# Health Disparities/Equity Self-Directed Clinical Performance Improvement


This activity provides a mechanism for meeting the Performance Improvement (PI) requirement by telling ABFM about how you have assessed and improved the way your practice addresses social determinants of health; health equity (broadly defined); and/or systemic ways in which you assure that patient access, experience, and care are equitable. This PI can address many different dimensions of care - such as assessing race/ethnicity, socioeconomic status, sexual orientation/ gender identity, disability, rural, or under-served groups of people. From this, you can plan an intervention to close gaps in care. For example, disparate outcomes of common screening activities (cancer, HIV) and conditions (quality measures for hypertension, diabetes, etc.)

## What Information Will You Need to Provide?

1. **The start and end date of the improvement project.**
   Your credit is applied at the end date of the project once it is confirmed to have met the American Board of Family Medicine (ABFM) PI requirements.

2. **If externally funded, how the project was funded.**
   The project must meet the ABFM Industry Support policy that prohibits pharmaceutical and device manufacturer influence on activities for certification credit.

3. **The relevant topic areas for the project.**
   Select one or more topic areas from the drop-down list provided in order to categorize the project.

4. **What problem or gap in quality was the project intended to address?**
   For example: a gap might be Colorectal Cancer screenings for patients of color was lower than that of other patient populations. “I wanted to ensure that all patient populations received the recommended cancer screenings.” e.g., Social Determinants of Health was not addressed for each of my patients. “I wanted to ensure that all patients received Social Determinants of Health screening at each visit.”

5. **As a result of identifying the gap in quality, what did the project aim to accomplish?**
   An aim statement is a clear, quantifiable goal set within a specific time frame. It states what you tried to change, by how much, and by when. An aim statement is broken into three parts:

   - ❑ **What did you try to change?**
     *e.g., We aimed to complete the recommended colorectal cancer screenings for all patients seen for a visit within 6 months.*

     *e.g., We aimed to screen for Social Determinants of Health for all patients seen for a visit within 3 months.*
   - ❑ **What was your improvement goal?**
     *e.g., improving our rate to 85% compliance*
   - ❑ **What was the time frame for this to be accomplished?**
     *e.g., within 9 months*

## Key Things to Know

- ☑ You may report on an improvement effort you conducted alone or within a single practice group, an ACO, other larger group practices or other organization coordinating quality improvement activities.
- ☑ You can use this pathway whether you see patients in a continuity setting, or if you are providing non-continuity episodic care (e.g., hospitalist, telemedicine, locums, urgent care, emergency department, etc.).

6. **What measures were used in the project to evaluate progress?**
   Measures are directly related to the aim statement showing whether a project's changes are resulting in improvement.

   **EXAMPLE:**
   - **Measure Name:** Recommended Colorectal Cancer Screenings Completed
   - **Goal:** Improve number of patients of color who completed the recommended colorectal cancer screenings to 75%
   - **Number of Patient Records:** 25 or more
   - **Baseline Percentage or Rate:** 50%
   - **Follow-up Percentage or Rate:** 75%

   **EXAMPLE:**
   - **Measure Name:** Social Determinant of Health Screenings Completed
   - **Goal:** Improve number of patients who have a Social Determinant of Health Screening Completed to 80%
   - **Number of Patient Records:** 25 or more
   - **Baseline Percentage or Rate:** 0%
   - **Follow-up Percentage or Rate:** 75%

7. **The results of the improvement effort.**
   Provide the baseline and follow-up percentage or number meeting the stated measure(s).

8. **The interventions or changes that were made during the project.**
   *e.g., Provided education to each patient seen on the recommended cancer screenings. Make needed appointments for screenings while patient is in the office. Work with community partners to encourage cancer screenings for patients of color.*

   *e.g., Assess your practice use of Social Determinants of Health Screening using www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/assessing-practice-web.pdf. Create a checklist that can be used for each patient visit to assess Social Determinants of Health.*

9. **Describe the impact of these changes in your practice. What lessons did you learn?**
   Use this space to share the positive outcomes of your changes.

10–15. **Complete attestation questions**
   Demonstration of active involvement in the improvement process is necessary for approval of a self-directed activity.
   - Were you the project leader?
   - Did you review the data periodically to assess improvement?
   - Were you part of the team that designed the project and reviewed the results?
   - Were you an active participant in deciding on the intervention(s)?

## Ready to get started?

Log into your MyABFM Portfolio, select Performance Improvement activities from the main screen. On the PI screen you can click on View All Activities and choose Health Disparities/Equity Self-Directed Clinical from the list.

## Support Center

ABFM is here to support you in your certification efforts. Our Support Center agents will answer your questions or direct you to the right person who can meet your needs. We are available by phone, email or live chat.

**PHONE:** **877-223-7437**
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**HOURS:** Monday–Friday: 8 AM – 9 PM (Eastern)
Saturday: 9 AM – 5 PM (Eastern)

American Board of Family Medicine

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