

Then & Now: A Decade of Resident & Faculty Scholarly Work in One National Framework

Victor O. Kolade, MD

Objectives

Describe one or more quality improvement or wellness programs conducted in Sayre Internal Medicine

Identify opportunities for creation of and/or collaboration on nationally relevant scholarly activity

Disclosure

- Financial – as part of our paid membership in the Alliance of Independent Academic Medical Centers, some of this data was presented at its National Initiatives V - IX (or was be presented at the 2023 & 2024 Annual Meetings)
 - The Alliance of Independent Academic Medical Centers (AIAMC) is an organization of teaching hospitals delivering exceptional patient care through education and innovation
 - We actively develop and apply real-world solutions to thrive in the continually changing regulatory and accreditation environment
 - In 2024, the AIAMC is celebrating our 35th anniversary and extraordinary track record of connecting graduate medical education as a strategic asset for achieving better outcomes



*GUTHRIE IN
THE AIAMC*

Learning Objectives

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graph TD; A[Learning Objectives] --> B[AIAMC National Initiatives]; B --> C[Plaques to Trophy]; C --> D[PosterSlam]; D --> E[Breakout session];
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AIAMC National Initiatives

Plaques to Trophy

PosterSlam

Breakout session

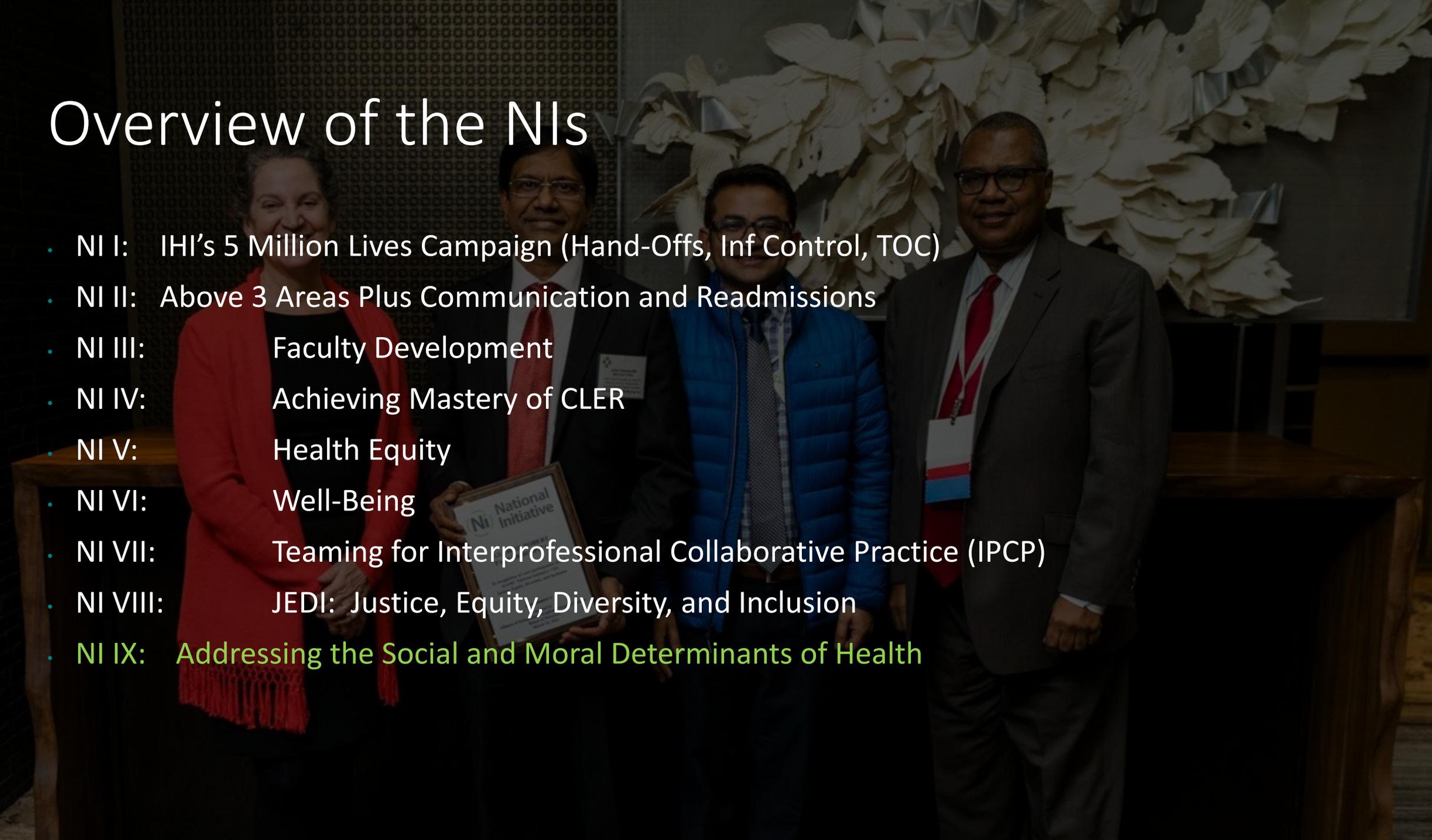
OUTLINE



Connecting Education to Exceptional Patient Care

Overview of the NIs

- NI I: IHI's 5 Million Lives Campaign (Hand-Offs, Inf Control, TOC)
- NI II: Above 3 Areas Plus Communication and Readmissions
- NI III: Faculty Development
- NI IV: Achieving Mastery of CLER
- NI V: Health Equity
- NI VI: Well-Being
- NI VII: Teaming for Interprofessional Collaborative Practice (IPCP)
- NI VIII: JEDI: Justice, Equity, Diversity, and Inclusion
- NI IX: Addressing the Social and Moral Determinants of Health



The AIAMC National Initiatives

The AIAMC National Initiative (NI) is the only national and multi-institutional collaborative of its kind in which residents lead multidisciplinary teams in quality improvement projects aligned to their institution's strategic goals. Seventy hospitals and health systems and over 1,500 individuals have participated in the AIAMC National Initiatives since 2007 driving change that has resulted in meaningful and sustainable outcomes improving the quality and safety of patient care.

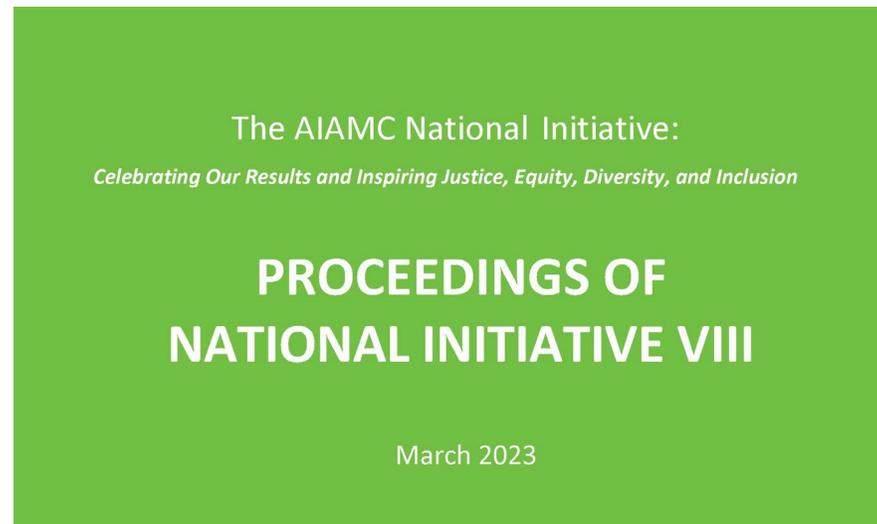


National Initiative I Meeting One
March 2007 – Austin, TX



Framework of the AIAMC National Initiative

- ✓ 18 Months in Length (NI IX to conclude March 2025)
- ✓ 4 Learning Sessions
- ✓ Monthly Zoom Meetings in “Cohort Groups”
- ✓ Scholarly Output



NI IX Goals and Outcomes

- Read and be able to articulate local Community Health Needs Assessment (CHNA)
- Assess social and moral determinants of health (SMDH)
- Establish and measure programs for learners and others related to SMDH
- Engage the C-Suite in a review of Medicare requirements and how SMDH affect the clinical learning environment
- Significantly and measurably advance the clinical learning environment's efforts in SMDH, disseminating results within your organization's Micro, Meso, and Macro environments
- Participate in a collaborative national effort to identify and share best practices
- Author one or more peer reviewed scholarly products at the conclusion of the Initiative

National Initiative IX Teams

Advent Health Orlando

Ascension St. Vincent Hospital

Ascension Providence Rochester

Atrium Health Carolinas Med Cent

Aurora Health Care

Baptist Health South Florida

Baystate Medical Center

Cedars-Sinai Medical Center

Cleveland Clinic Akron General

Good Samaritan Hospital

Guthrie Robert Packer Hospital

Hackensack Meridian-Ocean MC

Monmouth Medical Center

Ochsner Health

OhioHealth Doctors Hospital

Our Lady of the Lake

St. Luke's University Health
Network - Anderson

St. Luke's University Health
Network - Bethlehem

St. Luke's University Health
Network - Miners

TriHealth, Inc

UnityPoint Des Moines

Virginia Mason Medical Center



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



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Guthrie Robert Packer Hospital (RPH), Sayre PA 18840



Abstract

Background – Our hospital/health system is situated amidst several counties with low rates of CRC screening. In 2016, Guthrie joined the 80% by 2018 initiative of the National Colorectal Cancer Roundtable.
Objective – To see Guthrie Robert Packer Hospital meet the American Cancer Society target of 80% CRC screening of persons aged 50-75 years by 2018.
Methods Summary – Data on CRC screening in an internal medicine clinic was obtained prior to detailing of resident providers and direct calls to patients by a resident investigator.
Results Summary – The pre-intervention 10-year colonoscopy rate was 67.6% (207 of 306) in 2016. The other 99 patients were targeted for intervention; 10 elected to have colonoscopy, 11 chose to have fecal occult blood testing, and 18 wanted to discuss CRC screening with their primary care providers (PCP). The post-intervention 10-year colonoscopy rate was 74.1% as of March 2017.

