Workshop 3

Clinical Practice as a Key Resource in Improving Health in an Equitable Manner

XAVIER UNIVERSITY OF LOUISIANA COLLEGE OF PHARMACY
SIXTH HEALTH DISPARITIES CONFERENCE
IMPROVING MEDICAL EFFECTIVENESS AND HEALTH OUTCOMES TO ACHIEVE HEALTH EQUITY THROUGH INTERPROFESSIONAL COLLABORATIONS
NEW ORLEANS, LOUISIANA MARCH 7-9, 2013

Accreditation

UAN 0024-0000-13-006-L04-P

Participation in this activity earns 1.25 contact hours. To receive credit, participants must complete an evaluation form at the conclusion of this session.

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At the completion of this activity, participants will be able to:

- Identify practice strategies that are successful in clinical settings.

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Yolanda M. Hardy, PharmD

OPENING REMARKS

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1. The patient centered medical home (PCMH) is certified by which of the following?
   a. JCAHO (Joint Commission on Accreditation of Hospital Organizations)
   b. AHA (American Hospital Association)
   c. NCQA (National Committee for Quality Assurance)
   d. AMA (American Medical Association)
2. List the triple aims addressed by the PCMH.
3. List three (3) principles of the PCMH.

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LaKeisha G. Williams, PharmD, MSPH

ABSTRACT PRESENTATION

Utilizing Clinical Interprofessional Services to Improve the Care of an Indigent Diabetic Population

LaKeisha Williams, PharmD, MSPH
Drug Information Specialist
Xavier University of Louisiana
College of Pharmacy
March 8, 2013

Learning Objectives

- Discuss reasons for poor health outcomes in the United States
- Discuss the epidemic of diabetes in the U.S.
- Describe key elements of the Patient Centered Medical Home (PCMH) and its value in patient care
- Describe components of the Diabetes Internal Medicine (DIME) Clinic and the role of the healthcare professional
- Discuss current outcomes of the DIME clinic
- Discuss implications or clinical practice

Overall Ranking by Country

Country Rankings
1.00–2.33
2.34–4.66
4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).

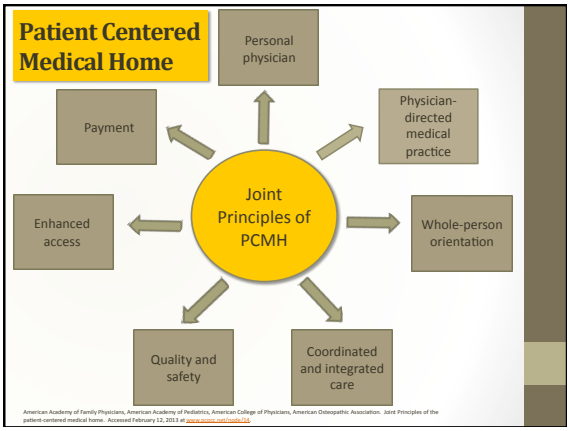
Why Disparity in U.S. Healthcare?

- Healthcare coverage
- Healthcare costs
- Household income
- Emphasis on specialty care versus primary care

Epidemic of Diabetes

- Diabetes affects at least **25 million** people in the United States
- Costs an estimated **$174 billion** in medical expenditures
- Disproportionately affects minority populations
  - African American adults are twice as likely than non-Hispanic white adults to have been diagnosed with diabetes
  - African Americans are more likely to experience complications
    - Rate of diabetic ESRD (end stage renal disease) is 2.6 times higher among African Americans than among Caucasians
  - Increasing prevalence among the elderly

Agency for Healthcare Research and Quality. Diabetes disparities among racial and ethnic minorities. www.ahrq.gov/research/diabdisp.htm. Office of Minority Health. Diabetes and African Americans. http://minorityhealth.hhs.gov/templates/content.aspx?ID=3012. Centers for Disease Control and Prevention. Diabetes Data & Trends. www.cdc.gov/diabetes/statistics/prevalence_national.htm



American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint Principles of the patient-centered medical home. Accessed February 12, 2013 at www.pcmh.net/node/314

What is the value of the PCMH?

Reduce health care costs

PCMH

Improve patient care

Improve patient care experience

Results: PCMH Initiatives

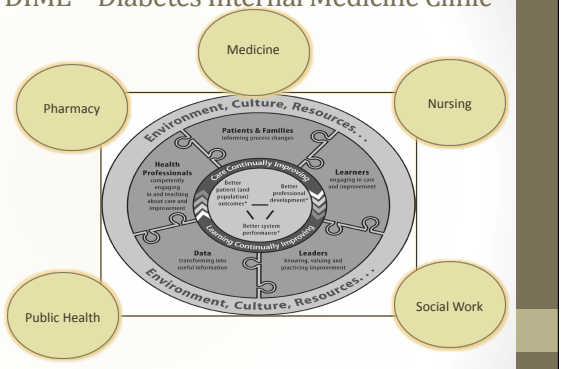
BCBS (Blue Cross Blue Shield) of Texas (2012)
- 23% lower readmission rates
- $1.2 million estimated health care cost savings
- Increased control of HbA1C levels from 81% to 93% of diabetes patients

Results: PCMH Initiatives

UPMC of Pennsylvania (2011)
- 20% long-term improvement in control of blood sugar
- 37% long-term improvement of cholesterol control
- Increases in eye exams from 50% to 90%

Benefits of Implementing the Primary Care Patient-Centered Medical Home: A review of cost and quality results, 2012. Accessed at www.pcpcc.net/files/benefits_of_implementing_the_primary_care_pcmh_0.pdf

DIME – Diabetes Internal Medicine Clinic



Exemplary Care and Learning Sites: Linking the Continual Improvement of Learning and the Continual Improvement of Care. Headrick L et al. Acad Med. 2011; 86:e6-e7.

