaid recipients in New York) to develop curriculum for the entire institution and the DSRIP consortium in cultural competency and disparities. DSRIP's timeline includes deliverables for curriculum development beginning in 2016.*

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was the collaboration among all of the individual groups (clinical, administrative, research, and education) who were working on various aspects of our diverse population. There were several efficiencies that resulted from this cooperative effort and duplication of efforts (which is a common occurrence here ordinarily) were minimized. We organized a multidisciplinary workshop/dinner with a focus on disparities of healthcare (elder care, chronic opioid users, and the trans- population were the topics of this first workshop) in November 2016. 75 individuals participated, with the majority of the Internal Medicine residents among them.* *We were inspired by the enthusiasm of all the stakeholders on the Steering Committee and the energy brought to the curricular offerings by the entire community and by the Internal Medicine residents.*
XI.	Barriers	*The largest barrier encountered was competing demands in the residency program. The development of a draft strategy for disparities at the institution and the development of a cultural competency/disparities curriculum for the institution and the DSRIP consortium was easier than developing an integrated, robust curriculum for the residents.* *We worked to overcome this by creating elective blocks in the IM residency program where residents could choose an experience in one of several community efforts to bridge one or more gaps in healthcare delivery. Residents are participating in brief block experiences at the Oneonta "Free" Clinic and the Gender Wellness Center. Experiences are being developed at the New York Center for Agricultural Medicine and Health, Pathfinder Village (a residential facility for people with Down syndrome), Springbrook (a facility for developmentally disabled people). An experience at the School-Based-Health Centers is also being considered.*

XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be to be inclusive and cast a broad net for the Steering Committee and then assign smaller groups to get specific tasks completed.We could have, should have, and will do more of that going forward. This is a project that has only begun with NI V .*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5* ***6*** *7 8 9 10*

Improving Obesity in the Hispanic Population

Austin Metting MD, Clare McCormick-Baw MD, PhD
Matthew Jepson MD, Hania Wehbe-Janek, PhD, Ravi Kallur, PhD
Baylor Scott and White Healthcare Temple, Texas

Overall Goal/Abstract

- Decrease the prevalence of obesity and overweight individuals in the local Hispanic community.
- This would hopefully narrow the disparity we have noticed in our population that the local Hispanic population has more obesity and overweight individuals than other ethnic groups.

Background

- We began by looking at the local healthcare needs assessment and finding the three most prominent disparities.
- These were noted to be obesity, breast cancer death rate, and sexually transmitted diseases.
  - When these were discovered the group voted on which area we would focus on.
- Likely due to the volume of people it would impact, increased obesity in the Hispanic community was the chosen disparity.
- We then met with the community to determine the best course of action using their ideas and opinions.
- During our meetings and literature search we discovered that interventions that are centered around community and family tend to do better and last longer.

Vision Statement

To promote obesity awareness and provide education that impacts the local Hispanic population by collaborating with the community.

Bibliography

Wilson KJ, Brown HS 3rd, Bastida E. Cost-effectiveness of a community-based weight control intervention targeting a low-socioeconomic-status Mexican-origin population. Health Promot Pract. 2015 Jan;16(1):101-8.
Sorkin DH, Mavandadi S, Rook KS, Biegler KA, Kilgore D, Dow E, Ngo-Metzger Q. Dyadic collaboration in shared health behavior change: the effects of a randomized trial to test a lifestyle intervention for high-risk Latinas. Health Psychol. 2014 Jun;33(6):566-75.
Schmied EA, Parada H, Horton LA, Madanat H, Ayala GX. Family support is associated with behavioral strategies for healthy eating among Latinas. Health Educ Behav. 2014 Feb;41(1):34-41. doi: 10.1177/1090198113485754. Epub 2013 May 27
Faucher MA, Mobley J. A community intervention on portion control aimed at weight loss in low-income Mexican American women. J Midwifery Womens Health. 2010 Jan-Feb;55(1):60-4.

Materials/Methods

- **Proposed Intervention:** The program will be an eight week course of families meeting once weekly for educational information, cooking class, exercise planning, and data gathering.
  - **Feasibility Study:** To determine whether a larger study is possible, a feasibility study including 25-30 participants (roughly 6-7 families) will be conducted.
  - **Recruitment:** Potential subjects/family volunteers will be recruited by a study member from a local church.
  - **Intervention Curriculum:**
    - Hour long weekly didactics covering a number of topics including stress management, healthy eating habits, and
    - Meal preparation that includes affordable, culturally centered dishes and the recipes to prepare them.
    - Development of a basic exercise plan formed by the individuals
    - A member from our support group to discuss weekly updates on how they are progressing.
- **Metrics:** Height, weight, and waist circumference, validated surverys and a physical fitness assessment will be measured at the beginning of the 8-week program (pre) and at the end of the 8-week program (post).
  - **Surveys:**
    - The National Cancer Institute Quick Food Scan
    - Social Support and Eating Habits Survey
    - Live 5-2-1-0 Healthy Habits Questionnaire
    - Godin Leisure-Time Exercise Questionnaire
  - **Fitness Assessment:**
    - Half-mile walk/run, timed.
    - Number of sit-ups performed in one minute.
    - Number of jumping jacks performed in one minute.
  - **Intra-Intervention Exercise:**
    - Pedometers issued at week 1 to track daily step counts.
    - Weekly, the pedometers will be synced.

Results

- No data has been gathered as of yet.

Success Factors/Lessons

- There were many lessons learned and we are still learning.
  1. Speak with the community about interventions before making any decisions.
  2. Plan with people who have done something similar before.
     - If involved in the planning stages, it will save much added time and speed up the process to implementation.

Barriers Encountered/Limitations-

- **Financial barriers** - Not only is cost a significant barrier to our patients accessing healthy food, but also to the project implementation. To be able to begin our intervention, we needed to apply for a grant. This was an internal institutional grant, but the application process takes time. The grant was approved eventually, but also required some additional assistance with an expert in this type of research.
- **Time-based** – Our participants will only have limited free time to commit and our team members, as well will be limited with their free time.
- **Cultural** – In the Hispanic culture, food is used as a bonding and coping mechanism and many social events are centered around food. Our intervention is trying to change not only the types of food, but the attitudes around food, as well. This will likely be met with some resistance at times and change is never an easy process.
- **Physical** – According to our research, no one single intervention will make a big enough impact on obesity. Therefor, ours is a combination of motivational, activity, and food-based interventions within social groups. This is in hopes that each tier of this will in turn help affect the others increasing the lasting effect of the intervention and amplify the affects of the others.

Conclusions

- No conclusions can be drawn from the study yet.
- However, there is interest in the community and in the resident side of things to get this accomplished.

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Baylor Scott and White Temple **Project Title:** Obesity in the Hispanic Population

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	To promote obesity awareness and provide education that impacts the local Hispanic population by collaborating with the community and Graduate medical Education.
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	Our main objective was to decrease the prevalence of obesity and overweight individuals in the local Hispanic community. This would hopefully narrow the disparity of the local Hispanic population having more obese and overweight individuals than other ethnic groups. Stakeholders include the Hispanic community, GME residents and faculty, local Hispanic churches, other healthcare personnel from Baylor Scott and White.
III.	Team Members & Accountability (list of team members and who is accountable for what)	Austin Metting Matt Jepson Hania Wehbe-Janek Tara Stafford Dorothy Winkler Angela Hochalter Virginia Flores Ravi Kallur Clare McCormick-Baw Dave Smith Maybelline Lezama Peggy Peters Niki Shah

IV.	Necessary Resources (staff, finances, etc.)	Funds to pay for food, people (residents, staff, dieticians, psychologists, pastors, patients), space (locations to do interventions), advertising, scales, pedometers, measuring tape
V.	Measurement/Data Collection Plan	At each weekly meeting, team leaders will collect the following data from the participants: **Metrics:** Height, weight, and waist circumference, validated surveys and a physical fitness assessment will be measured at the beginning of the 8-week program (pre) and at the end of the 8-week program (post). **Intra-Intervention Exercise:** Pedometers issued at week 1 to track daily step counts. Weekly, the pedometers will be synced. Team leaders will also collect the following data at the first and last meeting: **Surveys:** • The National Cancer Institute Quick Food Scan • Social Support and Eating Habits Survey • Live 5-2-1-0 Healthy Habits Questionnaire • Godin Leisure-Time Exercise Questionnaire **Fitness Assessment:** • Half-mile walk/run, timed. • Number of sit-ups performed in one minute. • Number of jumping jacks performed in one minute.

VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	Community stakeholders have been involved from the beginning. Team members have continuously discussed project plans with individuals who will be involved to get approval and acceptance. Especially, from people who will be giving the educational talks. The grant has been approved and IRB approval is pending. Once IRB approved then the dates of the events can be set and communicated and recruitment can start.
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	1) Developing a successful protocol 2) We need to be careful that this is not seen as discriminatory (meaning it is targeted at the Hispanic population, but I believe anyone who comes and wants to participate should be allowed) 3) Getting residents and hospital employees to participate 4) Language barrier and getting buy-in (may be hard for Hispanics to believe non-Spanish speaking individuals actually care. Need to make sure we have plenty of Spanish speaking individuals to help. 5) Making this sustainable
VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	Intervention development process Effectiveness of interventions Methods of collaborating with the community Methods of creating sustainability
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	Discussion with community -> Project development -> Grant application and approval -> IRB application and approval-> Recruitment and booking of events -> Gathering data and hosting events -> Completing intervention portion and followup studies -> Expanding project after feasibility study -> continually discuss and write manuscripts on the intervention and process

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	The most successful part of our work was pairing with leaders in the community to gather information and help develop the protocol. We were inspired by all groups continuing effort to move their projects forward. This is an eye-opening experience for some of us and can sometimes equate to moving mountains. We commend the groups who have been in implementation phase and doing quite well and hope to be there soon.
XI.	Barriers	The largest barrier encountered was organizing and obtaining the resources to actually allow us to begin the project. We worked to overcome this by collaborating with a research designer to help us fine tune the protocol and get grant approval and make this more efficient.
XII.	Lessons Learned	Start from day one with a research expert who has done this type of population research. While developing our protocol and applying for the grant we were working with previous papers from our literature review as our main source of design information. In doing this, we missed some key elements in the design process which lead to a significant delay in grant approval and IRB approval, which is still pending.
XIII.	Expectations Versus Results	On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish? 5 1 2 3 4 5 6 7 8 9 10

Hospital-Acquired Pressure Ulcer: Association with Population Disparities

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Overall Goal/Abstract

This project examined a variety of demographic factors and co-morbid conditions to determine the presence/absence of an association with the incidence of Hospital-Acquired Pressure Ulcers (HAPUs). HAPUs were statistically associated on subset analysis with race, gender, and medical diagnoses.

Background

In 2013, the national overall Hospital-Acquired Conditions (HACs) rate was 121 per 1,000 hospital discharges. Of these, HAPUs occurred at a rate of 32.5 per 1,000 hospital discharges, accounting for 26.9% of the total HACs. A 2010 study suggested older patients and African-American patients had a higher incidence of HAPU. Baylor University Medical Center (BUMC) had noted opportunities to decrease the incidence of HAPU in its inpatient population; this project was designed to examine whether factors such as race, ethnicity, socioeconomic status, or gender potentially could contribute to the development of HAPUs.

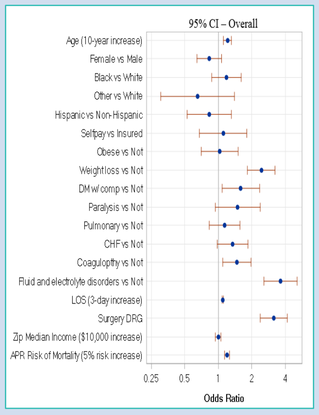
Vision Statement

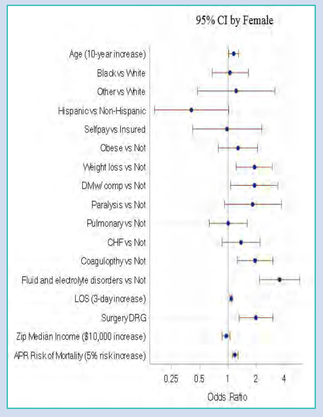
This project will attempt to identify demographic risk factors for development of hospital-acquired pressure ulcers in certain populations. Various demographic /comorbidity factors within populations will be examined to determine impact on the development of hospital-acquired pressure ulcers. If factors are identified, future directions could involve design of methods by which these risk factors can be mitigated to prevent pressure ulcers.

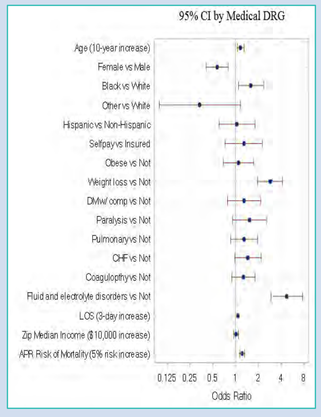
Materials/Methods

MIDAS/Datavision database was queried for incidence of HAPU (all stages) in inpatients > 15 years of age from 10/1/2012-9/30/2015. Variables examined include self-reported demographics [age, gender, race (African-American v. Caucasian), ethnicity (Hispanic v. Non-Hispanic)], insurance status (insured v. self-pay), median income by zip code, length of stay (LOS), medical v. surgical Diagnosis-Related Group (DRG), risk of mortality (ROM), and certain co-morbidities: congestive heart failure (CHF), obesity, weight loss, diabetes with complications, coagulopathy, paralysis, chronic pulmonary disease, and fluid/electrolyte abnormalities. Logistic regression was used to assess the effect of the variables of interest on odds of developing HAPU. Odds ratios and 95% confidence intervals were derived for each of the covariates in the logistic module.

Results







Success Factors and Lessons Learned /Discussion

Overall, the risk of HAPU in the population studied was less than the national average. On initial statistical analysis, HAPU incidence was associated with increased age, diabetes with complications, weight loss, fluid and electrolyte disorders, coagulopathy, surgical DRG, increased LOS, and increased ROM. On sub-analysis, subtle differences emerged within the data based on demographic factors and DRG. There was an increased risk of HAPU in African-American patients as compared with Caucasian patients in the medical population based on DRG, as well as a decreased risk of HAPU in females within the medical population based on DRG. There was an increased risk of HAPU development in females within the surgical population based on DRG. At-risk populations can potentially be targeted for additional interventions.

Barriers Encountered/ Limitations

The overall incidence of HAPU is relatively low in the study population as compared with the national average. Data is based on ICD-9 codes, thus is subject to bias in data entry. All data shows only correlation and not causation. While attempt was made to adjust data for known co-morbidities, this might not include all comorbidities that factor into an increased risk of HAPUs.

Conclusions

Disparities in incidence of HAPUs were seen on sub-analysis of demographic and DRG data points, with an increased risk of HAPU in African-American v. Caucasian patients in medical DRGs and in females with surgical DRGS. There was no difference in HAPU incidence in Hispanic v. non- Hispanics, self pay v. insured, or median income based on zip code data. At-risk populations can potentially be targeted for further interventions for HAPU prevention.

Bibliography

Agency for Healthcare Research and Quality, Medicare Patient Safety Monitoring System, 2010-2013; Centers for Disease Control and Prevention, National Healthcare Safety Network, 2010-2013; and Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2010-2011, and 2012 State Inpatient Databases quality analysis file.

2014 National Healthcare Quality Disparities Report. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html

Fogerty MD, Abumrad, NN, Nanney, LN, Arbogast, PG, Poulouse B, Barbul, A. (2008) Risk factors for pressure ulcers in acute care hospitals. *Wound Rep Reg;* 16: 11-18.

Humes KR, Jones NA, Ramirez RR. Overview of race and Hispanic origin: 2010. 2010 Census Briefs. Suitland, MD: U.S. Census Bureau; March 2011. Publication No. C2010BR-02. http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf

National Healthcare Quality and Disparities Report Chartbooks. Patient Safety. April 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.arhq.gov/research/findings/nhqrdr/chartbooks/index.html

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Baylor University Medical Center **Project Tile: Hospital-Acquired Pressure Ulcer: Association with Population Disparities**

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	This project will attempt to identify and mitigate demographic risk factors for development of hospital acquired pressure ulcers in certain populations.
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	Establish executive sponsor, resident team; design project in collaboration with Healthcare Improvement; examine MIDAS database for incidence of HAPU; compare with certain demographic factors, comorbidities; statistical analysis of variables
III.	Team Members & Accountability (list of team members and who is accountable for what)	William L. Sutker, MD – Emeritus Director, Graduate Medical Education, BUMC – design and implementation; Michael Krol, MD, PGY 3 IM resident/John Dale, MD, PGY 3 IM resident – design and implementation; David Nicewander, MS, STEEEP Strategic Analytics – design; Saleema Khan, BA and Mary Lankford, MNA, BSN, RN, Healthcare Improvement Department,

		BUMC – data query from MIDAS/Datavision database; Gerald Ogola, PhD, biostatistics; Cristie Columbus, MD – Director/DIO, Graduate Medical Education, BUMC – poster design and presentation
IV.	Necessary Resources (staff, finances, etc.)	Project manager and director, Healthcare Improvement, BUMC Statistical support, BSWH, Division of STEEEP Analytics Emeritus Director/Director/DIO/resident time
V.	Measurement/Data Collection Plan	HCI to query MIDAS database for incidence of HAPU all inpatients at least 15 years of age for following variables of interest – age, gender, race (African-American v Caucasian), ethnicity (Hispanic v non-Hispanic), insurance status (insured v non-insured), length of stay, mean income by zip code of residence, various comorbidities as defined by ICD-9 coding– obesity, diabetes with complications, paralysis, chronic pulmonary disease, fluid/electrolyte abnormalities, congestive heart failure, coagulopathy
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	Establish executive sponsor (CMO, Baylor Scott & White Health, NTx Division), establish collaboration with Healthcare Improvement/STEEEP Strategic Analytics/Biostatistics; recruit interested resident participants with consent of respective program directors.
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	Selection of data sources, reliability of data sources, resident/PD engagement and protected time for participation, Emeritus Director/Director/DIO time.

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	Submission for poster presentation at AIAMC NI V Spring Meeting 2017; potential manuscript preparation and publication – identification of suitable journals for submission
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	Project design and implementation, including data collection and statistical analysis – AY 15-16 (July 2015-June 2016). Draft project presentation at NIV meeting 10/16. Submission for presentation at AIAMC NI V Spring Meeting 2017.
X.	Success Factors	Teamwork with Healthcare Improvement Department and Division of STEEEP Analytics to mine data and determine potential disparities in the development of pressure ulcers.
XI.	Barriers	The largest barrier encountered was the graduation of the senior internal medicine residents involved with this project and difficulty in recruiting residents to continue with the project.
XII.	Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative would be to engage residents at an earlier level of training.
XIII.	Expectations Versus Results	10 – we were able to systematically analyze a variety of demographic and comorbidity factors that are associated with development of HAPU.

“A-HA!” Advancing Health Advocacy through Resident Education

Arlene Smalls MD[1], Renee Kottenhahn MD[2], Michael Maguire MD, MPH[3]
Loretta Consiglio-Ward MSN, David Paul MD
Christiana Care Health System, Newark-Wilmington, Delaware

Abstract

Christiana Care Health System (CCHS) Residency Program Directors confirmed that there is currently no standardized method of educating trainees on issues of health disparities and limited opportunities for busy residents to interact with the local community.

Our NI-V initiative consists of a multi-tiered educational curriculum (Figure 1) utilizing pre-existing resident group activities to develop experiential and didactic learning opportunities in health equity, cultural sensitivity and social determinants of health.

Background/Vision

Background: Physicians in training are exceptionally positioned to establish a new “culture of medicine” with an appreciation for diversity and the social determinants of health. Effective inter-disciplinary partnerships are necessary to create sustainable, system-based changes that impact the populations we serve. CCHS provides the clinical learning environment for more than 280 residents within 13 residency programs.

Our Vision: Leverage the current educational infrastructure to create a longitudinal, collaborative learning curriculum that addresses topics of diversity and health care disparities and resonates across all medical specialties. We aim to help our learners become competent, mindful and compassionate clinicians that are engaged in their local community (i.e. health advocates) via a curriculum that provides the opportunity for insightful (“A-HA!”) experiences.

Methods

- Utilizing a Poverty Simulation Kit ***(www.povertysimulation.net)*** designed for large scale audiences, the Community Action Poverty Simulation (CAPS) kit, a structured event was integrated into our multi-specialty intern orientation June 23, 2016. The seventy-four resident participants experienced what it might be like to be part of a typical low income family and were tasked to utilize a variety of hospital based and community resources). Representatives of hospital based resources and volunteer community organizations were recruited to participate in the immersion experience. Validated pre- and post-simulation surveys (included in the CAPS kit) were administered just before and after the experience to evaluate any changes in attitudes regarding poverty. This Simulation activity will now be a part of our annual new resident orientation.
- NIV leadership elicited commitment from Program Directors of core residency programs (EM, FM, IM, Med/Peds, OBGYN, Dentistry and Surgery) to substitute a relevant, specialty-specific health equity article into their existent, mandatory journal clubs. “Faculty champions” and resident trainees were enlisted to conduct “dual-purpose” journal clubs to include community resource tools (for practical execution of local patient advocacy) along with the article. (Figure 2)
- A GME-wide “Health Equity - Resident Survey” was developed utilizing validated, published resident surveys, vetted by the Residency Directors and Academic Affairs, and disseminated electronically to all our residency programs. Residents were invited to complete a brief-self assessment about their confidence with engaging patients in conversations about social determinants of health.
- Advocacy efforts led to establishing a formal venue for self-selecting residents to collaborate with a community partner in health advocacy. Residents participants receive mentorship and support as a result of interdepartmental collaboration.
- Visibility/Sustainment: Members explored various opportunities to sustain NIV initiatives and create a Certificate In Diversity and Health Equity, engaging members of the Office of Health Equity and GMEC along with the Value Institute, Virtual Education and Simulation Training (VEST) Center and Residency Programs.

Curriculum Overview

Figure 1. Proposed Curriculum

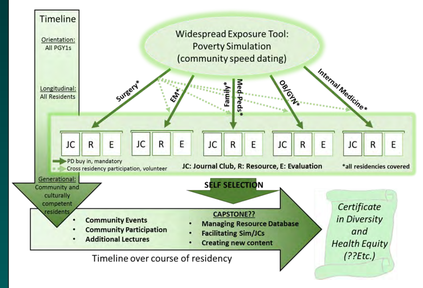


Figure 2. Journal Club Schedule

Health Equity Journal Club Schedule 2016-2017

Department	Department Champion	Resident Team Member	Journal Club Topic	Date and Location
Dental/OMFS	Susan Pugliese		Adult Dental Care access in a Medicaid Population	2/28/17 – 4 PM Wilmington Dental Conference Room
Emergency Medicine	Rob Hsu	Sushant Kapoor	Racial and Ethnic Disparities in Stroke and Treumatic Brain Injury care	4/13/2017 8 AM Christiana Hospital, Room 1100
Family Medicine	Lindsey Ashkenase Jamie Repecciuolo		Infant Mortality and Tobacco Abuse	11/14/2016 Wilmington Hospital
Internal Medicine	Jen Goldstein	Dina Hussam Ania Rodney	Racial Disparities in End of Life care	3/29/2017 – 5:30 PM (Location - TBD)
Med - Pediatrics	David Chen LeRoi Hicks	Mike Maguire	ACA JAMA Article	11/16/2016 5pm Wilmington Hospital
OB-GYN	Arlene Smalls	Marise Gilstrop Michelle Drew	Racial Disparities in Substance Abuse care in Women	3/22/2017 – 6:00 PM Brandywine Counseling Riverfront Site
Surgery	Sandra Medinilla			
Quality & Safety Health Equity Journal Club	Rob Dressler	Mike Maguire	Community Health Topic	5/18/2017 12:00 Noon Christiana Hospital

Updated: 2/19/2107

Results

POVERTY SIMULATION FEEDBACK AND RESULTS.

Poverty Simulation Debrief:

“Week by week, we had to juggle priorities and I definitely have greater empathy for people with very limited resources.”

—Jonathan Hilton, M.D.

There was a significant difference between pre and post survey response* for:

- “People with low income do not have to work as hard because of all the services available to them”, from pre 13.89 % (10/72) to post 4.05% (3/74) in strongly or somewhat reflect what I believe (p-value=0.04).

There were significant differences between pre and post survey response* for:

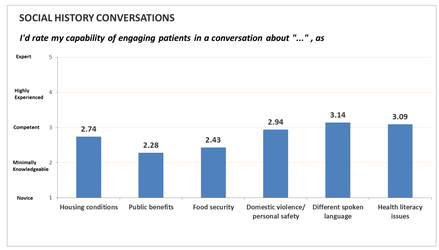
- “People are generally responsible for whether they are poor - they get what they have earned or deserve”, from pre 16.67% (12/72) to post 6.76% (5/74) in strongly or somewhat reflect what I believe (p-value=0.06);
- “People with low income could get ahead/improve their situation if they could just apply themselves differently “, from pre 44.44% (32/72) to post 30.14% (22/73) in strongly or somewhat reflect what I believe (p-value=0.08);
- “People with low income have low self-esteem”, From pre 34.72% (25/72)to post 50.00% (37/74) in strongly or somewhat reflect what I believe (p-value=0.06).

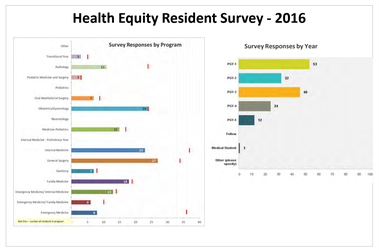
Small Sample size limit result validity

Responses were combined for survey question analysis: Reflect (combination of strong reflect and somewhat reflect) versus Not Reflect (combination of not reflect and “don’t know”).** Very few responses stated “don’t understand”.*

HEALTH EQUITY RESIDENT SURVEY RESULTS.

The survey identified areas for educational opportunities: Residents reported less confidence in their ability to engage patients in conversations about housing conditions, public benefits, food security and domestic violence/public safety. Response rate was high (72%).





Successes

- Poverty Simulation event was extremely well received by the inaugural resident trainee class and deemed the “highlight” of the week long orientation by Academic Affairs. The Simulation will be included within resident orientation longitudinally.
- After publication in CCHS internal magazine, “FOCUS”, the Poverty Simulation received interest across the health system resulting in requests to repeat the exercise with leadership to better integrate health equity into our clinical operations and strategies. CCHS has set aside time for our health systems’ managers and directors (Management Council) to experience the Poverty Simulation in 2017.
- A manuscript describing the Poverty Simulation experience with new residents and interns was accepted for publication within the Journal of Graduate Medical Education (JGME).
- The Health Disparities survey, which was distributed electronically, returned a very high response rate and will allow for longitudinal data collection to assess program impact.
- Journal Clubs began in November 2016, with a total of seven journal clubs anticipated throughout the remaining of the academic year. Seven residency programs have integrated a health equity journal club offering led by a program specific resident and attending champions.
- The long term goal of developing a collaborative community advocacy portion of this project gained unanticipated traction. Experiential learning at a local community center has now been incorporated into an existent, hospital wide QI course for residents and medical students to gain experience with at-risk populations.
- Our team developed a greater appreciation for the variety of advocacy activities and education that currently exist within our health system.

Barriers / Limitations / Lessons Learned

- Team members found it difficult to meet with regularity due to schedule conflicts and the lack of “protected time” for clinical faculty and residents serving in lead positions.
- Lack of an established clerical or administrative assistant was an additional hindrance
- The need to locate funds to support NIV activities, particularly the purchase of Simulation Kit, created additional stressors for team members.
- Hospital partners in project execution had competing priorities which made it difficult to establish their commitment to NI V activities.
- Engagement of faculty champions was difficult unless there was evidence of prior commitment to health advocacy.
- Our team was unable to complete the goal of establishing a systemwide health equity resource repository or wide scale method for publicizing journal clubs and other health equity activity due to time constraints. There is no current commitment to a Certificate.

Conclusions

- The Poverty Simulation is an innovative modality to engage and educate resident learners on the topics of health equity.
- Recognition of the need to recruit Faculty Champions and resident team members who have an identified commitment to health equity and resident education
- The resident surveys, health equity journal club topics and Poverty Simulation event are customizable which allows for targeted learner discussions on health equity topics.
- Data collected from surveying of the entire resident population about their attitudes and knowledge of social determinants of health can be utilized to tailor future journal club topics.
- Our Health Equity educational curriculum that utilizes the Poverty Simulation with specialty specific education has the ability to educate future generations of clinicians.

Bibliography

Missouri Association for Community Action, 2014 William Street, Jefferson City, *MO 65109,* www.povertysimulation.net
Klein M, Beck A, Kahn R, et al. Video curriculum on screening for the social determinants of health. MedEdPORTAL Publications. 2013;9:9575. http://dx.doi.org/10.15766/mep_2374-8265.9575
Wieland ML, Beckman TJ, Cha SS, Beebe TJ, McDonald FS; Underserved Care Curriculum Collaborative. Resident physicians’ ’ knowledge of underserved patients: a multi-institutional survey. *Mayo Clin Proc.* 2010;85(8):728-733.
Cox ED, Koscik RL, Behrmann AT, Young HN, Moreno MA, McIntosh GC, Kokotailo PK, Long Term Outcomes of a Curriculum on Care for the Underserved. *Journal of the National Medical Association*. 2015,107(1):17-25

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Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Christiana Care Health System **Project Title: Advancing Health Advocacy (AH-A), A Health Equity Educational Curriculum**

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	Physicians in training are exceptionally positioned to establish a new "culture of medicine" with an appreciation for diversity and the social determinants of health. Effective inter-disciplinary partnerships are necessary to create sustainable, system-based changes that impact the populations we serve. CCHS provides the clinical learning environment for more than 280 residents within 13 residency programs. Our Vision is to leverage the current educational infrastructure to create a longitudinal, collaborative learning curriculum that addresses topics of diversity and health care disparities and resonates across all medical specialties. We aim to help our learners become competent, mindful and compassionate clinicians that are engaged in their local community (i.e. health advocates) via a curriculum that provides the opportunity for insightful ("A-HA!") experiences.
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	Christiana Care Health System (CCHS) Residency Program Directors confirmed that there is currently no standardized method of educating trainees on issues of health disparities and limited opportunities for busy residents to interact with the local community. Our NI-V initiative consists of a multi-tiered, educational curriculum utilizing pre-existing resident group activities to develop experiential and didactic learning opportunities in health equity, cultural sensitivity and social determinants of health. Project Assumptions: • To integrate a structured poverty simulation event into the CCHS resident orientation. The simulation

		will introduce participants to the concepts of poverty and highlight both hospital based and community resources. • Utilize the Validated Pre and post simulation survey and consider the creation of other measures such as Attitude Toward Poverty Scale, Understanding Others Scale, Critical Thinking Scale or Customized Surveys and Word Mapping. • Repeat collection of the measures longitudinally during residency training (Simulation surveys, Resident Surveys) • Allow for feedback from Residency Program Directors and establish faculty champions to act as Healthy Equity Journal club mentors who work actively with resident team member. • To substitute a relevant, specialty-specific health equity article into the existent, mandatory residency specialty CCHS journal clubs • A key goal was to strengthen and create community partners to allow resident work within our community • Two Long Term Goals were identified: a. Creation of the identified resource tools into an accessible CCHS repository b. Creation of a pathway towards a CCHS Certificate in Diversity and Health Equity based on resident participation and leadership in multiple venues for community and health advocacy Stakeholders: • Resident & Education Faculty from our Residency programs • GME • Residency Directors • Offices of Quality, Safety

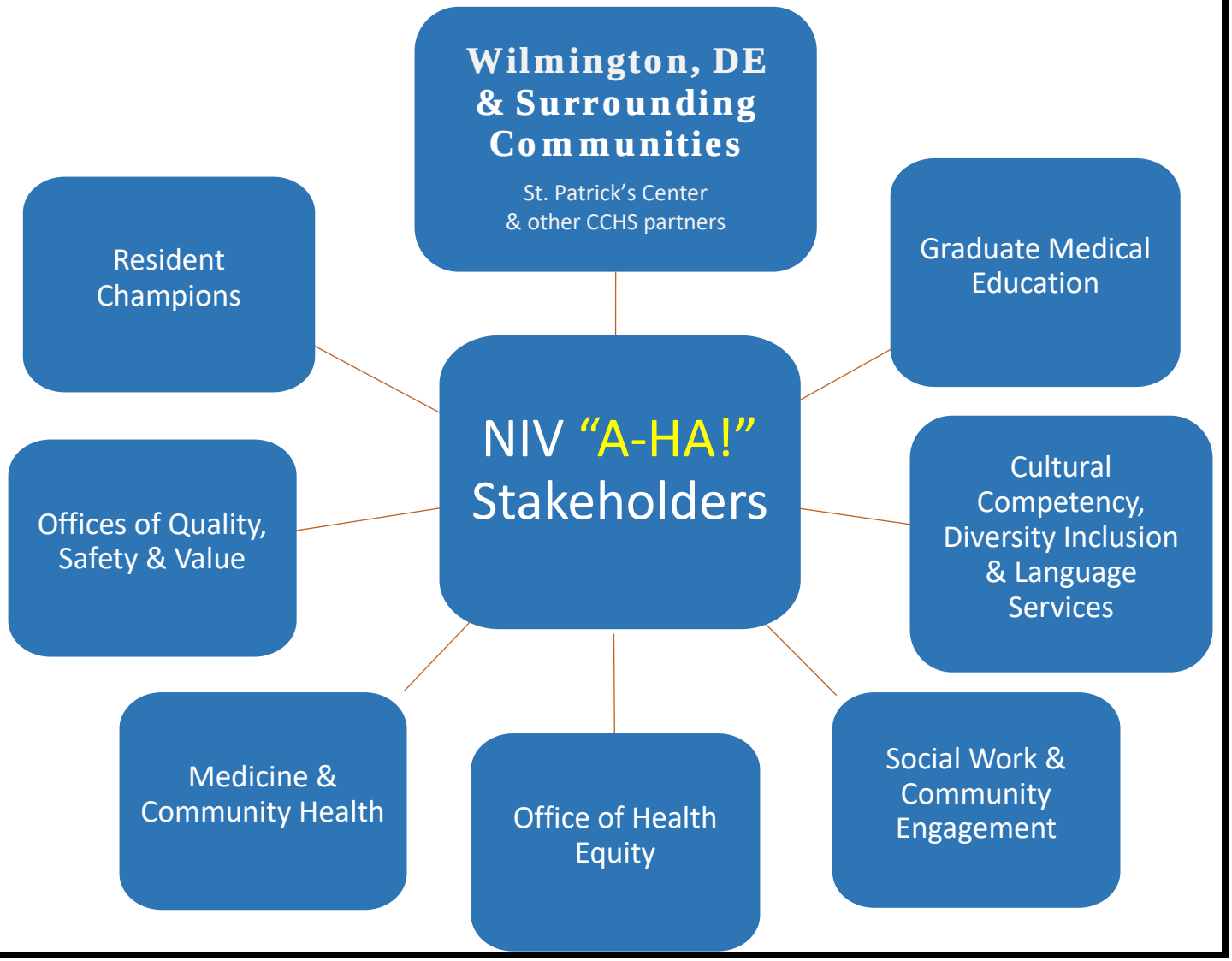
		• The Value Institute • Social Work and Case Management • Office of Health Equity and Cultural Competency, Diversity Inclusion & Language Services • The Vest Center • Poverty Simulation Volunteer Participants (Intra-hospital and Community) listed below • Community Partners: St Patrick Center
III.	Team Members & Accountability (list of team members and who is accountable for what)	**Core Team Members:** Dr. Arlene Smalls, Education Faculty OB/Gyne., Co- Lead Dr. Renee Kottenhahn, Education Faculty Pediatrics, Co-Lead Dr. Mike Maguire, Med Peds Resident, Lead Resident Loretta Consiglio-Ward, RN Safety and Quality Education Specialist, Value Institute

		David Paul, MD, Chairman, Dept. Pediatrics & Head of Maternal Child Svc. Line – Exec. Advisor **Ad hoc Team Members**: Dr. Marisa Gilstrop – OB/Gyne Resident Team Member Dr. Katelyn Fritzges – Med/Peds Resident Team Member Dr. Michelle Drew, PhD, Certified Nurse Midwife Dr. Lisa Maxwell, Associate Chief Learning Officer, Academic Affairs Dr. Neil Jasani, Chief Learning Officer & VP Medical Affairs Dr. LeRoi Hicks, Hugh R. Sharp Chair, Department of Medicine Dr. Robert Dressler, Quality and Safety Officer, Academic and Medical Affairs Dr. Omar A. Khan, Service Line Physician Leader, Primary Care & Community Medicine Kathy A. Cannatelli, Director, Eugene du Pont Preventative Medicine & Rehabilitation Institute & Center for Community Health Linda Brittingham, MS and LSCW Corporate Director Social Work and Care Management **Advisory Team:** Dana Beckton, Director of Diversity and Inclusion Jacqueline Ortiz, MPhil., Director, Cultural Competency and Language Services Timothy D. Rodden, M.Div., MA, BCC, FACHE, Director, Pastoral Services Bettina Riveros, Chief Health Equity Officer **Poverty Simulation:** Dr. Arlene Smalls, CCHS NIV Lead, Organizer Dana Beckton, Director of Diversity and Inclusion – Co-facilitator

		Jacqueline Ortiz, MPhil., Director, Cultural Competency and Language Services – Co-facilitator Dr. Susan Coffey-Zern, MD Director, Simulation Education Dr. Mike Maguire Event Support/Presenter Dr. Renee Kottenhahn Event Support/Survey Loretta Consiglio-Ward, RN Safety & Quality Educ. Specialist, - Community Outreach/Survey Dr. Marisa Gilstrop – OB/Gyne Resident Team Member –Event Support Volunteers from Christiana Care Health System departments: First State School, Language and Interpreter Services, Pastoral Care Department, Public Safety, Social Work Department including Healthy Beginnings, and the Vest Lab. Volunteers from Community Partner Organizations: Beautiful Gate Organization (Bethel AME Church), 5 (Five) Bilingual LEP Community volunteers Hockessin Community Center Inc., Westside Family Healthcare, Wilmington Police Stacey Burrell, Diversity Program Coordinator who assisted with the expedited purchase of the Poverty Simulation kits **Poverty Simulation Publicity** Patrick Ritchie and Jonathon Andrew Hilton, Christiana Care Health System External Affairs – Hospital Publication, “Focus”, event publication and images **Health Equity Survey Creation/Distribution/Evaluation:** Dr. Renee Kottenhahn, Education Faculty, Dept. Pediatrics Loretta Consiglio-Ward, RN Safety and Quality Education Specialist, Value Institute Dr. Mike Maguire, Med Peds Resident, Lead Resident Barbara Henry, Medical Librarian Director, Medical Staff Library Amy Mackley, Research Nurse Supervisor, Department of Neonatology Dr. Zugui Zhang, Lead Biostatician, Value Institute Dr. Lisa Maxwell, Associate Chief Learning Officer, Academic Affairs

		<u>Experiential Learning/Community partnership - St Patrick Center Community Project :</u> Loretta Consiglio-Ward, RN Safety and Quality Education Specialist, Value Institute Carol Moore, Safety & Quality Education Specialist, Value Institute Academy Sister Danielle Gagnon, Executive Director St Patrick's Center Resident Volunteers Social Worker Department, Christiana Care **<u>Manuscript Preparation for Journal of Graduate Medical Education (JGME).</u>** Dr. Mike Maguire, Med Peds Resident, Lead Resident Dr. Renee Kottenhahn, Education Faculty Pediatrics, Co-Lead Loretta Consiglio-Ward, RN Safety and Quality Education Specialist, Value Institute Dr. Robert Dressler, Quality and Safety Officer, Academic and Medical Affairs Dr. Arlene Smalls, Education Faculty OB/Gyne., Co- Lead
IV.	Necessary Resources (staff, finances, etc.)	*Missouri Community Action Poverty Simulation Kit $2000 plus shipping costs (www.povertysimulation.net)* Gift cards for community volunteers participating in the Simulation Event Refreshment budget for Simulation training events for volunteers. Gift Cards for coordinator and resident team with the greatest online survey participation. AIAMC conference travel fees for 2-3 team members
V.	Measurement/Data Collection Plan	Validated pre- and post-simulation surveys included in the Community Action Poverty Simulation kit ***(www.povertysimulation.net)*** were administered just before and after the Simulation Event to evaluate any changes in resident attitudes regarding poverty.