Background

care are very likely to result in poor outcomes. Rural dwellers are known to have lower rates of colorectal cancer (CRC) screening than their urban counterparts. Increasing screening rates is projected to save several lives nationwide. The Sayre Internal Medicine (IM) clinic hosts about 17000 visits a year from patients from at least five surrounding rural counties in New York (Tioga NY, Chemung, Broome) and Pennsylvania (Bradford, Tioga PA). About a fifth of these visits are to residents in their first, second or third years of training. The affiliated gastroenterology department reported a 53% site screening rate in 2015, up from a previous 35%. Prior to this project, the CRC screening rate among patients in the Sayre IM clinic who see residents was not known. Is the rate already at the 80% desired by organizations affiliated with the National Colorectal Cancer Roundtable (NCCR), including RPH? If the rate is lower than

Vision Statement

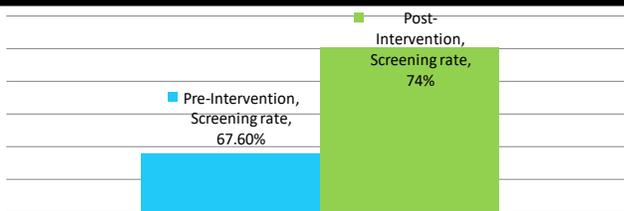


Vision: To create positive measurable change in our local communities
Mission: To create and implement a unique and sustainable approach to a local health disparity in order to move toward fulfillment of a national health objective.

Materials/Methods

- Project Requirements – Provider recommendation of screening and documentation of completion
- **Project Assumptions** – All Bradford County PA residents use Guthrie Robert Packer Hospital (the sole hospital in this county) for medical /primary care (per 2015 Medicare data, 90% of enrollees in the same zip code as RPH use this hospital for inpatient care)
- Stakeholders – Gastroenterologists, Primary Care Providers – including residents, Cancer Center, Graduate Medical Education (GME) leadership, Senior Quality Director
- Community Engagement - The Guthrie Cancer Center hosted a CRC Community Health Day on the RPH campus in August 2016
- Necessary Resources – Data mining support from EMR/Epic team, involvement of the Senior Quality Director
- Outcome Measure – Before-and-After screening rates obtained via EMR
- The chief investigator (SP, a second-year IM resident) obtained information on colonoscopy rates among patients aged 50-75 and listed as having IM residents as PCPs as of September 2016. She attempted to call all those who were due for CRC screening in September and October 2016
- Data handling – the pre-intervention rate was calculated from September 2016 data as persons who had completed colonoscopy within the preceding 10 years divided by the total number of patients aged 50-75. The post-intervention rate was calculated from March 2017 data as persons who had completed colonoscopy within the preceding 10 years divided by the total number of patients aged 50-75.

Results

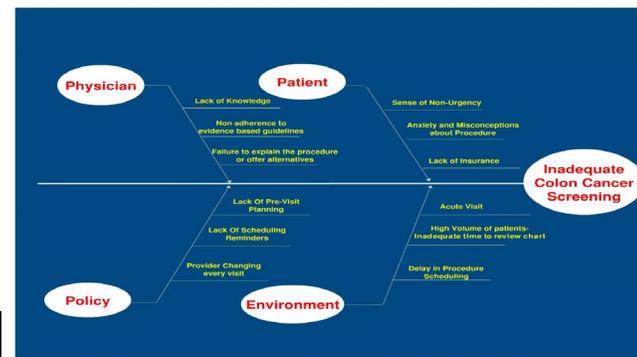


Success Factors and Lessons Learned (Discussion)

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

Barriers Encountered/Limitations

- A. Barriers/Limitations affecting this project:
- GME Leadership Transitions
 - Changes in Team Composition
 - Relative Inexperience of Team Members in Prosecuting a Community-Based Project
 - Time Constraints affecting team member commitment to, and activity on, the project
- B. Barriers affecting CRC screening in the IM residency clinic:

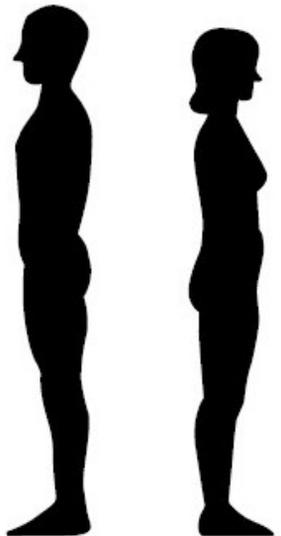


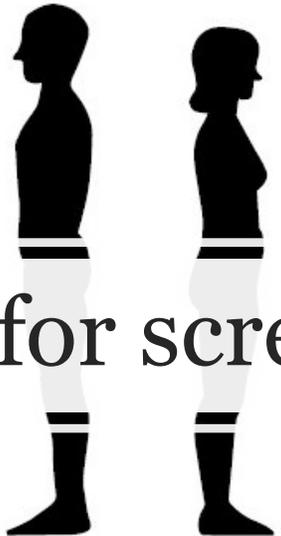
Conclusions

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

Bibliography

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- Meester RG, Doubeni CA, Zauber AG, et al. Public health impact of achieving 80% colorectal cancer screening rates in the United States by 2018. *Cancer.* 2015;121(13):2281-2285.
- American Hospital Directory (2016). Guthrie Robert Packer Hospital. Retrieved on 2/28/17 from: https://www.ahd.com/free_profile/390079/Guthrie_Robert_Packer_Hospital/Sayre/Pennsylvania/

	Male				Female		
Estimated New Cases	Prostate	299,010	29%		Breast	310,720	32%
	Lung & bronchus	116,310	11%		Lung & bronchus	118,270	12%
	Colon & rectum	81,540	8%		Colon & rectum	71,270	7%
	Urinary bladder	63,070	6%		Uterine corpus	67,880	7%
	Melanoma of the skin	59,170	6%		Melanoma of the skin	41,470	4%
	Kidney & renal pelvis	52,380	5%		Non-Hodgkin lymphoma	36,030	4%
	Non-Hodgkin lymphoma	44,590	4%		Pancreas	31,910	3%
	Oral cavity & pharynx	41,510	4%		Thyroid	31,520	3%
	Leukemia	36,450	4%		Kidney & renal pelvis	29,230	3%
	Pancreas	34,530	3%		Leukemia	26,320	3%
All sites	1,029,080			All sites	972,060		

	Male				Female		
Estimated Deaths	Lung & bronchus	65,790	20%		Lung & bronchus	59,280	21%
	Prostate	35,250	11%		Breast	42,250	15%
	Colon & rectum	28,700	9%		Pancreas	24,480	8%
	Pancreas	27,270	8%		Colon & rectum	24,310	8%
	Liver & intrahepatic bile duct	19,120	6%		Uterine corpus	13,250	5%
	Leukemia	13,640	4%		Ovary	12,740	4%
	Esophagus	12,880	4%		Liver & intrahepatic bile duct	10,720	4%
	Urinary bladder	12,290	4%		Non-Hodgkin lymphoma	10,030	3%
	Non-Hodgkin lymphoma	11,780	4%		Non-Hodgkin lymphoma	8,360	3%
	Brain & other nervous system	10,690	3%		Brain & other nervous system	8,070	3%
All sites	322,800			All sites	288,920		

Basis for screening

From: **Screening for Colorectal Cancer: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force**

JAMA. 2021;325(19):1978-1998. doi:10.1001/jama.2021.4417

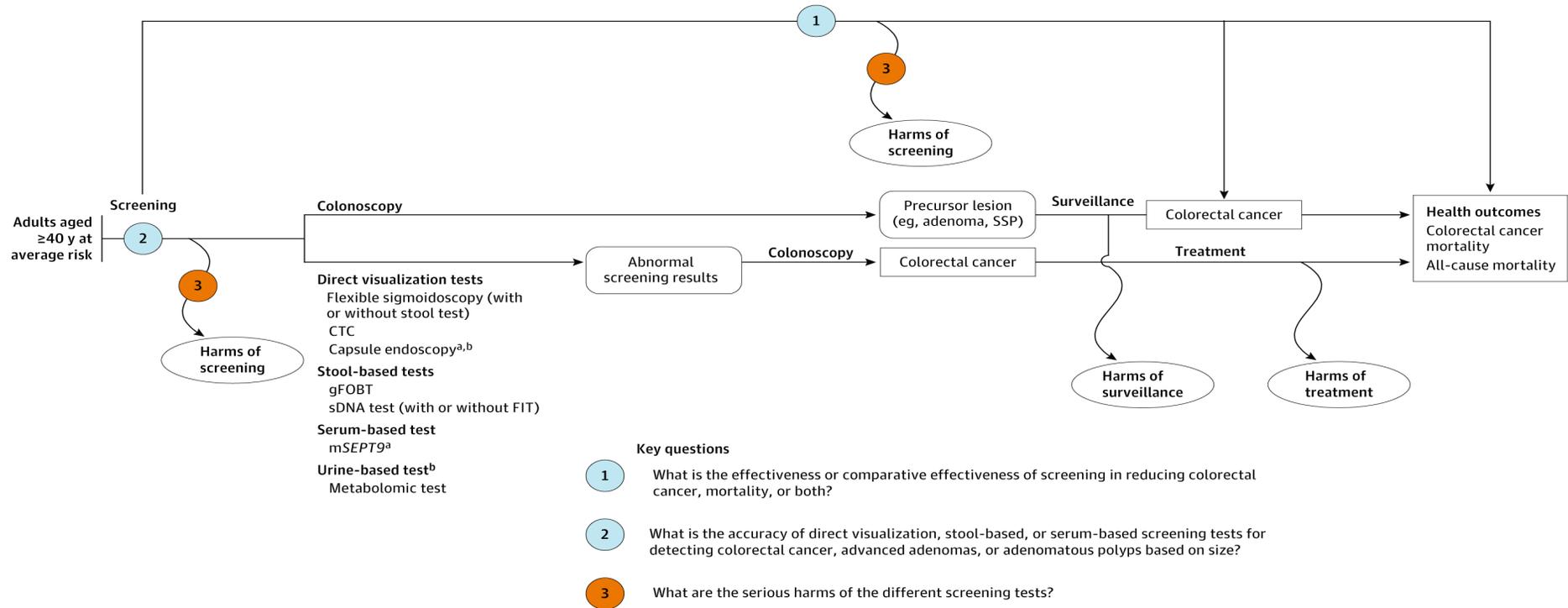


Figure Legend:

Analytic Framework: Screening for Colorectal Cancer Evidence reviews for the US Preventive Services Task Force (USPSTF) use an analytic framework to visually display the key questions that the review will address to allow the USPSTF to evaluate the effectiveness and safety of a preventive service. The questions are depicted by linkages that relate interventions and outcomes.

Additional Information available in the USPSTF Procedure Manual. FIT indicates fecal immunochemical test; gFOBT, guaiac-based fecal occult blood test; mSEPT9, methylated septin 9 gene; sDNA test, stool DNA test; SSP, sessile serrated polyp.

^aScreening technology with conditional approval from the US Food and Drug Administration for screening for colorectal cancer.

