AIAMC NATIONAL INITIATIVE IX

Meeting Two Storyboard Presentations -Cohort Breakout Sessions

Cohort One (8 projects)
Facilitator: Deb Simpson, PhD
NAC Member: Cara Dewberry

1. AdventHealth Orlando
2. Ascension St. Vincent/Good Samaritan (Three Projects in this initiative)
3. Ascension St. Vincent/Good Samaritan
4. Ascension St. Vincent/Good Samaritan
5. Atrium Health
6. Aurora Health (Four projects in this initiative. One project in this group)
7. Baptist Health
8. Baystate Health

Expanding Access to Rehabilitation and Primary Care Services to Underinsured Patients

Luis Isea Mercado MD, Sara Sierra MD, Nancy Zerpa Lira MD, Christine Moghimi ScD MAS, Alexandra Lajeunesse LMHC
Roxanne Richards BTAS COTA/L, Isaiah Cochran MD, Charis Courtney MS3, Nicole Lerner MS3
Stephanie Arsenault MS3, Cassy Louis MS3, Sarah Bushrow MS3

Introduction: Background & Context

AdventHealth mission is to provide whole person care to all patients regardless of their background or socioeconomic situation. Our project seeks to establish a relationship between our main primary care clinic (CMC) and rehab clinic (Hope Clinic) for underinsured patients.

These 2 clinics had not been working together, despite being part of the same organization. We are looking to streamline a referral workflow connecting both clinics, allowing patients to access rehabilitation or primary care services as needed.

The provision of primary care alone does not guarantee a healthy community. Rehabilitation partners can further explore and at times resolve the SDOH that are a detriment to achieving a healthy lifestyle/practice.

Many patients who attend the Hope Clinic, come from external facilities and cannot identify a primary care physician. This impacts their health, preventative care, and prompt diagnosis/management of acute or chronic conditions, leading to poor outcomes and increased hospital utilization.

SDOH have a major impact on patient's health, well being and quality of life. They represent a major contributing factor to health disparities and inequities.

Aim/Purpose/Objectives

- Streamline a referral process for patients that could benefit from the Rehabilitation services that are provided at the Hope Clinic for underinsured patients
- Offer primary care access to underinsured patients that may visit the Hope Clinic, coming from an external facility
- Provide a validated SDOH screening survey to all patients at the Hope Clinic and CMC. Identify SDOH that may impact show rate, patient outcomes and hospital utilization. Provide resources addressing flagged SDOH to patients in need
- Provide an educational experience to residents and medical students. Attend workshops at the Hope clinic, led by PT/OT faculty. Interact with patients and learn more about PT/OT evaluation and management of qualifying diagnoses.

Project Alignment/Advance Organization Priorities

- AdventHealth has a strong commitment to provide quality care to patients regardless of their insurance status and has several departments that work on patient experience, patient access, and community health. AH focuses on providing whole person care to all patients. The combination of primary care and rehabilitation services is a representation of such integral approach to patient care. It is a major step in achieving increased community health.
- Our project will track how this approach to whole person care affects hospital utilization, readmissions, and patient outcomes. Improving these metrics is a major goal of the organization. We will report our progress to major stakeholders in leadership

Methods: Interventions

Patients with qualifying diagnoses (Musculoskeletal pain, stroke, gait instability) will be referred from the CMC to the Hope Clinic. A screening SDOH form will be provided to patients before leaving the visit and will be faxed along the referral. We are using the CMS Accountable health communities SDOH screening form

If needs are identified by the SDOH screening form, patients will be connected with community resources.

Vice versa, patients visiting the Hope clinic, who do not have a primary care provider, will be referred to the CMC. A similar SDOH screening form will be administered.

Most common diagnoses, show rate, and hospital utilization will be monitored for all patients.
Hospital admissions in the past 12 months will be assessed at baseline. Subsequent hospital visits over the next 12 months will be monitored monthly.

Rehabilitation education workshops and volunteering opportunities will be offered to IM residents and Medical Students.

Our project has the support of the Medical Group leadership and Research Department. An IRB QI exemption was granted.

Methods: Measures/Metrics

- Referrals sent from CMC to Hope clinic and vice versa
- Attendance rate to appointments
- Referral diagnoses
- Flagged SDOH. Identify potential correlation with SDOH, show rate and hospital admissions
- Admission / readmission rate to an AdventHealth facility at baseline and over the duration of the study.
- Number of residents / students that attend educational workshops at the Hope Clinic
- Number of residents/students that attend volunteering opportunities at the Hope clinic or CMC

Results: Preliminary

- Patient tracking formally started in December 2023
- 23 referrals have been sent over and tracked from CMC to the Hope Clinic.
- 4 patients have completed their initial evaluation and are engaged in therapy services.
- SDOH survey has been provided for most referrals. Community resources are being offered.
- No referrals to CMC have been sent yet.

Barriers – Strategies

Barriers

- The main barrier has been limited staffing at the Hope Clinic, which impacts patient scheduling and referral tracking. The office manager is responsible for performing all these activities on top of providing OT services to patients. We are lagging on analyzing referrals and contacting patients, especially Spanish speaking.
- Resident and student involvement has been limited.
- Lack of EMR access at the Hope Clinic

Strategies

We recently included a Clinical Research Coordinator in our team, who will support the Hope Clinic staff. She will visit the clinic in person twice a month to help with scheduling.
We have had multiple productive meetings with the Medical Group leadership. They are very supportive of the project. We are exploring the possibility of securing EPIC access to the Hope Clinic.

Discussion

We need to secure engaging support to the Hope Clinic staff. It is essential to be able to track referrals on a timely basis and schedule patients accordingly.

We are exploring the possibilities to create a shared online calendar so that our QI team can contact patients remotely and help with scheduling.

Any ideas on how to create such a shared calendar? Our organizations do not allow Gmail access and do not share Outlook access either.

How can we promote resident and student meaningful involvement?

Expanding Post-Discharge Clinic Referrals To Address Social And Moral Determinants of Health

J Doyle[1] • C Mackay[1] • S Subramanian[1] • L Valdiviez[1] • R Bachar[1] • J Micho[1] • S Gill[1] • R Ficalora[2] • A Singson[1,3]

1. Indiana University School of Medicine • 2. Ascension St. Vincent • 3. Good Samaritan Hospital

INDIANA UNIVERSITY
SCHOOL OF MEDICINE
SOUTHWEST INDIANA INTERNAL MEDICINE RESIDENCY

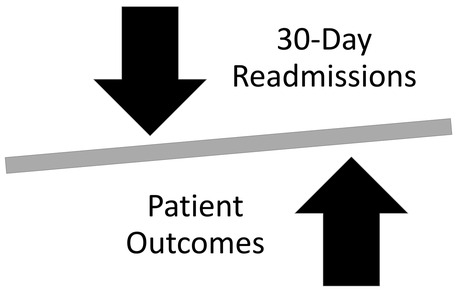
Ascension St. Vincent | Good Samaritan

AiAMC Alliance of Independent Academic Medical Centers

National Initiative

Introduction: Background & Context

- Literature emphasizes significance of post-discharge clinic (PDC) appointments



- Non-adherence of these appointments persists
- Social determinants of health (SDOH) are potential influencers on healthcare behavior
- Addressing SDOH is crucial to reduce disparities

Aim/Purpose/Objectives

- Identify the SDOH which affect PDC non-adherence the greatest within our community
- Utilize identified SDOH to develop a screening process key stakeholders can employ prior to discharge
- Future Goals:
  - Establish interventions to reduce the “no-show” rate

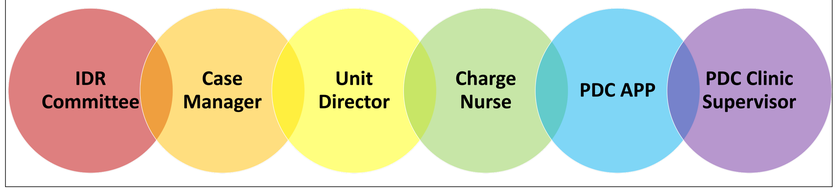
Project Alignment/Advance Organization Priorities

- Enhance overall quality of healthcare delivery within Ascension St. Vincent
  - Improving patient outcomes
  - Reducing 30-day readmissions
- Promote health equity within our community

NI IX Meeting #2: April 5-6, 2024
Tucson, Arizona

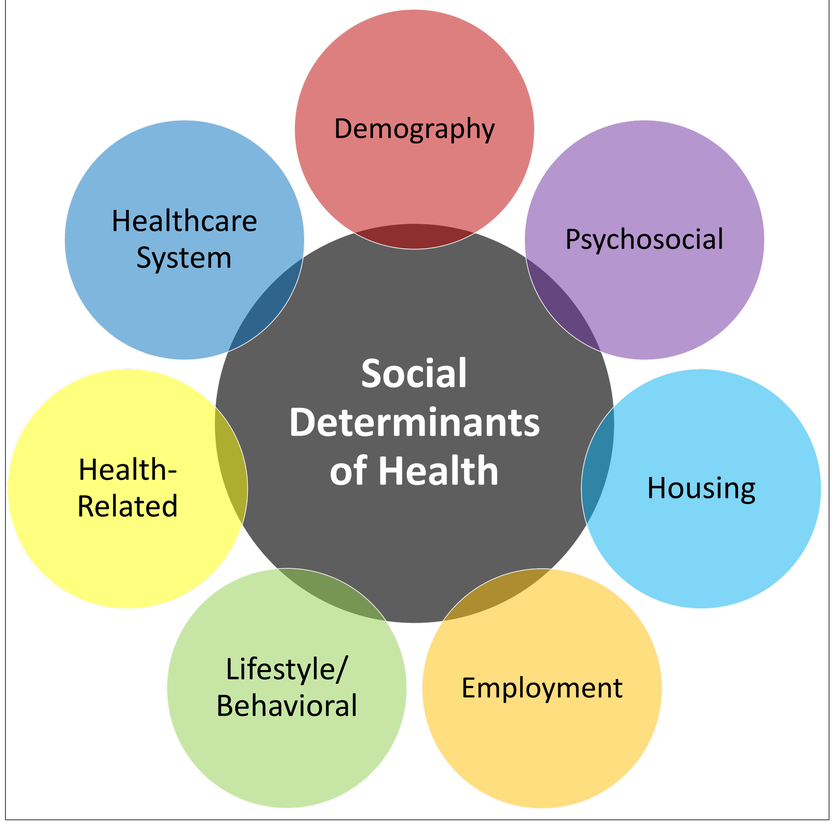
Methods: Interventions

- Mixed-methods: Quantitative & Qualitative
- Utilize existing referral data within REDCap
- Chart review for data collection
- IRB approval January 2024
- Meeting with inpatient care team stakeholders



Methods: Measures/Metrics

- Multivariate analysis with logistic regression

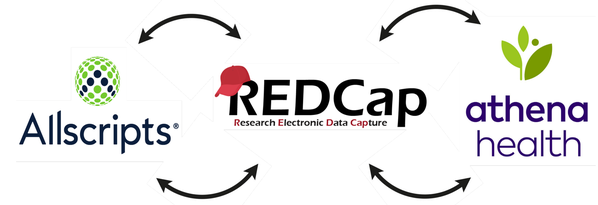


Results: Preliminary

- Chart review underway

Barriers – Strategies

- Chart review between separate EMRs
- Time-consuming data entry



- Implementing policies & procedures involving inpatient care team to screen & intervene prior to discharge

Discussion

- Critical next steps:
  - Complete chart review and build data set
  - Clarify roles for implementing necessary procedures
- Areas for guidance/input
  - Strategies for effective collaboration with inpatient discharge stakeholders
  - Ideas for interventions once SDOH identified

Supplement

References

Addressing Social Determinants of Health in Rural Southwest Indiana

L Valdiviez[1], C MacKay[1], J Doyle[1], J Micho[1], S Subramanian[1], R Bachar[1], S Gill[1], R Ficalora[2], A Singson[1,3]

1. Indiana University School of Medicine, 2. Ascension St Vincent – Evansville, 3. Good Samaritan Hospital

INDIANA UNIVERSITY SCHOOL OF MEDICINE
SOUTHWEST INDIANA INTERNAL MEDICINE RESIDENCY
Ascension St. Vincent | Good Samaritan

AiAMC Alliance of Independent Academic Medical Centers
National Initiative

Introduction: Background & Context

- Rural regions face unique challenges in providing equitable and accessible resources to promote health
- Barriers to accessing care include proximity to healthcare facilities, cultural resistance to modern medical practice, and financial instability
- Morbidity and mortality rates in urban areas have declined far more quickly than those in rural areas[1]
- As internal medicine physicians, our resident-faculty practice has an opportunity to comprehensively impact the lives of patients from Vincennes, IN and the surrounding region

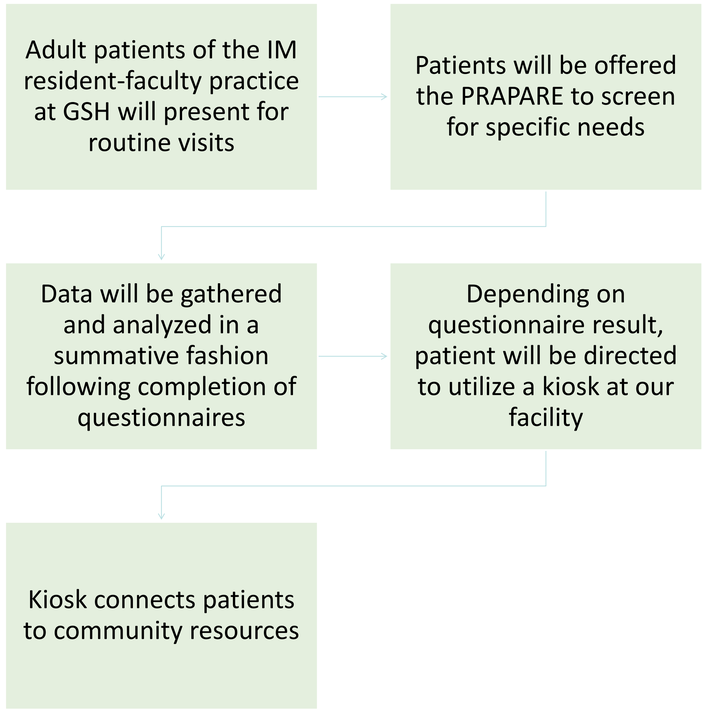
Aim/Purpose/Objectives

- Create a statistical profile of patients seen in our clinic who would benefit from referral to social services
- A validated tool, the PRAPARE protocol, will be utilized to achieve this objective
- Social work will link patients to resources to improve their health and wellbeing

Project Alignment/Advance Organization Priorities

- Good Samaritan Hospital (GSH) strives to promote wellness, healing, and education to those of Southwest Indiana and Southeast Illinois[2]
- Multi-disciplinary care is highly valued at GSH; our project will utilize an on-site social worker, in keeping with the mission and values of GSH

Methods: Assessment



Methods: Measures/Metrics

PRAPARE Survey

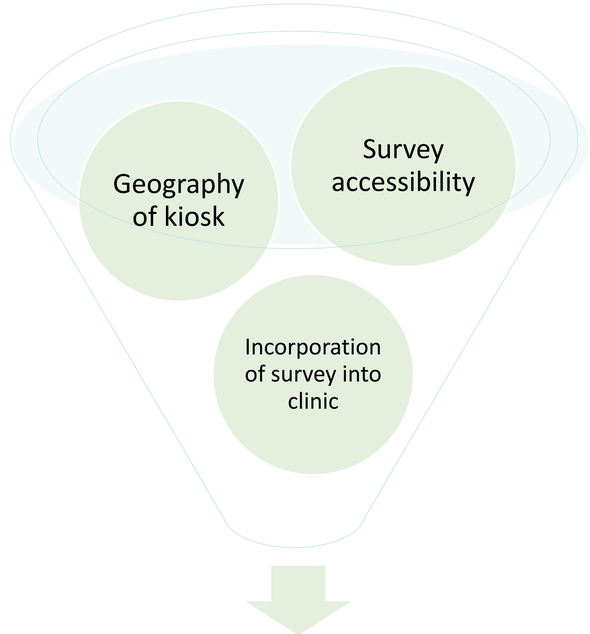
	Personal Characteristics
	Money and Resources
	Family and Home
	Social and Emotional Health

A nationally standardized and stakeholder-driven tool intended to utilize data to improve health equity[3]

Results: Preliminary

- Data acquisition planned for March-December 2024

Barriers – Strategies



Discussion

- Appreciate input on methods to most effectively capture patients' interest in completing the survey, taking the time to utilize the kiosk, and training clinic staff in furnishing materials to patients
- Guidance on the most effective statistical methods for leveraging our data to guide our intervention

Using Social Determinants of Health to Guide Social Intervention in a residency Post-Discharge Clinic

C MacKay[1], J Doyle[1], S Subramanian[1], L Valdiviez[1], R Bachar[1], S Gill[1], J Micho[1], R Ficalora[2], A Singson[1,3]

1. Indiana University School of Medicine, 2. Ascension St Vincent – Evansville, 3. Good Samaritan Hospital

Introduction: Background & Context

- The post discharge clinic is a "stop gap" between hospitalization and appointments with primary care and relevant subspecialties; specifically for our patients with a high risk for re-admission.
- The social determinants of health have a significant impact on our patients' well-being.
- The PRAPARE protocol is a validated tool "...designed to equip healthcare and their community partners to better understand and act on individuals' social drivers of health"

Aim/Purpose/Objectives

To identify specific social factors within our patients that can be addressed by a targeted social work intervention.

Project Alignment/Advance Organization Priorities

Ascension is an organization especially committed to serving vulnerable patients within their community.

As a residency program we are passionate about addressing any modifiable factors that impact the health of our patients.

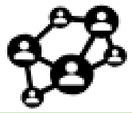
This project identifies patient-specific vulnerabilities and guides interdisciplinary intervention.

Methods: Assessment/Interventions

Assessment: PRAPARE Questionnaire domains

	Personal Characteristics
	Money and Resources
	Family and Home
	Social and Emotional Health

Change: Targeted Connection to Community Support

Specific	
Patient Centered	
Holistic and Interdisciplinary	

Methods: Measures/Metrics

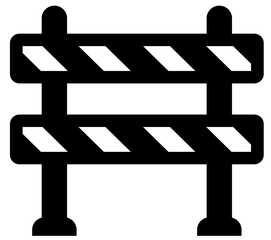
- Any identified trends among our patients as identified in the PRAPARE questionnaire domains
- Rate of successful connection to community resources
- Perceived impact of resources on patient well-being.

