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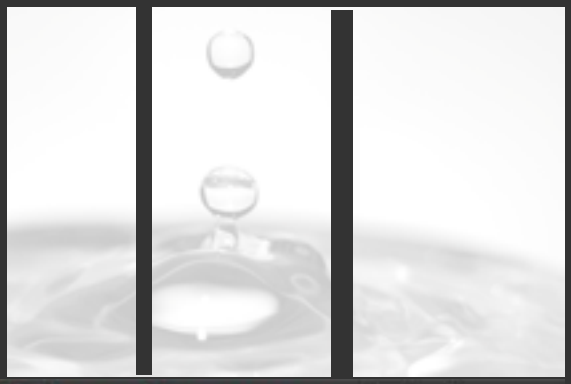

Shaping the Future

Division of Chronic Disease Prevention & Control, Office of Primary Care & State Rural Health
Division of Nutrition & Physical Activity · Tobacco Prevention & Cessation Commission

First Outcomes Congress

Office of Primary Care Highlights Pilot Community Health Centers

On March 12, 2014 the Office of Primary Care (OPC) held the first Primary Care Collaborative Outcomes Congress to highlight the accomplishments of the four pilot community health center (CHC) sites taking part in a quality improvement effort that is now being rolled out statewide.

Indiana's CHCs offer affordable, accessible, appropriate primary health care to residents in their communities. These clinics are staffed by state licensed professionals and are committed to providing quality care to their patients. Many of these patients are uninsured or face economic challenges that might otherwise prevent their ability to access the much needed care. The OPC offers grant funding to assist many of the CHCs in their efforts to improve health.

The initial thought for the Primary Care Collaborative began in Fall of 2010 with a partnership between the OPC and CDPC to aid in the development of clinical measures for a quality improvement project for CHCs.

After receiving the Coordinated Chronic Disease Prevention and Health Promotion grant in 2011, the ISDH was able to structure a pilot project for the CHCs and begin to search for possible CHCs. Seven were invited to participate based on geographic location, county health ranking data, county resource information, county data for incidence of disease and disease risk factors. Of those seven, five agreed to participate and four completed.

ISDH engaged Mike Hindmarsh of Hindsight Healthcare Strategies to guide the Pilot CHCs' quality improvement efforts based on the Chronic Care Model. Mr. Hindmarsh was associate director for clinical improvement at the MacColl Institute where he and his colleagues developed the Chronic Care Model.

For the next 13 months, the pilot sites would participate in the collaborative in order to improve patient outcomes with chronic conditions. The conditions included diabetes, cardiovascular disease, obesity, and the associated risk factors of tobacco use. The CHCs would also be required to improve on one of the three types of cancer screening rates (breast, cervical, colorectal).

The ISDH determined to assist CHCs in three specific areas to aid the CHCs in achieving success. Those areas included the use of evidence-based guidelines for each condition and screening, implementing the Chronic Care Model and the Model for Improvement.

As the CHC pilot sites determined their teams, attended learning sessions, monthly calls, site visits and direct assistance from a practice coach, they created aim statements to detail their desired outcomes, as well as PDSA (Plan, Do, Study, Act) Action Plans to work towards those outcomes.

The success of the CHC pilot sites in their quality improvement efforts to achieve better patient care was imperative in the development of the state wide effort that is now being implemented.

On the next few pages, we will highlight successes from the pilot site's presentations at the Outcomes Congress.

