

RESIDENT PHYSICIANS AND HEALTH DISPARITIES: ATTITUDE PREDICTS BEHAVIOR

RACHEL BERNARD,
DO

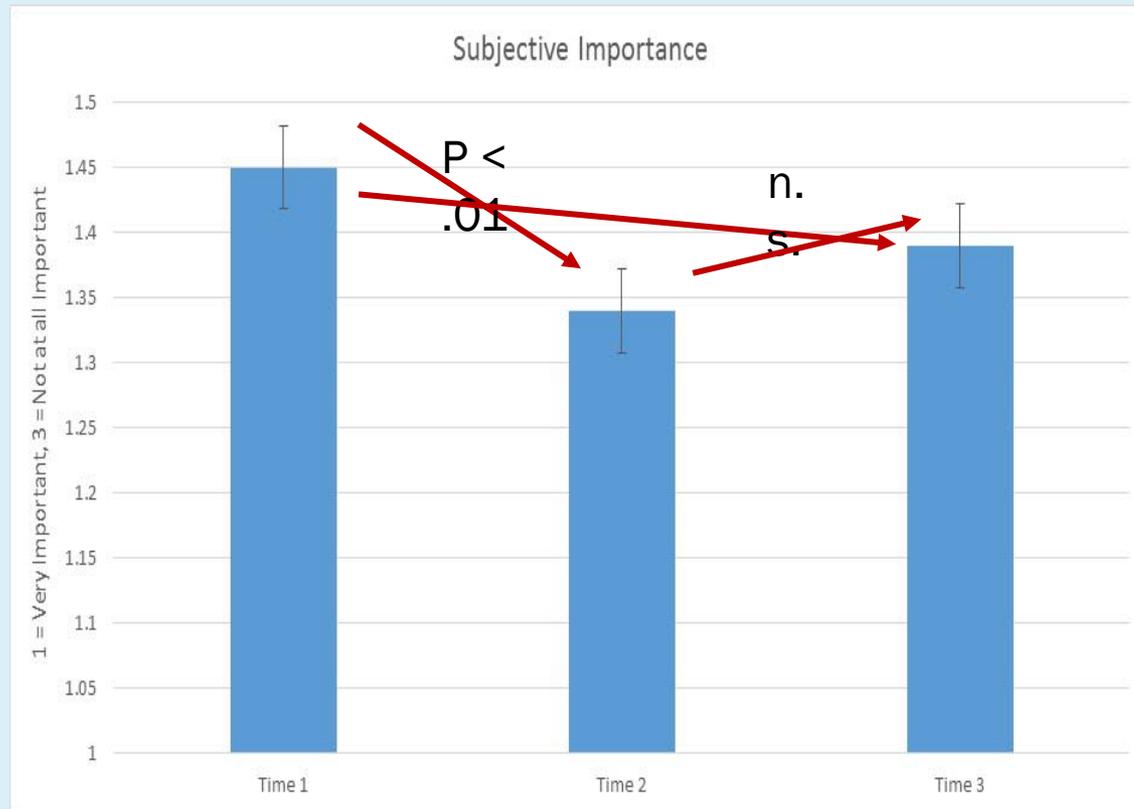
PGY-2 PEDIATRICS



METHODS



RESULTS- IMPORTANCE RATING



RESULTS- MID SURVERY (T2 RESPONSES)

- Did the didactic change your behavior?
55.3% yes
- Have you asked patients about barriers?
50% yes
- Have you made different recommendations?
63.2% yes
- Do you know your patients more now?
89.5% yes
- Have you done any solo research?
15.8% yes

RESULTS- POST SURVERY (T3 RESPONSES)

- How often did you ask your patients?
 - *None* = 10.5%
 - *<5x per week* = 60.5%
 - *6-15x per week* = 13.2%
 - *15+ per week* = 2.6%
 - *All patients* = 13.2%
- Did you learn new information by asking? 68.4% yes
- T2 mean importance correlated with T3 Ask frequency, $r = .44, p < .01$