		A GME-wide “Health Equity - Resident Survey” was developed utilizing validated, published resident surveys, vetted by the Residency Directors and Academic Affairs, and disseminated electronically to all our residency programs. Residents were invited to complete a brief-self assessment about their confidence with engaging patients in conversations about social determinants of health. This survey will be conducted yearly by the GME as a part of resident onboarding along with yearly surveys for all established resident trainees. Data analysis will be conducted by the Value Institute to provide longitudinal information regarding deliverables of the N-IV intitiative.

VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	

VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	Core team members of differing specialties were committed to the Project, contributing an array of talents and institutional knowledge. Momentum for NIV activities was, however, impeded by a number of factors: • Team members found it difficult to meet with regularity due to schedule conflicts and the lack of "protected time" for clinical faculty and residents serving in lead positions. • Lack of an established clerical or administrative assistant was an additional hindrance • The need to locate funds to support NIV activities, particularly the purchase of Simulation Kit, created additional stressors for team members. • Hospital partners in project execution had competing priorities which made it difficult to establish their commitment to NI V activities. • Engagement of faculty champions was difficult unless there was evidence of prior commitment to health advocacy. • Our team was unable to complete the goal of establishing a systemwide health equity resource repository or wide scale method for publicizing journal clubs and other health equity activity due to time constraints. There is no current commitment to a Certificate.

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	A manuscript describing the Poverty Simulation was accepted for publication within the Journal of Graduate Medical Education (JGME). The Health Disparities Resident survey, which was distributed electronically, returned a very high response rate and will allow for longitudinal data collection to assess program impact. The data from this survey may be analyzed and publishable at a future date.

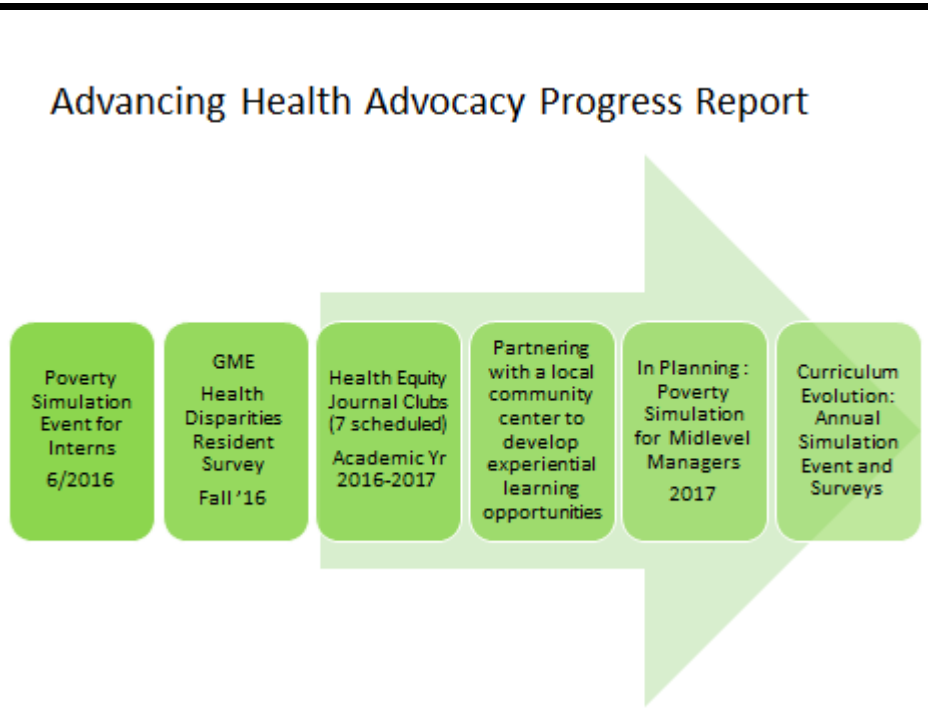
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	Utilizing a Poverty Simulation Kit designed for large scale audiences, the Community Action Poverty Simulation (CAPS) kit *(www.povertysimulation.net)*, a structured event was integrated into our multi-specialty intern orientation June 23, 2016. The seventy-four resident participants experienced what it might be like to be part of a typical low income family and were tasked to utilize a variety of hospital based and community resources). Representatives of hospital based resources and volunteer community organizations were recruited to participate in the immersion experience. Validated pre- and post-simulation surveys (included in the CAPS kit) were administered just before and after the experience to evaluate any changes in attitudes regarding poverty. This Simulation activity will now be a part of our annual new resident orientation. NIV leadership elicited commitment from Program Directors of core residency programs (EM, FM, IM, Med/Peds, OBGYN, Dentistry and Surgery) to substitute a relevant, specialty-specific health equity article into their existent, mandatory journal clubs. “Faculty champions” and resident trainees were enlisted to conduct “dual-purpose” journal clubs to include community resource tools (for practical execution of local patient advocacy) along with the article. A GME-wide “Health Equity - Resident Survey” was developed utilizing validated, published resident surveys, vetted by the Residency Directors and Academic Affairs, and disseminated electronically to all our residency programs. Residents were invited to complete a brief-self assessment about their confidence with engaging patients in conversations about social determinants of health. Advocacy efforts led to establishing a formal venue for self-selecting residents to collaborate with a community partner in health advocacy. Resident participants receive mentorship and support as a result of inter-departmental collaboration.

Visibility/Sustainment: Members explored various opportunities to sustain NIV initiatives and create a Certificate In Diversity and Health Equity, engaging members of the Office of Health Equity and GMEC along with the Value Institute, Virtual Education and Simulation Training (VEST) Center and Residency Programs.

Health Equity Journal Club Schedule 2016-2017

Department	Department Champion	Resident Team Member	Journal Club Topic	Date and Location
Dental/OMFS	Susan Pugliese		Adult Dental Care access in a Medicaid Population	2/28/17 – 4 PM Wilmington Dental Conference Room
Emergency Medicine	Rob Hsu	Sushant Kapoor	Racial and Ethnic Disparities in Stroke and Traumatic Brain Injury care	4/13/2017 8 AM Christiana Hospital, Room 1100
Family Medicine	Lindsay Ashkenase Jamie Rapacciuolo		Infant Mortality and Tobacco Abuse	11/14/2016 Wilmington Hospital
Internal Medicine	Jen Goldstein	Dina Hussam Ania Rodney	Racial Disparities in End of Life care	3/29/2017 – 5:30 PM (Location - TBD)
Med - Pediatrics	David Chen LeRoi Hicks	Mike Maguire	ACA JAMA Article	11/16/2016 5pm Wilmington Hospital
OB-GYN	Arlene Smalls	Marisa Gilstrop Michelle Drew	Racial Disparities in Substance Abuse care in Women	3/22/2017 – 6:00 PM Brandywine Counseling Riverfront Site
Surgery	Sandra Medinilla			
Quality & Safety Health Equity Journal Club	Rob Dressler	Mike Maguire	Community Health Topic	5/18/2017 12:00 Noon Christiana Hospital

Updated: 2/28/2107

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was…..* Poverty Simulation event was extremely well received by the inaugural resident trainee class and deemed the "highlight" of the week long orientation by Academic Affairs. The Simulation will be included within resident orientation longitudinally. After publication in CCHS internal magazine, "FOCUS", the Poverty Simulation received

		interest across the health system resulting in requests to repeat the exercise with leadership to better integrate health equity into our clinical operations and strategies. CCHS has set aside time for our health systems' managers and directors (Management Council) to experience the Poverty Simulation in 2017. Early data analysis suggests that the Poverty Simulation activity did impact resident trainees attitudes and knowledge regarding health equity topics. A manuscript describing the Poverty Simulation experience with new residents and interns was accepted for publication within the Journal of Graduate Medical Education (JGME).
XI.	Barriers	*The largest barrier encountered was…..* Team members found it difficult to meet on any regularity due to schedule conflicts and the lack of "protected time" for clinical faculty and residents serving in lead positions. *We worked to overcome this by…..* *Capitalizing on eachother's commitment with frequent handoff of key tasks between team members. We leveraged each other's strengths and professional network and maintained momentum via early AM and late night phone meetings/email and text communication.*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be…..* • Team members need to understand early the magnitude of time commitment necessary for successful project completion. • Recommend recruiting a diverse and actively engage group of core team members who have an identified, institutional commitment to health equity and resident education early within the project. • Recognize that the Hospital administrative partners who are key in the project

		execution may have competing priorities which make it difficult to establish their commitment to NI V activities.
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* ***8*** *1 2 3 4 5 6 7 8 9 10*

Improving Primary Care Follow Up After Sexual Assault

Tricia Olaes MD, Nancy Murphy MD, Mohamed Khayata MD, Cheryl Goliath PhD, Lily Holderbaum BSN, SANE-A, Nairmeen Haller PhD, Titus Sheers MD, Jennifer Savitski, MD

Abstract

Medical follow up after sexual assault plays a significant role in the physical, mental and emotional healing process. Patients who suffer sexual assault often experience a disparity in follow up health care and treatment of related and subsequent medical and psychiatric conditions. Our prospective cohort study aimed to improve medical follow up after sexual assault by assisting patients in attaining and keeping follow up appointments. All patients ≥ 18yo who had a forensic medical exam with evidence collection during the study period were included in our analysis. Of the 60 patients in the study, 57% agreed to schedule follow up appointments. Out of this group 59% kept their scheduled appointment. The follow up rate for the entire study population, however, remained consistent with previously published data at 30%. Not having access to reliable forms of communication was a significant barrier to ensuring adequate medical follow up after the sexual assault forensic medical examination.

Background

- >320,000 US adults are sexually assaulted yearly[1]
- Sexual Assault Nurse Examiners (SANE):
  - Provide trauma informed care
  - Perform forensic medical examinations and evidence collection
- PCP follow up provides essential care after the initial forensic medical exam:
  - Injury follow up
  - STI testing
  - Medication follow up
  - Referrals, ex. counseling, advocacy
- Historically reported follow up rates are low after a medical forensic exam for sexual assault (31-35%)[2,3]

Vision Statement

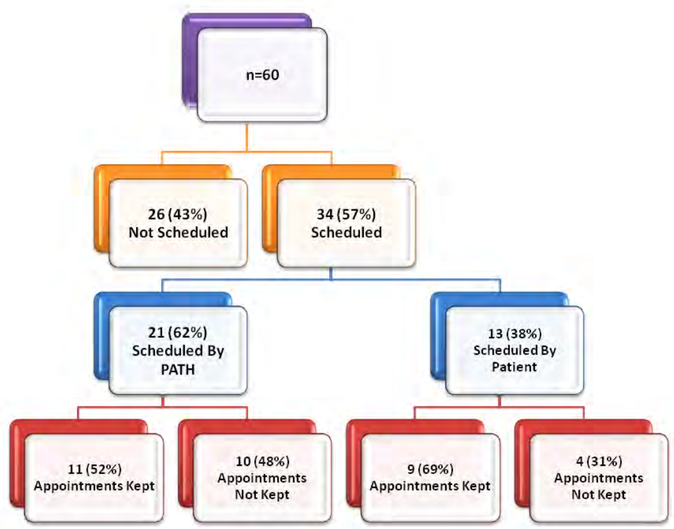
Decrease health care disparities associated with poor medical follow up after sexual assault by implementing a multidisciplinary plan to improve primary care follow up for patients cared for in our Sexual Assault Nurse Examiner Program (PATH Center)

Materials/Methods

- Study period May 1, 2016 - Oct. 31, 2016
- All patients ≥18 years old who underwent a forensic medical exam and evidence collection kit for sexual assault
- Coordination of follow up care offered to all patients
- SANE or Social Worker scheduled follow up appointments for patients who agreed
- Patients with appointments were mailed letters verifying dates, times, and physician locations
- Letters including patient information, suggested follow up testing and patient needs were mailed to the Physician
- Appointment compliance was verified via patient self-report and chart review

Results

- 60 patients included in the study
  - 38 (63%) Medicaid, 16 (27)% uninsured
- 20 of the 34 patients who had appointments scheduled saw their physician for follow up (59%)
- Of the 26 (43%) who were not scheduled appointments:
  - 24 (92%) declined follow up calls and appointment
  - 2 (8%) were homeless without ability to receive calls or get to appointment



Discussion

- Follow up for patients who agreed to be contacted and schedule appointments was higher than what has been historically reported (59% vs. 31-35%)
- 43% either declined follow up or did not have a means of communication/transportation
- Communication and transportation were identified as barriers to following up

Limitations

- Excluded patients who refused evidence collection kits
- Small sample size
- External appointment data relied on patient self-report
- Able to make appointments only during business hours

Conclusions

- Patients who agreed to follow up and scheduled their own appointments had the highest follow up rates
  - The fact that they scheduled their own appointments may indicate their *motivation* to follow up
- Further study needs to identify why patients refuse follow up appointments or calls
  - This data will be difficult to obtain due to the nature of the study population presenting after an acute sexual assault
- Resources to assist patients with communication and transportation needs may improve follow up

Bibliography

1. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, National Crime Victimization Survey, 2010-2014 (2015).
2. Holmes MM, Resnick HS, Frampton D. Follow-up of sexual assault victims. AM J Obstet Gynecol. 1998 Aug; 179 (2): 336-42.
3. Ackerman D. R., Sugar N. F., Fine D. N., Eckert L. O. Sexual assault victims: Factors associated with follow-up care. *American Journal of Obstetrics and Gynecology* 2006. 194(6), 1653–1659.

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Cleveland Clinic Akron General **Project Tile:** Improving Primary Care Follow Up After Sexual Assault

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	Decrease health care disparities associated with poor medical follow up after sexual assault by implementing a multidisciplinary plan to improve primary care follow up for patients cared for in our Sexual Assault Nurse Examiner Program (PATH Center)
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	• Medical follow up after sexual assault plays a significant role in the physical, mental and emotional healing process. Patients who suffer sexual assault often experience a disparity in follow up health care and treatment of related and subsequent medical and psychiatric conditions. • Develop Intervention Plan: - Bridge communication gap between acute and follow-up - Caregiver education curriculum • Project Requirements include protected time, patient database, staffing, and use of EHR systems • Project Assumptions: - Involve a small sample size due to expected loss to follow-up • Stakeholders include patients (improved care), caregivers (education), and community (support mechanism for this patient population) • Necessary Resources

		- Increased staffing as program grows and funding for this non-revenue generating program • Measures of Success: - 25% increase over reported national average 2-week follow-up rate in this population - Tracked ordering and completion of laboratory testing prior to 2-week follow-up visit - 100% scheduling of 2-week follow-up visit
III.	Team Members & Accountability (list of team members and who is accountable for what)	Cheryl Goliath, PhD – Oversee administration of project Lily Holderbaum RN, SANE-A – Collect data after sexual assault exam. Aftercare form discussed with patient prior to discharge. Assist with making follow-up appointments. Tricia Olaes, MD – Review records to see if patient followed up, provide follow up care Brooke Murphy, MD – Review records to see if patient followed up, provide follow up care Mohamed Khyata, MD – Review records to see if patient followed up, provide follow up care Jennifer Savitski, MD – Provide education to caregivers regarding follow up needs of patients Nairmeen Haller, PhD – Provide research support for project Titus Sheers, MD – Provide time for caregiver education, oversee administration of project
IV.	Necessary Resources (staff, finances, etc.)	Sexual Assault Nurse Examiners Social Worker
V.	Measurement/Data Collection Plan	Lily Holderbaum will collect and maintain data. Drs. Olaes, Murphy and Khyata will analyze data with assistance of Drs. Haller and Savitski

VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members& senior management, both internal & external)	• SANE nurses and social workers will be educated on the project/process • Residents will be educated on the project and components of the follow up exams • Private physicians will receive summary of referrals and recommendations for follow up exams
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	• Patient participation • Time taken away from other duties

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	• Residents can develop manuscript and presentation • Will use this study in Magnet update report
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which	• Resident education session • Regular check ins with team members • Regular review of data being collected

	will be presented at Meeting One)	

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	• Improve follow up rates by 25% as compared to what has been historically reported (31-35%)
XI.	Barriers	• The largest barrier encountered was inability to communication with patient after the initial encounter - Many patients refused follow up communication - Some patients were homeless without communication means • The next largest barrier was lack of transportation for the follow up appointments • We were not able to access the health records for all of the patients since some of them received follow up care outside our health system
XII.	Lessons Learned	• Be prepared to experience unanticipated results - We were surprised by the number of people who were homeless or without means to communicate and without transportation - This made us more aware of more fundamental lack of resources in our study population
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* 6 – We were able to improve follow up rates for a segment of our population. More importantly, we were able to identify further needs in our population that will help us to continue to address their health care disparities.

HEALTH DISPARITIES EDUCATIONAL INITIATIVE FOR RESIDENTS AT CRITTENTON HOSPITAL MEDICAL CENTER

Markova T, Benson B, Kumar S, Klamo R, Mateo M, Ha M, Takis L, Delpup A, Stansfield RB

Crittenton Hospital/Wayne State University. Rochester, Michigan

Overall Goals

- Enhancing resident awareness of the health disparities that exist in the hospital community
- Engagement of residents and increased resident knowledge about health needs in the community prioritized by the CHNA
- Improving population health in the hospital community

Background

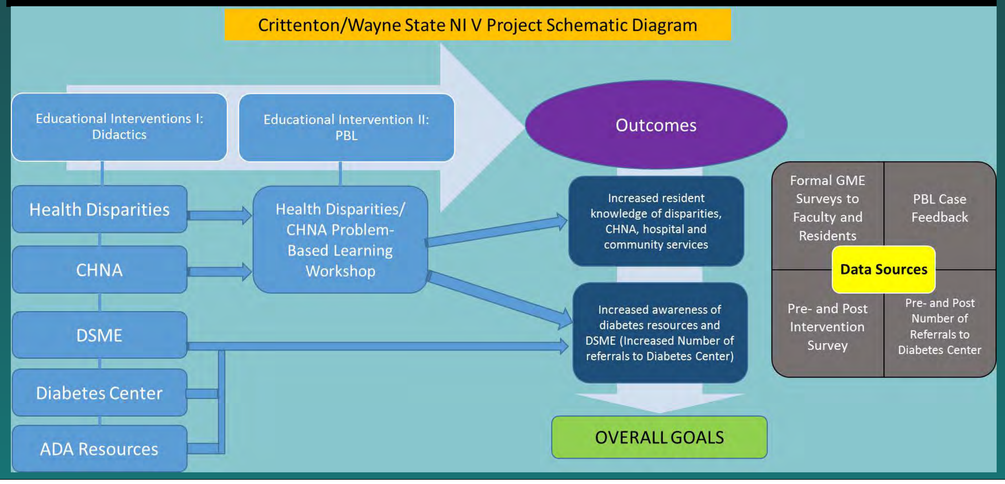
- Crittenton conducts a CHNA every three years as required by federal law.[1] The FY2016 CHNA identified three main priorities:[2]
  - Obesity/Overweight/ Nutrition/**Diabetes**
  - Mental Health
  - Access to Care.
- Collaborative partnerships are effective in achieving community-wide behavior change and improving population-level outcomes.[3]
- Curricula that increase resident knowledge about health disparities is an effective strategy for improving understanding about health disparities.[4-5]
- Diabetes self-management and education is a critical element of care for people with diabetes and improves patient outcomes.[6]
- Crittenton and WSU designed a health disparities educational curriculum to increase resident awareness of heath disparities and the hospital's CHNA/current priority areas, address disparities in diabetes care and increase referrals for DSME.
- The Family Medicine, Internal Medicine and Transitional Year Residency Programs committed to faculty and resident participation.

Vision Statement

Providing resident education in health disparities, the CHNA and DSME will:

- Increase resident awareness of health disparities, particularly diabetes care disparities present in the local community
- Result in an increasing number of appointments for DSME
- Improve resident understanding of the CHNA and its priorities.

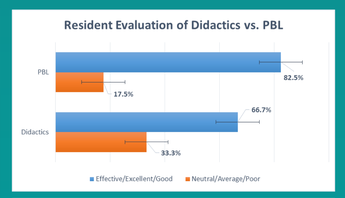
Materials/Methods

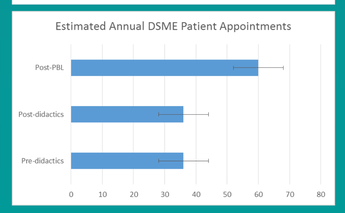


- **GME Survey**: Residents are surveyed annually by the GME Office on health disparities, social determinants of health, and their familiarity with their hospital's CHNA. Two years of survey results were used to examine resident knowledge and awareness of these topics.
- **Educational Intervention I**: Residency program directors, hospital personnel, GME Office leadership, and an American Diabetes Association representative designed four didactic sessions covering health disparities, CHNA, services provided by the hospital's Diabetes Center/DSME and resources available through the local chapter of the ADA.
  - Pre- and post- didactics session surveys were administered to residents regarding knowledge of health disparities, CHNA and diabetes resources including DSME.
- **Educational Intervention II**: A problem-based learning case was developed and conducted on health disparities, CHNA, and DSME. Residents completed evaluations of the PBL activity.
- **DSME Appointments Data**: Data was collected on the number of patient appointments for DSME for periods before the didactics, following the didactics and following the PBL case.
- **Statistical tests**: t-Test (two sample assuming equal variances) was computed to examine differences in pre- and post-didactic resident knowledge and use of DSME and in comparing the educational effectiveness of the didactics sessions and the PBL session.

Results

- **GME Survey/baseline data**: Over 90 percent of residents accurately defined "health disparities" over two years (2015/2016), although there was a slight decrease in 2016. The percentage of residents who know how to access CHNA slightly increased in 2016.
- **Pre- vs post-didactics survey results**: No significant differences found in diabetes practice patterns or knowledge about DSME. Low response rate to post-didactics survey limits ability to make statistical inferences.
- **Effectiveness of didactics compared to PBL**:
  PBL has a higher mean but not at a statistically significant level.
  PBL mean = 3.83; didactics mean = 3.78. p=0.4.
- **DSME referrals**: Pre- and post-didactics data show no effect on DSME appointments for patients referred by residents and program faculty. Following the PBL, the rate of DSME appointments nearly doubled.





Success Factors and Lessons Learned

Successes:

- **Raising resident awareness of health disparities** and identifying community resources to improve the health of an underserved population.
- Residents were involved in every aspect of **PBL case** development and delivery. A resident was instrumental in development of the case and nine residents served as preceptors during the session.
- **Increasing referrals for DSME** by residents and faculty

Sustainability

- **Resident Health Disparities Task Force** formed.

Barriers Encountered/Limitations

- Residents are required to complete many surveys; using data from existing surveys and developing other forms of data collection was required.
- Resident engagement and transition from attaining knowledge to change in behavior.
- Many residents did not understand that each didactic session was an interrelated component of the overarching initiative on health disparities.
- Patient barriers to completing DSME extend beyond physician/resident knowledge of DSME and referral frequency. Time, transportation, cost/lack of insurance and other barriers can prevent patients from following through with DSME.

Conclusions

- Residents arrive at their programs with a good understanding of health disparities, although they may not recognize the disparities that exist in the hospital community in which they practice.
- Lectures are ineffective in enhancing understanding of community programs/priorities and for applying knowledge.
- Problem-based learning is an effective instructional method for teaching and learning about local health disparities, CHNAs and DSME.

Bibliography

1. U. S. Department of the Treasury. Internal Revenue Service. New requirements for 501®(3) Hospitals Under the Affordable Care Act. Available at: https://www.irs.gov/charities-non-profits/charitable-organizations/new-requirements-for-501c3-hospitals-under-the-affordable-care-act

2. Crittenton Hospital Medical Center Community Health Needs Assessment. Available at: http://www.crittenton.com/public/uploads/2016/06/2016-Community-Health-Needs-Assessment.pdf

3. Roussos ST and Fawcett SB. A Review of Collaborative Partnerships as a Strategy for Improving Community Health. Annual Reviews of Public Health 2000; 21: 369-402.

4. Smith WR, Betancourt JR, Wynia, MK, et al. Recommendations for Teaching about Racial and Ethnic Disparities in Health and Health Care. Annals of Internal Medicine 2007;147(9): 654-665.

5. Cene CW, Peek, ME, Jacobs, E, et al. Community-based Teaching about Health Disparities: Combining Education, Scholarship and Community Service. Journal of General Internal Medicine 2010; 25(S2): 130-135.

6. Funnell MM, Brown TL, Childs BP, et al. National Standards for Diabetes Self-Management Education. Diabetes Care 2009; 32: S87-S94.

7. Jamal U, Hoover C, Wong C, Azzam A. Preventing obesity in patients through community health prevention programs. MedEdPORTAL Publications. 2014;10:9687. http://doi.org/10.15766/mep_2374-8265.9687

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Crittenton Hospital Medical Center **Project Tile:** Health Disparities Educational Initiative for Residents at Crittenton

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*This project builds on residents' existing knowledge of health disparities, meaningfully rectifies gaps in resident education about the Community Health Needs Assessment and diabetes disparities/services and triggers resident-driven community interventions and educational initiatives that ultimately help to reduce healthcare disparities.*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	*The objective of our National Initiative V project is to raise resident awareness of healthcare disparities in the community in a sustainable way through meaningful participation in educational initiatives, community health and quality improvement projects. We began with a baseline assessment of resident knowledge about health disparities, the hospital's Community Health Needs Assessment, and diabetes treatment and services. We developed educational interventions including a Problem-Based Learning case focused on the hospital's Community Health Needs Assessment and diabetes disparities. The primary objectives of this project are education on how disparities manifest in the hospital community, and how hospital and community resources can be used to address disparities.*
III.	Team Members & Accountability (list of team members and who is accountable for what)	*Dr. Markova provides oversight of the entire project and facilitates how project components can be carried out in an effective manner to ensure all objectives are met.* *Brian Benson coordinates the projects in the initiative, works with residents in developing and delivering the problem-based learning case, participates in data collection and analysis, is liaison to all partners in the initiative, designated participant for Call Group webinars and*

		teleconferences, and drafts/completes all project documentation requirements. *Dr. Minhchau Ha (Family Medicine resident) took a lead role in PBL case development.* *The WSU GME Director of Education developed and delivered the baseline data gathering and the diabetes educational intervention, and participated in data analysis.* *Internal Medicine, Family Medicine and Transitional Year residents and faculty participate in project activities. Selected faculty and residents have integral roles in developing and delivering the educational interventions and participate in drafting publications related to the initiative.* *Angela DelPup is the director of Community Health for the hospital. She provided education on the purpose of the Community Needs Assessment, what it is, how to access it, and how the hospital and residents can respond to needs in the community. She also participated in the problem-based learning case.* *Lisa Takis provides oversight of quality and process improvement aspects that can impact the project. She is also a liaison for various contacts within the hospital.* *Megan Ahee has a vast working knowledge of current diabetes resources that are available in the community. She provided resident education on resources as well as assisted in compiling a list of resources for sustaining the effects of the diabetes educational intervention.*
IV.	Necessary Resources (staff, finances, etc.)	*This initiative required a partnership among the hospital, residency programs and the GME Office. Resources were required to develop surveys of resident knowledge of healthcare disparities nationally and locally, diabetes disparities, the Community Health Needs Assessment, and knowledge and utilization of all resources available. The educational interventions consisted of didactic sessions and a problem-based learning case which needed to be developed. Residents are forming a Health Disparities Task Force for sustainment of health disparities activities/education; necessary resources to support this activity are presently undetermined. The collaboration is strong. The hospital, community, and residency programs have demonstrated their commitment throughout the project.*
V.	Measurement/Data Collection Plan	*Data collected:* *2015-16 and 2016-17 GME Annual Resident survey data related to social determinants of health, health disparities and Community Health Needs Assessment.*

		Pre and post-intervention survey data from didactic educational interventions. *Pre and post-intervention referrals to the hospital's Diabetes Center for DSME.* *Problem-Based Learning case evaluation.* *Data analysis summary:* *The survey data shows that residents have a very good understanding of the social determinants of health and healthcare disparities. Residents reported that the problem-based learning case was a good educational experience and improved understanding of how to access the CHNA and its usefulness. The didactic sessions had no effect on patient appointments for DSME; appointments for DSME increased following the problem-based learning case.*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	*Initial discussions of NI V began with the program directors who immediately wanted to be involved and sought out resident participation. GME representatives, interested residents, hospital quality and hospital IT met to identify disparities in the community served by the hospital, particularly among patients with diabetes. Hospital quality, community health, GME, and residents participated in meetings to discuss needs. Ultimately, the need for a comprehensive set of tools to mitigate disparities was identified. All partners continue to be active participants in the project, and project goals and objectives will be sustained as participants remain engaged in health disparities initiatives through the GME CLER Council.*
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	*Organizing and structuring project components that will translate into meaningful and measurable reduction in health disparities/improvement in health outcomes in the community are the greatest challenge. Incentivizing residents to complete surveys was a challenge, so we used survey data from our required GME surveys in addition to pre- and post- educational intervention web-based surveys. Discussions with faculty and residents as well as survey data suggested limited awareness of the healthcare disparities that are present in the community served by the hospital and how to rectify them.*

VIII.	Opportunities for Scholarly Activity (potential publications, conference	*Potential publications and conference presentations include reporting/publishing the educational intervention outcomes in a peer-reviewed journal; a poster presentation at the NI*

	presentations, etc.)	*V meeting in April 2017 and additional opportunities for conference presentations/poster presentations will be investigated. The problem-based learning case will be submitted for publication on MedEd Portal.*
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*Resident surveys (GME Annual Surveys, project specific surveys).* *Phase I educational interventions and evaluations for FM, IM, and TY residents in Spring 2016.* *Phase II educational intervention (PBL Case) and evaluation for residents in January 2017.* *Patient appointments at Diabetes Center referred by IM, FM, and TY residents and faculty (pre-Educational Intervention I, post-Educational Intervention I, post-Educational Intervention II).* *Resident participation in community health projects and project sustainment activities.*

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was the involvement of the residents in the problem-based learning case and the sustainment of the initiative through the GME CLER Council and the Resident Task Force on Health Disparities. A resident suggested using problem-based learning to bridge the gap in knowledge and use of the Community Health Needs Assessment; another resident assisted in development of the case; and nine residents served as small group preceptors for the case. We plan to use the case (or a modified version of it) at our new resident orientation to highlight the Community Health Needs Assessment and the health disparities in the local community that are likely to be encountered by incoming residents in our programs.* *We were inspired by the enthusiasm the case generated amongst the residents and the opportunities for using problem-based learning for other topics.*

XI.	Barriers	*The largest barrier encountered was getting a sufficient number of responses to voluntary surveys. We worked to overcome this by using results from existing surveys and adding project related questions to a mandatory survey. Another barrier was related to the continuity of the project due to changes in personnel.*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be to get resident buy-in and keep them involved in the planning and execution of project activities. Also, it is a good idea to continuously think about and plan for scale, spread, replication and sustainment of the initiative during all phases of the project, including at the outset.*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish? Our team accomplished our major goals and have developed a plan for sustainment and spread. Barriers were overcome through alternative strategies and getting input from residents. Interweaving the goals and objectives of the initiative with other GME and hospital projects/initiatives was not as extensive as expected, but it was effective when it occurred.* *1 2 3 4 5 6 7 8 9 10*

The Road to Understanding and Eliminating Health Disparities: *The Florida Hospital Journey*

Authors: Victor Herrera, MD, Joseph Portoghese,MD, Alric Simmonds,MD,
Florida Hospital, Orlando, Florida

Overall Goal

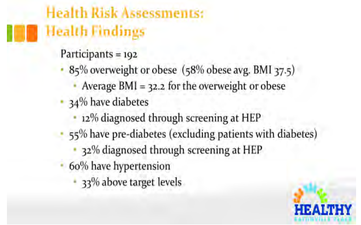
The primary goal of our project was to conduct an assessment at our organization to characterize the different institutional efforts, activities and quality improvement initiatives that had as a primary outcome the study and/or elimination of health disparities. We were also interested in understanding the current leadership structures that influence the decision making process related to addressing health disparities and how those interact with the efforts that primarily focus on community based projects. In this poster we present a successful project completed by our organization that highlights common opportunities and challenges encountered by teams when trying to implement similar initiatives.