Results: Preliminary

- Data collection 03/2024-12/2024
- No preliminary data to present

Barriers – Strategies

- Communication between the post discharge clinic and social work
- Impact on clinical work-flow
- Gap in addressing patients that do not present for their appointment



Discussion

Critical next steps:
- Implementation of PRAPARE protocol

Areas we could use guidance/input:
- Strategies for effective collaboration between primary care, social work and community resources
- Recommended approach on how to interpret and present the qualitative portion of our data.
- Solutions that could address the current gap in clinic "no shows"

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

Eric Anderson, EdD, Suzette Caudle, MD, Cheryl Courtland, MD, Aaron Levy, MD, and Charles Mitchell, MD

Atrium Health

Atrium Health Carolinas Medical Center

Introduction: Background & Content

As the Sponsoring Institution (SI), we recognize the importance for residents to develop ***knowledge***, ***understanding***, ***appreciation***, **and a *spirit of life-long advocacy*** regarding the health of their diverse patient populations and the impact that climate change has on their patient's health.

In response to this need we will create and deliver an educational strategy that develops and increases residents' knowledge and understanding that the impact and correlation health equity and climate have with each other. In addition, we desire to develop advocacy skills that will prepare our residents to be life-long advocates for their patients in regard to health equity and climate's effects on the health of their diverse patients and communities.

Aim/Purpose/Objectives

Our aim is to train residents in the graduate medical education programs to become climate change advocates who can address the health needs of their diverse patients and communities.

- Define and explain the relationship between health equity and climate as it impacts the health of their patients and communities.
- Develop resident advocacy skills that enhance their ability to be life-long advocates for their diverse patients and communities.

Curriculum and educational activities will focus on ease of accessibility, efficiency, collaboration and creativity in delivery.

Project Alignment/Advance Organization Priorities

Our project aligns with the Atrium Health strategic priorities around climate and health care. These priorities include:

- Educate medical providers and trainees on the delivery evidence-based medicine reflecting current climate & health science
- Understand that vulnerable and under-resourced populations disproportionately experience negative health impacts from the changing climate
- Identify specialty-specific improvement to patient care
- Engage in healthcare policy & advocacy to reduce healthcare delivery footprint

Methods: Interventions

The Plan: Utilizing new resident orientation to build the foundational knowledge of the relationship between health equity and climate we will deliver brief learnings targeted to all residents, fellows, program directors, and faculty with links to more detailed resources for those who are interested in learning more. In addition, GME will collaborate with our partners in community service activities that engage residents in the communities that are impacted by climate and health inequity.

- New Resident Orientation
- Instagram posts – with links to additional resources
- Institutional Grand Rounds
- Community Service Projects

Methods: Interventions

- Pre-survey measuring new residents' current knowledge and awareness of health equity and climate.
- #/% of views of Instagram posts
- #/% of programs reporting integration of educational activities linked to the additional resources made available, as reported on the programs APE
- #/% of residents participating in community service projects
- Post-survey measuring how the educational interventions have impacted the new residents 6 months after training.
- #/% of resident QI projects initiated on this topic and submitted to the annual QI Symposium.

AiAMC Alliance of Independent Academic Medical Centers

National Initiative

Results: Preliminary

- New Resident Orientation Session – 105 Residents
- 94% increased understanding of climate and health equity
- Engaged Program Directors
- And Resident Council
- Implemented Instagram

Barriers - Strategies

1. Time (GME office, NI IX Team)
2. Challenges with curriculum and delivery method
3. Effective outreach to residents and program directors
4. Recruiting team members who have resources, including time, to be effective

Discussion

Next Steps:

- Development of educational curriculum
- Clarify the roles of the community partners
- Plan and Schedule Institutional Grand Rounds of which one will be related to this project

List areas you could use guidance/input

- What delivery methods do you find to be effective when engaging residents and faculty?
- What are effective ways that you have reached out to residents and program directors to get engagement?
- How have you been able to secure resources, especially time of team members on your project?

Office of Academic Affairs
Aurora Health Care®

A Multi-Faceted Approach to Educating Physicians About the Impacts of Climate Change on Their Patients' Health

AiAMC Alliance of Independent Academic Medical Centers
National Initiative

Deborah Simpson, PhD; Anne Getzin, MD; Kjersti Knox, MD; Kari A. Schmidt Oliver, MD; Victoria Gillet, MD; Karen Hanus, MLIS, AHIP;
Amina Maamouri MD/MPH Candidate; Nicole Heilman; Rita Mitchell, MM, MLIS; Yolanda Manson; Kristin Ouweneel, MBA; Kathryn Agard, CMP, PMP

Aurora Health Care | Milwaukee, Wisconsin

NI IX Meeting #2
Tucson AZ |April 2024

Introduction | Background & Context

- **Climate change** is impacting our patients' health through[1]
  - Increased heatwaves, wildfires, vector-borne illnesses and worsening air quality
  - Amplification of existing health disparities in vulnerable communities
- ***Clinicians*** *have a powerful megaphone - and a profound responsibility - to effectively communicate* the relationship between climate change & health to their patients[2]
- Most clinicians are "*concerned*" about climate change
  - BUT only a few have knowledge and skills about climate changes specific impacts on health *and* how to discuss the implications with their patients [3,4]

References
1. APHA. How Climate Change Affects Your Health. Infographics https://www.apha.org/news-and-media/multimedia/infographics/how-climate-change-affects-your-health
2. Peters E, Salas RN. Communicating Statistics on the Health Effects of Climate Change. NEJM. 2022;387(3):193-6.
3. Luong KT, et al. Prescription for healing the climate crisis…how to activate hlth prof to advocate for climate and health solutions. J Clim Chang Health. 2021;4
4. den Boer AC, et al. Discussing climate change & other forms of global environmental change during the clinical encounter: Exploring US physicians' perspectives. J Clim Chang Hlth. 2021;4:100058.

Aim | Purpose | Objectives

- To design, implement and evaluate a multi-faceted approach to educate physicians about the impacts on climate change on their patients' health across the continuum of medical education

Project Alignment/Advance Organization Priorities

- Leading Environmental sustainability is 1 of only 6 system enterprise-wide pledges
- Climate education aligns with each of the other 5 pledges:
  1) Advancing Health Equity; 2) Building the next generation workforce; 3) Improving affordability;
  4) Accelerating learning and discovery; 5) Elevating clinical preeminence

Methods: Interventions

Primary Audience

- Physicians & teaching faculty across the continuum of medical education: UME-GME-CME

Interventions

- Climate +1: Add 1 slide, add a climate question, a case, and/or an article to an existing education topic/session highlighting impact of climate change (eg, heat, air quality, water quality) + eval QR
  - Use library +1 request form → 2-3 key articles linking climate to your topic
- Engage learners in creating climate related resources (eg, list of area cooling stations)
- Co-Sponsor Climate related continuing education sessions
- Create a SharePoint "hub" as climate related resources, upcoming events, slide templates

IRB

- Activities of this nature have been determined to be exempt (aka not human subjects research)

Results: Preliminary

- **Climate +1:** Oriented > 200 to the +1 "ask" including the library's request form, evaluation QR codes
- **Engaging Learners:**
  - Major emphasis in new Internal Medicine Primary Care Track
  - 2 resources created to date (eg, cooling sites); 1 resident focus on climate change
- **CME – Across the Enterprise**
  - Co-sponsoring 3 accredited CE sessions in 2024
  - Inclusion of Climate +1 in multi-state MedTalks beginning March 2024
- **SharePoint Site:** Went live February 2024 with Atrium Health GME / NI-IX partners

- **Bonus:** Co-chair and membership on an enterprise-wide task force on physician Climate Education

Barriers – Strategies

- **Barrier #1**: Faculty discomfort with unfamiliar topic and lack of time for in-depth learning
  - **Strategy**: Individual outreach to faculty by co-author assist with key points
- **Barrier #2**: Lack of centralized hub for climate medical education(QR eval codes) and time
  - **Strategy**: Create and launch a SharePoint site | Include budget for med educ in AH Task Force Charge

Discussion

Critical Next Steps

- Sustain volunteer team's energy for outreach, response to queries, agility to incorporate new partners
- Monitor/review eval data: Climate #1 implementations, usages of lib request, session evals, attendance

Areas Seeking Guidance

- Strategies to track transfer of education to clinical practice (eg, climate discussed with patients)
- Curating the *mass of research & activities locally, nationally and internationally re: climate and health*

Health Equity Advocacy Learning THrough Networking, Engagement, and Education to Drive Solutions (HEALTH NEEDS)

Seema Chandra, MD | Melissa Parlade, DO | JoVonnda Chresfield, MBA, B.Sc.
Deepa Sharma, DO | Elise McCormack Granja, MD | Kelsey Warren, MD | Lorena Bonilla, MD | Agueda Hernandez, MD

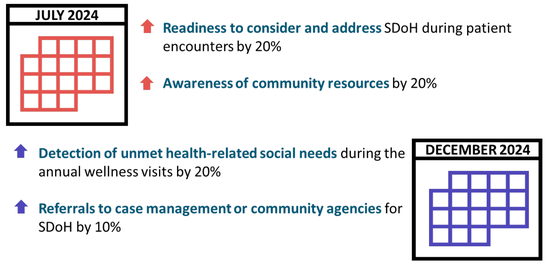
Introduction: Background & Context

At Baptist Health, care teams including physicians, nurses, care managers, and social workers collaborate to address social determinants of health (SDoH). We work with local community partners to leverage existing resources to help individuals and families in need of assistance. Some examples of current initiatives include establishing Grow2Heal Community Gardens at several of our system hospitals and supporting a pantry at a local high school as well as Habitat for Humanity.

Our system has implemented systematic screening for SDoH in the inpatient setting; we propose to expand this to the primary care setting in order to provide comprehensive holistic care to our patients.

Aim/Purpose/Objectives

We aim to enhance awareness among Family Medicine and Internal Medicine faculty and residents of the impact SDoH play in our patients' medical care and outcomes as well as the availability of community resources and services in our area. We will assess for SDoH during annual wellness visits (AWV) and implement a referral system. We encourage the recording of appropriate ICD-10 Z-codes in patient charts and monitor that documentation before and after the intervention.



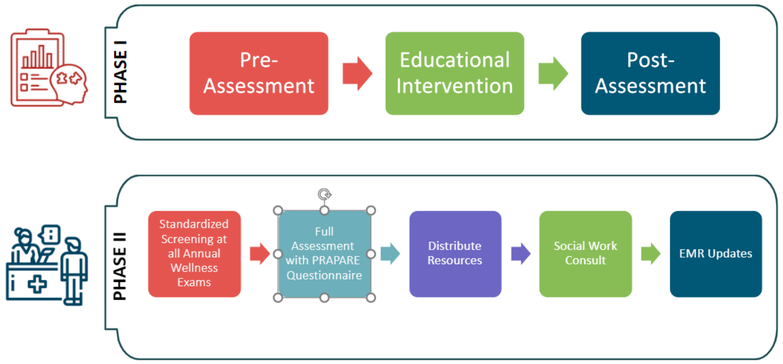
Project Alignment/Advance Organization Priorities

Our project is grounded in our commitment to the core values of Baptist Health South Florida. We want to be **transparent** about the challenges our patients face related to social and moral determinants of health. Striving for **excellence**, we aim for the highest standards in understanding and addressing health determinants with a central focus on valuing **people** and providing **compassionate care**.

Methods: Interventions

Phase 1: Starting in April 2024, residents and core faculty will receive a pre-intervention assessment followed by an educational intervention. The education will focus on educating participants about community resources and the importance of integrating assessments of SDoH in clinical practice. In June, a post-intervention assessment will be collected.

Phase 2: From July to December 2024, the two resident continuity clinics will implement routine screening for SDoH during AWV, complete a standardized assessment for those patients who screen positive, and refer to community resources. Clinicians will be encouraged to document appropriate ICD-10 Z codes correlating to the SDoH that were addressed in the patient encounter.



Methods: Measures/Metrics

Our measures include

- Physicians' awareness of each SDoH, comfort in addressing them with patients, familiarity with available community resources, and current referral patterns.
- Screening Rate: the proportion of patients screened during the annual wellness visit
- Referral Rate: percentage of patients identified with SDoH who receive a referral.
- Completion Rate: number of referrals made

How often do you consider the following when evaluating and treating patients:

	Never	Rarely	Sometimes	Often	Always
1) Food Insecurity * must provide value	○	○	○	○	○
2) Housing Instability * must provide value	○	○	○	○	○
3) Interpersonal Safety * must provide value	○	○	○	○	○
4) Utility Needs * must provide value	○	○	○	○	○
5) Transportation * must provide value	○	○	○	○	○
6) Healthcare Cost * must provide value	○	○	○	○	○

Excerpt from the pre and post intervention survey

Results: Preliminary

- Pre and Post Intervention Survey
- One question screening tool for wellness visit
- PRAPARE form for comprehensive assessment
- List of Community Resources
- IRB submission complete
- Time reserved for educational sessions

Barriers – Strategies

Barrier: Patients may be reluctant to disclose personal information

- Strategy: Develop appropriate outreach materials and explain to patients how sensitive information will be safeguarded.

Barrier: There is no process for ensuring completion of the community referral

- Strategy: Collaborate with Medical Informatics to implement a system to track all referrals and monitor for completion. In the future, would consider a follow up study to track patients longitudinally and monitor for improved health metrics.

Barrier: Residents and faculty may not actively engage in the educational intervention

- Strategy: Develop an interactive and relevant curriculum including the use of simulation

Discussion

Current State:

- Awaiting IRB approval
- Protocol development complete
- Multi-disciplinary task force with regular meetings
- Highly-engaged community partners

Next Steps:

- Complete phase 1 by July 2024
- Finalize phase 2 protocol
- Continue developing educational materials and simulation module
- Implement workflow for SDoH screening

Guidance and advice welcomed on developing education as well as creating a systematic process for tracking and ensuring closure of referrals to community-based organizations.

Baystate Medical Center

ADVANCING CARE.
ENHANCING LIVES.

OB Department Waste Reduction

Dr. Corina Schoen, Jason Leonard, Dr. Katie Barker, Dr. Margaret Griffith, Dr. James Wang
Dr. Jahel Santacruz, Dr. Salman Ali Jan, Dr. Alice Berenson
Dr. Elena Labovitis, Ariana Walker, Dr. Megan Weatherborn
Dr. Jaqueline Kates, Eric Von Hollander

AiAMC Alliance of Independent Academic Medical Centers

National Initiative

Introduction: Background & Context

Part of the Baystate core values include Quality, Safety, and Value to patients. From a quality perspective, limiting the environmental 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. Reducing cost through a reduction of unnecessary redundancy of surgical instruments will help sustain projects like these on a system-wide level.

Aim/Purpose/Objectives

With new processes and education, be able to achieve a reduction in solid waste, increase in recycling use, and a decrease in unnecessary surgical instrument processing after this twelve-month project.

Project Alignment/Advance Organization Priorities

Baystate Health as committed to the White House and HHS Health Sector Climate Pledge. Part of this pledge includes a commitment to reducing greenhouse gas emissions by 2030 and achieving net zero emissions by 2050.

Methods: Interventions

- All staff and patients will have the knowledge and opportunity to divert appropriate recyclable waste from general municipal waste into applicable recycling receptacles.
- Staff will take part in reducing unnecessary waste in the ORs by reducing the redundancy of instruments available and diverting recyclable OR waste to the appropriate recycling receptacles.
- Faculty wide grand rounds discussing climate change and the health care sector's impact.
- Engaging physicians and midwives with a survey on their surgical instrument use
- Monthly updates at business meeting on the department's current status with waste and recycling trends.
- Providing easy access to recycling containers and increased use of visual aids for recycling in patient rooms.

Methods: Measures/Metrics

- A reduction in weight of solid waste from OR cases and patient rooms after delivery accompanied by an increase in recyclable weight and volume.
- A reduction in waste in cesarean section case by decreasing the number of surgical instruments opened at the start of each case.
- A reduction in disposables used per delivery (both vaginal and cesarean).

Results: Preliminary

- Baseline - 20% of the one-month average of cesarean deliveries waste weighed (n=25). 20% of the one-month average of Vaginal deliveries waste weighed (n=55).
- Data to date –Cesarean Section - 25 deliveries- Average red bag waste weight per case is 5.1kg. Average clear bag waste weight per case is 5kg. Vaginal deliveries – 11 deliveries weighed. Average will be available upon completion of baseline weights.

Barriers – Strategies

- Data capture is at health system level for waste, not unit based. Project team members need time and communication to complete weights after cases move rooms.

Discussion

Next steps:

- Complete baseline data collection
- Establish education/visual aids
- Install recycling receptacles
- Monitor/engage staff on new processes and progress

AIAMC NATIONAL INITIATIVE IX

Meeting Two Storyboard Presentations -Cohort Breakout Sessions

Cohort Two (8 projects)
Facilitator: Ryan Pong, MD
NAC Members: Elisa Arespacochaga and David Henderson, MD

1. Ascension Providence Rochester/Wayne State
2. Aurora (Four projects in this initiative. One project in each group)
3. Cedars-Sinai
4. Cleveland Clinic Akron General
5. Hackensack Meridian Ocean
6. Monmouth Medical Center
7. Our Lady of the Lake
8. Tri Health

DEVELOPMENT OF A COMMUNITY SERVICE CURRICULUM IN A FAMILY MEDICINE RESIDENCY PROGRAM, ASCENSION PROVIDENCE ROCHESTER HOSPITAL/WSUGME

Eleanor King, MD,[1] Heidi Kenaga, PhD,[2] Anne Messman, MD,[3] Brent Stansfield, PhD,[2] Sheryl Wissman, MD[4]

[1] FM Prog Director, Ascension Providence Rochester Hosp, [2]WSUGME, [3]DIO, WSUGME, [4]CMO, Ascension Providence Rochester Hosp

Introduction/Background

The Family Medicine (FM) residency program at Ascension Providence Rochester Hospital (APRH) has well established resident participation in street medicine and outreach at multiple community sites in the Detroit area. Our NI IX initiative expands on such training and experiences and provides a preliminary mechanism for gauging outcomes. FM is using the NI IX initiative as a pilot for developing a **formal community service curriculum**. The WSU IRB Office has granted this project exempt status.

"When the fabric of communities upon which health depends is torn, then healers are called to mend it."

- Donald M. Berwick, MD, "The Moral Determinants of Health," ***JAMA Viewpoint*****, July 2020**

Objectives

This project will provide FM residents with curricular opportunities to learn more about the **social and moral determinants of health** (SMDH). We anticipate increases in resident knowledge of SMDH and its impacts on patient outcomes as well as improved wellness and meaning-in-work ratings. By sharing outcomes with all our residencies, WSUGME hopes that other programs may enhance their community engagement opportunities. We seek to equip our graduates with the experience and knowledge to provide and advocate for responsive, culturally competent healthcare for diverse patient populations in a variety of clinical settings.