^bScreening modality not discussed in this article

From: **Screening for Colorectal Cancer: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force**

JAMA. 2021;325(19):1978-1998. doi:10.1001/jama.2021.4417

Table 1. Key Question 1: Overall Summary of Impact of Screening vs No Screening on Colorectal Cancer Incidence and Mortality

Screening test (sample No.)	No. of studies (participants)	Rounds (intervals)	Follow-up, y	CRC incidence	CRC mortality
Colonoscopy ^{37,47}	2 cohort studies ^a (n = 436 927)	1	8-24 ^b	With polypectomy: HR, 0.53 (95% CI, 0.40 to 0.71) ^c Negative colonoscopy result: HR, 0.47 (95% CI, 0.39 to 0.57) ^c Age 70-74 y: RD, -0.42% (95% CI, -0.24% to -0.63%) ^d Age 75-79 y: RD, -0.14% (95% CI, -0.41% to -0.16%) ^d	HR, 0.32 (95% CI, 0.24 to 0.45) ^c
Flexible sigmoidoscopy ^{19,24,29,35}	4 RCTs ^a (n = 458 002)	1-2 (every 3-5 y)	11-17	IRR, 0.78 (95% CI, 0.74 to 0.83)	IRR, 0.74 (95% CI, 0.68 to 0.80)
Hemoccult II ^{20,21,27,36,39}	5 RCTs ^e (n = 419 966)	2-9 (every 2 y)	11-30	RR range, 0.90 (95% CI, 0.77 to 1.04) to 1.02 (95% CI, 0.93 to 1.12)	RR range, 0.78 (95% CI, 0.65 to 0.93) to 0.91 (95% CI, 0.84 to 0.98) ^f
FIT ⁴⁶	1 cohort study ^a (n = 5.4 million)	Every 2 y	6 (mean, 3)	NR	RR, 0.90 (95% CI, 0.84 to 0.95)

Abbreviations: CRC, colorectal cancer; FIT, fecal immunochemical test; HR, hazard ratio; IRR, incidence rate ratio; NR, not reported; RCT, randomized clinical trial; RD, risk difference; RR, relative risk.

^a Includes newly identified studies or newly identified articles with additional follow-up to a previously included study.

^b Twenty-two-year follow-up for incidence; 24-year follow-up for mortality.

^c Adjusted for age, body mass index, family history, smoking status, physical

activity, diet, vitamin use, aspirin use, nonsteroidal anti-inflammatory drug use, cholesterol-lowering drug use, hormone replacement therapy.

^d Standardized 8-year risk.

^e One RCT in Finland that only has interim follow-up is not represented in this table (n = 360 492).

^f Annual RR from 1 trial only, 0.68 (95% CI, 0.56-0.82); 11 rounds every 1 year, 30-year follow-up.

Table Title:

Key Question 1: Overall Summary of Impact of Screening vs No Screening on Colorectal Cancer Incidence and Mortality
Abbreviations: CRC, colorectal cancer; FIT, fecal immunochemical test; HR, hazard ratio; IRR, incidence rate ratio; NR, not reported; RCT, randomized clinical trial; RD, risk difference; RR, relative risk.

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Table 3. Key Question 2: Summary of Test Accuracy Results From Studies With Colonoscopy Follow-up for Stool and Serum Screening Tests^a

Screening test group	No. of studies	No. of participants	CRC		Advanced neoplasia		Advanced adenoma	
			Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)	Sensitivity (95% CI)	Specificity (95% CI)
High-sensitivity gFOBT: Hemoccult Sensa	2 ^b	3503	0.50-0.75 (0.09-1.0)	0.96-0.98 (0.95-0.99)	0.07-0.21 (0.02-0.27)	0.96-0.99 (0.96-0.99)	0.06-0.17 (0.02-0.23)	0.96-0.99 (0.96-0.99)
FIT								
OC-Sensor	13 ^{b,c}	44 887	0.74 (0.64-0.83)	0.94 (0.93-0.96)	0.25 (0.21-0.31)	0.96 (0.95-0.97)	0.23 (0.20-0.25)	0.96 (0.95-0.97)
OC-Light	4 ^b	32 424	0.81 (0.70-0.91)	0.93 (0.91-0.96)	0.27 (0.16-0.38)	0.95 (0.92-0.98)	0.28 (0.19-0.37)	0.94 (0.91-0.97)
Other	12 ^{b,c}	53 527	0.50-0.97 (0.09-1.00)	0.83-0.97 (0.82-0.97)	0.02-0.66 (0.01-0.99)	0.60-0.99 (0.58-1.0)	0.18-0.50 (0.13-0.56)	0.85-0.98 (0.84-0.98)
mtsDNA-FIT: Cologuard	4 ^b	12 424	0.93 (0.87-1.0)	0.85 (0.84-0.86)	0.47 (0.44-0.50)	0.89 (0.87-0.92)	0.43 (0.40-0.46)	0.89 (0.86-0.92)
Serum: Epi proColon	1	6857	0.68 (0.53-0.80)	0.79 (0.77-0.81)	0.25 (0.22-0.28)	0.79 (0.76-0.82)	0.22 (0.18-0.24)	0.79 (0.76-0.82)

Abbreviations: CRC, colorectal cancer; FIT, fecal immunochemical test; gFOBT, guaiac fecal occult blood test; mtsDNA, multitargeted stool-based DNA.

^b Includes newly identified studies.

^c One nested case-control study¹⁰⁴ (n = 516) is not represented in this table.

^a Pooled estimates and 95% CI from meta-analysis when available; otherwise, range of values and range of the 95% CIs reported.

Table Title:

Key Question 2: Summary of Test Accuracy Results From Studies With Colonoscopy Follow-up for Stool and Serum Screening Tests^a Abbreviations: CRC, colorectal cancer; FIT, fecal immunochemical test; gFOBT, guaiac fecal occult blood test; mtsDNA, multitargeted stool-based DNA.

^a Pooled estimates and 95% CI from meta-analysis when available; otherwise, range of values and range of the 95% CIs reported.

^b Includes newly identified studies.

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JAMA. 2021;325(19):1978-1998. doi:10.1001/jama.2021.4417

Table 4. Key Question 3: Summary of Serious Harms and Extracolonic Findings From Screening

Modality	Outcome	No. of studies	No. of participants	Events per 10 000 procedures (95% CI)
Screening flexible sigmoidoscopy	Serious bleeding	10	179 854	0.50 (0.0-1.30)
	Perforation	11	359 679	0.20 (0.10-0.40)
Screening colonoscopy	Serious bleeding	20	5 172 508	14.6 (9.4-19.9)
	Perforation	26	5 272 600	3.1 (2.3-4.0)
Colonoscopy following abnormal stool test result	Serious bleeding	11	78 793	17.5 (7.6-27.5)
	Perforation	12	341 922	5.4 (3.4-7.4)
Colonoscopy following abnormal flexible sigmoidoscopy result	Serious bleeding	4	5790	20.7 (8.2 to 33.2)
	Perforation	4	23 022	12.0 (7.5 to 16.5)
CT colonography	Radiation exposure	7	NA	≈1 to 5 mSv per examination
	ECF	27	48 235	E4: 3.4%-26.9% of CT colonography examinations; E3: 1.3%-11.4% of CT colonography examinations ^a

Abbreviations: CT, computed tomography; ECF, extracolonic finding; NA, not available.

^a Based on CT Colonography Reporting and Data System categorization of ECFs, where E3 = likely unimportant or incompletely characterized finding for which workup may be required and E4 = potentially important finding requiring follow-up.²⁷⁴

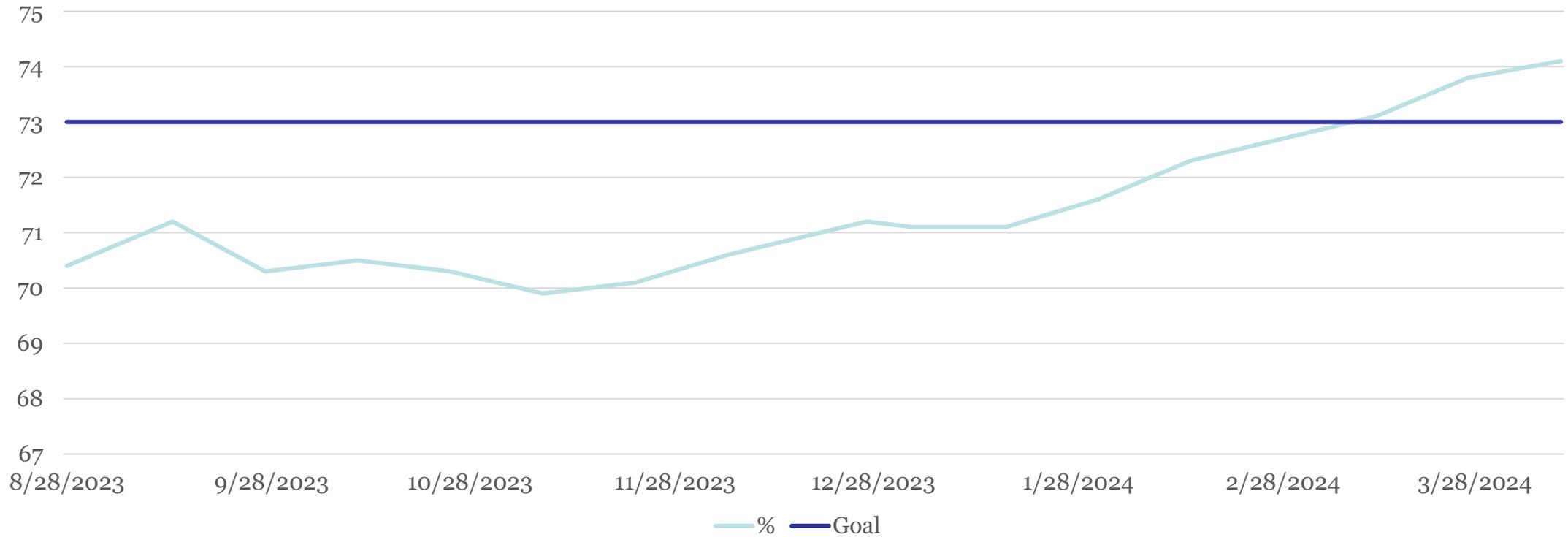
Table Title:

Key Question 3: Summary of Serious Harms and Extracolonic Findings From Screening Abbreviations: CT, computed tomography; ECF, extracolonic finding; NA, not available.

^a Based on CT Colonography Reporting and Data System categorization of ECFs, where E3 = likely unimportant or incompletely characterized finding for which workup may be required and E4 = potentially important finding requiring follow-up.

2023-24

Colorectal cancer screening rates in our resident clinic



Background

- Physician burn out is a national phenomenon that leads to poor quality of care, errors, diminished professionalism along with work-life integration
- Healthcare professionals are at risk, leads to suboptimal care, lower patient satisfaction, more suicidal ideation
- This is an opportunity to address burnout, to provide improved care, safety, efficacy along with lower turnover rates in our younger physicians

Aim/Purpose/Objective

Aim to improve the well being of our internal medicine residents.