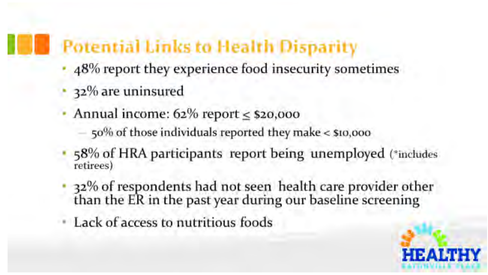
Background

In 2011, a community health study revealed a prevalence of diabetes in Eatonville Florida of 24 % (three times the national rate), which represents twice the national prevalence for African Americans, who comprise most of Eatonville's population. As a result, Healthy Central Florida –a group created by Florida Hospital and the Winter Park Health Foundation worked with Eatonville leaders and residents to support the creation of 'Healthy Eatonville Place' a diabetes education and research center built in the heart of Eatonville. The objective was to achieve early diagnosis of diabetes , support to those with the disease , and work on prevention. The facility offers numerous classes – with a focus on promoting topics such as exercise, nutrition, and diabetes counseling .

Materials/Methods/Results

Florida Hospital and the Winter Park Health Foundation created a partnership in collaboration with Eatonville leaders and residents to support the creation of the diabetes education and research center. The first step was the completion of a health risk assessment study to try to further characterize individual risk factors and characteristics of the Eatonville Community.





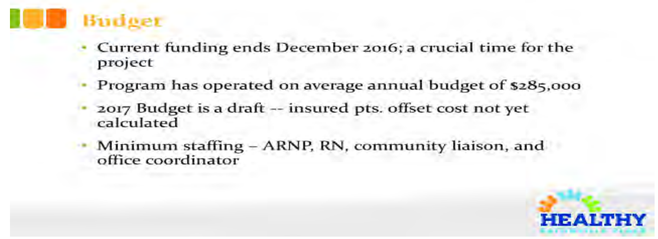
Eatonville Health Care Utilization

Florida Hospital Participants (pre-enrollment) = 31
Florida Hospital Participants (post-enrollment) = 27

	Pre	Post	Variance	% Change
Total ED Visits	86	66	20	23.26%
Number of admissions from ED	16	16	0	0.00%
Rate of admissions from ED visits	18.6%	24.24%	-5.64%	
Number of OP discharges from ED visits	70	50	20	28.57%
Average # of ED visits per participant	2.77	2.44	0.33	11.89%
Average # of ED Admissions per participant	0.52	0.59	(0.08)	-14.81%

	Cases	CM/Case[3]	Total	EBDIT/Case[4]	Total
Change in # of Admissions from ED visits	0	(929)	0	(2,752)	0
Change in # of discharges from ED visits	20	1	(27)	(103)	2,067
Total Estimated Savings Impact			(27)		2,067

Barriers Encountered/Limitations-



Conclusions

This project developed by Florida Hospital and the Winter Park Health Foundation demonstrated the positive impact of a community based diabetes education program that resulted on Improve Access to Health Care Services, Enhanced the Health of the community and advanced health care knowledge. The biggest challenges had to do with how to overcome barriers that prevent full engagement of the community and considerations related to the long term sustainability of the program.

Next Steps

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Florida Hospital **Project Tile: Characterization of Efforts to Study and Eliminate Health Disparities: The Florida Hospital Journey**

I.	Vision Statement	*A community where every patient receives equitable and high-quality care.*	
II.	Team Objectives	*The main objective of our project was to perform an assessment of current and past efforts by our organization to characterize and mitigate health disparities, including efforts related to formal evaluations of the specific health care needs of the communities that we serve. Our ultimate goal was to use our participation on NIV to learn where our institution is in our Journey to eliminate disparities, with the intent of identifying and increasing awareness around challenges and opportunities related to this effort.*	
III.	Team Members & Accountability	*Victor Herrera, MD*	*Director of Research and QI for GME*
		Joseph Portoghese,MD	*Chief Academic Officer, DIO*
		Alric Simmonds, MD	*Medical Staff Leader, Surgery Faculty*

IV.	Measurement/Data Collection Plan	*Data collected included reports created by the organization related to formal community needs assessments that had been performed during the last 5 years. Informal and Formal interviews with clinical and non-clinical stakeholders to determine current institutional plan and ongoing activities to understand and addressed health disparities. For specific projects, background, objectives, scope and results/impact if data was available. Describe any existing leadership structures at the organization dedicated to working on areas related to studying and eliminating health disparities.*
V.	Stakeholder Communication Plan and Relationship Building with Community	*Dr Portoghese is Chief Academic Officer, DIO and Faculty of the Surgery Residency program. Dr.Herrera is Director of Research for Graduate Medical Education and Faculty of the Internal Medicine Residency. Dr.Simmonds is Faculty of the Surgery Residency Program, Chairman of the Surgery Division and Chairman of the Florida Hospital Health Disparities Committee. Both Dr.Portoghese and Dr.Herrera are members of the committee.*
VII.	Potential Challenges	*Challenges related to demonstrating a return on investment for projects and initiatives focused on eliminating health disparities. Limited engagement. Misinformation related to the meaning and impact of health care disparities. Competing demands and time constraints.*

VIII.	Opportunities for Scholarly Activity	*Specific projects sponsored by our organization (ie. Healthy Eatonville Place Project) offer an opportunity to share lessons learned, experiences and results of interventions in the form of*

		potential peer-reviewed publications, conference presentations, etc.
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*See NI V Roadmap to 2017*

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

~~X~~.	Success Factors	*The most successful part of our work was to increase awareness at our institution on the importance of developing a plan to study health disparities in the communities that we serve that is aligned with the organization's strategic priorities.*
XI.	Barriers	*Limited engagement and support when working on areas related to studying and addressing health disparities. Time constraints and competing demands. Lack of knowledge related to factors that influence and determine health disparities.*

XII.	Main Lesson Learned	*In order to be successful you need strong support and commitment from clinical and non-clinical leaders and key stakeholders in your organization.*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5* **6** ***7*** *8 9 10*

80% by 2018? Accelerating Colorectal Cancer (CRC) Screening in NY and PA

Victor O. Kolade, Shilpa Pedapati, John Pamula
Guthrie Robert Packer Hospital (RPH), Sayre PA 18840

Abstract

Background – Our hospital/heath system is situated amidst counties with low rates of CRC screening. In 2016, Guthrie joined the 80% by 2018 initiative of the National Colorectal Cancer Roundtable
Objective – To meet the American Cancer Society target of 80% CRC screening of average-risk persons aged 50-75 years by 2018
Methods Summary – Data on CRC screening in an internal medicine clinic was obtained prior to detailing of resident providers and direct calls to patients by a resident investigator.
Results Summary – The pre-intervention screening rate was 67.6% in 2016. Of 99 patients targeted for intervention, 10 elected to have colonoscopy, 11 chose to have fecal occult blood testing, and 18 wanted to discuss CRC screening with their primary care providers (PCP)
Conclusion – It is feasible to increase CRC screening rates in internal medicine residency clinics.

Background

Rural areas are a hotbed for health disparities, as well as a venue where gaps in care are very likely to result in poor outcomes. Rural dwellers are known to have lower rates of colorectal cancer (CRC) screening than their urban counterparts. Increasing screening rates is projected to save several lives nationwide.

The Sayre Internal Medicine (IM) clinic hosts about 17000 visits a year from patients from at least six surrounding rural counties in New York (Tioga, Chemung, Broome) and Pennsylvania (Bradford. About a fifth of these visits are to residents in their first, second or third years of training. The affiliated gastroenterology department reported a 53% site screening rate in 2015, up from a previous 35%.. Prior to this project, the CRC screening rate among patients in the Sayre IM clinic who see residents was not known. Is the rate already at the 80% desired by organizations affiliated with the National Colorectal Cancer Roundtable (NCCR), including RPH? If the rate is lower than 80%, can it be increased to target?

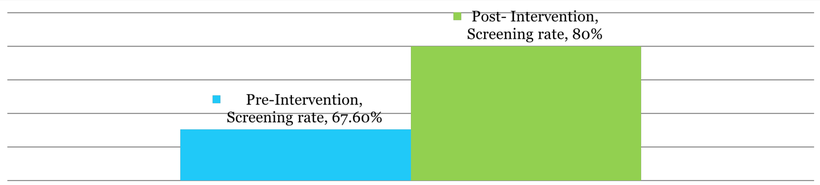
Vision Statement

Vision: To create positive measurable change in our local communities
Mission: To create and implement a unique and sustainable approach to a local health disparity in order to move toward fulfillment of a national health objective.

Materials/Methods

- Project Requirements – Provider recommendation of screening and documentation of completion
- Project Assumptions – All Bradford County PA residents use Guthrie Robert Packer Hospital (the sole hospital in this county) for medical /primary care (per 2015 Medicare data, 90% of enrollees in the same zip code as RPH use this hospital for inpatient care)
- Stakeholders – Gastroenterologists, Primary care providers – including residents, Cancer Center, GME leadership, Senior Quality Director
- Community Engagement - The Guthrie Cancer Center hosted a CRC Community Health Day on the RPH campus in August 2016
- Necessary Resources – Data mining support from EMR/Epic team, involvement of the Senior Quality Director
- Outcome Measure– Screening rates obtained via EMR
- The chief investigator (SP) obtained information on screening rates among patients of IM residents from March to August 2016. She sent reminders for scheduled patients and called those who were not scheduled in September and October 2016
- Data handling – the pre-intervention rate was calculated as persons who had completed appropriate CRC screening divided by total number of patients aged 50-75. The post-intervention rate includes persons who undertook screening as noted above, as well as those who took any of these actions towards screening:
  - Commit to colonoscopy, with order placed in EPIC;
  - Commit to fecal occult blood test
  - Elect to discuss screening with his/her primary care provider (PCP)

Results



Success Factors and Lessons Learned (Discussion)

A fifth of patients at average risk for CRC committed to having screening done after direct contact/discussion of the issue. Although colonoscopy is typically the commonest form of screening performed, as many patients in this study as planned colonoscopy chose fecal occult testing. Nearly another fifth expressed willingness to discuss screening with their primary care providers. This suggests that patients rely on their PCPs to help them navigate screening for colorectal and perhaps other cancers. Providing protected office time for the purpose of having telephone screening discussions with patients may be a good way to improve CRC screening rates.

Barriers Encountered/Limitations

A. Barriers/Limitations affecting this project:

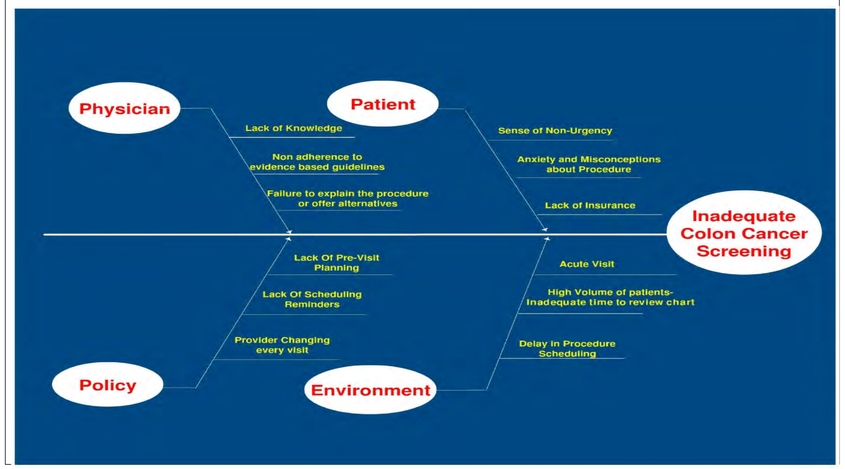
I. Leadership Transitions in Graduate Medical Education

II. Changes in Team Composition

III. Relative Inexperience of Team Members in Prosecuting a Project with Impact on the Community

IV. Time Constraints affecting team member commitment to, and activity on, the project

B. Barriers affecting CRC screening in the IM residency clinic:



Conclusions

It is possible to increase CRC screening rates in internal medicine resident clinics via direct approach of patients by a resident in the practice. If the improvement seen so far is confirmed, spread and sustained, our region will achieve the national goal of 80% screening by 2018, thus eliminating a disparity and saving lives.

Bibliography

•Centers for Disease Control and Prevention. Vital signs: colorectal cancer screening, incidence, and mortality --- United States, 2002--2010. *MMWR Morb Mortal Wkly Rep.* 2011;60(26):884-889.
•Cole AM, Jackson JE, Doescher M. Urban-rural disparities in colorectal cancer screening: cross-sectional analysis of 1998-2005 data from the Centers for Disease Control's Behavioral Risk Factor Surveillance Study. Cancer Med. 2012;1(3):350-356.
•Meester RG, Doubeni CA, Zauber AG, et al. Public health impact of achieving 80% colorectal cancer screening rates in the United States by 2018. Cancer. 2015;121(13):2281-2285.
•American Hospital Directory (2016). Guthrie Robert Packer Hospital. Retrieved on 2/28/17 from: https://www.ahd.com/free_profile/390079/Guthrie_Robert_Packer_Hospital/Sayre/Pennsylvania/

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Guthrie Robert Packer Hospital **Project Title: 80% by 2018? Accelerating Colorectal Cancer (CRC) Screening in NY and PA**

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*Vision: To create positive measurable change in our local communities* *Mission: To create and implement a unique and sustainable approach to a local health disparity in order to move toward fulfillment of a national health objective.*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	• *Project Requirements – Provider recommendation of CRC screening and documentation of completion* • *Project Assumptions – All Bradford County PA residents use Guthrie Robert Packer Hospital (the sole hospital in this county) for medical /primary care (per 2015 Medicare data, 90% of enrollees in the same zip code as RPH use this hospital for inpatient care)*
III.	Team Members & Accountability (list of team members and who is accountable for what)	Victor Kolade, MD, team leader

		Shilpa Pedapati, MD – resident and chief investigator John Pamula, MD – faculty overseer of resident QI/Systems-based Practice activities Marcelle Meseeha, MD – former chief resident/hospitalist; adviser Laura Fitzgerald, MPH – senior director of medical education; administrative link Sheela Prabhu, MD – section chief in Internal Medicine; study facilitator Rita Urbanek – Senior Director of Quality; data provision and advocacy for spread Prior members – Dwight Stapleton, MD – former department of Medicine chair; Ahmad Lone, MD, resident and attendee at Meeting One
IV.	Necessary Resources (staff, finances, etc.)	• *Data mining support from EMR/Epic team, involvement of Senior Quality Director* • *Administration support for spread/sustainment*
V.	Measurement/Data Collection Plan	• *Outcome Measure– Screening rates obtained via EMR*

VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	• *Community Engagement: The Guthrie Cancer Center hosted a CRC Community Health Day on the RPH campus in August 2016* • *Stakeholders – Gastroenterologists, Primary care providers – including residents, Cancer Center, GME leadership, Senior Quality Director*
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	*GME Leadership Transitions* *Changes in Team Composition* *Relative Inexperience of Team Members in Prosecuting a Project with Impact on the Community* *Time Constraints affecting team members*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Poster presentation at the Guthrie Primary Care Symposium, 3/25/17* *Potential manuscript*

IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*Direct patient intervention was done in September-October 2016.*

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was ... direct outreach to patients* *We were inspired by ... the enthusiasm of team members as they joined the team*
XI.	Barriers	*The largest barrier encountered was ... Team attrition* *We worked to overcome this by ... Networking with like-minded individuals and admitting/re-admitting to the team as needed*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be ...* *Offer opportunities for participation to residents at all levels, knowing some may graduate or disengage*

XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *6 – had hoped to expand to the Family Medicine resident clinic* *1 2 3 4 5 6 7 8 9 10*

A Panel Discussion by Community Members Is an Effective Strategy to Increase Residents' Knowledge of Cultural Competency

David Kountz, MD, Kristi Kosarin, DO, Ashleigh Clair, DO, Cecilia Phong, MD, Neel Patel, MD, Laura Frank, Darryl Hughes, Yen Hong Kuo, PhD, Asa Dewan
Jersey Shore University Medical Center – Hackensack Meridian Health, Neptune, NJ
NI V Story Board

Overall Goal/Abstract

We will demonstrate that a panel discussion format is effective at increasing resident knowledge regarding cultural competency.

During resident orientation all incoming residents will observe a panel discussion led by community members to better understand the needs of the communities that they serve and become more culturally competent as measured by a pre and post-panel test.

Key stakeholders in the project include the HMH Offices of Community Outreach and Diversity and Inclusion and the JSUMC Office of Academic Affairs.

Background

Inequity in health and healthcare are critical issues that will not likely be solved without adequate physician knowledge about underserved populations. The ACGME and medical schools have begun to address this by expecting competency in systems-based practice which embraces the greater systems issues that influence health inequities.

In our residency programs – and we suspect in many others – there is no baseline knowledge of issues affecting the communities residents serve. Previous studies have emphasized the importance of working with key stakeholders and experts to develop effective curricula and obtain needs assessments.

Vision Statement

Utilizing a panel discussion format to teach we will introduce incoming residents to issues impacting the communities that they will serve during their residency.

Findings from the pre- and post-panel survey will inform and influence systems-based presentations for residents for the remainder of the academic year.

Year-to-year improvement in resident knowledge regarding how best to serve residents from these communities will be tracked through surveys.

Materials/Methods

Through discussion with representatives of our Offices of Cultural Diversity and Community Outreach and Engagement, as well as review of the literature and our health system's most recent community needs assessment we modeled a survey to assess resident knowledge of four underserved groups in our community: African Americans; Latinos; LGBTQ; and Orthodox Jews. A multiple choice survey was developed and resident members of the team took the survey and recommended modifications in question clarity and length.

Local IRB approval was obtained and all incoming residents to our institution in June 2016 attended the panel discussion as part of orientation. All residents (N=46) were encouraged to take the pre- and post-panel survey. Forty three signed consent but one survey was blank and four were missing the post-panel survey results, leaving thirty eight were available for analysis.

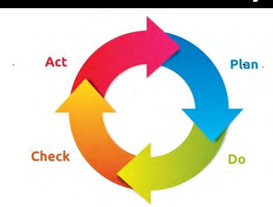
Barriers Encountered/Limitations

- From a time/logistical standpoint representatives from only four (4) groups could be accommodated. Next year we will plan to hold more than one panel session.
- Five of the 43 residents didn't turn in post-session surveys.
- Single site data may not be generalizable to other residency programs and issues in their communities

Figure/Picture that Portrays the Project

Hold panel discussion
Pre/post- panel results and data analysis

Pilot questionnaire with resident team members; organize panel



Develop vision and mission

Determine educational methodology; obtain IRB approval

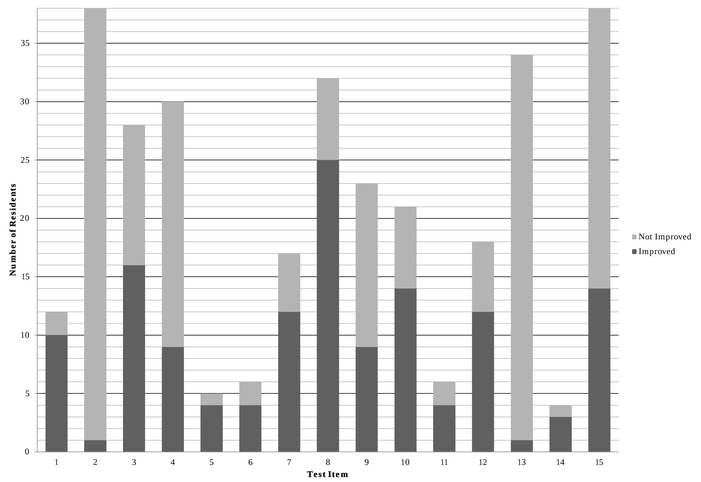
Success Factors and Lessons Learned

- Engagement of community members in resident education
- Residents learned about our Community Health Assessment
- Panel discussion format well-received by residents (compared to standard lecture); session was the most highly rated during orientation

Results

Overall Change in Resident Knowledge Pre- and Post-Panel Discussion

	Pre-Panel Test	Post-Panel Test	Difference	Statistical Test	P-value
Mean (SD)	49.6 (14.3)	69.4 (15.9)	19.8	Paired T-test	<0.001



- Resident knowledge was greatest (highest pre-test scores) regarding questions pertaining to knowledge of customs and issues involving African Americans and Latinos and poorest regarding cultural competency pertaining to LGBTQ and Orthodox Jews

Conclusions

- Use of a community member panel is an effective method to teach residents about cultural competency
- Panelists, more effectively that administrators or faculty, provide clinical pearls to improve patient interactions in addition to medical knowledge
- Results of pre- and post-survey findings can guide resident education for the system based practice ACGME competency

Bibliography

Mayo Clin Proc 2010;85(8):728-733;JAMA 2005;294(5):1058-1067; Med Care 2005;43(4):356-373;J Gen Intern Med 2008 2008;23(7):1028-1032; Acad Med 2004;79(12):1184-1191; J Natl Med Assoc 2006;98(5):687-689.

The authors would like to thank panelists Melissa Harker, MSN, RN, Daliah Spencer, MSN, RN, Julienne MontalvoMojica, MSW, LSW, and Miriam Lax for their support of this project

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Jersey Shore University Medical Center Project Title: A Panel Discussion by Community Members Will Increase Knowledge Resident of Cultural Competency

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	We will demonstrate that a panel discussion format is effective at increasing resident knowledge regarding cultural competency.
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	During resident orientation all incoming residents will observe a panel discussion of community members to understand the needs of the communities that they serve and become more culturally competent as measured by a pre and post-panel test. Key stakeholders include incoming residents and residency programs; the Meridian Health (MH) Office of Community Outreach; and the MH Office of Cultural Diversity
III.	Team Members & Accountability (list of team members and who is accountable for what)	Laura Frank, Director, Community Outreach and Engagement (providing and interpreting MH community health needs assessment) Darryl Hughes, Manager, Office of Cultural Diversity (identifying potential panelists from the community) Navneet Kathuria, MD, Vice President, Population Health David Arnold, IT Population Health Office Manager Kristi Kosarin, DO , Resident Member Ashleigh Clair, DO, Resident Member Cecilia Phong, MD, Resident Member Neel Patel, MD, Resident Member Providing resources to create the survey Providing feedback on survey prior to go-live

<table>
<tr><td>IV.</td><td>Necessary Resources
(staff, finances, etc.)</td><td>Active participation as panelists from representatives from the following groups at or affiliated with Meridian:
1. Guest relations at JSUMC (patient liaison for orthodox Jewish patients)
2. Representative from Pride and Allies, MH LGBT resource group
3. Representative from Partners in Care, MH African-American resource group
4. Representative from UNIDOS, MH Latino resource group</td></tr>
<tr><td>1.</td><td>Measurement/Data Collection Plan</td><td>
Data Collection Plan
<table>
<tr><th>Task</th><th>Source(s)</th><th>Steps to Accomplish</th><th>Schedule</th></tr>
<tr><td>1) Review Plan with Team;
2) Conduct literature search on resident knowledge of underserved populations</td><td>NI V Team;

Pubmed (Wieland ML et al, Mayo Clinic Proceedings, 2010)</td><td>1. Set up meeting
2. Review CLER report
3. Conduct resident interviews
4. Pilot potential questions for survey based on Weiland article and findings of local needs assessment</td><td>Q4 2015
Q1 2016</td></tr>
<tr><td>Engage Departments of Cultural Diversity and Community Outreach to Identify Key Community Groups</td><td>MH Community Health Needs Assessment</td><td>1. Review Needs Assessment
2. Interview key team members
3. Develop contacts within target community groups</td><td>Q1 2016
Q2 2016</td></tr>
<tr><td>Schedule Community Health Panel During Resident Orientation; Develop Survey; Obtain IRB Approval</td><td>Literature Review</td><td>1. Pilot survey with resident team members
2. Plan panel for orientation</td><td>Q3 2016</td></tr>
</table>
</td></tr>
</table>

		Conduct Panel and Analyze Results | *Data Collection* | 1. *Obtain IRB Approval* 2. *Conduct panel presentation* 3. *Analyze results* | *Q3 2016 Q4 2016 Q1 2017*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	*Communications Plan*

Communications Plan

Communication Type	*Objective*	*Medium*	*Frequency*	*Audience*	*Owner*	*Deliverable*
Kickoff Meeting	*Review Project Objectives*	*Face to Face*	*Once*	*Project Team*	*Project Leader*	*Agenda; Meeting Minutes*
Project Team Meetings	*Review Status of Project*	*Face to Face*	*As needed; Q8 weeks and at NI V meetings*	*Project Team*	*Project Leader*	*Agenda; Meeting Minutes*
GME Update	*Review Status of Project*	*Face to Face*	*Bi-annually*	*GME Committee*	*Project Leader or Team Member*	*Meeting Minutes*
Outreach to Community Member panelists	*Engage participation on the panel; describe objectives*	*Email invitation and telephone confirmation*	*As needed*	*Community group representatives; Cultural Diversity and Community Outreach*	*Project Leader*	*Panel Discussion*

VII.	Potential Challenges (engagement, budget, time,	1. *Engagement of potential panelists* 2. *Willingness of residents to participate in research study*

	skills gaps, etc)	3. *Obtaining IRB approval in advance of the scheduled panel session*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	1. *Use of community panel as a teaching strategy for cultural competence has not been systematically studied. This may represent a new contribution to the medical literature with a publication/presentation. However, the database of residents is small (46) and questions relatively few (15) so findings may not be statistically significant. This may be a barrier that we can overcome as this is a single-site pilot study.*
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	

Timeline	*Q3 2015*	*Q4 2015*	*Q1 2016*	*Q2 2016*	*Q3 2016*	*Q4 2016*	*Q1 2017*
Develop project plan	*XXXX*	*XXXX*					
Add Community Panel to Orientation Schedule			*XXXX*				
Draft Survey				*XXXX*			
Identify Panelists				*XXXX*			
Distribute Survey and Conduct Panel				*XXXX*			
Analyze and Write Up Study Results					*XXXX*	*XXXX*	*XXXX*

X.	Success Factors	*The most successful part of our work was…..the engagement of the residents with community members* *We were inspired by…..how community members spoke with pride about their cultures and were enthusiastic about the prospect of residents better understanding the needs of their communities*
XI.	Barriers	*The largest barrier encountered was…..identifying community members willing to sit in front of 40 residents for 90 minutes!* *We worked to overcome this by…..working with our Offices of Community Outreach and Diversity & Inclusion to identify panelists; also having the project PI meet with them in advance of the panel session*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be…..piloting the pre- and post-panel discussion survey with residents*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5 6 7 8* ***9*** *10*

Equitable Care Educational Strategy

Julie Cole, MPP[1], Allison Rengel[1], Miguel Ruiz, MD[2]

[1]HealthPartners Institute, Minneapolis, MN, [2]Regions Hospital, St. Paul, MN

Overall Goal

Align graduate medical education with HealthPartners' equitable care and community engagement priorities by:

- Developing an institutional equitable care educational strategy
- Incorporating residents into the equitable care work of HealthPartners and Regions Hospital.

Background

The HealthPartners organization is a health plan and a health system comprised of several hospitals and clinics in the Twin Cities area. Equitable care has long been a priority of the organization, but most work has been done through individual departments, training programs or individual entities within the larger organization.

In 2015, leadership from Regions Hospital, a HealthPartners hospital, participated in the Disparities Leadership Program. Their work focused on creating an equitable care infrastructure at the hospital, with a goal of reducing healthcare disparities. As a result, the Regions Equitable Care Committee was formed. This committee meets monthly to continue work on identifying and reducing disparities. Members of this group also participate in the health system's larger group, the Equitable Care Sponsors Group.

NI V provided the perfect opportunity to create an equitable care educational strategy that aligned with equitable care work of these committees.

Vision Statement

Residents are champions of change in reducing healthcare disparities

Materials

To align GME with HealthPartners' equitable care priorities, we partnered with leadership from the Regions Hospital Equitable Care Committee and the HealthPartners Equitable Care Sponsors Group, using their four main strategy areas to guide our work.

HealthPartners' Equitable Care Strategy

Results

Regions Hospital Equitable Care Video

- Video describing the Regions Hospital patient population and HealthPartners' equitable care priorities.
- To be shown at New Resident Orientation and potentially at all other trainee orientations.

HealthPartners Institute Equitable Care Graduate Education Toolkit

- Website of equitable care resources for educators
- The toolkit is grouped by the HealthPartners equitable care priority areas and is organized in a manner that guides the user's progression through each strategy area.

Success Factors and Lessons Learned

- Our biggest success is that the end product not only reflected the priorities of the organization, but was also co-created with representatives from across the organization. As a result, these tools may now be used for other purposes across the organization.
- Our biggest lesson learned was that it is worth taking the time to make sure our deliverable met our needs and was inclusive of all across our health system. We didn't accomplish everything we set out to in the beginning, but we needed to take the time to do this foundational work first.

Barriers Encountered/Limitations

Increased health system involvement changed our project scope

- The focus of our initial work changed, which caused re-work and lengthened our project timelines. The result, however, is a higher quality end product.

Resident participation in NI V process waned over time.

- As patient care activities take priority, residents were often unavailable to meet during standard work hours.
- A majority of our trainees are from affiliate institutions and only rotate in our hospital one month at a time. Maintaining momentum was difficult as the residents' rotations switched to other training sites.

Conclusions

- Both the equitable care video and toolkit will help give our residents and program directors a solid foundation in understanding healthcare disparities and how to identify and reduce them.
- Future work involves identifying resident champions to lead from within their programs and working with the health system to further their community engagement priorities.

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: HealthPartners Institute **Project Tile:** Equitable Care Educational Strategy

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*Residents are champions of change in reducing healthcare disparities.*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	*Align graduate medical education with HealthPartners' equitable care and community engagement priorities to improve health and reduce healthcare disparities.*
III.	Team Members & Accountability (list of team members and who is accountable for what)	*Miguel Ruiz – Regions Hospital Chief of Staff (co-lead)* *Julie Cole – GME Accreditation Manager (co-lead)* *Allison Rengel – Program Associate, Office of Health Professional Education* *Kelly Frisch – Chief of Clinical Learning* *Felix Ankel – DIO, VP and Exec. Dir. of Health Professional Education* *Jennifer Bennett – Resident, Emergency Medicine* *Andrew Nelson – VP and Exec. Dir. Of Research for the HealthPartners Institute* *Barb Banks – HealthPartners Diversity and Inclusion Consultant* *Demeka Campbell – Regions Hospitalist, Equitable Care Committee Member*

		Bjorn Westgard – EM Physician, Equitable Care Committee Member *Jen Augustson – Exec. Dir. Of Operations, HealthPartners Institute* *Kamalini Das – Site Director, OB-Gyn Residency* *Christine Bloom – Program Director, Clinical Quality Education* *Sidney VanDyke – Director, Health Equity and Language Access* *Brett Hendel-Paterson – Hospitalist, Global Health Faculty Member* *Matt Goers – Resident, Internal Medicine (Global Health Chief Resident)* *Pat Walker – Med Director, Travel and Tropical Medicine Center* *Bill Stauffer – Medicine Residency Global Health Course Director* *Mike Westerhaus – Clinic Chief, Center for International Medicine, Co-Director, SocMed* *Cecily Spencer – Office of Health Professional Education Development Manager* *Willie Braziel – GME Operations Manager* *Ryan Fabrizius – Internal Medicine Global Health Chief Resident* *Amy Stoesz – Emergency Medicine International Health Fellow* *Alice Lehman – Resident, Medicine-Pediatrics*
IV.	Necessary Resources (staff, finances, etc.)	*Staff: Video team: Vineeta Sawkar, Zandra Johnson* *Finances: Conference fees*
V.	Measurement/Data Collection Plan	*NA*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	*<u>HealthPartners health system</u>: Provided regular updates to the Regions Hospital Equitable Care Committee and the HealthPartners Equitable Care Sponsors Group meetings. Both committees have final review of our toolkit and video. Information about our progress was also shared in various HealthPartners Institute newsletters.*

		Program Directors/Educators: Provided regular updates and opportunities for feedback at monthly GMEC meetings.
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	*Time: Physician Faculty and residents are often in patient care activities/rotations during meeting times.* *Location: Meeting is problematic when participants are scattered around the twin cities.* *Program Director "capacity": Our resources, while helpful, may be seen by busy Program Directors as "one more thing" on their plate.*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*The experience/process of aligning our project with the organization's work to establish and finalize their equitable care strategy.*
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*Phase I: Develop an equitable care education strategy that increases disparities awareness among residents/fellows:* *1) Create an equitable care video that introduces the patient population and describes our equitable care priorities. To be shown at New Resident Orientation* *2) Create Equitable Care Toolkit for Program Directors/Educators* *Phase II: Integrate residents/fellows into existing equitable care priorities* *1) Re-introduce residents to the HealthPartners Equitable Care Champions group & increase resident membership on Regions Hospital Equitable Care Committee.* *2) Align resident work with upcoming Regions Hospital Community Engagement strategies (to be determined)*

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was….a deliverable that is truly aligned with our hospital's priorities and that will lay a solid foundation for our continued equitable care work.* *We were inspired by….the interest throughout the larger health system in this project. Many are seeing uses for our toolkit in their areas.*
XI.	Barriers	*The largest barrier encountered was….that increased interest by the health system also changed our project scope and the content of our video. The content veered a little from the original intent of the residents in order to meet the organization's goals.* *We worked to overcome this by….finding other ways to incorporate the resident's perspective in the toolkit.*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be…..to take the time you need to do it right. The time we took to build connections across our organization and learn about what the organization is working on makes us hopeful that this effort will be sustained.*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5 6 7 8 9 10*

Utilization of Community Resources to Address Food Insecurity in a FQHC

Javier Zayas-Bazan, MD; Sue Sadecki, MS, Ed; Cynthia Kegowicz, MD; Ann Garcia, MD; May Mar, DO; Tricia Kruger, MD
HonorHealth, Scottsdale, AZ

Overall Goal/Abstract

The Community Health Needs Assessment for HonorHealth Osborn identified food insecurity as a significant health disparity within our community. Overall, 15.9% of all Maricopa County households are food insecure, including 25.4% of Maricopa County children. With this in mind, we set out the following goals:

(1) Identify the prevalence of food insecurity at our practice site

(2) Initiate a triage/referral system to link patients with food resources

(3) Coordinate the distribution of food boxes

Background

The USDA defines **food insecurity** as "a state in which consistent access to adequate food is limited by a lack of money and other resources at times during the year." It affects ~14% of US households, including over **617,000 residents (15.9%) in Maricopa County, Arizona**.
Children are especially vulnerable with approximately 15 million children (21.4%) affected nationally and **450,000 (28%) within Arizona**. Maricopa County, AZ ranks 6th in the nation in the number of food insecure individuals and child food insecurity.
Desert Mission (DM) program (est. 1927) began under John C. Lincoln (JCL) Health Network to help underserved families meet their health and social needs. With the newly merged HonorHealth (Scottsdale Healthcare and JCL), DM expanded its services into a new geographic area. **We used a 2-question screening tool to identify those with food insecurity at Heuser Family Medicine Center.** Patients meeting criteria were offered services, including emergency food supplies, and a risk assessment to better define their overall social needs.

