AIAMC NATIONAL INITIATIVE IX MEETING ONE

Micro Environment Approach: Understanding SMDH and its Impact on Health Outcomes and the CLE

October 13, 2023 – Omni Chicago Hotel

Meeting Attendee Packet

National Initiative

What AIAMC NATIONAL INITIATIVE IX MEETING ONE

Micro Environment Approach: Understanding SMDH and its Impact on Health Outcomes and the CLE

October 13, 2023 – Omni Chicago Hotel

7:30 am – 8:30 am Chagall Ballroom	**Breakfast and Networking Time**
8:30 am – 8:50 am Chagall Ballroom	**Welcome to Meeting One (Include Introduction of NAC Members Present)** *NI IX Co-Chairs Rajiv Gala, MD, FACOG, Designated Institutional Official, Ochsner Health System, and James "JP" Orlando, EdD, Chief GME Officer and DIO, St. Luke's University Health Network*
8:50 am – 9:00 am Chagall Ballroom	**Personal Story** *Ellen Sullivan, MS, MSJ, CAE, Vice President, Communications, Accreditation Council for Continuing Medical Education*
9:00 am – 10:15 am Chagall Ballroom	**Keynote Address** *William McDade, MD, PhD, Chief Diversity and Inclusion Officer, Accreditation Council for Graduate Medical Education* 9:00 am – 10:00 am: Keynote 10:00 am – 10:15 am: Debrief and Takeaways *Rajiv Gala, MD, FACOG, Designated Institutional Official, Ochsner Health System*
10:15 am – 10:30 am Chagall Pre-Function	**Morning Break**
10:30 am – 10:45 am Chagall Ballroom	**Introduction of Project Management Plan and NI IX Roadmap** *Kimberly Pierce Burke, AIAMC Executive Director*
10:45 am – 11:30 am Chagall Ballroom	**What Will Success Look Like? And How Will We Measure It?** *Deborah Simpson, PhD, Academic Affairs Education Director, Aurora Health Care* *Kimberly Pierce Burke, AIAMC Executive Director* *Terry Frederick, Manager Medical Education Program, Aurora Health Care* Presentations from NI VIII Team Leaders: *Elizabeth Beiter, MD, Associate Program Director, TriHealth* *Parampreet Kaur, MD, Research and Quality Improvement, GME Data Management and Outcome Assessment Chair, St. Luke's University Network*
11:30 am – 12:15 pm Van Gogh and Pre-Function	**Lunch**
12:15 pm – 12:30 pm Chagall Ballroom	**Morning Debrief and Cohort Breakout Instructions** *Rajiv Gala, MD, FACOG, Designated Institutional Official, Ochsner Health System*
12:30 pm – 2:45 pm Monet Renoir Gauguin Executive Boardroom	**Cohort Breakouts** (NAC Member Assigned to Each Room) 12:30 pm - 1:45 pm: Cohort Activity One: Team Reports Based on Pre-Work and Cohort Feedback (7 minutes per team) 1:45 pm – 2:15 pm: Institutional Team Time and NAC members meet to share common themes/challenges for breakout groups based on facilitators' notes 2:15 pm – 2:45 pm: Cohort Activity Two NAC members share themes (5 minutes), 20 minutes for breakout groups to tackle themes, 5 minutes for report out to the larger group Cohort One Cohort Two Cohort Three Cohort Four/Five
2:45 pm – 3:00 pm Chagall Pre-Function	**Afternoon Break**

Updated
10/03/23

3:00 pm – 3:45 pm Chagall Ballroom	**Cohort Breakouts Reactor Panel: National Advisory Council Members** *Elisa Arespacochaga, MBA, Vice President, Clinical Affairs and Workforce, American Hospital Association* *Lisa Howley, PhD, Senior Director, Transforming Medical Education, Association of American Medical Colleges* *Ellen Sullivan, MS, MSJ, CAE, Vice President, Communications, Accreditation Council for Continuing Medical Education* *Elizabeth Zmuda, DO, Director of Medical Education, OhioHealth Doctors Hospital*
3:45 pm – 4:15 pm Chagall Ballroom	**Meeting One Closes** *NI IX Co-Chair Rajiv Gala, MD, FACOG, Designated Institutional Official, Ochsner Health System*

We're delighted that you're attending National Initiative IX Meeting One, and here are some last- minute details to help you enjoy your trip to magnificent Chicago:

Ground Transportation: The Omni Chicago Hotel is conveniently located 17 miles from the O'Hare International Airport (ORD) and 13 miles from Chicago Midway International Airport (MDW) There are various ground transportation options available, including Lyft and Uber, taxi service, rental cars, and private transfer.

Hotel Information: 676 North Michigan Avenue Chicago, IL 60611 Phone: (312) 944-6644**. Check-in time is 4:00 p.m.** Check-out time is 12:00 p.m.

Restaurant Guide: The AIAMC will provide breakfast and lunch on the day of the conference.
The Omni Chicago has dining on site at 676 Restaurant & Bar which is located on site on the 4th floor. Breakfast, lunch, and dinner are offered. Should you wish to try the local cuisine, check out these local restaurants: AIAMC National Initiative IX Meeting One List of Local Restaurants

Meeting Space: All of our activities – including plenary sessions, meals and breakout sessions will take place on the third floor of the hotel. Both stairs and elevators provide easy access to the meeting space.

Registration: The conference registration desk will open on Friday October 13th at 7:00 a.m. in the *Chagall Foyer.*

Conference Start Times: National Initiative IX Meeting One begins on Friday October 13th with a buffet breakfast at 7:30 am in the Chagall Foyer. The conference will start promptly at 8:30 a.m. in the Chagall Ballroom and end at 4:15 p.m.

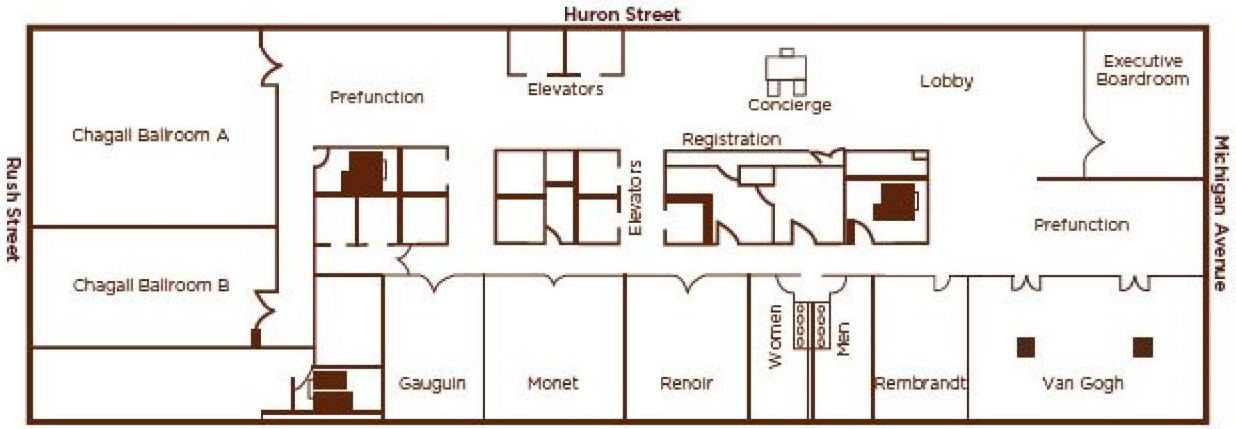
Conference Evaluation: The AIAMC takes great pride in providing educational sessions that are timely and substantive. We could not do this without your feedback. The National Initiative Meeting One evaluation form may be accessed via the below QR code or here: AIAMC National Initiative IX Meeting One Evaluation Survey (surveymonkey.com)

Weather Forecast: The extended forecast in Chicago over our meeting dates is reported to be highs in the high 60's and lows in the high 40's.

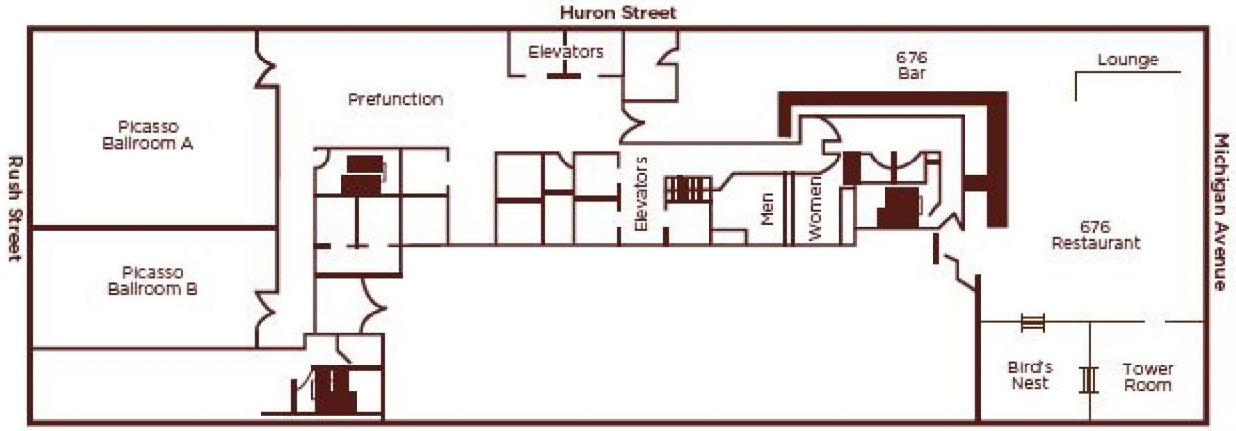
Dress: Business casual is appropriate for the conference. You may want to pack a sweater or light jacket for the meeting, as conference space temperatures can vary. Dress comfortably and plan to enjoy an outstanding National Initiative IX Meeting One!

I look forward to seeing you all and please let me know if you have any questions.

