Integration of Clinical Care and Public Health Systems: The need as reflected in the work of the Alliance to Reduce Disparities in Diabetes

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The Alliance Partners at Work in their Communities

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The Alliance to Reduce Disparities in Diabetes aims to change the outlook for those who experience the worst outcomes.

The Alliance aims to reduce disparities in diabetes outcomes by supporting:

Evidence-based, community-focused interventions

Efforts to ensure that successful programs and services are sustained in policy and practice

Collaboration with key stakeholders at the national level through local levels to achieve policy and system change that reduces inequities in care and outcomes

Four U.S. cities and a Native American reservation are the focus of the Alliance's community level efforts:

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Dallas, Texas

The Baylor Healthcare System's Office of Health Equity

Chicago, Illinois

The University of Chicago

Memphis, Tennessee

The Healthy Memphis Common Table

Camden, New Jersey

The Camden Coalition of Healthcare Providers

Wind River Reservation, Wyoming

The Eastern Shoshone Tribe in partnership with the Northern Arapaho Tribe

Alliance Community Programs have three components:

1. Innovative, evidence-based patient education
2. Front-line, proven health provider training including cultural competence
3. Sustainable quality improvements in health care access, coordination, and relevance

The Alliance is capitalizing on the unique strengths of its community partners.

Chicago, Illinois

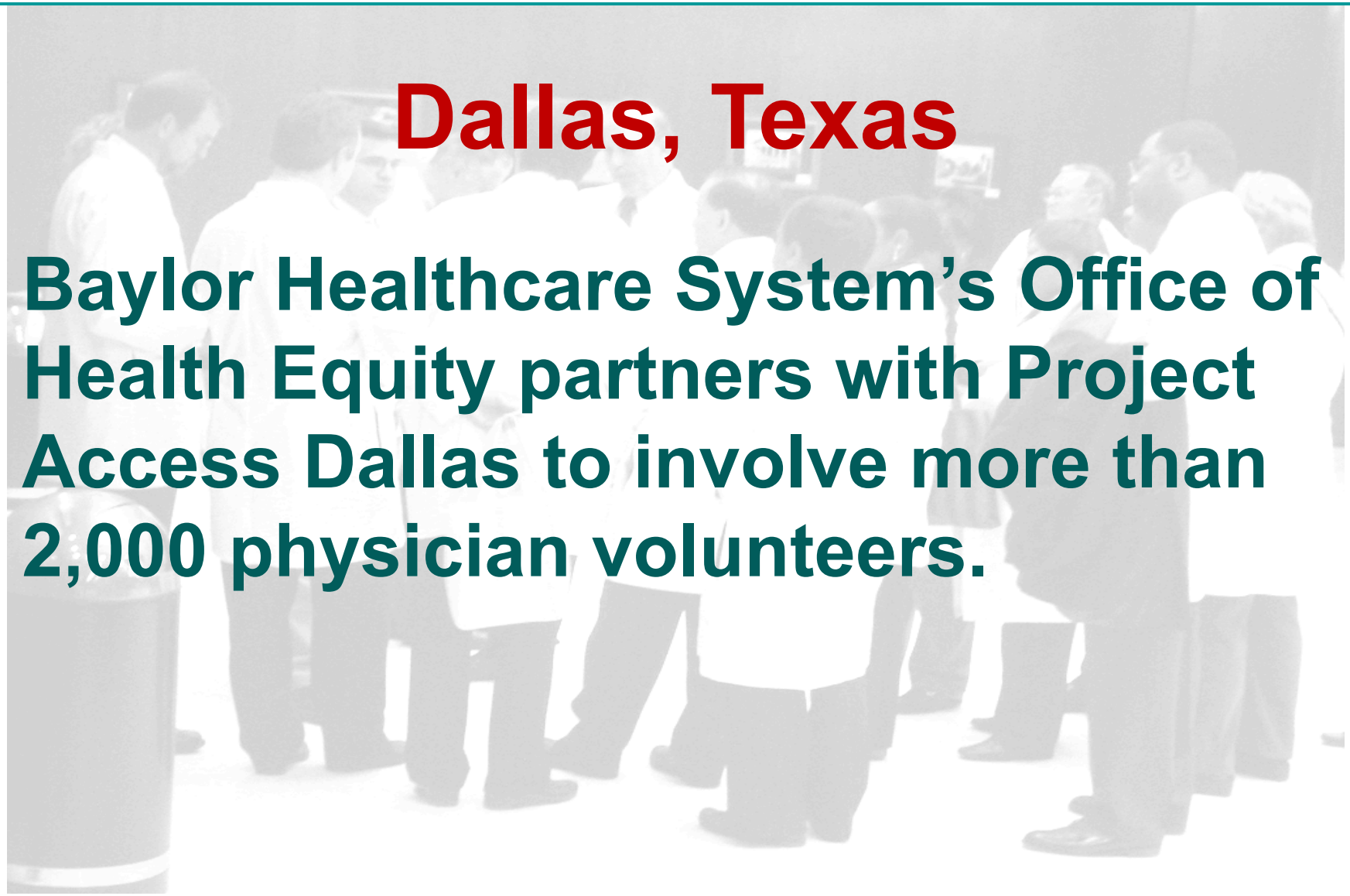
The University of Chicago has a history of community involvement in social and political activism in the Southside of Chicago.

