

Bureau of Minority Health Access Activities

Latino Commission

The Latino Commission is reviewing new immigration rulings by the Courts and how they affect the Hispanic community, and suggested steps that the Commission can take. The Commission outlined a set of priorities for the 2012-13 FY:

PRIORITIES FOR THE LATINO HEALTHCARE

- Improve the Latino health data collection, analysis and reporting under DHH data systems;
- Improve not only access to health services for Latino communities but also the quality of those services (addressed by CLAS);
- Ensuring that there are services provided in Spanish and to respect the Latino culture (addressed by CLAS);
- Improve the capacity of community organizations in order to provide health services;
- Increase community participation in the decisions affecting the Latino health;
- Increase the number of activities promoting health and preventing illness among Latino communities;
- Promote the increase of Latino health providers;
- There should be an emphasis on preventive care. Increase public health and preventative health information that is specific to Hispanics and Latinos following CLAS.

Healthcare Providers Suggested Initiatives:

- Programs in place to reduce risk for chronic and infectious illnesses;
- Ensure that standing orders are in place for screening tests;
- Assist seniors and medically compromised clients to get pneumococcal and influenza vaccinations. Make it available where these seniors will frequent, such as churches and health fairs geared towards Hispanics and Latinos;
- Conduct foot and kidney exams with diabetic clients during routine healthcare visits and recommend eye screenings annually. Awareness of this issue must be address among Latinos and Hispanics;

- Provide culturally competent and linguistically appropriate care by providers and/or health care management offices. The main other languages needed are Spanish, Portuguese and Vietnamese; and
- Ensure that out-sourcing private servicing entities have bilingual staff to address the fast Hispanic aging 1st and 2nd generation.

Strategies on Key Related Health Issues

- Diabetes: Reduce the rate of diabetes and its complications among high-risk populations, increase early detection and treatment, and increase efforts on diabetes self-management through outreach and education.
- Asthma: Reduce the frequency and severity of asthma attacks through appropriate medical care, monitoring of symptoms and objective measures of lung function, along with environmental control measures to reduce exposures to allergens and other asthma triggers.
- Adult Immunization: Promote effective provider-based intervention, increase community demand, enhance access to services, and encourage vaccination-related efforts in non-medical settings. Is it possible to have pharmacies offering these immunizations?
- Embrace the issue of heart attacks as now being the number one killer of Hispanic women that needs to be addressed.

Community/Organizations Outreach Leadership:

- Join with others to promote community-wide health activities and campaigns.
- Form coalitions with civic, professional, religious, and educational organizations to advocate health policies, programs, and services.
- Support policies that promote health-care access for all.

Asian/PI Community

Diabetes Initiative/Care Management Program

NOELA Community Health Center received funds from the Bureau of Minority Health Access is for the Diabetes Initiative/Care Management Program. As a result of the support from this grant, NOELA Community Health Center was able to begin a chronic care management program with the goal of improving the overall care provided to patients with diabetes. At the core of this program was the advancement of the center as a Patient-Centered Medical Home (PCMH), a model of primary care which has been associated with reduced racial and ethnic disparities. This

process included attention to the usual standards of care for medical homes as defined by the National Commission for Quality Assurance (NCQA) such as:

1. Providing access to culturally and linguistically appropriate routine and urgent care.
2. Systematically recording patient information and using it for population management to support patient care.
3. Identifying individual patients and planning, managing, and coordinating their care, based on their condition, needs, and evidence-based guidelines.
4. Acting to improve patient's ability to manage their health by providing a self-care plan, tools, educational resources and ongoing support.
5. Systematically tracking test and coordinating care across specialty care and
6. Using performance data to identify opportunities for improvement and taking action to improve clinical quality, efficiency, and patient experience.