Reduce stress using the concept model of human coping reservoir (Dunn et al, 2008).

Identify stressors in residents via survey. Engage residents in wellbeing initiatives.

Provide interventions and perform periodic assessments

METHODS: Interventions/Changes

Fall 2017

Spring 2018

Spring 2019

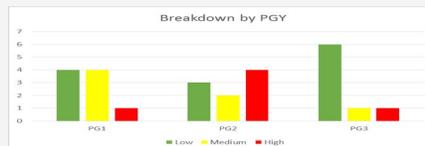
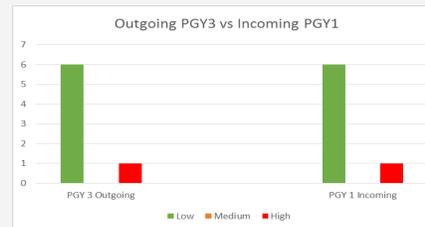
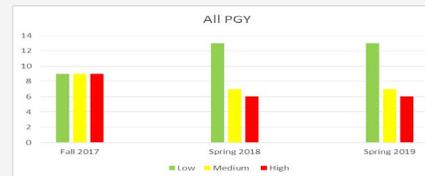
- Game

METHODS: Measures/Metrics

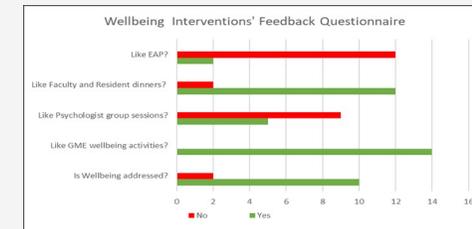
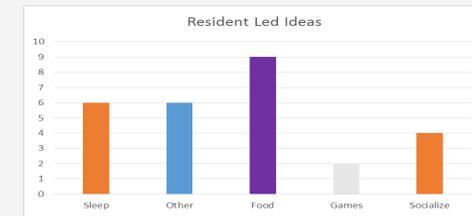
Subjects: Internal Medicine Residents at Guthrie Clinic
 Maslach Burnout Survey is a survey measuring emotional exhaustion, depersonalization and personal accomplishment

- Perform baseline Maslach Burnout Inventory
- Create Ombudsman position
- Develop Wellness Interventions Feedback Questionnaire to evaluate if current interventions were enjoyable
- Develop Resident Led Intervention Questionnaire to see what residents wanted given the choice

RESULTS



RESULTS: Continued



Discussion: Barriers & Strategies

Key Findings

- Residents improved and stayed at improved levels
- PGY2 were identified as having the most burnout
- Whatsapp had the most favorable and sustained response
- Limitations**
 - Limited cohesiveness amongst current residents results in low turn out at events
 - Project was limited to small committee
- Next Steps and Sustainability**
 - Expand to Internal Medicine faculty and the other residencies
 - Develop Wellness curriculum for faculty and incoming class
 - Implement quarterly Wellness activities

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- Epstein and Krasner. Physician Resilience: What it means, why it matters and how to promote it. Academic Medicine. 2013.

Multipronged Strategies to Improve Wellbeing and Work-life Balance of Residents

Robert Klein MD, Maria Aronson PhD, Sheila Primm MD, Arup Biswas MD, John Farnon MD PhD

Thomas Sampson, Laura Fitzgerald

Department of Internal Medicine, Catholic Robert Wood Johnson Hospital, Trenton, PA



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Background

Residency is a challenging time in a physician's career. Residents often experience high levels of stress, burnout, and work-life imbalance. This study aimed to identify and implement strategies to improve resident wellbeing and work-life balance.

Methods

A survey of residents was conducted to assess their current wellbeing and work-life balance. The survey included questions about stress, burnout, and work-life balance.

Interventions Implemented

- 1. Flexible scheduling options
- 2. Peer support groups
- 3. Wellness programs
- 4. Mentorship programs
- 5. Flexible clinical assignments

Outcomes

The study found that the implementation of these interventions led to significant improvements in resident wellbeing and work-life balance.

Conclusions

Multipronged strategies, including flexible scheduling, peer support, wellness programs, mentorship, and flexible clinical assignments, are effective in improving resident wellbeing and work-life balance.

Resident Satisfaction



Wellbeing



Work-life Balance



Discussion

The study highlights the importance of a multipronged approach to addressing resident wellbeing and work-life balance. By implementing flexible scheduling, peer support, wellness programs, mentorship, and flexible clinical assignments, we can create a more supportive and balanced environment for residents.

Conclusion

Multipronged strategies are essential for improving resident wellbeing and work-life balance. These interventions can lead to significant improvements in resident satisfaction, wellbeing, and work-life balance.

References

- 1. Aronson M, et al. (2018) Resident Wellbeing and Work-life Balance: A Multipronged Approach. *Journal of General Internal Medicine*.
- 2. Primm S, et al. (2019) Improving Resident Work-life Balance through Flexible Scheduling. *Academy of Medical Education*.



Victor Kolade, Sheela Prabhu, John Pamula, Colleen Woodring, Misty Mase, Bobbé Edwards, Shobha Mandal, Sydney Silverman, Manisha Raiker

INTRODUCTION: Background

- Assessment of primary care quality via standardized aggregate measures has been done by medical centers and monitored by insurers and patients in the US for years
- Several primary care office visits are provided primarily by residents each year; patients seen by residents have been shown to have similar (1) or worse than (2) performances on their quality metrics than patients seen by staff providers
- The effectiveness of interdisciplinary collaboration in improving this disparity is not known

References

- Edwards ST, Kim H, Shull S, Hooker ER, Niederhausen M, Tuepker A. Quality of Outpatient Care with Internal Medicine Residents vs Attending Physicians in Veterans Affairs Primary Care Clinics. JAMA Intern Med. 2019 May 1;179(5):711-713
- Essien UR, He W, Ray A, Chang Y, Abraham JR, Singer DE, Atlas SJ. Disparities in Quality of Primary Care

Aim/Purpose/Objectives

- To improve the 'diabetes bundle' compliance to 62% across patients in Sayre Internal Medicine being cared for by non-resident providers (faculty, non-faculty doctors, and advanced practice providers) by June 2021
- To improve the 'diabetes bundle' compliance to 54.6% across all patients being cared for by resident providers by June 2021
- To see or maintain a colorectal cancer screening rate of 70% or more among patients in Sayre Internal Medicine being cared for by non-resident providers by June 2021
- To see a colorectal cancer screening rate of 65.2% or more among patients in Sayre IM being cared for by resident providers by June 2021
- To see or maintain a diabetic retinopathy screening/assessment rate of 72% or more among patients in Sayre Internal Medicine being cared for by non-resident as well as resident providers by June 2021
- To see or maintain a depression screening rate of 80% or more among patients in Sayre Internal Medicine being cared for by non-resident as well as resident providers by June 2021
- To see or maintain a fall screening rate of 85% or more among patients 65 and older in Sayre Internal Medicine being cared for by non-resident as well as resident providers by June 2021

METHODS: Interventions/Changes

Subjects: Selection, Recruitment – see table

Interventions

- We sought to leverage daily office huddles to achieve these aims (as a complement to pre-visit planning calls implemented earlier as part of processes required for Patient-Centered Medical Home certification)
- Redesigned in July 2020, huddles occur from 8:40-9 am and include the office director, care coordinator, providers, residents, nurses, patient service specialists and nurse practitioner/physician assistant/medical students
- Data provided by administration is reviewed by providers and in huddle every 1-2 weeks

METHODS: Measures/Metrics

Metric	System Numerator	System Denominator	Inclusions	Exclusions
Diabetes bundle	Diabetic Patients Seen in the Past 2 Years Who Have an Active Guthrie PCP, With an A1C <= 8 in the Past 6 Months, an LDL < 70 (or currently prescribed a moderate or high dose statin) in the Past Year and age 40-75, and medical attention for nephropathy (a microalbumin test in the Past Year, or a nephrology visit, or are on an ACE/ARB, or have ESRD/CKD Stage 4)	Diabetic Patients Seen in the Past 2 Years With an Active Guthrie PCP	Patients Who Have: Diabetes On Their Problem List, An encounter with a Diabetes Diagnosis in the past 2 Years, or a Health Maintenance modifier for Diabetes. Patients must have an active Guthrie PCP and have had an office visit in the past 2 years	Gestational Diabetes & Long-Term Care Patients
Colorectal Cancer Screening	Colonoscopy (10 years), Fit test (annual), and Cologuard (3 years), Or Health Maintenance Modifier marked as completed(Past 10 Years)	Patients Aged 50-75 Seen In The Past Year		Long-Term Care Patients
Diabetic Retinopathy	Negative Eye Exam In the Past Two Years Or Positive Exam In The Past Year	Diabetics Aged 18-75	Patients Who Have: Diabetes On Their Problem List, An encounter with a Diabetes Diagnosis in the past 2 Years, or a HM modifier for Diabetes. Patients must have an active Guthrie PCP and have had an office visit in the past 2 years	Gestational Diabetes & Long-Term Care Patients
Depression Screening	Patients aged 12 years and older screened for depression using the PHQ-2, and if positive, the PHQ-9, during their encounter	Patients seen by practice in the last year	Patients seen in the past year by Primary Care with a Guthrie PCP	Patients with a history of an active diagnosis of depression or bipolar
Fall Risk Assessment	Patients >=65 with a fall risk screening completed in the past year	Patients >=65 and seen in the past 2 years by Primary Care	Patients seen in the past 2 years by Primary Care with a Guthrie PCP	

RESULTS: Continued

- The 'diabetes bundle' compliance **reached 62%** across patients in Sayre Internal Medicine being cared for by non-resident providers in **August 2020, but fell to 56.4% in February 2021; the residents have not met goal for this metric**
- The colorectal cancer screening rate **was 70% or more** among patients being cared for by non-resident providers by **July 2020, and stayed at goal through March 2021**
- The colorectal cancer screening rate **exceeded 65.2%** among patients being cared for by residents by October 2020, likely due to a resident-led QI initiative, and **stayed at goal through early March 2021**
- The diabetic retinopathy screening/assessment rate **was 72% or more** among patients being cared for by non-resident as well as resident providers by **July 2020, but the resident rate fell to 66.9% in December, then hit 73.5% in March 2021**
- The depression screening rate **was 80% or more** among patients in Sayre Internal Medicine being cared for by non-resident and resident providers by **July 2020, and stayed at goal through March 2021**
- The fall screening rate **was 85% or more** among patients in Sayre Internal Medicine being cared for by non-resident and resident providers by **July 2020, and stayed at goal through March 2021 for residents, but staff providers fell below goal in January - February 2021 only to rebound to 85%**