Memphis, Tennessee

Healthy Memphis Common Table is a collaborative partner with over 100 churches in the faith-based community through Memphis Healthy Churches.

Wind River Reservation

The Wind River Reservation Alliance leaders have a history of cultural bonds that are shared across the Shoshone and Arapahoe tribes.



Dallas, Texas

Baylor Healthcare System's Office of Health Equity partners with Project Access Dallas to involve more than 2,000 physician volunteers.

Camden, New Jersey

Camden Coalition of Healthcare Providers has exceptional capacity to work across health care institutions and coordinate city-wide information exchange.

Patient Education

1

Alliance communities are employing evidence-based patient education programs to enable diabetes self-management and empower patients to become:

- more engaged
- better at managing
- adopters of productive behaviors
- effective communicators

Patient Level Education Examples

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Chicago, IL

BASICS curriculum adapted and piloted for the target population - intensive, ten-week series

Dallas, TX

Diabetes self-management education adapted from CoDE™ and featuring 7 one-on-one education sessions conducted by community health workers

Patient Level Education Examples

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Memphis, TN

3 sessions of DSME based on "Conversation Mapping" diabetes education with follow-up support provided by case managers.

Wind River Reservation

Expanded diabetes self-management education with 6 classes and including patient coaching, support for lifestyle changes and culturally appropriate diabetes materials

Health Provider Education

2

Alliance interventions aim to enable clinicians to be more effective in working with diverse patients through training in cultural competence and effective communication skills.

Provider Level Change Examples

Camden, NJ

Provider level 'Practice Transformation' based on the Primary Care Medical Model

Chicago, IL

Physician CME series (4 sessions) that includes:

1) cultural awareness,
2) motivational interviewing techniques,
3) treatment tailoring based on stages of behavior change,
4) shared decision making and a 4-month booster session

Provider Level Change Examples

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Dallas, TX

CME training program entitled “A Patient-Centered Approach to Cross-Cultural Care” is integrated into an existing physician forum in the Dallas area

Wind River Reservation

Workshops for IHS staff focusing on education regarding cultural beliefs, health literacy and effective communication and motivational interviewing techniques.

SUSTAINABLE ORGANIZATION AND SYSTEMS CHANGE

3

Each Alliance community is introducing sustainable changes to how health organizations and providers manage their patients with diabetes and identify patients at risk of developing diabetes.

Systems Level Change Examples

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Camden, NJ

- Implementation of Health Information Technology (HIT)
- Evolution into a citywide Accountable Care Organization (ACO)

Chicago, IL

Clinic Redesign' following the "Model for Improvement" plan-do-study-act methodology to improve care for patients with diabetes.

Systems Level Change Examples

Dallas, TX

Institutionalizing the community health worker role (diabetes health promoter) into the Baylor Health Care System; career path for DHP.

Wind River Reservation

Formation and expansion of a Diabetes Coalition of key partners to improve the health of the tribes living on the Wind River Reservation.

Preliminary and Promising Evidence

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Dallas Observational Study*

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Average Hgb A1c decreased

*Walton, J., it al. (2012) Reducing Diabetes Disparities Through the Implementation of a CHW–led Diabetes Self-Management Program. *Family and Community Health*: 35(2), 161-171.