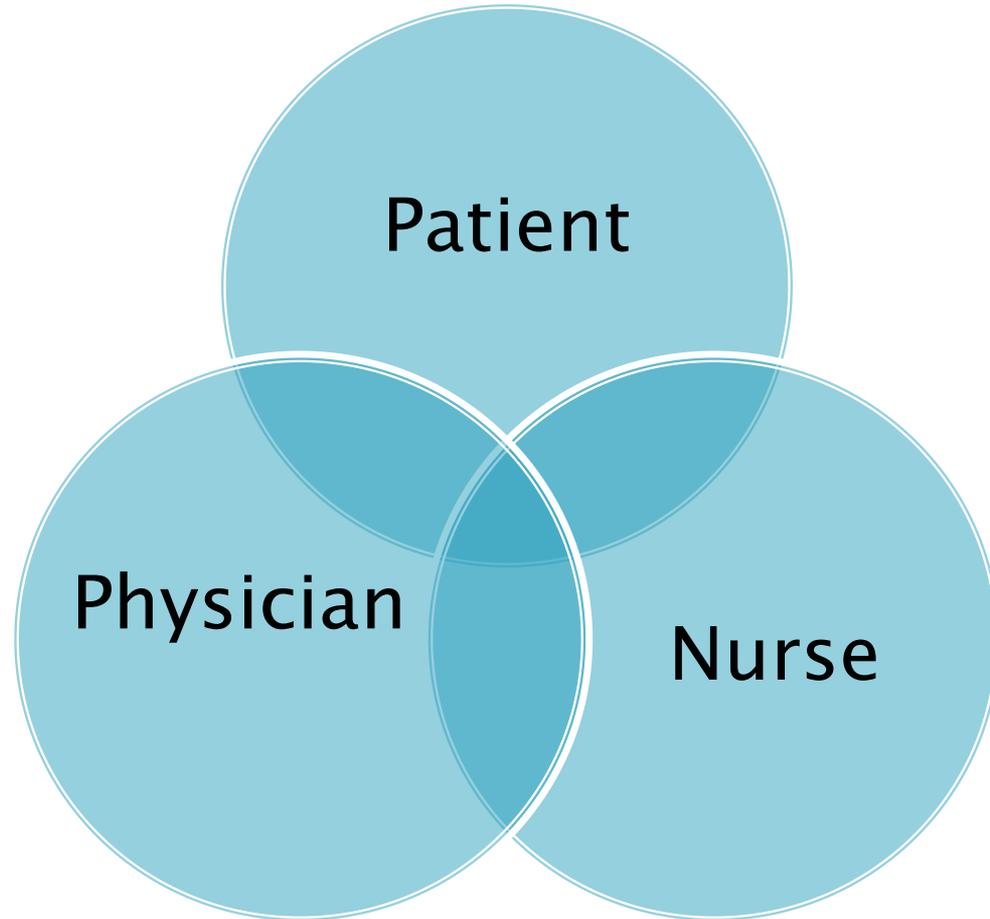


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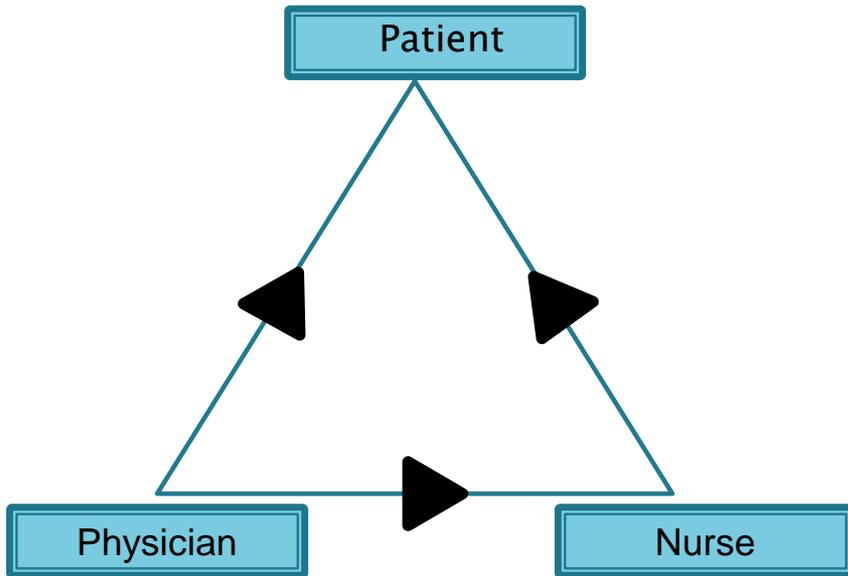
Concordance of knowledge of care plan in hospitalized adults: Outcomes and drivers