Discussion

Key Findings

- Diabetes bundle completion rates fell when COVID-19 infections rose among our patients and communities
- Colorectal cancer screening data was rather resistant to the changes in COVID-19 prevalence
- Disparities in metric completion rates were seen between resident and non-resident provider patient cohorts from July 2020 till date

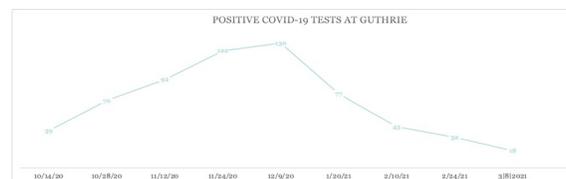
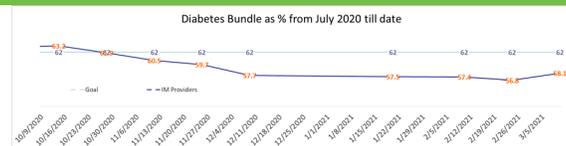
Limitation

- It came to light in January 2021 that some residents were unaware of the nuances involved in the quality metric assessments

Next Steps and Sustainability

- Resident education is ongoing
- Quality star boards have been incorporated into our huddles – and our model has been shared with senior leadership

RESULTS



An Interdisciplinary approach to improve TCM visit completion rate in IM resident and faculty clinic



NI VII Meeting #4

Dr. Tejaswini Maganti, Dr. Sudhir Pasham, Dr. John Pamula, Dr. Victor Kolade, Dr. Sheela Prabhu

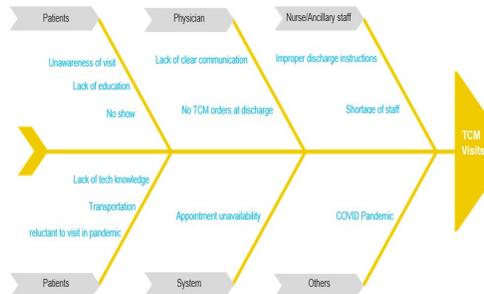
Introduction

- Transitional Care Management (TCM) services were established under the Affordable Care Act in 2010 to improve quality of care and to reduce healthcare costs.
- Naylor summarized twenty-one-randomized clinical trials of transitional care interventions and the positive effect on patient care (1).
- However, there are barriers for TCM services implementation.
- In Guthrie primary care clinics, we track multiple ambulatory quality metrics to improve healthcare for patients; we included a focus on TCM compliance rate to improve patients' health and prevent readmissions.

Aim

- To improve the TCM visit compliance rate by leveraging the process of interdisciplinary morning huddles among the care team via a multidisciplinary approach and multiple interventions at different times.
- Specifically, we aim to improve the TCM rate in the Internal medicine clinic by 10% from 7/1/2020 to 6/30/2021.

Root cause analysis

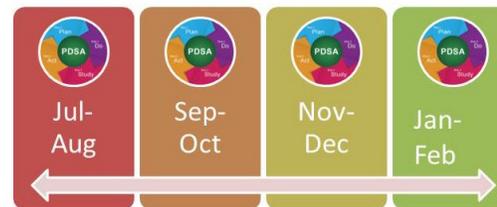


METHODS: Metrics

- Collected data from our clinical data analyst every week: Number of patients discharged, TCM order, 48-hour call after discharge, 1 week visit, 2-week visit, readmissions/ED visits.
- We collected data from January and interventions that mentioned above were started in June except virtual visits, which were started by end of December.

METHODS: Interventions

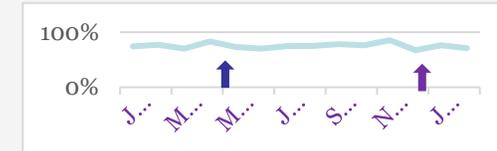
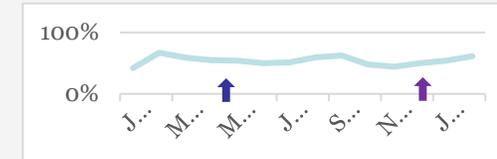
- I. Team approach: Huddles occur in the morning in the IM clinic every day in a team-based approach. They include the office director, care coordinator, providers, residents, nurses, patient service specialists, and nurse practitioner/physician assistant/medical students.
 - ❖ We discussed the barriers and where necessary, use of vacant slots for TCM appointments was done.
 - ❖ We implemented a mandatory reminder to patients 24 hours before visits by a patient service specialist (PSS), in addition to utilizing a 48-hour outreach call by a care coordinator.
- II. Utilized a specific EMR TCM visit order, which is a part of the inpatient discharge order set.
- III. Resident workshops were conducted:
 - ❖ To educate regarding the process and importance of TCM, and to teach the patients to comply with TCM.
 - ❖ To facilitate (where needed) transition from generic follow up appointment to specific TCM appointments in the EMR.
- IV. We audited the data every week to assess the barriers and brainstorm solutions.
- V. We commenced virtual visits to improve access and promote patient compliance.



RESULTS

- ✓ We have achieved our goal for the 1-week TCM rate with increase from 50% in June 2020 to 61.3% by the end of February 2021.

RESULTS



- Intervention one: Multidisciplinary approach
- Intervention two: Virtual visits

Discussion

As per our analysis and based on reviewing our multiple PDSA cycles, we conclude that among the interventions used the most important ones for maximum and sustainable benefit are:

- ❖ mandatory calls made by a PSS 24 hours before visits, and
- ❖ virtual visits.

Reference

1. Naylor MD, Aiken LH, Kurtzman ET, Olds DM, Hirschman KB. The care span: The importance of transitional care in achieving health reform. Health Aff (Millwood). 2011 Apr;30(4):746-54.



NI VII Meeting Four – Capstone Presentation
Cohort Four: Teaming to Improve Care

Interprofessional Collaboration Practice (IPCP) to Improve Colorectal Cancer Screening

Shobha Mandal, MD

PGY-2, Internal Medicine



Core NI VII team



Team Members: Dr. Balkishan Malviya, Dr. Sneha Singh, Dr. Manas, Dr. Tanya Gupta, Dr. John Pamula, Dr. Victor Kolade

Introduction: Background & Context

- ❑ The five key social determinants of health as recognized by Healthy People 2030 include economic stability, education, social and community context, health and healthcare, and neighborhoods and built environment.
- ❑ Robert Packer Hospital serves mostly a rural population over a large geographic area from four counties of New York and Pennsylvania.
- ❑ In order to serve such a unique population, having a holistic view of health that includes social, behavioral, and physical drivers can have the greatest impact on the health.

Mission/Aim

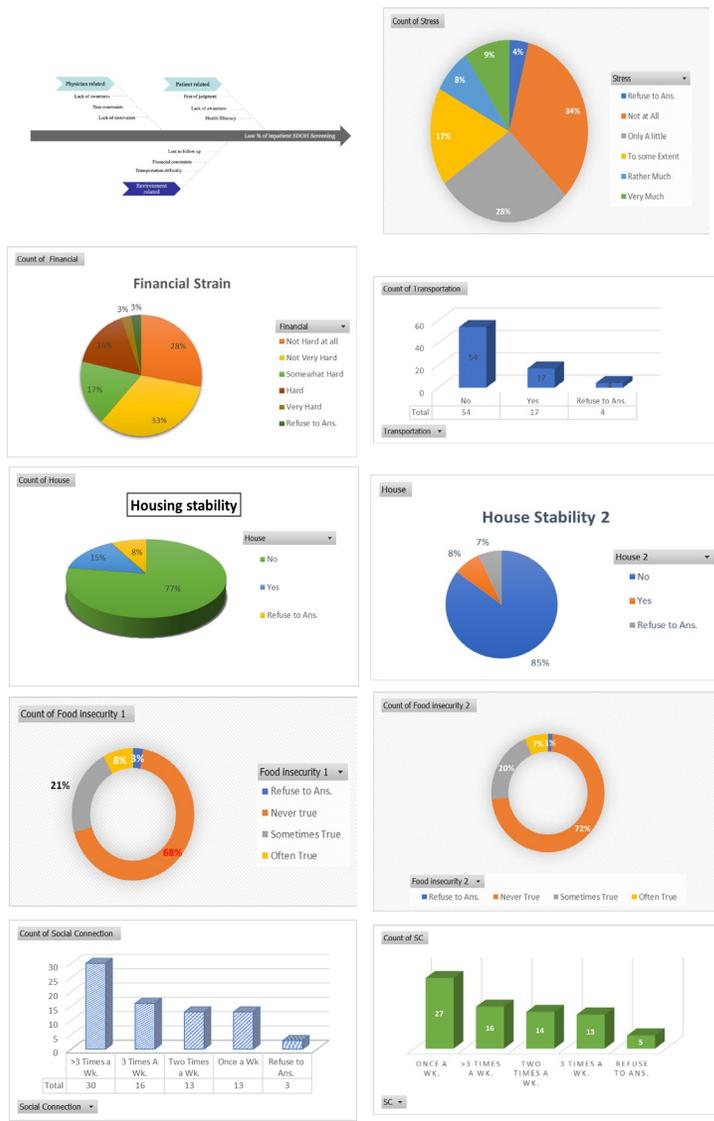
Improve the SDOH screening in the inpatient setting and identify the SDOH barriers to enhance and provide better patient care.

Methods: Interventions/Changes

- ❑ Key improvement initiatives focused on creating awareness among residents and faculty about the prevalence and importance of SDOH in the overall health outcome of the patient, including workshops and presentations.
- ❑ SDOH questionnaire was prepared including questions regarding financial strain, housing stability, transportation, food insecurity, social connection and stress
- ❑ Primary data was collected through distribution of questionnaire amongst patients admitted to resident driven inpatient services. (n=75)
- ❑ Patients who screened positive from the questionnaire were provided resources and support with help of social workers/case managers.

Results

- ❑ Financial strain : 21% reported somewhat hard, 19 % reported hard to very hard
- ❑ Housing stability: 11 % reported housing instability
- ❑ Food insecurity: 17% reported somewhat true, 8 % reported often true
- ❑ Social connection: 19% reported < 1/week social connection
- ❑ Stress: 7% report some stress and 7 % report stress to extent
- ❑ Higher financial difficulty and food insecurity were associated with higher stress with $p < 0.001$



Test	ChiSquare	Prob>ChiSq	Test	ChiSquare	Prob>ChiSq
Likelihood Ratio	42.585	0.0155*	Likelihood Ratio	46.336	<.0001*
Pearson	80.404	<.0001*	Pearson	78.910	<.0001*

Financial strain with stress Food insecurity with stress

Conclusion

❑ Upon chi-square analysis, there is statistically significant ($p < 0.001$) association between stress and financial stability, as well as stress and food security. Those who reported higher stress, also reported higher financial strain and food insecurity

- ❑ Patients had hesitancy in answering some of the questions due to it's personal nature.
- ❑ Healthcare providers were hesitant to ask some of these questions.
- ❑ Due to higher patient acuity in the inpatient setting, less priority given to identifying SDOH barriers for patients.