Vision Statement

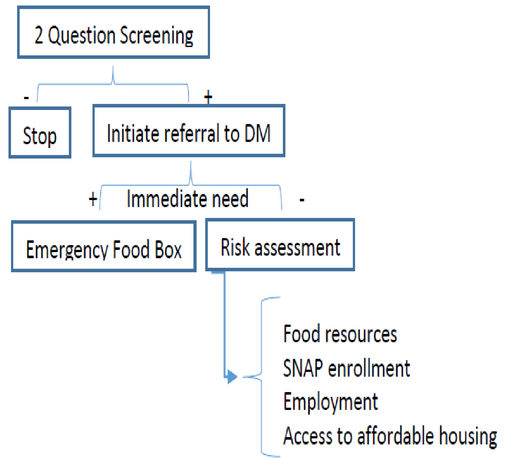
To have a diverse community outreach program that will reduce food insecurity while being a model that others can emulate.

Materials/Methods

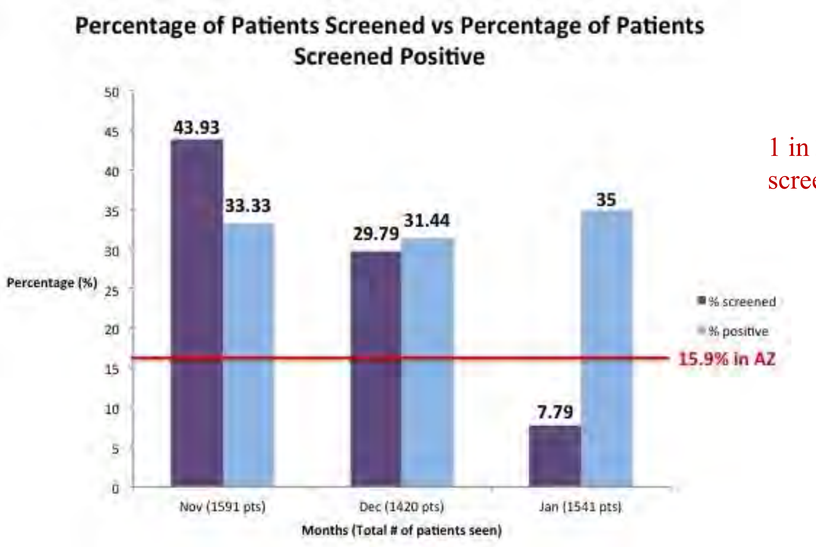
1. **Within the past 12 months, we worried whether our food would run out before we got money to buy more. This was true:**
"often" "sometimes" "never"

2. **Within the past 12 months the food we bought just didn't last and we didn't have money to get more. This was true:**
"often" "sometimes" "never"

97% Sensitivity; 83% specificity



Results



1 in 3 patients screened positive

Bibliography

USDA Report Shows That Food Insecurity Remains High; More Than 50 Million Americans Face The Reality of Hunger. (n.d.). Retrieved February 20, 2017, from http://www.feedingamerica.org/hunger-in-america/

Community Commons. Retrieved February 20, 2017, from http://www.communitycommons.org/chna

Hager, ER., Quigg, AM., Black, MM, et al (n.d.). Development and Validity of a 2-istem screen to identify families at risk for food insecurity. Retrieved February 20, 2017, from http://www.ncbi.nlm.nih.gov/pubmed/2059543

Success Factors and Lessons Learned

Successes:
- Implementation of a 2-question screening tool
  - Fast and easy to use
  - Easily replicated
- Utilization of community resources
  - Many agencies with programs already in place that are eager to partner with providers

Lessons Learned:
- Best practice recommendations did not translate into a successful screening program
  - Recommended to 'screen every patient at every visit' but patients declined such frequent screening
  - Screening now occurs every 6 months
- De-identified forms maintained patient confidentiality but could not be easily tracked without EHR integration
  - Partnered with IT to develop easy to find food security screening dates and data within EHR

Barriers/Limitations

Technological infrastructure:
- Working with IT further integrate food insecurity screening into EHR.
- Working with IT to streamline referral process to allow patients screening positive to be referred for food resources

Geographic Separation –
- DM food bank is located ~ 14 miles from our clinical site.
- Investigating options to overcome distance (food delivery, transportation to and from site, refrigerated food trucks to act as mobile distribution centers, etc.)
- Long term solution is to establish a permanent distribution site in the form of a second food bank.

Conclusions

Implementation of a 2-question screening tool is a rapid, easily reproducible way to identify a previously unseen portion of our patient population that is food insecure. Partnering with community food banks and utilizing their resources can help this vulnerable population address this health inequity. Future efforts targeting EHR integration will make it easier to follow these patients and improve screening efficiency

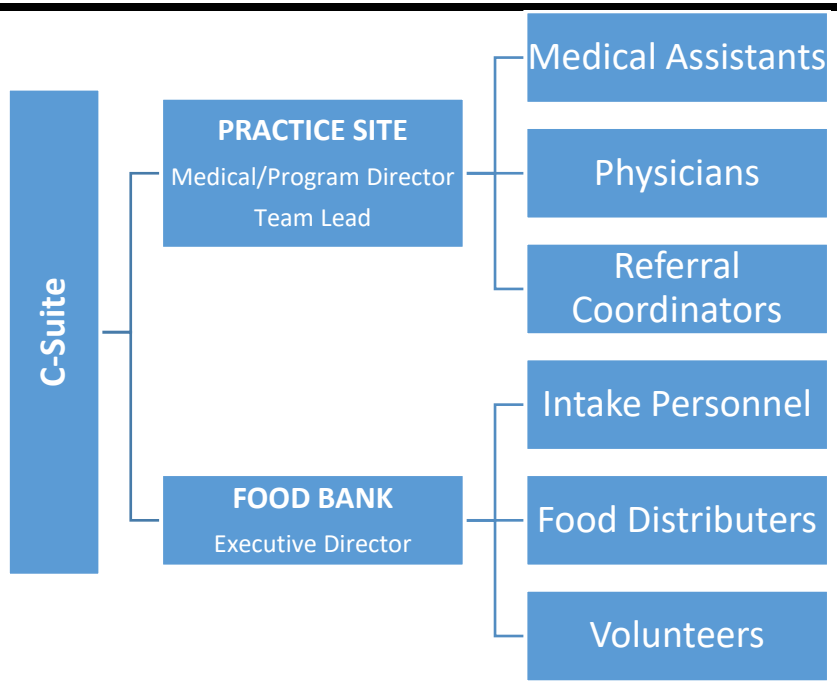
Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: HonorHealth **Project Title: Utilization of Community Resources to Address Food Insecurity in a FQHC**

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*To have a diverse community outreach program that will reduce food insecurity while being a model that others can emulate.*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	**Team objectives:** *(1) Identify the prevalence of food insecurity at our practice site* *(2) Initiate a triage/referral system to link patients with food resources* *(3) Coordinate the distribution of food boxes* **Project assumptions:** *(1) Our patient population lives in Desert Mission Food Bank serviceable zip codes* *(2) Patients can read and understand the 2 question food insecurity screening tool* *(3) Patients can be contacted and have the means to obtain the food boxes* **Measures of Success:** *(1) Implementation of a food insecurity screening program with a screening rate >40%.* *(2) Identification and referral of patients identified as food insecure*
III.	Team Members & Accountability (list of team members and who is accountable for what)	**J. Zayas-Bazan, MD –** *Team lead. Creates and oversees project* **A. Garcia, MD –** *Resident physician; assists with project implementation and data gathering* **M. Mar, DO –** *Resident physician; assists with project implementation and organization* **T. Kruger, MD –** *Resident physician; assists with project implementation and organization*

		S. Sadecki, MS, Ed – *Executive Director, Desert Mission; assists with project design, implementation and coordination of care when patients are referred for food resources after a positive screen* **C. Kegowicz, MD –** *Program Director, Family Medicine Residency Program; assists with project design, implementation, and oversight* **A. Prestanski, MPH –** *assists with data gathering and authored the Community Health Needs Assessment*
IV.	Necessary Resources	**Necessary Resources:** **Food resources** – *required to directly meet patient need* **Distribution site** – *relative location(s) to house and distribute food resources* **Workforce** - *Screening site needs physicians and staff that can administer and interpret the screening tool and subsequently generate a referral. The food distribution site needs personnel that can evaluate the food resource needs and assist with the food distribution and data gathering.*
V.	Measurement/Data Collection Plan	**Short term goals:** *(1) Identify food insecure patients and initiate a referral to Desert Mission Food Bank* *(2) Develop a referral tracking system to help coordinate the patient's needs* *(3) Distribute food resources to patients who are identified as food insecure* **Long term goals:** *(1) Build a permanent food distribution facility to support our practice population* *(2) Integrate food bank data into the institution's EHR* **Data and Measurement**: *A data analyst provides reports at scheduled intervals which will include the number of patients seen, the number of patients screened for food insecurity, the number of patients referred to the Food Bank, and the number of patients who are obtaining food resources.*

VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc.)	**Technologic infrastructure** - *Engaging the IT department to address the integration of Food Bank referrals and the food insecurity screening tool into the current EHR. This is in its final stages and is expected to go live soon.* **Geographic Separation** – *The DM Food Bank is located ~ 14 miles from the practice site. There is discussion regarding developing outreach plans to assist patients with obtaining the food resources or delivering it to their homes. The use of refrigerated food trucks as mobile distribution sites is also being investigated.* **IRB Submission** – *Our institution's IRB declined inclusion of this project as an IRB exempt program; it would require each participant to sign a consent form prior to receiving the screen. This requirement would have resulted in an unsurmountable design challenge. The decision*

		was made to move forward with this as a quality improvement project rather than as a formal IRB approved project. **Engagement –** *We experienced high provider engagement and screening rates during the first 6 weeks of implementation. Screening rates and provider engagement declined in the subsequent month. Patient complaints regarding redundant screening played a significant role in provider and patient engagement. We are increasing efforts to incorporate screening data into our EHR to improve screening efficiency.* **Communications barriers –** *(1) The screening tool is available in both English and Spanish; however, it does not accommodate other languages. (2)The screening form is written at a 4th grade level so patients of lower literacy may be unable to complete the form. (3) Food Bank Intake personnel are unable to make contact with some patients that have screened positive due to the lack of accurate or functioning contact information (e.g. telephone number or mailing address).*

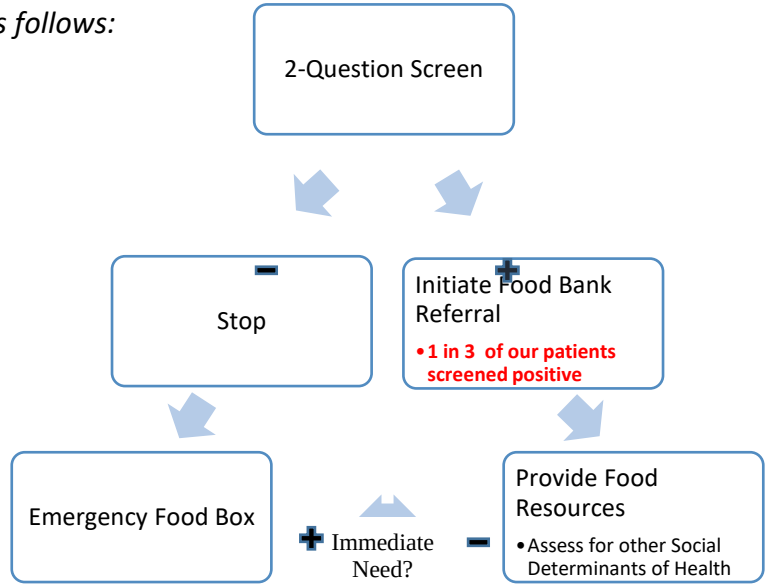
VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Our work on this project will be presented at the Annual Program Directors Workshop (PDW) and Residency Program Solutions (RPS)* Residency Education Symposium Spring 2017 in Kansas City, MO (hosted by AAFP). Upon integration into our EHR, we will investigate potential publications to report project design, initial and subsequent data utilizing the JANE database (http://jane.biosemantics.org/index.php)
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	***Pre-Work/Background:*** *Our Community Health Needs Assessment was reviewed and food insecurity was identified as a health inequity in our community. We researched the subject and discovered a validated 2-question food insecurity screening tool that could be utilized to identify food insecure patients in our practice setting. We investigated existing programs targeting food insecurity within our*

organization and discovered that the Desert Mission Food Bank was a partner of our institution. Several initial meetings took place; key team members and stakeholders were identified; and a workflow was developed to identify patients with food insecurity and to assist them with obtaining food resources.

Methods/Measurement:

We used a validated 2-question screening tool to identify patients in our practice with food insecurity. A positive response to either question has a 97% sensitivity and 83% specificity for identifying an individual as food insecure. Our initial goal was to screen every patient at every visit (due to the cyclical nature of food insecurity).

The workflow is as follows:



We captured data daily for further analysis including total number of patients seen, number of

		patients screened and number of patients that screened positive. That data was analyzed to determine the percentage of patients screened that are food insecure and to identify opportunities to improve the screening process. We have begun to analyze referral data and are beginning PDSA cycles to address gaps in identified patients reaching food resources. ***Measure-Adjust-Sustain*** *Preliminary data analysis revealed several opportunities for improvement of our food insecurity screening process. Initial screening rates were 44% at our practice site; however subsequent months showed that the screening rate dropped to 30% and subsequently 8%. While initial engagement from providers and patients was high, screening rates began to drop as patients declined repeat screening at subsequent visits since it was difficult to easily identify patients who had already been screened. We are addressing this issue by incorporating the 2-question screen into our EHR and decreasing the frequency of patient screening.* *Incorporation of this screen into our EHR along with increased ease of tracking screening results will make it possible to potentially expand this program to other practices and our neighboring hospitals. We are currently meeting with executive leadership at our institution to expand the use of this inexpensive screening tool across other primary care practice sites.* *Another area of current and future focus is to improve the rate of food resource acquisition by patients who have already been identified as food insecure and who have been referred for food resources services. Food Bank intake personnel often have a difficult time reaching patients. Many patients have inaccurate contact information listed in their chart (e.g. phone numbers are disconnected, mailing addresses have changed) or may simply choose to not answer their phone or return a message left by the Food Bank staff. Intake personnel at our practice site may make it easier for patients to complete an initial evaluation and make arrangements to obtain food resources.*

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	**The most successful part of our work was…..** *Implementing a simple tool that has uncovered a significant healthcare disparity in our patient population (food insecurity)* **We were inspired by…..** *The alarming number of individuals who are food insecure in our community*
XI.	Barriers	**The largest barrier encountered was…..** *Engaging patients and physicians to consistently complete the 2 question food insecurity screening tool at every office visit* **We worked to overcome this by…..** *Integrating this screening tool into our EHR to identify patients who have already been screened. We decreased the frequency of screening to every 6 months and will continue to reevaluate the process and make adjustments to the workflow*
XII.	Lessons Learned	**The single most important piece of advice to provide another team embarking on a similar initiative would be…..** *I am listing responses of 3 key team members here as they are all vital to this project in different ways:* **Dr. Annie Garcia** - *have an established form of documentation of screening questions prior to starting the initiative; preferably embedded into each patient's EMR.* **Dr. Tricia Kruger** - *try to collaborate with a food distributor prior to kicking off your food insecurity screening tool so that resources will be available for those in need at the time of diagnosis.* **Dr. May Mar** – *find creative methods to consistently engage providers and patients to complete the questionnaire; identify EMR tools to mainstream and standardize the questionnaire.*
XIII.	Expectations Versus Results	**On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?** *8 of 10*

Health Equity & Disparities Track

Thomas Baudendistel, MD; Nailah Thompson, DO;

Calvin Wheeler, MD; Theresa Azevedo, Michelle Loaiza

Kaiser Permanente Northern California Residency Programs

Overall Goal/Abstract

Kaiser Permanente (KP) developed a Health Equity and Disparities track within the Internal Medicine-Oakland Residency Program. The residency is located in a diverse community of socio-economic differences in its population as well as vast health disparities. Through advocacy, research ,and direct community involvement, trainees will better understand the construct of public health, social determinants of health, and disparities. Trainees will be able to identify and implement strategies that support healthy communities.

Background

Kaiser Permanente Oakland serves an incredibly diverse population, whether defined by socioeconomic status, social determinants of health, or race and ethnicity. Nationally, such diversity is usually matched by similar discrepancies in healthcare outcomes. Kaiser Northern California has been shown to be a significant exception to this rule, thereby providing a unique window to observe a model of healthcare delivery which can reduce or even eliminate disparities in healthcare outcomes within a diverse population. (*N Engl J Med* 2014; 371:24) .

Educationally, the residency track will grant trainees the opportunity to examine Kaiser's population-based health care delivery system alongside a community health model, positioning graduates of the track to understand varied health outcomes and actively engage in solutions to eliminating health disparities. The 3-year track will consist of four components: a) longitudinal clinical experiences, b) didactic experiences, c) scholarly activity, and d) community advocacy.

Vision Statement

Kaiser Permanente is a leader in identifying, measuring, and understanding disparities in health and health care. We will deepen our engagement in the promotion of health equity and the elimination of health disparities through research, advocacy, education, and dissemination of such work with the communities we serve.

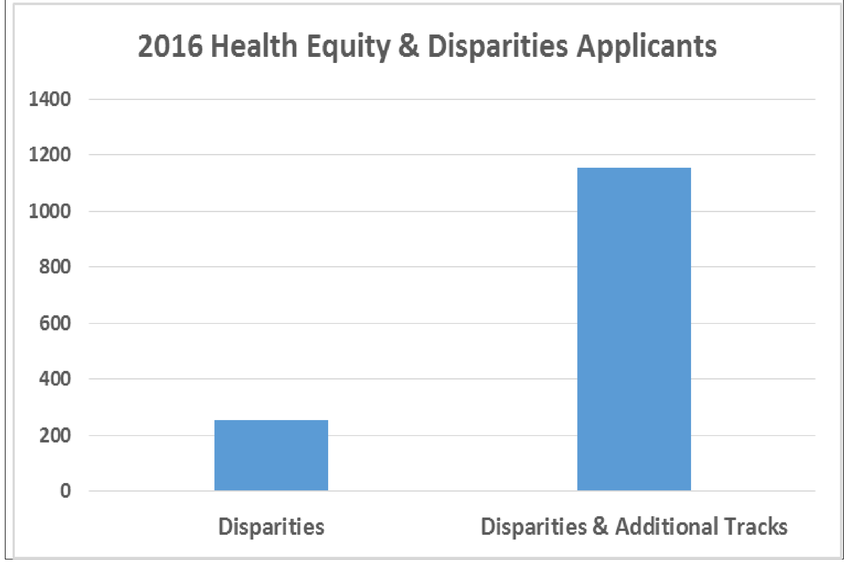
Residents will have in-depth patient care experience in Kaiser and non-Kaiser care models, learning the resources to study strategies for eliminating health disparities.

Materials/Methods

- Expanded the number of ACGME accredited Internal Medicine residency positions by two residents each training year over a three year period
- Recruitment of Track Program Director
- Marketed track externally (recruitment, website)
- Alignment of the community health needs assessment with the residency program
- Curriculum Development:
  - Research: align with KP Division of Research
  - Advocacy and Health Policy Course
  - Community longitudinal rotations
  - Didactic development

Results (data gathered is quant. & qual.)

- Six new residency positions between 2017 – 2020
- One new Community Medicine Fellow/Health Equity & Disparities Fellow to precept residents in community setting
- Applicant Data:
  - # of applicants who applied to disparities track only: **252**
  - # of applicants who applied to disparities and one or more additional tracks: **1155**



Success Factors and Lessons Learned

- Track development increased communication between KP and Federally Qualified Health Centers
- Demonstrated financial commitment by KP leadership
- The development of a track increased interest internally and externally by medical students, residents, and faculty, leading to discussions of track expansion in KP's other residency programs and locations.
- Plans to recruit six Community Medicine Fellows to precept residents in community settings

Challenges/Limitations

1. Program Director recruitment
2. Establishing a community partner for rotations
3. Selecting KP residency program for the track
4. Increase GME coordinator support
5. Preceptor time
6. Development of community medicine fellowship and community medicine rotations simultaneously as development of track
7. Executive commitment for funding additional slots and fellowships

Conclusions

At full development (2020), six residents, in collaboration with a community partner, will provide health care to under/uninsured and underrepresented patients in the community. We aim to assess educational outcomes of this track and initiate similar programs in other KP residencies, We are committed to developing leaders and eliminating health disparities in the communities we serve.

Bibliography

Meyers, KSH, *Racial and ethnic health disparities: influences, actors, and policy opportunities.* Kaiser Permanente Institute for Health Policy; 2007

Wong, W. *Confronting the Uncomfortable: Health Plans and Health Disparities: A Moral Dilemma in Morally Driven* Industry Perm J. 2008 Winter; 12(1): 81–86. 2008.

A.N. Trivedi . *Quality and Equity of Care in U.S. Hospitals, N Engl J Med 2014; 371:24*

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Kaiser Permanente, Northern California **Project Tile: Development of a Health Equity and Disparities Residency Track**

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	***Kaiser Permanente is a leader in identifying, measuring, and helping to eliminate disparities in health and health care. We will deepen our engagement in the promotion of health equity and the elimination of health disparities through research, advocacy, education, and dissemination of such work with the communities we serve.***
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	*Kaiser Permanente Oakland serves an incredibly diverse population, whether defined by socioeconomic status, social determinants of health, or race and ethnicity. Nationally, such diversity is usually matched by similar discrepancies in healthcare outcomes. Kaiser Northern California has been shown to be a significant exception to this rule, thereby providing a unique window to observe a model of healthcare delivery which can reduce or even eliminate disparities in healthcare outcomes within a diverse population. (N Engl J Med 2014; 371:24)* *Educationally, a residency track will grant trainees the opportunity to examine the Kaiser population based model alongside a community health model, positioning graduates of this track to become active leaders in eliminating health disparities. This 3-year track will consist of four components: a) clinical, b) didactic experiences, c) scholarly activity, and d) community advocacy. Residents will have in-depth patient care experiences in Kaiser*

		Permanente and non-Kaiser care models, learning the resources to study strategies for eliminating health disparities.
III.	Team Members & Accountability (list of team members and who is accountable for what)	*Thomas Baudendistel, MD; Program Director Internal Medicine-Oakland* *Nailah Thompson, DO, MPH; Program Director Health Equity & Disparities Track* *Tessa Stecker, MD, Program Director, Regional Community Medicine Programs* *Theresa Azevedo, DIO, Associate Institutional Director, UME/GME Regional Office* *Michelle Loaiza, Project Manager, UME/GME Regional Office* *Alex Dummett, MD, Internal Medicine* *Jean Nudelman, MPH, Community Benefit Manager, Kaiser Foundation Health*
IV.	Necessary Resources (staff, finances, etc.)	*Financial Support for:* 1. *Program Director for the new track.* 2. *Payroll and non-payroll support for six new Categorical IM residents* 3. *Community Medicine fellow payroll and non-payroll costs* 4. *GME Coordinator time* 5. *Travel support for NI-V team members* 6. *Marketing/website changes* *Additional Resources* 1. *Division of Research staff* 2. *Community partner staff* 3. *Project Manager time* 4. *Support from The Permanente Medical Group and Kaiser Foundation Hospitals & Health plan*
V.	Measurement/Data Collection Plan	*Initial measurement will include recruitment and program expansion:* • *Six new ACGME approved categorical residency positions* • *Development of Community Medicine/Health Equity & Disparities Fellow to precept resident in community setting*

		• *Applicant data: number of applicants to the program* • *Additional data to be collected during project implementation:* *a) Community rotation data, both quantitative and qualitative* *b) Research productivity* *c) Post-graduation survey of residents and fellows* *d) Project spread to additional residency programs*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	*Establish partnership with community clinic so as to align resident education with community needs assessment. Project communication provided to KP leadership in one-on-one meetings, Presentation to The Permanente Group Board of Directors, to medical center directors during site visits, and the Institutional Graduate Medical Education Committee.* *Community Partnership* *Lifelong Medical. Longitudinal community experience; Residents in this track will rotate to the clinic to provide care to underprivileged/underserved/underinsured patient population*
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc.)	*Challenges included:* *1. Recruitment of Program Director in the timeline needed to successfully launch the track.* *2. Increasing FTE of Community Fellowships to preceptor residents in the community.* *3. Identifying community partner and establishing a relationship for successful integration of a resident continuity clinic.* *4. Budget cycle for new resident FTEs not in alignment with interview/recruitment timeline, requiring financial commitment outside of budget cycle.*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Residents will work with Kaiser's Division of Research and its researchers whose work focuses on Healthcare Disparities. A KP researcher/principal investigator has offered to mentor residents in this track. The researcher is the recipient of a renewable mentorship grant which stipulates mentoring residents as a requirement for the grant. Other options for scholarly work will include quality improvement projects within or outside of Kaiser. One example is a project aimed at reducing the disparities in hypertension management between black patients and non-black patients.*
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*Phase 1:* *a) Communication and Buy-In from all Stakeholders* *b) Assess and Establish Funding Commitment* *c) Establish Community Partnership* *d) Communication with Program Director of KP Community Medicine Fellowship Program* *e) Obtain ACGME Approval for Six Categorical Residents* *f) ERAS & NRMP Codes/Track Changes* *Phase 2:* *a) Recruit Track Program Director* *b) Assess Need to Increase GME Coordinator Support* *c) Development of Curriculum & Objectives* *Phase 3:* *a) Medical students Interviews and NRMP Match* *b) Measure Match Outcome/Track Data* *c) Develop Rotation Schedules* *Phase 4:* *a) Expansion of Health Equities & Disparities Rotations to additional KP residency programs* *b) Expansion of Community Medicine Fellowship Program* *c) Measurement/Outcomes of Track and Overall Program*

X.	Success Factors	*The most successful part of our work was…..* *We were inspired by…..* *The vision and dedication of our organization to serve the needs of the community through the development of the Health Equity & Disparities track. We were able to receive the leadership support to a) recruit a track Program Director, b) expand the residency program, and c) consider integration of the track concept into additional Kaiser Permanente Residency Programs.*
XI.	Barriers	*The largest barrier encountered was…..* *Identification of a community-based continuity clinic for consistent resident rotations.* *We worked to overcome this by…..* *Consideration of additional community partners/sites who may not have otherwise considered resident education in their setting. The development of a Community Medicine Fellowship to precept the residents in their setting also reduced concerns of patient care access/faculty time.*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be…..* *a) Ensure that executive leadership is educated early in the development of a track to receive buy-in, support, including financial resources.* *b) Allocate a project manager to coordinate communication and project milestones.* *c) Promote the track at medical student marketing events early in the interview season.* *d) Recruit a track program director early in the track development.* *e) Understand community partner concerns about resident rotations in their health care setting.*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *We were able to accomplish our project and also begin "project spread" to other residency programs.* *1 2 3 4 5 6 7 8 9* ***10***

Linking Patients to Community Resources Via a Smartphone App

Joseph A. Greco, M.D., Chinwe Onyekere, MPH, April Lockley, D.O., Sharon Iannucci and Jennifer Banas

Main Line Health System, Wynnewood, PA

Overall Goal

Provide a smartphone app to residents that facilitates the referral process of patients to community services at the bedside.

Background

Medical Student Advocates (MSAs) have located needed community resources for vulnerable patient populations. Over 600 local resources have been vetted and listed on a Wikipedia Page. Residents had been disconnected from these efforts and found it challenging to efficiently provide resource information at the bedside.

The Main Line Heath (MLH) System Strategic Plan stresses the importance of improving the health of the community and to “seek, identify and ameliorate disparities in care.”

The smartphone app aims to support both efforts.

Materials/Methods

1) Residents and MSAs attended a GME sponsored dinner to “Meet and Greet” to learn about patient and provider needs and the resources identified on the MSA Wikipedia Page. Categories include food, transportation, utilities, child care, job training, education and legal services.

2) Residents were asked to complete an anonymous questionnaire to assess knowledge and opinions regarding linking patients to community resources and uploaded a link to the Wikipedia Page onto their smartphones.

3) GME collaborated with Texas A&M School for Public Health to enlist MLHS as a sponsor for the MyHealthFinder App. MSA community resources were grouped according to the applications categories of need. Resources for food and transportation were uploaded to the app.

Success Factors and Lessons Learned

Residents in Internal Medicine and Family Medicine recognize and affirm their desire to play a role in properly and efficiently linking their patients with appropriate community resources.

Residents also want to track whether resources are utilized.

The usage of the smartphone app can identify areas of highest community needs to complement and inform the MLH Community Health Needs Assessment.

Barriers Encountered/Limitations

Collaboration between two large organizations is time consuming.

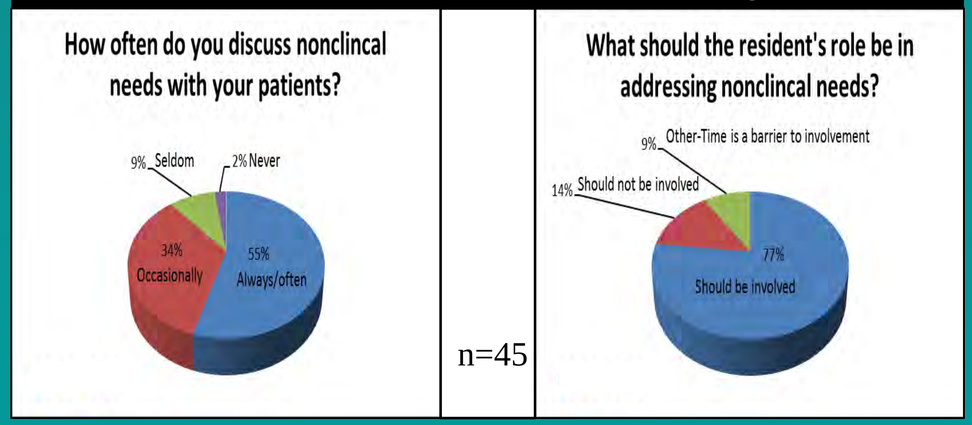
Analytics of app usage does not drill down to the provider level.

Two distinct locations of the IM and FM programs created logistical challenges of implementation.

Vision Statement

The Department of GME aligns with Main Line Health System to reduce disparities in health by providing access to primary care, subspecialty care and linking our community’s vulnerable populations with resources to live a better quality of life.

Results of Resident Survey



Conclusions

Supplying a smartphone app to search for community resources at the bedside was received enthusiastically by residents and energized the MSAs efforts to vet resources.

Future goals include obtaining metrics of resident access, usage and satisfaction with the app.

Email questions/comments to grecoj@mlhs.org

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Main Line Health System **Project Tile: A Community Service app to Link Pts with needed Resources**

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*Main Line Health System along with the Department of GME will reduce disparities in health by affording individuals access to primary care, subspecialty care and linking them with community resources to live a better quality life for our community.*
		For Reference: **GOAL 4 of Main Line HealthSystem Strategic Plan:** Provide culturally competent patient-focused care and eliminate ethnic and racial disparities **Objectives:** • Establish vision, mission, goals and infrastructure for comprehensive MLH program of cultural competency and equality • Improve collection and use of race, ethnicity and language preference data to identify the greatest barriers to culturally competent care and eliminate ethnic and racial health disparities • Provide Cultural Competency Training to MLH staff and physicians • Establish program to actively promote identification and placement of leaders with diverse cultural, racial and ethnic backgrounds that mirror our community
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	1. *Build and define a relationship between the existing Health Student Advocate program and the residents within our sponsoring institution.*

		2. *Develop an app for community resources based on Health Student Advocate's Wikipedia Page of resources which will bring awareness of community resource bedside for trainees and patients in the clinical inpatient and ambulatory settings.*
III.	Team Members & Accountability (list of team members and who is accountable for what)	*Dr. Greco and Joanne Glusman will take the lead on the overall project at BMC Campus..* *Dr. Greco and Chinwe Onyekere will take the lead on the overall project at LMC Campus.* *Drs. Greco, Burke and Mann will communicate needs and accomplishments to administration via GME Steering Committee.* *Shaun Essex and Deborah Mantegna will refine team goals and secure resources to further align missions of GME and the Hospital Administration.* *Judy Spahr, Lankenau Institute of Medical Research will head the scholarly writing subgroup.* *Jennifer Nesfeder PGY2 IM, and Jennifer Lawrence PGY1 FM will engage residents at both campuses and provide resident perspective during the team process.* *Dr. Burke and Sharon Iannucci will coordinate GME resources needed for resident education, faculty development and write system GME policies as needed.*
IV.	Necessary Resources (staff, finances, etc.)	1. *Protected time for Physician Champion* 2. *Administration support financially for NI V tuition and offsite collaborative meetings.* 3. *Legal support for contractual arrangements when needed between Main Line Health*

		System and physician specialists or community resources. 4. *Community liaisons.* 5. *IRB support and guidance with Scholarly Projects as needed.*
V.	Measurement/Data Collection Plan	*Awareness and number of referrals to HSA Program.* *Use of App, number of resources accessed, completed referrals.*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external) Stakeholder Communication Plan and Relationship Building with Community *(continued)*	*National Initiative V project description and goals are presented at <u>local</u> GMEC meetings, program faculty meetings, at <u>system level</u> GME Steering Committee and at the Research and Education Committee. Updates will follow on meeting agendas in an ongoing fashion.* *The project will be present verbally and in written format to the Medical Executive Committee during annual GME report.* *Deborah Mantegna will lead with Relationship Building within the Community.* *Team members who are on the Diversity and Inclusion Committee will communicate project goals to that committee at system and local hospital level.*
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	*Two geographically distinct campuses make organizing and communication to residents across the system a logistical challenge.* *Faculty Development Needed* *Resident turnover (graduation) and keeping momentum* *Securing physician resources willing to provide patients in MLHS community needed access to care.* *Contract negotiations between legal departments of both MLHS and My Healthfinder app*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Provide GME voice in the Community Health Needs Assessment at Main Line Health System.* *Resident and Medical Student teams to reduce disparities in vulnerable patients.* *Using the app with community resources to improve patient care.* *Using analyticals from the app to track physician behaviors and target most often needed resources in the community.*
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*Defining a GME voice on the CHNA System Steering Committee.* *Resident and HSA Dinner, "Meet and Greet" to learn about the program.* *Sharing an electronic version of the Wikipedia with residents and faculty.* *One Marker will be CLER Visit report from ACGME- Below is the measure they will address: "QI-Including how the sponsoring institution includes resident, faculty and medical students in the use of data to improve systems of care, reduce healthcare disparities, and improve patient outcomes."* *Development/utilization of the Community Services App*
X.	Success Factors	*The most successful part of our work was the integration and collaboration between GME and the Administration of MLHS as we partnered to bring this smart phone app into working form.* *We were inspired by the resources that our organization was willing to put into reviewing the legal contract needed with the creators of the smart phone app as well as the $10K to become a sponsor of the app along with Texas A&M School of Public Health.*
XI.	Barriers	*The largest barrier encountered was creating an app that our legal team and our IT team at MLHS would support.*

		We worked to overcome this by teaming with Texas A&M School of Public health who had already created a similar app for cancer patients. We collaborated with them to populate resources in our community on their smart phone app.
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be if contracts with outside organizations might be required, include your legal and IT departments early on rather than getting approval when you have a prototype pilot ready. Nowadays hospitals are particularly conservative when it comes to HIPPA protected information and having complicated and thorough contracts in place before proceeding.*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5 6* ***7*** *8 9 10*

Discharge Planning

Promoting provider awareness regarding high cost medications commonly prescribed upon discharge.