South Side of Chicago

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Improved diabetes care and control

Data Source: Assessment of Chronic Illness Care (ACID) Tool

COMMUNITY CASE STUDIES

By Monica E. Peek, Abigail E. Wilkes, Tonya S. Roberson, Anna P. Goddu, Robert S. Nocon, Hui Tang, Michael T. Quinn, Kristine K. Bordenave, Elbert S. Huang, and Marshall H. Chin

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Early Lessons From An Initiative On Chicago's South Side To Reduce Disparities In Diabetes Care And Outcomes

ABSTRACT **Interventions to improve health outcomes among patients with diabetes, especially racial or ethnic minorities, must address the multiple factors that make this disease so pernicious. We describe an intervention on the South Side of Chicago—a largely low-income, African American community—that integrates the strengths of health systems, patients, and communities to reduce disparities in diabetes care and outcomes. We report preliminary findings, such as improved diabetes care and diabetes control, and we discuss lessons learned to date. Our initiative neatly aligns with, and can inform the implementation of, the accountable care organization—a delivery system reform in which groups of providers take responsibility for improving the health of a defined population.**

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Racial and ethnic disparities in diabetes care and outcomes arise from multiple causes. These include differential access to high-quality health care, healthy food, and opportunities for safe recreation; cultural traditions regarding cooking; beliefs about disease and self-management; distrust of medical care providers; and socioeconomic status. Consequently, the solution must be multifactorial. Improving patients' knowledge and increasing their motivation to make healthy lifestyle changes will have minimal impact if their limited access to healthy food and physical activity is not simultaneously addressed.

To date, few interventions have taken a multifaceted approach to improving outcomes among

and practice are encouraging greater interaction and collaboration among health care providers and communities. One driver of this collaboration is the creation of accountable care organizations, as authorized under the Affordable Care Act of 2010.[4] Accountable care organizations are likely to have financial incentives to take responsibility for broad health care outcomes and costs for a defined population. Thus, accountable care organizations are potentially motivated to prioritize evidence-based prevention strategies that build on community resources and create a continuum of care from community settings to health care systems.

Racial or ethnic minorities are disproportionately represented among high-risk patients with complex medical conditions. Thus, accountable