Surekha Bhamidipati, MD
Christiana Care Health System
Poster Slam Session
4/1/2017

Background: Concordance of Care plan



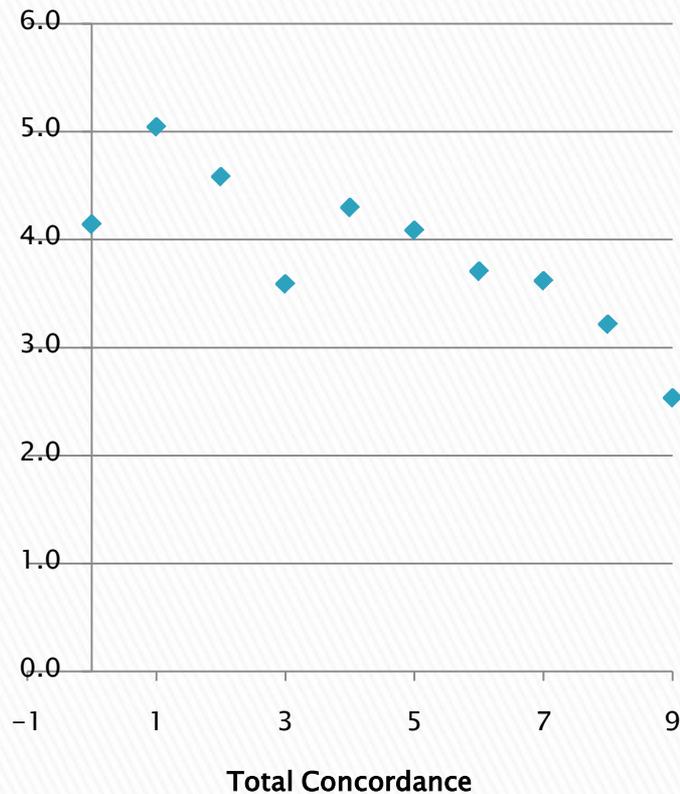
Methods: Interviews



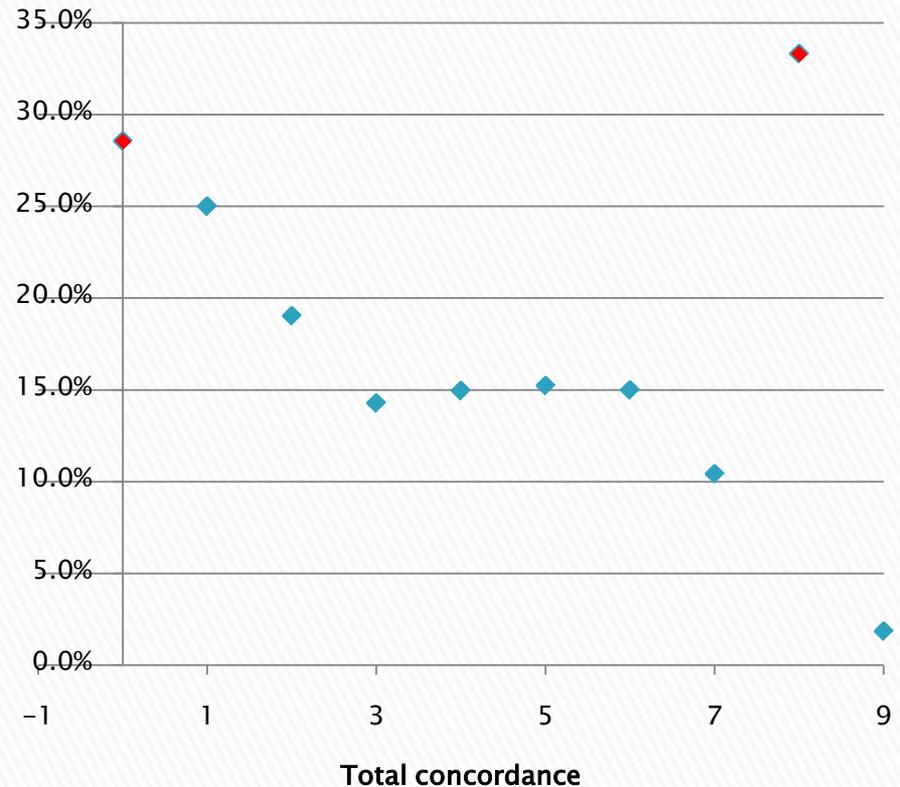
	Patient-Physician	Patient-Nurse	Nurse-Physician
Diagnosis	0= No/partial concordance	0	0
	1= Full Concordance	1	1
Tests and procedures	0	0	0
	1	1	1
Anticipated discharge date	0	0	0
	1	1	1