Carmen Bruno, DPM; Mohammad Yousef, MD; Asia Downing, MD; K. Jones, MD; Ahlam Alzennaidi, MD; Emily Paulk, MD; Fahad Javed, MD; Kateryna Poole, MD; MD; Sherif Michael, MD; Stephanie Bender, MD; *MEDICAL STUDENTS*: Jennifer Paul; Leah Mortensen ; Miranda Hann; Sagie Moshe Henig; Sita Maha Yerramsetti; N. Rentschler, BA; *FACULTY* R. Gala, MD; J. Piazza, MSN, MBA; R. Amedee, MD

Ochsner Health System

NI V Story Board

Overall Goal/Abstract

Discharge planning is provided to all patients and is an essential component of patient care to ensure appropriate follow up and continuity of care[1]. Discharge planning is required for all patients according to the guidelines of the Joint Commission on Accreditation of Healthcare Organizations.[1] Patients who are un/underinsured present a unique challenge in providing accessible follow up upon discharge. Lack of appropriate follow up care can lead to hospital readmission and poor health outcomes.
The aim of this project is to identify the most common discharge barriers and tailor discharge planning resources accordingly.

Background

The Community Health Needs Assessment provides insight into the discrepancies inherent in the care delivered to Ochsner's patient population and identifies its most vulnerable groups. Some of the major barriers to healthcare delivery experienced by Ochsner patients include access to health services, affordability of medications, patient health literacy, and awareness of community health resources.

The consideration of the elements in this report lead the work group to evaluate the impact of these barriers on readmission rates. Building on this information and the individual resident's experience with their population it was concluded that greater resources and direction was needed in the discharge planning process. It became apparent that socio-economic status, literacy levels, community resources and provider lack of knowledge of these resources contributes to poor adherence to discharge plans, particularly related to medication adherence.

Based on these factors the work group will address identifying and making readily available information resources from the communities Ochsner serves, education residents and teaching faculty about these resources, engaging the discharge planning team to address barriers and standardizing access to community resource information via the EMR.

Vision Statement

It is the vision of this project to reduce these disparities by making Ochsner physicians and other healthcare staff increasingly aware of the characteristics particular to the patients served by Ochsner Medical Center .

Promoting awareness of discharge instructions among patients by expanding resources available to physicians prior to writing prescriptions upon discharge.

Materials/Methods

1. Developed and distributed a survey to pharmacists, case managers and social workers identifying common reasons for readmission
2. Conducted a focus group with pharmacists to identify barriers for patients to obtain medications upon discharge
3. Recruited hospital pharmacists to create a reference list of expensive commonly prescribed medications
4. Printed cards out and distributed them to hospital medicine teams on 2/16/17. Plan to monitor readmission data two months prior and post intervention on two hospital medicine teams.

Ochsner Health System

Drug	Alternatives (if applicable)
Vimpat (lacosamide)	• Other Anti-epileptics (would need to touch base with Neurology/Epilepsy)
Sabril (vigabatrin) Required to go through the manufacture, can't get it at a regular pharmacy	• Other Anti-epileptics (would need to touch base with Neurology/Epilepsy)
Keppra	• Other Anti-epileptics (would need to touch base with Neurology/Epilepsy)
Oral vancomycin Best to fill at the pharmacy downstairs as they can compound it instead of using the capsules, however this can still sometimes be pricey	• No alternative
Moxifloxacin	• Levofloxacin
Cefpodoxime	• Cefixime (also can pricey or hard to find) • Cefdinir
Linezolid	• No alternative
All biologics	• No alternative
All immunosuppressants	• No alternative (coordinate with Transplant team)
Colchicine	• Allopurinol (if clinically appropriate)
Insulin (pens/vials/all diabetic supplies) Don't forget the supplies (pen needles if on the pens, syringes if on the vials, test strips, meter, lancets)	• Walmart has their own Relion products (including diabetic supplies) of NPH 70/30, NPH, and Regular insulin (all vials), which is ~20 bucks/vial; cheapest option on the market
Direct Oral Anticoagulants/DOACs (Rivaroxaiban/Apixaiban/Edoxaiban/ Dabigatran)	• Warfarin • ****Must have INR follow-up
Antiplatelets (clopidogrel, ticagrelor, prasugrel)	• Even though clopidogrel is generic, it's still expensive for some patients. It's on the Winn Dixie 4 dollar list though

Ochsner Health System

Drug	Alternatives (if applicable)
Enoxaparin	• All LMWH will require price checking
Sacubitril/valsartan	• No alternative • Valsartan alone, but unable to get sacubitril component alone
Bidil	• Order as the separate components: • Hydralazine • Isosorbide dinitrate
Long acting pain meds Especially Oxycontin and fentanyl patches	• Can try MS Contin (morphine ER) • Depends on insurance
Lyrica	• Gabapentin (if using for neuropathic pain) • Duloxetine (if using for fibromyalgia/ alternative pain medication to avoid opioids) • Other anti-epileptics (if using for seizures)
BID PPIs	• Just need to try all the PPIs until one is covered by patient's insurance • Or OTC PPI such as Nexium OTC, Prilosec OTC, or Prevacid OTC (generics available as well)
Mepron	• Bactrim (if clinically appropriate) • Dapsone (if clinically appropriate and may also require price checking)
Tenofovir, lamivudine, entecavir	• For Hep B, lamivudine is cheapest • Refer to Ochsner Specialty Pharmacy for help
Rifaximin	• Should fail lactulose alone • No alternative
Pyrimethamine	• No alternative
Dronabinol	• Megestrol (if clinically appropriate) • Cyproheptadine (if clinically appropriate) • Mirtazapine (if clinically appropriate)
Lidoderm patches	• New OTC Lidocaine patch called Lidocare

Created by: Ashley Casey, PharmD, BCPS and Britta Staubes, PharmD, BCPS

Results (data gathered both quant & qual.)

The intervention is currently in progress and will be completed on 4/16/17. Once this phase is completed hospital readmission rates will be analyzed from two medicine teams pre and post intervention.

Success Factors and Lessons Learned

The project team realized success when we were able to focus on a specific driver of the of discharge planning that drives readmissions. Focusing on a project with a smaller scope initially allowed for the development of a more specific stratgy

Barriers Encountered/Limitations-

1. Vastness of the Community Health Needs Assessment and identifying patient populations that experiences disparities in healthcare – resulting in a delay in project implementation as scope was determined
2. Project specific:
   1. Medication affordability for patients
   2. Lack of physician awareness of actual medication costs to patients
   3. Community resource availability, transportation, insurance restrictions,
   4. Health literacy issues of the patient population impacted

Conclusions

Once a specific issue was identified from the barriers of discharge planning an intervention was implemented. One of the key components of the intervention is collaboration across hospital medicine services and al members of the care team . The intervention is currently in progress and will be completed on 4/16/17. Once this phase is completed hospital readmission rates will be analyzed from two medicine teams pre and post in

Bibliography

1. HSR: Health Services Research 27:2 (June 1992) Impact of Hospital Discharge Planning on Meeting Patient Needs after Returning Home Joyce Mamon, Donald M. Steinwachs, Maureen Fahey, Lee R. Bone, Julianne Oktay, and Lawrence Klein
2. Hospital Case Management Vol. 20, No. 4Pages 49-64 April 2012 Uninsured patients require creative discharge plans www.hospitalcasemanagement.com.

Improving LGBT Patient Cultural Competency of Internal Medicine Residents

K. Jones, MD; Miranda Hann; Ahlam Alzennaidi, MD; Asia Downing, MD; Carmen Bruno, DPM; Emily Paulk, MD; Fahad Javed, MD; Kateryna Poole, MD; MD; Mohammad Yousef, MD; Sherif Michael, MD; Stephanie Bender, MD*; MEDICAL STUDENTS*: Jennifer Paul; Leah Mortensen ; Sagie Moshe Henig; Sita Maha Yerramsetti; N. Rentschler, BA; *FACULTY* R. Gala, MD; J. Piazza, MSN, MBA; R. Amedee, MD

Ochsner Health System

Overall Goal/Abstract

The goal of this project was to improve the LGBT cultural competency of internal medicine residents at Ochsner Medical Center. First, we administered a survey to internal medicine residents to measure their baseline level of comfort taking an LGBT sexual history, which demonstrated a deficit in LGBT sexual history taking comfort. We then utilized training modules and lectures in an effort to improve both comfort and overall competency in caring for our LGBT patient.

Background

In a survey In a survey of 176 allopathic medical schools in North America, only 5 hours were dedicated to teaching lesbian, gay, bisexual, and transgender (LGBT) related content over 4 years 1 . As contained in the 2015 Ochsner Medical Center Community Health Needs Assessment 2, the LGBT community faces enormous healthcare challenges and barriers to accessing care, further exacerbated by healthcare practitioners' discomfort around asking difficult questions. Taking a comprehensive sexual history helps build initial rapport with LGBT patients; thus, we set out to assess internal medicine residents' baseline comfort level in obtaining a sexual history in LGBT patients. We found a discrepancy in the level of comfort taking a LGBT patient's sexual history as compared to a heterosexual patient. Additionally, 30% percent of those surveyed described their level of training in LGBT sexual history taking as "some, but inadequate" and 1 in 5 responded they had received "no training". Based on this information, we incorporated several workshops and lectures into the internal medicine resident curriculum at Ochsner. These have included a sexual history taking workshop, a lecture on HIV pre-exposure prophylaxis, and topics commonly encountered in the LGBT primary care setting. A post education survey assessing comfort has been given, with data currently being analyzed. These lectures and workshops will continue indefinitely, with future topics to be determined.

Vision Statement

OMC delivers care to over 600,000 annually representing a very diverse patient population. There are various environmental and socioeconomic factors specific to this patient group that influence their health care and the subsequent healthcare disparities they may experience.

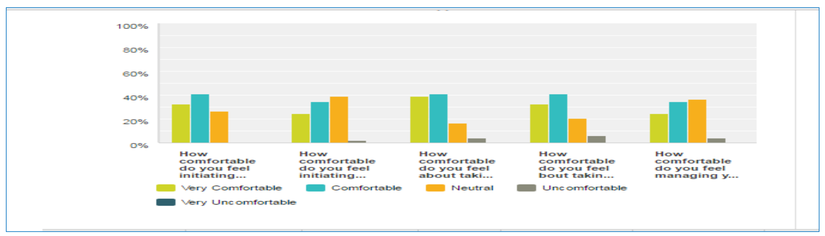
Our goal is to deliver outstanding patient care to all of those treated by the Ochsner Health System, regardless of sexual orientation and gender identity.

Materials/Methods

An initial survey was administered to 47 residents and 2 staff physicians from the Internal Medicine residency program. The survey consisted of 9 multiple choice questions and a brief demographic section. We inquired about residents' comfort level taking sexual histories in LGBT patients and in the general patient population. Respondents selected from the following options: very comfortable, comfortable, neutral, uncomfortable, and very uncomfortable. Additional questions asked about previous sexual history taking training and exposure to training specifically tailored to LGBT patient care. This same survey was administered to residents following the workshops and lectures to quantify any improvement in comfort level following the educational initiative.

Results (data gathered both quant & qual.)

One of the main successes of this project is sustainability for the future. After having demonstrated a need for education specific to LGBT patient care, these lectures and workshops can easily become a permanent component of the internal medicine curriculum. Additionally, this same training can be expanded to other areas of medicine, including obstetrics and gynecology, family medicine, and pediatric residency programs at Ochsner. Our hospital has an extraordinarily diverse patient population, and has been very enthusiastic about educational initiatives which improve our abilities to care for marginalized populations.



1.% responded they were "very comfortable" taking a sexual history from any patient, compared to 32.7% when taking a sexual history in LGBT patients. A Fisher test was performed to compare two variables: comfort level in taking a sexual history and comfort level in taking a sexual history in LGBT patients ($p < 0.0001$). This demonstrated a statistically significant difference in the level of comfort taking a sexual history in LGBT patients as compared to heterosexual patients. Of note, 20% replied they had previously received "no training" in LGBT patient care. We have utilized this same survey to assess the efficacy of our workshops and lectures, with post-intervention data currently being analyzed.

Success Factors and Lessons Learned(Discussion)

One of the main successes of this project is sustainability for the future. After having demonstrated a need for education specific to LGBT patient care, these lectures and workshops can easily become a permanent component of the internal medicine curriculum. Additionally, this same training can be expanded to other areas of medicine, including obstetrics and gynecology, family medicine, and pediatric residency programs at Ochsner. Our hospital has an extraordinarily diverse patient population, and has been very enthusiastic about educational initiatives which improve our abilities to care for marginalized populations.

Barriers Encountered/Limitations-

1. Vastness of the Community Health Needs Assessment and identifying patient populations that experiences disparities in healthcare
2. Healthcare teams perception of LGBT equality
3. Comfort in discussing LGBT specific issues
4. Acknowledging the importance of taking a sexual history in the LGBT patient
5. Reliability of and researcher reliance upon surveys
6. Difficulties of critical self appraisal

Conclusions

Disparities in healthcare continue to affect the LGBT patient population. We have demonstrated a statistically significant difference in internal medicine residents' comfort level in obtaining a sexual history from LGBT patients. The goal of implementing LGBT specific teaching into the internal medicine curriculum was to improve the comfort level in sexual history taking and reduce this healthcare disparity. After quantifying the effect that educational sessions have had on sexual history taking comfort, we will use this information to further design educational initiatives aimed at improving LGBT cultural competency and working toward eliminating disparities in LGBT patient care

Bibliography

•Obiden- Maliver et al. Lesbian, Gay, Bisexual, and Transgender–Related Content in Undergraduate Medical Education. JAMA, 2011; 306(9): 971977.

•2015 Ochsner Medical Center Community Health Needs Assessment. Available from: https://www.ochsner.org/img/uploads/static/2015_CHNA_Ochsner_Medical_Center_final.pdf

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Ochsner Health System **Project Tile:** Processes to Address Health Disparities

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*The Ochsner Health System serves a community that is defined by its diversity. A portrait of this community displays a spectrum of individuals from different ethnic, cultural, and socio-economic backgrounds. It is the vision of the National Initiative V Team that we will leverage the Ochsner Community Health Needs Assessment to identify and evaluate these populations and their needs, leading to the development of toolkits for improvement to be applied across the education continuum to drive improvement*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	1) *All activities will be directed toward improvement in the care of populations in need* 2) *Populations will be identified by those engaged in the project, based on their experience in the Ochsner clinical environment as well as interest and passion to improve a specific aspect of care.*

		3) Stake holders will identified as specific populations are defined and will become part of workgroup activity *4) Based on knowledge gained from the organization Community Health Needs Assessment, develop focused projects that will address the needs of specific populations with targeted strategies to improve the quality of care provided.*
III.	Team Members & Accountability (list of team members and who is accountable for what)	*Primary Team:* *Rajiv Gala, MD – Team Leader* *Ron Amedee, MD- Faculty Advisor* *Janice Piazza, MSN, MBA - facilitation* *Residents : Kathryn Jones, MD – LGBT Project Lead* *Carmen Bruno, DPM- Discharge Planning Project Lead*

IV.	Necessary Resources (staff, finances, etc.)	*D/C Medications Project :* *Access to real time data to assess benchmark status and project outcomes* *Coordination with care team in hospital setting* *Time and human resources to facilitate implementation in the clinical setting* *Opportunity to integrate with ongoing system projects addressing like / related issues* *LGBT Project :* *Faculty engagement to include content in standard curriculum* *Opportunity to integrate with ongoing system projects addressing like / related issues* *Trained faculty to deliver curriculum*
	Measurement/Data Collection Plan	*D/C Medications Project :* *Track readmissions data to evaluate readmissions related to non-compliance with discharge medications* *Ongoing Focus groups with pharmacists to review barriers to medication fill rates at discharge* *Survey care team to determine compliance to utilization of cost information provided by project team* *LGBT Project :* *Results of pre-intervention will directly compared to the post –intervention survey results to determine if the comfort level with taking a sexual history from a member of the*

		LGBT community has been improved
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	• *Initial communication with the CHNA development group as well as key stakeholders in that project to determine current ongoing projected future efforts that would lend themselves to integration into this project* • *Grand Rounds and Program Director meeting presentations to share concept of the NIV initiative and proposed project focus* • *Efforts shared as Sr Mgt and Executive level through reporting at the System and site Performance Improvement committees and Patient Safety Executive committees*
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	*Time for engagement* • *Knowledge of CHNA and specific information about the populations served* • *Defining appropriate, manageable scope for this project* • ***D/C Medication Project:** access to data, knowledge of and access to available data, time , ongoing engagement is project that will be long term* • ***LGBT Project :**Health care teams perception of LGBT equality, comfort(lack of) discussing LGBT specific issues, Acknowledgement of the importance of taking a sexual history in the LGBT patient**,** difficulties of critical self appraisal*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Both project teams have developed abstracts and will publish in the Ochsner Journal prior to the end of 2017* *Information has been presented internally at grand rounds and program specific meetings*

IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*Phase 1 – **Team Prep**: considerable time spent on the learning required to be able to effectively determine project general direction and aim.* *Phase 2- **Design –** project evolved through multiple phases of design moving from a macro approach to micro approach – landing small victories to build on* *Phase 3 – **Gap Analysis- Design – Implement** – initial data to include the CHNA and independent surveys by the 2groups validated project focus, first PDSA cycle implements* *Phase 4- **Implement – measure – adjust – sustain –** very early in this phase, but positive momentum - will need to continue to provide support through transition of academic year to sustain, although project leads will continue, also seek to integrate into broader organizational efforts to leverage broader base of support*

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was…..there is a much broader understanding of the inequity of the care provided and the populations in greatest need. Also* *We were inspired by…..the overwhelming interest and determination of the residents and students who participated to work toward addressing these inequities*
XI.	Barriers	*The largest barrier encountered was…..engagement of the long haul and maintaining the level of organizational commitment required to effectively* *We worked to overcome this by…..continue project monthly check –ins, identify broader organizational efforts to leverage available support for sustaining and spreading existing work*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be : don't try to conquer the world, and spend enough time on the front end of the project to clearly define realistic aims and outcomes*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 **5 6** 7 8 9 10*

Increasing Vietnamese Patients in the Resident Clinic

Annie Chau, MD; Kwabena Ayesu, MD; Caroline Nguyen, MD

Orlando Health Internal Medicine; Orlando, FL

Goals

The aim of this project is to increase the number of Vietnamese patients in the Internal Medicine Residency Continuity Clinic by 25% within a period of six months by raising awareness of the Hepatitis B Virus (HBV).

Background

As of late, there has been focus on addressing healthcare disparities for underrepresented groups. Orlando ranks as a city with one of the largest Vietnamese populations in the US. The Mills-50 district in Orlando has a large Vietnamese community and is in close proximity to the Internal Medicine Residency Continuity Clinic.

Despite the proximity, Vietnamese patients enrolled in the clinic are less than 5%. Many immigrated to the area without access to healthcare. A literature review and needs assessment identified HBV as a prevalent disease amongst the immigrant Vietnamese population. Therefore, educational awareness was focused on hepatitis B transmission, screening, treatment and prevention by participating in health events in the community. Through these events we raised awareness of our resident clinic as a resource for health care. We made Tuesdays our Vietnamese clinic days so that patients knew they would see a doctor who spoke the same language and had an understanding of the culture and its impact on health.

We hoped to increase the Vietnamese patient population by 25% within 6 months at the residency clinic.

Vision Statement

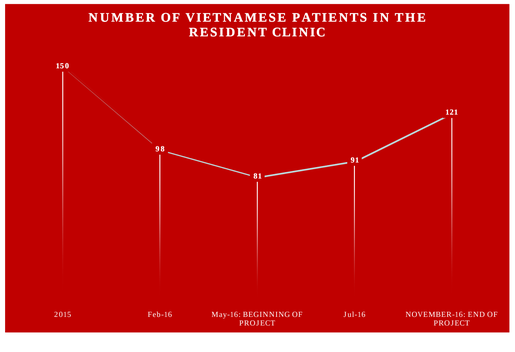
- Through this project, we look to increase access to healthcare in an underrepresented group by bringing awareness of a disease prevalent to this group.
- We seek to apply the strategies learned by this project to increase access of care for other underrepresented groups in the community.

Methods

- A questionnaire was created and distributed to 40 current Vietnamese patients in the resident clinic to determine their knowledge of HBV and their immunization status.
- Several health screening events were held in the community and information for the clinic was provided for eligible individuals.
- Eligible individuals included those living in the county who were uninsured and without a primary doctor.
- The number of Vietnamese patients in the clinic were compared before and after intervention.

Results

- Of those surveyed, 3 in 5 patients answered questions incorrectly regarding transmission of HBV. 1 in 3 patients were not aware of the immunization status.
- After the intervention, the Vietnamese population in the resident clinic increased by 33% in 6 months.



Barriers Encountered

The residency clinic is funded by the Orange County government, which sets the requirements for eligibility. The most frequent barrier we encountered were those who applied did not live in the country for longer than the 3 years required or made above the income requirement.

Also, due to limited funding, we were able to hold only a few events in the community despite significant interest. However, after this project and building relationships with those in the community, we hope to continue participating in these events in the future.

Lessons Learned

We learned that there was great interest in the Vietnamese community to learn more about HBV. We found the best way to educate the community was to coordinate with local leaders and participate in health screening events. Many of those who attended these events were uninsured so we were able to provide information for our resident clinic and increase access to healthcare. We also learned that local pharmacists and the ED frequently saw uninsured patients so we were able to collaborate with them to provide primary care.

Conclusions

Access to health care is still an evident problem in our community. By participating in community health events, we were able to increase awareness of a disease most prevalent in the Vietnamese community and increase their access to healthcare. We hope to utilize the skills we learned from this project to improve access of care to other groups experiencing health disparities in our community.

Bibliography

Hepatitis B testing among Vietnamese American men. Cancer Detect Prev. 2004; 28(3): 170–177

Factors Associated with Hepatitis B Testing Among Vietnamese Americans. J Gen Intern Med. 2010 Jul; 25(7): 694–700.

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Orlando Health **Project Tile:** Increasing Vietnamese Patients in the Resident Clinic

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*Through this project, we look to increase access to healthcare in an underrepresented group by bringing awareness regarding screening, transmission and treatment of a disease prevalent to this group.* *We seek to apply the strategies learned by this project to increase access of healthcare for other underrepresented groups in the community.*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	*The aim of this project is to increase the number of Vietnamese patients in the Internal Medicine Residency Continuity Clinic by 25% within a period of six months by raising awareness of the Hepatitis B Virus (HBV).*
III.	Team Members & Accountability (list of team members and who is accountable for what)	*Dr. Annie Chau: worked with Dr. Ayesu to create a validated questionnaire to determine baseline knowledge of HBV. She also was responsible for collaborating with community leaders*

		to plan health events. The referral coordinator at our clinic was responsible for screening patients and determining eligibility status.
IV.	Necessary Resources (staff, finances, etc.)	*We worked with drug companies to help contribute funding for the community events.*
V.	Measurement/Data Collection Plan	• *Create questionnaire to current patients in the clinic to determine their knowledge of HBV including methods of transmission and their immunization status* • *Determine in EMR number of Vietnamese patients before and after intervention in the residency clinic*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	• *Built relations with the Asian American Chamber of Commerce in Central Florida and Vietnamese Health Professionals of Central Florida to participate in community health events* • *Connected with local temples and churches and held educational events about HBV after services.*
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	• *Limited funding to host events* • *Limited time as only one resident working on the events*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Journal of Patient-Centered Research and Reviews* *Journal of Primary Care and Community Health*
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*First, we created a questionnaire to determine if there was a need for HBV awareness in our current patients.* *Once we identified a need, we worked with community leaders to create and participate in health events.* *When we finalized the dates for the community events, we were able to review the number of patients in the clinic to see if there was any change or impact.*

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was…..* *Raising awareness about HBV by providing free educational events. We also were able to increase access to health care by providing information about our clinic for the uninsured.*

XI.	Barriers	*The largest barrier encountered was…..* *Many of the uninsured we encountered were not eligible for our clinic because of their citizen status or they made above the income requirement.* *We worked to overcome this by making them aware of another clinic in the community where they could receive primary care.*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be…..* *Establish relationships with community leaders!! They have experience with getting out into the community and having an impact.*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5 6* ***7*** *8 9 10*

The Influence of Comprehensive Care Coordination on Patients with Chronic Medical Conditions and Special Health Care Needs in a Community Pediatric Residency Program Continuity Clinic

OSF Saint Francis Medical Center, Heartland Health Systems, and University of Illinois College of Medicine in Peoria
Zohra Moeenuddin MD, Joshua Baker DO, Erica Owchar MD, Amy Duffield MSW LCSW, Caroline Kim MD MPH, Crystal Coan MBA, Kristin Crawford MBA, Thomas Santoro MD

Overall Goal/Abstract

Objectives- To study the influence of team based comprehensive health care coordination on outcomes for children with complex health care needs in a pediatric resident continuity clinic. To study the feasibility of incorporating comprehensive coordination in a resident clinic, to create a framework of resources and strategies for sustainability, and to better understand the educational needs of pediatric residents as they prepare for future practice.
Methods-27 children with complex medical conditions were enrolled for a 12 month period in care management.
Conclusion-the intervention did not have an effect on no-show rates or on parent satisfaction survey results. However, there was a significant improvement in continuity of care, as defined by the patient seeing the PCP rather than another doctor in the clinic. In addition, the number of hospitalizations and visits to the emergency department decreased.

Background

The prevalence of chronic disease among American children has increased due to decreased mortality from once-fatal diseases. Pediatric health care providers must be prepared to tend to an increasing number of children with special health care needs (CSHCN). Doctors-in-training are often not well versed in the care of CSHCN nor do they receive training in advocacy or care coordination, yet the patients they see in continuity clinic are very likely to be underrepresented minorities who are uninsured or publicly insured and less likely to have access to care management, which has been shown to decrease burden on families and parents, improve patient satisfaction, strengthen ties with providers, and decrease visits to the ED.

Materials/Methods

CSHCN were identified from two resident continuity clinic panels. Patients were eligible for the study if their score on the CSHCN Screener was ≥2. They were excluded from the study if they were unable to schedule appts during research panel appt times or if they moved. 27 patients enrolled.
Interventions included a one hour initial visit, 40 minute follow-up visits with face-to-face time with all team members, telephone access directly to the social worker, and follow-up scheduling during office visits. A care-coordination binder was provided to each patient and monthly team meetings were held to discuss enrolled patients. The study period lasted 12 months.
Data was collected for the time period 12 months prior to initiation of the study. Patients served as their own historical controls, as matched controls were not feasible. IRB approval was obtained December 2015.
Data collected included completed and no show visits for primary care and subspecialty appointments, hospitalizations and ED visits, continuity of care, use of care-coordination binders and medications, and results for parent satisfaction surveys, which were administered every 3 months.

Vision Statement

To educate, motivate, and empower vulnerable patients and young physicians by clarifying the roles of existing resources, streamlining communication among stakeholders, and utilizing a team-based strategy to deliver excellent care

Results

Process	Results
Patient satisfaction and perceived quality of life	No significant change between baseline and post surveys
Number of missed appointments at continuity clinic (No Show rate)	p=0.95; no significant difference for the no show rate overall Patients with a CSHCN Screener score of ≥4 were 5.3x more likely to show for the appointment (p=0.01)
Number of missed appointments at specialty clinics (No Show rate)	Pre-26% Post-24%
Continuity (patient saw PCP during clinic visits)	p<0.05; significant increase (17% with 95% CI of 0.32-0.56) in appointments with PCP
Number of hospitalizations	Pre-4 Post-2
Number of ED/Urgent care visits	Pre-40 Post-26

Success Factors and Lessons Learned

- Total number of primary care visits increased.
- Significant improvement of continuity with PCPs resulted from increased access to the social worker and regularly scheduled appts with care team. Continuity of care with a "usual" provider has been shown previously to improve adherence and patient satisfaction and decrease ED visits.
- Missed appts at continuity and subspecialty clinics were unchanged but pts with more chronic medical issues were more likely to keep their appt. Missed appts for mental health visits decreased.
- Decreased ED/urgent care visits and hospitalizations decreased health care costs (avg charge per ED visit was $2244)
- Ethnicity, educational level of parent, transportation needs, and type of insurance had no significant impact on no show rates.

Barriers Encountered/Limitations

- Small number of subjects enrolled and high baseline no show rates affected statistical power
- Families often did not bring binder to office visits. Medication compliance was difficult to track
- Families experienced instability of living situation, lack of transportation, and limited access to telephones, which our study was unable to address
- Medicaid status has been shown to limit access to subspecialists and community resources. Of our 27 patients, 21 had Medicaid or Medicaid managed care and 1 had no insurance
- Residents' clinic schedules and availability to see patients were limited by duty hour rules and other clinical responsibilities

Conclusions

Our project successfully decreased costs. More importantly, we found that continuity with the PCP played a key role in developing relationships, connecting patients with critical resources, and instilling in residents a sense of confidence and self-efficacy with which their patients were hopefully imbued. Identifying patient barriers to care (eg unstable living situation) will necessitate engagement with other community stakeholders. Future implementation and study of this project will require recruiting a larger number of patients, investigating which subgroups benefit more from care management programs, and integrating our process across all resident panels to promote study generalizability, improve continuity and care team collaboration, and foster resident education and a desire to care for CSHCN in residents' future practices. An important future focus is to better assess quality of life, patient and family satisfaction, and emotional wellness by developing a validated survey for CSHCN.

Bibliography

http://www.cahmi.org/wp-content/uploads/2014/06/CSHCNS-Survey-and-scoring.pdf
AAP Council on Children with Disabilities. Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children With Special Health Care Needs. *Pediatrics* 2005; 116:1238-44.
Bethell CD, Read D, Stein REK, et al. Identifying Children with Special Health Care Needs: Dev and Eval of a Short Screening Instrument. *Ambulatory Pediatrics.* 2002;2:38-47.
Brown, N., Green, J., et al. Need and Unmet Need for Care Coordination Among Children With Mental Health Conditions. *Pediatrics*. 2014; 133: 530-7.
Inkelas M, Schuster MA, Olson LM, et al. Continuity of Primary Care Clinician in Early Childhood. *Pediatrics* 2004;113:1917–1925.
Klitzner, T., Rabbitt, L., Chang, R., Benefits of Care Coordination for Children with Complex Disease: A Pilot Medical Home Project in a Resident Teaching Clinic. *The Journal of Pediatrics*.2010; 156:1006-10.
Cleave, J., Boudreau, A., et al. Care Coordination Over Time in Medical Homes for Children With Special Health Care Needs. *Pediatrics*. 2015; 135: 1018-26.
Nazarian, B., Glader, L., et al. Identifying What Pediatric Residents are Taught About Children and Youth with Special Health Care Needs and the Medical Home. *Pediatrics*. 2010; 126: 183-9.
Newacheck, P., Kim, S., et al. Who is at Risk for Special Health Care Needs: Findings From the National Survey of Children's Health. *Pediatrics*. 2008; 122: 347-59.
Serwint JR, Thomas KA, Dabrow SM. Comparing Pts Seen in Ped Resident
Continuity Clinics and Natl Amb Med Care Survey Practices: A Study From the Continuity Research Network. *Pediatrics* 2006;118:e849-e858.
Turchi RM, Berhane Z, Bethell C, et al. Care Coord for CSHCN: Assoc With Family-Provider Relations and Family/Child Outcomes. *Pediatrics* 2009;124:S428–S434.

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: OSF St Francis Hospital Project Title: The Influence of Comprehensive Care Coordination on Patients with Chronic Medical Conditions and Special Health Care Needs in a Community Pediatric Residency Program Continuity Clinic

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*To educate, motivate, and empower vulnerable patients and young physicians by clarifying the roles of existing resources, streamlining communication among stakeholders, and utilizing a team-based strategy to deliver excellent care.*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	*Objectives- To study the influence of team based comprehensive health care coordination on outcomes of children with complex health care needs in a pediatric resident continuity clinic at Heartland Community Health Clinic-Armstrong. To study the feasibility of providing comprehensive coordination in a resident's continuity practice and to create a framework of resources and strategies for sustainability. To understand the educational needs of pediatric residents in preparation for future practice.* *Project Requirements- Dedicated staff in a primary care pediatric residency clinic with clear roles in care coordination and advocacy, care delivery and supervision, and data collection* *Project Assumptions- pediatric residency clinics care for a highly vulnerable patient population with health care disparities. CSHCN are at risk for poor outcomes.* *Stakeholders- OSF Healthcare, UICOM-P residents and faculty, Heartland Community Health Clinic* *Necessary Resources- Research coordinator/statistician* *Measures of Success-see IV*

III.	Team Members & Accountability (list of team members and who is accountable for what)	*Caroline Kim, team leader; Zohra Moeenuddin, project leader; Joshua Baker, resident; Erica Owchar, resident; Amy Duffield, social worker and patient care coordinator; Crystal Coan, project blackbelt; Kristen Crawford, project blackbelt; Thomas Santoro, senior advisor and Designated Institutional Officer for residency program*
IV.	Necessary Resources (staff, finances, etc.)	*In kind support for supplies (Heartland)* *In kind support data collection and statistical analysis (UICOM-P)* *In kind support for clinic staffing, including social worker and triage nurses (Heartland, OSF)* *In kind support for additional institutional financial data (OSF)*
V.	Measurement/Data Collection Plan	*Measures of Success- Improved patient/parent satisfaction, decreased visits to the ED and hospitalizations, better compliance with health care regimen, decreased no show rates at primary care and subspecialty visits, improved continuity of care, cost savings*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	*Identification of community resources (mental health, occupational and physical therapy, etc) that our patients use most often to streamline communication efforts* *Ongoing involvement of university and hospital leadership*
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	*Competing demands of other job responsibilities* *Limitations of resident clinic schedules due to rotations during which they could not see patients in clinic* *Engagement of community partners* *Climate of competition in the community* *Lack of budget for patient incentives* *Lack of patient resources (transportation, language, etc) that we could not overcome*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Presented at Population Health Symposium, Peoria, December 2016 (Moeenuddin)* *To be presented at Academic Pediatric Association Regional Meeting, Indianapolis, March 2017 (Baker)* *To be presented at Association of Pediatric Program Directors meeting, San Francisco, April 2017 (Owchar)* *To be presented at Pediatric Academic Societies, San Francisco, May 2017 (Owchar)* *To be presented as Chief Resident Research Project, Peoria, May 2017 (Owchar)* *Planned submission for consideration for publication in Ochsner Medical Journal*
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*Weekly Tuesday AM clinic for patient engagement* *Monthly meetings with care team* *Periodic meetings with senior advisor*

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was…..* *The level of patient engagement that was achieved* *The trust that patients put in the team (they kept in close contact, made extraordinary efforts to keep their appointments)* *Small clinical "wins" (successful visits with subspecialists, approval for meds or durable medical equipment)* *Increased understanding/fund of knowledge about non-medical challenges, such as guardianship and disability enrollment* *The significant increase of PCP continuity in a resident clinic* *Decrease in no shows for mental health visits* *Decrease in ED/Urgent care visits (avg charge per ED visit was $2244)*

		We were inspired by….. *The commitment of the parents of our patients and their ability overcome barriers with our help* *The commitment of the residents to their patients despite busy work schedules*
XI.	Barriers	*The largest barrier encountered was…..* *Research issues: families often did not bring binder to office visit, some data was difficult to obtain/track (eg medication compliance)* *Family issues: instability of living situation, lack of transportation, and limited access to telephones* *Researchers issues: residents' schedules are affected by work duty hours and their panels have a limited number of spaces each clinic day* *We worked to overcome this by…..* *Increased access to care with direct social work contact and regularly scheduled appts with care team* *Regularly reassessing patient needs with patient care team meetings*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be…* *Make sure resident continuity is the highest priority for children with special health care needs in the residency clinic setting, utilizing whatever resources the clinic can use to make this happen (schedulers, dedicated RN coordination, etc). This has improved the team's ability to build relationships and improved their ability to care for the patients.* *Advice for another team….* *Follow strict protocols throughout the entire research process and meet regularly to discuss*

		the protocol itself *(1) Pay attention to the enrollment process and exclusion criteria (adequate numbers; adequate enrollment period; scripted individual enrollment to include educating families about their commitment to the project and introducing families to the entire team to get them excited)* *(2) Choose data that are easily obtained and not dependent on patient behavior (eg patient binders) and regularly review that the data is being documented properly, systematically, and in a timely fashion* *(3) Obtain funding to help patients and families overcome barriers such as transportation needs or telephone access*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5 6 (7) 8 9 10*

Healthcare Disparities Knowledge, Attitudes, and Behaviors in Resident Physicians

Rebecca Hammarlund, PhD, Diana Hamer, PhD, Lauren Rabalais, MPA, Laurinda Calongne, EdD

Our Lady of the Lake Regional Medical Center, Baton Rouge, LA

Overall Goal/Abstract

To integrate a brief population health curriculum into resident education and to engage residents in the assessment of healthcare disparities in the communities they serve.