	Director	Phone Number	E-mail
Division of Chronic Disease Prevention & Control, Office of Primary Care & State Rural Health	Ann Alley	(317) 233-7451	aalley@isdh.in.gov
Section			
Cancer Control Section	Keylee Wright	(317) 234-2495	kwright@isdh.in.gov
Cancer Early Detection	Kathryn Tewanger	(317) 233-7901	ktewanger1@isdh.in.gov
Cancer Surveillance	Laura Ruppert	(317) 233-7424	lruppert@isdh.in.gov
Cardiovascular Health & Diabetes Section	Laura Heinrich	(317) 233-7449	ltheinri@isdh.in.gov
Chronic Respiratory Disease Section	Vacant	(317) 233-7415	vbarrett@isdh.in.gov
Division of Nutrition & Physical Activity	Eden Bezy	(317) 233-7092	ebezy@isdh.in.gov
Office of Minority Health	Antoniette Holt	(317) 233-3006	aholt@isdh.in.gov
Office of Women's Health	Vacant	(317)	
Tobacco Prevention & Cessation Commission	Miranda Spitznagle	(317) 234-1780	mspitznagle@isdh.in.gov

Available **Online**/New Resources

Expanding Pediatricians' Roles in Breastfeeding Support:
Continuing Medical Education (CME) Online Tutorial

As more mothers choose to breastfeed, health care professionals are in a unique position to provide the instruction, encouragement ans support that mothers and their infants need to be successful. This CME is designed to provide pediatric professionals with a refresher course on breastfeeding.

AMA PRA Category 1 Credit(s) - 1.5 max
American Nurses Credentialing Center - 1.5

Click here to view the online tutorial.

Community Eligibility: What Policymakers Need to Know About Changes Coming to School Meals
from the National Association of State Boards of Education Webinar Series

The Community Eligibility Provision of the Healthy Hunger Free Kids Act starts with the 2014-15 school year and expands a program that gives all students, regardless of income, free school meals. All states will need to comply - but there are challenges.

Register here up for the Webinar on April 9 at 3:00 p.m.

America's Health Rankings U.S. & State-Level Health Disparity Graphs

To aid in communicating health disparities, America's Health Rankings has created graphic representations of the disparity in smoking, obesity, diabetes, physical inactivity and health status by educational attainment (four levels), gender and race/ethnicity (White, Black, & Hispanic). Information is available for viewing and download.

Click here to view disparity graphs.

Chronic Care Model & Primary Care

by Champ Thomaskutty, MPH

Chronic diseases are among the most prevalent, costly and preventable of all health problems in the United States. In Indiana, chronic conditions account for over two-thirds of all deaths. Additionally, it is estimated that nearly half of all Hoosier adults have at least one chronic condition. Many within this group have two or more chronic conditions.[1]

While the effectiveness of treatment for most conditions has advanced, research demonstrates that patients frequently don't receive the care they want or need to effectively address these conditions. As the number of people living with multiple chronic conditions continues to grow, more of the nation's health care dollars are consumed to address them. A growing body of research suggests that coordinated care results in better outcomes at lower cost for people with serious chronic conditions.[2]

The Chronic Care Model (CCM) is a systematic approach designed to address these issues by improving ambulatory care. It was developed and implemented to provide a blueprint for quality improvement initiatives in the primary care setting. The CCM identifies the essential elements of a health care system that encourage high-quality chronic disease care and impact functional and clinical outcomes. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Effective self-management support acknowledges the patient's role in their own care. It incorporates a collaborative approach, where providers and patients work together to define problems, set priorities, establish goals, create treatment plans and make decisions that support optimal disease management. Additionally, by engaging community resources, the influence of clinical management can be extended beyond the brick and mortar practice setting. In combination, evidence-based change concepts under each element foster productive interactions between providers with resources and expertise, and informed patients who have become capable of actively participating in their care.[3]

Research highlights the importance of an integrated approach to improving chronic disease care.[4] In order to improve clinical quality, the CCM was designed to leverage the relationships between the six evidence-based elements mentioned previously. CCM-based interventions may require practice redesign across most or all of the six elements. These changes may not be simple, and as a consequent CCM is not a discrete, immediately replicable intervention. It is, however, a framework within which care delivery organizations can translate general strategies for change into unique, often site-specific applications. As a result, the practice improvements associated with a particular CCM element vary from practice to practice and from community to community. These improvements result in more personalized, patient-centered interactions with providers, increased patient engagement, increased usefulness of electronic systems, increased practice efficiency, and ultimately improved outcomes.[3]

1. Indiana State Department of Health, Data Analysis Team. 2013. Indiana Mortality Report, 2011; Behavioral Risk Factor Surveillance System, 2012.