Results

Estimated Mean LOS (Days)

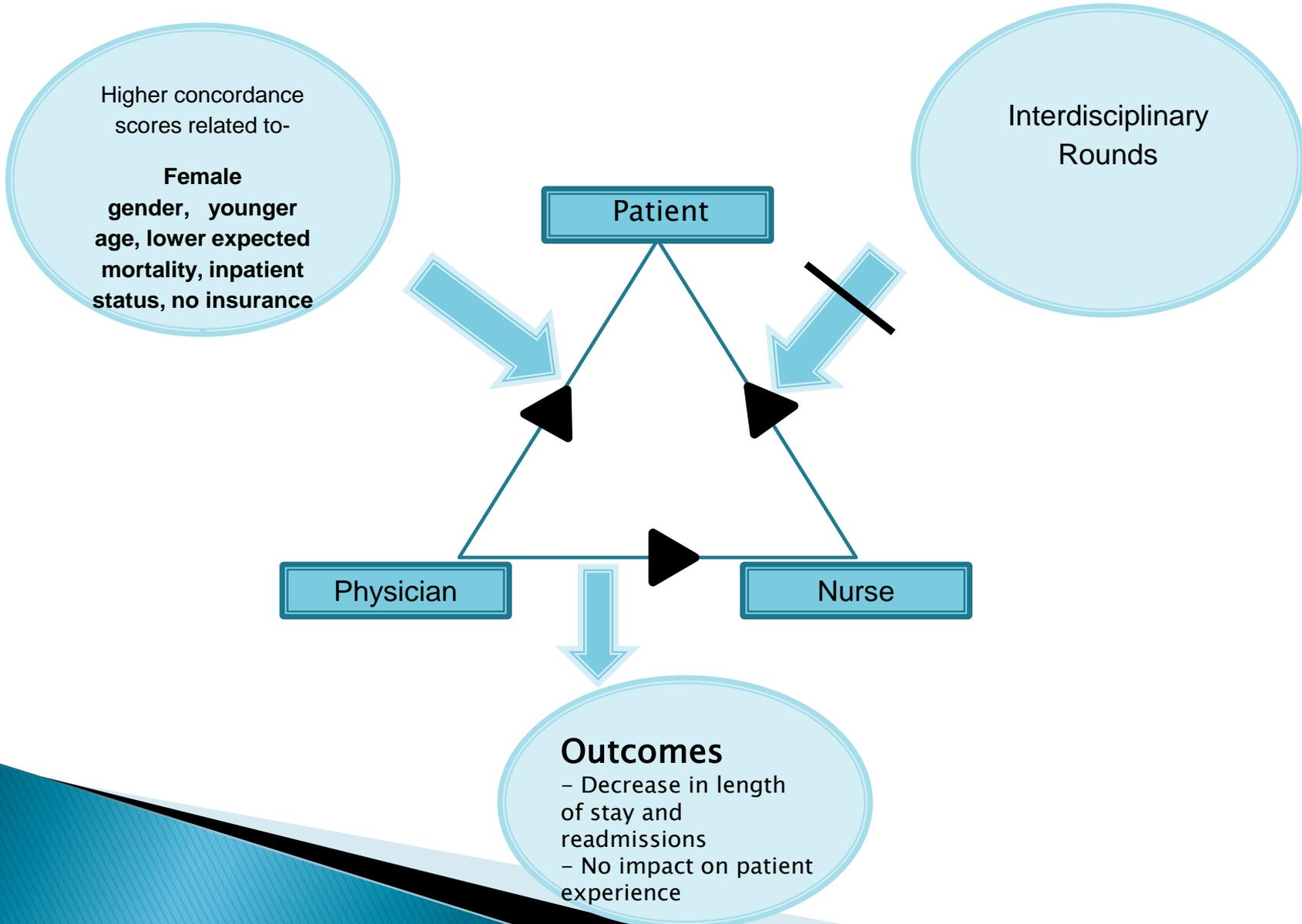


% 30-day readmissions



Adjusted for age, gender, race, ethnicity, admission status, health literacy, physician group, expected mortality and

Results and Conclusions



Predictors of Admission Status in Emergency Department Patients with COPD

Hayden Smith, Joe Walters, Craig Cookman
Saturday, April 1st, 2017

Introduction

- COPD associated with high incidence of morbidity & mortality
 - 3rd most common cause of death in US
- CDC estimated cost burden of COPD in 2010 approximately 36 billions dollars
- Aim of the study
 - Identify COPD patients utilizing ED resources
 - Identify/examine predictors of hospital admission
 - Identify role of socioeconomic determinants of health



Methods

Retrospective study

- Study period: 4th quarter 2011 - 3rd quarter of 2014
- Location: 3 Midwestern hospitals

Inclusion criteria

- ED encounter with a primary or secondary diagnosis of COPD

Exclusion criteria

- Missing vitals data

Primary dependent variable: hospital admission status

Statistical analysis

- Multilevel regression modeling to control for patient data dependence related to multiple ED encounters

Results

- 10,899 eligible ED encounters
 - 10,569 w/ complete vitals
- Mean age was 68 years
- 58% of encounters females
