



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

Breakout Session C

Abstract Podium Presentations:
Health Maintenance and Prevention
in Special Populations



XAVIER UNIVERSITY OF LOUISIANA COLLEGE OF PHARMACY
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This session will include abstract presentations discussing health maintenance and prevention strategies in special populations across disciplines.




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Jill H. White, EdD, RD, LDN
OPENING REMARKS



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Meagan Brown, PharmD
ABSTRACT PRESENTATION




Pharmacy Cardiovascular Risk Reduction Project:
Preliminary Results from One Rural Clinic Site in the Mississippi Delta

Administered in Partnership with the Mississippi State Department of Health and the Centers for Disease Control and Prevention Delta Health Collaborative

Meagan A. Brown, PharmD, BCACP
Clinical Assistant Professor, Pharmacy Practice
Coordinator of Community Pharmacy Development

Lauren Bloodworth, PharmD, BCPS
Clinical Assistant Professor, Pharmacy Practice
Co-Principal Investigator
Program Administrator, Community-Based Research Program

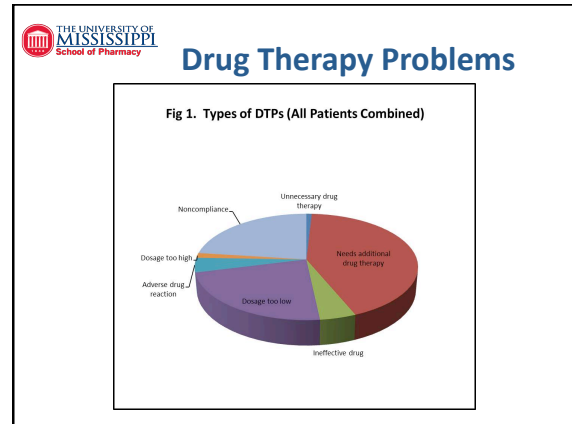


Objective

- Implement pharmacist medication therapy management (MTM) services in clinic settings in the Mississippi Delta region to improve patient outcomes related to diabetes and cardiovascular disease (ABCS)
 - HbA1c, aspirin use
 - Blood pressure
 - Cholesterol
 - Smoking cessation

Clinical Outcomes

No. of patients	80	No. DTPs identified/resolved	460
No. of encounters	182	Avg no. of DTPs per patient	5.8
% Female	56.3%	No. of pts with ≥ 1 DTPs	80 100%
% Male	43.7%	No. of pts with ≥ 3 DTPs	70 87.5%
Mean age (yrs)	49.9	No. of pts with ≥ 5 DTPs	46 57.5%
Mean no. of medical conditions	6.0 (range 1-10)	• DTP = Drug therapy problem	
Mean no. of meds (Rx & OTC)	6.4 (range 2-14)		



Clinical Outcomes - ALL

	Number of Patients	First value (mean)	Most recent value (mean)	Change	p-value*
Hemoglobin A1C (%)	48	11.8	9.9	(1.9)	<0.001
Systolic blood pressure (mmHg)	47	133.4	125.1	(8.3)	<0.05
Diastolic blood pressure (mmHg)	47	83.3	77.9	(5.4)	<0.005
Total cholesterol (mg/dL)	32	197.3	186.1	(11.2)	0.103
High-density lipoprotein (mg/dL)	32	49.9	50.2	0.3	0.799
Low-density lipoprotein (mg/dL)	32	114.7	103.2	(11.5)	0.061
Triglycerides (mg/dL)	32	162.7	157.0	(5.7)	0.711
Weight (lbs)	38	209.9	209.6	(0.3)	0.839

* Statistically significant improvements demonstrated for A1C, SBP, DBP (baseline vs. most recent value) - using Student's t-test for paired data, two-tailed

Clinical Outcomes – Subset with initial values elevated

	Initial values elevated	Number of Patients	First recorded value (mean)	Most recent recorded value (mean)	Change	p-value*
Hemoglobin A1C (%)	HbA1c > 9%	48	11.8	9.9	(1.9)	<0.001
Systolic blood pressure (mmHg)	SBP ≥ 130 mmHg	27	145.7	129.9	(15.8)	<0.001
Diastolic blood pressure (mmHg)	DBP ≥ 80 mmHg	29	89.9	79.5	(10.4)	<0.001
Total cholesterol (mg/dL)	TC ≥ 200 mg/dL	15	245.7	220.7	(25.0)	<0.05
High-density lipoprotein (mg/dL)						
Low-density lipoprotein (mg/dL)	LDL ≥ 100 mg/dL	19	145.7	125.2	(20.5)	<0.05
Triglycerides (mg/dL)	TG ≥ 150 mg/dL	6	394.2	333.2	61.0	0.461