Third Floor



Fourth Floor



OMNI® HOTELS & RESORTS
chicago

AIAMC
National Initiative IX Meeting One
List of Local Restaurants

Nomi Kitchen Lounge Garden

800 N Michigan Ave, Seventh Floor, Chicago, IL 60611

312 239 4030

NoMI | Unique Dining Experiences in Chicago, IL (nomichicago.com)

TZUCO

720 N State Street Chicago, IL 60654

312-374-8995

TZUCO | Mexican restaurant in River North, Chicago

The Purple Pig

444 N Michigan Ave, Chicago, IL 60611 Hubbard St & Illinois St

312- 464-1744

THE PURPLE PIG (thepurplepigchicago.com)

PEQUOD'S PIZZA

2207 N CLYBOURN AVE

CHICAGO, IL 60614

773-327-1512

Reserve A Table - Chicago Location |

AIAMC
National Initiative IX Meeting One
List of Local Restaurants

FUN Food establishments

Eataly Chicago
43 East Ohio Street
Chicago, Illinois 60611
https://www.eataly.com/us_en/stores/chicago/

World's Largest Starbucks
646 N Michigan Ave
Chicago, IL 60611
https://www.starbucksreserve.com/en-us/locations/chicago

Donut Vault
401 N Franklin St
Chicago, IL 60654
https://doughnutvault.com/

Garrett Popcorn
27 W Jackson Blvd
Chicago, IL 60604
https://www.garrettpopcorn.com/

NATIONAL INITIATIVE IX DELIVERABLES AND DUE DATES

Sept – Dec 2023

Sept

9/8: Toolkits 1 thru 4 to Mindi
9/29: Online Registration for Meeting One Closes

Oct

10/13: MEETING ONE at the Omni Chicago Hotel

Nov

Monthly Cohort Zoom Meetings Commence; Monthly Progress Update Form (aiamc.org) to Mindi Prior

Dec

Monthly Cohort Zoom Meeting; Monthly Progress Update Form (aiamc.org) to Mindi Prior Self-Reported Milestones Due

Jan – Aug 2024

Jan

Educational Webinar (T) Instead of Monthly Cohort Zoom Meeting (Choice of 2 Dates)

Feb

Monthly Cohort Zoom Meeting; Monthly Progress Update Form (aiamc.org) to Mindi Prior
Register for Meeting Two

Mar

Meeting Two Storyboard Template (aiamc.org) Due (electronic and ship)
Monthly Cohort Zoom Meeting; Monthly Progress Update Form (aiamc.org) to Mindi Prior Self-Reported Milestones Due

Apr

4/4 thru 4/6: AIAMC 2024 Annual Meeting
4/5 & 4/6: MEETING TWO at the Loews Ventana Canyon

May

Monthly Cohort Zoom Meeting; Monthly Progress Update Form (aiamc.org) to Mindi Prior

Jun

Educational Webinar (T) Instead of Monthly Cohort Zoom Meeting (Choice of 2 Dates)
Self-Reported Milestones Due

Jul

Monthly Cohort Zoom Meeting; Monthly Progress Update Form (aiamc.org) to Mindi Prior

Aug

Monthly Cohort Zoom Meeting; Monthly Progress Update Form (aiamc.org) to Mindi Prior
Register for Meeting Three

NATIONAL INITIATIVE IX DELIVERABLES AND DUE DATES

Sept – Dec 2024

Sept

Monthly Cohort Zoom Meeting;
Monthly Progress Update Form (aiamc.org) to Mindi Prior Self-Reported Milestones Due

Oct

10/11: MEETING THREE
(Virtual)

Nov

Monthly Cohort Zoom Meeting;
Monthly Progress Update Form (aiamc.org) to Mindi Prior

Dec

Monthly Cohort Zoom Meeting;
Monthly Progress Update Form (aiamc.org) to Mindi Prior Self-Reported Milestones Due

Jan – Apr 2025

Jan

Educational Webinar (T) Instead of Monthly Cohort Zoom Meeting (Choice of 2 Dates)
Register for Meeting Four

Feb

Final Storyboard Template (aiamc.org) Due (electronic and ship) Project Management Plan (aiamc.org)
Due Selection of Cohort Presentations

Mar

3/20 thru 3/22 AIAMC 2025 Annual Meeting
3/21 & 3/22 MEETING FOUR at Loews New Orleans Hotel
Final Self-Reported Milestones Due

Apr

Team Leaders Complete National Initiative IX Longitudinal Survey

Project Management Plan (PMP)

Begin completing this Project Management Plan (PMP) with your team before year's end, i.e., by December 2023. Teams will have the opportunity to review/revise their PMPs throughout the 18-month Initiative at each of the on-site meetings. The collective data from all the teams' completed project management plans will be invaluable as we share and learn from this collaborative experience. Your final PMP is due prior to Meeting Four in March 2025.

Team: _____ **Project Title:** _____

I.	Vision Statement (markers of success by March 2025; Refer to Toolkit #5 after meeting one)	
II.	Team Objectives ('needs statement,' project requirements, project assumptions, stakeholders, etc.)	
III.	Team Members & Accountability (list of team members from Toolkit #6 [after meeting one] and who is accountable for what)	

IV.	Necessary Resources (staff, finances, etc.)	
V.	Measurement/Data Collection Plan (Refer to Toolkit #2)	
VI.	Stakeholder Communication Plan (may be helpful to draft a flow chart of team members & senior management (Refer to Toolkits #4 and #6)	
VII.	Potential Challenges (engagement, budget, time, skills gaps, etc. (Refer to Toolkit #3)	

VIII.	Opportunities for Scholarly Activity (potential publications, conference presentations, etc.)	
IX.	Markers (project phases, progress checks, schedule, etc.; Refer to *NI IX Roadmap to 2025*)	

Sections X thru XV to be completed first quarter 2025 for "Final Proceedings" booklet:

X.	Success Factors	*The most successful part of our work was….* *We were inspired by….*
XI.	Barriers	*The largest barrier encountered was….* *We worked to overcome this by….*
XII	Surprises	*What surprised you and why?*
XIII.	Lessons Learned	*What would be the single most important piece of advice to provide another team embarking on a similar initiative and how to be successful?*
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 and how were your results the same or different from your expectations?* *1 2 3 4 5 6 7 8 9 10*
XV.	Sustainability and Next Steps	What does your CEO need to know to help keep your work sustainable?

Breakout Rooms:

Cohort One Monet DEB ELISA ARESPACOCHAGA	Cohort Two Renoir GILLIAN LISA HOWLEY	Cohort Three Gauguin KELLY ELIZABETH ZMUDA	Cohort Four Executive Boardroom VICTOR ELLEN SULLIVAN
AdventHealth Orlando	Our Lady of the Lake	Ochsner	Guthrie Robert Packer (Youth Health)
Atrium Health	TriHealth	Aurora Health Care (FM)	Guthrie Robert Packer (SDOH Inpatient)
Aurora Health Care (Climate Smart)	Aurora Health Care (Vot-ER	Aurora Health Care (IM)	Guthrie Robert Packer (SDOH Outpatient)
Baystate	Monmouth Medical Center	Ohio Health	St. Lukes (ACE QI Study)
Cleveland Clinic	Ascension Providence Rochester	UnityPoint Des Moines (LWBS)	St. Lukes (ED Patients)
Baptist Health	Cedars -Sinai	UnityPoint Des Moines (Healthcare Violence)	St. Lukes (Psychiatric Care)
Ascension St. Vincent/Good Samaritan	Hackensack Meridian Ocean		Virginia Mason

National Initiative

Cohort One
Project Summaries

Teams: AdventHealth Orlando, Atrium Health, Aurora Health Care (Climate Smart), Baystate, Cleveland Clinic, Baptist Health, Ascension St. Vincent/Good Samaritan

Institution Name: AdventHealth Orlando

Presenter Name: Nancy Zerpa Lira, MD

Project: Expanding Rehabilitation and Primary Care access for underinsured patients who use AdventHealth healthcare services.

1. Summary of your project including aims and intended measurements

Our goal for this IX National Initiative is to connect our Community Medicine Clinic (CMC) at Orlando/East Campuses with the Hope Clinic from the AdventHealth University. Both clinics provide healthcare services for underinsured patients. CMC provides primary care services whereas the Hope Clinic focuses on rehabilitation. However, they have not been working together up until now, despite being part of the same organization. We are looking to streamline a referral process for patients that could benefit from the Physical Therapy/Vestibular PT/Cardiac rehab/Occupational Therapy/Nursing services that are provided at the Hope Clinic for uninsured patients.

We want to expand the access of underinsured patients to rehab services. For this goal, we will be monitoring:

- Number of patients referred from the CMC to the Hope Clinic
- Patients' diagnoses prompting referral to the Hope Clinic
- Number of patients who attended their appointments at the Hope Clinic
- Identify SDH that may influence patient's attendance rate to their rehab appointment, and/or hospital utilization.
- Rehab services used by these patients at the Hope Clinic
- Admission/readmission hospital rate to an AdventHealth facility

We also want to provide primary care access to underinsured patients who may visit the Hope Clinic, coming from an external referral. For this goal, we will be monitoring:

- Number of patients referred from the Hope Clinic to CMC
- Number of patients who attended their appointments at the CMC
- Identify SDH that may influence patient's attendance rate to their primary care appointment
- Prevalence of chronic diagnosis for these patients after evaluation at CMC.
- Admission/readmission hospital rate to an AdventHealth facility

Finally, we want to incorporate an educational experience for our residents and medical students. Residents and medical students will attend workshops at the Hope Clinic, led by PT/OT faculty. They will interact with patients and learn more about PT/OT evaluation and management of qualifying diagnoses.

We will be monitoring:

- Number of residents who attend workshops at the Hope Clinic

- Number of medical students who attend workshops at the Hope Clinic
- Resident and students' satisfaction with the workshops.
- Number of residents that attend volunteering sessions at the Hope Clinic
- Number of students that attend volunteering sessions at the Hope Clinic

2. Progress to date on project

   Planning phase is almost complete. We have held multiple meetings with CMC and Hope Clinic/AHU/AHMG leadership. We have already designed a referral system for patients between CMC – Hope Clinic. We selected a validated SDOH screening survey from CMS, which will be administered to patients at the Hope Clinic. We are finalizing our research team to determine how we are going to track our metrics. In addition, we are also applying for our IRB exemption next week.

3. Challenges faced to date

Resident and student recruitment has been difficult. We have 2-3 residents who are part of our research team, but despite reaching out to several Program Directors, we have not heard back from other interested programs or residents.
Lack of EMR access in the Hope Clinic poses a challenge when tracking referrals and hospital utilization.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

   How can we connect better with residents? Need more engagement.

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

The SDOH screening survey from CMS is thorough and well validated. Can be found as part of the AHC (Accountable Health Communities) Health Related Social Needs Screening Tool.