2. Schuster M, McGlynn E, Brook R. How Good Is the Quality of Health Care in the United States? Milbank Quarterly. 2005;83(4):843–895.

3. Coleman K, Austin BT, Brach C, Wagner EH. Evidence on the Chronic Care Model in the New Millennium. Health Affairs. 2009;28(1):75–85.

4. Tsai AC et al. A Meta-Analysis of Interventions to Improve Care for Chronic Illnesses. American Journal of Managed Care.2005;11(8):478–488.

Everyday, Hoosiers take action to change local policies, systems and environments to improve the health of their neighbors. Their success can assist us in our own challenges by providing proven programs and ways to implement these in our own communities.

Maple City Health Care Center

GOSHEN, Ind. - Maple City Health Care Center (MCHCC) joined the Learning Collaborative with a desire to provide excellent, culturally sensitive care to their community. Housed in an old renovated firehouse, the four member team set forth to improve outcomes of chronically ill patients.

The MCHCC team knew their unique community was faced with socioeconomic challenges, many of their individuals work multiple jobs with limited time off and do not have insurance. Also, there are few physical activity opportunities available to the area and many other individuals are faced with child care and elder care responsibilities.

MCHCC set out to improve patient outcomes in diabetes, obesity, smoking and colorectal screenings. Three notable changes the team initiated proved to be of great value and are mentioned below.

MCHCC determined training all staff, including interpreters and medical assistants, in motivational interviewing would greatly benefit their patients. This one day training helped to change the atmosphere and approach of all staff with patients. Patients were empowered to make changes and address challenges in addressing their self management goals.

Healthy Living Groups were formed to encompass all health areas and individuals. They assisted patients in making lifestyle changes and becoming more empowered in their own healthcare. Some groups were for adults and other groups served the entire family. Outcomes proved effective with one all of the members of one group of diabetes patients lowing their A1C - for some by as much as two points.

MCHCC stated team huddles will continue on and will be expanded. This opportunity for the health care team to meet provided them with a time of "finding out what we didn't know, that we didn't know and enlightened them on patient's false beliefs, barriers to care, family problems, lack of support and financial problems.

To learn more about MCHCC, visit their website.

North Shore Health Centers

PORTAGE, Ind. - North Shore Health Center (NSHC) was excited to join the Learning Collaborative and improve outcomes in diabetes, obesity, tobacco use and cervical cancer screenings. The team members also knew to anticipate certain barriers. Those barriers involved data not being captured or missing from the Electronic Medical Record (EMR), unavailable reports, patient non-compliance, medication regiment and required testing to manage, as well as, staff/ provider support, staff turnover, and overall sustainability of the changes.

NSHC saw great improvements in diabetes outcomes by adding team huddles, EMR reminders and protocols, patient self management education was introduced by the nurse upon arrival and sock removal to prompt foot checks. Other initiatives implemented were reminder phone calls to patients and informing patients of diabetes group visits and education classes.

Education of patients on the need for cervical cancer screening and adding protocols and reminders to the EMR prompted an increase in screening rates that exceeded the team's goal, as well as, in the areas of tobacco use and referral to the Quitline and obesity rates for adults and children.

Currently, NSHC is awaiting status of Patient Centered Medical Home (PCMH) recognition through National Committee for Quality Assurance (NCQA). The team is rolling out to other teams in their health centers, as well as, reporting their documentation to the QA committee. They noted that improvements have reduced chaos, increased collaboration among internal and external partners and created happier patients, providers and staff.

To learn more, visit the NSHC website.