* In these subsets of patients, statistically significant improvements were demonstrated for A1C, SBP, DBP, total cholesterol, and LDL-cholesterol (baseline vs. most recent value) - using Student's t-test for paired data, two-tailed

- Conclusions**
- Identifying a strategy to curb disease progression and the associated economic burden is critically important
 - Preliminary data suggest a decrease in HbA1c, SBP, DBP, TC, and LDL for the targeted population (subset)
 - Implementation of successful pharmacy MTM services that decrease the risk of cardiovascular complications in underserved populations can enhance patient care in similarly challenging rural areas throughout the nation

Pharmacy Cardiovascular Risk Reduction Project: Preliminary Results from One Rural Clinic Site in the Mississippi Delta

We would like to acknowledge our PI, Dr. Leigh Ann Ross, BCPS and the Mississippi State Department of Health (MSDH) is also gratefully acknowledged for the support of this project through Grant Number 5U50DP003088-03.

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Apophia Namageyo Funa
ABSTRACT PRESENTATION

The University of Georgia

**Coping with Type 2 Diabetes:
The Experiences of Black Men
Living in Georgia**

Apophia Namageyo Funa, PhD, MPH
Jessica Muilenburg, PhD, MPH
Mark Wilson, HSD
March 8, 2013

The University of Georgia

Background

- The prevalence of type 2 diabetes today is 25.8 million (diagnosed and undiagnosed) and has doubled since 2000¹
- 18.8 million individuals have type 2 diabetes (diagnosed)¹
 - Blacks (12.6%) compared to Whites (7.1%) are disproportionately affected by type 2 diabetes¹
- Compared to Black women, Black men
 - Lower prevalence of type 2 diabetes²
 - die earlier³
 - engage less in health seeking behaviors^{4,5}

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Background⁶

Rates of hospital admissions per 100,000 of adults with type 2 diabetes 18 and over by race and sex in 2006 (Agency for Healthcare Research and Quality, 2010)

Type of admission	Black		White	
	men	women	men	women
Uncontrolled type 2 diabetes without complications	67.9	63.1	13.0	11.4
Type 2 diabetes with short-term complications	170.2	132.9	47.0	46.7
Type 2 diabetes with long-term complications	330.0	319.0	108.5	73.6

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Background⁶

Preventive care practices: Percentage of adults over 40 with type 2 diabetes by race and sex in 2006 (Agency for Healthcare Research and Quality, 2010)


Preventive care practice	Black		White	
	men	women	men	women
A flu shot in the last 12 months	46.3	51.8	57.0	65.4
Receive a dilated eye examination	48.0	56.5	58.3	62.1
Receive a hemoglobin A1c examination	DSU*	89.2	89.2	90.8
Check feet for sores or irritation	74.8	80.3	67.5	68.7
All 3 (A1c, eye exam, flu shot) practices	32.1	40.0	41.2	43.1

*DSU - data do not meet the criteria for statistical reliability, data quality, or confidentiality.

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Background

- Managing type 2 diabetes can be complex and challenging
- Few studies have focused on the experiences of living with type 2 diabetes among Black men⁷
- No studies have focused on the coping mechanisms used by Black men with type 2 diabetes.
- Understanding the coping mechanisms used by Black men can guide the development of interventions to help them live with and manage type 2 diabetes.