Institution Name Atrium Health Carolinas Medical Center

Project Healthy Climate, Healthy Lives: Engaging Residents in Advocating for Health Equity

1. Summary of your project including aims and intended measurements

Aim: By the end of National Initiative IX, we will have engaged residents across our graduate medical education programs in educational and community engagement activities that increase their awareness and knowledge of how climate change impacts the health of patients and communities, in order to better prepare them to become climate change advocates who focus on improving the health of their patients and communities. The educational and engagement activities will be designed based on the community health needs identified by the institution's Diversity and Social Impact Report (Building Healthy Communities | Atrium Health).

Measures: 1. Quantitative: a. Number of educational and community engagements scheduled. b. Number of residents who complete educational activities. c. Number of residents, faculty, and staff who participate in community engagement activities. d. Number of individual department level projects impacting climate health and health equity initiated during the initiative 2. Qualitative: a. Survey of resident's experience with the community engagement activities with specific questions around climate change and its impact on social and moral determinants of health

2. Progress to date on project

June 2023 we incorporated health equity and climate into our new resident orientation. Through community partnerships with Community Building Initiative, Envision Charlotte's Innovation Barn, and The Bulb, as well as sessions led by our faculty, first-year residents gained foundational knowledge: understanding the past, present, and future of the communities of Charlotte in relation to access to healthcare, understanding of food insecurity, increased knowledge or our implicit bias, climate in relation to healthcare and how to be advocates who focus on improving the health of their patients and the communities in which they practice medicine now and in the future. Several of our first-year residents have returned to the Innovation barn this year to volunteer their time.

At the conclusion of the day residents completed a survey and provided feedback about each of the activities. Here are some select comments from the survey:

> *"Super helpful for bettering my understanding of the history of CLT and to help prepare me to better understand my future patients." – Bus Tour*

" Awesome tour and lecture by the historian! Really important to put things in sociohistorical context." – Bus Tour

"Loved working through examples and discussing practical ways to address concerns." - Implicit Bias Session

"I loved the discussion, would have liked to receive the resources when we see or experience something we'd like to bring to someone's attention. "– Implicit Bias Session

"Working together to prepare meals for members of our community was a special way to wrap-up our day." – Community Service Project at the Innovation Barn with The Bulb.

The team continues to work on developing the project with plans of hosting three climate-focused community service activities this academic year in addition to the community service project completed during new resident orientation. Teaching components will be woven into the projects. In addition, we are in the process of interviewing key stakeholders to understand more about what deliverables will excite them and convince them to invest additional resources in our project.

About Our Community Partners:

Community Building Initiative -CBI's mission is to give people and organizations the knowledge, skills, and courage to fight bias, remove barriers to opportunity and build a more equitable and just Charlotte-Mecklenburg.

Envision Charlotte - Envision Charlotte is a public private plus collaborative that leads Charlotte's progress as a global Smart City through innovations that strengthen economic competitiveness, environmental sustainability, and positive community impacts. The Innovation Barn is a combination of entrepreneurial businesses, zero-waste initiatives, and a space to convene groups in order to learn more about and implement circular projects. The City of Charlotte owns the building and Envision Charlotte manages, designs, and implements the programming within.

The Bulb - The Bulb is a donation-based nonprofit serving Charlotte and its surrounding area through mobile farmer's markets that pop-up in vulnerable communities around the city. Operating under the motto, "take what you need, give what you can," our goal is minimize barriers, including lack of transportation, physical disability, unreliable income, etc., so that all people have access to fresh and healthful food options.

3. Challenges faced to date
a. Gathering residents and external team members
b. Engaging stakeholders who may be able to assist with additional funding
c. Funding to support travel for more team members
d. Balance – is what we are planning rigorous enough?
e. Finding meaningful (trackable) measures that will impact the bottom line for the healthcare system

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

   a. What are you doing now to bake-in a plan for sustainability?
   b. What are you doing to build a sense of urgency and buy-in from faculty (and others) who are stretched and tired?

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

   US Dept Health and Human Services Climate Change and Health Equity page is a good introduction Climate Change and Health Equity | HHS.gov

   American Public Health Association website (apha.org) Climate Change, Health and Equity (apha.org)

Institution Name Aurora Health Care

Projects Getting Climate Smart

Presenter: Deb Simpson, PhD

Summary of your project including aims and intended measurements

TITLE: "PLUS 1" FOR GETTING CLIMATE SMART – ACROSS THE CONTINUUM

AIM: To improve physicians ability across the continuum of medical education to address the (inequitable) impacts of climate on their patient's health from anticipatory guidance to in-the moment consultation.

INTERVENTION: Multiple strategies will be used to achieve this aim and to coalesce an array of education efforts.

(1) Plus one is a strategy adapted from business to extend thinking/performance to the next level. In education this strategy has been adapted to be "plus one slide". We will invite all medical education program leaders to add "one slide" on the impacts of climate on patient care to any topic they are current presenting for teaching sessions from core curriculum sessions to grand rounds.[1]
   A. To support the +1 strategy, the library will create a "link" request specific to this project that will allow faculty to request 3 or less relevant climate impact related articles for their specific presentation topic with an emphasis on review articles. This eases the added burden for faculty of "searching" the vast and expanding literature on climate impact. If no slides we will provide a standard slide on the inequity of climate change and to anticipate evidence will emerge specific to their topic.
   B. Community Resources – as part of the required Family Medicine longitudinal residency curriculum on Community Health, Advocacy, and Managing Populations all PGY1s are required to share the findings of community asset project. CHAMP leader(s) will encourage residents advocacy/focus community resources related to climate (eg, community based resources to respond to heat). These resources will be shared with all "Plus 1" for Getting Climate Smart team members with a central site for access.
   C. To disseminate the why, what, how of this project to faculty, we will prepare a short, annotated (<5 min) slide show for presentation in various med ed leadership forums (eg, UMEC, GMEC) and within programs by their "equitable climate champion". Emphasis on faculty may not be the expert but like audience is learning.

(2) The new internal medicine primary care track will have an emphasis on environmental sustainability. Educational experiences are currently being designed but will include moral and SDH health as areas of emphasis.

(3) Two climate sessions at Aurora Sinai Medical Center CME Accredited Grand Rounds will be presented in impacts of climate on patients and care.

(4) Two interprofessional CE Getting Climate Smart sessions will be presented focusing on impacts of climate on patients through interprofessional lens including what our system is doing to reduce its adverse climate impacts (eg, sustainability).

[1] Park Y, Ku-Borden T. Incorporating DEI Content Longitudinally during Didactics at AHWM. STFM Annual Meeting. Tampa, FL. April 29-May 3, 2023.

MEASURES: (1) Number of requests for support on climate topics via library link; (2) Survey of faculty who have added climate topic to their existing presentation re: confidence, interest, impact on learners and willingness continue to +1 including professional identity as a physician in this space; (3) ACGME survey item results on "taught about health care disparities" will be examined longitudinally for to monitor change; (4) CE Quick survey of participants in the Get Climate CE Smart Series.

1. Progress to date on project
    A. Climate
        a. Library form drafting/revising
        b. 1+ strategy piloted in FM added to GDM - gestational diabetes
        c. 1 Climate resource guide developed (CHAMP-FM): Anthony Zotto, Cooling Centers in MKE 8.22.23
        d. Aurora Sinai Medical Center CME
            i. Victoria Gillet (APD IM) September 15, 2023 Climate Change & Health Care. What Wisconsin needs to know. CME accredited.
        e. Evaluation: Convened Evaluation stakeholder workgroup with Atrium Colleagues
        f. Scholarship:
            i. Focused Discussion Accepted At AAMC Nov 2023 | Raising the Temperature! Infusing the Impacts & Implications of Climate Change on Patients Across Med Ed Continuum
            ii. Seminar submitted to STFM 2024
2. Challenges faced to date
    A. Climate
        a. What data remains a challenge – utilizing a stakeholder process to identify evidence
        b. Coordinating and tracking all the different activities

3. Specific questions for the cohort colleagues: In what areas is guidance needed?
    - Data – what would convince you project was of success!

4. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc.

Institution Name: Baystate Medical Center

Project: Restore American leadership to reverse climate change

Presenter: Jason

1. Summary of your project including aims and intended measurements
    - Part of the Baystate core values include Quality and Safety and Value to patients. From a quality perspective, limiting the impact in terms of landfill use and carbon used for excess waste and instruments will lead to long term effects on the regional community. Value is important to sustain the mission of the system. The aim of this project is to reduce cost in upfront purchasing and in waste disposal through a more robust recycling initiative.

The measurement metrics to be used during this project are as follows:

- Weight of solid waste diverted to new recycling bins per delivery.
- Cost decrease per delivery through a reduction in excess supplies provided in standard delivery trays. Pre and post project surveys will be conducted with clinicians to assess satisfaction with delivery kit content.
- Red bag waste decrease by Kg per delivery through diversion of non-biohazard waste to the appropriate waste bin.

2. Progress to date on project

    - The project team has been established. Preliminary project design and goals have been established. Ancillary project partners such as Environmental Services and our Green Initiative leader have been engaged and have committed to partnering on this project.

3. Challenges faced to date

    - Competing priorities and availability of project partners has been our biggest challenge thus far. As we further establish our project rhythm, this is anticipated to improve.
    - Baystate Medical Center has been transitioning away from many reusable patient care items towards single use items for some time. Fiscal challenges may be prohibitive to transitioning items back to reusable.

- Operational challenges with our Sterile Processing Department (SPD) are currently prohibitive to making meaningful changes to our instrumentation flow for cleaning. This is being addressed and may change in the near future. The project team thought addressing some of these issues would be impactful for our project, but the capacity isn't there with SPD at this time.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

   - None at this time.

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

   - Baystate Health has an existing partnership, previously unknown to this project group, with Practice Greenhealth. This relationship is available to us for this project, and we will engage with them as needed.

     https://practicegreenhealth.org/topics/greening-operating-room/greening-or

Institution Name: Cleveland Clinic Akron General

Project REACH Akron: The impact of a primary care residency practice with Head Start

(**R**aise **E**ngagement to **A**dvance **C**hildrens' **H**ealth)

Presenter Name: Cheryl Goliath, PhD

1. Summary of your project including aims and intended measurements :

   Our academic Family Medicine practice will partner with our local Head Start to provide needed medical services such as school physicals, wellness exams and family education to provide improved access to care helping to address SMDH with support from our community health worker, social worker and a team of health care providers. We will measure the number of services provided, student absenteeism, and the potential increase of children under 18 enrolled at CFM during study period.

