INTRODUCTION / BACKGROUND

- **VALUE-BASED CARE** is person-centric and population based
- **IDENTIFYING AT RISK POPULATIONS** – those with disparities in clinical measures – using REAL-G categories
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RESULTS: FAMILY MEDICINE CRC SCREENING

- CRC screening population records were sampled for eligible patients >/= age 50 for MKE-S (N=59,745), FCC (N=846), and FPC (N=1,458)
- Largest CRC screening disparity was associated with age with screening gaps ranging from 13-15% between populations aged > 65 vs age 50-54
- CRC Screening Rate disparities by race, ethnicity and gender were <10%

**QI AIM:** Achieve a 5% decrease in CRC screening age disparity (50-54 yo) in residency clinics by 1.2017

**CHANGES INCLUDE:**
- Enhance clinical workflow
- Education re: 3 CRC screening options

RESULTS: INTERNAL MEDICINE DIABETES

- **DM Patients <2 HbA1c in 12months**
  - African American: 64% (Goal = 71%)
  - Other Hispanic: 55% (Goal = 71%)
  - White Non Hispanic: 63% (Goal = 71%)

**QI OUTCOMES:**
- Improve by 10% the number of African American/Black patients that receive 2 HbA1c checks per year
- Outcome: Improve by 5% the number of African American/Black patients with BP control <140/90

**CHANGES INCLUDE:**
- Implement POC HbA1c checks
- Diabetics with poor glycemic control or poor BP control will be referred to a pharmacist for additional medication management/review
- Diabetic Education for all residents
- Resident/Faculty Champions for each clinic ½ day

RESULTS: OB POSTPARTUM HTN

- Ob/Gyn data required deeper analysis due to database/sample size – chart audit conducted
- N=28 pts readmitted with Postpartum HTN
  - 57% of all readmissions
- **AGE:** 68% 18-34; 29% 34-40; 3% < 18
- **RACE:** 82% African American; 7% White; 7% Asian; 4% Hispanic
- **LANGUAGE:** 92% spoke English
  - 18% had HTN discharge instructions printed
  - 46% had postpartum BP appointments
- Large # readmitted w/in 48-72 hrs discharge

**QI AIM:**
- Educate pts prior to discharge on their dx with understandable written/verbal info
- Ensure patient understanding + recognize symptoms
- Create easier access to follow up with scheduled appointments + access to Rx meds prior to discharge

**CHANGES INCLUDE:**
- Provider + Nursing Education: Increased surveillance for postpartum vital at risk pts; Verbal + written precautions for signs/sx of de novo or worsening disease
- Access to Care: BP checks w/in 72 hours with VNA services.

DATA ANALYTICS: Analyzing clinical quality data at the site level using REAL-G disparity categories yields insights to support pop QI

COLLABORATION IS ESSENTIAL: Data analysts provide site/market level metrics; Diversity & Inclusion Leadership; Clinic Leaders...

PATIENCE, PERSISTENCE AND SUSTAINABILITY: Resident duties impacts consistent leadership & participation + they graduate necessitating succession planning

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RESOURCES


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METHODS

- Three 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

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