- 62% of encounters admitted

Predictors of admission		
Variable	AOR	p-value
Physical exam findings		
Heart rate > 100 bpm	1.84	< 0.0001
Respiratory rate > 20 bpm	1.39	< 0.0001
SpO2 < 92%	2.35	< 0.0001
Co-morbid conditions		
Anxiety	4.78	< 0.0001
Depression	5.43	< 0.0001
Demographics		
Male sex		
Older age (68+)		
Married		
Private vs federal insurance		
Private insurance vs self-pay		
Reside outside primary service area		
PCP vs no PCP		

Discussion

Study was a good initial start

Limitations:

- Secondary data set
- No data on:
 - Current tobacco use
 - Medication regimen compliance
 - Health literacy

Further studies needed to better characterize COPD population

Future goal is to create a COPD care team to better assist the patients in the community and prevent recurrent ED visits and subsequent hospitalizations



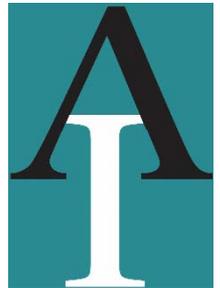
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Initiative to Improve Pediatric Outpatient Asthma Management

Andrew Fondell, DO, and Cynthia Hoque, DO
AIAMC Annual Meeting
April 1st, 2017

Goals

- ▶ Decrease the number of Emergency Department encounters for pediatric patients with asthma-related symptoms
- ▶ Increase office follow-up visits after ED encounter
- ▶ Decrease time to follow-up visits
- ▶ Identify barriers to controlling asthma