2. Progress to date on project:

   NI 9 team has been identified and monthly meetings are being scheduled. Agreements have been drafted and awaiting final signatures. A bi-weekly schedule has been set to begin visits once agreements have been signed. Investigating logistics of providing lead testing for students.

3. Challenges faced to date:

   Additional agreements needed for billing were identified which delayed providing appointments by one month. Needed to create a separate "build" in EMR once agreements are finalized. Identifying a family representative on the NI 9 Team has not been communicated yet from Head Start. (Suggested by AIAMC). Furnishing space and purchasing supplies.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?
   - Does anyone have experience in providing services to Head Start or a school?
   - We are new to Lead Testing and this has been challenging, any insight?
   - Strategies to engage families and students

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

   Not yet.

Institution Name: Baptist Health South Florida

Presenter Name: Seema Chandra

Project: Incorporating Social and Moral Determinants of Health into the Comprehensive Wellness Exam

Summary of your project including aims and intended measurements

The project aims to improve our ability to address the pressing issues of hunger and homelessness affecting the patients we serve, recognizing their interconnected nature and impact on vulnerable individuals. We believe that no person should suffer due to food or housing insecurity, and we are committed to tackling the contributing social and moral factors. Although our health system works closely with various community organizations, as clinicians we do not always share this vital information with patients. Furthermore, we do not always capture the complex social needs of our patients. Given the significant influence of social determinants on health outcomes, routine screening and addressing of these factors during patient encounters is imperative.

1. Aim 1: improve screening for social and moral determinants of health for patients at our two teaching primary care clinics (the Family Medicine Center – FMC and the Internal Medicine Center – IMC) by implementing a standardized questionnaire to be administered at all wellness and annual visits.
2. Aim 2: increase understanding by our resident and attending physicians of the complex role that social and moral determinants of health play in our patient's health by using both simulation-based activities as well as increasing our engagement with and exposure to various community partners.
3. Aim 3: strengthen connections between the FMC/IMC and multiple community partners so that our physicians and staff can directly make referrals and provide meaningful resources to patients struggling with food or housing insecurity, medication and healthcare costs, transportation difficulties, or personal safety.
4. Aim 5: encourage and increase documentation of social and moral determinants of health in the patient chart to draw attention to the importance of these factors in overall patient health

Our hope is that our intervention will increase our providers' ability to comprehensively care for their patients who struggle with meeting basic needs while also advancing adoption of the systematized screening and referral system for addressing patients' health related unmet social needs in both of our primary care resident practices.

5. Progress to date on project

Our group has met twice over zoom to review and draft a protocol for the project. We are now working on identifying potential community partners as well as preparing a complete research proposal for IRB submission.

6. Challenges faced to date
   Our health system is in the process of implementing a standardized screening and referral system for the inpatient services. We are working on how to best approach implementing this as a pilot in the outpatient setting.

7. Specific questions for the cohort colleagues: In what areas is guidance needed?
   Could use some guidance on setting up study design and also capturing some of the downstream outcomes from referrals and connections (how do we measure if patients were actually helped by the intervention?)

8. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)
   PRAPARE questionnaire
   ALICE poverty simulator through the United Way

Institution Name: Good Samaritan Hospital partnering with Ascension St. Vincent Evansville

Project: Post Discharge Clinic

Presenter: Jesse

1. Summary of your project including aims and intended measurements

   -Post-Discharge Clinic Project (PDC Project): Will we identify patients with Social Determinants of Health (SDOH) through the Post-Discharge Clinic and measure readmission rates. We will utilizes a validated survey, such as the PREPARE survey, to identify patients who have SDOH. We discussed measuring readmission rates. This project could potentially be 2 projects (a non-intervention and intervention arm). The non-intervention arm would be data collection to identify high-yield SDOH areas, followed by a smaller intervention arm.

   -Wabash Valley Connect Project (WVC Project): We will increase community knowledge and accessibility of resources using the Wabash Valley Connect (WVC) resources already available at one of our sites. WVC uses an iPad-based kiosk from which we can track utilization.

2. Progress to date on project

   -Post-Discharge Clinic Project: We have finalized a project focus, population of study, and have a proposed validated survey. We also discussed creating two projects within this larger project, a data collection non-intervention arm followed by an intervention arm; both can be run through the IRB at the same time.

   -Wabash Valley Connect Project: We discussed resources and personnel required for project and accessibility for data collection. We ran into issues with regard to operationalizing the iPad-based kiosk at one site. We will need to mirror similar resources at our other site.

3. Challenges faced to date

   -Post-Discharge Clinic Project: For the PDC project, identified barriers include: Patients must fill out the survey (so it must be under 10 questions for ease-of-use); the survey must be incorporated into the existing workflow of medical assistants/techs/nursing; accessibility of questions may be proprietary; because of pre-existing validation studies, we may not be able to alter the questions to suit our specific populations. In addition, we need to get

information on the number of patients required to see statistical significance. In addition, we will run this project through the IRB, which can take time.

-Wabash Valley Connect Project: We are challenged with the WVC project relying on a small group of content experts (not everyone on the NI9 team has the ability to troubleshoot this project if issues arise). We are also challenged by completion of tasks, as some steps of the project are handled by third-parties outside of the NI9 team (such as IT). We also will try to mirror this resource at our other site. This will likely require hardware and finances.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

   -Post-Discharge Clinic Project: What is the value/utility of targeting SDOH patients and measuring readmission rate vs. those without SDOH (given that readmission rate is a multifactorial issue). What happens to validation if we were to alter/use fewer of the PREPARE survey questions?

   -Wabash Valley Connect Project: For the WVC project, we can track utilization of the kiosk, but how did other groups/organizations meaningfully measure utilization of third-party resources that are directed from the kiosk?

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

   -PREPARE questionnaire.

   -American Academy of Family Physicians Social Determinants of Health Questionnaire.

Cohort Two
Project Summaries

Teams: Our Lady of the Lake, TriHealth, Aurora Health Care (Vot-ER), Monmouth Medical Center, Ascension Providence Rochester, Cedars Sinai, Hackensack Meridian Ocean

Institution Name: Our Lady of the Lake Regional Medical Center (OLOLRMC)

Project: Enhancing Health Outcomes through Addressing Food Insecurity in Baton Rouge

Presenter:

1. Summary of your project including aims and intended measurements

Initial groundwork for this project has been active since 2018. Both FMOLHS, our health system, and OLOL committed to a strategic plan in identifying and screening for social determinants of health. Within this body of work have been the initiatives of electronic health record optimization for screening, resource referral for those with risk and need, and closed loop channels for full data capture. A subcomponent of this initiative is the current project proposal, specifically hardwiring food insecurity and food resources for patients with a positive screen for risk. A firm collaboration has been established with our local food bank to both distribute food boxes to our patients at risk at the time of their discharge, and to connect them to ongoing aid for food in security.

The program aims to reduce food insecurity among both children and adults in Baton Rouge, with a particular emphasis on vulnerable populations. By integrating medical education and community service, we aim to nurture future healthcare professionals who are well versed in addressing social determinants of health and are committed to social responsibility. Specific measurements will include a initial and follow up survey of medical residents in our hospital teaching units for perception indices, number of patients screened within the pilot units over the project period, number of patients connected to food box distribution out of those at risk, and finally completion of enrollment to the maintenance program.

2. Progress to date on project

Electronic health record screening has already been implemented and is in constant iterative improvement for screening among all our hospital team members. Collaboration with our food insecurity partner, Greater Baton Rouge Food Bank, has been hard wired with agreements. Food box distribution is in preparation stages, and presently is undergoing logistics of location, storage, and hospital protocols for safe storage. All medical residents, teams, and pilot units have received education on the program, though ongoing education and updates are expected to continue for knowledge transfer.

3. Challenges faced to date.

Program awareness and logistics of screening for patients at different phases of their hospitalization both remain as challenges in infection control procedures also add complexity to storage of food boxes, and logistics of distribution to patients ready for discharge. Though not new, this program was formally vetted with the pediatrics (separate geographic facility) hospital and teams, and is not yet as the same level of preparedness as the adult facility.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

1) How has your facility/team addressed capture of social determinants of health (SDOH)?
2) Have you assigned a specific role/champion to own the documentation and resolution of SDOH risks in your institution?
3) What specific areas have been successful or problematic when considering the need to integrate cultural sensitivity with screening for social determinants?
4) Has anyone encountered challenges with the designation of food as medicine from a medico-legal standpoint. If so, what was the basis, and what if any were pathways to resolution.

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

Visuals and goals: https://health.gov/healthypeople/priority-areas/social-determinants-health

Impact of social vulnerability, Interactive Heat Map:
https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html

Curriculum content: https://www.aha.org/news/blog/2019-03-28-four-keys-applying-quality-performance-tools-and-tackling-social-determinants

Z-Code infographic- for capture of social determinants into the patient's story. This particular resource is important for selling the distributed story such that we can understand the aggregated problem and learn about specific regions and racial/cultural groups with disparities yet to be highlighted.
https://www.cms.gov/files/document/zcodes-infographic.pdf

Institution Name: TriHealth

Presenter Name: Libby

Project: The benefits of Incorporating Food insecurity screening and food pantry access in residency programs

1. Summary of your project including aims and intended measurements

   Percentage of patients who screen positive for food insecurity across IM, FM, and OB residency and by zip code compared to CHNA assessment and other sources of food risk by zip code

   Utilization of food pantry measured by pounds of food per site per week

   Effect of access to food pantry on no show rate- look at random cohort of patients and number of no shows in the 6 months prior to accessing the food pantry and 6 months post.

   Start building health related suggestions into food pantry- identifying foods that are DASH, Mediterranean, diabetic friendly, providing recipes for meals by diet recommendation and seeing if utilization of these products increases

2. Progress to date on project

   We have assembled our team, including research analyst, DEI office partner, diabetes educator, have built smart phrase in EPIC for screening and referral process for patients to utilize pantry

3. Challenges faced to date

Consistent engagement cross multiple programs

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

   Other outcomes to study?
   Opportunities to study other disparity-based interventions including community health worker in FM

Also developing longitudinal health disparities/pop health curriculum in family med so opportunities to study/share this

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

   Robert Wood Johnson foundation life expectancy by zip code has been really compelling to share with residents as they see patients.