Discussion

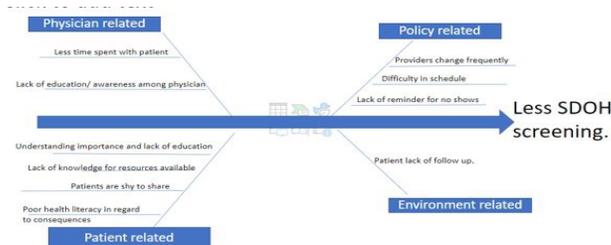
- ❑ In the screened in-hospital patients; financial, housing and food insecurity hardship ranges from 11 to 21 %. According to US census bureau 2021, poverty prevent is 10.7 % in Bradford county PA.
- ❑ This study highlights the percentage of inpatients in need of assistance is much more than the average poverty percent in that community. SDOH screening is important to capture them and plug them into community resources.

❑ Development of inpatient EPIC based tool

Group Feedback (leave blank)

Introduction: Background & Context

- Social determinates of health (SDOH) as defined by WHO include environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks
- A recent study nationwide concluded that only 24% of hospitals and 16% of physician practices are screening for all five key SDOH needs
- Guthrie Robert Packer Hospital (RPH) primarily serves five counties in the Twin Tier regions of New York and Pennsylvania - rural communities with health disparities and gaps in both preventive and therapeutic care when compared to national data because of low literacy and lower average household income compared to national data.
- Less than 40% of the patient population has their SDOH screening done prior to initiation of this project.



Mission/Vision Statement

- To envision, create and implement a ingrained and sustainable team-based approach to improve the percentage of SDOH screening in IM Resident clinic via Inter-Professional Collaborative Practice (IPCP)

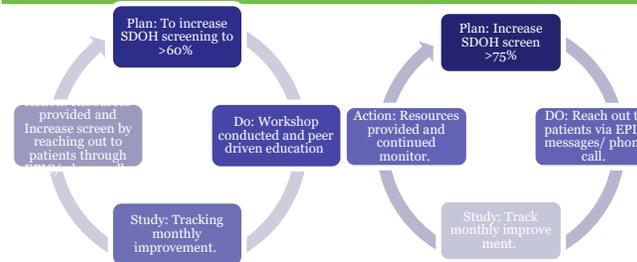
Aim/Purpose/Objectives

- The goal of this project is to increase the SDOH screening rate from 38 % to a target range of more than >60% among patients seen in the resident clinic and improve the outcomes.

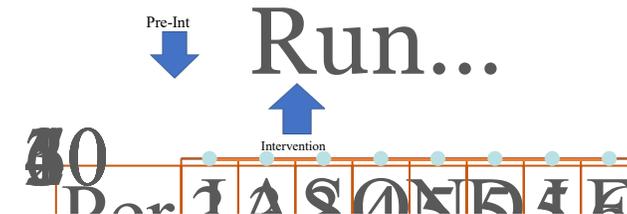
Methods: Interventions/Changes

- Pre intervention data of SDOH screening was collected from EPIC from June 2021 to September 2021 which stood at 38.6% (n= 300) among the resident providers.
- Focus was given to financial resources, housing, transportation and food insecurity.
- Residents were educated on the importance for SDOH screening through a workshop, and peer driven education for the care gaps closure.
- Post intervention capture of data of SDOH in the resident IM clinic was done from October 2021 to February 2022 (n= 324) which showed an improvement to 66.7 %
- As of we currently were able to identify about 5.9% of patient population who

Methods: Measures/Metrics



Results & Conclusion



- Results indicate screening and incorporating of SDOH into patient health record address care gaps and also provide much needed resources to our patients.

Barriers – Strategies

- Educating the Allied staff of the importance of SDOH screening.
- Some of the patient/s were unwilling/ refuse to share the details.
- Time constraints during the patient visit to complete the screening
- Engaging and building relationship with the community for sustained benefits

Discussion: Next Steps & Areas Seeking Input

What are critical next steps?

- Increase the screen to cover more than at least >85%.
- Follow up of the positive screened patients to ensure the resources provided are accessible.
- Continued screen and monitor.

List areas you could use guidance/input

- What to do when patients say, do not need our help, yet the need is critical?
- Some PCP indicate it is difficult/ awkward to address both initial and follow-up of positive responses.
- Overcoming cultural, language barriers and assumptions.

Group Feedback (leave blank)

Introduction: Background & Context

Social Determinants of Health (SDoH) are the physical, social, and environmental factors such as food insecurity, financial strain, transportation needs, and housing needs that can determine if an individual will have positive or negative health outcomes. The Robert Packer Hospital provides statistics showing the SDoH screening tool completion rates at various centers to show how many providers are addressing these factors with patients. Identifying patients that need additional support can help in improving patient care at hospitals.

Mission/Vision Statement

After examining the SDOH screening data from 20 family practice centers across Guthrie, we would like to investigate the barriers to completing the screening tool by sending out a survey to providers.

Aim/Purpose/Objectives

To see improved completion rates by providers over the next few months for all 20 FM centers and thereby find ways to provide resources for patients.

Methods: Interventions/Changes

- The SDOH questionnaire was added to the Care gaps on Storyboard in Epic in September of 2021 to make it easier for providers to access.
- We would like to send out the survey to 103 eligible providers via Microsoft Forms anonymously making the information received IRB exempt.
- After seeing the rates of completion, we propose to educate providers and patients about the importance of the SDOH.

Methods: Measures/Metrics

- Barriers and knowledge of the SDOH screening questionnaire will be assessed in this survey. Participants are asked about their gender, role on the healthcare team, years worked in healthcare, their hospital location as well as other more specific questions about the SDOH.
- Pilot testing of the survey was conducted by obtaining input for recommendations from internal medicine residents.

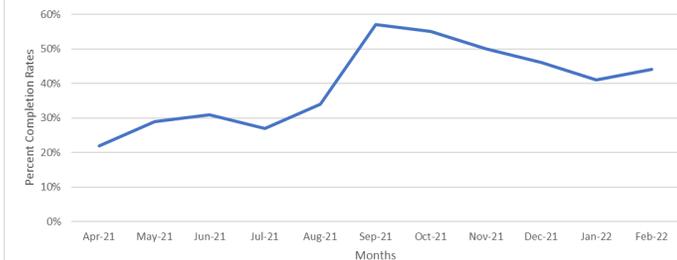
Barriers – Strategies

The biggest challenge has been getting providers to answer the survey questions.

Discussion: Next Steps & Areas

- For the next steps of this project, the survey will be sent out to Family Medicine providers via Microsoft Forms. FM providers will be selected from the “Family Medicine Care Team” found on the Guthrie Robert Packer Hospital website. Exclusion criteria included providers who are walk-in staff since they may not address care gaps and/or were registered nurses.
- Figuring out how to help patients in the most beneficial way after learning about the various insecurities they are facing.
- It would also be beneficial to discover ways to educate providers about the SDOH and its importance which would thereby increase the rates of completion.

Overall Completion Rates from 20 Family Practice Centers in the Guthrie Network



Introduction: Background & Context

Social Determinants of health is a hot topic in medicine right now. We know that financial insecurity, housing insecurity, food insecurity, transportation trouble and others have a huge impact on patients' health and their ability to properly manage their conditions. Children can be particularly vulnerable to these insecurities, especially since they are out of their control. It is becoming increasingly important to be able to understand a patient and their families' situation in these areas to be able to provide them with the appropriate resources in each area to assist them.

Mission/Vision Statement

We want to increase the percentage of patients who are being screened for SDOH at well child visits in order to catch families who need assistance and be able to provide them with the appropriate resources to help better their medical care.

Aim/Purpose/Objectives

To increase completion of Social Determinants of Health Questionnaire in 3 Pediatric offices in the Guthrie Health System (Corning, Southern Tier, and Sayre Pediatrics) to 50%, 50% and 75% completion, respectively, over a 3-month average by Spring of 2022.

Methods: Interventions/Changes

- We collaborated with a task force at The Guthrie Clinic to implement an EPIC Care Gap for SDOH screening
- We created and distributed a survey to assess the attitudes of clinical staff in 4 pediatric offices regarding SDOH and barriers they have faced when using the EPIC screening tool
- We propose to create an educational intervention to help both providers and patients understand the purpose of SDOH screening and reasoning behind the questions being asked

Methods: Measures/Metrics

- We are measuring SDOH screening completion percentages at well-child visits in 3 pediatric offices on a monthly basis and analyzing trends in completion rates from month-to-month
- Along with completion rates, we are also measuring the percentage of positive screening in the different areas of SDOH including financial, food, housing insecurity
- We are using Microsoft Forms to analyze clinical staff survey responses regarding their opinions on and barriers to using the SDOH screening tool

Barriers – Strategies

- One challenge is finding out ways to effectively reaching out to contacts who can put us in touch with clinical office staff.
- Consequently, the main challenge is getting enough survey responses.

Discussion: Next Steps & Areas Seeking Input

- Our next steps are focused on obtaining more survey responses from providers.
- We would like to use the survey responses to help guide us in designing educational material that would target the main concerns of patients and providers regarding SDOH screening. We could also use the responses to help us make screening more convenient.
- When patients test positive in an area of SDOH screening, we need to determine the most effective way to refer them to the appropriate resource to get them the help they need.
- We need guidance on ways to increase our survey completion rates and better strategies to reach clinical staff members.

14. What barriers have you faced in completing the SDOH screening questionnaire at office visits? Check all that apply.

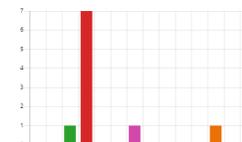
8 Responses

ID#	Name	Responses
1	anonymous	[Patients do not want to be uncomfortable answering the questions.] [I do not feel comfortable asking the questions to my patients]
2	anonymous	[There's not enough time to ask the questions.] [Patients do not want to be uncomfortable answering the questions.]
3	anonymous	[Patients do not want to be uncomfortable answering the questions.]
4	anonymous	[Patients do not want to be uncomfortable answering the questions.]
5	anonymous	[Patients do not want to be uncomfortable answering the questions.]
6	anonymous	[Patients do not want to be uncomfortable answering the questions.] [assume that other nurses/providers will complete the survey.]
7	anonymous	[Other]
8	anonymous	[Patients do not want to be uncomfortable answering the questions.]

