

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

Abel Irena, MD, MSc; Kushal Patel, MD; David B Thompson, MD; Abiy Gesese, MD;
Gregory J Schleis, MD; Richard J Battiola, MD

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

Molly K Lopic, DO; Sara M O'Meara, DO; Carla J Kelly, DO; Rebecca Eberhardt, RN;
Deborah Simpson, PhD; Jeffrey Stearns, MD

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

numbers were higher, providing a system opportunity to improve healthcare quality and education and thereby reduce readmissions.

Methods: In a retrospective chart review from November 2014–2015, we identified 27 readmissions for postpartum hypertension, representing 57% of all obstetric readmissions. Discharge instructions and a decreased interval to blood pressure reassessment were identified as areas of improvement. Provider and nursing education focused on awareness of hypertension readmissions, increased surveillance of postpartum vitals for patients with risk factors, and discharge instructions with appropriate verbal and written precautions for signs and symptoms of disease. Blood pressure checks were scheduled for 72 hours after discharge.

Results: Written discharge instructions regarding postpartum hypertension significantly improved. However, improvement in discharge instructions did not decrease overall readmissions for postpartum hypertension. The average days to readmission increased from 6 to 8 days.

Conclusion: Improved patient care and patient education can occur with small changes. Engaging nursing assistance and providing education for comprehensive discharge planning helped with consistency. Large projects driven by administrative priorities are best addressed with a multidisciplinary approach.

PROJECT MANAGEMENT PLAN – From Population Data to Patient: Analyzing Clinical Quality Data Using REAL-G Categories to Design Clinical Unit–Based Strategies for Intervention

Vision Statement	Aurora Health Care (AHC) aspires to provide ALL people better healthcare than they can get anywhere else. Our vision is to improve healthcare through engaging residents and faculty in identifying and addressing disparities in clinical quality metrics, creating a win-win for patients and providers.
Team Objectives	<p>Our objectives were as follows:</p> <ul style="list-style-type: none"> • Use existing clinical quality data to identify healthcare disparities using REAL-G (race, ethnicity, age, language, gender) categories • Design and implement evidence-based strategies to address disparity gaps in targeted clinical settings (resident clinic and postpartum obstetrics) through partnerships among residents, faculty, caregivers, Aurora data management individuals, patients, and communities • Share our processes and outcomes within the AHC community to sustain/spread our initiatives
Success Factors	<p>The most successful part of our work was addressing clinically important hospital/clinic performance needs (eg, postpartum hypertension readmissions). We also framed disparities in terms of REAL-G by making disparities clinically relevant to providers who work on a daily basis with the underserved as well as to quality/care management leaders. We were among the earliest adopters of REAL-G data analysis to inform quality improvement initiatives for patients served by our residency programs. We served as pilots for system partners to explore how to analyze REAL-G data and educate physicians on diversity and inclusion, etc. We also demonstrated the value of integrating residents with their respective healthcare teams to actively engage in process improvement, resulting in better care. We were inspired by the following:</p> <ul style="list-style-type: none"> • Collaboration with residents, faculty, and clinic/hospital staff to implement change to improve care for our target disparity population (and all eligible patients as a whole): “We moved a metric that had been static for years.” • The passion and commitment of the healthcare team members • The power of teamwork and bridging the gap between resident and clinic staff: “It’s as close as we’ve gotten of bridging our patient care and resident education—and impact.” • The great projects and passion of all the projects presented by other teams at the AIAMC meetings and the passion all the teams had for making a difference: “It was really cool.”
Barriers	The largest barrier encountered was the use of REAL-G data to frame our work—from engaging data analysts and teams to implementation—which added time and complexity to the normal change processes. We worked to overcome this challenge by patience, persistence, strong and visible C-suite support for the project, new partnership, expanding involvement of the clinical care/project team(s), and humor.

<p>Lessons Learned</p>	<p>Paradigm Shift: With each project, residents, faculty, and staff came to the realization that a new engagement between residency education and clinical change is needed. We are shifting the paradigm to recognize that the knowledge and skills for process change are critical to improving care of patients and populations.</p> <p>Protected Time: Formalize time involved in the project with acceptance by faculty/attendings (eg, protected/block time) and to be firmer with the team's time commitments and timelines.</p> <p>Increase Clinic Engagement: Push harder to engage a larger group with a clear delineation of roles, expectations, and accountabilities. We also need to increase involvement of the core team to draw on residents/faculty and clinic staff (eg, the operations staff who were at the pilot clinic such as the clinic medical director and supervisor of clinical operations).</p> <p>Education: Increase the curricular emphasis/formal education for residents with ongoing reeducation.</p> <p>Data: Increase the ability to access data in a format that supports analysis at the system level with data analyst support to more agilely answer emerging questions.</p>
------------------------	---

Bassett Medical Center, Cooperstown, NY Partnerships for Developing Strategy and Curriculum in Disparities

James Dalton, MD; Edward Bischof, MD; Sue van der Sommen; Kara Travis; Sarah Mader, DO

Background: Bassett's first CLER visit in February 2015 demonstrated that while we had a number of programs dedicated to helping underserved segments of our population in rural, upstate New York, we did not have an overall strategy to assess healthcare delivery to diverse parts of our population. We also did not have an educational program to expose resident physicians to the diverse parts of our population. Our project goals were to develop an institutional strategy for understanding and addressing the diverse population Bassett serves and to develop a curriculum in disparities for our GME programs.

Methods: A steering committee was convened in September 2015 that included leaders from clinical areas in both the Bassett and the private practice community, as well as leaders from public health, administration, research, quality improvement, outreach, mental health, and medical education. The CEO of Bassett was a frequent participant in the steering committee. The committee met every 6 weeks to monitor progress and to give input to work groups focused on institutional strategy and curriculum development.

Results: An institutional strategy was developed that calls for the following: tie the elimination of healthcare disparities to Bassett's mission/vision/values; use IT and research to better understand the demographics of our region; create dashboards for our disparate populations for preventive care, cancer, and heart care; provide cultural competency training across the institution; achieve a high Health Equity Index; target interventions understanding cost and impact; continue and enhance collaboration with the community; and engage leadership at the board level. An internal medicine disparities curriculum was created that includes experiential blocks at the Gender Wellness Center and the independent, grant-funded free clinic. Didactic curriculum supports the experiential learning. In partnership with the *Delivery System Reform Incentive Payment* program (a New York state program designed to reduce healthcare disparities among Medicaid enrollees) and Leatherstocking Collaborative Health Partners, a curriculum in cultural competency was developed with the intention of rolling it out to the entire organization and its partners.

Conclusion: The partnership of internal and external stakeholders at Bassett and its surrounding communities has successfully developed a draft of an institutional strategy for addressing healthcare disparities in our region. A residency program has been initiated in the internal medicine residency. A curriculum in cultural competency has begun for the entire organization and its partners. Multiple research opportunities have been created because of the development of these curricula.