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Purpose

To examine and explore the experiences of Black men with type 2 diabetes with an emphasis on the coping mechanisms used to manage the disease

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Methods

- In-depth semi-structured interviews
- Purposive sample of 30 men from Grady Diabetes Clinic
- Approved Institutional Review Board from
 - University of Georgia
 - Grady Health System
- Participants signed consent forms and received \$20 incentive

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Methods

- Eligibility criteria
 - Ages 45 – 65 years
 - Black men (African, African American, African Caribbean descent)
- Ineligibility criteria
 - Individuals with type 1 diabetes
 - Individuals with type 2 diabetes for < 1 year
 - Individuals who have lived in Atlanta < 1 year

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Methods

- Interviews transcribed by Verbal Ink
- Data organized for analysis using HyperRESEARCH version 3
- Transcripts reviewed and coded according to themes related to the research question
- Findings reported for only 25 of the 30 Black men

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Results

Demographic Variable	n	Valid %
Age Range		
46 – 50	3	12.0
51 – 55	6	24.0
56 – 60	9	36.0
61 – 65	7	28.0
Family History of Diabetes		
Yes	19	76.0
No	5	20.0
Unknown	1	4.0

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Results

Demographic Variable	n	Valid %
Duration of Type 2 Diabetes		
Less than 5 years	12	48.0
More than 5 years	13	52.0
Marital Status		
Married	6	24.0
Single	9	36.0
Single (Divorced)	3	12.0
Single (Widowed)	3	12.0
Single (Separated)	3	12.0
Unknown	1	4.0

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Results


Demographic Variable	n	Valid %
Uses Insulin to Manage Type 2 Diabetes		
Yes	18	72.0
No	7	28.0
Insurance Type		
Medicaid/Medicare/ Supplemental Security Income	16	64.0
Income based insurance from Grady Diabetes Clinic	3	12.0
No insurance	4	16.0
Unknown	2	8.0
Has Other Health Illness or Injury		
Yes	19	76.0
No	6	24.0

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Results

Coping mechanisms and number of men reporting use of these mechanisms

Coping mechanism	# of participants reporting use of coping mechanism
Acceptance	25
Taking action to change behavior	25
Support from healthcare professionals	23
Support from family	21
Seeking healthcare information	20
Support from friends	17
Religion and spirituality	12
Not focusing on the disease	5


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Results

Acceptance

I mean, I've learned to accept that I got the diabetes, you know. Like I said, most of my family got it. It's something that we accepted... You can manage it and you come off the medicine, but it's really not going to go away. (Participant 24)


I put in my mind saying, well hey, if I want to continue to live and be healthy about it, this is what I got to do. I just basically put one foot in front of the other and went for it. (Participant 23)

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Results

Taking action to change behavior


I stopped drinking. Don't drink anymore. Stopped eating a lot of fried -- all the food, just about, that I ate was fried food 'cause most of the foods you get at your fast restaurant, they all fried -- and stopped eating out. Don't eat out like I used to. Don't drink like I used to. Don't -- just don't do the bad things since I been told that I have diabetes that I did before I was told that. (Participant 25)

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Results

Support from healthcare professionals

They are helping me by giving me prescription[s], writing me a prescription, giving me, what you call it, some kind of lectures and I say, "Man". Like that lady, the nurse today told me "Mr. [Participant 19] your sugar is so high. I don't want you to come in here having your kidney's shut down." You know. That's getting me be aware that this can happen or that can happen. I mean, they talk to you depending on if you are doing okay. ... they say "Oh man your sugar is down Mr. [Participant 19], that's very good. The doctor there just told me that my blood pressure is down, that is very good, you know, I mean, they encourage you, talk to you and encourage you. (Participant 19)


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Results

Support from family

My mother has had it. My mother had taught me very much about it. Therefore, you know, I'm aware of the disease so I know about it. I know what it's like when I got it and how it affects me because of the way that it affected her. And also the way it affects a few of my sisters, you know. Other than that, you know, I would say I was more or less educated before it happened to me. (Participant 23)


I mean -- I watched my brother, I seen like, you know, how he had to deal with his and he was, "But I don't want to be sticking myself and pricking myself," so, you know, I said let me just do it and get this under control. So every morning I get up and I do -- I do my exercises at night and I walk during the daytime and then I take my medicine in the morning when I get up. (Participant 05)

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Results

Seeking healthcare information


Yeah, the classes, they really educational. I advise anybody to go to your class. Go to your class and go to your diabetic visit. Go to your doctor to see about your diabetes on a regular basis and you check on it. You learn yourself. You learn what your diabetes is doing to yourself. You learn what you can and can't do with food, what type of food. You learn to eat what you know you can get by with without raising your sugar level. You have to learn yourself. Physician, heal thyself. (Participant 15)