Institution Name Aurora Health Care

Project Vot-ER

Presenter: Terry

1. Summary of your project including aims and intended measurements

TITLE: VOT-ER
AIM: To engage interested members of our medical education community in talking with their patients (and peers, colleagues) about the importance of voting for their health and that of their communities.

INTERVENTION: Using the resources and guides developed by Vot-ER we will:
(1) Invite each medical student group and residency/fellowship program to identify 1-2 nonpartisan "Vot-ER Champion(s)".
(2) The champions will attend an orientation to the Vot-ER program, to explore resources, and be provided with an annotated < 10 min PowerPoint presentation outlining the "why" this is a physician's role, what they can do (eg, Vot-ER badge), and how – sample scripts of conversation starters to have with their patients. A fact sheet will also be provided.
(3) Champions will present to their colleagues and determine interest. Slides will also be presented at established forums including UMEC and GMEC meetings.
(4) Badges and other resources will be ordered from Vot-ER– with the potential for competition between our UME and GME sections – for distribution to champions and their respective coordinators.
(5) Champions will periodically (depending on election schedule) circulate reminders and scripts for patient conversation starters and additional FAQs – authored by steering committee.
(6) Using the Vot-ER site impact dashboard – team leaders will periodically post the total number of voter registration processes and absentee ballot requested initiated through our Vot-ER badge.

MEASURES: (1) Number of champions; (2) Number of participants x role (UME, GME from Vot-er.org; (3) ACGME survey item results on "taught about health care disparities" will be examined longitudinally to monitor change; (4) Brief retrospective pre-post survey of our Vot-ER advocates (eg, those who volunteered) re: their experiences and perceptions specific to the role of physicians in addressing this moral and social determinant of health (M&SDH).

A. Vot-ER
    a. Steering Committee met and detailed plans
    b. Contacted Vot-ER and "free badges" may be challenge (limit)
    c. Pending:
        i. Seeking Champions with info at upcoming events (eg, GMEC, UMEC, Shared Noon Conference, TRIUMPH)
        ii. Seeking to schedule orientation within each programs groups as champions identified (or as way to get a champion)

2. Challenges faced to date
    A. Vot-ER

a. Tracking: who interested, scheduling orientations, etc. – across continuum.
b. Trying to get each location to understand approval and support from Leadership. i.e. we had approval and moved forward in some spots while other locations kept questioning if they had permission to use tools. Created fits and lost momentum.
c. Limit on "free" badges, lanyards, etc.… from Vot-ER

3. Specific questions for the cohort colleagues: In what areas is guidance needed?
   - Data – what would convince you project was of success!

4. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc.)
   - Use the Vot-ER website to track your results

AIAMC NATIONAL INITIATIVE IX MEETING ONE

Institution Name: Monmouth Medical Center

Presenter Name: Deonna Williams-Square (who will be presenting for your team?)

Project: Life Saving Education

1. Summary of your project including aims and intended measurements
   Our aim is to enhance education and awareness regarding bystander CPR, with a specific focus on Hands-only CPR. This initiative is motivated by research indicating that communities with lower socioeconomic status are less likely to receive bystander CPR compared to those in more affluent areas.

   Currently, we are assembling a team of residents and nurses who will venture into our community to demonstrate Hands-only CPR, collect bystander pledges for assistance, and educate the community about differentiating between a heart attack and cardiac arrest, as well as the crucial role bystanders can play. We intend to measure morality rates within the area due to cardiac arrest along with measuring how many pledges and or number of people we can reach within the community to educate.

2. Progress to date on project
   We completed our goal for September which was to engage with residents, and other departments on the topic at hand. Our current goal for October is to recruit residents for this initiative, each team member was tasked with recruiting a resident, or recommending a resident for the team lead to reach out to.

3. Challenges faced to date
   Our current challenges include residency recruitment, and the expenses associated with the project.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?
   Motivating residents to get involved is where guidance is needed the most, along with C-suite buy-in.

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)
   A lot of our resources come from scholarly articles, mostly the American Heart Associations and Journals.

Institution Name: Ascension Providence Rochester Hospital/WSUSOM Office of Graduate Medical Education, Detroit, MI

Presenter Name: Heidi Kenaga

Project: Development of a Community Service Curriculum in a Family Medicine Residency Program, Ascension Providence Rochester Hospital

1. *Summary of your project including aims and intended measurements*

As a participant in the AIAMC's National Initiative IX on *The Social and Moral Determinants of Health*, the WSUSOM Office of Graduate Medical Education and our primary clinical partner, Ascension Providence Rochester Hospital (APRH), located in Rochester, Michigan, are taking the first steps toward the formal implementation and assessment of a community service curriculum as a standard part of residency training in our Family Medicine (FM) program.

APRH/GME is committed to a residency education that includes an understanding of and knowledge about local social and moral determinants of health and providing equitable patient care. For NI IX, we elected to center our activities around the provision of healthcare as a human right to the homeless and underserved. APRH will provide resident physicians in FM with an opportunity to reflect upon the impacts of their work providing medical services that reduce inequity among urban, uninsured, and other marginalized populations, and GME will carry out evaluation and assessment of their engagement with and responses to these experiences.

The FM community service curriculum includes the following sites: the Wayne State University School of Medicine (WSUSOM) Student-Run Free Clinic; Street Medicine Detroit (SMD); urban locations in downtown Detroit frequented by homeless populations; in Rochester, Michigan, Neighborhood House (women/children's community center); and the Older Persons' Community Senior Center, Samaritas Affordable Senior Living.

Our methodology for NI IX engages the contemporary practice of *narrative medicine*, by which healthcare providers use journals and diaries to record observations and thoughts after clinical encounters, drawing upon storytelling modes. Narrative medicine helps healthcare providers foster empathy, experience cultural humility, and unpack unexamined biases. Reflective writing in particular can provide residents with a "safe space" for ameliorating the stresses of training and thus help them

find renewed meaning in work, which may stem from feeling disconnected to their neighbors and communities. GME may also use interview and possibly focus group data to elicit responses from resident participants in specific areas. In addition, across 2023-24 FM will host a series of forums for residents to talk about various challenges in their career in a safe and nonjudgmental space. Modeled after Balint group methods, FM Program Director Eleanor King has coined the acronym RESPITE (Residents Expressing the Stresses of their Profession in a Therapeutic Environment) to describe the format and function and of these sessions.

2. *Progress to date on project*

In early September, we secured institutional IRB approval (exempt) for the development and assessment of the Family Medicine community service curriculum. GME/APRH also submitted poster proposals for the 2024 AIAMC Annual Meeting and the 2024 ACGME Annual Educational Conference on outcomes for FM's 2022-23 RESPITE sessions, for which data from questionnaires as well as written prompts were used. Whereas last year's RESPITE groups addressed topics such as racism/sexism/abuse directed toward physicians or bias toward FM as a specialty, for 2023-24 FM will gear the sessions towards narrative medicine, with pre/post surveys and written prompts. FM Program residents are a central part of NI IX activities, including conducting literature reviews on narrative medicine and researching prompts to be used in the RESPITE sessions. On Oct. 3, FM held an introduction to narrative medicine session during which residents and faculty brainstormed various possible approaches to narrative medicine in order to plan the upcoming RESPITE sessions. In addition, Dr. King (a graduate of WSUSOM and active in alumni activities) and FM faculty have established a narrative medicine interest group at the undergraduate level, so going forward we foresee collaborations between our institution's medical school and APRH/GME NI IX activities.

3. *Challenges faced to date*

One key challenge may be steady and sufficient engagement of residents in reflection activities, given that their primary commitment is to clinical care, ongoing study/didactics, preparation for exams, involvement in hospital Quality Improvement projects, and the like. However, the Program Director has shown much leadership in this initiative, and there is an ongoing tradition of community service

opportunities, commitment by faculty preceptors, and firm support from the APRH Chief Medical Officer Sheryl Wissman, a member of the NI IX project team.

4. *Specific questions for the cohort colleagues: In what areas is guidance needed?*

APRH/GME would like to frame NI IX as a pilot for how to develop a community service curriculum, for adoption by other primary care residencies at APRH (e.g., Internal Medicine), but also potentially by our surgical specialties that may not have an established tradition of community outreach and service provision (Anesthesiology, Dermatology, Otolaryngology, Urology). Research in medical education on the adoption of narrative medicine in surgical programs is scant, so guidance would be helpful.

5. *Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)*

Zaharias G. "What is narrative-based medicine? Narrative-based medicine 1," "Narrative-based medicine and the general practice consultation: Narrative-based medicine 2," "Learning narrative-based medicine skills: Narrative-based medicine 3," *Can Fam Physician*, Mar-May 2018

Bradley J et al., "Healing Through History: A qualitative evaluation of a social medicine consultation curriculum for internal medicine residents," *BMC Med Educ*, Feb 2021

Website at Columbia University on their Narrative Medicine program

AIAMC NATIONAL INITIATIVE IX MEETING ONE

Institution Name Cedars-Sinai Medical Center

Project C.O.R.E. Expansion Project

Presenter: *Nishita*

1. Summary of your project including aims and intended measurements.

Our educational initiative, known as C.O.R.E., aims to empower residents through knowledge and community engagement. Aligned with our institutional mission, C.O.R.E. was developed specifically for the Internal Medicine Residency Training Program. Its objectives include: 1) fostering understanding of socioeconomic barriers, 2) actively participating in community-based programs to tackle health disparities, and 3) promoting advocacy in healthcare. To curate our content, we collaborate with experts who provide direct care to marginalized individuals in our community. Additionally, we engage with community members by volunteering and participating in community engagement events. Residents actively participate in skills training sessions that aim to reduce barriers to care, such as Nexplanon certification and opiate use disorder management, among others.

Currently, the program is exclusively available to internal medicine residents. However, over the next eighteen months, we plan to expand its reach to include trainees across GME. Each month, we will create learning opportunities and organize community engagement events on various topics, including criminal justice reform, climate change, advocacy, mental health, homelessness, and more. These opportunities may take the form of workshops, lectures/panels, volunteering events, and site visits. By doing so, we aim to provide trainees with a unique chance to interact with our community and make a positive impact on the complex barriers that hinder good health and wellbeing.

To gauge the effectiveness of our program, we will conduct assessments of knowledge, skills, and attitudes before and after addressing each topic. This ongoing review of our curriculum will help shape future topics and address any gaps in learning.