Project Outline

- ▶ Identify patients from ED encounters based on inclusion criteria
 - ▶ ED care manager contacts patient's guardian to encourage follow-up visit with PCP
 - ▶ Family contacted by clinic staff if follow-up not scheduled in order to assess patient's symptoms and encourage follow up visit
 - ▶ During office visit, attempt to meet with care manager to identify barriers in controlling asthma and triggers for asthma exacerbations
- 

Results

- ▶ Collected 2016 data and compared to similar patients in 2015
 - ▶ Improved follow-up visit rates from 59% to 66%
 - ▶ Increased ED repeat encounters from 9% to 35%
 - ▶ Decreased rates of hospital admission from 27% to 14%
- 

Outcomes of the Project

- ▶ Created a new route of communication between the Emergency Department and outpatient providers
 - ▶ Increased visibility of the Healthy Homes project
 - ▶ Further identified a group of patients requiring increased assistance and follow-up
- 

THREE RESIDENCY PROGRAMS' LESSONS LEARNED ABOUT DISPARITIES FROM A DEEP DIVE INTO OUR POPULATION DATA

Carla J. Kelly, DO, Wilhelm Lehmann, MD, Jeffrey Stearns, MD,
Deborah Simpson, PhD, David B. Thompson, MD, Jonathan Blaza, MD,
Sara M. Stanenas, DO, Molly K. Lepic, DO, Abel Irena, MD, Jasmine Wiley, MD,
Kushal Patel, MD, Richard Battiola, MD, Abiy A. Gesese, MD, Tracy
Greiten, MHA, Shelby L Pischke, BS, Jacqueline Gisch, RN, MS, Rebecca
Eberhardt, RN

From: Ob/Gyn, Family Medicine and Internal Medicine Residency Programs

WHO WE ARE – OB/GYN, FM, IM

- **Residency Clinics & Hospital Services**
 - Locations: Oldest hospital in MKE ... and clinics
 - Patients: REAL-G (underserved)
 - Disparities – every day!!
- **Continuously seek to improve care & training**
 - Get clinical metrics but not by **REAL-G** disparities
 - **R**ace, **E**thnicity, **A**ge, Preferred **L**anguage – **G**ender
 - ACGME Accredited and CLER (Health Care Quality)
 - AIAMC NI-V Participants

Health Research & Educational Trust. (2014, October). A framework for stratifying race, ethnicity and language data. Chicago, IL: Health Research & Educational Trust. Accessed at www.hpoe.org

AIM & METHODS: DISPARITIES

- **AIM:** To identify actionable disparity gaps for QI through detailed analysis of selected clinic level quality metrics by REAL-G Categories
- **METHODS:** 3 residency programs identified clinical quality disparity targets:
 - Family Medicine – Colorectal Cancer Screening
 - Internal Medicine – Diabetes
 - Ob/Gyn – Postpartum Readmissions for HTN
- Retrospective 12 mos analysis of targeted metrics using REAL-G categories to identify disparities by target
- Each residency team reviewed data and identified a REAL-G disparity target

RESULTS



- **FAMILY MEDICINE CRC**

- Age disparity (50-54 yo patients)

- **INTERNAL MEDICINE**

- African American/Black patients:
- 2 HbA1c checks/yr and BP control < 140/90

- **OB/GYN POST PARTUM HTN READMISSIONS**

- No REAL-G disparities (sm sample – chart audit)
 - 18% had HTN discharge instructions printed
 - 46% had postpartum BP appointments
 - Large # readmitted w/in 48-72 hrs discharge



WHAT WE LEARNED?