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Results

Support from friends


The only thing I know of is like when we be out, you know what I am saying, picking up donations or something and we have to get something to eat. They look at me right and now, what they start doing, they start thinking of healthier ways of eating so they start suggesting Subway, like I said, so that's how they help me out. So they can eat Subway also, so they take me there. They help me with my diabetes. That's the way I see it, they help me. (Participant 18)

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Results

Religion


I pray to Him to heal me, but I know that in order to heal me, heaven helps those who help themselves. In order for Him to heal me, I have to try to heal myself and that's what I want. You understand what I am saying? So that's the way – I am not going to go blind, acting blind and say, oh I am going to pray to God, because I pray to Him, He's going to heal me. He's going to send somebody. He's going to send me somewhere to get treatment. That is the way God works, to the best of my knowledge. (Participant 19)

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Results


Not focusing on the disease

It [reading] helps me relax. It's no longer the need to just put something in your face. It's like a smoker, a smoker will constantly smoke. I had got to the point where I was substituting cigarettes for food. So I was constantly eating and I was eating the wrong things. Reading makes me more relaxed where I no longer need to smoke as much or eat as much. (Participant 30)

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Summary

- Coping mechanisms similar to that reported among individuals with type 2 diabetes⁸⁻¹¹
- Coping mechanisms were interrelated
- Use of problem solved coping versus emotion based coping mechanisms⁸
- Positive coping mechanisms were reported by the men which aligns with recommendations by diabetes educators¹²⁻¹³

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Limitations

- Self report data
- Data is not generalizable
- Interviewer and participant bias
- Duration of diabetes impacts experience
- Personal events impact reporting of experience

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Implications

- Healthcare providers and professionals:
 - working with Black men in different settings where they live, work, play, and pray should be aware of the different coping mechanisms used among men with type 2 diabetes
 - working in faith based settings should consider how to creatively include Black men with type 2 diabetes in these settings
 - tailoring interventions to meet the coping needs of the Black men should consider that not all men with type 2 diabetes are the same e.g. those with a family history versus those without a history of type 2 diabetes

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Implications

- Additional research should be done in the following areas:
 - Coping mechanisms among low income Black men with type 2 diabetes in different settings
 - Role of different family members in the management of type 2 diabetes
 - Reaching Black men who do not attend church

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- Grady Health System

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Thank you and questions



Pilar Z. Murphy, PharmD
ABSTRACT PRESENTATION

Effectiveness of Cardiovascular Risk Reduction Clinic in Perry County, Alabama

XULA 6th Health Disparities Conference
March 2013

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Disclosure Statement

Disclosure statement: these individuals have the following to disclose concerning possible financial or personal relationships with commercial entities (or their competitors) that may be referenced in this presentation.

- Investigator: Pilar Z. Murphy—Nothing to disclose
- Advisors: Charles Sands, Roger Lander, Dan Halberg, Frances Ford—Nothing to disclose

