Housekeeping tips

» Microphones will be muted by the host

» Please note the audio and video controls in the top left corner

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Audio & Video controls
Achieving Optimal Integration of Clinic and Community Interventions in Diabetes Care

A panel discussion with renowned diabetes experts

This webinar series is funded by the Bristol-Myers Squibb Foundation and conducted by the National Center for Primary Care at Morehouse School of Medicine as part of the Partnership for Diabetes Health Equity project.
The panel discussion with nationally renowned diabetes experts, Dr. James Gavin, Dr. Ann Albright, and Dr. George Rust. The webinar entitled "Achieving Optimal Integration of Clinic and Community Interventions in Diabetes Care," will examine ways health professionals are working together to make a difference.
GEORGE RUST, MD, MPH
CO-DIRECTOR
NATIONAL CENTER FOR PRIMARY CARE AT
MOREHOUSE SCHOOL OF MEDICINE

MODERATOR
Health Disparities

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

-- Martin Luther King, Jr.
Diabetes Health Equity

- Equality in Risk
- Equality in Pre-Disposing Conditions
- Equality in Prevalence
- Equality in Treatment
- Equality in Self-Management
- Equality in Complication Rates
- Equality in Adverse Outcomes
- Equality in Survival

Equity = Equality + Fairness
Disparities in Outcomes

• Adults with diabetes-related End-Stage Renal Disease (ESRD), 2003-2010

The 2010 top 5 State achievable benchmark was 71 per million population. Among all racial groups, AI/ANs are progressing toward the benchmark but would not achieve it for 17 years. At their current rate of improvement, Blacks would take 77 years. Rates among non-Hispanics and Hispanics are improving slowly; neither group could achieve the benchmark for more than 60 years. – AHRQ, National Healthcare Disparities Report 2013
How Do We Tie it All Together?

Can we continuously improve interventions in each domain and in the spaces in-between the practice and the community or between the hospital and home, with a rapid-cycle outcomes feedback loop and provider-community coalitions all working together to keep improving connections and processes and outcomes until we achieve more optimal and equitable outcomes for all?
JAMES R. GAVIN III, MD, PHD
CEO AND CMO
HEALING OUR VILLAGE

Panelist
Community-Based Care in Chronic Disease Prevention & Management

James R. Gavin III, MD, PhD
Clinical Professor of Medicine
Emory University School of Medicine
CEO & Chief Medical Officer
Healing Our Village, Inc.
Atlanta, Georgia
Speaker Disclosure Information

» James R. Gavin III, MD, PhD, receives honorarium as a speaker for Astra Zeneca, BI, Janssen Pharmaceuticals and Lilly

» He receives compensation for his role as a consultant for Abbott Diabetes Care, Intarcia Pharmaceuticals, Janssen Pharmaceuticals, Astra Zeneca, and Sanofi
How do disparities arise?

» Differences in the quality of care received within the health care

» Differences in access to health care, including preventive and curative services

» Differences in life opportunities, exposures, and stresses that result in differences in underlying health status
Racial and Ethnic Disparities in *Health Status*

» African Americans make up almost half of the U.S. HIV/AIDS population and African American women are over 20 times more likely to die from HIV/AIDS than white women.¹

» American Indians and Alaska Natives are six times more likely to die from tuberculosis and over five times more likely to die from alcoholism than whites.²

» Hispanic adults are twice as likely to be diagnosed with diabetes than white adults.³

» South Asians have up to four times the risk of death related to heart disease compared with other ethnic groups.⁴


Racial and Ethnic Disparities in *Health Care*

» Racial and ethnic people have more medical errors with negative clinical consequences.¹

» Even among insured populations, people of color are less likely to receive preventive health services. African Americans especially are twice as likely to utilize emergency room service than non-Hispanic whites.¹

» Racial and ethnic people undergo more tests in emergency rooms due to poor communication, and those who need medical translators often do not have access to them.²

» Hispanics are less likely to receive or use medications, especially for asthma, cardiovascular disease, HIV/AIDS, mental illness or pain.²

» Racial and ethnic people make up 51% of the transplant waiting list.³

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THE BURDEN OF CHRONIC DISEASE

» The major chronic diseases account for the majority of morbidity and mortality in the USA

» These conditions are the core elements that drive ~ $3,800,000,000,000 healthcare budget in the USA

» These are conditions that often result from inadequate use or failure of earlier interventions designed to prevent progression from high-risk states to full-blown disease

» Examples include pre-diabetes, mild essential HTN, obesity/overweight, dyslipidemias, etc.

» We have failed to adequately translate discovery into policy or practice or to leverage community-based interventions, especially in the highest risk
DIABETES FAVORS MINORITIES.

Diabetes strikes one out of three Native American Indians; one out of seven Hispanic Americans; and one out of fourteen Blacks. See your doctor about how you can prevent or control diabetes. And stop this discrimination.

A message from the American Diabetes Association.

Data show adults ≥40 years of age diagnosed with T1D or T2DM who received all 3 recommended services.