- **Data Analytics:**

- Tough to be 1st use REAL-G data in our system
- Analyzing clinical data at site level yields new insights to support pop QI

- **Patience, Persistence and Sustainability:**

- Project & Data = Heart (*have you pooped today?*)
- Leadership & participation
 - Resident and faculty duties
 - Competing projects



RESIDENT PHYSICIANS AND HEALTH DISPARITIES: Increasing Resident Knowledge

Carine Nzodom, MD
PGY-3 PSYCHIATRY



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Franciscan Missionaries of Our Lady Health System

Project AIMS and Methods

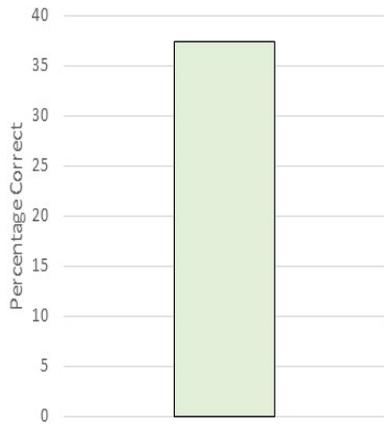
- 1.) Integrate a population health curriculum into resident education
- 2.) Engage residents in the assessment of healthcare disparities in the communities they serve

The project was designed to provide both a didactic intervention session and a targeted behavioral intervention with residents in six different residency programs.

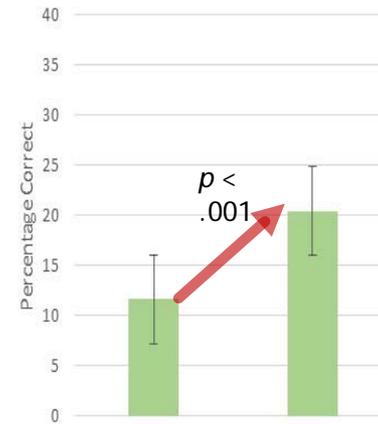


Results (N = 99)

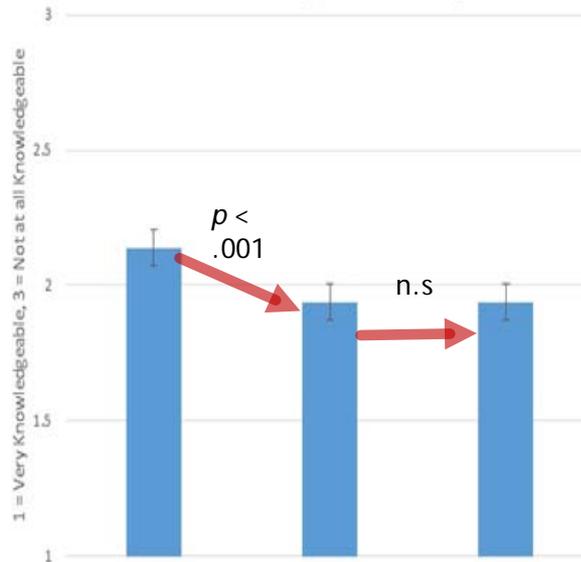
T1 General Knowledge



T1 and T2 Specific Knowledge



T1, T2, and T3 Subjective Knowledge



Results - T3 Ask Frequency

- ▶ How often did you ask your patients?
 - ▶ None = 6%
 - ▶ <5x per week = 34%
 - ▶ 6-15x per week = 14%
 - ▶ 15+ per week = 2%
 - ▶ All patients = 7%
- ▶ T2: Do you know more about your patients now than you did before the didactic?
 - ▶ 90% yes, 10% no
- ▶ T3: Did you learn anything new about your patients by asking them about barriers to care?
 - ▶ 71% yes, 29% no

CONCLUSION

- ▶ There is a deficit in resident knowledge of healthcare disparities
- ▶ The didactic increased Specific Knowledge
- ▶ Both interventions led to increased Subjective Knowledge Ratings
- ▶ Residents felt they gained more from the didactic than the behavioral intervention

INTERPROFESSIONAL EDUCATION AND THE CLINICAL LEARNING ENVIRONMENT: KEY ELEMENTS TO CONSIDER

Deborah Simpson PhD, John Brill, MD, MPH,
Jennifer Hartlaub, DNP, APNP, Kristin Rivera, Heather
Rivard, Heather Hageman, MBA,* Katherine Huggett, PhD+

