

PROJECT MANAGEMENT PLAN – Collaborating with Our Hispanic Population to Improve Diabetic Education, Prevention, and Care

<p>Vision Statement</p>	<p>Our vision is to serve the health needs of the Hispanic community through a holistic approach with an emphasis on education as an immediate step toward preventing and reducing the impact of diabetes. Markers of success were as follows:</p> <ul style="list-style-type: none"> • Build sustainable partnerships with the 60018 Hispanic community • Increase awareness and understanding of risk factors for and management of diabetes mellitus in the 60018 Hispanic community • Improve education and involvement of residents and attending physicians in understanding disparities and improving health equity in this population
<p>Team Objectives</p>	<p>ZIP code 60018 in our primary service area (PSA) has twice the Hispanic population of our other PSAs. It is well known that diabetes disproportionately impacts the Hispanic community. We first seek to understand the medical and community needs and resources and then to work with them to address their needs.</p>
<p>Success Factors</p>	<p>The most successful part of our work was obtaining executive leader sponsorship and grant dollars to sustain and expand the work of our NI V team. We were inspired by the people in the community who enthusiastically participated in the screening and educational sessions.</p>
<p>Barriers</p>	<p>The largest barrier encountered was the unrecognized challenges within our partner church. We worked to overcome this challenge by being patiently and respectfully persistent as well as flexible in developing a community health worker position when the church was unable to commit to a faith community nurse.</p>
<p>Lessons Learned</p>	<p>The single most important piece of advice to provide another team embarking on a similar initiative is to be prepared to listen to both the words and the nonverbal communication with an open and flexible mind.</p>

**Aurora Health Care, Milwaukee, WI
Disparities in Colorectal Cancer Screening**

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

Background: Colorectal cancer (CRC) is a national healthcare priority, as well as an Aurora Health Care (AHC) quality metric and a care gap per AHC’s CHNA. Our residency clinics face challenges associated with urban underserved populations, and the clinics are currently under the goal for the CRC screening quality metric. Studies have identified disparities in CRC screening, with screening less prevalent among patients who are uninsured and/or of lower socioeconomic status, African American/black, Asian, or non-English speaking Hispanic. Information on age-related disparities in CRC screening rates among eligible patients is limited.

Methods: A team of residents/faculty framed our approach using the Institute for Healthcare Improvement Model for Improvement. Providers at 2 family medicine clinics identified barriers to CRC screening using a fishbone approach to engage them in the improvement process. A retrospective analysis of all patients eligible for CRC screening at 2 targeted clinics, a control clinic (a residency clinic in the same ZIP code), and our care region during a 12-month period (December-November 2015) was completed in collaboration with AHC quality improvement specialists. The percentage of patients achieving the CRC screening metric was reported by REAL-G (race, ethnicity, age, language, gender) and insurance status. Categories with an n<25 were omitted. The criterion for disparity within a category was identified as >10%. The analysis was repeated in January 2017 for the intervention period (January-December 2016).

Results: The analysis showed that screening rates at all facilities and in the care region overall were lowest among patients in the 50- to 54-year-old age bracket. Identifying a specific disparity group provided a focus for improvement. After the intervention, screening rates in this age group increased in the 2 targeted clinics and overall.

Increased CRC screening rates appear to be influenced by improved CRC ordering workflows, clinic provider/staff education, and staff champions who are CRC advocates and who implement changes. The project created dialog about CRC screening rates in several AHC-wide groups, which may have encouraged change in our care region.

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

Diabetes—Improved Service Efficiency Improves Racial Disparity

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Background: Disparities are seen in diabetes management with poor outcomes in black/African American patients compared to white patients. Two of the 4 diabetic indicators showed racial disparity: at least 2 glycohemoglobin (A1c) checks per year and blood pressure control of <140/90 mmHg. Known strategies to reduce racial disparities in patients with diabetes include community engagement and patient empowerment, increasing access and improving care coordination, and improving the quality of care.

Methods: Patient disparities were identified using REAL-G categories (race, ethnicity, age, language, gender) from Epic analyses. Data collected through staff interview, group discussion, and a review of the workflow identified key barriers: on-time A1c ordering, patients staying for laboratory work, timely availability of laboratory results, and resident/staff workload. The optimal interventions identified and prioritized for diabetes mellitus targeted REAL-G disparities via literature and the healthcare team's perceptions of available resources. An A1c testing machine was purchased, and the clinic workflow was streamlined for point-of-care/day of patient appointment access. Orientation and training were provided for residents, faculty, and staff. Resident and faculty clinic champions were available each day of the workweek. Numerous PDSA cycles were conducted with the leadership of the clinic staff to improve the workflow related to point-of-care/day of A1c access.

Results: The Internal Medicine Clinic showed an overall increase in diabetes mellitus measures from 2015 to 2016. Overall, the patients receiving twice-yearly A1c checks increased by 9%. This result was under goal, but the clinic no-show rate remained static at 30%, challenging further improvement. Among African Americans, the percentage of patients receiving twice-yearly A1c checks increased from 63% in 2015 to 71% in 2016. Among white patients, those receiving twice-yearly A1c checks increased from 74% in 2015 to 80% in 2016. Overall, the number of patients with blood pressure <140/90mmHg increased by 2%.

Conclusion: Racial disparities exist in clinic settings where African Americans are the predominant customers. The disparities may be associated with overall service quality that can be improved by implementing interventions that improve service for all patients. The ability to sustain the project is increased through active involvement of clinic staff/leaders at project inception.

Preventing Postpartum Readmissions for Hypertension

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Background: Preventable readmissions related to hypertension were flagged as an area for improvement in OBGYN at Aurora Health Care. Hospital readmission rate is a Centers for Medicare and Medicaid Services focus, and in 2009, 27% of obstetric readmissions nationally were attributable to hypertensive disease. Our readmission