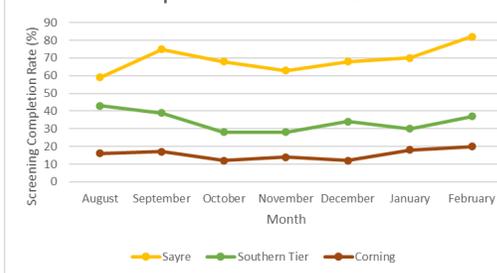
What barriers have you faced in completing the SDOH screening questionnaire at office visits? Check all that apply.

8 Responses

- I do not know what the questi... 0
- I have never seen the SDOH s... 0
- There's not enough time to as... 1
- Patients do not want to be un... 7
- Not relevant to office visits 0
- I don't know how to use the E... 0
- I assume that other nurses/pr... 1
- I do not know the right time t... 0
- only ask the questions to pat... 0
- The questions are confusing 0
- The questions are too long 0
- I do not feel comfortable aski... 1
- I don't know who to refer the... 0
- Other 1



SDOH Completion at Guthrie Pediatric Offices





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 area²
- 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 obesity³
- 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 value⁴⁻⁵
- 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 dreams⁶
- 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

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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, Westertorp 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.
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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/>

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

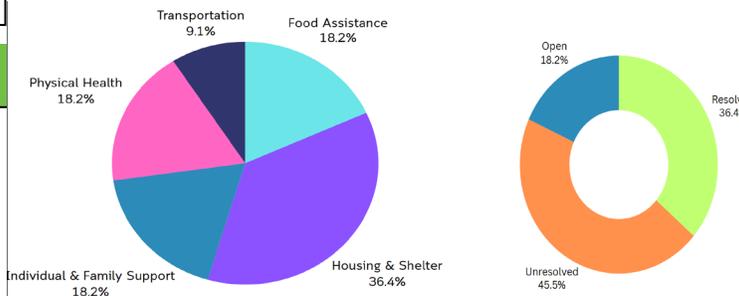
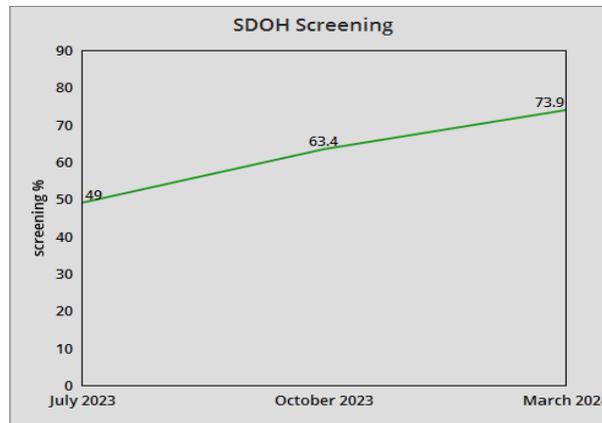
- Increase SDOH (Social Determinants of Health) screen-positive by 5% from the baseline in August 2023.
- Improve structured referrals to the care coordinator by 5% from the baseline in August 2023.
- Track the number of referred patients who are integrated into Unite US.
- Identify the percentage of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

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

Methods: Interventions/Changes

- 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.



Outcomes of referrals

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

Results:

- 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

Discussion

- Screening for SDOH is important as it indirectly impacts chronic medical conditions.
- After integrating SDOH 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.

Next Steps

- Critical next steps: Tracking the positive screened patients and following the outcomes
- Input: Arrange the Logistics

From Screen to Reality: Translating In-Patient gathered Social Determinants of Health Information to Discharge Care

Imran Amer, Ayesha Anwar, Shraddha Bhattarai, Daebin Im, Khwaja Hasan, Mahathi Kunduru, John Pamula & Victor Kolade

Introduction: Background & Context

Social determinants of Health (SDOH) are defined as the factors which impact health outcome 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.

Recognizing social determinants is significant for providing equitable health to communities which in turn results in growing trust in physicians and improved health outcome

Thus, early identification and intervention for various SDOHs, particularly in-patient settings where patients spent more time and less hesitant to discuss with team, is essential to impart knowledge to physicians regarding the needs of the population being served and relieve them from stress and financial burdens

Aim/Purpose/Objectives

- Increase the tracking of SDOH screen: Positive patients by 5% from baseline 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 of patients by survey

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

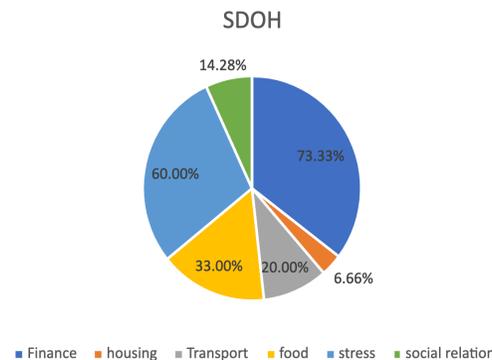
- Randomized sample of patients in resident run inpatient services- GMS, hospitalist, Cardiology will be selected and screening SDOH questionnaire will be provided.
- Patients who screen positive will be identified and case manager along with social worker will be involved according to the patient needs.
- 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
- Identification of the time-specific analysis of interventions by the SW, the proportion of the patients who get aid.

Results:

Around 65 patients admitted in inpatient resident services such as GMS, hospitalist and cardiologist have been screened
 Out of 65, 15 screened positive with a rate of 23.07%
 Intervention - SW follow-up to address the screen-positive problems
 Patient satisfaction survey is pending



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 constraint was 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. Lack of dedicated staff to use EPIC tool
- **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 used the 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.

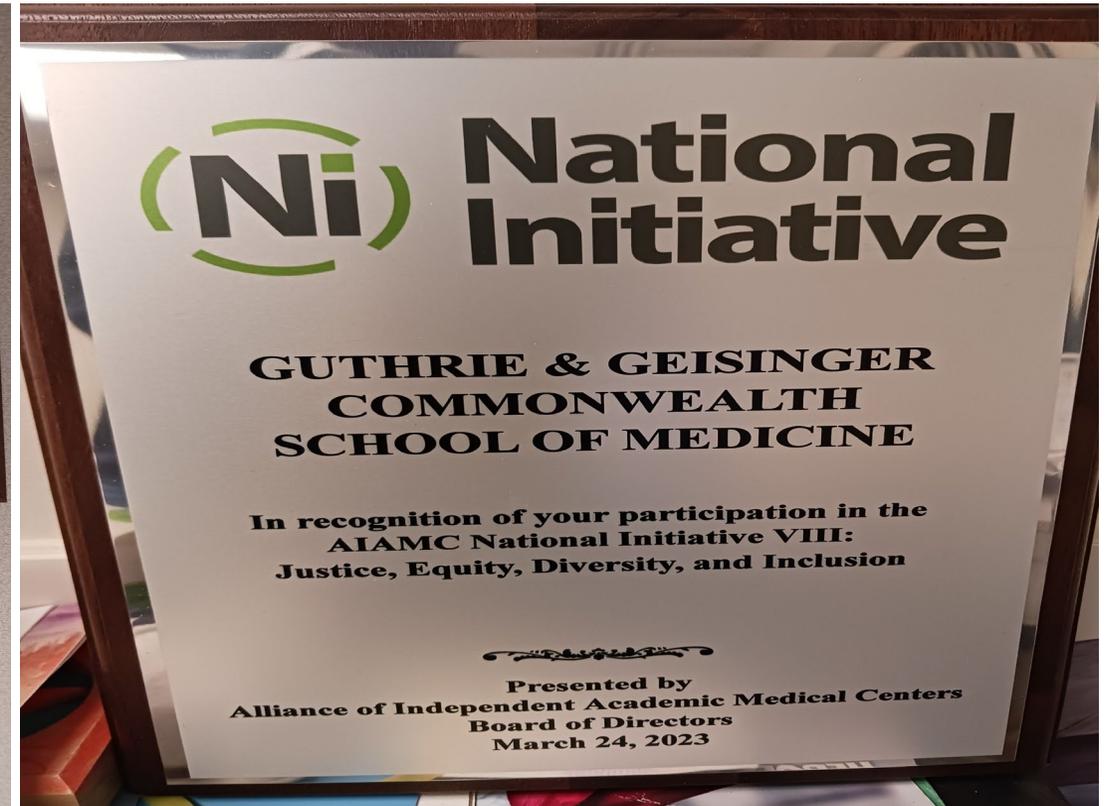
It will further help us in determining the impacts of addressing these factors on physical health and may highlight implementing biopsychosocial approach model for managing inpatient population in hospitals

Next Steps

Critical next steps: EPIC SDOH tool usage in in-patient admissions and Patient satisfaction tracking

Input: Logistics

National Initiative plaques





ALLIANCE

January/February 2024 Issue

update

Connecting
education
to exceptional
patient care

2024 Innovation Award Winner Named

The AIAMC Board of Directors recently announced **Guthrie Robert Packer Hospital** as the winner of the 2024 AIAMC Innovation Award.



GUTHRIE

They will be recognized with this esteemed honor at our awards dinner in Tucson on Friday, April 5th. *Widening the QI Team: Riding on Huddle-Back 2.0* was submitted by **Victor Kolade, MD**, Internal Medicine Clerkship Director, and **John Pamula, MD**, Vice Chair for Quality, Department of Medicine.