Wind River

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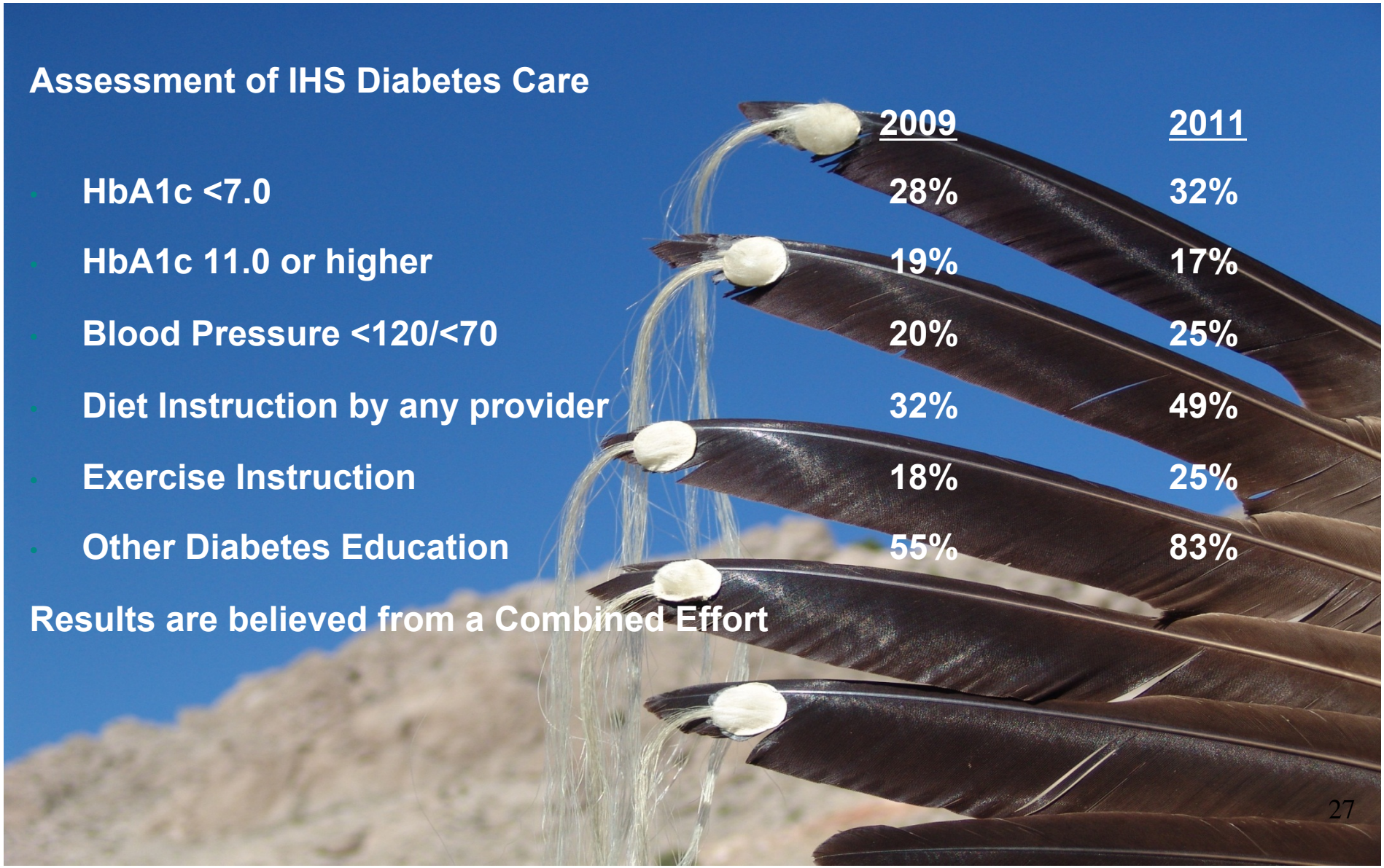
Improvements in Diabetes Care provided by the local Indian Health Service

Results: (Indian Health Service)



Assessment of IHS Diabetes Care

	2009	2011
HbA1c <7.0	28%	32%
HbA1c 11.0 or higher	19%	17%
Blood Pressure <120/<70	20%	25%
Diet Instruction by any provider	32%	49%
Exercise Instruction	18%	25%
Other Diabetes Education	55%	83%

Results are believed from a Combined Effort

Camden

Success in “Hot-spotting” high-cost, high-risk patients in order to better coordinate medical care and social services to address their needs.

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MEDICAL REPORT

THE HOT SPOTTERS

Can we lower medical costs by giving the neediest patients better care?

BY ATUL GAWANDE

JANUARY 24, 2011

If Camden, New Jersey, becomes the first American community to lower its medical costs, it will have a murder to thank. At nine-fifty on a February night in 2001, a twenty-two-year-old black man was shot while driving his Ford Taurus station wagon through a neighborhood on the edge of the Rutgers University campus. The victim lay motionless in the street beside the open door on the driver's side, as if the car had ejected him. A neighborhood couple, a physical therapist and a volunteer firefighter,

Lessons Learned from collaboration with clinical staff, community organizations, and health systems to improve diabetes care in high-risk populations

Lessons

- Targeting more intense self-management intervention to higher risk patients can maximize intervention effects, improvement in health outcomes, and reduction in health care costs.
- Practice/clinic transformation is most successful with a variety of ways to engage based on practice/clinic interests and capacity and with coaching support.
- It is important to document capacity for "readiness" of organizations to invest in change and to understand organizational and political dynamics and culture.
- Committed "champions" and opinion leaders are essential to program success, mobilizing community support, and planning for sustainability long-term.
- Leverage the evidence to advance policies and align with other strategic initiatives.

Needed Policy Changes and Next Steps

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Systems and Policy Change Evolving from the Community Level

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September 2012

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The On-the-Ground Experience

Despite great efforts and success in making substantive progress in their communities, the Alliance sites continue to face real, systemic barriers in the health care system that affect the success of the interventions.