Alignment with Institution's Values

Our NI IX project aligns well with the **WSU School of Medicine's (WSUSOM) mission** to "educate a diverse student body in an urban setting and within a culture of inclusion, through high quality education, clinical excellence, [and] local investment in our community" to prepare physicians to "achieve health and wellness for our society." Further, WSUSOM seeks to "transform the promise of equal health into a reality for all."

Methods: Intervention

The population is all FM residents at APRH (*n* = 27). FM seeks to increase trainee understanding of SMDH by engaging in **narrative medicine**, whereby *reflective writing* modes are used to enhance their listening and observational skills to expand a perspective of patients as more than their medical histories. Narrative medicine can foster greater empathy and cultural humility as well as reveal unexamined biases; reflective writing can provide a "safe space" for ameliorating stress and thus contribute to improved wellness and finding renewed meaning in work and connection to patients and communities.

FM residents witness the impacts of inequity on community health via **Street Medicine Detroit** and WSUSOM's **Student-Run Free Clinic**, providing care to those experiencing homelessness and exclusion from the US healthcare system. Residents also work in **community outreach sites,** such as the Neighborhood House of Rochester and Samaritas Senior Living, among others.

At monthly didactics, the Program Director discusses the goals of narrative medicine and **efficacy of reflective writing genres**. In fall 2023, residents collected patient narratives, and in spring 2024 engaged in reflective writing. For 2024-25, APRH/GME may shift to a case study approach, soliciting reflective documents from a cohort of FM residents to unpack the complexity of the provider/patient relation and impacts of SMDH on health outcomes via more detailed textual explorations.

Methods: Measures

APRH/GME is using **mixed methods**, combining qualitative analysis of patient narratives and reflection documents with quantitative analysis of survey responses (GME's Resident Wellness Survey, ACGME survey). These measure resident knowledge of SMDH and provide ratings for wellness, meaning and connection to work, and community involvement and engagement. At the end of 2023-24 AY, FM will also administer a survey to residents and at the APRH orientation in July 2024 will distribute a baseline survey on SMDH to incoming interns.

Preliminary Data: Resident Reflections

"As time has passed, I do realize, most of the time, that *I am enough*. Even if others don't see it or if the system is broken, it doesn't define the kind of doctor I am and the amount that I can help my patients."

"Time mocks me. The notion that I cannot re-board the educational train that runs smoothly from undergrad to medical school to residency haunts me."

"The journey through medicine is really the culmination of a multitude of failures, presenting in different ways. Success in medicine is learning to accept failure."

Barriers & Strategies

Although APRH/GME anticipated challenges in maintaining sufficient resident engagement in reflection activities since their primary commitment is to clinical care and training requirements, this has proven less of a barrier. One reason may be that FM dedicates a **block of time in the monthly didactics schedule** for discussion of narrative medicine and writing sessions rather than asking residents to devote time outside of training to composing reflection documents. In addition, FM participates in **MIDOCS**, a state program addressing physician shortages in underserved areas, which tends to attract those with a strong commitment to community health service.

NI IX Meeting #2: April 5-6, 2024 Tucson, Arizona

Academic Affairs
Aurora Health Care®

Vot+ER: Voter Registration to Address Structural & Social Determinants of Health

Terry Frederick, LSSGB; Tricia La Fratta, MBA; Deborah Simpson, PhD; Victoria Gillet, MD; Lawrence Moore, MD; Kjersti Knox, MD; Esmeralda Santana, C-TAGME; Oyinkansola Okubanjo, MD; Nicole Salvo, MD; Jacob Bidwell, MD; Kristin Ouweneel, MBA
Aurora Health Care | Milwaukee, Wisconsin

AiAMC Alliance of Independent Academic Medical Centers
National Initiative
NI IX Meeting #2
Tucson AZ |April **2024**

Introduction | Background & Context

- Civic health has been emphasized as an integral part of physician education
  - "… improving a community's civic health shifts the distribution of power towards patients, better enabling them to address SDH that are affecting their well-being.[1]
- American Medical Association June 2022 policy resolution
  - Supporting safe and equitable access to voting
  - Opposing restrictions to mail-based voting
  - Recognizing voting as a social determinant of health[2]
- ACGME - Programs must understand the structural and SDH of the populations they serve…[3]

Aim | Purpose | Objectives

- To engage interested members of our medical education community in talking with their patients (and peers, colleagues) re: importance of voting for their health and the health of their communities
  - Voting affords citizens a direct say in their leaders and policies that affect their health
  - Wearing the Vot-ER badge conversations are usually started by the patient asking, not the clinician pushing

Project Alignment/Advance Organization Priorities

- Our Enterprise-Wide Health Care System
  - **Pledge:** To advance health equity (1 of 6)
  - **Purpose:** By supporting voting as health team members living in the community, we will help people live well
- Medical Education
  - Civic health should be incorporated into Medical Education because civic health is directly actionable.[1]

Methods: Interventions

Audience

- UME and GME students, residents, fellows and faculty and staff

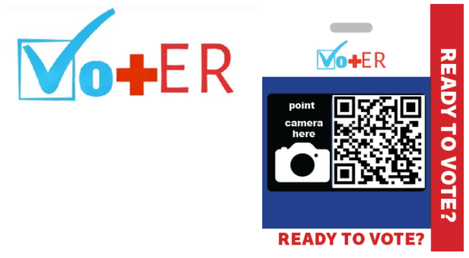
Intervention

- Vot-ER champions presented to multiple medical education venues
  - 10-minute presentation developed by Vot-ER team leaders; Updated with VotER impact data
  - Updates re: Key voting dates via E-mails, standing meetings and agendas
- Provide Vot-ER Badges to all interested med educ teammates with QR code link to voting registration
- Circulate scripts, flyers and information on how to embed QR code within clinic after visit summary

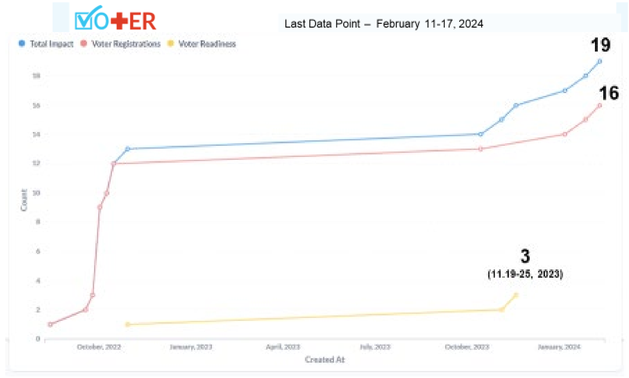
References
1. Barrere-Cain R, Garriga, M, et al. Why and How Civic Health Should Be Incorporated Into Medical Education. Acad Med. 2022;97(12):1760-1764
2. Ganguly A, et al. Voting As a SDH: Leveraging Health Systems to Increase Access to Voting. NEJM Catalyst Innovations in Care Delivery. 2023 Jan 26;4(1).
3. ACGME Common Program Requirements 2023 - CPR II.A.4.a).(2) and IV.B.1.f)]

Results: Preliminary

- **Disseminated information:** Presented to 12 different medical education groups with > 250 participants
  - **Strategy:** Provided education on why it is part of healthcare – Voting IS structural determinant of health
- **Materials:** Provided badge hang tags, flyers, Epic dot.SmartPhrase with QR code for easy access



- **Vot-ER Results First 2.5 months:**
  - Vot-ER website shows Total impact, voter registrations & voter readiness



Barriers – Strategies

- **Barrier #1**: Engagement from physicians and other health care workers – concern – Is this something that should be part of health care?
  - **Strategy**: Provided education on why it is part of healthcare – Voting IS structural determinant of health
  - **Strategy**: Educate that Vot-ER tools are undisruptive, optional, nonpartisan
- **Barrier #2**: Concern from physicians re time in appointments; Not having answers if asked questions b
  - **Strategy**: Provided scripts and Epic dot.SmartPhrase for physicians to use during appointments or on the after-visit summary. These visual cues spark the interest and mean it's a conversation with patient not "another thing to remember".

Discussion

Critical Next Steps

- Continue to find champions within educational programs and clinics to keep effort moving forward
- Evaluate effectiveness of different resources to determine best use of efforts – hang tags, flyers, Epic SmartPhrase, word of mouth, presentations

Areas Seeking Guidance

- Strategies to increase awareness and engagement in voting in the healthcare setting
- Identify additional results measures other than Vot-ER usage
- How to make educational efforts sustainable beyond big elections but integrated into curriculum

CS-CORE: Community Outreach Education to Empower GME Trainees at Cedars-Sinai

Nishita Jain, MD; Amy Day Rossa, EdD, MBA; Aum Solanki, MD; Cynthia Mark, MD; Pauline Hoosepian-Mer, MD; Kushagra Mathur, MD; Diana Tran, MD; Rita Rossi-Foulkes, MD; Mark Noah, MD

Introduction: Background & Context

Social and moral determinants of health significantly influence the well-being of both individual patients and the broader community. Physicians, as frontline healthcare providers, bear a social responsibility to comprehend and address these influences on health outcomes. Despite this imperative, there is a notable absence of structured programs within Graduate Medical Education (GME) aimed at engaging with communities, fostering awareness, and effecting change. Recognizing this gap, Cedars-Sinai has spearheaded the development of CS-CORE, an educational initiative expressly designed to empower trainees through advocacy. Through CS-CORE, our project endeavors to extend this initiative to the broader GME community, fostering engagement with community health leaders, facilitating participation in volunteering efforts, and promoting immersion within the community. By enhancing trainees' understanding of community dynamics and available resources, CS-CORE seeks to bridge gaps in care and promote health equity.

Aim

Over the course of six months, we strive to foster a better understanding of socioeconomic barriers that impact healthcare access. Second, we actively engage in community-based programs to address and alleviate health disparities affecting marginalized populations. Third, we commit to promoting advocacy in healthcare, encouraging trainees to become champions for equitable and inclusive medical practices.

Project Alignment

Cedars-Sinai is committed to education, with a particular emphasis on addressing equity within the community. Our project's mission aligns seamlessly with this institutional goal. Through collaborative efforts with key stakeholders such as the executive director of Graduate Medical Education (GME), representatives from Cedars-Sinai Community Benefit team, and our Chief Health Equity Officer, significant strides have been made in advancing organizational objectives.

These achievements include expanding health equity education across all GME programs, fostering interdisciplinary learning opportunities, and facilitating trainee engagement in community events and volunteerism.

Methods: Interventions

Participants

Participants in this study comprised residents and fellows at Cedars-Sinai Medical Center who applied to be a part of the CS-CORE program. There are twenty-five trainees spanning across different specialties including internal medicine, obstetrics-gynecology, anesthesiology, cardiology, pulmonary and critical care, and others. The program spanned a duration of 6 months.

CS-CORE Program Overview

CS-CORE aimed to address a diverse spectrum of healthcare-related topics each month. The topics covered during the Academic Year (AY) 2023-2024 included Access to Care, Climate Change, Correctional Medicine, Global Medicine, Gun Violence, and Mental Health and Wellbeing.

Learning Opportunities and Community Engagement Events

Throughout the duration of the program, monthly learning opportunities and community engagement events were organized. These events were designed to facilitate interaction with the community and address the complex barriers that impact health and wellbeing. The learning opportunities encompassed a variety of formats, including workshops, lectures/panels, volunteering events, and site visits.

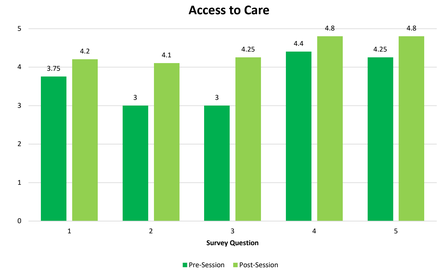
Implementation

Each month, the CS-CORE team curated content and activities related to the designated topic. This involved collaborating with subject matter experts, community organizations, and relevant stakeholders to develop comprehensive learning experiences and impactful engagement opportunities.

Methods: Measures/Metrics

During major sessions, participants are provided surveys to assess the effectiveness and impact of the CS-CORE program. These evaluations were used to gauge participant satisfaction, knowledge acquisition, and the perceived impact on community engagement and understanding of the addressed topics. Surveys will be designed using the Likert-scale to assess knowledge, skills, and attitudes and are administered pre- and post-session.

Results: Preliminary



Graph 1:
1 - Understanding the basic health insurance terminology and concepts.
2 - Knowledge of the roles of different entities in the payer structure (e.g., insurance companies, government programs, employers).
3 - Awareness of current challenges in the US healthcare system related to health insurance and payer structure.
4 - I believe understanding health insurance and payer structure is essential for providing quality healthcare.
5 - I am motivated to advocate for my community as it pertains to access to care.

In this study, we aimed to evaluate the impact of a specific CS-CORE workshop on participants' understanding of healthcare payer structures and their attitudes towards access to care. Participants completed surveys before and after the workshop, which involved a one-hour mock debate between health policy experts.

Graph 1 depicts changes in participants' understanding of healthcare payer structures before and after the workshop, indicating an overall increase in comprehension post-workshop. Additionally, specific questions (Survey Question 4 and 5) focused on attitudes towards access to care showed heightened engagement post-workshop.

Overall, the data demonstrate improved understanding of the US healthcare system among CS-CORE workshop participants. This heightened understanding correlated with increased motivation to advocate for healthcare-related issues, highlighting the workshop's effectiveness in both education and empowerment.

Barriers – Strategies

Current barriers encompass resource availability, engagement, and competing priorities. Resource availability involves securing funds and time for external speakers and workshops. Engagement concerns arise over potential declines in trainee participation over time. Competing priorities stem from the challenges of balancing education and clinical duties, particularly within the demanding schedules of GME trainees.

To address these challenges, we have formed partnerships with key parties to align priorities and allocate resources, such as GME, community benefits program at CS, and others. To maintain trainee engagement, strategies include involving trainee representatives on the CS-CORE steering committee, fostering a safe learning environment, implementing higher-order learning techniques, and utilizing diverse teaching method.

Discussion

Our study demonstrates the positive impact of the CS-CORE workshop on participants' understanding of healthcare payer structures and attitudes towards access to care and level of engagement with advocacy. We hope to continue replicating this in various aspects of social and moral determinants of health. Moving forward, critical next steps include continued study of the curriculum's effectiveness and validation of findings through external review, as well as expansion beyond our institution to reach a broader audience. However, we acknowledge the need for guidance in measuring outcomes beyond surveys and focus groups. These steps are essential to further refine and enhance the CS-CORE program, ensuring its continued success in empowering trainees and promoting health equity within communities.

RAISE Akron: The Impact of a Primary Care Practice Relationship with Head Start

Brandon Foreman, DO; Frances Kokos, DO; Estee George, PhD; Elliot Davidson, MD; Nkosi Mason, MD; Kristina Fey, APRN; Kami Rodgers; Denise Seegert, LPN; Linda Fox; Jessica Hurst; Cheryl Goliath, PhD

Introduction: Background & Context

Head Start is a federally funded program that facilitates school readiness and promotes access to health services for economically disadvantaged children by partnering with community agencies.[1,2] Together with its family medicine residency program, Cleveland Clinic Akron General's (CCAG's) Center for Family Medicine (CFM) strives to serve the community's children and their families by providing comprehensive lifetime medical care. The Accreditation Council for Graduate Medical Education (ACGME) indicates pediatric patients should make up at least 10% of the residents' patient panel.[3] This expectation has posed a challenge for CFM. The Relationships, Access, Inclusion, Social Determinants of Health, Engagement (RAISE) initiative was developed in response to the needs of Akron's Head Start program and CCAG's family medicine residency.

1. Community Action Akron Summit. About Head Start. Accessed March 10, 2024. https://www.ca-akron.org/head-start/about.
2. Community Action Akron Summit. *Head Start and Early Head Start State Early Childhood Education Program 2022/2023 Program Year-End Report*. Published July 2023. Accessed March 10, 2024. https://www.ca-akron.org/sites/default/files/editor/2022-2023%20Final%20Program%20Year-End%20Report.pdf.
3. Accreditation Council for Graduate Medical Education. *ACGME Program Requirements for Graduate Medical Education in Family Medicine.* 2023. Accessed March 10, 2024. https://www.acgme.org/globalassets/pfassets/programrequirements/120_familymedicine_2023.pdf.

Aim/Purpose/Objectives

The goal of this initiative is to improve access to medical care among local Head Start children and their families. Specific aims include the following:

- Aim 1: Measure and address the following social determinants of health (SDOH): financial resource strain, housing stability, food insecurity, and transportation needs.
- Aim 2: Determine current access to medical care and address barriers.
- Aim 3: Increase the number of pediatric patients who receive medical care at Cleveland Clinic Akron General's (CCAG's) Center for Family Medicine (CFM).

Project Alignment/Advance Organization Priorities

One of the Cleveland Clinic Foundation's top four priorities is "Care for the Community We Serve," and three of its five core values are empathy, teamwork, and inclusion. As such, ***RAISE Akron seeks to understand and address health disparities and improve access to health care among the community's pediatric population*** by connecting CFM caregivers with Head Start children and their families.

Methods: Interventions

CFM caregivers will provide resources, services, and education to address SDOH and access to medical care. Resources and services may include regular onsite clinics at Head Start, health screenings, and well checks. Educational topics may include navigation of health care systems, health literacy, nutrition and healthy lifestyles, preventative care, and effective use of medical homes. Caregivers will help parents and guardians of Head Start children establish care with CFM as needed.

Methods: Measures/Metrics

Aim 1

At the start of the initiative, financial resource strain, housing stability, food insecurity, and transportation needs will be measured using a SDOH tool built into CCAG's electronic medical record (EMR) system (Figure 1). Based upon results, CFM caregivers will provide resources and education to address needs. At the end of the initiative, SDOH will be measured again using the same EMR-based tool.

Aims 2 and 3

A survey will be administered to parents/guardians of Head Start children. Prompts will be designed to evaluate current access to medical care. Based on survey responses, CFM caregivers will provide resources and education to address barriers to care. Caregivers will help parents/guardians establish care with CFM if needed. The number of pediatric patients who receive care at CFM at the start and end of the initiative will be determined. A percent change will be calculated.

Results: Preliminary

Figure 1. Overview of SODH tool which gives indication of risk. Red symbols indicate significant risk, orange symbols indicate medium risk, and green symbols indicate low risk for the associated determinants. For this initiative, we will measure financial resource strain, transportation needs, housing stability, and food insecurity. (Data represented here are synthetic.)

Barriers – Strategies

Challenges ahead include the development and effective delivery of resources, services, and education to address the needs we expect to identify at the start of the initiative.