Open Door Health Services

MUNCIE, Ind. -- Open Door Health Services (ODHC) team knew their community had great needs. Delaware County is ranked 82nd of the 90 Indiana counties in overall health rankings (County Health Rankings, 2013). ODHC was set though to improve overall health of their patients utilizing the chronic care model and focusing on the outcomes of patients with diabetes, adult and child obesity rates, patients who quit tobacco use and women that received recommended cervical cancer screenings.

ODHC identified specific plans to address each area. The team's innovative plan to address diabetes initiated shared medical appointments (SMAs). Each SMA consisted of up to 12 patients with the same diagnosis receiving care in a group settings. The SMAs allowed for increased education and a built a network of support for others experiencing the same issues when facing daily struggles with diabetes. These SMAs have shown an increase in provider and patient engagement and improved outcomes for patients with diabetes.

Another area that the ODHC team noted as a great success was in their plan to address obesity in adults and children. A change to their Electronic Health Records (EHR) was required and work began with their EHR vendor. Self management goals for patients were added to the EHR. Also, the "Obesity Goals" handouts that noted lifestyle changes was given a new title to "Healthy Lifestyle Goals". This title change opened up conversation with patients on a sensitive topic.

There were similar changes in the area of obesity and children. Addressing the BMI percentile needed for determining obesity in children and getting that information as structured data was a notable challenge. This change and the need to address Healthy Lifestyle Goals with the entire family provided a plan to find much success in addressing obesity in children.

Other changes that have roved successful are their nurse med check call backs, rechecking blood pressure at end of visit when first reading is high, and health educator and dietitian presented to patients as part of the team. The team also has dedicated meeting times and continue to report regularly on their PDSA outcomes.

To learn more about their clinic and services, view the ODHC website.

Valley Professionals Community Health Center

CLINTON, Ind. -- Valley Professionals Community Health Center (VPCHC), formerly Vermillion-Parke Community Health Center, has been finding innovative ways to improve the health of those in their community since the doors opened in 2008.

The VPCHC team realized their patients and staff at their three health centers located in Clinton, Cayuga and Bloomingdale, as well as, a mobile school-based health center (MSBHC) faced many challenges. Over 60 percent of their patients live in rural areas, nearly 20 percent of adults are uninsured, almost 16 percent are below poverty and the unemployment rate is almost ten percent. The team anticipated data issues with their EMR, patient non-compliance and staff buy-in, as well.

As they set out to address their outcomes in the diabetes, obesity,

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Resources from the CDC

Let's Make the Next Generation Tobacco-Free
Your Guide to the 50th Anniversary Surgeon General's Report on Smoking & Health

This guide for consumers looks back at the important gains made in the last 50 years, notes the devastating effects of smoking and exposure to secondhand smoke, and looks the work to be done to achieve our goal of a society free of tobacco-related disease and death.

View the new guide.

View other resources available from the 50th Anniversary.

CDC Tier 1 Genomic Applications Toolkit for Public Health Departments

The toolkit focuses on specific evidence-based applications for persons at risk of hereditary colorectal cancer due to Lynch syndrome, hereditary breast and ovarian cancer due to BRCA mutations, and cardiovascular disease due to familial hypercholesterolemia.

View the toolkit.

View more Public Health Genomics Tools & Video Resources.

CDC Tools & Policy Resources
for Public Health Practitioners, Researchers, & Decision Makers

CDC has released many heart disease and stroke prevention policy resources and tools that public health practitioners, researchers, and decision makers may find useful in promoting heart health, as well as, the new Chronic Disease State Policy Tracking System - a state-searchable database to provide policy information by state.

View the heart & stroke tools.

View the Tracking System.

Valley Professionals Community Health Center

(cont. from page 5)

tobacco use and breast cancer screenings, the team also considered what specific goals they wanted to meet and new ways to meet those goals.