Disparities in Diabetes Care (2001-2006): Hospital Admissions for Short-term Complications

Adults ≥18 years of age; short-term complications include ketoacidosis, hyperosmolarity, or coma and exclude obstetric admissions and transfers from other institutions.

Strategies to Improve Societal Barriers: Community Resources

» Encourage patients to participate in effective programs
  > Disease-specific educational or support services

» Form partnerships with community organizations to support or develop programs
  > Churches, housing authority, parks and recreation departments, employer groups (through human resources department), library, and schools

» Advocate for policies to improve care in all sectors (home, school, work, community)
Partnerships Needed to Implement Chronic Disease Treatment/Prevention

- Community-based Solutions
  - DSHS
  - Food Industry
  - Urban Planners, Developers, Architects
  - Providers & Hospitals
  - Community Groups
  - Elected Officials
  - Worksites & Schools
  - Higher Education
  - Non-Traditional Partners
The Collaborators in Project Dulce-1997 and Other Examples of Community-Based Efforts

» Hospitals
» County Health Dept
» School of Public Health
» School of Medicine
» Healthcare Foundations

» Community Health Improvement Partners (CHIP)

» Council of Community Clinics

» The Whittier Institute for Diabetes

» Clinic-based Design Teams
Project Dulce

Community
- San Diego County
  - County adopts model
  - Clinics sponsor model

Health System Collaboration
- Community Health Improvement Partners
- Council of Community Clinics
- Whittier Institute for Diabetes

Self-Mgmt Support: Peer-led Education

Delivery System Design: Nurse-led teams and PCPs

Decision Support: Standards of Care; SDM

Clinical Information Systems: DEMS

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes
Pilot Project Dulce – 1998-1999
Baseline versus 1 Year

Philis-Tsimikas et al. Diabetes Care, 37; 110-115, 2004
Standards of Care - Dulce Pilot

- Foot Exams (1/yr): 100%
- HbA1c (2/yr): 100%
- Lipids (1/yr): 100%
- Retinal Exam (1/yr): 81%

Comparison Group
- Foot Exams (1/yr): 33%
- HbA1c (2/yr): 28%
- Lipids (1/yr): 46%
- Retinal Exam (1/yr): 6%

Philis-Tsimikas et al. Diabetes Care, 37; 110-115, 2004
### Coordinated, Culturally Competent Education & Care Result in Savings--HOV

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Pre Intervention</th>
<th>Post Intervention</th>
<th>Difference</th>
<th>% increase or decrease</th>
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<tr>
<td>Knowledge</td>
<td>58</td>
<td>85</td>
<td></td>
<td>↑ 27%</td>
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<tr>
<td>A1C (mean)</td>
<td>8.7</td>
<td>7.1</td>
<td>1.6%</td>
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<tr>
<td>% at A1C goal</td>
<td>33</td>
<td>64</td>
<td></td>
<td>↑ 94%</td>
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<tr>
<td>Systolic BP</td>
<td>154 (mean)</td>
<td>137 (mean)</td>
<td>17 mmHg</td>
<td></td>
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<tr>
<td>Diastolic BP</td>
<td>96</td>
<td>84</td>
<td>12 mmHg</td>
<td></td>
</tr>
<tr>
<td>% BP Goal</td>
<td>24%</td>
<td>61%</td>
<td></td>
<td>↑ 154%</td>
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<td>*Costs for DM over a 2 year period (n=52)</td>
<td>$50,092.55</td>
<td>$37,412.15</td>
<td>$12,680.40</td>
<td>↓ 25% ($243 per patient per year)</td>
</tr>
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</table>

* n=52 / 319 patients for whom complete cost data on hospitalizations, emergency room visits, ambulance were available
Successful Strategies to Improve Diabetes Outcomes in African Americans and Hispanics

» Use social networks (family members, peer support groups, churches, one-on-one interactive education, community health workers)

» Use culturally tailored interventions and education (see )

» Language, diet, social emphasis, family participation, cultural beliefs

» Emphasize cognitive behavioral education, self-care management, and adaptations of the Diabetes Prevention Program (DPP)

» Focus on improving patient resilience to stressors

Does it Work?
Engage Community Churches

Community-based African American churches successfully implemented diabetes prevention programs (DPP) and diabetes self-management programs

- Lowered fasting glucose and weight in at-risk participants
- Lowered HbA1C, weight, and diabetes related quality of life in participants with T2DM

Does it Work? Fit Body and Soul Feasibility Study in Atlanta African-American Church Community

Percentage of adult members of the church at high risk for diabetes who lost weight

- 48% for 5% weight loss
- 26% for 7% weight loss
- 14% for 10% weight loss

Improvements in A1C ($P = 0.001$) and systolic blood pressure ($P = 0.006$), diabetes knowledge, exercise, healthy eating, foot care, glucose self-monitoring, medication adherence

Partnerships Needed to Implement Chronic Disease Treatment/Prevention

- DSHS
- Food Industry
- Urban Planners, Developers, Architects
- Providers & Hospitals
- Community Groups
- Elected Officials
- Worksites & Schools
- Higher Education
- Non-Traditional Partners
- Community-based Solutions
ANN ALBRIGHT, PHD, RD
DIRECTOR, DIVISION OF DIABETES TRANSLATION
NATIONAL CENTER FOR CHRONIC DISEASE
PREVENTION AND HEALTH PROMOTION
CENTERS FOR DISEASE CONTROL AND PREVENTION

Panelist

www.diabeteshealthequity.org
Faculty Disclosure

In compliance with ACCME Guidelines, I hereby declare:

I do not have financial or other relationships with the manufacturer(s) of any commercial services(s) discussed in this educational activity.