2. Progress to date on project

Timeline:

September 2023: C.O.R.E. Leadership Steering Committee selected based on application process.

October 2023: Monthly Topics selected based on resident survey, previously covered topics, and community health partnerships.

October 11, 2023: C.O.R.E. Information Session at GME Committee Meeting

October 13, 2023: AIAMC NI IX Meeting One

December 2023: C.O.R.E. Launch Event/Orientation + Mentor Assignment for longitudinal component. Applications open for Cedars-Sinai GME trainees. Selection process complete. Aim for 30-40 trainees.

January – May 2024: C.O.R.E. Monthly Topics

June 2024: C.O.R.E. Graduation Event and Advocacy Month

3. Challenges faced to date.

Some challenges that we have recently faced during the initial project launch:

- Developing the project timeline – especially since we would like to break it into two phases.
- Organizing meetings to include all/most members of the team.
- Time constraints for members of the team in the setting of heavy clinical duties.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

- We are hoping for better guidance on measurables outside of pre/post assessments for the various monthly topics as outlined above.
- Are there better ways to structure each monthly topic?
- Are there speakers that would be interested in speaking on the topics above?

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc.)

- MedEd Portal.
- Colleagues in various fields, especially those in leadership position or with background on the institution.
- Our institution's community benefits program.

AIAMC NATIONAL INITIATIVE IX MEETING ONE

Institution Name: Hackensack- Ocean University Medical Center

Project: Addressing the social and moral determinants of health

Presenter: Saba

1. Summary of your project including aims and intended measurements

1) Education/Awareness: Social determinants of health grand rounds
2) Clinical:

   Creating a list of 4 questions to add for the patient interview regarding social determinants of health (Sdoh screening)

   Teach students/trainees to consider the impact of psychosocial variables on pharmacologic treatment outcomes.

3) Training: Human dimension program via HMSOM
4) Windshield tours/Community Mapping
5) Engaging network community outreach committee/Strengthen community partnerships
6) Social Justice Curriculum

2. Progress to date on project

Updates given at Medical Executive Committee, Graduate Medical Education Committee

Working on creating a list of questions that would be the most helpful in assessing social determinant of health and need

Working on creating a lecture with list of resources available

Human dimension is about community service (Residents have completed the 1st lecture in introduction to the Human Dimension, Family Medicine Residents have completed a dashboard tour of their community and presented findings during residency didactics)

FM Program

3. Challenges faced to date

Competing Demands for Time/Participation
Engagement in Educational Events by faculty/attendings/administration
Educational sessions for the staff
Expanding the education to other hospital departments

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

Using metrics to ascertain growth /learning

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

Population health curriculum

https://www.graham-center.org/maps-data-tools/pop-health-curriculum.html

NAMI

https://www.nami.org/Blogs/NAMI-Blog/August-2020/Ways-We-Can-Address-the-Social-Determinants-of-Mental-Health

Cohort Three
Project Summaries

Teams: Ochsner, Aurora Health Care (FM), Auora Health Care (IM), Ohio Health, UnityPoint Des Moines (LWBS), UnityPoint Des Moines (Healthcare Violence)

AIAMC NATIONAL INITIATIVE IX MEETING ONE

Institution Name: Ochsner Health

Project: Creating an E-Social Work Consult Service for Resident Training Clinics to Improve Social Determinants of Health for patients within the Gulf South

Presenter: Rajiv or Ellen

1. Summary of your project including aims and intended measurements

AIM: Piloting an E-Consult for Social Work (SW) services for IM Ochsner Health residents. This will provide them access to a SW in real-time while in ambulatory clinic visits to improve and manage patients' SDOH. Program Volume and Extent of Use will be tracked through referrals logged on Epic EHR, while service effectiveness will be tracked via Redcap feedback from all three parties involved: residents, social workers, and patients. Content and utilization of all recommendations will be monitored via EPIC.

2. Progress to date on project

Medical Student leaders will be involved with the early groundwork and coordination. They are the point persons for coordination of the project amongst teams and are established as Point of Contacts with intended participation in the first meeting in Chicago October 13th, 2023.

SW who is helping with the responses to the E-consults is involved in spear-heading the pilot. This SW is collaborates with Manager of Social Services at OH. We are meeting weekly following our clinical IDT meetings.

3. Challenges faced to date

Finding the time to block from many clinical duties for all involved. Finding engaged team to see the project through completion. We are addressing this challenge by engaging medical student leaders to work with the coordination.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

1) Should there be a set list of questions for residents to consider at the start of the visit when seeing patients to figure out when to initiate E-consult? If so, what questions would work best?
2) What ways would best work to stratify consultations made with the E-consult? What would classify as successes in each group?

3) What measures must be taken to track utilization and count it as effective for the patient? How long should post-consult monitoring of the patient's case be done to deem it as effective?
4) How should this be utilized in conjunction with other health care systems and their involvement with patients in our care? Would patients involved in multiple systems be excluded from the pilot program?
5) What situations will involve the E-consult being "upgraded" to a full consultation with Social work?

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc:

R1: https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/Standards-for-Technology-in-Social-Work-Practice#section2 --> This is from the National Association of Social Workers

R2: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5135524/--> Taking action on the social determinants of health in clinical practice: a framework for health professionals

R3: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4985884/ --> Social Workers as Behavioral Health Consultants in the Primary Care Clinic (specifically realtime consults w/ behavioral health focus)

R4: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4561452/ --> Electronic consultations (e-consults) to improve access to specialty care: A systematic review and narrative synthesis (Explanation of E-consult services with examples outlining feedback from PCP, patient, and consulted service. Also showed workflows used with the VA, Mayo Clinic, and SFGH, San Francisco's large safety net hospital, to showcase possible variations in workflow)

Institution Name Aurora Health Care

Project Patients who Leave Against Medical Advice (AMA)

Presenter: Morgan

1. Summary of your project including aims and intended measurements

TITLE: "POP-SPOTTING" POPULATION HEALTH HOT SPOTTING – FAMILY MEDICINE

AIM: To utilize population health data from our clinic to identify optimal patients for our existing FPC Pop-Spotting Program and adopt/adapt Pop-Spotting to our second residency clinic with metrics to demonstrate value to patients and system.

INTERVENTION: THIS PROJECT WILL INVOLVE MULTIPLE STEPS INCLUDING:

(1) Identification of 1-2 SDH screening items to implement within our Milwaukee (MKE) south clinic (eg, safe housing, food insecurity, transportation)
(2) Use the SDH screening item(s) along with other EHR metrics to develop a way to identify the best patients for Pop-Spotting (eg, who would yield best ROI)
(3) Adapt the current hot-spotting implementation as needed and implement with the Pop-spotted patients.
(4) Monitor results and revise as needed.
(5) Work with MKE North clinic to adopt/adapt the model and repeat the process.

MEASURES: We will continue to utilize prior hot-spotting measures to measure ROI including patient satisfaction, ED visits, hospitalization, and clinician reactions (eg, job satisfactions, whole patient care, learning). We will explore ability to use pharmacy costs as a new measure.

2. Progress to date on project

3. Challenges faced to date

4. Specific questions for the cohort colleagues: In what areas is guidance needed?
   - Data – what would convince you project was of success!

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc.)

Institution Name Aurora Health Care

Projects Internal Medicine

Presenter: Sean

1. Summary of your project including aims and intended measurements

TITLE: "POP-SPOTTING" POPULATION HEALTH HOT SPOTTING – FAMILY MEDICINE

AIM: To utilize population health data from our clinic to identify optimal patients for our existing FPC Pop-Spotting Program and adopt/adapt Pop-Spotting to our second residency clinic with metrics to demonstrate value to patients and system.

INTERVENTION: THIS PROJECT WILL INVOLVE MULTIPLE STEPS INCLUDING:

(1) Identification of 1-2 SDH screening items to implement within our Milwaukee (MKE) south clinic (eg, safe housing, food insecurity, transportation)
(2) Use the SDH screening item(s) along with other EHR metrics to develop a way to identify the best patients for Pop-Spotting (eg, who would yield best ROI)
(3) Adapt the current hot-spotting implementation as needed and implement with the Pop-spotted patients.
(4) Monitor results and revise as needed.
(5) Work with MKE North clinic to adopt/adapt the model and repeat the process.

MEASURES: We will continue to utilize prior hot-spotting measures to measure ROI including patient satisfaction, ED visits, hospitalization, and clinician reactions (eg, job satisfactions, whole patient care, learning). We will explore ability to use pharmacy costs as a new measure.

2. Progress to date on project
3. Challenges faced to date

4. Specific questions for the cohort colleagues: In what areas is guidance needed?
   - Data – what would convince you project was of success!

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc.)

Institution Name: OhioHealth Doctors Hospital

Project: ACE: Advancing HealthCare Equity: Creating Medical Neighborhoods Among Vulnerable Populations

Presenter:

1. Summary of your project including aims and intended measurements
   Our project is titled **ACE**: "Advancing HealthCare Equity: creating a medical neighborhood for vulnerable populations." We intend to lateralize the work of our current Transition of Care Clinic (TCC) as a "phase zero" leading up to the launch of our population health clinic in July 2024. TCC serves the same community that we hope to engage in our future population health clinic: high ER utilizers, complex patients with multiple medical co-morbidities, and a community with a plethora of SDOH that create barriers to accessing care. We believe that healthcare is an unequivocal universal human right, and as such, we aim to increase healthcare access to our community by providing primary healthcare access while addressing upstream social determinants of health drivers. The Transition of Care clinic connects ER and hospitalized patients without an assigned PCP for close follow-up and screening of their social determinants. By understanding who this population is and how they are affected by social determinants, we hope reduce ER utilization for low acuity patients by 5% in month 6 of opening our population health clinic.

2. Progress to date on project
   We have begun examining our standard work around screening for SDOH at TCC, including engagement with case management system leaders, data analysis of baseline screening, discussion of barriers to screening, and improving the implementation process. We have begun to engage our C-suite early in this work and already pitched how our project. We have begun to build a strong multidisciplinary team with partnerships with care management, community leaders, informatics, and resident and medical student representation. We have identified the core members for our cohort group.