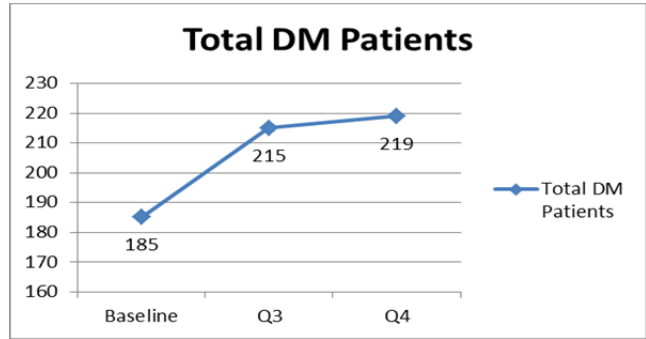
We began by developing a culturally competent diabetes care management team capable of providing disease specific education and responding to the needs of our diabetes patients for whom the majority are predominately African-American, Vietnamese, and Hispanic. A team charter was developed to provide clarity and assign roles and responsibilities to individual team members, consistent with national examples of Diabetes Care Teams. Thus, the Clinical Pharm D was designated as Care Manager and our Vietnamese and Hispanic speaking medical office assistants were designated as Care Coordinators.

Next, we used the advanced features of our electronic medical record system, SuccessEHS, to create a diabetes registry. The information obtained from this registry allowed us to identify all diabetic patients of the NOELA CHC and to stratify them based on clinical measures (i.e. A1c levels >9.0%, LDL > 100, BP >160/90, BMI >30), co-morbid conditions (i.e. Hypertension, Hyperlipidemia, or other Cardiovascular disease) and lifestyle factors (i.e. tobacco, ETOH, or substance abuse). In addition to the disease registry, we used the *Clinical Decision Support* tools within our EHR to remind providers of evidenced-based services for which their patients were due at the point of service. Examples of these alerts included key HEDIS measures of quality such as:

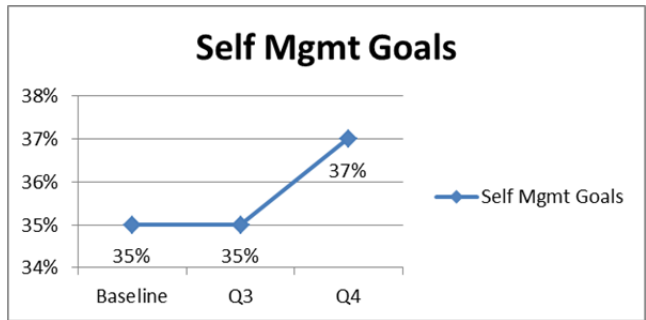
- DM patients with no HbA1c on record in the past 12 months
- DM patients with poorly controlled HbA1c (> 9.0%)
- DM patients with HbA1c control (<8.0% and <7.0%)
- DM patients with no LDL on record in the past 12 months
- DM patients with LDL >100

- DM patients not seen in the past 12 months
- DM patients requiring ASA
- DM patients with a BMI >30

We began the program providing services to 185 diabetic patients, and at the end of the funding year we were managing the care of 219 diabetic patients.



The patients at greatest risk (i.e. HbA1c >9.0%, BMI >30) were targeted for intensive management which included more frequent office visits with the primary care provider, close interval follow-up with the diabetes care manager, telephone monitoring by culturally and linguistically appropriate care coordinators, participation in Diabetic Group Visits, and enrollment in a medical weight loss program. The Care Manager provided diabetic education, counseling and guidance with self-management goal setting and the Care coordinators contacted the patients via telephone between visits to answer questions regarding the self-care plan, encourage compliance with management recommendations, and remind patients of upcoming appointments and special services being offered at the center.



Interventions offered as part of intensive management included:

- Standing Orders
 - Point of care HbA1c testing on all new DM patients and patients not seen within the past 3 months
 - IFV vaccination for all DM patients without contraindication
- Diabetes Self-Management Education provided by Clinical Pharm D
- Coordinated one-time Diabetic Foot Clinic with local Podiatrist to improve rates of screening diabetic foot exams
- Diabetic Group Visits
 - Linguistically and culturally tailored
 - Partnership with local chefs to provide healthy diabetic menu options

- Medical Weight Loss Program to assist patients with safe, effective weight loss
 - Targeted diabetic patients with a BMI > 30

For the remainder of the program, we implemented evidence-based guidelines taken from the American Diabetes Associations 2012 Standards for Diabetes Care. Resources from this grant supported additional staff activities including building out the infrastructure for data and quality monitoring. We assessed outcomes at follow-up during the 2-month period of May 1, 2012 to June 30, 2012 and Appendix A provides a comparison of baseline and follow-up measures of process and functional outcomes.