Background

Effective population health interventions must be grounded in the specific needs of the communities being served. Medical residents in community clinics have great potential to be the primary drivers of these interventions, as they make direct contact with a large number of community members on a regular basis. However, it is not clear that these residents are being provided with sufficient knowledge of population health issues to fulfill this role. One issue is that many residents are not native to the communities they serve. Thus, the current project was designed to provide both an educational and a behavioral intervention to residents currently training in the LSUHSC Internal Medicine, Psychiatry, Emergency Medicine, ENT, Surgery and Our Lady of the Lake Regional Medical Center (OLOLRMC) Pediatric Residency Programs in order to lay the educational foundations for the future development of targeted population health interventions.

Vision Statement

To educate residents about the powerful effects of healthcare disparities on their patient population and inspire them to address these disparities as part of routine care practices.

Materials/Methods

Time 1

-Pre-measures
- Objective Knowledge
  - General
  - Specific
- Subjective Knowledge
- Subjective Importance

-Didactic Intervention
- 4 faculty presented to all 6 residency programs

Time 2

+ 1 month

- Mid-measures
  - Objective Knowledge
    - Specific only
  - Subjective Knowledge
  - Subjective Importance
  - Subjective Learning
  - Behavioral Change
- Resident Champion Questions

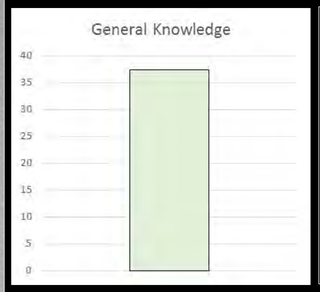
Time 3

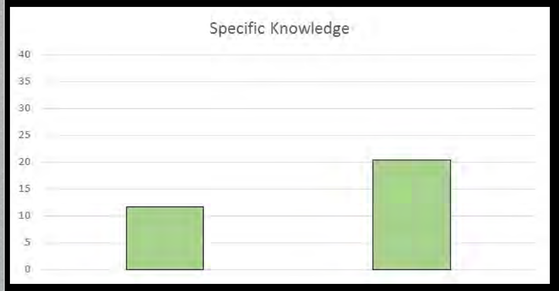
+2 weeks

- Behavioral Intervention
  - Clinic Questions for 1 month
  - Text reminders
  - Dot phrases
  - Reminder cards
- Post-measures
  - Subjective Knowledge
  - Subjective Importance
  - Subjective Learning
  - Behavioral Change

Results

Time 1



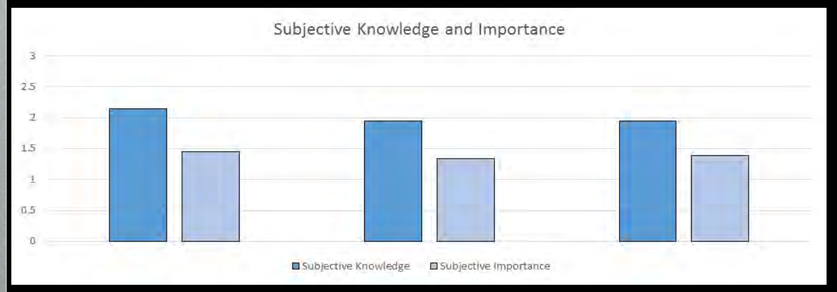


Time 2

- **55.6% "didactic changed my Tx plans"**
- **68.7% "know more about my patients"**

Time 3

- **Participation**
  - **6% did not ask**
  - **34% asked < 5 x per week**
  - **16% asked 6+ x per week**
  - **7% asked every patient**
- **41% "know more about my patients"**
- **More Asking, More new knowledge, r = .26, p < .05**
- **More new knowledge, more new attitude, r = .36, p < .01**
- **Top 3 Barriers : Transportation, Lack of copay $, No insurance**



Time 1 → Time 2:

- 38%/27% reported more Subjective Knowledge/Importance

- Change in Subjective Knowledge correlated with T2 Subjective Importance ratings, r = -.26, p < .05.

Time 2 → Time 3

- 17.1% reported more Subjective Knowledge

- 12.1% reported more Subjective Importance

Time 1 → Time 3

- **31.2% reported more Subjective Knowledge**
- **20.2% reported more Subjective Importance**

Time 2 → Time 3

Importance at T2 correlated with Ask Frequency at T3, r = .39, *p* < .01

Success Factors and Lessons Learned

Overall the success of our interventions was directly related to buy-in and participation from faculty and Resident Champions. Resident Champions were able to take ownership of the project and motivate their peers to participate, while faculty facilitated dissemination of information vital to project implementation. While both interventions showed at least some gain in resident knowledge or change in resident attitude, the Didactic appeared to be more effective.

Barriers Encountered/Limitations-

1. The behavioral intervention phase coincided with the end of the academic year, meaning that graduating residents did not have time to implement it. Timing the intervention mid-year would have allowed more residents to participate fully. **2.** In addition, some residents reported struggling to remember to ask the questions. We sent text reminders at standardized times but this meant some residents were reminded when they were not even in the clinic. We also provided a dot phrase to add to note templates, but there was no way to be sure each resident added it. Finally, we provided reminder pocket cards, however, residents have several of these and ours may have been lost in the shuffle. A slower, more thorough roll-out of the behavioral intervention may have been more effective at getting residents in the habit of implementing it. **3.** Some residents reported awkwardness with asking the questions. It is possible residents needed more guidance as to how to create a comfortable rapport that would encourage patient disclosures regarding healthcare disparities. Objective, patient-specific disparities data would also be helpful, if it could be obtained.

Conclusions

Our General and Specific Knowledge results reveal large deficits in our residents' knowledge about healthcare disparities in their patient population. Our Didactic session helped make strides in correcting this deficit as well as in changing resident attitudes about the importance of disparities in their practice. When residents believe that healthcare disparities are important, they are more likely to ask their patients about specific barriers to care that may indicate a need for alterations to the treatment plan. Finally, interventions like those utilized here can be effectively implemented across a range of residency programs from Pediatrics to Surgery, given proper buy-in.

Bibliography

Wieland ML, Beckman TJ, Cha SS, Beebe TJ, McDonald FS; Underserved Care Curriculum Collaborative. Resident physicians' knowledge of underserved patients: a multi-institutional survey. *Mayo Clin Proc.* 2010;85(8):728-733

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Our Lady of the Lake RMC **Project Tile: Residents as Data Collectors & Leaders in Identifying Community-Relevant Healthcare Disparities**

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	The ultimate goal of this project is to build a resident-led healthcare disparities initiative that will enhance resident, faculty and organizational knowledge of the healthcare disparities affecting the patient we serve, thereby allowing OLOL to better address its patients healthcare disparities in the future.
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	OLOL is the sponsoring institution for a pediatric residency program and serves as the primary clinical site for 4 LSU residency programs OLOL has an opportunity to better engage its residents in identifying and addressing the healthcare disparities that exist within our patient population. Effective population health interventions must be grounded in the specific needs of the communities being served. Medical residents in community clinics have great potential to be the primary drivers of these interventions, as they make direct contact with a large number of community members on a regular basis. The purpose of our project is to explore the effects of educational and behavioral interventions on the willingness of resident physicians to engage their patients in discussions of socio-economic determinants of health as well as resident knowledge regarding their patient population's health disparities. Our project will focus on residents from programs that have significant outpatient and ED contact with patients. The following specialties will be included: Internal Medicine, Emergency Medicine, Pediatrics, Psychiatry, ENT, and Surgery.

		We have designed a two-phase project. Phase one involves a didactic session on health disparities while phase two is a behavioral intervention in which residents will be tasked with asking their clinic patients at least 3 resident-selected questions related to health disparities.
III.	Team Members & Accountability (list of team members and who is accountable for what)	Representatives from each of the residency programs, including faculty site directors and resident champions are included in the AIAMC NI V Team. Laurinda Calongne, Ed.D. – Chief Academic Officer/DIO Keith Rhynes, M.D., MBA – OLOL GME Medical Director, Assoc. Program Director, LSU General Surgery Residency Program Trey Dunbar, M.D. – OLOL Pediatric Residency Program Director (2015-2016) Chris Woodward, M.D. – EM Faculty, Pediatric Emergency Department Site Director Kathleen Crapanzano, M.D. – Program Director, LSU-OLOL Psychiatry Residency Program Rebecca Horn, Ph.D. – Academic Research Director, LSU-OLOL Psychiatry Residency Program Laura Hetzler, M.D. – Program Director, LSU ENT Residency Program London Guidry, M.D. – General Surgery Faculty Jessica LaCombe, M.D. – IM Faculty Lauren Rabalais, M.P.A. – Divisional Director, Academic Affairs Diana Hamer, Ph.D. – Academic Research Director, LSU IM Residency Program Diane Kirby, M.D. – Faculty, OLOL Pediatric Residency Program Robert Peden, M.D. – Faculty, LSU ENT Residency Program Bahnsen Miller, M.D. – Fellow, OLOL PS/CQI Fellowship Program (2015-2016) Cheri Ausberry – OLOL Director of Community Development Angie Johnson, M.D. – Assistant Program Director, LSU Internal Medicine Residency Program John Whitaker, M.D. – General Surgery Faculty <u>Resident Champions:</u> Courtney James, M.D. (Pediatrics) C.J. Bordelon, M.D. (Internal Medicine) Rachel Bernard, M.D. (Pediatrics) Carine Nzodom, M.D. (Psychiatry) Jesse Sulzer, M.D. (Surgery) Kevin Hogan, M.D. (Emergency Medicine)

IV.	Necessary Resources (staff, finances, etc.)	For the success of this two phase intervention, the following resources were necessary: - Team members have dedicated one hour per month to participate on the workgroup - Faculty members have dedicated time to implement phase one (didactic session) and phase 2 (educational intervention) of the project. - Time Commitment from Sr. Research Director to facilitate post-intervention resident focus groups - Printing and laminating costs associated with pocket cards - Informatics Systems to include health care disparities dot phrase. and z-codes in residents' electronic notes.
V.	Measurement/Data Collection Plan	Pre and post-educational measurements: Prior to the Didactic Session, residents will complete the Learner's Needs Assessment Survey (Wieland et al 2010) to measure their perceived and actual knowledge of underserved patient population topics. One month after the Didactic Session, the residents will be re-surveyed to measure changes in perception/knowledge after the educational intervention and will be asked to complete a self-assessment survey. Post-intervention measurements: One month after the residents begin asking the interview question in their respective clinics, they will once again complete the Learner's Needs Assessment Survey in order to measure changes in perceived and actual knowledge of underserved patient population topics. Post-intervention focus groups: Focus groups will be led with the resident champions of the project and their peers to further assess the impact of the project on their knowledge and perceptions of healthcare disparities in the OLOL/BR community. The educational intervention will help resident champions develop the residency-specific questions that will guide the intervention phase. Furthermore, we will be able to determine if there was a change in residents' behavior that stems from the intervention. Comparison between pre and post education and intervention measures will help identify changes or increases in residents' subjective knowledge and subjective importance as well as actual knowledge on health care disparities.

VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	Team members were carefully selected for their expertise and ability to reach their perspective groups. - The team will meet monthly to discuss the progress of the project - Team members will be assigned to give presentations about the project to stakeholder groups, including their residency programs, OLOL Operations and Executive Leadership, etc. - Members of OLOL Leadership invited to attend Phase 1 Didactic Session and review our project data The Director of Community Development will assist in tying this project in to larger OLOL initiatives focused on addressing population health needs. Communication and support of the Mayor's Office is also important to success.
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	- Engagement of all residents, particularly Emergency Medicine residents who may not see themselves as leaders in addressing healthcare disparities because of their limited outpatient/clinic exposure and brief ED patient encounters. Education for this group and faculty support will be key to engagement. - This project will take place within a relatively limited time frame; therefore, impact on culture may be limited; however, this pilot project is intended to inform future projects centered on addressing healthcare disparities.

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	Publications Goals: - Two peer-reviewed manuscript by July 2017 - Two resident-led poster presentations by March 2017

IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	See Project Timeline document included on next page. - Baseline – mid-March 2016 - Didactic Intervention – end of March 2016 - Post-DS Survey – end of April 2016 - Practice Intervention – May 2016 - Post Practice Int. Survey – June 2016 - Data analysis – Summer 2016 - Resident Focus Groups – late Summer 2016 - Further data analysis – Fall 2016 - Publications – Spring 2017

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	The most successful part of our work was the buy-in and participation from faculty and resident champions. This highlights the importance of the topic to medical education and the commitment of the team to engaging all stakeholders. Resident Champions took ownership of the project and motivated their peers to participate in the education and intervention phases. Faculty members were essential in disseminating information vital to the project implementation. While both interventions showed at least some gain in resident knowledge or change in resident attitude, the didactic session appeared to be more effective. We were inspired by the level of motivation from the Resident Champions as well as participating residents. The education and intervention led residents to engage in quality

		interventions and research projects, outside the scope of this project, which focused on health care disparities. This motivation to further pursue projects that address issues within their patient population is an attestation of what the project accomplished.
XI.	Barriers	The largest barrier encountered was that there was no way to be sure each resident added the residency-specific dot phrase to their note templates. Resident reported willingness but often forgetfulness in asking the specific question. This could be reason the didactic session had an stronger impact on resident knowledge and behavior compared to the intervention phase We worked to overcome this by asking the residents to self-report if they did ask the questions/used the dot phrase. There is bias in self-reporting but results did show that the residents who asked their patients the questions more frequently had a higher increase in subjective importance after the intervention phase.
XII.	Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative would be to plan a slower, more thorough roll-out of the behavioral intervention to ensure the successful adoption of a dot phrase or z-codes so that the intervention is more effective in getting the residents in the habit of asking their patients about barriers to health care.
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5 6 7 8* ***9*** *10*

Special Needs Ambassador Program

Joseph Jaeger, Alex Puma, Margaret Fisher, Juliet Gossett, Patricia Gossett, Johanna Rosario,
Penny Stechman, Sweatha Kasala, Erum Khalil, Sayee Alagusundaramoorthy, Danielle Hilliard, Kristin Kuhi, Laura Parshelunis, The Arc of Monmouth

Monmouth Medical Center, Long Branch, New Jersey

Background

Research studies commissioned by Special Olympics have found that people with intellectual disabilities have poorer health profiles than their neurotypical counterparts, and that our doctors report a lack of competency to treat them ("Changing Attitudes," 2005). As New Jersey's largest integrated health care delivery system and a Premier Partner of Special Olympics New Jersey, RWJBarnabas Health is committed to reducing these differences. At Monmouth Medical Center (MMC), the first step to increasing means of access is to take advantage of healthcare resources that already exist within our system.

Methods

- Secured academic, clinical, and administrative support from GME, C-suite, and board-level leadership;
- Collaborated with community partner plus local, regional, and national experts in developmental medicine to identify unmet patient needs;
- Issued a community wide request for information about ideas to improve the patient experience;
- Developed and administered resident survey about preparedness to deliver IDD competent care;
- Launched SNAP (9/2016) - 6 person core team and ≈$11K in materials (incl. communication devices, sensory toys, iPads for patients, families, and staff);
- Next steps are to introduce SNAP at 2017 new resident orientation and recruit trainee champions.

Success Factors & Lessons Learned

- Capturing leadership buy-in is critical to success;
- Surveying residents' preparedness to care for patients with IDD is key to establishing the importance of program and curricula;
- RFI is a great tool for creating community engagement and patient-centered programming.

Barriers Encountered & Limitations

- Resident engagement
- Competing priorities (incl. other disparities initiatives)
- Clinical expertise in IDD

Vision Statement

Provide the highest quality care to all individuals affected by an intellectual and/or developmental disability (IDD) through healthcare excellence, superior service, and compassionate care.

Mission Statement

Engage the community and GME in the establishment of a Special Needs Ambassador Program (SNAP) to support individuals and families throughout their experience at MMC.

Results

- Successfully established a SNAP to address unmet patient needs and identified gaps in resident preparedness to deliver IDD competent care.
- Patient, caregiver, and SNAP ambassador surveys will gather quantitative and qualitative feedback for regular 360° evaluation of the program.
- Patients utilizing SNAP services will be identifiable within administrative datasets, allowing for future investigations about impact on selected measures of importance (e.g. length of stay, patient satisfaction scores).

Conclusions

A SNAP can support individuals and families affected by IDD in overcoming impediments to receiving care, and, with resident involvement, may help to close gaps in trainee knowledge and performance about a patient population that they will undoubtedly care for.

Bibliography

Changing Attitudes Changing the World: The Health and Health Care of People with Intellectual Disabilities. (2005). Retrieved from http://www.specialolympics.org/uploadedFiles/LandingPage/WhatWeDo/Research_Studies_Desciption_Pages/policy_paper_Health.pdf

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Monmouth Medical Center, Long Branch, New Jersey **Project Tile:** Special Needs Ambassador Program

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	Provide the highest quality care to all individuals affected by an intellectual and/or developmental disability (IDD) through healthcare excellence, superior service, and compassionate care.
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	• Identify strengths and weaknesses in IDD education and experience in GME programs; • Understand and prioritize areas for IDD community health and IDD community engagement; • Engage hospital administration and GME in review of IDD community health needs; • Develop and implement a Special Needs Ambassador Program (SNAP); • Significantly and measurably advance MMCs engagement through GME; • Participate in a collaborative national effort to identify and share best practices; and • Author one or more manuscripts.
III.	Team Members & Accountability (list of team members and who is accountable for what)	Dr. Joseph Jaeger (Team leader), Alex Puma (Team leader; SNAP ambassador), Danielle Hilliard (SNAP program champion; SNAP ambassador), Dr. Margaret Fisher (GME faculty champion), Juliet Gossett (Human resources), Patricia Gossett (Quality), Reverend Penny Stechman (Community member; Patient advocate), Dr. Sweatha Kasala (Resident champion), Dr. Erum Khalil (Resident champion), Dr. Sayee Alagusundaramoorthy (Resident champion), Laura Parshelunis (Social work), Kristin Kuhi (Child life; SNAP ambassador), Johanna Rosario (Patient experience; SNAP ambassador), Theresa Archer (SNAP ambassador), Virginia Heggen (SNAP ambassador), and The Arc of Monmouth (Community partner).
IV.	Necessary Resources (staff, finances, etc.)	Volunteer SNAP core team (6 staff), ≈ $11,000 in one-time expenses (Communication devices – phones; SNAP tool kits – sensory toys, dry erase boards, transport cases; and iPads with LifeProof cases), and promotional material (e.g. signage, flyers, ID tags).

V.	Measurement/Data Collection Plan	Patients, parents/caregivers, and SNAP ambassadors are invited to complete a 5-7 question survey about each SNAP experience. Surveys gather quantitative and qualitative feedback, and will be reviewed regularly to provide a 360° evaluation of the program. In addition, patients utilizing SNAP services will be identifiable within administrative datasets, allowing for future investigations about impact on selected measures (e.g. length of stay).
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	**Stakeholder communication plan summary:** Internal communications (non-GME): Engaged C-suite and board level stakeholders to secure buy-in, and solicit high-profile community leaders for in-kind and financial support; Presented to hospital management team (employees at Director-level and above) to create engagement, and recruit physical, intellectual, and human resources; Published online content to educate and recruit hospital staff. Internal communications (GME): Announced NI V participation at Graduate Medical Education Committee (GMEC); Administered web-based survey about resident-preparedness to deliver IDD-competent care; Collaborated with The Arc of Monmouth to offer continuing medical education (CME); Next steps - present SNAP program and recruit trainee champions at 2017 new resident orientation. External communications: Issued community wide request for information (RFI) to define unmet needs for individuals affected by IDD; Conducted interviews with patients and key stakeholders (including national and regional experts in developmental medicine; administrators of a state University Center for Excellence in Developmental Disabilities Education, Research, and Services; chairperson of a State Council on Developmental Disabilities; and representatives from several major advocacy organizations).
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	Challenges include resident engagement; competing priorities (including other disparities initiatives); and clinical expertise in IDD.

XIII.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	**Project schedule:** Jun – Sep 2015: Announce NI V to GMEC; Convene NI V team and complete pre-work; Collaborate with community partner to develop survey of resident preparedness to deliver IDD competent care, public RFI, and CME program; Conduct interviews with key stakeholders. Nov 2015 – Mar 2016: Administer resident survey; Issue community wide RFI; Execute CME program; Conduct interviews of RFI respondents; Synthesize background knowledge and key findings; Develop improvement goals for SNAP program. Mar – Sep 2016: Recruit SNAP core team; Present to hospital President/CEO & CNO; Present to children's hospital board of trustees; Present to hospital management team; Publish online content and assign house-wide; Present policies, procedures, and forms to hospital committee; SNAP go-live. Nov 2016 – Mar 2017: Present at nursing grand rounds; Initiate monthly training classes; Initiate monthly lunch and learns for SNAP ambassadors; Next steps - Present SNAP at community events/doctors' offices; Next steps - Present SNAP program at 2017 new resident orientation.

Sections IX thru XII to be completed first quarter 2017 for "Final Proceedings" booklet:

IX.	Success Factors	*The most successful part of our work was…..* securing buy-in from hospital leadership. *We were inspired by…..* the resilience and perseverance of individuals and families affected by IDD.
X.	Barriers	*The largest barrier encountered was…..* lack of clinical expertise in IDD. *We worked to overcome this by…..* engaging local, regional, and national experts.
XI.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be…..* to engage radically with the communities that you serve.
XII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* 7

Enhancing Services for Recently Incarcerated People and Their Families

Jeri Hepworth PhD, Ashley Negrini MS, Arth Patel MD MPH, Heidi Tucker DO,
Rebecca Crowell PhD, Marcus McKinney D.Min. LPC, Lawrence Young MPH
Saint Francis Hospital and Medical Center, Hartford, CT

Overall Goal/Abstract

We wanted to help clinicians feel more comfortable about assisting patients with incarceration history, an identified vulnerable population.
After consultation with regional and national experts, a Grand Rounds was created about the health impacts of incarceration and its sequelae.
Pre- and post-tests gauged level of knowledge, understanding, and comfort before and after educational session.
The second phase included follow up discussion with the residents focused on communication skills, changes in behavior, and best practices.
The project resulted in education for residents and clinical teams to help them communicate with patients and families, identify resources, and better serve this vulnerable population.

Background

The Curtis D. Robinson Center for Health Equity at Saint Francis is dedicated to serving our community for optimal health through education, research, engagement, and health advocacy.
Drs. Patel and Tucker, Family Medicine residents, identified the project's focus.
Resources included Physicians, Community Health Workers and Patients from the Yale Transitions Clinic, a nationally recognized program providing healthcare and re-entry assistance.

Vision Statement

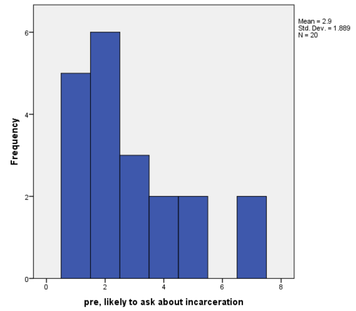
We will facilitate equitable health of people who have been incarcerated and their families.
Our team of hospital leaders, resident and community members will collaborate to advance health access and treatment for recently incarcerated people.

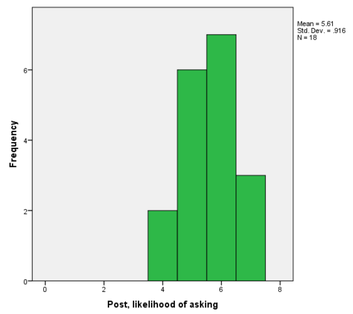
Methods

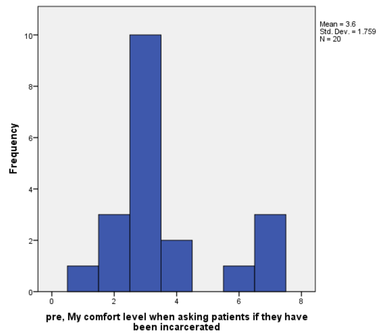
- Identified and met with regional experts in correctional managed health and in innovative clinical treatment programs
- Held educational session July 2016
- With key informants, developed pre- and post-test measures to evaluate the educational session
- Planned and held a follow up discussion with residents, focused on reflection, communication skills, changes in behavior, and best practices

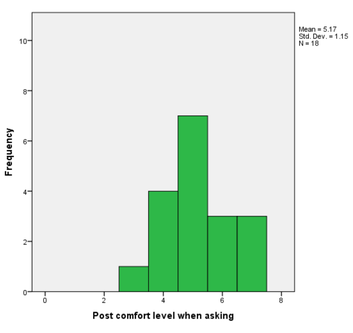
Results

Pre- and post-tests compared level of knowledge, understanding, and comfort before and after the educational session. Data revealed significant differences in participants reports about importance and awareness of the issue, in likelihood of asking about incarceration, in comfort level when asking, in perceived knowledge of health issues, in confident linking patients with resources, in awareness of barriers to care, and in empathy.









Success Factors and Lessons Learned

Successes

- Educational session was well attended and highly regarded
- Recording the session allowed for dissemination
- Pre- and post-test measures demonstrated increases in importance, awareness, likelihood of asking about, and comfort level
- Follow up discussion with residents revealed perceived changes in behavior and identified best practices

Lessons Learned

- Time for resident participation needs to allocated
- Slight modifications and adaptability still allowed for a successful project
- Provision of comprehensive care is achieved with an integrative behavioral health care model

Barriers Encountered/Limitations

- "I know what that means, but I don't know what it's like" A McGregor, MD, resident.
- Perceived comfort with initiating conversation doesn't result in comfort in identifying services
- Project identified perceived changes in attitudes and behavior, with no objective evaluation

Conclusions

The educational session resulted in an increase in awareness, likelihood and level of comfort asking about incarceration, and perceived knowledge of health issues and barriers to care. Follow up discussions are important to affirm learning and continue to address unconscious bias and equitable care.

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Saint Francis Hospital and Medical Center **Project Tile:** Enhancing Services for Recently Incarcerated People and Their Families

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*We will facilitate equitable health of people who have been incarcerated and their families.* *We will have identified unmet needs and community resources, developed and implemented an educational module, and assessed its effects.*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	*We will create an educational session about the health impacts of incarceration and its sequelae for residents, faculty and staff. Resources include regional and national experts. The second phase will include a follow up discussion with residents focused on communication skills, changes in behavior following the educational session, and best practices. The project will result in education for residents and clinical teams to help them communicate with patients and families, identify best practices, and better serve this vulnerable population.*
III.	Team Members & Accountability (list of team members and who is accountable for what)	*Responsibilities will be shared amongst the team. Meetings are scheduled for every three weeks to ensure active participation.* *Team Members* Jeri Hepworth, PhD Marcus McKinney, D.Min., LPC Rebecca Crowell, PhD Lawrence Young, MPH Ashley Negrini, MS Arth Patel, MD, MPH Heidi Tucker, DO

IV.	Necessary Resources (staff, finances, etc.)	*The team has appropriate staff and fiscal support.*
V.	Measurement/Data Collection Plan	*Conduct a needs assessment of existing community resources.* *Conduct pre- and post-tests to gauge level of knowledge, understanding, and comfort before and after educational session.* *Review and discuss the data with residents during the follow up session, identify perceived changes in practice, and elicit themes regarding best practices.*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	*The Center for Health Equity has significant community relationships which will be accessed with this project.*
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc.)	*1) Identification of the people who comprise this population, particularly family members.* *2) Scheduling challenges and time constraints.*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Development of educational module and assessment of process will result in presentations and potential publications.*	
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*Phase 1 Summer 2016: Co-sponsored Family Medicine Grand Rounds on "A Conversation about Incarceration: Healthcare Implications" with the team from the Yale Transitions Clinic, including the lead physician, a community health worker, and a formerly incarcerated patient.* - *Pre- and post-tests were conducted to gauge level of knowledge, understanding, and comfort before and after educational session.* - *Feedback received was overwhelmingly positive and we planned to use the recording of the session along with a facilitated discussion to further engage residents on the topic.* *Phase 2 Winter 2016/Spring 2017: Planned and held follow up discussion with Family Medicine residents.*	

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was having these engaging discussions about the needs of this vulnerable population, and establishing best practices to help have the conversation about incarceration and increase awareness.* *We were inspired by the residents initiation of this topic based on their experiences, and by the work done by the team at Yale Transitions Clinic.*

XI.	Barriers	*The largest barrier encountered was resident time constraints, and realities of resident developmental interests.* *We worked to overcome this by modifying the project plan.*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be to ensure that considerable and consistent time is built into the residents' schedules in order for them to continue working on the project throughout the 18 months.*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5 6 **7** 8 9 10*

AIAMC NI V Poster

Reducing Disparity through Advanced Care Planning

Ted Glynn, MD, FACEP & Lisa Powell, MBA

Sparrow Hospital Lansing, Michigan

Overall Goal/Abstract

The overall goal of this project is to decrease health care disparity through the utilization of advanced care plans. By creating a mutual plan that takes into consideration the patients beliefs, desires, and available resources we hope to improve the management of chronic health conditions in the primary care/ambulatory settings. The foundation to success is to assure that providers have the skills and tools to conduct advanced care planning visits with their patients, as well as an accessible place to store those plans for others on the care team.

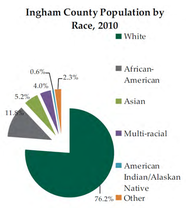
Background

Advanced care planning is a strategic objective of the health system , resources are being committed to standardizing advanced care planning

Present residency curriculum lacks standardized education on leveraging an advanced care plan to manage patients with chronic conditions

Baseline data shows elevated rate of readmission in targeted population

Access to and utilization of existing ambulatory care resources to manage complex chronic disease states may be limited



Behavior, Physical Condition, and Access to Care Indicators – Ingham County			
Indicator	Definition	Percentage	Comparison With Michigan
Obesity	Percentage of adults who are obese	24.1%	●
	Percentage of adolescents who are obese	16.7%	●
Tobacco Use	Percentage of adults who currently smoke	21.4%	●
	Percentage of adolescents who smoked in the past month	10.0%	●
Alcohol Use	Percentage of adults who binge drank in past month	16.7%	●
	Percentage of adolescents who binge drank in past month	10.9%	●
Access to Care	Percentage of residents lacking a primary care physician	29.1%	●
	Percentage of population enrolled in Medicaid	11.9%	●
	Ratio of population per primary care physician	762 per physician	●
Prevention	Percentage of children 19 to 35 months old with recommended vaccinations	76.0%	●
Mental Health	Percentage of adults who report their mental health is "not good"	12.1%	●

● Better than statewide average ● About average ● Worse than statewide average

Ingham County is the largest county within the 6-county Sparrow Health System service area, with a population of almost 300,000 residents. The City of Lansing (population 114,297) is the largest city in Ingham County and the 6-county region. Approximately one of every four Ingham County residents is a member of a minority group, and there is considerable poverty in the county. More than 20% of all county children live in poverty, and more than one-third of households spend more than 30% of their income on housing. Almost one in four adults in the county is obese, and more than one in five adults is a smoker.

Vision Statement

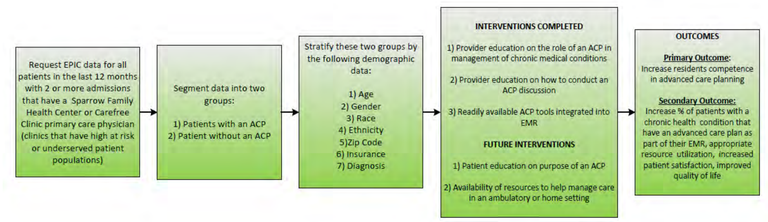
VISION STATEMENT:

To integrate advanced care planning into routine care so the treatment patients receive is always aligned with their goals and values

MISSION STATEMENT:

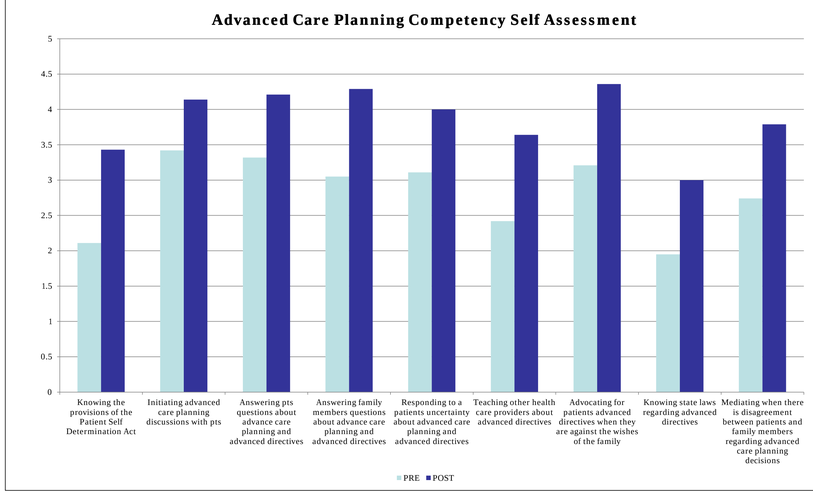
To improve management of chronic health conditions in the ambulatory setting through advanced care planning

Materials/Methods



•Completion of a pre-intervention survey regarding advanced care planning competency
•Completion of the Respecting Choices Person Centered Care Advanced Care Planning Facilitator curriculum
•Completion of a post-intervention survey regarding advanced care planning competency

Results



Success Factors and Lessons Learned

Significant improvement in all nine domains resulted from providing standardized education regarding how to facilitate an Advanced Care Planning patient visit. This project required very minimal resources and was deemed as valuable use of educational time by the residents. This pilot did not include faculty, so the next cycle will be faculty development. For continued project success, it is imperative that the faculty have the tools to provide support as we expand this project to include simulated and real visits with patients.