VPCHC wanted to address tobacco use by increasing their referrals to the Quitline. Initially providers offered the referral during appointments, but the team quickly realized that having the community health and nursing students call patients on providers behalf increased the number of referrals. Training all of the students and staff and having the time during the call to provide patients with all of the details of the referral and registration process showed considerable increases to their Quitline referrals.

The community health and nursing students offered assistance again in the team's efforts to increase diabetes patients with self-management goals. VPCHC utilized nurses, as well, to introduce patients with the goals setting sheets upon arrival and the provider would then follow up during their visit. The team also realized the value of training all staff on the goal setting sheet and utilizing the sheet effectively with patients.

Education of staff and patients was emphasized in each of their goal areas. As they pushed to improve lipid profile screenings in their patients with diabetes, they noted the need to train nursing staff on updated protocols. Meeting this goal also meant improvements to their EMRs. This same formula was effective in breast screenings, as they implemented preventive care screening priorities during team huddles, nurse and patient education.

To learn more about all of VPCHC's innovative solutions, view the VPCHC website.

Upcoming Events

ISDH Public Health Nurse Conference

Public health nurses are the driving force behind population health and play a vital role in shaping Indiana's new integrated primary care and public health landscape. Discover what opportunities and challenges lay before us with the passage of the Patient Protection and Affordable Care Acts.

May 1-2, 2014
Sheraton Indianapolis Hotel
8787 Keystone Crossing
Indianapolis, IN 46240

Click here to register.

Indiana Cancer Consortium (ICC) 2014 Annual Meeting:

"Collaborating to Conquer Cancer"

This year's meeting will describe the coalition's coordinated, statewide effort to support comprehensive cancer control; highlight stories of success in comprehensive cancer control from ICC partner organizations and volunteers; and provide a call to action to public, private, and non-profit organizations, and individuals, to renew commitments to reducing the burden of cancer in Indiana.

Registration is free and lunch will be provided.

April 30, 2014
Indiana Landmarks Center

Click here for more information or to register.

State Coalition Updates

Indiana Cancer Consortium

For more information on the ICC or to become a member, contact Caleb Levell at caleb@indianacancer.org or 317-520-9344

Indiana Joint Asthma Coalition

The 2nd Annual Statewide Asthma Conference will be held on Tuesday, May 13, from 8 a.m. until 4 p.m., at the Valle Vista Golf and Conference Center in Greenwood, Ind. Please visit our website for up-to-date information including the agenda and registration details.

The Asthma Management Plan has been approved for usage in Indiana Schools by the Indiana Department of Education (IDOE). It can now be offered as an option alongside plans already in use. Indiana Joint Asthma Coalition (InJAC) will be conducting school nurse training sessions on the AMP around the state with representatives from the ISDH Asthma Program. We will fully explain the plan and the proper way to complete it.

Please visit injac.org for updates on all of our projects.

Indiana Healthy Weight Initiative

To learn more visit www.inhealthyweight.org or email ahammerand@inpha.org

Cardiovascular and Diabetes Coalition of Indiana

The Cardiovascular and Diabetes Coalition of Indiana (CADI) just held it's first all-coalition meeting on 2014. Visit incadi.org to read the meeting minutes. The next meeting is June 11, 1 p.m. to 4 p.m., Location TBD

CADI's Community Linkages workgroup is compiling a statewide directory of resources for those who provide care for or are affected by cardiovascular disease, diabetes and stroke. They are pilot testing data collection in Public Health Preparedness District 2. Their next meeting is April 8 at 9 a.m.

CADI's Systems of Care workgroup is working with the Department of Homeland Security Emergency Medical Services Division to improve training, widen the scope of practice for technicians and paramedics, and locate innovative community-based health interventions with emergency medical responders (commonly referred to a mobile integrated health). Their next meeting is April 21 at 2 p.m.

Please contact coordinator Caitlin V. Neal at caitlin@incadi.org for more information.