Drs. Kolade and Pamula stated in their application, "Our health system is 'hard-wired' to pursue several ambulatory quality metrics systemwide every academic year. This is included in the current strategic plan (2023-27) and will likely continue beyond that. Our system also expects daily office huddles to include provider and non-provider staff." Huddles occur at 8:40 am and include the office director, care coordinator,

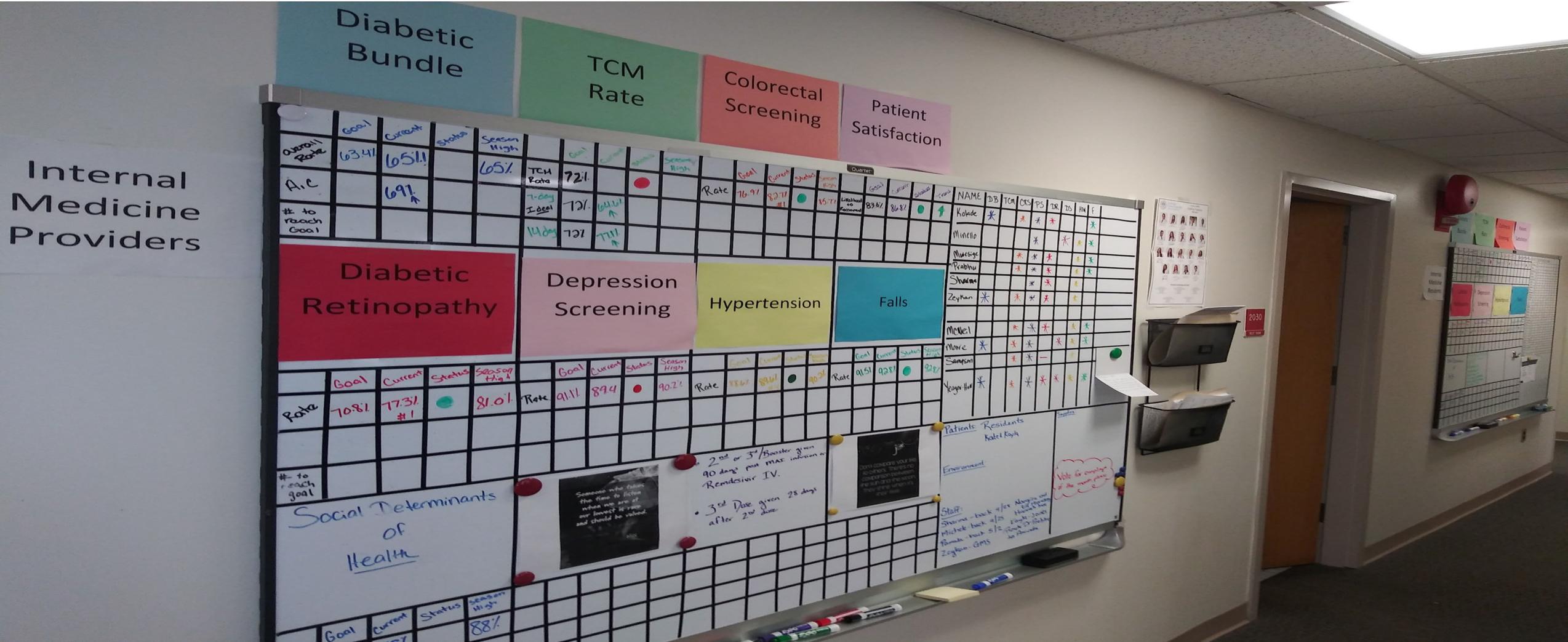
The AIAMC Innovation Award is presented on an annual basis to our institutional member who best exemplifies creative and innovative approaches to medical education and research in the following categories:

- The development and/or implementation of innovative medical education programs for residents, physicians and other staff and may include curriculum development and implementation, assessment methodologies, and/or outcomes*

Innovation Award requirements

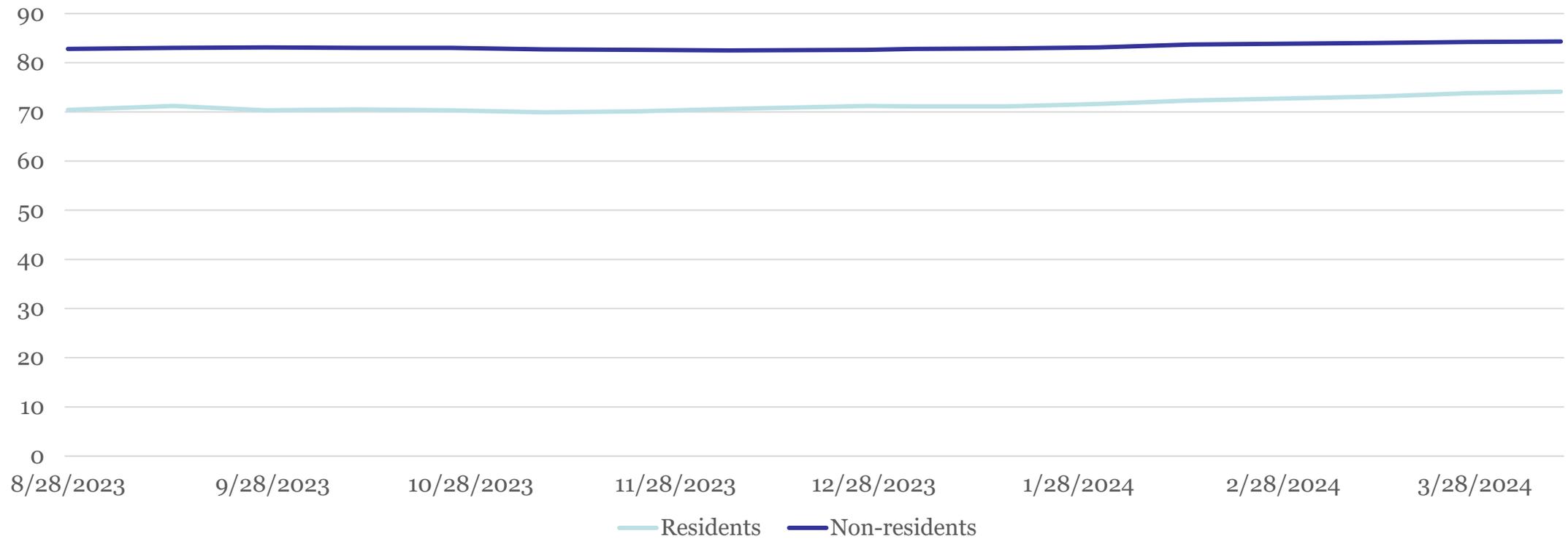
- AIAMC will present the Alliance Innovation Award on an annual basis to its institutional member who best exemplifies creative and **innovative approaches to medical education and research**
- The institution selected for this prestigious honor must demonstrate an innovation in the following categories:
 - The development and/or implementation of innovative medical education programs for residents, physicians and other staff and may include curriculum development and implementation, assessment methodologies, and/or **outcomes** related to medical education initiatives
 - Innovation significant themes such as **provider well-being, quality improvement, population health, health disparities** and/or cultural competency initiatives involving residents, physicians and other staff and related outcomes
 - The development and/or application of scientific discoveries/areas of research may include education, **health care improvement**, biomedical research and/or translational research

An 'Everyday Innovation' (Burrus, 2017)



2023-24

Colorectal cancer screening rate disparity in our clinic



About administrative fellows

Differences in Hypertension Control by Demographics and Social Determinants of Health

Lea Scopelliti, MHA; Victor O. Kolade, MD, MS, FACP
The Guthrie Clinic, Sayre, PA



INTRODUCTION: Background

The Guthrie Clinic began a journey towards health equity by diversity, Equity, and Inclusion (DEI) initiative that consists of committees under executive leadership that focus on employees, and patients. A focused committee worked with clinical stakeholders to identify diversity indicators. Physician leaders determined that hypertension control would be a suitable first metric to set a baseline for patient care equity, as it was a health system ambulatory quality metric at the time. We hypothesized that one or more selected demographic measures would demonstrate an effect on hypertension control among our patients. Of race, we hypothesized that White patients would have the best hypertension control.

Wang, Chin MH, et al. Development of PRAPARE Social Determinants of Health and Correlation with Diabetes and Hypertension Outcomes. *J Gen Intern Med.* 2022;37(4):668-679. doi:10.3122/jabfm.2022.04.200462

Anstey DE. Social Determinants of Health: Past, Current, and Future. *Hypertension and Blood Pressure Control. Am J Hypertens.* 2021;34(7):680-682. doi:10.1093/ajh/hpab023

Aim/Purpose/Objectives

To identify gaps in patient outcomes by one or more diversity indicators and provide data to support implementation of UniteUs to facilitate closing the loop on identified SDOH needs.

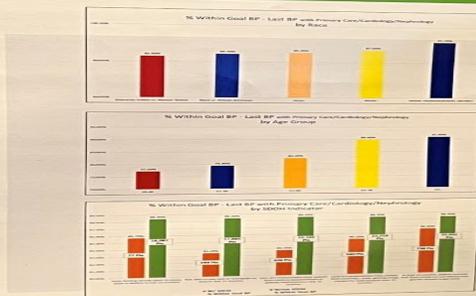
METHODS: Interventions/Changes

- Selection of Data from Epic EHR
- Dependent variable: Rate of hypertension control for patients with hypertension seen by primary care, cardiology, or nephrology
 - Age: 30-84
 - Visit dates: 2 year look-back from 31 January 2022
 - Data was sliced by "diversity indicators"
 - Age
 - Race
 - Indicated presence of a negative social determinant of health

METHODS: Measures/Metrics

Measure: Hypertension Control
The data was examined for hypertension control – defined as blood pressure (BP) of 140/90 or less in patients aged 59 years or younger and 150/90 or less in patients 60 years or older.

RESULTS



RESULTS: Continued

- **Demographics**
 - Patients aged 30–40 years, patients who self-identified as American Indian or Alaskan Native (AI/AN) and Black or African American (Black/AA), and patients who had indicated the presence of a social determinant of health were found to have worse rates of hypertension control than comparator groups, as shown below:
 - Amongst 30-40 year old patients 82.9% of AI/AN patients had blood pressures within goal at their last primary care, cardiology, or nephrology visit, compared to 84.4% of Black/AA, 85.3% of Asian, 87.7% of White, and 91.7% of Native Hawaiian/Pacific Islanders
 - 77.2% of patients aged 30-40 had BP control, versus 79.4% of 41-50 year-old patients, 82.4% of 51-60 year-old patients, 89.9% of 61-70 year-old patients, and 91% of patients aged 71 and over
- **Social Determinants of Health (SDOH)**
 - 85.6% of patients who admitted to worrying that food would not be available before they got money to buy more had BP control
 - 88.4% of patients who did not worry about running out of money had BP control
 - 83.7% of patients who reported lack of transportation to get to appointments from keeping medical appointments or getting to appointments
 - 83.4% of patients that reported not having that problem in the preceding 12 months attained BP control, compared to 83.4% of patients that said they were not able to get to appointments or a mortgage on time in the preceding 12 months
 - 83.4% of patients that said they were not able to get to appointments or a mortgage on time in the preceding 12 months attained BP control, as opposed to 88.4% of patients without that problem

Discussion: Barriers

- **Key Finding**
 - SDOH have direct bearings on hypertension control
- **Limitation**
 - 60% or fewer of patients with hypertension had SDOH data
- **Next Steps and Sustainability**
 - Opportunity exists to test whether SDOH to relevant community health workers such SDOH on clinical appointments
 - Implementation of UniteUs



And PosterSlams





Teaching Hospitals & Medical Schools: Moving Beyond Affiliation Agreements to Impactful Strategic Partnerships

Prepared for: Alliance of Independent Academic Medical Centers Annual Meeting

Tucson - April 2024



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Looking ahead

- PosterSlam and Breakout session entries due: 9/15/24
- Next NI IX presentation: 10/11/24
- Innovation Award submissions due: 11/15/24
- NI X proposal due: 6/1/25

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2024 RECIPIENT = SHELLY MONKS, FACHE

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