Barriers Encountered/Limitations-

BARRIERS:

- Lack of understanding of the role advanced care planning plays in the management of chronic health conditions
- Lack of a standard process for conducting and documenting advanced care plans

LIMITATIONS:

- This pilot was limited to one specialty (conducted within the Family Medicine Residency program at Sparrow Hospital)

Conclusions

- The initial intervention brought significant improvement in the resident's self rated competency to perform an advanced care planning visit.
- The residents reported the need for practice in this skill to master competency, supporting expansion of this project to include:

Spread of Phase 1:
Begin educational component with other primary care and specialty programs within Sparrow (Internal Medicine, Cardiology, Pulmonary Critical Care)

Phase 2:
Provide faculty development on Advanced Care Planning
Protect time for simulated Advanced Care Planning visits
Provide training on how to document and bill for visit

Phase 3:
Monitor the number of ACP visits conducted for continuity patients
Monitor outcomes/utilization of patients with ACP in place versus those who do not have a formal ACP

Bibliography

•Alderman JS; Nair B; Fox MD. **Residency training in advance care planning: can it be done in the outpatient clinic? Am J Hosp Palliat Care. 2008; 25(3):190-4 (ISSN: 1938-2715)**

•Sarah Leatherman Allen, Kimberly S. Davis, Paul C. Rousseau, Patty J. Iverson, Patrick D. Mauldin, and William P. Moran (*2015*) Advanced Care Directives: Overcoming the Obstacles. Journal of Graduate Medical Education: March 2015, Vol. 7, No. 1, pp. 91-94

•Sulmasy, D.P., Song, K.Y., Marx, E.S. et al. J Gen Intern Med (1996) 11: 657. doi:10.1007/BF02600156

•PAUL V. AITKEN, JR., M.D., M.P.H, State University of New York Health Sciences Center, Stony Brook, New York. *Am Fam Physician*. 1999 Feb 1;59(3):605-612

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Sparrow Hospital **Project Tile:** Reducing Disparities through Advanced Care Planning

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*To integrate advanced care planning into routine care so the treatment patients receive is always aligned with their goals and values*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	*The overall goal of this project is to decrease health care disparity through the utilization of advanced care plans. By creating a mutual plan that takes into consideration the patients beliefs, desires, and available resources we hope to improve the management of chronic health conditions in the primary care/ambulatory settings. The foundation to success, and first project phase, is to assure that providers have the skills and tools to conduct advanced care planning visits with their patients, as well as an accessible place to store those plans for others on the care team.*
III.	Team Members & Accountability (list of team members and who is accountable for what)	*Lisa Powell, MBA – GME Specialist* *Ted Glynn, MD, FACEP – Vice President, Medical Education & Research* *Jim Olson, MD – Program Director, Family Medicine Residency* *Elizabeth Cholakis – Program Coordinator, Family Medicine Residency* *Family Medicine Residents*

IV.	Necessary Resources (staff, finances, etc.)	*The project will be led by a member of the GME staff, with support from the GME office and Family Medicine. The project requires minimal financial resources, with educational intervention at only $155 per resident.*
V.	Measurement/Data Collection Plan	*The following surveys were completed via New Innovations, which provided reports at the completion of each survey window:* *Completion of a pre-intervention survey regarding baseline advanced care planning competency* *Completion of a post-intervention survey regarding changes in advanced care planning competency*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	*Communication with GME team to brainstorm areas of opportunity -> communication with the CMO to secure alignment with organizational imperatives and institutional support -> work group of key stakeholders developed and regular meetings conducted -> engagement of Family Medicine Residency through communication with program administration -> communication plan to residents*
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	*Engagement of the residency program to pilot the project* *Time allocation to complete the training* *Time constraints due to multiple priorities in GME*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*In addition to sharing with members of the AIAMC, this project is slated for internal presentation as it aligns with a 2017 strategic imperative to increase the number of Advanced Care Plans in the EHR, to educate the successful foundation created within the Family Medicine Residency for future ACP visits and the possibility of spread to the entire medical staff. In addition, we are considering potential publication after subsequent phases of the project are completed.*
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*<u>Phase 1:</u>* *Baseline assessment of competency* *Deploy educational component* *Repeat assessment of competency* *<u>Phase 2:</u> (concurrently begin phase 1 in Internal Medicine, Cardiology, PCC)* *Provide faculty development on Advanced Care Planning* *Protect time for simulated Advanced Care Planning visits* *Provide training on how to document and bill for visit* *<u>Phase 3</u>:* *Monitor the number of ACP visits conducted for continuity patients* *Monitor outcomes/utilization of patients with ACP in place versus those who do not have a formal ACP*

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was making meaningful change in the residents preparedness to have advanced care planning discussions with their continuity patients. We were inspired by the significant increase in their self-assessment scores post intervention. This is just step one in a multi-phase project that will hopefully bring better management of chronic medical conditions to disadvantaged patients in our community.*
XI.	Barriers	*The largest barrier encountered was scale of the project. We worked to overcome this by continuing to map out the project plan, get input from anyone impacted by the project, and seek advice from those who had gone down this path before us. We continued to transform this from one large project into a project with 3 smaller phases so that we could share measures of success in March 2017, and still continue to work towards our original vision.*
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be to keep your first project to a very small scope. We all want to make significant change, but we need to complete a manageable initiative to gain valuable experience before we grow in future quality improvement endeavors. All improvement, not matter how minimal the scope of the project, is meaningful.*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5 6 7 8 9 10*

In Their Own Words:
Improving Interpretation and Language Access

Isabelle Trepiccione, MD, Hailey Wilson, MD, Jessica Portillo, MD, Lauren Sonderegger, MD
Swedish Medical Center

Overall Goal/Abstract

Objective: Reduce language barriers of Swedish' most-used languages and improve care experience for limited English proficiency (LEP) communities at Swedish
Project Target: Top 5 non-English speaking communities at Swedish Medical Center
Project Scope:
- First Hill Campus Inpatient Units (medical/surgical, post-partum, and pediatric)
- Outpatient Clinics: First Hill and Cherry Hill Family Medicine Resident Clinics
- Target Languages: Spanish, Chinese (Cantonese & Mandarin), Vietnamese, Somali, Amharic

Project Requirements:
- Access and compilation of data, forms, documents, surveys pertaining to project. Identify key stakeholders and contact information
- Conduct patient experience and utilization of interpreter services surveys, analyze baseline data, and launch interventions to track progress

Project Assumptions: Lack of culturally sensitive menus (translated menus, special diets) for inpatients, lack of translated forms/documents/signage, need for universal signage for wayfinding, and limited and suboptimal user experience of interpreter services all contribute to impaired communication and suboptimal hospital experiences for LEP patients
Stakeholders: LEP Patients and families, Swedish Family Medicine resident teams, Interpreter Services, clinic and unit support staff, unit/charge nurses, GME office, Equity of Care Steering Committee, Resident Quality and Safety Committee, and community support groups,
Measures of Success:
- Increased use of interpreter services and translated forms, and increased awareness of internal organization's language support and resources
- Improved LEP patient satisfaction scores, increased physician satisfaction when providing care to LEP patients
- Meeting communities' cultural needs as part of culturally competent care

Background

- Swedish Medical Center is located in the rich multicultural city of Seattle, WA. 1/3 of Seattle residents (approx. 217,500) are persons of color and 17% foreign-born.
- In 2015, Swedish recorded 114,282 patient requests for interpretation in 143 different languages.
- Community Health Needs Assessments and interviews with community leaders have both identified the importance of cultural and linguistic competency when designing healthcare services. There are many opportunities to partner with particular population groups to offer culturally-specific services to non-English speaking minority groups.
- Swedish' vision is to provide the highest-quality, best-value healthcare to all we serve. There is strong leadership and system awareness to provide culturally responsive care to minority groups.

Vision Statement

To improve engagement, bridge communication gaps, and deliver culturally responsive care to limited English proficiency (LEP) communities we serve.

Materials/Methods

Phase I
- Review community health needs assessments
- Discussion with various LEP community stakeholders about experience at Swedish
- Develop in-language patient satisfaction survey for baseline
- Compile translated forms and documents; review VRI data; review menus
- Create communication plan to units and clinics

Phase II
- Socialize and engage charge nurses to project
- Survey, language aids rollout
- Update forms and documents
- Develop training program to internally share and educate caregivers

Phase III
- Internal presentation and communication with medical staff.
- Communication/feedback with minority support groups and interpreter services dept.
- PDSA process and workflow.

Phase IV
- Socialization of project with Swedish Leadership at MEC, Quality Council, Nurse Executives.
- Kick-off training at New Provider Orientation, New Resident Orientation
- Recommend opportunities to improve Interpreter Svcs website
- Develop sustainability plan

Results (both quant & qual. data)

Qualitative
- Raise awareness through project presentation to Swedish Leadership, Medical Executives, Nursing Executives, and GME Quality and Safety Committee.
- Develop Interpreter Services Training and embed presentation to monthly New Provider Orientation and yearly New Resident Orientation
- Include language scenarios to Swedish' Culture of Safety Training

Quantitative

Do you know how to use interpretive svcs?

User	Pre Training (n=57)	Post Training (n=52)	6mo Post Training (n=18)
VRI	35 (61.40%)	52 (100%)	14 (77.8)
In-Person	23 (40.35%)	48 (92.31%)	13 (72.2%)
Phone	36 (63.16%)	50 (96.15%)	13 (72.2%)

Non-English Pt. Comm. – Baseline

	Difficult Comm.	Felt respected	Understood Info
Always	14 (14.74%)	80 (84.21%)	80 (91.95%)
Often	18 (18.95%)	4 (4.21%)	7 (8.05%)
Never	61 (64.21%)	3 (3.16%)	0 (0%)

Non-English Pt. Comm. – Post-intervention

	Difficult Comm.	Felt respected	Understood Info
Always	3 (4.92%)	57 (93.44%)	50 (85.26%)
Often	6 (9.84%)	2 (3.29%)	9 (14.75%)
Never	52 (85.25%)	0 (0%)	0 (0%)

Success Factors and Lessons Learned

Success Factors
- Strong passion and engagement from our own teammates. Project was 100% led, planned, and executed by Family Medicine Residents.
- Leverage and build upon existing internal resources and structures

Lessons Learned
- Need for strong leadership sponsorship to help clear system obstacles and obtain data and reports

Barriers Encountered/Limitations

- Language barriers – over 140 different languages registered in database
- Challenging for LEP patients to navigate healthcare system
  - Wayfinding in hospital/clinics
  - Access to translated resources
  - Communication with care team
- Patients not feeling culturally respected
- Resources underutilized by physicians and staff:
  - In-person or video remote interpreting (VRI) services
  - Translated aids, forms and documents for patient care and communication
- No consistent or periodic culturally responsive training and education to physicians and staff to deliver better care
- Lack of mechanism to measure minority group patient satisfaction
- Limited financial budget/resources
- Access to resources for data/report – reliant on busy resident physicians to volunteer time for data collection
- Staff bandwidth and flexibility to changes in workflow improvements
- Conflicting priorities within system leads to resistance to change management and governance accountability

Conclusions

LEP patients and staff alike have frustrations when it comes to the impact of communication limitations on patient care. We, the residents, felt passionate about the various opportunity gaps that this project can bring to bridge the daily interactions between providers and patients. As such, we believe that the interventions developed in this project have the potential to improve numerous patient/staff interactions and patient experiences, especially for LEP communities.

Although data collection to support this conclusion has proven to be difficult, we received positive feedback from nursing staff regarding the compilation and organization of frequently used documents. Our hope is that our Interpretive Services department can build upon the work we have delivered so far to sustain, scale, and spread our efforts to the entire Swedish Health Services system.

We are honored to represent Swedish Medical Center as the 1st team to participate in AIAMC National Initiative and grateful for this experience to be one step closer to the communities we serve.

Bibliography

- Flores G[1].The impact of medical interpreter services on the quality of health care: a systematic review.
- Med Care Res Rev. 2005 Jun;62(3):255-99.
- Karliner LS[1], Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature.
- Health Serv Res. 2007 Apr;42(2):727-54.
- Refugee Health Technical Assistance Center.2011. "Best Practices for Communicating Through an Interpreter." Retrieved 16 Mar 2016 from http://refugeehealthta.org/access-to-care/language-access/best-practices-communicating-through-an-interpreter/
- Center for Disease Control and Prevention. 2014. "Effective TB Interviewing for Contact Investigation: Self-Study Modules- Working with Interpreters." Retrieved 16 Mar 2016 from http://www.cdc.gov/tb/publications/guidestoolkits/interviewing/selfstudy/module2/2_6.htm
- University of Washington Interpreter Services. 2016. "Interpreter Services: How to Effectively Work with Interpreters and Translator to Communicate with Your Patients." Retrieved Mar 2016 from http://www.uwmedicine.org/uw-medical-center/documents/Interpreter-Services-How-To-Work-With.pdf
- King County.Gov "King County Community Health Needs Assessment 2015/2016." Retrieved 16 July 2015 from http://www.kingcounty.gov/depts/health/data/community-health-indicators/~/media/depts/health/data/documents/2015-2016-Joint-CHNA-Report.ashx
- Swedish Medical Center "Swedish Health Services 2012 Community Health Needs Assessment." Retrieved 16 July 2015

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Swedish Medical Center **Project Tile:** In Their Own Words: Improving Interpretation and Language Access

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	To improve engagement, bridge communication gaps, and deliver culturally responsive care to limited English proficiency (LEP) communities we serve.
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	**Objective:** Reduce language barriers of Swedish most-used languages and improve care experience for Limited English Proficiency (LEP) communities at Swedish **Project Target:** Top 5 non-English speaking communities at Swedish Medical Center. Target Languages: Spanish, Chinese (Cantonese & Mandarin), Vietnamese, Somali, and Amharic. **Project Scope:** • First Hill Campus Inpatient Units: Medical/surgical, post-partum, and pediatric units • Outpatient Clinics: First Hill and Cherry Hill Family Medicine Resident Clinics **Project Requirements:** • Access and compilation of data, forms, documents, surveys pertaining to project. Identify key stakeholders and contact information. • Conduct patient experience and provider utilization of interpreter services surveys, analyze baseline data, launch interventions, and track progress/impact of interventions via post-training surveys

		Project Assumptions: Lack of culturally sensitive menus (translated menus, special diets) for inpatients, lack of translated forms/documents for clinical communication, need for universal signage for wayfinding, and limited and suboptimal user experience of interpreter services all contribute to impaired communication and suboptimal hospital experiences for LEP patients. **Stakeholders:** LEP patients and families, Swedish Family Medicine resident teams, Interpreter Services, clinic and unit support staff, unit/charge nurses, GME office, Equity of Care Steering Committee, Resident Quality and Safety Committee, community support groups. **Measures of Success:** increased use of interpreter services and translated forms and increased awareness of organization's language support and resources; improved patient satisfaction scores, increase physician satisfaction when providing care to LEP patients; and meeting communities' cultural needs as part of culturally competent care.
III.	Team Members & Accountability (list of team members and who is accountable for what)	**Resident Leaders** Leah Baruch, MD Glenna Martin, MD Jessica Portillo, MD Lauren Sonderegger, MD Isabelle Trepiccione, MD Hailey Wilson, MD **Faculty** Barry Saver, MD Kevin Wang, MD **Team Members** Bethany Bennett, Manager, Medical Education I-Nong Lee, Project Manager

		Executive Sponsors John Vassall, MD, CMO Sandy Norris, MBA, DIO, Admin. Director Medical Education/Med Staff Services Elizabeth Wako, MD, VP of Medical Affairs Sherry Williams, Community Engagement Director
IV.	Necessary Resources (staff, finances, etc.)	Voluntary time commitment to project Staff to conduct inpatient and outpatient survey Executive leadership buy-in Institutional commitment to sustainable success Data extraction & analysis Available patient satisfaction data on non-English speaking patients Financial commitment from project sponsors to fund resources and direct/indirect costs
V.	Measurement/Data Collection Plan	**Measurements** • Pre- and Post-intervention surveys for inpatient and outpatient patient experience o Inpatient floors: Medical/surgical, post-partum, and pediatric units. o Outpatient: First Hill and Cherry Hill Family Medicine Resident Clinics • Verify/validate culturally sensitive menus • Pre/post training survey to residents; follow up measurement post-survey **Intervention (overall)** • Include Interpreter Services presentation training at monthly New Provider Orientation and annual New Resident Orientation • Case scenarios added to institutional Culture of Safety Training (iSBAR, QVV, etc.) • Recommendations for more optimal utilization of Interpreter Services - Website layout for easier navigation

		- How to use interpreter services - Access to translated documents **Outpatient Intervention** • Universal Healthcare Signage • "Accessing Interpreter Services" Signs **Inpatient Intervention** • Language binders distributed to each of the inpatient floors • In-service with nursing on targeted inpatient floors • "Accessing Interpreter Services" Signs
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	**Presentation to Executive Sponsors:** John Vassall, Sandy Norris, Sherry Williams **Meeting with Community Stakeholders:** Ethiopian Leadership meeting, Somali group meeting, South Park Latino Center Senior Focus Group meeting, and Asian Counseling. **Connecting to Internal Stakeholders:** Interpreter Services, Multicultural Engagement, Community Engagement **Socializing Project with Executive Committees:** Institutional Quality and Safety Committee, Medical Executive Committee, Nursing Executive Committee, Graduate Medical Education Committee, Equity of Care Steering Committee.

VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	• Language barriers – over 140 different languages registered in database
		• Challenges for LEP patients to navigate healthcare system
		  - Wayfinding in hospital/clinics
		  - Access to translated resources (e.g. translated menus)
		  - Communication with care team
		• Patients not feeling culturally respected
		• Resources underutilized by physicians and staff:
		  - In-person or video remote interpreting (VRI) services
		  - Translated aids, forms and documents for patient care and patient communication
		• No consistent or periodic culturally responsive training and education to physicians and staff to deliver better care
		• Lack of mechanism to measure minority group patient satisfaction
		• Limited financial budget/resources
		• Access to resources for data/report – relying on busy resident physicians volunteer time for data collection
		• Staff bandwidth and flexibility to changes in workflow improvements
		• Conflicting priorities within system leads to resistance to change management and governance accountability

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	• Structure of project solely for Quality improvement and patient safety. • Results and analysis were used as impetus to improve community health, not intended for broader dissemination • Utilize project findings for CME Grand Round learning and sharing opportunities

IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	Phase I • Review community health needs assessments • Discussion with various LEP community stakeholders about their experience at Swedish • Develop in-language patient satisfaction survey for baseline • Compile translated forms and documents; review VRI data; review menus • Create communication plan to units and clinics Phase 2 • Socialize and engage charge nurses to project • Survey, language aids rollout • Update forms and documents • Develop training program to internally share and educate caregivers Phase 3 • Internal presentation and communication with medical staff. • Communication/feedback with minority support groups and interpreter services dept. • PDSA process and workflow. Phase 4 • Socialization of project with Swedish Leadership at MEC, Quality Council, Nurse Executives, • Kick-off training at New Provider Orientation, New Resident Orientation • Recommend opportunities to improve Interpreter Svcs website • Develop sustainability plan

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was…..* Presenting our project to the various Swedish executive leadership and admin teams, as well as getting the unexpected approval of including interpreter services presentation to all new provider orientation as part of their onboarding training. *We were inspired by…..* The passion and engagement of our own teammates. This project is driven, planned, and executed purely by residents, who voluntarily dedicated time to support and contribute to the project, for the goal of doing the right thing for our LEP patients.
XI.	Barriers	*The largest barrier encountered was…..* Resources for data extraction and analysis (technical or operational) was not as rich as group had originally anticipated *We worked to overcome this by…..* Acknowledging missing gaps and remaining flexible to adjust project approaches while keeping target of our goals.
XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be…..* Have strong leadership sponsor to help manage change and clear system obstacles for project
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* (Please share your thoughts) *1 2 3 4 5* ***6.5*** *7 8 9 10* We believe score between 6-7 is the level of work we were able to accomplish.

		Collecting baseline patient data was a real challenge in this project. By the time this data had been obtained, the majority of the project timeline had lapsed. In addition, we were unable to engage with all of the inpatient floors in the way that we had hoped and we still face the actual utilization challenge of our language resource binders. Challenges aside, the team adjusted well to unforeseen changes and ultimately we had a few unexpected wins in the form of the opportunity to present our project to executive leadership and administration teams as well as the approval for the inclusion of interpretive services training in the new provider orientation.

Smoking Cessation Project

Divine Ribakare, DO; Brian Rasmussen, MD; Alison Kortekamp, MD

The Christ Hospital Health Network, Cincinnati / Ohio

Overall Goal/Abstract

- Lung Ca, CAD, and COPD are the three leading causes of death in Hamilton County, Cincinnati OH.
- The Smoking Cessation Project is a sustainable program within the internal medicine resident Clinic at the Christ Hospital that will Improve documentation of smoking status and design smoking cessation program by educating nursing staff and medical residents on smoking cessation clinical skills.
- The implementation will have a meaningful positive impact on the established underserved population from Internal Medicine residency clinic community by improving early detection of lung cancer.
- We were able to achieve 100% documentation of smoking status in our clinic patient population.

Background

- Design a smoking cessation program and create a standardized documentation of smoking status.
- Project requirement:
- Educate residents and nursing staff how to review and record smoking status in patient's chart during each visit
- Create a usable algorithm that residents and nursing can follow when educating patient on smoking cessation.
- Implement a follow up phone call visit by nurse after patient has agreed to stop smoking.
- Assumption is to achieve 100% documentation of smoking status.
- Long term goal is to provide at no charge Low dose CT scan to high risk patients if smoking history has been documented correctly.

Vision Statement

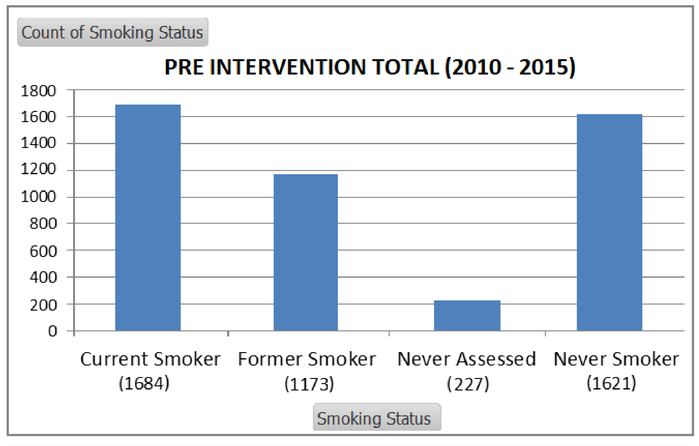
- To improve the health of a sub-set of our underserved IM clinic patient population by implementing a sustainable program to assist with smoking cessation.
- To have a meaningful positive impact on the established underserved population from Internal Medicine residency clinic community concerning healthy behaviors.

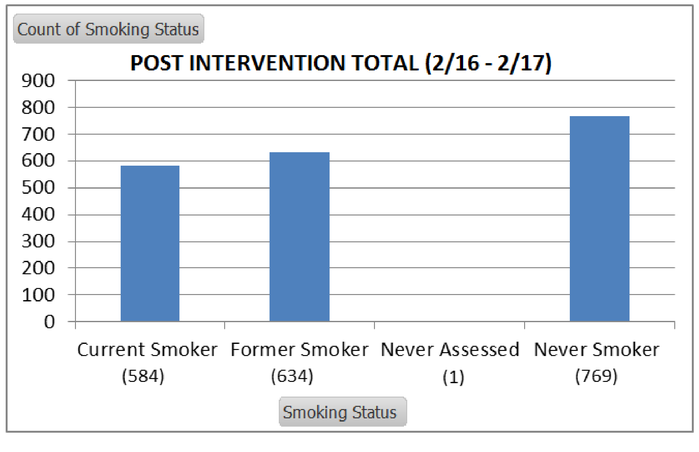
Materials/Methods

Team Members:

- Brian Rasmussen and Divine Ribakare: data collection and running reports from EMR
- Alison Kortekamp: educate residents and nursing staff on accurate documentation and resources for smoking cessation.
- We collected data from 2010-2015 of all the patients in the medical residency Clinic and assessed their smoking status.
- After the implementation of the smoking cessation program, we looked at the data from 02/16-02/17 to assess improvement of smoking documentation.
- We ran patients' reports using data in EPIC
- Results show ed significant improvement in smoking status

Results (data gathered both quant & qual.)





Success Factors and Lessons Learned

The most successful part of our work was threefold:

- Improved smoking status documentation
- Creating a follow up program called the Don't Do It protocol to help support patients in their efforts to quit smoking. This included close nursing follow up with phone calls to monitor progress and for any medication side effects.
- Updated and accurate documentation of smoking status identified patients that qualify for lung cancer screening with low dose CT scans.

We were inspired by the progress made in both improving smoking status documentation and counseling. This, along with implementing an entirely new follow up program for smoking cessation shows that we can leave a lasting impact on our internal medicine clinic.

Barriers Encountered/Limitations

The largest barrier encountered was twofold:

- Patient demographics and willingness / insight to quit smoking.
- Number of residents and nurses who required education about documentation and our new follow up program in an extremely busy clinic.

We worked to overcome these two barriers in the following ways:

- Regarding our patient population, we attempted to both incentivize them and have close follow up. We did this by hanging visual aides in patient rooms showing the money they would save if they quit smoking and we created the Don't Do It protocol for close follow up with nurse phone calls after visits.
- Regarding reaching and educating staff, we had multiple venues with education on how to correctly document smoking status at each visit and about the new follow up program we initiated - the Don't Do It protocol.

Conclusions

- Increased smoking status documentation
- Increased smoking cessation counseling
- Long term goal is to screen patients for lung cancer with low dose CT scans who should qualify for screening with correct smoking history documentation
- This project will continue as a QI project by future residents.
- Hope in the future to decrease the number of smokers

Bibliography

- Community health needs assessment-Hamilton County, Cincinnati, Ohio. https://www.hamiltoncountyhealth.org/files/files/Reports/2012_HCPH_Annual_Report_Web.pdf.
- Results of Initial Low-Dose Computed Tomographic Screnning for Lung cancer. The National Lung Screening Trial Research Team.N Engl J Med 2013; 368:1980-1991

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: The Christ Hospital, Cincinnati, OH **Project Tile:** Smoking cessation Project

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	• Lung Ca, CAD, and COPD are the three leading causes of death in Hamilton County, Cincinnati OH. • The Smoking Cessation Project is a sustainable program within the internal medicine resident Clinic at the Christ Hospital that will Improve documentation of smoking status and design smoking cessation program by educating nursing staff and medical residents on smoking cessation clinical skills. • The implementation will have a meaningful positive impact on the established underserved population from Internal Medicine residency clinic community by improving early detection of lung cancer. • We were able to achieve 100% documentation of smoking status in our clinic patient population.
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	Design a smoking cessation program and create a standardized documentation of smoking status. Project requirement: • Educate residents and nursing staff how to review and record smoking status in patient's chart during each visit • Create a usable algorithm that residents and nursing can follow when educating patient on smoking cessation. • Implement a follow up phone call visit by nurse after patient has agreed to

		stop smoking. • Assumption is to achieve 100% documentation of smoking status. • Long term goal is to provide at no charge Low dose CT scan to high risk patients if smoking history has been documented correctly.
III.	Team Members & Accountability (list of team members and who is accountable for what)	Team Members: Brian Rasmussen and Divine Ribakare: data collection and running reports from EMR Alison Kortekamp: educate residents and nursing staff on accurate documentation and resources for smoking cessation.
IV.	Necessary Resources (staff, finances, etc.)	Support from Residents and nursing staff. Help for data collection and reports by the Chief Medical officer. Medications provided by TCH through GME office
V.	Measurement/Data Collection Plan	• We collected data from 2010-2015 of all the patients in the medical residency Clinic and assessed their smoking status. • After the implementation of the smoking cessation program, we looked at the data from 02/16-02/17 to assess improvement of smoking documentation. • We ran patients' reports using data in EPIC. • Results show significant improvement in smoking status.
VI.	Stakeholder Communication Plan and Relationship Building with Community(may be helpful to draft a flow chart of team members & senior management, both internal & external)	Stakeholders included: IT department, GME, IM residents, Clinic patients, and TCH medical clinic staff. Support from GME office; which provided drug therapy at no cost to patients.
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	1. lack of time, (Residents' busy schedule) 2. patient unwillingness to change, 3. inadequate patient resources, 4. inadequate provider resources

		5. inadequate cessation clinical skills. 6. Inconsistent documentation

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	- A Quality Improvement Project is a core requirement of our Internal Medicine residency, and this project was ours. - This project can be passed down to other residents as part of their scholarly activity. - Opportunity to present at the ACP Ohio in the future.
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	- Deciding on a project to help serve our community and clinic patient population. With lung cancer being one of the leading causes of death in our local community, we felt a smoking cessation project would best serve our community. - Developing a plan on how to improve documentation and counseling of smoking cessation at each visit. Also, developing a follow up program that consisted of nurse phone calls. - Educating our residents and nurses about our new program. - Implementing our strategies and then surveying our results.

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	- The most successful part of our work was threefold:
		  - Improved smoking status documentation
		  - Creating a follow up program called the Don't Do It protocol to help support our patients in their efforts to quit smoking. This included close nurse follow ups with phone calls to see how they were doing and check on any medication side effects.
		  - Inadvertently assuring that smoking status documentation was correct so that patients who should qualify for low dose CT scans for cancer screening did. This came about when we realized updated smoking status when a patient had cut

		back could skew the numbers and make the patient look like their smoking history was less than it actually was in EMR. By noticing this, more correct documentation helped them qualify through insurance to get the screening they needed. - We were inspired by the progress we made in both improving smoking status documentation and counseling. This, along with implementing an entirely new follow up program for smoking cessation shows that we can leave a lasting impact on our internal medicine clinic.

XI.	Barriers	- The largest barrier encountered was twofold:
		  - Patient demographics and willingness / insight to quit smoking.
		  - Number of residents and nurses who we needed to educate about documentation and our new follow up program. Both are extremely busy in both resident clinic and with their other duties, so to reach everyone and have them remember was difficult.
		- We worked to overcome this two barriers by the following ways:
		  - For barriers with our patient population, we tried to both incentivize them and follow up closely with them to help them quit smoking. We did this by hanging visual signs in patient rooms showing how much money they would save if they quit smoking and we created the Don't Do It protocol for close follow up with nurse phone calls after their visit.
		  - For the barrier or reaching and educating everyone, we had multiple venues with education about how to correctly document smoking status at each visit and about the new follow up program we initiated - the Don't Do It protocol. This way, we tried to reach all residents and nurses and remind them if they had not been doing this at each visit.

XII.	Lessons Learned	*Know as early as possible what to focus on the project.*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2* ***3*** ***4*** *5 6 7 8 9 10*

The Effect of a Mobile Produce Market on Dietary Habits in Two Low-Income Urban Neighborhoods

E.Browning DO, S. Bdeir MD, S. Iloka MD, J. Martin MD, L. Hussain MSc, N. Gandhi MD, E. Beiter MD, S. Zitelli MD, B. Putnam MD, S. Gordon MD, E. Hennen MD, C. Morrison MD, B. Williams MS, S. Johnson MD, D. Dhanraj MD

TriHealth, Cincinnati, OH

Overall Goal/Abstract

The primary purpose of this project is to measure the impact of the mobile food market among FMC (Faculty Medical Center) and BFP (Bethesda Family Practice) patients with the aim to influence their fruit and vegetable consumption. The secondary purpose of the study is to measure the impact of mobile food market among the residents of low income communities of Northern Kentucky and Cincinnati with the aim to improve the availability and accessibility of fruit and vegetables.

Background

In Cincinnati, Ohio, there is lack of access to fresh fruits and vegetables in our low income neighborhoods. TriHealth has partnered with a local food bank, The Freestore Foodbank, which has been awarded a grant through the philanthropic organization, Impact 100, to start a year round mobile market in the Northern Kentucky and Cincinnati metro areas. The aim of our quality improvement project is to increase access of fresh fruits and vegetables in food scarce neighborhoods. We plan to address the TriHealth community directly by providing market days at two of our locations associated with resident clinics.

Vision Statement

Our vision is to develop a sustainable process for addressing food disparities in our community and making a healthy diet a consistent part of medical care. We are developing a cultural in which Graduate Medical Education (GME) is leading the path towards improving healthcare disparities within TriHealth community.

Materials/Methods

Food perception data obtained from Fruit and Vegetable Inventory survey developed by the University of California Cooperative Extension (University of California, 2008).

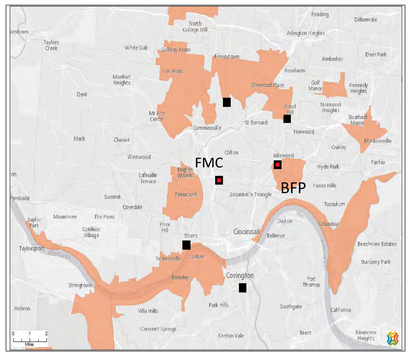
- ❑ This survey is an evaluation tool for nutrition education programs serving low-income communities. The content is mediators of fruit and vegetable behavior change. The survey contains **13 psychosocial** items with 6 constructs shown to be related to fruit and vegetable intakes.
  - ❑ The 6 constructs are **perceived benefits, perceived control, self-efficacy for eating fruit & vegetables, readiness to eat more fruit, readiness to eat more vegetables, and perceived diet quality.**
- ❑ Survey repeated 6-8 months after enrollment via a phone call from residents & physicians
- ❑ Pre/post-participation BMIs collected (pregnant or post-natal pts excluded)

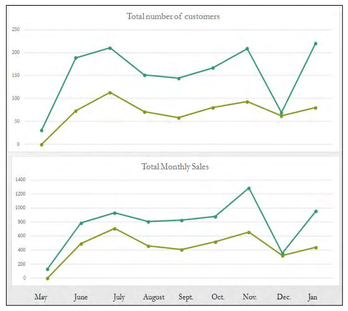
Inclusion Criteria:
- ❑ >18 years of age
- ❑ Male and Female
- ❑ Community population with an office visit at FMC and BFP on the day of the mobile food market
- ❑ Have not utilized the mobile food market

Quality Improvement Project Plan

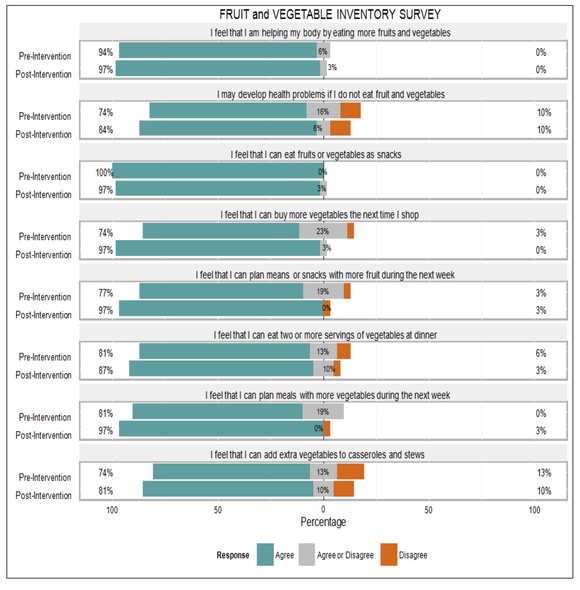
MOBILE FOOD MARKET INTRODUCED	FIRST ENCOUNTER	SECOND ENCOUNTER	DATA ANALYSIS
• Promote mobile food market	• Enroll patients from clinic into study • Conduct first survey • Offer market flier	• Conduct second survey and collect pre and post participation BMIs	• Compare results of first/second survey • Review medical record for biomarkers • Collect monthly data on number of market visits • Assess impact from market

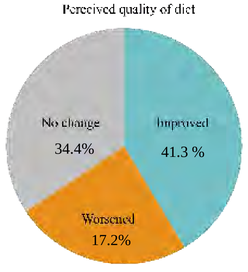
Results

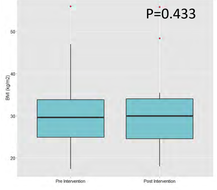




Data Analysis from 31 patients (15.5% of cohort)







20 patients were included for BMI analysis. Wilcoxon nonparametric test for paired samples with a level of significance of 0.05

Barriers Encountered/Limitations

- ❖ Nutrition department reorganization and turnover kept them from engaging in our project
- ❖Difficulty obtaining follow up data; especially with post-participation BMI and many patients were not able to be reached via the number they provided
- ❖No efficient method of tracking how often participants shopped at the market or how much/what they purchased

Discussion

We were able to successfully partner with a local organization to provide our patients with weekly access to purchase fruits and vegetables. We were able to establish and maintain a customer base.