Discussion

Next steps include finalization of the survey to assess access to medical care, submission of a "Request to Use Protected Health Information Preparatory to Quality Improvement Form" to CCAG's Institutional Research Review Board (IRRB), and initiation of regular onsite clinics at Head Start.

Addressing the Social and Moral Determinants of Health

Amir Elsamadisi MD, Harsh Patel MD,
James Ding MD, Shmilah Choudhary DO, Kelly Ussery-Kronhaus MD, Saba Afzal MD

Hackensack Meridian Ocean University Medical Center

AiAMC Alliance of Independent Academic Medical Centers

National Initiative

Introduction: Background & Context

- In recent years, there has been a growing recognition of the significant impact that social and moral determinants have on health outcomes. These determinants play crucial roles in shaping individual's health and wellbeing. This project involves interdisciplinary collaboration among healthcare professionals to identify key areas of concern and develop interventions to mitigate disparities.
- Our vision is to take proactive approach by initiating this project and equip all of GME, faculty, staff and leadership at Hackensack Meridian Health (HMH) with the tools to not only understand but also appreciate the impact of social and moral determinants of health, so we can work towards making health care unequivocally a human right.

Aim/Purpose/Objectives

1. Increase knowledge and understanding of SDoH via educational curriculum.
2. Identifying key determinants and educating physicians and implementing SDoH questioning and resources in day to day clinical practice.
3. Engage in collaborative efforts with the local community to address specific facets of social determinants of health (SDoH).
4. Create a database of community resources to seamlessly share with patients.

Project Alignment/Advance Organization Priorities

- Health Equity
- Patient Centered Care
- Community Engagement
- Interdisciplinary Collaboration
- Ethical responsibility

Overall, the project's alignment with the organization's priorities reflects a holistic approach to healthcare that values inclusivity, collaboration, and ethical integrity in promoting health and well-being for all.

Methods: Interventions/Changes

- We created the clinical workflow focused on addressing social and moral determinants of health with the hope to fully integrate structured screening tool into patient intake process.
- Longitudinal Social Justice curriculum for two GME programs.
- Grand Rounds/Faculty retreat
- We worked with the Hackensack Meridian School of Medicine to implement an educational curriculum called "Human Dimensions."
- Community immersion

Methods: Measures/Metrics

- To understand resident beliefs, surveys designed to assess:
  - Familiarity with SDoH
  - Comfort in Addressing SDoH
- Then, we created series of questions that would be routinely implemented in psychiatric and primary care office visits to assess their SDoH needs.
- These questions were made into Smartphrases in EMR.

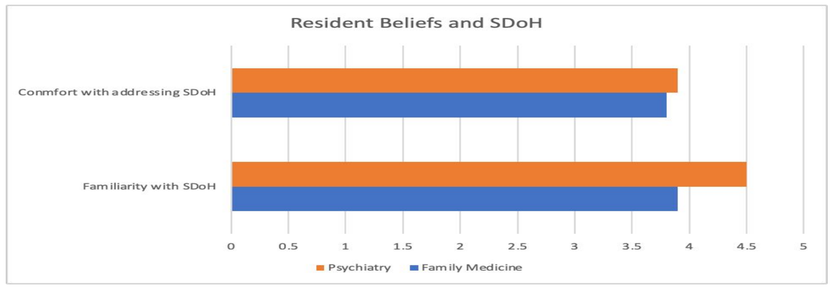


Table 1: Residents comfort and familiarity with SDoH in clinical practice

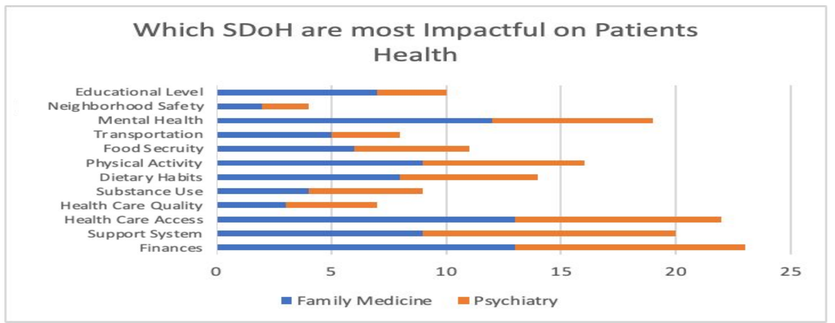


Figure 2: Resident survey highlighting key SDoH impact vs. clinical visit scope

Results: Preliminary

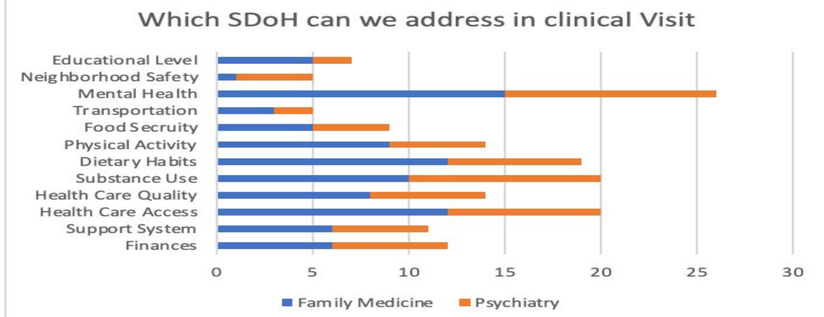


Figure 2: Resident survey highlighting key SDoH impact vs. clinical visit scope

Barriers – Strategies

- Expanding education to other hospital departments and competing with demanding times/participation.
- Improving accessibility to gather input from large group of residents.
- EPIC accessibility and interoperability concerns.
- Training and referral needs to ask and address SDoH questions sensitively and effectively.

Discussion

- Consolidating community resources through assessment and stakeholder survey
- Launch an Ambassador program to attract more committed members and enhance retention by recognizing and rewarding contributions
- **Critical Next Steps**
  - Measuring the frequency SDoH smart phrases are used in the EMR to provide us with objective measurable data to assess its impact factor.
  - Reviewing this EMR data at frequent intervals to understand barriers and optimize resident assessments of SDoH needs.
  - Involving biostatistician to assist with data analysis
  - Increasing Resident education about these Smartphrases and reaching good compliance rate.

Hands Only-CPR – Life Saving Education

Joseph Jaeger, DrPH, Deonna Williams- Square MPA, MPH, Violet Kramer MD, FCCP
Sylvia Jacobs, SHRM-CP, Frederic C. Pachman, AHIP, Christine Steinberger, MHI,
Francesca Ferrari, MHA, Kylee Tacopino, MASc

Introduction: Background & Context

Bystander CPR, crucial in improving survival rates for cardiac arrest, is less prevalent to minorities and individuals of lower socioeconomic status.

A large U.S. registry (2013-2019) showed Black and Hispanic individuals consistently received less bystander CPR, regardless of location or neighborhood demographics (Garcia, 2022). This data highlights the need to address these disparities through targeted intervention, education, and building trust within underserved communities.

Aim/Purpose/Objectives

Increase bystander CPR rates within the next 24 months among community members of minority and lower socioeconomic neighborhoods in Long branch, NJ

- **Accessibility:** Expands basic skills, creates access to all thorough free, simplified training.
- **Simplicity:** Reduces the intimidation factor for those hesitant to perform traditional CPR due to complexity.
- **Increased Confidence:** Emphasizes chest compressions, equipping individuals to confidently respond to cardiac emergencies.

Project Alignment/Advance Organization Priorities

Beyond the Monmouth Medical Center walls, Hands-Only CPR supports our hospital's mission by:

1. Increasing CPR Education to elevate survival rates.
2. Fostering community engagement through free training.
3. Addressing healthcare disparities by targeting underserved areas.

NI IX Meeting #2: April 5-6, 2024

Methods: Interventions

Health Disparities Addressed:
We target populations facing healthcare access and education disparities, offering tailored CPR training to bridge equity gaps and empower the community to take action.

Intervention Strategy:
Our approach focuses on hands-only CPR training to equip and empower community members with essential life-saving skills, emphasizing simplicity for all.

Tailored Approach:

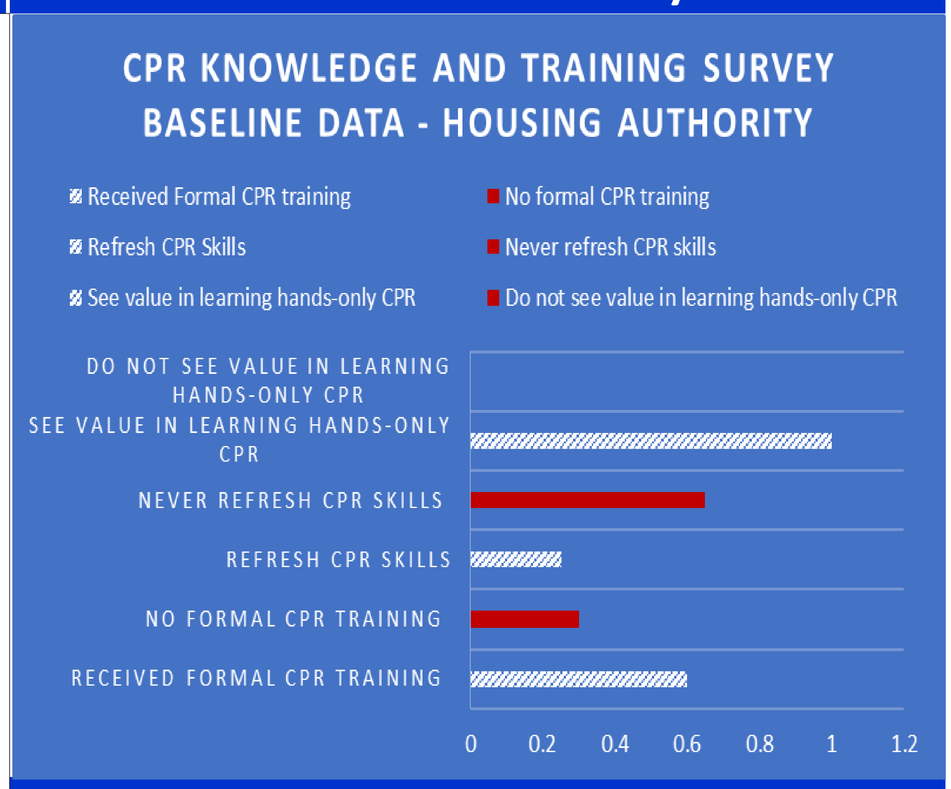
- **Cultural Sensitivity:** We use imagery, examples, and language relevant to the community.
- **Simplified Language:** Complex medical terms are replaced with clear explanations.
- **Interactive Tools:** We demonstrate hands-only CPR techniques on manikins, then encourage community members to practice on them.

Methods: Measures/Metrics

Methodology: Our inclusive, sustainable methodology prioritizes effectiveness through feedback, outcome tracking, and continuous refinement.

- Hands-Only CPR performance metrics
- Pre/Post Knowledge Surveys
- Community health pledges
- Feedback

Results: Preliminary



Barriers – Strategies

- Demographic data capture
- Reaching the intended demographic
- Accurate Survey Participation and Responses

Strategies: Work with the Community health and DEI department on how to engage with the community, especially the targeted audience.

Discussion

Next steps:

- Utilize feedback from baseline data and pilots
- Expand Community outreach efforts
- Recruit more residents for the initiative

Tucson, Arizona

Food is Medicine
Our Lady of the Lake Health

Our Lady of the Lake Health | LSU
CHAMPIONSHIP HEALTH PARTNERS

AiAMC Alliance of Independent Academic Medical Centers
National Initiative

Introduction: Background & Context

OLOL Health is focused on a Food is Medicine initiative that screens inpatients for food insecurity and distributes an emergency food box prior to discharge and connects them to services at the Greater Baton Rouge Food Bank. While this project is in the early stages of implementation, there is an opportunity to expand this effort beyond the current pilot units and from the adult to pediatric population. In the Baton Rouge region, 11.5% of the population is considered food insecure compared to 10.4% nationally.

Access to the food box bridges an immediate need and connection to the Food Bank provides ongoing support as needed. In addition to clinical team participation, residents, faculty and program directors in the Pediatric and Internal Medicine programs are actively engaged in this effort.

Aim/Purpose/Objectives

The aim of Food is Medicine is to have 50% of patients screened for food insecurity as part of the inpatient admission, and 80% identified as food insecure set up with an emergency food box and connected to resources through referrals upon discharge by project end.

Project Alignment/Advance Organization Priorities

The Food is Medicine initiative addresses one of our strategic priorities for SDOH. Specifically, Health Equity and "Partner with local and state entities to address select social determinants of health"

Methods: Interventions/Changes

Describe your methods/interventions/changes (actual or proposed):

- Patients in pilot units within OLOLRMC and OLOL Children's Hospital will be screened for the five SDOH.
- Patients that positively screen as food insecure will be:
  - Set up with an emergency food box from the Baton Rouge Food Bank
  - Connected to resources through referral to the Baton Rouge Food Bank

OLOL intends to seek IRB submission for this project through the OLOL Office of Research.

Methods: Measures/Metrics

- % of patients screened for food insecurity in an inpatient encounter
- % of patients that screen positive for food insecurity that receive/ are offered an emergency food box
- % of patients that screen positive for food insecurity that are referred to the Greater Baton Rouge Food Bank.

Barriers – Strategies

- Greater Baton Rouge Food Bank exploring permanent solution to cardboard packaging issue. Looking for a new shipping system regardless of location. Currently repackaging boxes in Central Supply, but not a long-term solution. Hope to resolve in the next few weeks.
- Determine primary screener for SDOH, today, open to all clinical team but no ultimate accountability.
- Linkage to patient data for outcomes still to be determined
- Explore how to make screening questions more face up to clinical team.

Results: Preliminary

Social Drivers of Health: OLOLRMC Inpatient Pilot Units

Adult Inpatient Data Only: **HVC7, HVC8, MED5, SUR1 & SUR2**

Performance Period: October 2023 - February 2024

CMS SDOH-1: Social Drivers of Health Screening Rate:

The percentage of admitted inpatients 18 years or older who were screened for all five primary social drivers of health during their hospital encounter.

48.12%

1,655 patients screened for all five primary Social Drivers of Health of 3,439 patient encounters

Organizational Performance Goal: 80%

CMS SDOH-2: Social Drivers of Health Needs Identified:

The percentage of admitted inpatients 18 years or older screened for all five primary social drivers of health during their hospital encounter who have an identified health-related social need.

SDOH-2 is reported as five separate identified needs rates.

Food Insecurity Need Identified
8.76% (145 needs)
Housing Instability Need Identified
8.82% (146 needs)
Interpersonal Safety Need Identified
0.42% (7 needs)
Transportation Need Identified
8.64% (143 needs)
Utilities Difficulty Need Identified
3.75% (62 needs)

Data Source(s): Epic Social Drivers of Health Screening Rate, Positive Needs
Quality Analytics Department, Our Lady of the Lake Regional Medical Center

Discussion

What are critical next steps?

- Alignment of screening (CH v. Adult Hospital)
- Clarification of primary screener; ultimate owner
- Finalize process with the Food Bank.

List areas you could use guidance/input

- How have others identified primary screener?
- Are other programs separating child and parent when asking SDOH questions?

Examining the Impact of Food Pantry Incorporation in the Clinical Setting on Patient No Show Rates and Food Insecurity for Patients and Their Families

Elizabeth Beiter MD[1], Shelby Blanton DO PGY-2[1], Adriana Delgado Cady MD PGY-2[1], Nicholas Racchi DO PGY-2[2], Angela N Fellner PhD CCRP[3], Becky Fleig MEd[4], Angel Mena MD[5], Nima Patel MD[2], Tira Williams DNP RN NE-BC[6], Steven Johnson MD[4], Deborah Ballinger RN BSN CDCES[1], Kim Collins RN[2], Molly Lawson RDN LD[5], Laura O'Donnell BSN[2]

[1]FM residency, [2]Ob/Gyn residency, [3]TriHealth Hatton Research Institute, [4]GME Administration, [5]IM residency, [6]Health Disparities & Population Health

Introduction: Background & Context

- As food insecurity has increased in our community, **TriHealth has made a significant investment in Health Equity** through development of a Center for Health Equity.
- GME has partnered with the work ongoing in our institution to **standardize and deploy a universal assessment tool for social determinants of health.**
- GME has also **partnered with various community and payor resources to address patient needs** as they are identified.
- Our **FM, IM, and Ob/Gyn** residency programs recently **added a food pantry at their clinical sites** for patients identified to have food insecurity.

Aim/Purpose/Objectives

- To analyze the **impact of food pantry incorporation in the clinical setting** and the frequency of **patient No Show rates** for appointments.
- To study the impact of a **simple labeling system** for foods that are appropriate for a diabetic diet on the overall **patient selection** of these foods.
- To ensure patients with food insecurity who are **eligible for WIC services** are connected for a more sustaining and readily **accessible resource**.

Project Alignment/Advance Organization Priorities

- This project is in **partnership with TriHealth's Center for Health Equity** to address disparities in care and improve health outcomes.
- Access to primary care and routine prenatal care has been demonstrated **to decrease morbidity and mortality and reduce health disparities**.

Methods: Interventions

- Assess **No Show rates** before and after referral to the food pantry began at each clinic site.
- **Label foods available at the pantry as "diabetic diet friendly"** to **determine** if there is a change in the quantity of food ordered meeting that definition.
- In the FM office, the OH managed Medicaid representative will **help with determining patients' WIC services eligibility**.

Methods: Measures/Metrics

- **No Show rates** from 2022-2024 as reported in the EMR
- WIC utilization **(eligibility vs receiving)** for OH managed Medicaid enrolled patients attributed to our practices
- **Pounds of "diabetic diet friendly" foods** on a weekly basis

Results: Preliminary

- IRB acknowledged **QI project designation**.
- **Initiating data collection**.