3. Challenges faced to date
   We have learned recently that our TCC clinic will physically remain in its present location, rather than being merged with our population health clinic. There were already concerns with accessibility and expansion of TCC, and this does raise questions around how we can still lateralize TCC work for our population health. Additionally, SDOH screening within CareConnect has poor visibility, poor provider awareness for screening, inequitable access to non-English speaking patients, and no formal standard of work for implementation. We also have identified concerns with the reliability and accessibility of our reporting tools, mining ER data, and clearly defining PCP attribution.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?
   -Overcoming barriers to data mine in the absence of a dedicated clinical informaticist
   -How to leverage track meaningful interventions beyond “screen and refer”

5. Are there any helpful resources that you’ve found and can share with the group? (online resources, websites, journals, curriculum designs, etc)
   We have leveraged our local and state health department’s work to engage system leadership. OhioHealth also happened to consult with Vizient a few years ago which provided vulnerability metrics that we were able to utilize for this work. We have taken every opportunity to do on-site visits with our sister hospital and engage with other like-minded leaders in the system. We have also found the work from the IHI to be helpful. And finally, our medical students are also doing important work in their literature reviews.

Institution Name: UnityPoint Health

Presenter Name: CHANTEAU AYERS

Project: Impact of additional Emergency Department triage nurse staffing on patient care and left without being seen (LWBS) status

1. Summary of your project including aims and intended measurements

   The purpose of this study is to examine the impact of additional triage nurse staffing in the Emergency Department (ED), relative to waiting room volume and patient arrivals, and its association with improved triage order set utilization, lower rates of patients leaving without being seen (LWBS), and higher rates of patient treatment initiation.

   This will be an observational study of a recent ED staffing change and involve the review of electronic medical records (EMR) of patients who presented to a UnityPoint Health – Des Moines ED. Specifically, Emergency Medicine was approved to hire a 2.8 FTE of additional triage nurse staffing, equal to 16 hours per day. This change went into effect on August 1, 2023 and occurred specifically at Iowa Methodist Medical Center. Data will be reviewed for the period of August 1, 2022 through December 31, 2024. Relevant variables will be collected and contrasted based on LWBS status and ED/hospital volume numbers for our three Eds in the greater metro-area.

   Characteristics of the index ED visit will be recorded. This includes factors such as the patient's available characteristics (e.g., age, sex, insurance status, listed primary physician), presenting chief complaint, acuity, vital signs and when collected, public health screening question responses, ED triage nurse (e.g., suicide screen, fall risk screen, infectious exposure concern, pain score), date/time, ED wait time, and time when roomed. Data from Iowa Lutheran and Methodist West, where no additional staffing change has occurred, will serve as comparator data. Data on the ED circumstances will also be recorded (i.e., number of ED arrivals, number of patients in waiting room, beds occupied and bed capacity for routine and surge beds, overcrowding score, number of COVID-19 inpatients, daily census, and number of inpatient bed holds – all time stamped).

   Additional variables will include:
   - ED patient arrivals (measured as patients per hour in discrete hour intervals)
   - ED Waiting room volume (measured as average census in discrete hour intervals)
   - Nurse triage hours and name of nurse
   - Any use of a float nurse and name of nurse
   - Triage orders placed by nurse with time stamp
   - Vital Sign frequency of rechecks (should be ~ every 2 hours)

- Arrival-to-room assigned or arrival-to-provider assigned (as surrogate for patient recognized as needing care earlier due to closer monitoring)
- Available nurse triage staffing data (name of nurse(s) and time/date

2. Progress to date on project
   Our team has met to identify our focus, objecticves and interventinos. We are still finalizing our team roster. We have reached out to the data analyst to obtain a contact for the project. We have submitted our IRB application.

3. Challenges faced to date
   Access to data and identifying data sources. There have been several critical departures in the data analytics team as well. So, we need to identify a person to work with on project.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?
   None.

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)
   No.

Institution Name: UnityPoint Health – Des Moines

Project: Healthcare Violence

1. Summary of your project including aims and intended measurements

   Our proposed project plans to evaluate the amount of healthcare violence at our local affiliate hospitals (i.e., Blank [free standing children's hospital,] Iowa Methodist [level I Trauma Center], Iowa Lutheran [level IV trauma center/community-hospital], and Methodist West [level IV trauma center/community hospital]). We also plan to review our available data sources related to healthcare violence and assess their quality/completeness, as well as create an inventory of existing initiatives occurring at the facilities that address healthcare violence. Lastly, we plan to report this information back to the institution and work to explore/develop possible data-lead interventions.

2. Progress to date on project

   We have worked on establishing our project team and taking inventory/reviewing existing data sources.

3. Challenges faced to date

   Theorizing how to quantify the magnitude and causes of the problem.

   Specific questions for the cohort colleagues: In what areas is guidance needed?

   We plan to initially attempt to define what is and can be known about the problem and then carve out some possible manageable tasks, given this is a very large and complex issue. Any thoughts and feedback on how to proceed would be appreciated.

4. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc.)

   Nothing as of yet, beyond reviewed data on the severity and magnitude of the problem across our national healthcare systems.

Cohort Four Project Summaries

Teams: Guthrie Robert Packer (Youth Health), Guthrie Robert Packer (SDOH Inpatient), Guthrie Robert Packer (SDOH Outpatient), St. Lukes University Network (ACE QI Study), St. Luke's University Network (ED Patients), St. Luke's University Network (Psych Care), Virginia Mason

Institution Name: Guthrie Robert Packer Hospital & Geisinger Commonwealth School of Medicine

Project: Engaging local youth in healthy lifestyle practices

Presenter: Victor

1. Summary of your project including aims and intended measurements

Aim – Create a Girls on the Run chapter in Sayre PA to engage girls aged 8-16 in physical activity and didactics

Measurements – pre- and post-engagement surveys of participants

2. Progress to date on project
   Liaison with 2 key stakeholders in the Guthrie Weight Loss center
   Liaison with 2 key stakeholders in the Guthrie Strategic Planning and Marketing team
   Discussion with 2 Guthrie administrative fellows
   Initial discussion with Guthrie legal
   Initial discussion with GOTR staff
   Initial submission to IRB
   Identification of potential sponsor(s)
   Pending support: athletic trainer/director of the host internal medicine practice

3. Challenges faced to date:
   Securing funding for participant sponsorship desired to mitigate income-based disparities
   Non-foreknowledge of aligned but new program, Guthrie Engage
   Absence of a Girls on the Run chapter in a 100-mile radius from desired site
   Lack of a dedicated Office of Community Engagement at Guthrie
   Need to engage local high school for facility
   Time – delay of planned program inception to incorporate stakeholder input
   Pending – inclusion of resident(s)

4. Specific questions for the cohort colleagues: In what areas is guidance needed?
   Any thoughts about how best to engage schoolchildren in a weekly evening (given the schedules of medical students and residents) activity, vs right after-school?

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)
   ?

4. Specific questions for the cohort colleagues: In what areas is guidance needed?
   Any thoughts about how best to engage schoolchildren in a weekly evening (given the schedules of medical students and residents) activity, vs right after-school?

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)
   ?

Institution Name: Guthrie/Robert Packer Hospital

Project: From Screen to Reality - Translating the In-Patient Gathered Social Determinants of Health Information to the Post-Discharge Care of Our Patients

Presenter: Shraddha

1. Summary of your project including aims and intended measurements

AIM:

To evaluate the impact of social determinants of health on the health outcome, recurrent hospitalization and frequent Emergency visits as these factors shape the conditions of daily life and in turn the health conditions

To determine the effects of intervention, policies and systems or agendas by providing higher quality, well collaborative and more effective services incorporating and addressing these factors

To provide a comprehensive biopsychosocial model of care to the patients admitted to a rural hospital with a variety of restraints and issues

MEASUREMENTS:

After the initial screening, a social services consult will be placed to help and provide the essential services to the patients who screen positive in the respective determinant of health. The team will work with them in meeting the psychological needs and addressing the social issues

A post-intervention survey comprising of patient satisfaction will be performed, which will be the primary outcome

Hospital visits and Readmissions will be considered as well, which will be secondary outcomes

2. Progress to date on project

   a. IRB paperwork, filed and approval received
   b. Obtained pre-intervention data
   c. Resident Education: formal presentation will be done, those rotating in SBP has been provided with education
   d. Data collection and tabulation- in-process

3. Challenges faced to date

    a. In-patient admission comprises more of older population and need help in filling the Questionnaire
    b. Delirium, Encephalopathy and Devices (such as CPAP/ BiPaP) used impair the timely filling of forms
    c. Many patients experience tiredness from the disease process itself and denies filling an extra form
    d. Too much hospital staff visiting patients and refusing to see any more un-familiar faces
    e. Early discharge of the patient before the social services could work with them or establish the course for addressing the needs

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

    a. Post intervention survey questions detail- patient satisfaction survey vs including psychology team in dealing with psychological factors impacting health
    b. How social services is providing the help needed
    c. How to work on sustainability of the project over the years
    d. Incorporating a national/global built in screening tool in the EPIC
    e. Views on devising a yes/no questionnaire vs multiple choices to choose from
    f. Views on expansion and study beyond medicine specialties
    g. Views on Nurses vs Physicians vs non-medical staff implementation of questionnaire
    h. Implementing the online patient portal for getting the post-discharge satisfaction survey vs including it as a part of TCM visit

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

    https://health.gov/healthypeople/priority-areas/social-determinants-health

    https://www.aafp.org/pubs/fpm/issues/2018/0500/p7.html#screening-tools

    Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations (chcs.org)

Institution Name Guthrie Robert Packer Hospital

Project Streamlining SDOH screening and improving follow up and outcomes in the Internal Medicine Clinic

Presenter: Shraddha

1. Summary of your project including aims and intended measurements

Aims:

- The goal of this project is to increase the SDOH screen-positive by 5% from baseline in August 2023
- To improve structured referrals to care coordinator by 5% from baseline in August 2023
- Track the number of referred patients who are plugged into Unite US.
- Identify the Percentage of patients who had resources provided by Unite US.

2. Progress to date on project:

- Created an EPIC slicer dicer tool to obtain real time report on screened and unscreened outpatients and shared the tool with all the residents working on the project for quick access
- Encouraged RNs to continue screening for SDOH during every visit, discussed during daily morning huddles
- Encouraged residents to place referrals to care coordinator for screened positive patients
- Obtained data on screened positive patients and referrals made to care coordinator

3. Challenges faced to date

- Some patient related barriers like fear of judgement might increase false negative screening rates
- Time constraints especially when patient have a different primary reason for visit, leading to quicker screening and possibly missing the true positives
- Patient's not picking up calls when care coordinator or Unite US tries to reach out to them leading to lack of opportunity to provide resources

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

- What challenges are other organizations doing the SDOH facing? Are they facing similar challenges?
- How are other organizations providing resources to people who screen positive for SDOH?