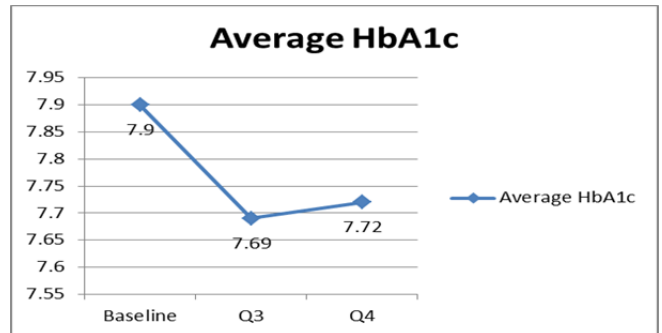
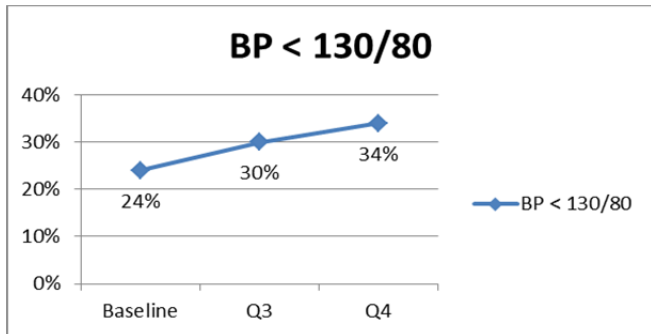
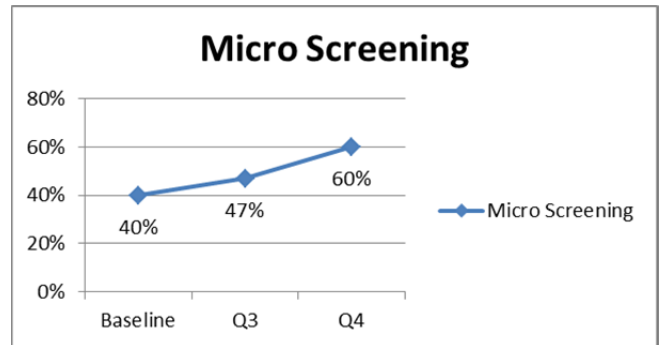
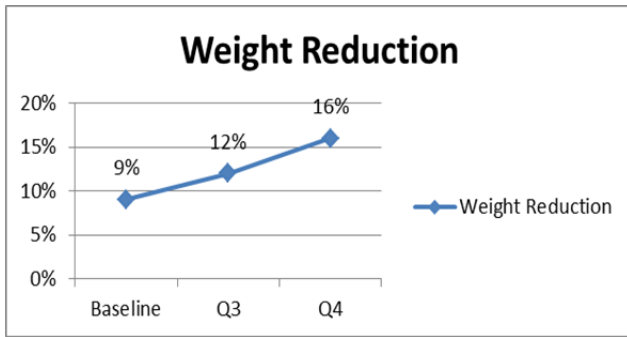
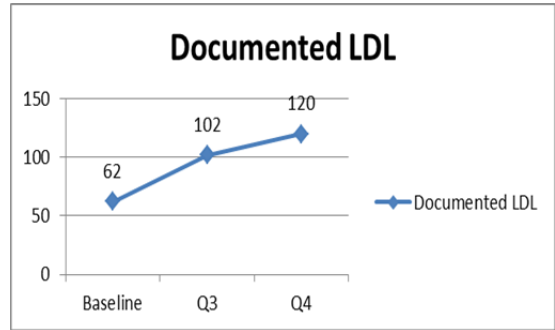
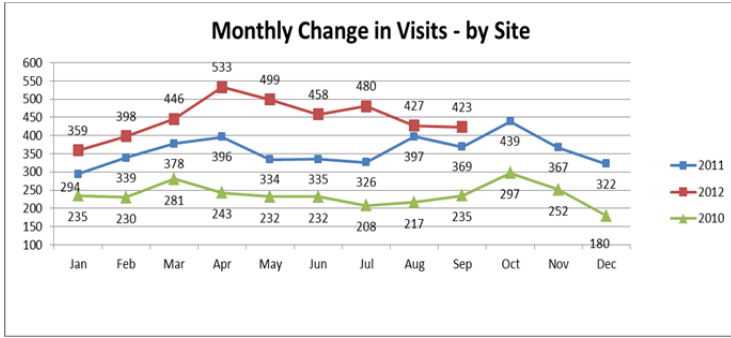
LESSONS LEARNED