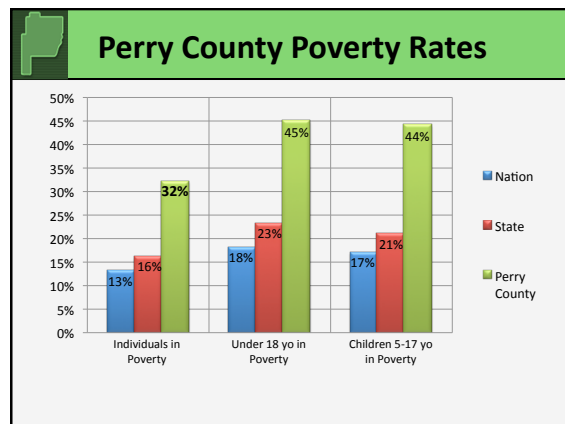
Perry County, Alabama Overview

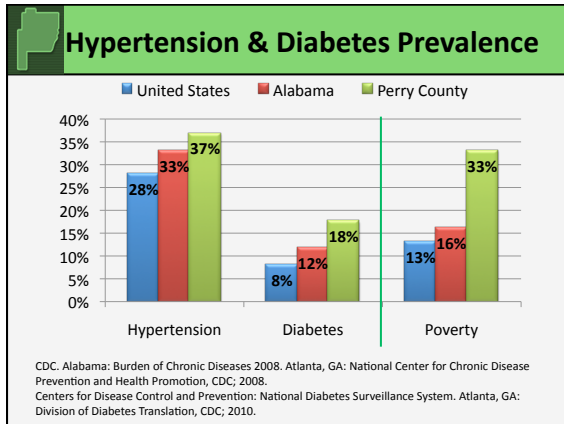
- Rural community of 10,373 people (2011)
- Majority African American population
- High rates of hypertension and diabetes
- High poverty level
- Limited access to healthcare
 - Four local physicians
 - Two local pharmacies
 - Nearest hospital 25 miles away in neighboring county

Perry County, Alabama Overview

	Perry County	Alabama	Nation
Unemployment Rate ¹ (Dec 2012)	12.0%	7.1%	7.8%
Median Household Income ² (2008)	\$26,513	\$42,586	\$52,029
% High School Graduate or higher (2007-2011) ³	71.7%	81.9%	85.4%
Bachelor's or higher (2007-2011) ³	12.6%	22%	28.2%





Alabama's Chronic Disease Burden

Area	HTN	DM	Overweight / Obesity
State of Alabama	27.2%	12.2%	68.1%
Bibb County	37	11	71
Jefferson County	38	10	66
Chilton County	31	11	69
Perry County	47%	17%	78%

Percentages presented by Public Health Areas from The Risk of Heart Disease and Stroke in Alabama: Burden Document 2010

Our Approach: Free Pharmacist-Enabled Classes/Clinics Clinics

- Body Love Radio Show
 - Wednesday mornings at 8:30am
- Hypertension Clinic (weekly)
 - Wednesday afternoons 2-4pm
- Diabetes Classes (monthly)
 - Thursday afternoons 2-3:30pm (Uniontown)
- Patient Assistance
- Medicare Part D

Free Cardiovascular Risk Reduction Clinics

- Collaboration between Sowing Seeds of Hope and McWhorter School of Pharmacy
- Free pharmacist-enabled Cardiovascular Risk Reduction Clinics at the Perry County Health Department

Free Cardiovascular Risk Reduction Clinics

- Clinic Goals:
 - Improve health outcomes for HTN, diabetes, obesity, dyslipidemia, and chronic kidney disease
 - Improve communication and coordination of various health care workers in Perry County
 - Improve overall health and minimize health disparities

Clinic Format

- Patient History (new patients)
 - Health Status Interview, Disease States, Family History, Medications
 - Medication list from local pharmacy*
- Review Past Visits and Medication List with Patient
- Measurements: Weight, BP, HR, BG, Waist/Hip Ratio, BMI
- Interventions/Counseling
 - Weight Reduction, Diet, Exercise, Tobacco Use, Drug Therapy/Compliance
 - Prevention of Disease Complications
- Recommendations faxed or taken directly to physician's office

Clinic Format

- Review blood sugar logs
- Review diet
 - Indicate foods that increase blood sugar the most
- Foot exams
- Wound healing information and referrals
- Self-monitoring of blood glucose
 - Does patient SMBG?
 - Signs and Symptoms of Hypo & Hyperglycemia
 - What should you do?
- Counseling on regular physician exams and labs
 - A1C, Lipid Panel, Dilated Eye Exam, Kidneys (microalbumin), Influenza & Pneumococcal Vaccinations

Sample Patient Brochures

Sample Patient Brochures

Education Models

Purpose

- To investigate the effectiveness of the pharmacist-enabled hypertension and diabetes clinics in Perry County and their impact on reducing modifiable cardiovascular risk factors in patients utilizing the clinical services provided

Objectives

- Primary objective: To detect a clinically significant difference in reduction of systolic blood pressure
- Secondary objectives: To detect reductions in diastolic blood pressure and body mass index

Methodology

- Single-center, Samford University IRB-approved, retrospective chart review
- Compare baseline blood pressure, body mass index, and weight to the most recent measurements recorded during cardiovascular clinic visits prior to July 1, 2010
- Inclusion criteria:
 - Patients must be age 19 years and older
 - At least two clinic visits prior to July 1, 2010
 - Visits must be at least one month apart