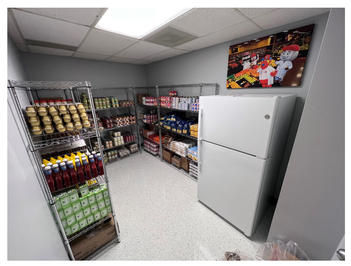
Barriers – Strategies

- **Variability in food availability** for the pantries across sites
- **Limitations in reporting tools** for capturing referral, No Show rates and food procurement
- **Inconsistency in resource availability** across the clinical sites

Discussion

NEXT STEPS:

- Devise consistent **food labeling strategy** and **deploy across sites**
- Begin **data collection**



AIAMC NATIONAL INITIATIVE IX

Meeting Two Storyboard Presentations -Cohort Breakout Sessions

Cohort Three (7 projects)
Facilitator: Five Kelly Ussery-Kronhaus, MD
NAC Member: Elizabeth Zmuda, DO

1. Aurora (Four projects in this initiative. One project in each group)
2. Ochsner
3. OhioHealth
4. St. Lukes (Five projects in this initiative. Two projects in this group)
5. St. Luke's
6. UnityPoint (Two projects in this initiative)
7. UnityPoint

Aurora Health Care®
Family Medicine Residency

Population Health Pop-Spotting

Stephenie Quirke, DO; Morgan Erickson, MD; Catherine de Grandville, MD;
Glenda Sundberg, FNP-CS; Christina Dukehart, DO; Will Lehmann, MD
Aurora Health Care | Milwaukee, Wisconsin

AiAMC Alliance of Independent Academic Medical Centers
National Initiative

NI IX Meeting #2
Tucson AZ |April 2024

Introduction | Background & Context

- Family Practice Center (FPC) is a resident lead primary care clinic
  - Leader in global health providing care for diverse underrepresented populations
- Despite our best efforts, there are subsets of our community that have persistent care gaps in multiple quality measures
  - What are the barriers to meeting these health maintenance needs?
    - Transportation, mobility issues, childcare, financial constraints, work obligations
  - How can we help to overcome these barriers?
    - **Population Hot-Spotting or "Pop-Spotting" [1-2]**
      - Interdisciplinary approach designed to improve outcomes for our most at-risk patients by mobilizing primary care services

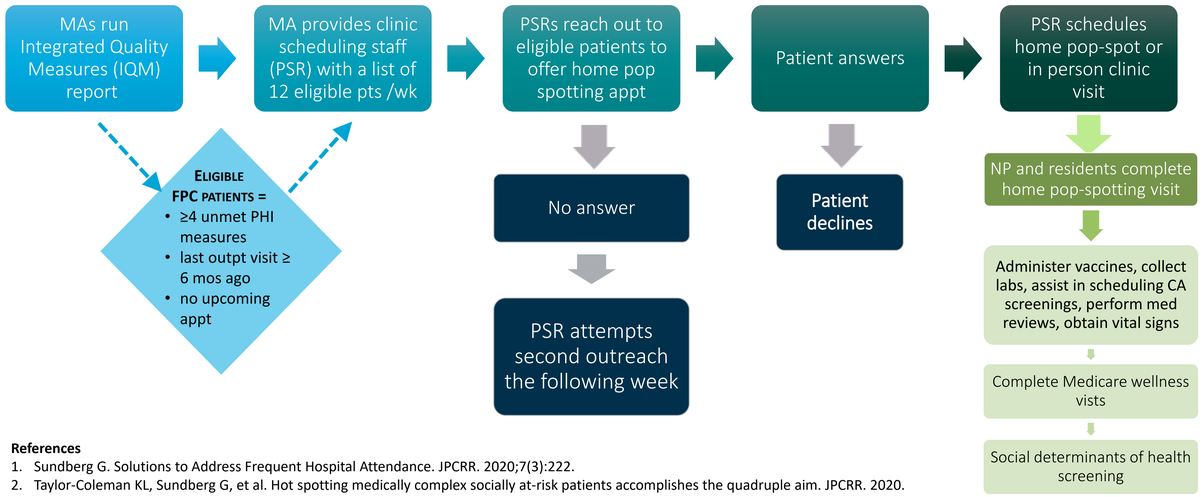
Aim | Purpose | Objectives

- To use Population Health Indicator (PHI) data to identify patients & schedule Pop Spot or in-person visit
- To create a pop spotting model that can replicated across any primary care setting

Project Alignment/Advance Organization Priorities

- Address health care needs for our patients most affected by various social determinants of health
- Emphasizes primary care services including preventative health and routine screenings

Methods: Interventions



References
1. Sundberg G. Solutions to Address Frequent Hospital Attendance. JPCRR. 2020;7(3):222.
2. Taylor-Coleman KL, Sundberg G, et al. Hot spotting medically complex socially at-risk patients accomplishes the quadruple aim. JPCRR. 2020.

Results: Preliminary

- Insufficient outreach attempts
  - Initial MA & clinical scheduling staff outreach attempts did not fill the pop spotting schedule
- Implemented social determinants of health (SDH) screening questionnaire has resulted in:
  - Deeper connections with our patients
  - Improved ability to identify their limitations
    - Primary barriers: Transportation and financial resource strain
- Consider comparing screening scores from in person FPC visits vs home pop-spotting visits
- Tracking longitudinal improvement in PHI quality improvement scores

Barriers – Strategies

- Inadequate clinic support staff for outreach efforts
  - **Strategy:** Hiring new lead RN and clinic supervisor to ensure adherence to workflows
- Recent EMR system change in quality measures interrupting data stratification and metrics
  - **Strategy**: Await Epic update
- Eligible patients are declining appointments or not responding to outreach attempts
  - **Strategy**: Make 2nd attempt to schedule the following week
- Time constraints during rooming process to complete control group screening
  - **Strategy:** Incorporate criteria and flow process into current rooming processes and staff training

Discussion

Critical Next Steps

- Reassess if revised methodology has resulted in increased pop spotting visits
- Further data analysis
- Create a final model that can be replicated in any primary care clinic environment & adapting it to our second Family Care Center (FCC) clinic

Areas Seeking Guidance

- How should we measure standards of success?
- How can we increase clinic stakeholder engagement?

E-consult to Social Work Support in the Internal Medicine Resident Continuity Clinic

Praveena Mylvaganam MD, Ellen Giddings MD, Michele LeBlanc LCSW, Victoria Kirnion LPN, Evan Dvorin MD, Kathy Jo Carstarphen MD

Introduction: Background & Context

- Louisiana is ranked 50th in most health metrics, with the New Orleans area being uniquely underserved and under-resourced. Ochsner Health (OH) is in a unique position to address this need due to its provision of care to 1.4 million patients in the Gulf South.
- Outpatient Case Management (OPCM) for OH provides support to all high-risk patients enrolled in Medicare-managed health plans, however the IM Resident PCP Clinic is the sole clinic at OH main campus that accepts Medicaid and Self-pay as the primary insurance payors. There is no social work (SW) support for this clinic at this time.

US News and World Report. *Overview of Louisiana*. Retrieved March 18, 2024, from https://www.usnews.com/news/best-states/louisiana

Aim/Purpose/Objectives

- Provide access to a SW in real-time during ambulatory IM Resident PCP visits to address and manage patients' Social Determinants of Health (SDOH)
- Provide IM residents and clinic staff with increased awareness of resources available for patients requiring assistance

Project Alignment/Advance Organization Priorities

- This project is in line with the 2020 "Healthy State Initiative", where OH announced investments to address health inequities and expand Louisiana's healthcare workforce and community-based health services.
- Many residency programs within the OH system are also looking to adopt some elements of the work done here so that patient's needs are addressed systemically.

Methods: Interventions

- SW inbox pool created by Epic team
- OPCM SW Supervisor attached herself to the SW inbox and monitored for messages daily
- Training for residents to use the pool performed by MD and LPN in the resident clinic
- Plan to have residents and clinic staff message pool as needed
- Any complex cases will remain in pool with continued discussion between residents, attendings and SW until acceptable outcome achieved by SW standards.
- Resident focus group to determine areas of need

Methods: Measures/Metrics

- Measures included volume of messages sent to the SW pool, content of the message sent, content of response to the message
- After completing a pool request it will be marked as "done" by the SW addressing messages
- Feedback would be provided by the patients via survey after identification of patient's case being sent to pool
- Workflow efficiency feedback from resident and SW

Results: Preliminary

- Residents in focus group survey estimated that approximately 30-40% of their patient roster required additional services that could not be provided by residents themselves and was at risk of being unaddressed
- SW identified 7 common areas for assistance:
  - ➢ Food and Housing;
  - ➢ Transportation; Check insurance for specific plan-supported assistance, otherwise NOLA resources

Results: Preliminary (Cont'd)

- SW Areas (Cont'd):
  - ➢ Psych services; Ochsner Behavioral Health
  - ➢ OTC Supplies; check insurance, compare with pharmacy
  - ➢ Employment; Assisting patients with application for state Vocational Rehabilitation
  - ➢ Medical Equipment; Check insurance, after which recommended DME company would get involved
- **No resident has reached out to SW pool since go-live date in November, 2023**

Barriers - Strategies

- Original project idea was E-consult service with OPCM, but this was not possible due to issues with billing for service, per system leadership
- Historically limited support provided to IM resident continuity clinic; there are no ongoing discussions of hiring a SW
- Residents are not always aware of resources available for the patients that are part of the clinic's roster, there is no training
- SW who agreed to managing pool is also the supervisor for all SW and CHWs throughout OH and has many responsibilities

Discussion

- A Plan-Study-Do-Act model is a better way to identify barriers and track case progress due to engagement issues
- Need effective resident training and engagement on utilizing the SW pool, including a resident champion
- SW should speak with resident clinic in person to establish ongoing feedback for pool use

Advancing HealthCare Equity (ACE): Creating Medical Neighborhoods for Vulnerable Populations

Joy Walton MD, Alexandra McKenna DO, Miriam Chan PharmD

Introduction: Background & Context

- OhioHealth Doctors Hospital (DH) has been identified as the leading care site within our healthcare system for highest vulnerability metrics, according to the Vizient Vulnerability Index (VVI). Highest VVI score for percentage patients:
  - 57% residing in a high vulnerability neighborhood
  - 49% on Medicaid or uninsured
  - 31% with a behavioral health diagnosis
  - 24% with uncontrolled diabetes
  - 20% with return to ED within 30 days
- DH leadership and Graduate Medical Education (GME) are collaborating to open the first OhioHealth Community Care at DH in July 2024 to provide access and reimagine how we deliver care to our underserved population. GME is uniquely positioned to train future physicians how to unconventionally and collaboratively address the proximal causes of poor health outcomes and how to significantly improve population health.

Aim/Purpose/Objectives

- Increase patient access to primary care services, particularly for those who are unassigned to a primary care provider (PCP).
- Understand the impact of social determinants of health (SDoH) among patients who present to Community Care by screening every patient at every visit. Offer face-to-face interactions with the Care Management (CM) team to begin addressing SDoH at the time of the visit.
- Create meaningful partnerships within our community to help better serve our patients.
- Reduce Emergency Department (ED) utilization for low acuity (ESI 4/5) by altering the behavior of patients to choose the appropriate level of care.

Project Alignment/Advance Organization Priorities

- System priorities: All hospital organizations must screen and demonstrate how they are addressing SDoH. Five priority domains have been identified: food insecurity, housing insecurity, transportation, financial strain, and intimate partner violence.
- OhioHealth is currently in the process of becoming a High Reliability Organization (HRO), which involves delivering the right patient the right care in the right setting at the right time. This project has received support and input from OhioHealth's Population Health system team, Care Management system team, DH FM & IM GME clinics, and DH & OPG operations teams.

Methods: Interventions

Since our clinic is not set to open until July 2024, we utilized the GME IM Transition of Care Clinic (TCC) as a pilot. The community served by TCC is the same target population as that of our future Community Care and will eventually converge into the same location.

Phase 1 (August 2023 – December 2023):

- Completion of screening: We created a Standard of Work (SOW) to screen every patient at every TCC visit utilizing the system's preset SDoH screening tool within EPIC CareConnect.
- Management of results: A signage system on the room door was created to ensure that the resident physician was aware of a positive SDoH result before the start of the visit.
- Training: Resident physicians framed their TCC visit with consideration of the positive SDoH and offered to link to CM services.

Phase 2 (January 2024 – June 2024):

Identified that our current SOW and screening tools may not be accurately or appropriately screening patients for SDoH and/or capturing the data. We determined that a re-investigation of our approach to SDoH was necessary.

- Internal interventions:
  - Focus groups to interview members of our CM team to better understand the process of screening for and addressing SDoH
  - Align with system CM to develop and implement a new SOW to capture SDoH data
- External interventions:
  - Interviewing community-based clinics to assess their processes and leverage potential strategies.
  - Focus group with community members to better understand the impact of scripting when screening for SDoH

Phase 3 (July 2024 – March 2025):

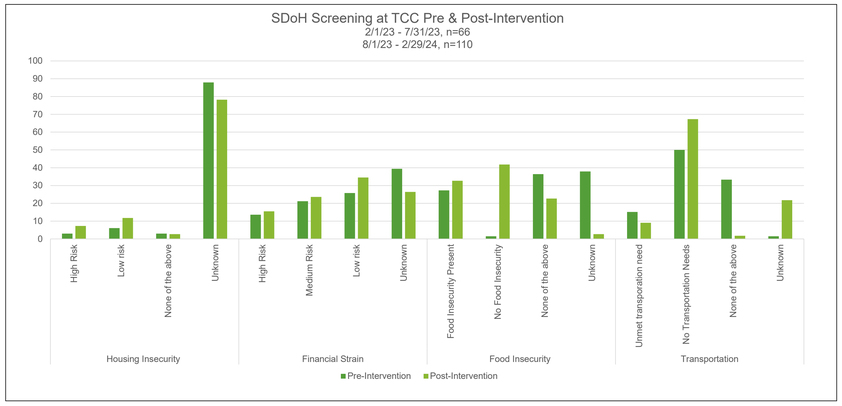
- Implement new screening methods within clinic opening July 2024.

Methods: Measures/Metrics

Understanding the impact of SDoH on our clinic patients:

- Screen 100% of patients for SDoH at every visit
- Document SDoH results 100% within the note and Problem List
- Refer (if accepted) to Care Management
- Track engagement with CM referral

Results: Preliminary



Barriers – Strategies

Current challenges:

- C-suite altered priorities for Community Care. ED group no longer aligned with priorities to decrease ESI 4/5s
- Accelerated need to find sustainable CM model

Discussion

- Preliminary results suggest that the system's current SDoH screening process may not necessarily lateralize well to our patients with high vulnerability. OhioHealth implemented this process using CMS resources based off predominately singular studies and pediatric data. We suspect that the way we ask the questions may not be giving us accurate results.
  - ASK: Suggestions for resources or models of care utilized at other sites to screen vulnerable patients. Looking for how language is utilized, patient and staff education, SDoH tools that offer improved engagement.
- We have learned from some of our successful community partners that to have a meaningful impact on a population, there are only enough resources to address case management for a small group. We expect that this will be a challenge to lateralize into our work since our healthcare system is large.
  - ASK: Suggestions on how to leverage the conversation within a large healthcare system to try something that centers our vulnerable population.
- Our Care Management team has tracked referrals and patient engagement with the team but has been unable to track resource engagement to close the referral.
  - ASK: How can a large healthcare system follow through to engage the community resource --- not measuring the rate of referral but the rate at which SDoHs are meaningfully addressed.

St. Luke's University Health Network Anderson Emergency Department Study on Social Determinants of Health (SDOH)

Kelsey Steele DO, Parampreet Kaur MD, Jennifer Irick MD,
Michael Salibi MD, Miri Son-Cha MD, Dustin Wells DO, Tracy Rendano MD

Introduction: Background & Context

Along with health equity and health literacy, SDOH has been identified by the CDC as a priority area of interest for Healthy People 2030. SDOH has been shown to have a greater influence on health than genetic factors or access to healthcare services.
Emergency departments see a disproportionate share of low-income and uninsured patients. Up to 25% of patients visiting emergency departments nationwide view them as their usual source of care due to 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, ultimately facilitating access to community-based resources offered through our network and the Lehigh Valley community.

Aim/Purpose/Objectives

•To increase the current SDOH screening to double the baseline by Dec 2024 in Anderson Campus ER and Easton Outpatient FM Clinic during routine health services.

•To increase the utilization of Findhelp.org to double the baseline by patients in need by Dec 2024 in Anderson Campus ER and Easton Outpatient FM Clinic during routine health services.

•To improve the process by increasing the number of patients receiving assistance from the care manager by 25% by decreasing wait time by Dec 2024 in Anderson Campus ER and Easton Outpatient FM Clinic during routine health services.

Methods: Interventions

The IRB-approved study project was separated into three Phases:
Phase 1: Residents distributed SDOH survey via QR code with questions and topics that affect our population- 8/14/23 to 1/18/24. The survey was offered in English and Spanish.
Phase 2: Papers containing a QR link to the survey were distributed to patients by ED registration for 4 weeks, from 1/20/24 to 2/17/24.
Phase 3: A poster board containing the **s**urvey QR code will be placed in the ED waiting room and restrooms for 4 weeks – dates TBD

*During each phase, patients were given the option to be contacted by case management if they requested health care assistance.
*Permission was granted from the ED Director and Director of ED Nursing before executing phases 2 and 3.

Project Alignment/Advance Organization Priorities

St. Luke's Mission is to care for the sick and injured regardless of their ability to pay, improve our communities' overall health, and to educate our healthcare professionals.

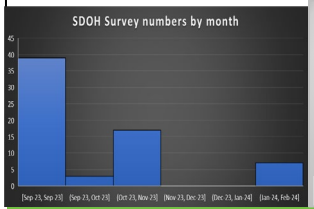
This project embodies our mission statement in identifying and quantifying the needs of our patients in order to provide better care.

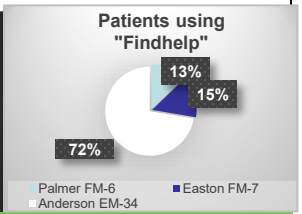
Methods: Measures/Metrics

Measures:
- Number of overall survey responses
- Number of patients utilizing resources via the Findhelp.org website
- Number of patients contacted by case management
- Number of patients who receive assistance from case management
- Wait time of the patient to receive care manager consultation.

Results: Preliminary

- Our survey contains questions regarding food and housing insecurity, as well as access to medical care, heating, and transportation. After the survey, patients can gain access to an internet link for local existing resources or can request to be contacted by case management.
- Data: from Phase 1 and 2





Barriers – Strategies

- Execution Error: Residents required frequent reminders to hand out QR codes and explain the survey to patients. This resulted in few data points during phase 1.
- The use of QR codes limited data collection to tech-savvy patients with access to cell phones.
- Communication Error: During phase 2, the ED registration team only provided surveys to those who expressed interest as opposed to handing them out to each registering patient.

Discussion

Critical next steps:
- We aim to improve the accessibility of our survey to patients who have limited access to smartphones or who do not have the technological literacy to utilize the QR code. Overall, we plan to identify and implement the concrete ways in which we can expand the reach of our survey to our ED patients.

Adverse Childhood Experiences, Chronic Disease, Intervention, and Accessibility

Franzes A. Liongson, Maria Martinez-Baladejo, Rina Bhalodi, Christopher McCarthy, Chris Gauthier, Brooke Lipton, Madeleine Kaiser, Christine Marchionni, Parampreet Kaur, and Jill Stoltzfus

Introduction: Background & Context

Adverse childhood experiences (ACEs) have considerable influence over factors such as family dynamics, community cohesion, and access to healthcare. Furthermore, they are often complicated by social and moral determinants of health (SMDH).