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

- *Lavizzo-Mourey RJ, Besser RE, Williams DR. Understanding and Mitigating Health Inequities - Past, Current, and Future Directions. N Engl J Med. 2021 May 6;384(18):1681-1684. doi: 10.1056/NEJMp2008628. Epub 2021 May 1. PMID: 33951376.*
- *Berwick DM. The Moral Determinants of Health. JAMA. 2020 Jul 21;324(3):225-226. doi: 10.1001/jama.2020.11129. PMID: 32530455.*

Institution Name: St Luke's University Health Network
Project: ACE study and chronic disease
Presenter: Christine

1. Summary of your project including aims and intended measurements

The objective of the project is to discover the association between ACE and chronic disease and to see if our psychotherapy intervention (mindfulness) modified the severity of chronic disease. We will measure the success of intervention by looking at markers of chronic disease.

2. Progress to date on project

We are still actively recruiting and enrolling participants and still developing our mindfulness-based intervention.

3. Challenges faced to date.

Meeting recruitment goals and continuing to encourage providers to educate appropriate patients on the study.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

We are looking to get more consistent recruitment and enrollment in our outpatient setting and discuss other novel ways for physician enrollment opportunities.

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

We are fortunate enough to have our own mindfulness expert at our institution who will help with developing the intervention.

Institution Name: *St. Luke's University Health Network Anderson Campus*

Project: *Increasing a Social Determinants Screening and Referral Infrastructure During Routine ED Visits and FM Outpatient Visits*

Presenter: *Mini*

1. Summary of your project including aims and intended measurements.

According to the CDC, SDOH is one of three priority areas for Healthy People 2030, along with health equity and health literacy. SDOH has been shown to have a greater influence on health than either genetic factors or access to healthcare services.

Across the nation, emergency departments see a disproportionate share of low-income and uninsured patients. Approximately, up to 25% of patients visiting emergency departments view them as their usual source of care because of convenience and because of referrals from and barriers to primary care.

We intend to develop a process for screening and identifying social needs among emergency department patients, for facilitating access to community-based resources offered through our network and the community in the Lehigh Valley area. The project was initiated at ED but we have tried to add two of our FM offices to increase the screening so that many of our patients can utilize the programs for better health.

Study Aim:

- To improve the current SDOH screening and implement an upgraded process for systematically identifying the social needs of patients visiting the Anderson Campus ER and possibly Easton Outpatient FM Clinic during routine health service.

- To increase the screening on social determinants of health and the outpatient referral process in the Anderson ER and Easton FM Outpatient Clinic.

- To assist patients with access to community-based support services throughout the network by offering guidance to online resources or to be reached by care management.

Intended Data Collection

- ✓ Age, Gender, Ethnicity
- ✓ Number of patients filling the SDOH survey
- ✓ Number of patients visiting FindHelp link
- ✓ Number of readmissions of patients with SDOH-positive screen

2. Progress to date on project

- A brief survey (3-4 questions) has been built in different languages with questions and topics that most affect our population of patients at the Anderson ER and the Easton outpatient clinics. The questions are in the **form of (YES/NO)** answers, **regarding housing, transportation, food, and financial difficulties**.

- A REDCap URL link/QR Code is being provided via phone text, in-house IPAD, email, or QR code to patients during their visit at check-in, triage, or before discharge by the nurses/care managers/resident or attending staff. Paper surveys is also be used to collect data. Patients who answer positively are guided to an online link to our network's resources "FindHelp, community star".

- A different process improvement has been charted out at each site, namely ED Anderson, FM
- The provider is putting an order for the care management team for a positive screen. Patients who opt to be contacted for help will be approached by our community outreach and care management.

- Data is being collected using RedCap

3. Challenges faced to date.

ED DEPARTMENT

- The logistics of data acquisition. Ideally, the surveys would be given to every patient who visits the ED, however, there are several barriers to this:
    - Nursing already has an extensive triage process to complete at the beginning of the patient visit. We have considered adding the survey to the triage process but have not due to concern that it would be **burdensome to our nursing staff** who already have a great deal on their plate.
    - Increased **administrative focus on door-to-disposition time in ED patients**. Any process of distributing the surveys/or obtaining data cannot elongate the length of stay.
- We **are currently relying on residents** to distribute the surveys to their patients, resulting in the survey being accessed by only a small subset of our patients. Motivating the ED residents who are not directly involved in the project to distribute our survey to their patients as it may still be difficult for some to incorporate this task into their workflow.
- Acquisition of data relies on a **patient's ability to use their phone to access** the survey through a QR code or link. Our elderly and technologically illiterate patients may have difficulty accessing the survey per the existing format.

- After using the QR code paper, there was an increased number of patients using the "Findhelp" website but fewer patients filling out the survey.
- Administrative buy-in. In the future, would like to **consider placing a sign with the QR code for FindHelp in prominent locations in the ED (waiting room, restrooms, etc.).** To get approval to

do this our data will need to demonstrate tangible benefit to our patients from the screening/referral process.

FM OUTPATIENT OFFICE

- The biggest problem the outpatient offices are facing is largely with time constraints and the general busyness of the office space. It has been difficult to find a time when office staff can pause and the project can be discussed, so a lot of communication has taken place via email. As such, there has not been that coordinated push to start consistently distributing the QR codes. This problem is still a work in progress, and a different approach may need to be trialed.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

- We would be interested to hear how other EDs are implementing SDOH screening without affecting throughput times.
- Other options are being discussed like to make the survey/QR codes part of the discharge paperwork. Is there any team that has done this? If so, were they able to connect their patients to the required resources in a timely manner?

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

Engaging Emergency Nurses in Strategies to Address the Social Determinants of Health
Engaging Emergency Nurses in Strategies to Address the Social Determinants of Health - PubMed (nih.gov)

Institution Name: St. Luke's University Health Network

Project: Acceptance of psychiatric care in rural Eastern PA: challenges and barriers

Presenter: Beth

1. Summary of your project including aims and intended measurements

The primary goals of the project are to obtain data to evaluate current barriers to care with the goal of improving quality of delivery of psychiatric care in rural areas of Eastern PA, and to evaluate the results of the care improvement. These goals are divided into different aim statements, including evaluating stigma within the community, design psychoeducational programming based on the data to address stigma, and improve anonymity in accessing care.

Baseline data will be gathered via a survey that depicts stigma, cultural factors, and anonymity concerns. All patients visiting Emergency Departments and outpatient Family Medicine practices at the rural campuses of St. Luke's University Health Network (such as Miners, Carbon, and GSH campuses) will be provided with the inventory.

Once baseline data are collected, the team will create a psychoeducation program in collaboration with PA Department of Health and St. Luke's Community Health Department to eliminate misconception about mental health and psychiatric disorders, reduce self-stigma and public stigma, and associated fear and shame, and address cultural factors that prevent receiving psychiatric care, including increase in "psychological openness". The education will also address distrust in psychiatric services and large networks. The dissemination of the psychoeducational information will be in collaboration with local business, religious organizations, local police, community centers and self-support groups.

The results of the education will be measured by a number of follow-up visits, measurement-based clinical improvement scores and patients' satisfaction reports.

2. Progress to date on project

Current progress is limited, but includes beginning the survey creation as well as continued team meetings for planning and collaboration. Resident recruitment and involvement has begun, as well.

3. Challenges faced to date

Challenges so far have been getting the team together, as August and September were heavy travel months for many team members.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

What do you recommend to strengthen the project? What gaps do you see/challenges do you anticipate? How have you managed differing schedules and campus centers in planning?

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

A resource that could be helpful for other rural projects:

Rural Health Information Hub: https://www.ruralhealthinfo.org/

Institution Name: Virginia Mason Franciscan Health (VMFH)

Presenter Name: Kate Vogeli, MD _(who will be presenting for your team?)

Project: Reducing Hospital Admissions in Patients Screening Positive for Social Determinants of Health (SDOH)

1. Summary of your project including aims and intended measurements

One of VMFH's strategic priorities is to reduce readmissions, an area of needed improvement that has resources available to improve. Analysis of patients readmitted within 7-days found that SDOH were the drivers of most readmissions rather than gaps in clinical care. These include access to primary care, barriers in obtaining medications, lack of follow-up, and transportation problems. Leaders created a dashboard of SDOH and Readmissions but thus far minimal work has been done to create visibility and solutions. We plan to work together using Virginia Mason Production System tools to run a week-long Rapid Process Improvement Workshop (RPIW) in the spring to involve stakeholders and move forward.

The goal of the project is to reduce 7-day and 30-day readmissions for patients screening positive for SDOH. Metrics will likely include:

Readmission rate: Percentage of patients screening positive for SDOH readmitted at 7- and 30-days

Lead time: Time from admission to action taken addressing SDOH(s) impacting health.

Quality: Percentage of screenings that inaccurately identify social and moral determinants of health (goal 0%).

Visibility of SDOH to care team

2. Progress to date on project

The majority of the effort has been connecting with the people involved in this work which includes executive leadership, hospitalists, nurse managers, and administrators and establishing the "current state." We know that relationship building is essential for success and we need to understand the current process which includes identifying defects and lack of standard work.

3. Challenges faced to date

The main task has been coordinating with the many stakeholders involved in this process and setting up meetings is slow. We will also need considerable institutional support to make meaningful progress and in a time of budget constraints, that may be challenging. However, we selected this project specifically because it is a strategic goal of our institution that aligns with the goals of our project and we expect we can be impactful with time.

4. Specific questions for the cohort colleagues: In what areas is guidance needed?

Is anyone tackling a similar project? How are you screening for SDOH? We currently know that our screening is incomplete and at times inaccurate as it is supposed to be done on admission by very busy nurses and with patients who are ill and may not be able to participate in the screening process. Is there a better time to screen? Who does the screening? What are the outcomes of screening?

5. Are there any helpful resources that you've found and can share with the group? (online resources, websites, journals, curriculum designs, etc)

Virginia Mason has a long history with successful quality improvement utilizing the Virginia Mason Production System (VMPS) and we plan to use those tools. We are happy to share our prior experiences.

https://www.surveymonkey.com/r/NIIXMtg1

Please share your feedback

National Initiative