Barriers Faced by the Alliance Grantees

- The current health care system focuses payments based on units of care, on specialty care, and on high-cost, high-tech interventions.
- State credentialing standards present barriers to payments for vital health workers.
- Technological, cost and policy barriers can obstruct a timely, comprehensive and robust exchange of patient information.
- A lack of designated and consistent payment for community health worker services inhibits linking of people with diabetes to community resources and to education.

Success in turning the tide on diabetes and on reducing disparities requires that real world, on-the-ground experiences of health care providers and health systems are reflected in health policies and regulations implemented at federal, state and local levels.

Alliance Invited Summit Convened

- The Alliance Invited Summit was organized to link national policymaking and on-the-ground realities.
- A series of considerations sparked discussion about achievable actions that can bring about significant reductions in health care disparities among people with diabetes.

Target Policy Considerations

Systems Level:

Consideration 1 – Integrate public health and health care systems

Consideration 2 – Share and report community-wide health data

Consideration 3 – Eliminate incentives that encourage underinvestment in low-income high-risk patients

Target Policy Considerations (cont.)

Provider Level:

Consideration 4 – Make optimum Accountable Care Organization's (ACO) ability to reduce disparities

Consideration 5 – Support deployment of Community Health Workers (CHWs)

Patient Level:

Consideration 6 – Enhance coverage for self-management supports

Focus on Integration of Public Health and Clinical Health Systems

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- March 28, 2012 – The IOM released a report calling for more integration between primary care and public health. The report reviewed new and promising integration models, many of which include shared accountability for improved community and population health outcomes.

- The need for greater integration between clinical systems and public health emerged as a consistent theme at the Alliance's National Summit. Experts from around the country identified this as a top concern.

Outside and inside

September 12, 2012

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National Association of County and City Health Officials

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National Association of County and City Health Officials

- **Numbers**
- **Vision**
- **Mission**

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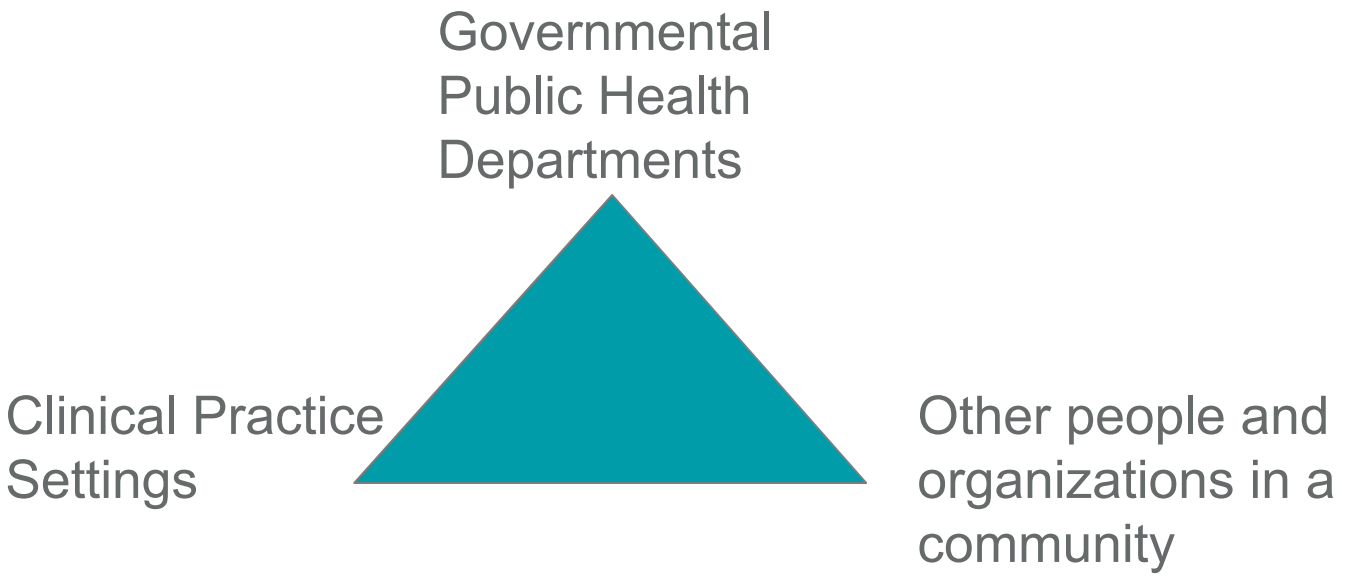
Better integration: Outside