Growing research indicates that higher ACE burden correlates with increased risk of multiple chronic diseases[1] and maladaptive coping behaviors that further exacerbate chronic disease[2]. However, there is minimal research exploring the relationship between ACE burden and chronic disease severity, as well as the effectiveness of mindfulness interventions. This reality calls for additional exploration, given the potential for profound impact on the trajectory of SMDH policy changes at a macro and micro level.

Aim/Purpose/Objectives

To investigate the correlation between ACE survey scores and the severity of specific chronic diseases, while assessing if an 8-week mindfulness intervention impacts chronic disease markers (calculating changes to HbA1c, LDL, etc.) at St. Luke's University Health Network (SLUHN) by December 2024. The study also aims to enhance healthcare accessibility by incorporating Spanish-speaking components.

Project Alignment/Advance Organization Priorities

SLUHN is a nonprofit organization that has been providing accessible and affordable healthcare to the Lehigh Valley and surrounding areas for more than 150 years. SLUHN's mission and values include promoting health, wellness, and health lifestyles while simultaneously improving access to care for underserved and/or at-risk populations. These outcomes align with our objectives, which are fully supported by SLUHN's C-suite leadership.

Methods: Interventions

The target audience is English- or Spanish-speaking adult patients, with or without a history of ACEs, as well as chronic disease, and the capacity to consent. Our project is Institutional Review Board (IRB) approved. Materials and tools include 1) standardized REDCap ACE surveys with additional demographic questions; 2) EPIC electronic health record system, including the "slicer dicer" program tailored for data collection; 3) REDCap platform for secure data storage; 4) 8-week virtual mindfulness series led by a certified mindfulness coach in weekly 1.5 hour sessions; 5) REDCap pre- and post-mindfulness survey.

Patients are recruited from SLUHN's Sacred Heart Hospital and SLUHN's Behavioral Health Outpatient Clinic, with pending expansion into SLUHN Star Wellness clinics. We introduce the study, then obtain consent and administer the ACE survey via REDCap or paper, based on participant choice. Recruited patients are then contacted via their preferred mode of communication and enrolled in the virtual mindfulness series.

Modifications to the project include addition of pre- and post-intervention surveys to assess accessibility, confidence, and satisfaction using a Likert scale, as well as expansion of patient recruitment to additional clinics

Methods: Measures/Metrics

Measures/metrics include ACE survey scores; biomarkers of chronic disease, such as vital signs and lab values (lipid panel, CMP, CBC, HgA1C, TSH, FEV1); and pre- and post-mindfulness intervention surveys.

References

Results: Preliminary

20 participants completed the initial survey, 3 opted out of mindfulness intervention, and 0 have signed up for mindfulness intervention.

Barriers – Strategies

Current barriers include screening for social determinants of health (SDOH)-- namely inconsistent data collection, which we attempt to mitigate by including demographic questions in the ACE survey. Proposed solutions include discussing the importance of documenting SDOH and providing resident education.

Another barrier is lack of service availability, as SLUHN does not have a Spanish-speaking mindfulness coach. Recruitment for this position is ongoing because hiring someone is preferable to utilizing a medical interpreter, which takes time away from the intervention itself.

Other challenges include patient recruitment and retention. As one solution, dividing the study team into subgroups with more focused objectives has resulted in a 200% increase in recruitment in 2 months, while other team subgroups focus on expansion into additional patient clinics and retention. Another solution is developing a plan to increase patients' participation and subsequent ownership as stakeholders so they can assist with both recruitment and retention efforts.

Discussion

Critical next steps include 1) further develop team subgroups to tackle challenges more effectively; 2) continue involving C-suite leaders to address barriers to accessibility; 3) develop a plan to increase patient and community "ownership" of our project as active stakeholders; 4) consider mental health branch to project.

Addressing Emergency Department Left without Being Seen

UnityPoint Health Des Moines

AiAMC Alliance of Independent Academic Medical Centers

National Initiative

Nicholas Kluesner, Clint Hawthorne, John Yost, Rory King, Michael Olivier, Hayden Smith, Jill Heilskov, Jonathan Hurdelbrink, Kerry Hagedorn, Chanteau Ayers

Background

Patients that leave the Emergency Department before being seen by a provider represent an area of medical concern. Since it is not clear the reasoning for their departure or whether medical care may still be needed.

Left without being (LWBS) seen also represents an area of potential lost revenue for an institution.

Aim

To evaluate the impact of increased nurse triage staffing in the Emergency Department on LWBS rate.

Project Alignment/Advance Organization Priorities

The presented project aligns with our institutional mission:

"Improve the health of the people

and communities we serve."

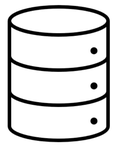
In addition, the general topic has been vocalized as a concern by hospital administration and the C-suite. In particular, addressing Emergency Department bottle necks and overall hospital throughput as well as our census.

Our study team hopes that understanding the impact of additional and earlier patient engagement in the Emergency Department may assist in improving our LWBS rate and potential patient bounce back.

Methods

Initial Project Steps:

- Establish a multidisciplinary team:
  - Medical Education
  - Emergency Department
  - Family Medicine
- Acquire Institutional Review Board approval
- Establish an inventory of available data:



* Electronic Medical Records
* Orders in Emergency Department
* Staffing logs

Purposes:

- To understanding impact of staffing change
- To potentially decrease LWBS rate

Measures/Metrics

Intervention:

In August 2023, we increased the Emergency Department nurse triage staffing by 2.8 FTEs at the reviewed hospital.

Controls:

- Historic data from reviewed hospital w/ intervention
- Historic and contemporaneous data from two community hospitals in the same greater Midwestern city and health system.

Preliminary Results

Data ascertained for:

- Nurse staffing sheets
- All Emergency Department encounters for three hospitals across previous year (and going forward)
- All event/orders in Emergency Department including those for patients prior to rooming

Barriers – Strategies

Barriers:

Large datasets (100Ks patient encounters and millions of orders)

Ability to link all data elements

Next Critical Steps:

Data cleaning, validation, and analytics

Discussion

This project requires assistance from Clinical Quality for complex data schemas and substantial time related to data cleaning and organizing.

Control facilities may not be completely exchangeable in patient populations and processes.

Even with a reduction in LWBS – those patient that still leave will continue to represent an ongoing concern.

UnityPoint Health
Des Moines

Evaluation of Workplace Violence in the Healthcare Setting

AiAMC
Alliance of Independent Academic Medical Centers

National Initiative

John Yost, Gabriel Conley, Tyler Schwiesow, Megan Simpson, Chanteau Ayers,
Alexis Roberts, Mark DeRee, Jonathan Hurdelbrink, Hayden Smith

Background

Workplace violence can be a common vocational concern, especially within the healthcare sector.

As a part of our National Initiative project, we plan to document and evaluate violence and associated mitigation efforts at our local affiliate hospitals:

- Iowa Methodist Medical Center (Level I Trauma Center)
- Blank Children's Hospital (Level II Trauma Center)
- Iowa Lutheran Hospital (Level IV trauma center)
- Methodist West Hospital (Level IV trauma center)

Aim

To better understand workplace violence and available data within our organization

Project Alignment/Advance Organization Priorities

Our project aligns with two key areas within our organization – both via improving health through safety.

Firstly, our organization's mission is to, "improve the health of the people and communities we serve."

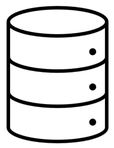
Secondly, our organization has been dealing with staffing and turnover issues over the past few years.

A better understanding of our data and efforts to address workplace violence may function to improve the health and retention of employees.

Methods

Initial Project Steps:

- Establish a multidisciplinary team:
  - Medical Education
  - Behavioral health
  - Public Safety
  - Employee health
- Acquire Institutional Review Board approval
- Establish an inventory of available/associated data:



*Workers' compensation claims
*Patient behavioral flags
*Public safety calls and event log
*Any additional sources

Purposes:

- To understand the quality/completeness of existing data
- To allow decisions to be evidence based

Measures/Metrics

There is currently no direct patient engagement planned at this time.

We do plan to review 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 and conduct descriptive and inferential statistics. Lastly, we plan to report this information back to the institution and work to explore/develop possible data-lead interventions.

Preliminary Results

We have reviewed the last 8-years of workers' compensation claims for the four hospitals.
(See research poster)

We are now reviewing all newly posted behavioral flags placed in medical records over the past 2-years.

2022 – 280 new flags
2023 – 306 new flags
2024 – 32 new flags (pending)

After committee review ~24% of flags were removed and letters sent to the remaining patients.

Barriers – Strategies

Barriers:

Trying to determine scope for such a complex topic.

Next Critical Steps:

Continue with data analyses. We will also have a paid Research Fellow (medical student) for 12-weeks starting this summer. We hope this additional team member, who has an interest in the project area can serve as a daily catalyst for making progress.

Discussion

Input Needed/Comment:

Defining the scope of project is a continued area of concern along with how to make changes to such a large and multi-faceted/heterogeneous issue.

AIAMC NATIONAL INITIATIVE IX

Meeting Two Storyboard Presentations -Cohort Breakout Sessions

Cohort Four (8 projects)
Facilitator: Victor Kolade, MD
NAC Member: Ellen Sullivan, MS, MSJ, CAE

1. Aurora Health Care (Four projects in this initiative. One project in this group)
2. Guthrie Robert Packer (Three projects in this initiative)
3. Guthrie Robert Packer
4. Guthrie Robert Packer
5. St. Luke's (Five projects in this initiative. Three projects in this group)
6. St. Luke's
7. St. Luke's
8. Virginia Mason

Aurora Health Care®
Internal Medicine Residency

STOP-AMA
A Quality Improvement Project To Reduce AMA Discharges Through Early Recognition and Intervention

Sean Fabry, MD, MBA; David Hamel, MD
Aurora Health Care | Milwaukee, Wisconsin

AiAMC Alliance of Independent Academic Medical Centers
National Initiative

NI IX Meeting #2
Tucson AZ |April 2024

Introduction | Background & Context

- **Discharge Against Medical Advice (DAMA)** is a recurring challenge in the hospital setting[1-2]
  - National prevalence of ~1–2% of all hospital admissions
  - Negative impacts to patients' health outcomes and healthcare systems
- Nationwide readmissions after DAMA costs = $822 million in 2014[1]
  - $1,082 million in 2024
- Readmission risk 12x higher in patients who left AMA compared to non-AMA[3]
  - Retrospective matched cohort study of 656 patients
  - AMA group had an increased 12-month all-cause mortality (6.7% vs. 2.4%, p = 0.01)

Aim | Purpose | Objectives

- To reduce AMA discharges on Internal Medicine Teaching Service (IMTS) at Aurora Sinai Medical Center (ASMC) through provider education, early identification of AMA risk through screening, and implementation of the STOP-AMA toolkit in patients who screen positive

Project Alignment/Advance Organization Priorities

- Project can positively improve all quintuple aim components
- Key Performance Indicators (KPI) are continuously monitored by all hospital CMO's including: Patient experience data and 30-day readmission rates

Methods: Interventions

Literature Review

- Identified DAMA causes and characteristics of patients at higher risk for DAMA
  - Findings used to develop a screening tool to identify patients at higher risk for DAMA
- Review identified best practices in preventing DAMA[3]
  - Informed creation of the STOP-AMA toolkit with interventions
    - Residents screen every patient >18 years old on admission to ASMC IMTS beginning March 2024
    - Patients who screen positive for DAMA risk (defined by a "yes" to any of the screening questions) will be evaluated for the use of interventions laid out in the STOP-AMA toolkit

Metrics:

- Monthly DAMA rates on IMTS compared to non-teaching hospitalist service at ASMC (control group)

Selected References
1. Foster K, et al. The risk factors, consequences, and interventions of discharge against medical advice - A narrative review. *Am J Med Sci*. 2023;366(1):16-21. doi:10.1016/j.amjms.2023.04.007;
2. Holmes EG, et al. Against Medical Advice Discharge: A Narrative Review and Recommendations for a Systematic Approach. Am J Med. 2021;134(6):721-726. doi:10.1016/j.amjmed.2020.12.027
3. Albayati A, et al. Why Do Patients Leave against Medical Advice? Reasons, Consequences, Prevention, and Interventions. Healthcare (Basel). 2021;9(2):111. Published 2021 Jan 21. doi:10.3390/healthcare9020111;

Results: Preliminary

Screening Questionnaire (Y/N)

- Is the patient experiencing homelessness?
- Age < 50?
- Substance use d/o?
- Mental illness?
- Insurance: Medicaid, Exchange, or Self-pay?
- Prior AMA discharge?

Interventions: STOP – AMA Toolkit

- **S**ocial work consult within 24 hrs of admission
- **T**reat
  - Opioid withdrawal w/ COWS protocol
  - Alcohol withdrawal w/ CIWA protocol
  - Nicotine withdrawal w/ nicotine replacement
  - Insomnia, anxiety, and pain, as indicated
- **O**ther services: sitter, volunteer, chaplain
- **P**sych consult early

- **1-year pre-intervention period** (March 2023 – Feb 2024) 3.9% of pts on ASMC IMTS discharged AMA
- Patients who LEFT AMA were:
  - 2.9 times MORE likely to have Medicaid primary insurance
  - 2.5 times MORE likely to have Exchange insurance
  - 1.6 times MORE likely to be uninsured
  - 2.7 times LESS likely to have Medicare primary insurance
  - 2.6 times MORE likely to be < 50 years old

Barriers – Strategies

- **Barrier #1**: Difficulty identifying homelessness in Epic data
  - **Strategy**: Ongoing training on SlicerDicer and reaching out to local experts
- **Barrier #2**: Will IMTS providers be less likely to code a discharge as AMA w/o changing other practice?
  - **Strategy**: Work to clearly define AMA; Encourage providers to provide follow up care despite DAMA
- **Barrier #3**: Low uptake/rate of screening and interventions
  - **Strategy:** Work to track and gamify screening and interventions (sticker chart w/ rewards)

Discussion

Critical Next Steps

- Introduction/training for residents, faculty, staff on ASMC IMTS
- Connect with Epic data analysts to ensure we can track screening through dotphrase
- Develop competition to reward screening and interventions

Areas Seeking Guidance

- Recommend other interventions?
- Recommend other screening questions?

GUTHRIE GIRLS ON THE RUN

Sophie Roe, Dianna Quijano, Lakshmi Ilango, Arpitha Pamula, Victor Kolade, M.D.

Introduction: Background & Context

- Sayre is a rural, low-income community in Northeastern PA; 68% of children in school district eligible for free or reduced lunch[1]
- According to the Robert Packer Hospital (RPH)'s 2019 Community Health Needs Assessment, obesity and poor self-reported mental health are two of the three most prevalent chronic conditions across the primary service area[2]
- Resources to address these issues are slim -- Guthrie Weight Loss Center targets qualifying obese adults however Guthrie presently has limited outpatient psychiatric services
- There is a near complete lack of community programs aiming to prevent obesity and poor mental health via an upstream, preventive approach focused on youth
- Poor self-esteem, poor mental health, and a lack of exercise habits in childhood are top predictors of adult obesity [3]
- Team-based structured exercise programs have been shown to improve self-esteem, resilience, and healthy habits among youth; interventions that teach life skills offer additional value [4-5]
- Girls on the Run (GOTR) is a national organization with an after-school program for girls in 3rd-5th grade that uses running as a platform to teach life skills, promote healthy behaviors, and empower girls to unlock their full potential, boldly pursuing their dreams[6]
- Feedback from a team of physicians, nutritionists, marketing representatives, and community members affirmed the need for a Guthrie GOTR chapter

Aim

To create a Girls on the Run (GOTR) chapter in Sayre PA by the spring of 2024 (secondary aim = to sustain the chapter through 2025)

Project-Institution Alignment

- **This program advances RPH priorities by:**
  - Offering upstream intervention to address the most prevalent chronic conditions in the community
  - Partnering with Guthrie Engage – a systemwide community engagement platform - for outreach via local and social media

Methods: Interventions

Interventions Facilitated by Partnerships:

- Partnership with GOTR Mid State PA provided legitimacy, training, and curriculum
- Strategic Planning and Marketing/Guthrie Engage ran an advertising campaign on social media
- Robert Packer Hospital Auxiliary provided funding that nearly halved the registration cost and offered local 5k option
- The elementary school in the Sayre Area School District provided the location for afterschool practices

Audience:

- Primary: Sayre community members, particularly adults with daughters in 3rd-5th grade
- Secondary: 3rd-5th grade girls

Materials/Tools adopted/adapted/developed:

- **Developed:** Guthrie GOTR flyer, social media content
- **Used/Adopted GOTR resources for:** advertising, curriculum, teaching strategy, parent communication

Methods: Measures/Metrics

- Number of registrants; number of trained coaches
- Practice/lesson attendance
- Feedback from participants : post-season participant survey will assess program satisfaction, likelihood of participating again, and recommendations for improvement
- Engagement from Guthrie patient & provider community: social media posts, clicks, likes, etc.
- Sustainability – are resources (human, financial, and institutional sufficient at Guthrie to support a second season next fall or spring?

Results: Preliminary

- 3 GOTR coaches recruited and trained, 1 assistant coach recruited
- 10 girls signed up
- ~70% attendance at initial Parent meeting
- Positive anecdotal responses from girls and parents

Barriers & Strategies

- **Barrier:** High cost of program ($175/head) in a low-income community and additional cost of $30 each for the capstone 5k event
  - **Strategy:** Secured sponsorship from the RPH Auxiliary for both the afterschool program and the 5k
- **Challenge:** The ceiling of 15 participants was not reached, though the minimum of 7 was exceeded
  - **Strategy**: depends on results of participant survey (we will ask a question about how they heard about the program)

Discussion

- This project applies core principles of preventive medicine, public health, and community engagement
- **Future aspiration:** research study to measure if participation in Guthrie GOTR can yield significant increases in traits the program emphasizes: self-efficacy, self-esteem, resilience, etc.
- Is Guthrie GOTR a "scalable" model? Could it be replicated by other medical students via hospital partnership, particularly in rural communities?