YOU'VE JUST GOTTEN A CALL... CLINICAL PLACEMENT

- **Organization values**
 - Collaborative, team-based care
 - Education – and pipeline potential
- **But** barriers to effective IP learning in the clinical environment
 - Facility and Logistical Issues
 - Differing Requirements by Profession
 - Adds stressors to teachers, staff and patients
 - Limited literature to IPE clinical workplace



AIM & METHODS: IP-CLEC

- **Aim:** To create an Interprofessional Clinical Learning Environment Checklist (IP-CLEC)
 - Critical elements needed to operationalize IPE integration into the clinical workplace
- **Methods:** IP-CLEC combined two data sets:
 - Ambulatory-based clinical site quality indicators¹
 - Recently identified key features associated with operationalizing IPE in the clinical workplace²

1. Bowen JL, Stearns JA, Dohner C, Blackman J, Simpson D. Defining and evaluating quality for ambulatory care educational programs. Acad Med. 1997 Jun 1;72(6):506-10.

2. Hageman H, Huggett KN, Simpson D, et al. 12 Tips for Operationalizing IPE in the Clinical Workplace. Findings from the AAMC Regional Group on Educational Affairs Annual Spring Meetings 2016.

IP-CLEC: 3 DOMAINS

1. PEOPLE: Strong and visible IPE support

- from clinical and education leaders, clinical teachers across the professions and providers
- ✓ See IPE as “value added” to clinical mission
 - ✓ Recognize time/changes in clinical ops

2. CLINICAL SITE IPE READINESS:

- ✓ Teachers, providers/staff, patients IPE ready
- ✓ Must model appropriate IPE behaviors
- ✓ Sufficient clinical workspace for trainees

3. PROCESSES: See workplace-based IPE as opportunity for

- ✓ Rapid cycle PDSA and use of workflows
- ✓ IPE clinical placements + trainee on-boarding

Interprofessional Clinical Learning Environment Checklist	
✓ if yes	Key Features to Consider/Discuss when Considering IPE in the Clinical Workplace
PEOPLE: LEADERSHIP AND TEACHERS (ACROSS THE PROFESSIONS)	
	1. Leaders and teachers actively champion and support IPE in the clinical workplace
	2. Leaders see trainees as adding value to patient care by aligning patient and educational priorities
	3. Delineate various IPE trainees’ scope of practice and align with accreditation & supervision requirements
	4. Providers in the clinical workplace embrace IPE and the principles of patient-centered collaborative care
	5. Adapt existing evidence-based educational strategies approaches to support IPE (e.g., case conferences, clinic huddles)
	6. Teacher development resources/training available for on-site and web-based IPE oriented with option for continuing education credit
CLINICAL SITE READINESS	
	7. Clinical workplace provides patient centered care using a collaborative practice, team-based approach with multiple professions active at the site
	8. Sufficient clinical workspace to accommodate multiple health professions students (e.g., desktop/mobile workstations to access/review EHR, size/# of clinical and/or patient care rooms, debriefing areas)
	9. Clinical teachers available in each IPE profession
	10. Experienced clinical teacher(s) in at least one profession
	11. Provide ongoing feedback to IPE trainees and end of experience final assessments
	12. Patients willing to see interprofessional trainees
PROCESSES: RAPID CYCLE PDSA & WORKFLOWS	
	13. Workplace providers and trainees consider workplace-based IPE as opportunity for rapid cycle PDSA
	14. IPE can “start small”, be tested and “spread” results consistent with IHI Improvement Model
	15. Workflows for IPE clinical placements and onboarding to health care system and site

CURRENT & FUTURE STEPS

ONE STEP
AT A TIME

Piloting IP-CLEC in primary care clinic:

- 1. PEOPLE:** Key educ & clinical stakeholders mtgs
 - Explore/assess leader views of IPE as “*VALUE ADDED*”
- 2. FACILITIES:** Clinical site + provider are IPE ready
- 3. PROCESSES:** Connecting workplace-based IPE to
 - GME required QI → PI - CME

Future Steps include:

1. Review and refine IP-CLEC - then spread!
2. Evaluate the “value” of workplace based IPE