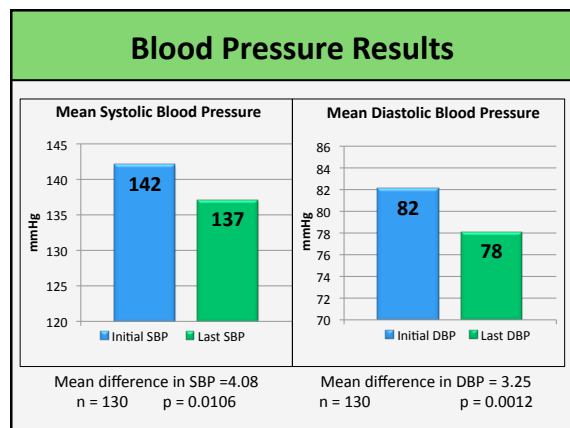
Methodology

- Study: Two-sample t-test for unequal variances
- Design: Paired data
- Alpha: 0.05
- Power: 0.8 (80%)
- Sample size: 130
- Difference considered clinically significant is 10 mmHg decrease in systolic blood pressure

Patient Demographics

Patient Characteristics (n=130)			
		Number	Percentage
Race/ethnicity	African American	116	89%
	White	14	11%
Sex	Female	90	69%
	Male	40	31%
Age	Average: 61 years	19 min	92 max
Reported Disease States	Hypertension	80	62%
	Diabetes	3	2%
	Hypertension & Diabetes	46	35%
	Other/None	1	<1%

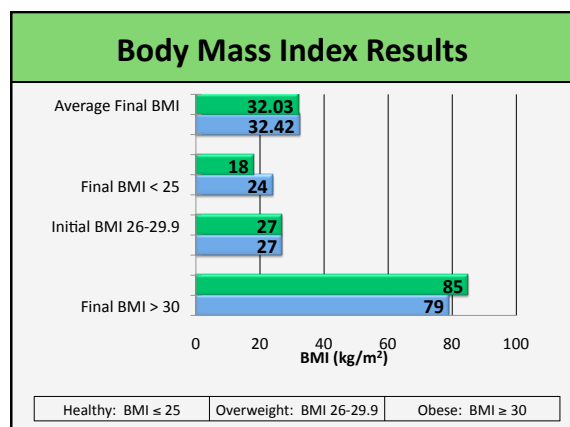
402 patient files reviewed 130 patients met inclusion criteria



Blood Pressure Results

HTN Patients at Goal BP < 140/90 (n= 80)	
Initial visit	38 (48%)
Last visit	47 (59%)

DM Patients at Goal BP < 130/80 (n=49)	
Initial visit	14 (29%)
Last visit	17 (35%)



Discussion

- Primary objective to detect a clinically significant difference in reduction SBP was not reached
 - Small decreases in both systolic and diastolic blood pressure
- Statistically significant drop in SBP of 4.08 mmHg
 - Diastolic blood pressure decreased an average of 3.25 mmHg
- Average Body Mass Index remained constant
 - 6 patients moved from obese category

Discussion

Reduction in Stroke Death Rate			
	1991-1998	2000-2006	% Decrease
US National Rate	166	140	15.7
Alabama Rate	180	168	6.7
Perry County	190	153	19.5
Perry County (Whites)	163	133	18.4
Perry County (AAs)	244	193	20.9

Stroke rate = avg. annual age-adjusted rate (deaths/100,000) for people ages 35 years and older

Discussion

- Perry County residents are working to close the gap in cardiovascular health disparities
- Increased awareness about disease states
- Working to control risk factors
- Controlling and maintaining weight
- Increased counseling on proper medication use and compliance

Discussion

- Study weaknesses and limitations:
 - Inconsistencies in documentation
 - Lack of a control group
 - Limited comparison data parameters
- Future directions
 - Additional statistical analysis
 - Formal article presentation
 - Consistent scheduling of follow-up appointments
 - Incentive program to encourage regular attendance
 - Increased medication patient assistance enrollment
 - Electronic medical record

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Effectiveness of Cardiovascular Risk Reduction Clinic in Perry County, Alabama

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03/08/13



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Panel Discussion



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Closing Remarks