References

1. https://datacenter.aecf.org/data/line/2720-school-lunch--students-eligible-for-free-or-reduced-price-lunch?#10/5849,5971/false/2547,1771/asc/any/10325
2. Community Health Needs Assessment for Robert Packer Hospital, 2019. https://www.guthrie.org/about-us/community-benefits/community-health-needs-assessment
3. Pietiläinen KH, Kaprio J, Borg P, Plasqui G, Yki-Järvinen H, Kujala UM, Rose RJ, Westerterp KR, Rissanen A. Physical inactivity and obesity: a vicious circle. Obesity (Silver Spring). 2008 Feb;16(2):409-14. doi: 10.1038/oby.2007.72.
4. Pascoe M, Bailey AP, Craike M, et al. Physical activity and exercise in youth mental health promotion: a scoping review. BMJ Open Sport Exerc Med. 2020;6(1):e000677. doi:10.1136/bmjsem-2019-000677
5. Andermo S, Hallgren M, Nguyen TTD, et al. School-related physical activity interventions and mental health among children: a systematic review and meta-analysis. Sports Med - Open. 2020;6(1):25. doi:10.1186/s40798-020-00254-x
6. https://www.girlsontherun.org/what-we-do/3rd-5th-grade-program/

From Screen to Reality- - Translating the In-Patient Gathered Social Determinants of Health Information to the Post-Discharge Care of our patient

Ayesha Anwar, Imran Amir, Daebin Im, Khawaja Yusuf f Hassan, Mahathi Kunduru, Sharadha Bhattari

Introduction: Background & Context

- Social determinants of Health (SDOH) is defined as the factors which impact health outcomes and comprises of conditions in which people are born, grow, work, live and age.
- Our hospital serves a rural population over a large geographic area, where the unemployment rate is 5.5% and average household income is only $ 71645.
- Early identification and intervention for various SDOHs, particularly in in-patient settings where patients spent more time and less hesitant to discuss with team, is essential to impart knowledge to physicians regarding the holistic review of the population being served and providing biopsychosocial care to patients to improve health outcomes in a community

Aim/Purpose/Objectives

- Increase the tracking of SDOH screen in resident-driven services (General Medical Service, hospitalist and in-patient cardiology)
- System-based improvement for communication, active involvement and updates for nursing and SW in the process of SDOH screening and intervention
- Performing post-hospitalization satisfaction survey by calling the patients

Project Alignment/Advance Organization Priorities

- Our mission is to work with the community we serve to attain social justice and equity. We are doing this by understanding our community's social and economic needs
- Our project aims to improve the screening rate of social determinants of health factors and provide intervention through social worker support to help overcome the issues faced by patients during inpatient admission

Methods: Interventions/Changes

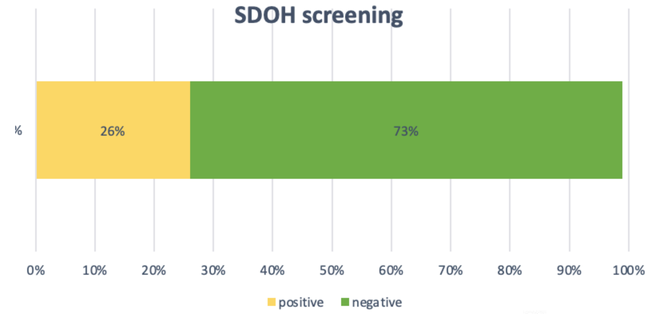
•Randomized sample of patients in resident run inpatient services- GMS, hospitalist, Cardiology will be selected and screening SDOH questionnaire will be provided.

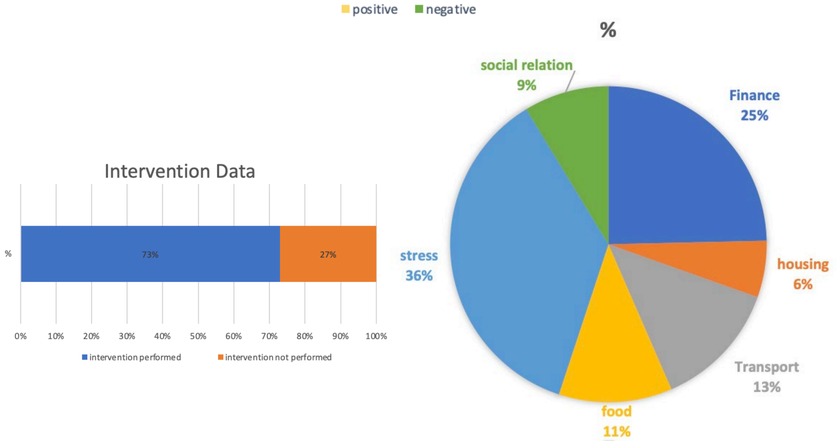
•Patients who screen positive will be identified and case manager along with social worker will be involved according to the patient needs.

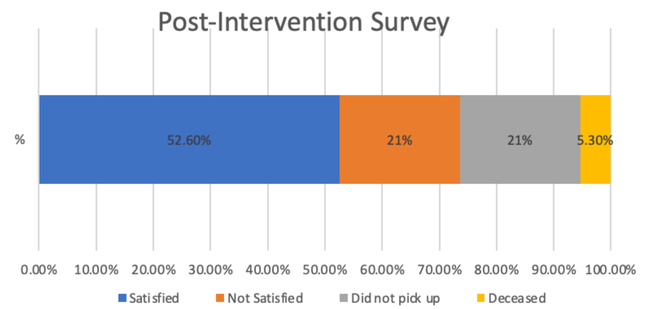
•Outcomes will be measured by patient satisfaction survey (primary outcome) and hospital visit and readmission rate (secondary outcome).

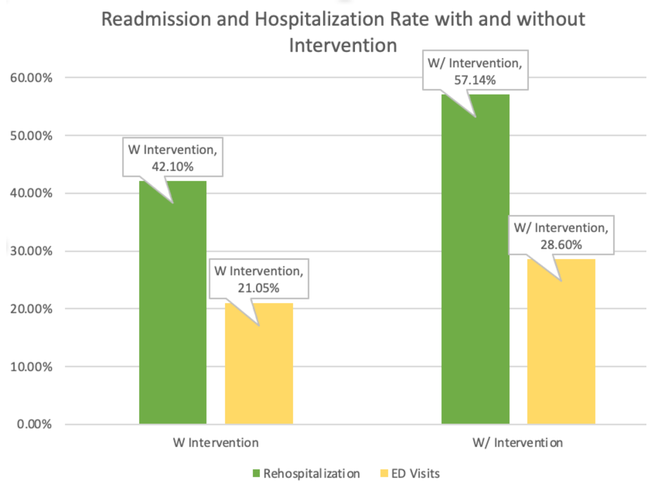
Methods: Measures/Metrics

- Percentage of patients screened during the period specified
- Percentage of patients who screened positive and for whom intervention was performed through social worker involvement
- Percentage of patients who were satisfied with the intervention
- Hospital Readmission and ED visit rate in patients whom intervention was done as compared to those in whom no intervention was performed









Results: Preliminary

- Around 100 patients admitted in inpatient resident services such as GMS, hospitalist and cardiologist have been screened
- Out of 100, 16 screened positive and 73% screened negative. Out of 26% who screened positive, intervention was performed in 73%
- Among patients who screened positive, major social determinant of health was psychological health with stress comprising 36% of positive responses and finances comprising 25%. Least issue was found to be housing.
- Post-intervention, showed patient satisfaction was observed in 52.6%, with 21% of patients did not pick up phone and 5.3% passed away
- Rehospitalization rate was 42.1% in patients in whom intervention was performed as compared to 57% in whom no intervention was done with a p-value of 0.23. For ED visits, rate in those with intervention was 21% as compared to 28.6% in no intervention group, p-value 0.336

Barriers – Strategies

•**Provider-related**: Acute medical issue for which patient is hospitalized takes priority. Lack of awareness and insight into the prevalence and importance of the SDOH and the hesitation on the part of the physician to discuss personal, non-medical issues. Time constraints were also an important factor.

•**Patient-related**: Hesitation and fear of judgment to discuss the social issues, the belief that the hospital setting is just for medical care, lack of awareness of the available resources in the hospital.

•**System issues:** SDOH data is obtained and addressed in a fragmented manner, not in a structured way.

•**Environment-related**: Patients are lost to follow-up after the hospital discharge due to social factors themselves, such as lack of transportation, financial constraints, and lack of time. No mention of SDOH screening on the discharge summary, which results in it being missed during routine TCM visits in the IM clinic.

Discussion

In the Inpatient Prospective Payment system 2023 final rule, Center for Medicaid and Medicare Services has mandated reporting of SDOH inpatient screening for the hospitals reporting to inpatient quality reporting by 2024.

It comprises performing screening of patients on five domains and can be performed by hospitals using self-selected screening tools with no definite set of values recommended by the committee.

We build a screening tool, collected the data with intervention performed through social worker consultation followed by patient satisfaction survey.

The results of our SDOH screening carried out in a rural community will show the significance of addressing the factors in five domains in improving the satisfaction and reducing rate of hospitalization.

It will further help us in determining the impacts of addressing these factors on physical health and may highlight implementing biopsychosocial approach model for managing inpatient population in hospitals

Breaking Barriers, Building Health: SDOH Screening for Equitable Medicine

Rashmi Subramani MD, Sundas Zahra MD, Nimmi Ravindranath MD, Asnia Kauser DO, Bijay Phuyal MD, Lavanya Dondapati MD, John Pamula, MD, FACP; Victor Kolade, MD, MS, FACP

Introduction: Background & Context

- Social determinants of health (SDOH), as defined by the World Health Organization, refer to the conditions in which individuals are born, grow, live, work, and age.
- The varying levels of income and education have immediate and complex effects on health, with studies showing a substantial discrepancy in life expectancy between the lowest and highest income brackets.
- They encompass five key domains recognized by the US Department of Health: economic stability, education access and quality, social and community context, health access and quality, and neighborhoods and built environment.
- Economic stability includes factors such as employment, income, cost of living, poverty, food security, and housing stability.
- Health access and quality involve access to healthcare, insurance coverage, health literacy, primary care availability, and preventive screenings

Aim/Purpose/Objectives

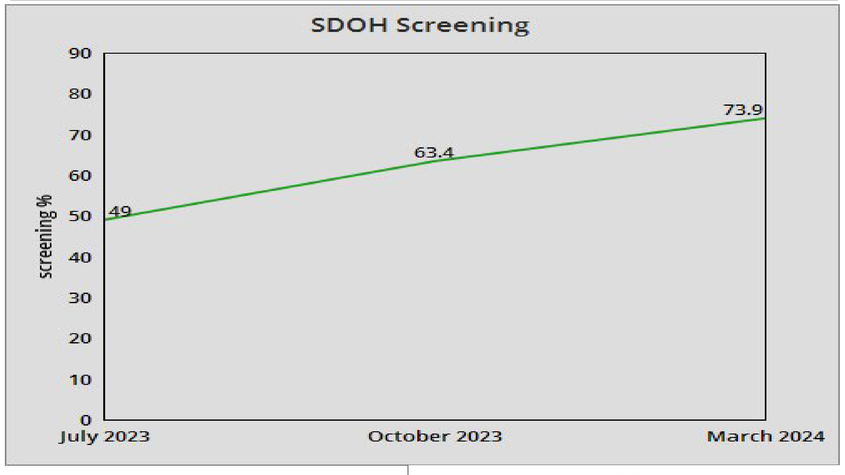
- Increase SDOH (Social Determinants of Health) screen-positive by 5% from the baseline in August 2023.
- Improve structured referrals to the care coordinator by 5% from the baseline in August 2023.
- Track the number of referred patients who are integrated into Unite US.
- Identify the percentage of patients who received resources through Unite US.

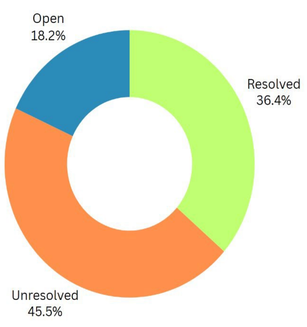
Project Alignment/Advance Organization Priorities

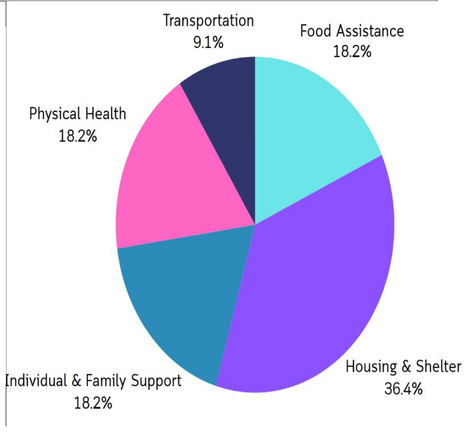
- Our mission is to work with the community we serve to attain social justice and equity. We are doing this by understanding our community's social and economic needs
- Our project aims to improve the screening rate of social determinants of health factors and provide intervention through social worker support to help overcome the issues faced by patients during inpatient admission

Methods: Interventions

- Providers were educated on the importance of SDOH screening through a workshop, and peer driven education for the care gaps closure
- Nursing staff were involved in helping with screening during rooming process.
- Staff were reminded of SDOH screening daily during the morning huddle.
- Information regarding resources were made easily available to providers
- Data of SDOH screening was collected from EPIC monthly with focus being given to housing, transportation, finance and food insecurity.







Methods: Measures/Metrics

- To assess the outcomes of referrals placed to the care coordinator to provide screen positive patients with resources.
- EPIC specialist will send data biweekly.
- Meetings with care coordinator to go over the outcomes of referrals placed.
- Screen positive referrals to clinical care coordinator as well as percentage of patients who had resources provided to them

Results: Preliminary

- Total number of patients screened-= 1153
- Total percentage screened = 73.9%
- Positive = 10%
  - 11 referrals were sent from IM clinic to Unite US
  - These were for different components of SDOH
  - The unresolved cases were due to inability to reach the client by Unite Us services

Barriers – Strategies

➢**Physician related:** communication barrier and time constraints

➢**Patient related:** stigma, mistrust and low medical literacy

➢**Policy related:** Discrepancies among providers in initiating screenings, and lack of reminders

➢**Environmental Challenges:** poor follow-up and scheduling challenges

Discussion

- Screening for SDOH is important as it indirectly impacts chronic medical conditions.
- After integrating SODH screening into EPIC we were able to identify patients with SDOH deficiency and provide resources.
- Ensuring resources for SDOH deficiencies ensures improvement in population health.
- As PCPs, we are in a unique position of access and trust, to be able to address these issues and provide information to community resources that may help better the situation.

FQHC-LA Screening patients for SDoH through an external community organization database: Focusing on Communities Needs and Insecurities

Alycia Walty, M.D.; Dania Mosquera, M.S.; Karen Hepworth, BSN, RN; James P. Orlando, Ed.D; Rajika Reed, PhD; Elizabeth Adams, MPH; Holly Stankewicz, DO.; Kelly Copeland, M.D.; Rehab Tabchi, DO. ;Julie Wentzel, MSW, LSW; Sarah Jane Muder, DO.; Alexandra Smith, M.D.; Ashley Schultz, M.D.; Tuan Vo, M.D.; Ajibola Oluwatomi, M.D.

NI IX Meeting #2: April 5-6, 2024

Tucson, Arizona

Introduction: Background & Context

Star Community Health, is an FQHC-LA committed to streamlining low-cost resources and social services for patients in the Lehigh Valley in Northeast Pennsylvania.

SDoH screening started in 2021 when several tools were combined to build a list of questions. Reducing the number of questions to three in 2022 helped us focus on financial issues, food insecurity and transportation needs. In late 2022 we introduced FindHelp, a national organization of social service databases. It allows clinicians to connect vulnerable patients to free or low-cost resources from community-based organizations. In partnering with FindHelp and the SLUHN Care Management team, we found a way to help our patients when insecurity was identified. By the end of 2022, almost 80% of our patients had been screened.

To quantify the impact, we further investigated the FindHelp data in 2023. Not only did it reveal an increased number of searches by patients, but it narrowed these searches by zip code, and point to the number of inquiries and distinct users. We can share this information with community partners to ensure the services being searched are available in the zip codes identified.

Aim/Purpose/Objectives

Primary goal: Appropriately quantify the volume of patients receiving support from internal and external sources for SDoH challenges.

Study Aim:

Aim #1: Increase access to resources for the underserved surrounding population.

Aim #2: Appropriately quantify the impact of case management interventions.

Aim #3: Assess the impact of SDoH screening and interventions on the patient population.

Smart goals

Increase access to FindHelp for patients with positive SDoH screenings with targeted marketing by 5% by December 31, 2024.

Increase completion of referrals to community-based organizations for patients with positive SDoH screenings to by 5% by December 31, 2024

Data from the emergency department referrals and the providers offices to compare which has a greater FH usage between 1/1/24- 12/31/24 .

Project Alignment/Advance Organization Priorities

Our vision is to align our services and care delivery with patient's native language, cultural, and community needs by supporting, growing, and nourishing our patients' ability to independently research resources and services available to them via FindHelp.com.

Our mission is to empower our patients with access to services and care and to limit roadblocks that otherwise might have been prohibiting access to federal, state, and local services. In collaboration with providers and practice staff, the community will receive the resources needed to address their social determinants of health.

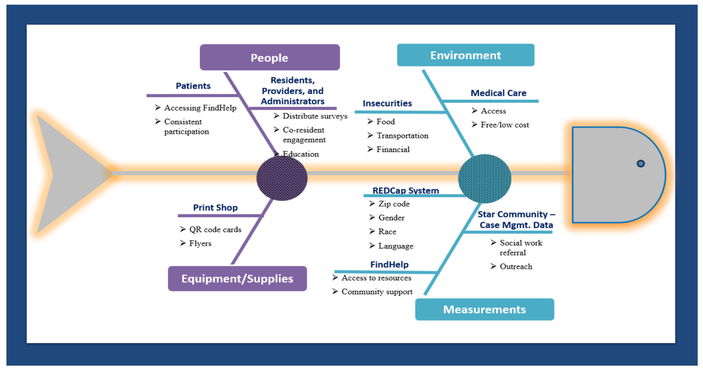
Star Community Health and St. Luke's University Health Network, along with senior leadership, have committed to investing in this project by incorporating different departments to assist with the various components and needs.

Our commitment is to increase SDoH screening across our clinics, track utilization of resources by demographics and steward resources to demographics with the most pressing SDoH need. These efforts align with both organization's priorities to provide services to the local community.

Methods: Interventions

A quantitative and qualitative study designed to identify the demographic of patients in our community requiring social service resources.

We plan to collect data through surveys distributed to patients seen at 5 locations, receiving emergency, pediatric, family medicine, or women's health services.



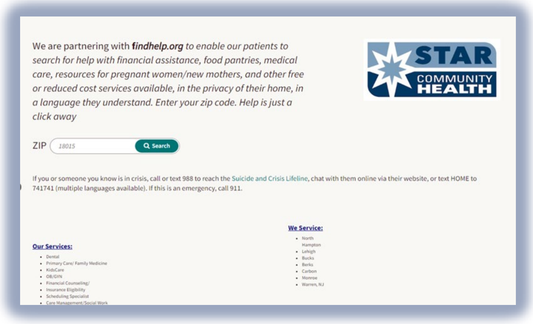
***Our initiative has received IRB approval**

Methods: Measures/Metrics

- **Research Electronic Data Capture (REDCap) survey: (Multilingual Module: English, Spanish, and Vietnamese)** utilized at every patient encounter. Data will be gathered via the Research Electronic Data Capture system (REDCap) to identify the minority and underserved populations and if language is a barrier to further resources.