Name: Ann Albright, PhD, RD
Title: Director, Division of Diabetes Translation, CDC
Prevention and Control of Diabetes
The Community – Clinic Partnership

- **Informed Population**
- **Strong Community Organizations**
- **Healthy Public Policy**
- **Supportive Environments**

**Partnership Zone**
- **Screening for High Risk**
- **Structured Lifestyle Programs**
- **Diagnosis of Prediabetes**
- **Regular Glucose Monitoring**
- **Reimbursement**
- **Proactive Practice Team**
- **Decision Support**
- **Information Systems**
- **Informed, Activated Patients**
- **Insurers**
- **Employers**

**Surveillance**
- **Total Population** → **Pre-diabetes** → **Diabetes** → **Complications**
Trends in Age-Standardized Rates of Diabetes-Related Complications from 1990 to 2010 among U.S. Adults with Diagnosed Diabetes

- **Myocardial Infarction**
- **Stroke**
- **Amputation**
- **ESRD**
- **Hyperglycemic Death**

Events per 10,000 Adults with Diagnosed Diabetes

<table>
<thead>
<tr>
<th>Year</th>
<th>Myocardial Infarction</th>
<th>Stroke</th>
<th>Amputation</th>
<th>ESRD</th>
<th>Hyperglycemic Death</th>
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<td>1990</td>
<td>150</td>
<td>110</td>
<td>70</td>
<td>90</td>
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<td>2000</td>
<td>100</td>
<td>70</td>
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<td>50</td>
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<tr>
<td>2010</td>
<td>50</td>
<td>50</td>
<td>30</td>
<td>30</td>
<td>1</td>
</tr>
</tbody>
</table>
**BASIC SCIENCE**

- Molecular/physiological

**EFFICACY**

- Ideal settings

**EFFECTIVENESS**

- Real world settings

**EFFICIENCY**

- Biggest effect on most people

**AVAILABILITY**

- Supply

**DISTRIBUTION**

- Diffusion of interventions

National Diabetes Prevention Program

COMPONENTS

Training: Increase Workforce
Train the workforce that can implement the program cost effectively.

Recognition Program: Assure Quality
Implement a recognition program that will:
- Assure quality.
- Lead to reimbursement.
- Allow CDC to develop a program registry.

Intervention Sites: Deliver Program
Develop intervention sites that will build infrastructure and provide the program.

Health Marketing: Support Program Uptake
Increase referrals to and use of the prevention program.

Model for Social Change

• Collective Impact
  – Common agenda
  – Shared measurement systems
  – Mutually reinforcing activities
  – Continuous communication
  – Backbone organization

Kania and Kramer, 2011
Announcements

PDHE 3- Element Model to Integrated Diabetes Care Learning Collaborative

Activities will include:

» Guidance and coaching from expert faculty who have successfully decreased disparities using integrated 3 element model of care
» Key content such as models of care for key population segments, measurement strategies and testing
» Face-to-face learning sessions, virtual calls, and extranet support.
» Opportunities to explore additional virtual coaching services above and beyond the activities of the PDHE Learning community

Who can apply:

» Applicants must have a lead organization with at least 2 partner organizations or a diabetes or health equity coalition as lead
» Have already demonstrated strength in 2 of the 3 elements (clinic / community / outcomes data), and be prepared to learn and implement a missing 3rd element, and develop and maximize the connections between elements.
<table>
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<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>January 21, 2015</td>
<td>Special Recruiting Webinar for Partners</td>
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<tr>
<td>February 18, 2015</td>
<td>Special Recruiting Webinar for Participants</td>
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<tr>
<td>March 31, 2015</td>
<td>Applications Available</td>
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<tr>
<td>April 13, 2015</td>
<td>Conference call regarding questions on application</td>
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<tr>
<td>May 1, 2015</td>
<td>Applications due</td>
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<tr>
<td>May 31, 2015</td>
<td>Decisions Announcement</td>
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<td>September, 2015</td>
<td>Collaborative Begins</td>
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This webinar series was funded by Bristol-Myers Squibb Foundation Partnership for Diabetes Health Equity.

The following disciplines are qualified to receive credit for this webinar: MD, DO, NP, & PA. Nurses can receive a certificate of attendance.

If you are seeking credit for this webinar training, please click the following link from your computer now:

CLICK HERE for CME Credit Survey
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- D4H
- Nucleus Health Communications
- National Network of Public Health Institutes

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