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Better integration: Inside

1) Collaboration and partnership
2) Evidence-, experience-, and reality-based practice
3) Technology
4) Workforce
5) Funding/Sustainability

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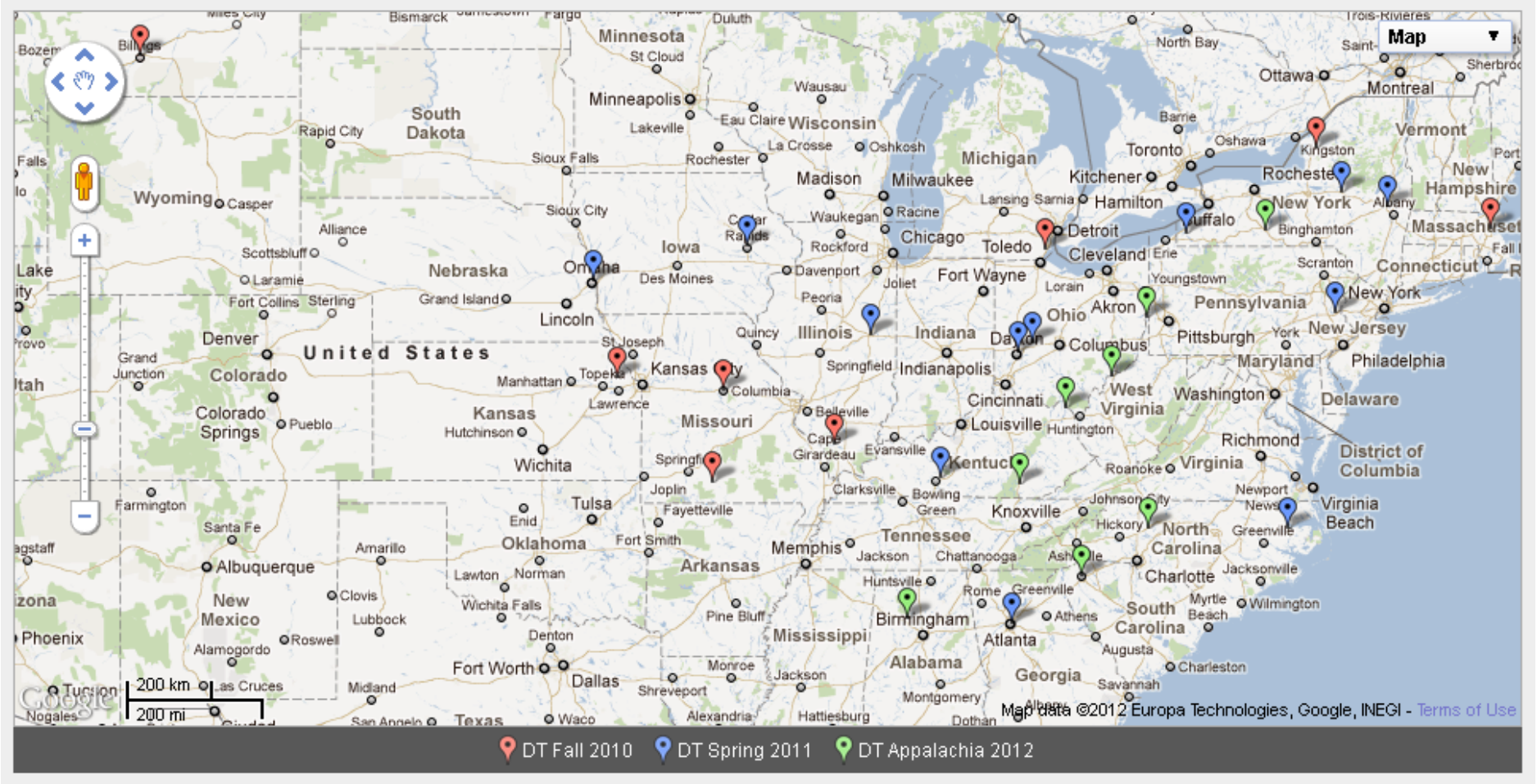
NACCHO *Diabetes Today* Grantees, 2010 - 2012



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For More Information

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