Promoting Health: Improving Patient Outcomes for Childhood Obesity through a Coordinated System of Care ("Promoting Health")

Illinois Chapter, American Academy of Pediatrics
Obesity Prevention Initiatives
Health Disparities and Social Justice Conference
August 8, 2017
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Grecia Rodriguez, MPH, Care Coordinator
Illinois Chapter, American Academy of Pediatrics (ICAAP)

- Chapter, AAP
- Nonprofit/public health
- 2,200 + members statewide
- Mission – ensure quality care
- CME, QI, systems change, advocacy, collaboration
Childhood Obesity
Health Equity and Social Justice

- Disparate impact – 50% or more of pediatric patients at community health centers have overweight/obesity

- 80% of adolescents with obesity at increased risk
  20 chronic conditions
  - Cardiovascular disease
  - Stroke
  - Diabetes
  - Arthritis
  - Certain cancers
Learning Objectives

- Understand steps to integrate clinical and community systems through a coordinated system of care
- Identify communication flow among partners to collaborate in a referral system with medical and nonmedical community resources
- Summarize different technological systems adapted for referral systems
Coordinated System of Care
Pilot Goals

- Create model for coordinated system of care, including digital communication
- Improve quality of pediatric obesity care among all providers
- Improve health behaviors and patient outcomes through increased clinical and community integration
Clinical and Community Integration Strategies to Improve Health

“Obesity is a continuing unmet challenge”

Closing the Integration Gap for Childhood Obesity
Project Steps

1. Engage clinic partners
2. Build community partner network
3. Identify care coordinator (navigator)
4. Continuous quality improvement
5. Consider HIPAA compliance
6. Data and Evaluation
Clinic Partners

- Erie clinic sites
  - Division Street
  - Evanston

- Heartland clinic site
  - Devon – Rogers Park
2-17 y.o. patient well child visit

Primary Care Provider
- Screen
- Assess
- Refer
- Schedule

Care Coordinator
- Initiate contact
- Research Consent
- or Usual Care
- Intake, FNPA
- Care Plan
- Referral to CP
- Track Progress

Community Partner
- Initiate contact
- Enroll patient
- Report progress

Primary Care Provider
- Medical follow up
- CC feedback to inform care

2-17 y.o. patient, improved nut/PA habits
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Data Flow for ICAAP Promoting Health Care Coordination pilot project

- **Alliance of Chicago**
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  - 

- **Erie and Heartland Clinics**
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- **hDirectMail Secure Message**
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- **ICAAP Care Coordinator**
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- **CLOCC Evaluators**
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- **Pieces Iris**
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  - 

- **Community Partners**
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**Table:**

<table>
<thead>
<tr>
<th><strong>Activity</strong></th>
<th><strong>Description</strong></th>
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</thead>
<tbody>
<tr>
<td>PHI input to and extraction from Pieces Iris by ICAAP Care Coordinator</td>
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<tr>
<td>Care Coordinator sends secure messages to Clinics, Evaluators, and maybe Community partners</td>
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<tr>
<td>Community Partners access and send research and non-research client data to and from Care Coordinator via secure message OR email</td>
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<tr>
<td>The Alliance sends reports with de-identified data to evaluators via secure messaging</td>
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<tr>
<td>Clinics input referral to EHRS; Alliance accesses all data from clinics</td>
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<tr>
<td>Clinics will access patient status updates from care coordinator via secure messaging</td>
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<tr>
<td>Evaluators access reports from the Alliance and Care Coordinator via secure messaging</td>
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<tr>
<td>Care Coordinator accesses patient referrals from Alliance data warehouse</td>
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</tbody>
</table>
Evaluation

- Outcome Measures: provider counseling and referral (quality improvement); physical activity and nutrition habits; BMI for relevant patients
- Data collection: surveys (providers, participant, patient, community partner), care coordination database, data warehouse (EHRS data from each clinic)
Technology and Evaluation Partners

- **Technology**
  - Centricity – EHRS
  - Data warehouse
  - Pieces Iris – care coordination platform

- **Evaluation**
  - Maryann Mason, PhD
    Principal Investigator

  - Amy Christison, MD, FAAP, University of IL, College of Medicine
<table>
<thead>
<tr>
<th>BMI &gt;= 85</th>
<th>BMI &gt;= 95</th>
<th>Nutrition/Physical Activity Counseling</th>
<th>Nutrition/Physical Activity %</th>
<th>Readiness to Change Question Asked</th>
<th>Ready Change %</th>
<th>ICAAP Referral TO DATE</th>
<th>ICAAP Referral %</th>
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<tbody>
<tr>
<td>1155</td>
<td>679</td>
<td>451</td>
<td>39%</td>
<td>270</td>
<td>23%</td>
<td>254</td>
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<tr>
<td>ICAAP Referral Report</td>
<td>CP Referrals</td>
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<td>Actors Gymnasium</td>
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<tr>
<td>3</td>
<td>Cooking Matters held at Heartland</td>
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<td>Howard Area Community Center Summer Camp</td>
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<tr>
<td>55</td>
<td>Total Referrals</td>
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Takeaway

- Extremely complicated to streamline digital systems in healthcare, especially to nonmedical sectors
- Need to address underlying causes of OW/OB (food insecurity, transportation, poverty, lack of equity, systems that are not readily accessible)
- Healthcare system financing – duplicative administrative systems, and invasive/expensive care rather than primary care and effective community-led efforts
Promoting Health Grant Funders

- Telligen Community Initiative
- Otho S.A. Sprague Memorial Institute
- Wellcare Innovation Institute
For More Information

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