REDCap QR Code

- Monitoring responses to survey on a weekly basis
- Gathering data from FindHelp
- Identifying resources individuals are accessing



•**References: 1.** If you build it, they may not come: Understanding factors influencing use of a community resource referral technology. Health Services Research, 59(S1). https://doi.org/10.1111/1475-6773.14234

•**2.** Community Health Partners in Unexpected Places. Mayo Clinic Proceedings, 98(12), 1833–1841. https://doi.org/10.1016/j.mayocp.2023.07.031

•**3.** Differentials and predictors of food insecurity among Federally Qualified Health Center target populations in Philadelphia: a cross-sectional study. BMC Public Health, 23(1). https://doi.org/10.1186/s12889-023-16208-3

•**4.** Factors Associated with Patients' Connection to Referred Social Needs Resources at a Federally Qualified Health Center. Journal of Primary Care & Community Health, 12, 215013272110243. https://doi.org/10.1177/21501327211024390

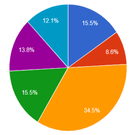
Results: Preliminary

Number of results returned: 58

How difficult is it for you to pay for the very basics like food, housing, medical care, and heating? (flo_rel_str) Refresh Plot | View as Pie Chart

Total Count (N)	Missing*	Unique
58	0 (0.0%)	6

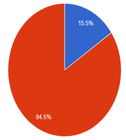
Counts/frequency: Very difficult (9, 15.5%), Difficult (5, 8.6%), Somewhat difficult (20, 34.5%), Not very difficult (9, 15.5%), Not difficult at all (8, 13.8%), Prefer not to answer (7, 12.1%)



In the past 12 months, has lack of transportation kept you from medical appointments or from getting medication? (trans_needs) Refresh Plot | View as Pie Chart

Total Count (N)	Missing*	Unique
58	0 (0.0%)	2

Counts/frequency: Yes (9, 15.5%), No (49, 84.5%), Prefer not to answer (0, 0.0%)



Within the past 12 months, have you been concerned that food would run out before you receive money to purchase more food? (food_ins) Refresh Plot | View as Pie Chart

Total Count (N)	Missing*	Unique
58	0 (0.0%)	6

Counts/frequency: Very unconcerned (13, 22.4%), unconcerned (10, 17.2%), Neutral (15, 25.9%), Concerned (8, 13.8%), Very concerned (8, 13.8%), Prefer not to answer (4, 6.9%)

Barriers – Strategies

Barriers:

- Epic data and FindHelp do not communicate. Demographic and insecurities could not be established and compared for resources and support. We are utilizing REDCap as data mgmt. resource.
- SDoH screening approaches are inconsistent and not visible to partner organizations
- High partner staff turnover and lack of training on screening.
- Screening is being done in the offices during rooming. Asking patients to do it again for the research project may decrease the return rate.
- Distinguishing research data from patients not in the study using the same website to do searches.

Solutions:

- REDCap system for data gathering.
- Standardize SDoH domains in screening tools.
- Only give QR code to patients that you did not screen that day.
- Give QR code to all positives and discuss FH.
- Standardize demographic questions with other AIAMC studies being done so data can be reviewed and broken down the same way.
- Trial run a search via REDCap to see if it can be distinguished from non-study patients in FH.

Discussion

Next steps:

- Comparison of pre-REDCap and post-REDCap data
- Increase referrals to SLUHN Care Management Team
- Link the resources accessed with our Community Health Partners

Areas seeking guidance/input:

- Best method to distribute the survey. We have gaps in response rate.
- Provider and staff education to support patients with resources.
- Patient accountability with the utilization of FindHelp with regards to local resources.

Improving Adult Immunization Rates in Ethnic and Minority Populations

Gregory Dobash, M.D.; Dania Mosquera, M.S.; Thomas McGinley, M.D.; James P. Orlando, Ed.D; Micah Gursky;
Kerri Quick, MS, CCHW; Catherine Wang, M.D.; Benjamin Wenger, D.O.; Biju Babu, M.D.

NI IX Meeting #2: April 5-6, 2024

Tucson, AZ

Introduction: Background & Context

St. Luke's Miners Campus Family Medicine Residency and Graduate Medical Education is actively involved in a Campaign for the Social and Moral Determinants of Health with our minority population in the rural health program to improve adult immunization rates. We are in the 4th year of a 5-year program. This project is the first in the RHC area of NEPA.

The PDSA cycle series consists of direct patient outreach via phone.

1. Patient and staff education.
2. Creating a registry of new patients who self-identify as Black, Hispanic, or other via REDCap. We are addressing recommended vaccines in ethnic and minority populations. This project will consist of a 6-month data gathering and two improvement cycles. This project protocol can be easily replicated in any of our residency programs.

About 34.8% of adults and 32.5% of children in Pennsylvania (not including Philadelphia) received the flu vaccine during the 2022-2023 season. 62.6% of boys and girls 13-17 years old throughout the USA were up-to-date on the HPV vaccine in 2022, with about 66.7% in Pennsylvania (75% in Philadelphia, 65.6% in the rest of the state).[1]

Pneumococcal coverage (≥1 dose of PPSV23 or PCV13 among adults ≥65 was 72.4% in 2020. Coverage for White adults ≥65 (72.4%) was higher compared with Black (50.8%), Hispanic (48.1%), and Asian (13.8%) adults.[2]

In 2019-2020, vaccination rates for the flu, pneumococcal, and shingles vaccines were 46.3%, 70.1%, and 31.6%, respectively.[3]

Aim/Purpose/Objectives

Primary goal:
Develop practical tools and strategies to establish a practice environment that addresses immunization disparities and promotes vaccination rates in underserved populations.

Aims

1. Determine best practices to increase vaccination rates in our patient population self-identifying as Black, Hispanic, or other.
2. Investigate reasons for "missed opportunities" in vaccination administration in our target population.
3. Explore different methods of communicating with patients (telephone, mail, EMR patient portal) to increase vaccine administration in our target population

Smart goals

Percentage of racial and ethnic minority patients 19 years of age and older who have received the influenza vaccine during the influenza season.	Increase rates by 15%
Percentage of racial and ethnic minority patients 19-45 years of age who have received or completed HPV vaccination series.	Increase rates by 10%
Percentage of racial and ethnic minority patients 50 years of age and older who have received a single dose of the zoster vaccine.	Increase rates by 5%
Percentage of racial and ethnic minority patients 65 years and older who have received one dose of either pneumococcal vaccines (PCV13 or PPSV23).	Increase rates by 15%

Project Alignment/Advance Organization Priorities

Leading Social Moral Determinants of Health (SMDoH) with 2 of 6 St. Luke's priorities

- **Achieve top decile performance in the following quality and safety priorities.**
  - ➢ Primary Care practice star ratings
- **Improve Access.**
  - ➢ Increase rate of SLPG Annual Wellness Visits

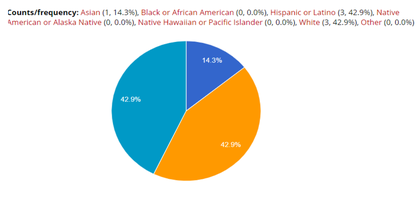
Our project aligns with these St. Luke's priorities by:

- being able to align services and care delivery with the underserved community.
- Increase SDoH screening clinics, track utilization of resources by demographics and steward resources to demographics with the most pressing SDoH needs.

Methods: Interventions

Intervention	
Patient and staff education	Patient information on target vaccines
Pre-charting patients	Included the Ashland clinic, which had a higher percentage of patients with commercial insurance, which covered the vaccines
Calling patients	records indicated they had not received the HPV, influenza, pneumococcal, or zoster vaccine.
Identify Providers	writing prescriptions for vaccines that we don't stock (i.e. Zoster) with a letter describing our project and a vaccine information sheet (VIS). Follow-up by phone.
Screening	now screening for the new pneumococcal vaccines and the RSV vaccine.
Surveying patients	in the office who refused the recommended vaccines to assess reasoning behind vaccine hesitancy Access to the survey is obtained via a QR code

- Audience: Patients who self-identified as Black, Hispanic, or race other than white



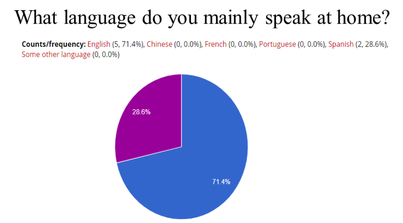
- We performed a chart audit to get baseline data on vaccination rates in the target population
- Materials used and developed
  - ➢ Non-branded, Network-approved patient information
  - ➢ SLUHN Family Medicine Vaccination Survey
- Project was waived by IRB since we had no identifiable patient information.

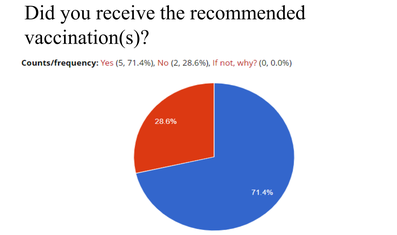
Methods: Measures/Metrics

- **Research Electronic Data Capture (REDCap)** survey: (Multilingual Module: English, and Spanish) will be utilized during minority patient visits to better assess the vaccination rate, and if language is a barrier to further resources.
  - ➢ **REDCap QR Code**
- After each intervention, we did a new chart audit to calculate vaccination rates

References: 1: https://www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/data-reports/index.html
2. "Estimated proportion of adults aged ≥19 years who ever received pneumococcal vaccination by increased-risk status and race/ethnicity" – National Health Interview Survey, United States, 2020. https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/pubs-resources/vaccination-online-report-2019-2020-Table-1.xlsx
3. (2022, September). *Routine Vaccinations: Adult Rates Vary by Vaccine Type and Other Factors*. United States Government Accountability Office. https://www.gao.gov/assets/730/722666.pdf

Results: Preliminary





	Baseline	Cycle 1	Cycle 2	Cycle 3	Cycle 4
Influenza	41%	67%	62%	63%	42%
HPV	6%	65%	100%	91%	95%
PPV23/PCV	37%	67%	80%	78%	40%
Zoster	11%	35%	4%	9%	13%

Barriers – Strategies

Barriers:

- ➢ SDOH screening approaches are inconsistent and not visible to partner organizations.
- ➢ High partner staff turnover and lack of training in screening.
- ➢ Inconsistent payment for target vaccines (zoster).
- ➢ We do not stock the zoster vaccination due to cost.
- ➢ Transportation to the pharmacy for vaccine administration is inconsistent.
- ➢ The vaccine database in the EMR is frequently inaccurate.

Solutions:

- ➢ Standardize SDOH domains in screening tools.
- ➢ Disseminate best practices on screening frequency.
- ➢ Encourage a common platform for screening to reduce redundancy. Patients are directed to their local pharmacy to run their insurance coverage.
- ➢ Patients are given hard-copy prescriptions for zoster vaccination to take to their local pharmacies.
- ➢ Patients are given hard-copy prescriptions for target vaccines and can receive them when transportation is available.
- ➢ Direct patient outreach and manual editing of the vaccine database.

Discussion

Next steps

- Incorporate pneumococcal and RSV vaccines
- Generate a new list of patients
- Collect data about vaccine hesitancy and social determinants of heath through the questionnaire

Areas seeking guidance/input:

- Best method to distribute the survey.
- Patient accountability with attending appointments.

Acceptance of psychiatric care in rural Eastern PA: Challenges and Strategies

Andrei Vedeniapin, MD, Beth Adams, MPH, Gregory Golembeski, MD, Manisha Kalaga, MD

Introduction: Background & Context

Mental health stigma in rural areas contributes to some patients not accessing psychiatric care resources that already exist. Although literature exists examining mental health stigma itself, few studies address community's access of provided mental health services.

This project seeks to understand barriers to accessing psychiatric care, including stigma as well as others, and educate the community to decrease those barriers, with the end goal of increased utilization of mental health services by community members. This project is limited to the rural Schuylkill and Carbon counties of Pennsylvania.

Aim/Purpose/Objectives

To address stigma and the lack of anonymity in rural areas when accessing mental health care, using educational materials.

To increase psychiatry care access by 20% in patients served by Miners campus.

Project Alignment/Advance Organization Priorities

This project aligns with St. Luke's mission of "improv[ing] our communities' overall health," specifically by allowing practitioners to understand and overcome barriers faced by rural patients

This also aligns with the prioritized issue of mental and behavioral health in the St. Luke's CHNA

Methods: Interventions

- The audience for the project consists of adult residents in Schuylkill and Carbon counties
  - All adult patients visiting Family Practices in Schuylkill and Carbon counties will receive the inventory as part of their initial paperwork
- Once baseline data on attitudes are collected, educational materials will be designed and shared with patients in these counties.
- The inventory used is adapted from the Stigma and Self-Stigma Scale (SASS) developed by Docksey et al. (2022)
- IRB Submission is in progress
- Patients will be asked on the inventory if they would be interested in participating in the design of the educational materials
- After 3-6 months of educational materials, patients will again be surveyed using the same inventory

Methods: Measures/Metrics

- The results of the education/stigma reduction will be measured by a post-survey and patients' satisfaction reports. Statistical analysis of the results will be provided by the Graduate Medical Education research team.
- Three months after the post-survey, access to psychiatric services will be measured and compared to pre-education numbers

Results: Preliminary

The survey design is complete. Below is a sample question:

Q4. I am confident that I could ask for help if I had a mental health problem. (Circle one)
Strongly disagree, Disagree, Neutral, Agree, Strongly agree

No data points have been collected yet.

Barriers – Strategies

- Demographic data capture—data might overlap and provide inaccurate numbers
- Limited resources/CBOs as this is a rural area. Strategy is to utilize telehealth as available.
- Current challenges and strategies: timeline struggles, as schedules don't always allow for protected time (strategy—Teams, asynchronous work)

Discussion

Next steps:

- Launching the initial survey to gather baseline data
- Engaging members of CBOs in creating education materials based on initial data

Guidance/Input:

- Timeline help--progress has been slow

NI IX Meeting #2: April 5-6, 2024

Tucson, Arizona

Optimizing Screening for Social Determinants of Health in Hospitalized Patients

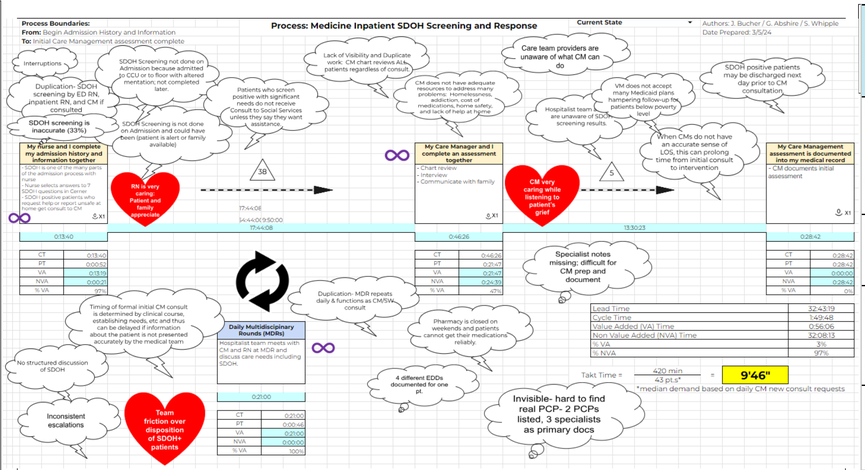
Rajan Bhardwaj, MD; Kate Vogeli, MD;
Gillian Abshire, RN, MS; Joy Bucher, MD

Background

Reducing hospital readmissions is a strategic priority for Virginia Mason with direct impacts on the quality of care of underserved populations, provider, care manager and nursing burnout, and the financial health of the institution. Analysis of patients readmitted to medicine services found that patients with barriers to accessing transportation, obtaining medications, and concerns about home safety had elevated rates of readmission, providing opportunities to impact care delivery successfully and equitably.

Wastes observed in the process included defects (screening not completed or inaccurate), redundancy (ER, admitting RN, and care manager all screening), process variation (outcome of screening not standardized) and invisibility (outcome of screening poorly visible to care team).

Current State: Value Stream Map



Results: Baseline

Metric (units of measurement)	Baseline	Target
Lead Time From beginning of Nursing Admission History and Information to Initial Care Management assessment complete for SDOH positive patients who requested assistance	34:51:00	24:00:00
Quality Measure 1: Screening Completed % of patients with no SDOH screening completed upon admission (CP14)	2.9% (10/344)	0%
Quality Measure 2: Screening Discordant % of patients readmitted at 30 days whose index visit screened SDOH negative **and** readmission visit screened SDOH positive	17.4% (4/23)	0%
Environmental, Health & Safety (6S) Measured as a Level from 1 to 5 (there is no level 0), as described in the 6S Audit Tool. ★	Level 1	Level 4

Goals

Primary aim:

1. Reduce hospital 7-day and 30-day readmission rate for patients screening positive for SDOH

Secondary:

1. Increase screening rate for SDOH
2. Improve quality and accuracy of SDOH screening
3. Increase visibility of SDOH screening to care team

Project Alignment/Advance Organization Priorities

To optimize the screening of hospitalized patients for SDOH by improving quality of tools, process standards, and visibility so that the multidisciplinary team is better enabled to connect this vulnerable population to resources thus improving the quality of care and preventing readmissions.

Metrics

- **Lead time**: Time from SDOH screen to completion of Initial Care Management assessment for SDOH positive patients who request assistance
- **Quality Measure 1**: Percentage of patients with no SDOH screening upon admission
- **Quality Measure 2**: Percentage of patients readmitted at 30 days that screened negative on initial admit and screen positive on readmission
- **6S level of achievement**: Improving visibility of SDOH screening

Barriers – Strategies

- SDOH screening is inconsistent: Create visible standard work
- Screening for SDOH screening may be inaccurate: Consider better timing for screening
- Care managers may not have an accurate sense of length of stay or patient needs before their assessments: Improve communication tools
- Visibility of SDOH screening results is limited: Make providers aware of screening and encourage incorporating screening in notes and care plans
- Lack of resources for SDOH factors: Improve connections with community resources

Discussion

Next steps:

- A team of nurses, care managers, patients, and hospitalist, primary care, and resident physicians are convening the week of March 18-22 to use Virginia Mason Production System (VMPS) tools to create standard work for SDOH screening and response.

Areas for guidance/input:

- How else can we address the social determinants of health and the readmission rate for these patients?