Though no statistically significant data was obtained, the intervention did appear to have a positive influence on attitude regarding fruit and vegetable intake. There was an increase in the percentage of participants who both saw a perceived benefit in a diet containing fruits and vegetables, as well as a perceived risk of a diet void of fruits and vegetables. The majority of participants had an improvement in their perceived diet quality.

At this point there has not been an improvement in the BMI of participants. This is an secondary outcome which may take a longer time to achieve.

Conclusion

Increased access to fruits and vegetables appears to have a positive impact at least on attitude toward eating a more healthy diet. Future studies can see if this change in attitude results in a change in behavior by identifying if customers are study participants. Future studies will also continue to follow BMI, as well as other possible secondary outcomes including blood pressure or A1c, to see if a change in diet results in improved health. Though we were able to establish and maintain a customer base, future efforts will continue to focus on increasing patronage. A mobile food market appears to be a viable option to address food desserts.

We hope to set an example of stewardship addressing our community's healthcare needs. We envision equipping medical trainees with tools to effect change in the future communities in which they will practice.

Bibliography

Cole, K., McNees, M., Kinney, K., Fisher, K., & Krieger, J. W. (2013). Increasing access to farmers markets for beneficiaries of nutrition assistance: evaluation of the farmers market access project. *Preventing Chronic Disease*, *10*, E168. http://doi.org/10.5888/pcd10.130121

Jennings, A., Cassidy, A., Winters, T., Barnes, S., Lipp, A., Holland, R., & Welch, A. (2012). Positive effect of a targeted intervention to improve access and availability of fruit and vegetables in an area of deprivation. *Health and Place*, *18*, 1074–1078. http://doi.org/10.1016/j.healthplace.2012.05.001

Jilcott Pitts, S. B., Gustafson, A., Wu, Q., Leah Mayo, M., Ward, R. K., McGuirt, J. T., … Ammerman, A. S. (2014). Farmers' market use is associated with fruit and vegetable consumption in diverse southern rural communities. *Nutrition Journal*, *13*, 1. http://doi.org/10.1186/1475-2891-13-1

Larsen, K., & Gilliland, J. (2009). A farmers' market in a food desert: Evaluating impacts on the price and availability of healthy food. *Health & Place*, *15*(4), 1158–1162. http://doi.org/10.1016/j.healthplace.2009.06.007

Levine, J. A. (2011). Poverty and obesity in the U.S. *Diabetes*, *60*(11), 2667–2668. http://doi.org/10.2337/db11-1118

USDA. (n.d.). Food Access Research Atlas. Retrieved January 1, 2016, from http://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx

University of California. Fruit and Vegetable Inventory. 2008. http://townsendlab.ucdavis.edu/PDF_files/FV/FV_Inventory_invent.pdf

Project Management Plan

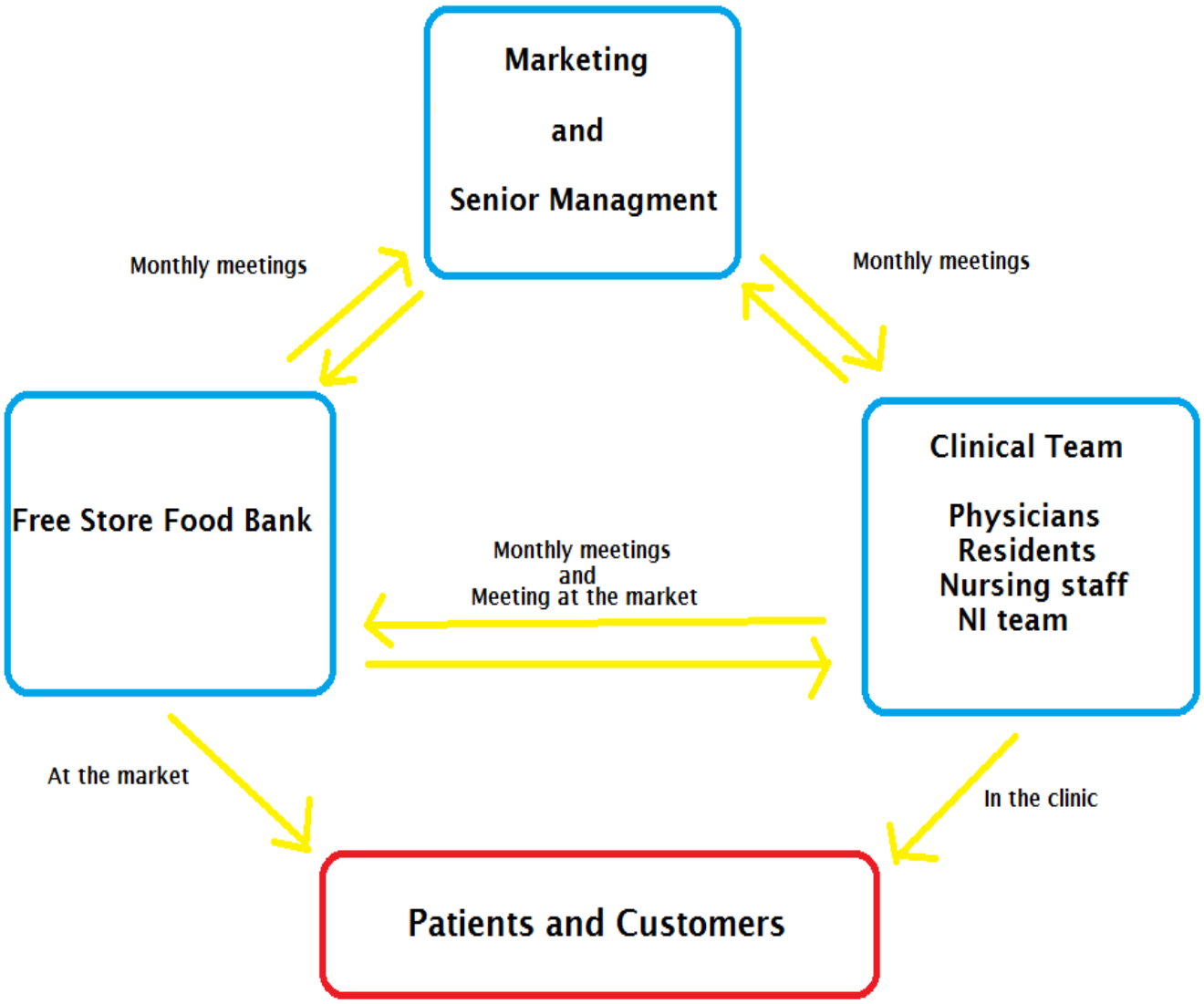
As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: TriHealth **Project Tile: The Effect of a Mobile Produce Market on Dietary Habits in a Low Income Urban Neighborhood**

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*Our vision is to develop a sustainable process for addressing food disparities in our community and making a healthy diet a consistent part of medical care. We are developing a cultural in which Graduate Medical Education (GME) is leading the path towards improving healthcare disparities within TriHealth community. We hope to set an example of stewardship addressing our community's healthcare needs. We envision equipping medical trainees with tools to effect change in the future communities in which they will practice.*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	• *Measure food access impact on patient food preferences* • *Project Requirements – Mobile vehicle, nutrition services available o patients, resident education about food disparities in community* • *Project Assumptions – Mobile vehicle will travel to TriHealth clinics and patient will visit market, mobile vehicle will travel to food scarce neighborhoods and community will visit market* • *Stakeholders – TriHealth GME, The Freestore Food Bank, Department of Mission, TriHealth Department of Community Engagement, Department of Diversity*

III.	Team Members & Accountability (list of team members and who is accountable for what)	*TriHealth GME, The Freestore Food Bank, Department of Mission, TriHealth Department of Community Engagement, Hospital Operations, Faculty Medical Center and Bethesda Family Medicine, Department of Nutrition, Department of Diversity, Xavier University* *Physician Faculty: Dr. Dave Dhanraj, Dr. Libby Beiter, Dr. Steve Zitelli, Dr. Neha Ghandi, Dr. Steve Johnson* *Fellow: Dr. Ginger Klarquist and Dr. Lily Browning* *Residents: Dr. Jennifer Martin, Dr. Sandra Iloka, Dr. Sami Bdeir, Dr. Benjamin Putnam, Dr. Sashana Gordon, Dr. Christopher Morrison, Dr. Erin Hennen* *Research staff: Lala Hussain* *TriHealth Marketing: Jeanette Altenau, Drew Ross* *Front desk and back office staff: Madeline Rolfes, Constance Zimmer, Rebecca Picadio* *Free Store Food Bank: Nick Reynolds, Jessie Fossenkemper, Mick Clay*
IV.	Necessary Resources (staff, finances, etc.)	*Vehicle, fliers, advertising, produce, packaging, finances, staff from FSFB to run the market, volunteers, nurse recruitment, resident education about food disparities in community*

V.	Measurement/Data Collection Plan	*To achieve the primary purpose of the study, we will conduct a prospective survey study. Any of the community population that visited the FMC and BFP on the day that the mobile food market will be stationed at these locations will be invited to participate in the study. 200 patients from two primary care areas in or near urban food deserts were recruited; 150 participants from Good Samaritan Faculty Medical Center and Obstetrics Clinic and 50 participants from Bethesda Family Practice in Norwood. Data was collected via a Fruit and Vegetable Inventory survey developed by the University of California Cooperative Extension (University of California, 2008). The Fruit and Vegetable Inventory is an evaluation tool for nutrition education programs serving low-income communities. The content is mediators of fruit and vegetable behavior change. The survey contains 13 psychosocial items with 6 constructs shown to be related to fruit and vegetable intakes. The 6 constructs are perceived benefits, perceived control, self-efficacy for eating fruit & vegetables, readiness to eat more fruit, readiness to eat more vegetables, and perceived diet quality* *Measures of Success – Number of patron visits to market, percent of patient visits from resident clinics, change in patient food preferences as observed via survey and change in BMI*

VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	

VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	1. *Culturally unacceptable food provided* 2. *Not being available to the community at large* 3. *Not something the community needs/desires* 4. *No cooking supplies at home* 5. *Limited knowledge on how to prepare meals* 6. *Profitability* 7. *Awareness and engagement within the institution* 8. *More in-depth education*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Hatton Forum Presentation* *TriHealth Quality Days* *AIAMC* *IHI* *Public Health Conferences:* *Ohio Public Health Combined Conference* *Journals:* *American Journal of Public Health (4.138 *impact factor)* *Health Affairs (5.23)* *International Journal of Public Health (2.754)* *The Patient – Patient Centered Outcomes Research (2.227)* *Medical Education (3.369)*

IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	*For the most part we were able to meet most of the progress check with completion or near completion during the course of the project. Our data analysis is ongoing, as we make follow ups based on 6 month follow ups, and our last participants were registered in November.*

Implement – Measure – Adjust – Sustain	Progress
Interpret results (process measures, structural measures); data presentation plan	✓
Revise implementation based upon ongoing data analysis	✓
Execute on communication plan	✓
Prepare poster for April's AIAMC annual meeting	✓
Interpret results (process measures, structural measures); data presentation plan	✓
Project sustainability; path forward	✓

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was…..* *The engagement with the institution and the staff. People took pride in this work and felt they were contributing to a noble cause. Increasing availability to patients and customers, testimonials from them.* *We were inspired by…..* *We were initially inspired by the AIAMC work that Main Line Health had done regarding food insecurities and providing fresh produce at their clinic.* *Our TriHealth team learned through our CHNA that our resident clinic sites were located in food deserts and that food insecurity was an issue for many of our patients. Our GME team decided to pursue addressing food insecurity for our National Initiative 5 project. We made contact with our Vice President of Mission who quickly referred to us to our Marketing and Community Relations department. Our marketing department had already begun a relationship with our local food bank that had received a grant for a truck and trailer to create a mobile market. Our team partnered with this effort and helped launch the mobile market at our clinical sites making fresh produce available to our patients on a weekly basis.* *…and of course we are always inspired by our patients and their desire to eat better and lead healthier lives.*
XI.	Barriers	*The largest barrier encountered was…..* *Nutrition department reorganization and turnover kept them from engaging in our project.* *We worked to overcome this by…..* *Educating and promoting the market through our own resident and staff. We still have work to do on this.*

XII.	Lessons Learned	*The single most important piece of advice to provide another team embarking on a similar initiative would be…..* *Connecting your idea/initiative to a mission/objective of your health system and identifying a C-suite champion.*
XIII.	Expectations Versus Results	*On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish?* *1 2 3 4 5 6 7 8* ***9*** *10*

Improving Pediatric Asthma Management by Using Care Coordination to Reduce ED Visits

A. Fondell, C. Hoque, C. Wright, E. Hill, H. Smith, A. Dirkx, C. Ayers, C. McCarthy, J. Walters, J. Anderson-Suddarth, W.J. Yost
UnityPoint Health, Des Moines, Iowa

Overall Goal/Abstract

To decrease the number of Emergency Department (ED) encounters for pediatric patients with asthma symptoms by improving care coordination with increased follow-up office visit rates, decreased time to follow-ups, and more comprehensive assessments/management.

Background

The control of asthmatic symptoms in pediatric patients is an important medical concern. Without optimized medical care children are at risk for repeated exacerbations and unnecessary medical encounters. Recurrent Emergency Department (ED) visits for asthma-related symptoms in pediatric patients may be minimized with better outpatient management. Approachable barriers in both short- and long-term asthma management should be identified and addressed.

A multi-disciplinary team including an ED physician, ED care manager, pediatric and family medicine (FM) residents, pediatric and FM clinical care coordinators, and medical education department staff was assembled. Hospital and community resources were ~~used~~ utilized to provide a robust plan to address barriers in a comprehensive fashion.

Vision Statement

Develop a health system-based initiative targeting children with an asthma-related ED encounter to improve outpatient management of patients using a multi-disciplinary team of ED and clinic personnel.

Materials/Methods

Design: A prospective study was conducted targeting pediatric patients with an ED encounter related to asthma symptoms.

Time Period: 2/2016 - 1/2017

Location: Midwestern children's hospital

Inclusion Criteria:

Age 2-12 years
English-speaking
ED presentation for acute asthma exacerbation
Primary care physician within health system

Study Procedure: Patient/guardian contacted by ED manager after encounter and encouraged to have a follow-up outpatient clinic visit within 7 days.

At clinic visit, patient evaluated using questionnaires, barriers, and goals.

Subsequent clinic telephone contacts made to patient as needed.

If suspected eligible, patient referred to community partner for home assessment and renovation.

A historic control group (prior year's clinic and ED data) was collected to serve as a comparative reference group.

Results

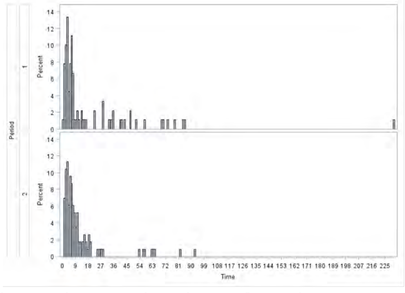
There were 765 (n=553 unique patients) ED encounters reviewed from the historic and prospective time periods, with 148 (136 unique patients) and 176 (130 unique patients) respectively eligible.

Excluded patients across the Historic and the Prospective time periods included:

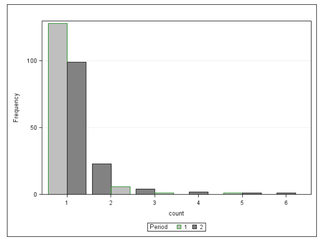
228 non-network provider patients;
61 non-English language:
Spanish (32);
Karen (6);
Burmese(3);
Arabic (2);
Somali (2);
Other (16)

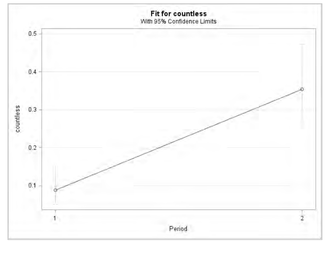
Table and Figure (time to follow-up visit) of patient information by study period:

CHARACTERISTIC	TIME PERIOD Historic (1) n=136	Prospective (2) n=130
Family Medicine PCP Pediatric PCP	31(23%) 105(77%)	31(24%) 99(76%)
Admitted from ED	40(27%)	24(14%)
Letter Sent	0(0%)	90(69%)
Follow-Up Visit	97(59%)	117(66%)
Median Days to Follow-Up	6 (IQR:4-22)	7 (IQR: 3-13)



Figures display the number of ED encounters by study period and rate for subsequent ED encounters. The Prospective period patients had a 4 (RR: 95% CI 2.1, 7.5) times greater rate of at least an additional ED encounter than Historic period patients, rates being 9% (95% CI: 5%, 16%) versus 35% (95% CI: 27%, 47%).





Follow-up visit rates were 59% versus 66% for the Historic and Prospective periods, respectively. Of note, personnel interruptions occurred during the Prospective time period (i.e., two key study members were no longer in their roles). These changes were visible in study data, with a drop in follow-ups. Hypothetical prevention of the interruption would have meant a 63-72% clinic follow-up rate for the Prospective time period.

Results (cont.)

Of referrals made to the community health partner, 59% were from the study's health system, which representing more than all other community hospitals combined.

Of referred patient families, 59% of received some type of service including:

Asthma Education;
Home Supplies
Home Repairs

Barriers Encountered/Limitations

- Difficult to control for possible data dependencies for patient observations within and between study periods.
- Difficult to attribute outcomes to interventions in a non-randomized study.
- Patients could have been seen at EDs or clinics outside of our health system, limiting accuracy of documented outcomes.
- Processes dependent on individual employees to manually produce notes and letters, and contact patients. This should be automated to improve efficiency.
- Process dependent on specific people (not role-based), making it difficult to adjust upon employee reassignments/extended leave.
- Non-English speaking patients had to be excluded, decreasing the number of disparate patients reached.

Success Factors and Lessons Learned

- Real-life application of a planned protocol can be confounded by reality.
- Return on investments can be very difficult to quantify.
- Study components need to be embedded into personnel job descriptions.
- Effectiveness limited by our ability to share data with other organizations due to HIPAA concerns.
- Our intervention was limited to English-speaking households.
- Success depends on vision and commitment, persistence, relationships, and sweat equity.
- Collaboration with community partners is key…. We believe that the "hard wiring" of that collaboration with a dedicated department at UPH-DM is important for success.

Conclusions

Management of asthma symptoms in pediatric patients is a very dynamic problem with many contributing factors. The present study focused on creating a greater collaborative relationship between pediatric ED, primary care clinics, and community partners. Results were encouraging, though many future opportunities were revealed.

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: UnityPoint Health – Des Moines **Project Tile:** Reducing Disparities in Pediatric Asthma

I.	Vision Statement (markers of success by March 2017; refer to Toolkit #5)	*In an effort to address the social and environmental needs of children presenting with uncontrolled asthma, we will identify patients who present to the ED with an acute asthma exacerbation (or asthma related diagnoses) and implement protocols to increase follow-up rates to primary care clinics after the acute episodes. Our plan is to implement long-term strategies/programs that assess and address, both, obstacles to children obtaining access to routine asthma care and control of environmental causes of asthma. We will focus on UnityPoint Health Pediatric and Family Medicine clinics within the metropolitan Des Moines area. We will collaborate with the existing efforts of the Healthy Homes Des Moines project to attempt to address the environmental causes of asthma. The overall objectives are to reduce readmissions to the ED for patients and increase the primary care follow-up and management of asthma exacerbations.*
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	*Reduce the disparities, improve healthcare, and increase follow-up in asthma related cases. To reduce the disparities in the management of outcomes in better care coordination, education, medication compliance and patient education. To funnel potential patients into the Healthy homes program for assessment of environmental causes contributing to asthmatic exacerbations.* *We assume that there are patients who are not managing asthma, want to participate, and*

<table>
<tr><td></td><td></td><td colspan="2">that our interventions will actually effect the outcomes.

EDs, clinics, program directors, residents, patients, support staff,

Do a subset analysis of patient population with Healthy Homes projects.

Identify population (3 groups), come up with intervention/plan, track outcomes,</td></tr>
<tr><td>III.</td><td>Team Members & Accountability
(list of team members and who is accountable for what)

Former members are indicated with an asterisks in front of the name.</td><td colspan="2"><table>
<tr><td>Chanteau Ayers, JD
Director, Medical Education Administration
Team Leader</td><td>Project Manager: organize meetings, assign tasks, update documents, keep team informed, obtain resources, assist in developing communication pieces</td></tr>
<tr><td>William Yost, MD
VP, Medical Education and Research</td><td>Physician Provider resource, provide medical advice from provider perspective, mentor team, provide access to C-Suite.</td></tr>
<tr><td>Julie Anderson-Suddarth, MD
Pediatric Residency Program Director</td><td>Develop project requirements, identify patients in the ED, develop care plans</td></tr>
<tr><td>Camella Wright, RN
Care Manager, Pediatric Emergency Department</td><td>Develop project requirements, needs statement, project assumptions, identify patients,</td></tr>
<tr><td>Cynthia Hoque, MD
Resident, Family Medicine</td><td>Develop project, identify patients in the ED, develop care plans, design research/data collection, develop measurements, articulate analysis, develop publication</td></tr>
<tr><td>Andrew Fondell, MD
Resident, Pediatrics</td><td>Develop project, identify patients in the ED, develop care plans, design research/data collection, develop measurements, articulate analysis, develop publication</td></tr>
<tr><td>Hayden Smith, PhD
Resident Facility Research Coordinator</td><td>Design research/data collection, develop measurements, articulate analysis, develop publication</td></tr>
<tr><td>Chris McCarthy
Community Health Project Manager</td><td>Community Partner liaison, providing comparative data from Healthy Homes project, develop communication plan</td></tr>
</table></td></tr>
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		Joe Walters *Regional OSC Analyst-Quality I*	*Design research/data collection, develop measurements, articulate analysis, develop publication*
		Douglas Dorner, MD *Chief Academic Officer*	
		Emily Hill, RN *Care Coordinator, Pediatric Clinics*	*Assist with implementation of follow-up care in clinics, mentor clinic care coordinators during project, educate patients*
		Amanda Dirkx, RN *Care Coordinator, Family Medicine Clinics*	*Replaced Laura Quinn.*
		** Paige Moore* *Director Patient Experience*	*Promoted early in the project.*
		** Laura Quinn, RN* *Care Coordinator, Family Medicine Clinics*	*Transferred positions.*
IV.	Necessary Resources (staff, finances, etc.)	*Pediatric Physician providers, ED physicians, ED nurses, ED administrative staff, clinic physicians, clinic care coordinators, clinic administrative staff.* *Access to patient records, access to patients, access to EPIC, access to SharePoint database.*	
V.	Measurement/Data Collection Plan	*Data will be collected on pediatric patients with an ED encounter related to asthma exacerbation during the study year. Inclusion criteria will be applied to these data. Information on date of encounter and days until a follow-up visit will be collected along with number of subsequent ED encounters. Comparable data elements will be collected for a historic reference group. Some secondary data elements will be collected in the prospective time period related*	

		to intervention processes (e.g., follow-up letter/phone call made, asthma evaluation made during clinic visit, etc.). *Measures of interest will be "did follow-up clinic visit occur"; "time to follow-up clinic visit"; and "number of subsequent asthma related ED encounters".*
VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	*Chris McCarthy may be able to help with this part. We will need to develop a plan to meet with clinics and ED about the project. We will need to develop brochures and info sheets that describe the project. We will need to educate administrative staff about the project and process. We will need to develop a protocol for identifying and contacting participants in the project.*
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	*Time, project must be completed in 18 months. We will need to develop and implement project very quickly. We spent 6 months designing the project. We implemented the intervention protocols in February 1, 2016. We tracked patients from February 1, 2016 through January 31, 2017.* *We have no budget set aside for this and we are entering a very tight budget year. This project is expected to require minimal funds. Will have to be careful to identify costs early on. Position changes, employee turnover, and department organizational structure changes added challenges.*

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	*Currently, submitting overview of the project to NI V conference along with a research version of the project. No present plan to disseminate to peer-reviewed medical journal due to negative study findings and inexact ability to equate/measure study's total impact on patient*

		sample or health care changes.
IX.	Markers (project phases, progress checks, schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	Design Obtain historic data, develop one page include Implement Analysis Dissemination
	Communication Pieces	Project Flyers Phone call protocol Patient Communication Letter Template Patient Follow-up Goals and Evaluation Forms

Identifying and helping people with unhealthy alcohol use in primary care

Thomson A, Chu M, Geyer L, Lincoln L, Magnusson C. Virginia Mason Medical Center, Seattle, WA

VISION STATEMENT

Our aim is to identify patients in primary care with alcohol misuse and provide them with appropriate interventions both in the clinic and in the community

BACKGROUND

- Alcohol misuse is a spectrum ranging from risky consumption to alcohol use disorder (AUD)
- Approximately 30% of the US population has alcohol misuse [1, 2]
- Alcohol is the 3rd leading cause of preventable death[3]
- Brief multi-contact interventions in primary care are an effective method of decreasing risky alcohol use[4]
- Our primary care clinics lack standard work around screening and treatment of alcohol misuse
- Stigma, denial, and fear make alcohol a difficult topic to discuss, but reluctance to address this important health issue creates disparities in care

METHODS

- Background research involved surveys of 80 providers and 25 patients, interviews with 8 Alcoholics Anonymous members, and direct observation and timings of 7 visits
- Multi-disciplinary team conducted four Plan-Do-Study-Act (PDSA) cycles to create a new screening and treatment process (see Fig. 1-4)
- Chart review measured the screening rate at annual wellness visits of 5 providers within 1 clinic site
- Screening that did not use the NIAAA question was coded as no screening
- 20 charts pre-intervention and 50 charts after each intervention were audited, with equal numbers from each physician

INTERVENTIONS

Fig. 1 Patient fills out screening tool while in waiting room. Tool includes the NIAAA validated single question screen. If screen is positive then patient flips paper over to AUDIT questionnaire which provides validated risk stratification

Fig. 2 Educational fact sheets are stocked in patient rooms and provided for patients with positive screen. Fact sheet includes contact information for community resources

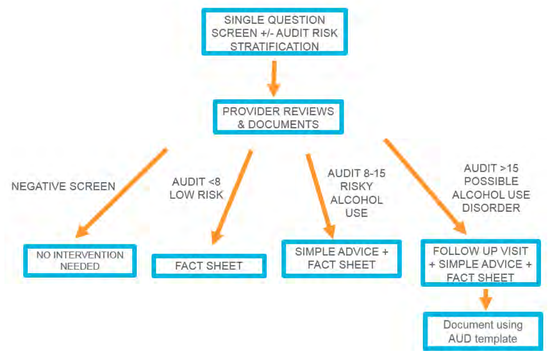

Fig. 3 An auto-text was created to provide clinicians with treatment recommendations based on AUDIT scores. If high risk for AUD then an additional note template was created (not pictured) which includes suggested labs, immunizations, medications, and referral options

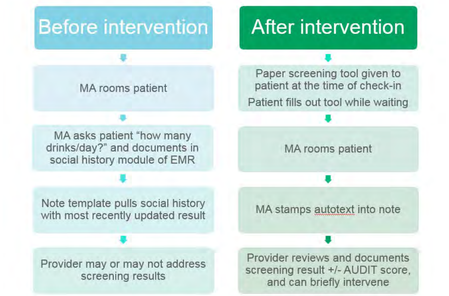

Fig. 4 Changes to screening process are delineated in this flow map

RESULTS

- Observation of the pre-intervention screening process revealed a 0% appropriate screening and the absence of a reliable system
- Major barriers to screening were patient preference to defer this discussion to the provider (64%), patient fear of judgment, provider frustration with substance use (70%), and provider knowledge deficits (79%)
- After 4 PDSA cycles over 1 year, screening for alcohol misuse during annual visits has increased to 92% based on chart review

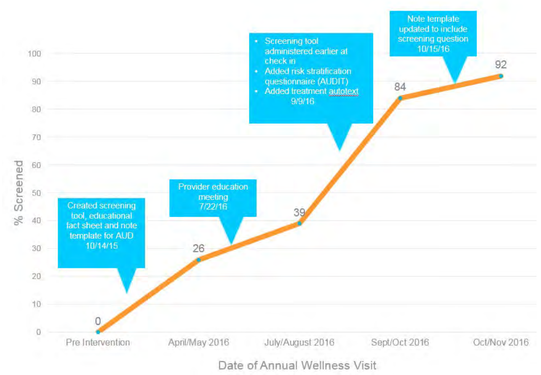

Fig. 5 Percent of patients screened at annual wellness visits rises from 0 to 92% after a series of interventions.

DISCUSSION

- Background research revealed areas to target our interventions
- Multiple PDSA cycles were key to addressing unforeseen barriers and refining our tools and process
- Partnership with clinic staff and institution-wide committees was vital to improving implementation and sustainability
- Screening limited to annual wellness visits may miss vulnerable community members
- Process based on a single institution may limit reproducibility
- Major barriers encountered included resistance to change, standard work fatigue, visit length time, electronic medical record limitations, misconceptions about alcohol use, and balancing needs of all stakeholders

CONCLUSIONS

- We implemented a standard process for screening patients in primary care for alcohol misuse and provided targeted treatment options that engage resources in the clinic and the larger community
- After a series of interventions, screening for alcohol misuse has increased to 92%
- We have extended our standard process to all 8 of our clinic locations
- In the future we hope to assess screening results and patient outcomes

BIBLIOGRAPHY

1. Saitz R. Unhealthy alcohol use. N Engl J Med. 2005 Feb 10;352(6):596-607.
2. Hasin DS et al. Prevalence, correlates, disability, and comorbidity of DSM-IV alcohol abuse and dependence in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry. 2007;64:830-42.
3. Centers for Disease Control and Prevention. FastStats: Alcohol Use. Atlanta:Centers for Disease Control and Prevention; 2012.
4. Jonase DE et al. Behavioral counseling after screening for alcohol misuse in primary care: A systematic review and meta analysis for the U.S. Preventative Services Task Force. Ann Intern Med. 2012 Nov 6;157(9):645-654.

Project Management Plan

As a team, complete this Project Management Plan to the best of your ability prior to the mid-October meeting. Teams will have the opportunity to work on their Project Management Plan at meeting one and will review/revise their plan throughout the 18-month Initiative at each of the on-site meetings. The collective data from all of the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience.

Team: Virginia Mason Medical Center **Project Tile: Identifying and helping people with unhealthy alcohol use in primary care**

<table>
<tr><td>I.</td><td>Vision Statement
(markers of success by March 2017;
refer to Toolkit #5)</td><td>Our aim is to identify patients in primary care with alcohol misuse and provide them with appropriate interventions both in the clinic and in the community</td></tr>
<tr><td>II.</td><td>Team Objectives
('needs statement,'
project requirements, project
assumptions, stakeholders, etc.)</td><td>We need to create a standardized screening process using validated measures and create treatment tools for patients and providers that are targeted to their level of risk and include community resources</td></tr>
<tr><td>III.</td><td>Team Members & Accountability
(list of team members and who
is accountable for what)</td><td>
<table>
<tr><th>Name/Credentials</th><th>Position/Title</th><th>Accountability</th></tr>
<tr><td>Amy Thomson</td><td>IM Chief</td><td>Development of Screening/Tx process, Implementation across multiple sites</td></tr>
<tr><td>Camille Johnson</td><td>IM Chief</td><td>Quip, vision statement, team assembly</td></tr>
<tr><td>Leah Geyer</td><td>IM Chief</td><td>Quip, vision statement, team assembly, literature review</td></tr>
<tr><td>Elly Bhatraju</td><td>Addiction Specialist</td><td>Development of Screening/Tx process, expert opinion, development of AUD template</td></tr>
</table>
</td></tr>
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		<table><tr><td>Karina Uldall</td><td>Psychiatrist</td><td>Development of Screening/Tx process, expert opinion</td></tr><tr><td>Leighe Lincoln</td><td>Resident</td><td>Chart Review</td></tr><tr><td>Michael Chu</td><td>Resident</td><td>Development of Screening/Tx process</td></tr><tr><td>Carly Magnusson</td><td>Resident</td><td>Development of Screening/Tx process</td></tr><tr><td>Norris Kamo</td><td>IM Provider- Primary Care</td><td>Implementation across multiple sites</td></tr><tr><td>Julie Pattison</td><td>IM Provider- Primary Care</td><td>Implementation across multiple sites</td></tr><tr><td>Mark Levy</td><td>IM Provider—Primary Care</td><td>Development of Screening/Tx process</td></tr><tr><td>Brian Owens</td><td>GME Director, DIO</td><td>Institutional support</td></tr><tr><td>Alvin Calderon</td><td>IM Program Director</td><td>Institutional support</td></tr><tr><td>Gillian Abshire</td><td>GME Administrative Director</td><td>Institutional support</td></tr><tr><td>Lynne Chafetz</td><td>VP</td><td>Institutional support</td></tr></table>
IV.	Necessary Resources (staff, finances, etc.)	Kaizen resources
V.	Measurement/Data Collection Plan	Prior to any interventions direct observation of 7 annual wellness visits was performed. The team also surveyed 80 providers and 25 patients on their experiences with alcohol. Structured interviews were held with 8 Alcoholics Anonymous members. Chart review of 50 charts at each time point was performed to measure the NIAAA screening rate at annual wellness visits.

VI.	Stakeholder Communication Plan and Relationship Building with Community (may be helpful to draft a flow chart of team members & senior management, both internal & external)	Communication via pre-existing institutional meetings (e.g. section meeting, best practices task force meeting, standard work guiding team meeting).
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc)	Visit length Electronic medical record Misconceptions about alcohol use Resistance to change Standard work fatigue fatigue Multiple stakeholders

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	Potential to submit to quality improvement journal such as BMJ
IX.	Markers (project phases, progress checks,	Intervention 1: 10/14/15 Intervention 2: 7/22/16

	schedule, etc.; refer to *NI V Roadmap to 2017*, which will be presented at Meeting One)	Intervention 3: 9/9/16 Intervention 4: 10/15/16

Sections X thru XIII to be completed first quarter 2017 for "Final Proceedings" booklet:

X.	Success Factors	The most successful part of our work was we implemented a standard process for screening patients in primary care for alcohol misuse and provided targeted treatment options that engage resources in clinic and the larger community. As a result of serial interventions, screening for alcohol misuse has increased to 92% and we have begun to expand these efforts to our 7 other clinic locations.
XI.	Barriers	The largest barrier encountered was balancing the needs of multiple stakeholders-the patient, clinic staff, providers, and community members
XII.	Lessons Learned	The single most important piece of advice to provide another team embarking on a similar initiative would be to involve clinic staff and committees early on.
XIII.	Expectations Versus Results	On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything), how much of what you set out to do was your team able to accomplish? 8