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Phase II

Engaging Partners In An Evidence-Based Health Management Project

Xavier University of Louisiana College of Pharmacy
Sixth Health Disparities Conference
March 8, 2013

D Sunda-Meya, BS; KI Rapp, PharmD, AE-C; L Jack Jr., PhD, MSc; CM Wilson, MPH; SD Denham, MSW, MPH, AE-C; M Sanders, MSEd, AE-C; AP Porter; P Dixon, N Morris, PhD; R Arnaud, RN; F Malveaux, MD, PhD

Presentation Overview

- Implementing An Evidence-Based Health Management Project
- HEAL, Phase II Partners
- Role of Partners
- Engaging Partners
- Challenges and Successes
- Conclusion

Implementing An Evidence-Based Health Management Project

Selecting Partners
- Specific to project needs and goals
- Understanding of partners' history and values
- Endorsed and supported by funders
- Target population

Partners Concerns
- Sensitive to partners' history and values
- Value of partners' expertise in health care
- Effectiveness of evidence-based tools
- Integrating into partners' system

Implementation & Integration
- Adopting implementation
- Applying evidence-based practices
- Evaluating and re-evaluating process measures
- Realistic outcome measures

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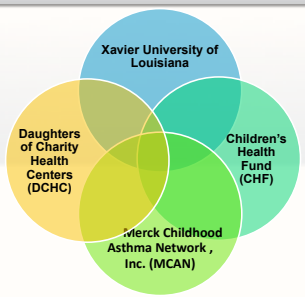
HEAL, Phase II Partners



Head-off Environmental Asthma in Louisiana II

About Xavier University of Louisiana

- College of Pharmacy
- Center for Minority Health & Health Disparities Research and Education
- Mission: To integrate health promotion education, and disease prevention into primary care services

About Daughters of Charity

- Catholic non-profit healthcare system
- Primary and preventative care
- Medical home based on Chronic Care Model
- Low income population
- Core Team:
  - Director of Program Affiliations
  - Director of Quality Improvement
  - Chief Nursing Officer
  - Pediatrician
  - Nurse Care Manager
  - Director of Community Care
  - Director of Pharmacy

About Children's Health Fund

- Nation's leading pediatric provider of mobile-based health care
- Tulane University Health Sciences Center
- Brings health care to all children and low income population
- Team:
  - Director of CHF-NO
  - Program Manager

About HEAL, Phase II Project

- Extend and build upon the lessons learned from HEAL I
- Utilize a partnership model to implement elements of the Chronic Care Model to address pediatric asthma
- Implement a multifaceted intervention in a real world setting
- Components:
  - Asthma education and management
  - Electronic health system
  - Healthcare provider training
  - Community outreach

More About HEAL, Phase II…

- Funded for 4 years
  - 1st Year: Planning Year
  - 2nd Year: EHS enhancements, IRB proposal, Asthma Educator integration, recruitment and 3-4 month pilot phase
  - 3rd Year: Implementation, recruitment, home environmental assessment and data collection at baseline, 6 and 12 months
- HEAL, Phase II Team:
  - Principal Investigator/Director
  - Program Manager
  - 2 Certified Asthma Educators (AE-Cs)
  - 2 Community Health Workers (CHWs)
  - Biostatistician
- Number of patient seen: 194 patients (December, 2011- January, 2013)
- Target sample size: 174 patients

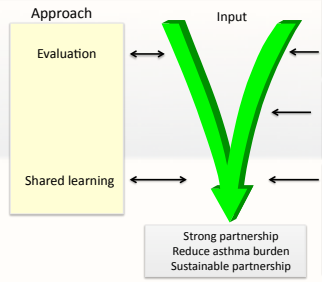
Role of Partners

DCHC	Xavier University of Louisiana	CHF
• Clinics • Patients (2-18 yr) • Electronic Health System - Asthma Severity Index • Data	• HEAL, Phase II Project • AE-Cs - Tailored Asthma Education • CHWs - Home Environmental Assessment • Evidence-based tools • Provider trainings	• Mobile unit • Patients (2-18 yr) • Data

Engaging Partners

- Phone calls
- Meetings
- Workgroup
- Shared objectives, mission and goals
- Shared common interest (data collection, ASI, asthma education, number of patients, asthma outcome measures
- Trainings
- Team work

Planning Phase Process



Phase 1: Building the Vision
- Goals
- Objectives
- On-going meetings

Phase 2: Building on Best Practices
- Literature reviews
- Evidence based-tools
- Additional tools

Phase 3: Building for Integration, Implementation and Sustainability
- IRB approval
- EHS enhancement
- Variable outcomes
- Clinic workflow
- Trainings

www.bcbsmnfoundation.org/download.cfm?oID=19607

Challenges and Successes

Successes	Challenges
• Adoption of asthma guidelines • Adoption of evidence-based tools • EHS enhancement • Expansion of ASI • Health care team leadership endorsement • Partner buy-in • Partnership synergy • Effective management structure • Provider trainings • Integration of AE-Cs • Adoption of ACT to adult population	• Organizational history • Differences in goals and priorities • Differences in desired outcomes • Key personnel presence at meetings • Resistance to change • Follow-up on hard-to-reach population

Conclusion

- Sustaining partnerships
- Achieving mutual benefits
- Monitoring outcomes
- Evaluating outcomes

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Phase II

QUESTIONS?

THANK YOU!

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Panel Discussion