The growing incidence of obesity and type 2 diabetes mellitus globally is widely recognized as one of the most challenging contemporary threats to public health and uncontrolled diabetes leads to debilitating complications and escalating health care costs. Research studies have found that high-quality diabetes care requires: a systematic and organized approach, an effective coordination and collaboration among all available personnel within a practice and with external resources (specialists, diabetes educators) - a team-based approach. NOELA CHC has adopted this approach as the foundation for the chronic care program and uses the PCMH model as its mode of delivery.

There were several lessons learned by implementing a team-based approach within the health center setting. First, primary care transformation is an ongoing challenge, which requires patience, persistence, and a vision for improvement. In order for us to improve chronic illness care at NOELA CHC, a culture that supported improvement and change had to be created on all levels, beginning with the senior leadership. NOELA CHC used a widely accepted method for rapidly testing a change, the PDSA (Plan-Do-Study-Act) cycle to make small scale changes to care delivery throughout the funding period. Next, the Diabetes Care Team specifically learned a number of lessons over the course of the program that can be used to develop best practices and standards of care management for future programs. These practices included: expanding standing orders, offering diabetic group visits, utilizing risk stratification, clinical decision support tools and point of care testing, establishment of communication protocols, providing telephone follow-up, and improving transitions of care.

Measurable improvements in quality of care are obtainable for medically underserved communities when patient data is organized electronically and when a center employs a team-based approach to care.

2010 – 2012 NOELA Visit Comparison



Community Preparedness Response Network (CPRN) Activities Chahta American Indian Tribe Report on Hurricane Isaac

CPRN is designed to assist low-income communities with establishing their own community emergency preparedness plan in the event of a natural disaster or pandemic flu outbreak. The Bureau and its community partners and stakeholders provide these hard-to-reach populations a point of contact during natural disasters or pan flu outbreak and make available resources to assist them with relief and recovery efforts specific for their communities.

Barriers:

Several barriers have been identified as a result of actions and incidents observed before, during and after Hurricane Isaac:

- Still, seven years later, there has been no assistance to minority and low income communities to help them become personally prepared for disasters. A vast number of people thought that supplies such as water, batteries were just for a few days and the government would intervene.
- Most were afraid to leave because they were threatened and/or afraid that they would lose their jobs. Some companies forced their employees to return the day after the hurricane with no allowance for excavation locations or allowing employees to access their personal situation or losses.
- People expressed concern about getting on evacuation buses without knowing where they were going or how they would get back.
- Utilizing faith-based organizations are not the only way to organize the community and oftentimes churches only assist their members, not the general community.
- Designated disaster preparedness radio stations had too much political bickering and sports talk instead of specific storm-related information.
- People that were going into flood-prone and remote areas to check on family members were turned around by police officials and not allowed to check on family members.
- Confusing messages about the seriousness of the storm by advice of the State, weather stations, and politicians was downplayed; so when people did make decisions to evacuate or take other measures it was too late.

Solutions:

- Funding needs to be made available to help people prepare prior to a storm or disaster.
- Year-round preparedness training needs to be available, especially in low-income communities.
- Integrate the state and CDC implementation plans into the grass-roots level so that the average citizen can be better prepared and understand the totality of storm dynamics, evacuation procedures and personal preparedness.
- The ability for the Health Department and CDC need to be given back the authority to deal with emergency health and environmental issues in the field as they arise, instead of having to go through the red tape of each Parish government.
- Evacuation materials and information need to be disseminated in English and Spanish.

