

D-RAP



- Patients are seen every three days at the site of their choice until goal
- Blood sugars are called in daily
- Patient is monitored closely until glucose is within normal range

D-RAP



- Goal A1c: 6.5 - 7.0
- Fasting Glucose constant, elevated Post Prandial
- Symlin or Januvia if patient on insulin
- Byetta or Januvia if patient on orals

D-RAP

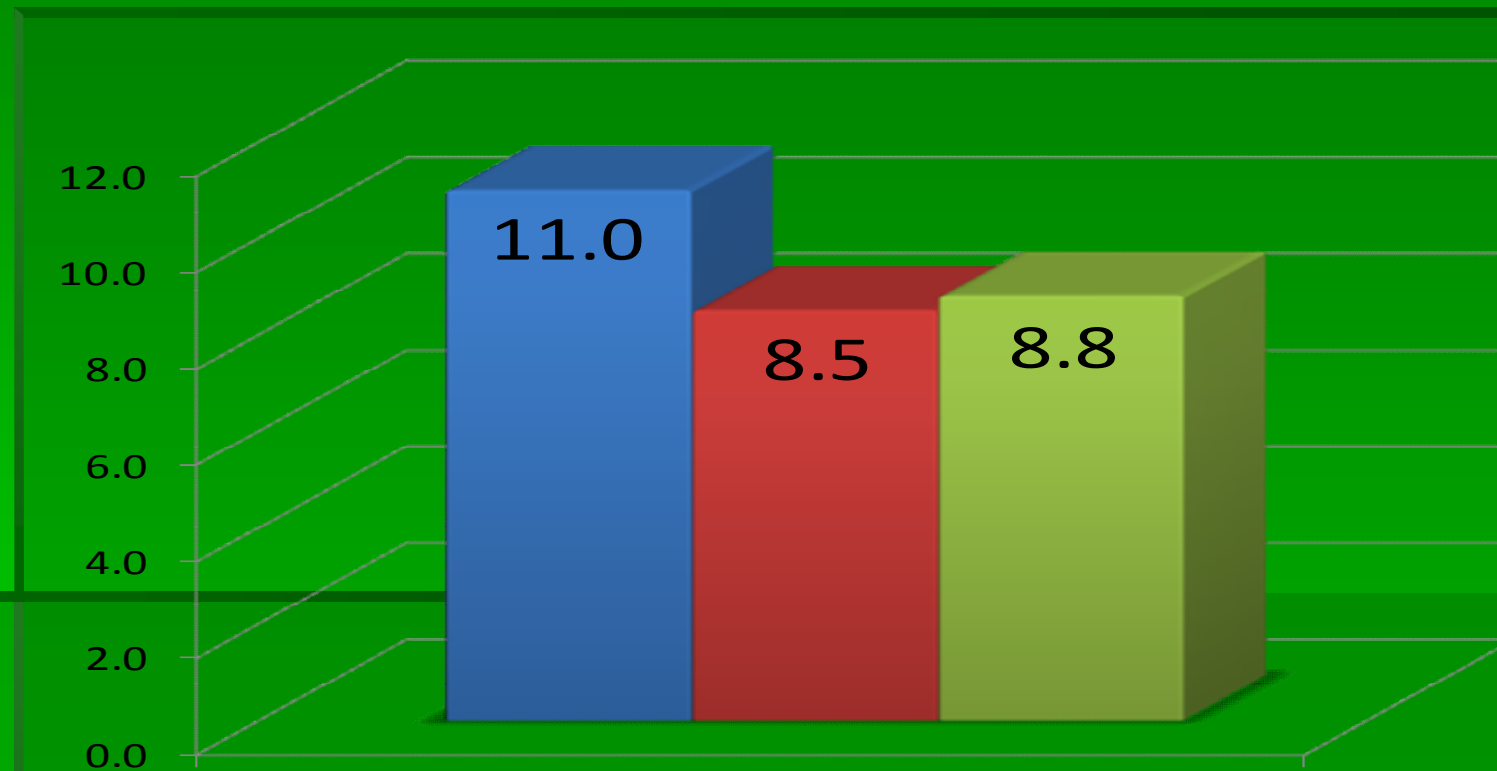


Results:

- Beginning of program study group of 300, average A1c - 11.0
- 11 months into the program average A1c - 8.5 at which time all diabetics enrolled
- The program promotes a simple regimen, which initially optimizes once a day dosing
 - Lower HgbA1c's decrease the risk of developing complications, improve the quality of life and result in fewer medical complications
 - Lower A1c's decrease health care costs

D-RAP STUDY GROUP

AVERAGE A1C RESULTS



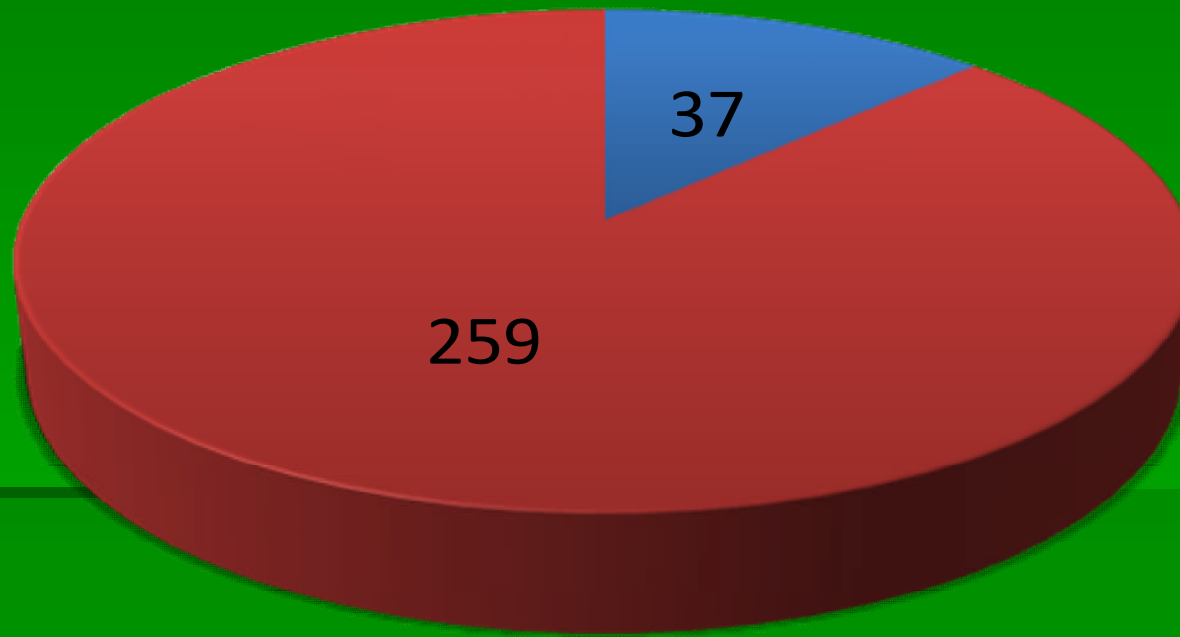
D-RAP

■ 1st Avg. ■ 2nd Avg. ■ 3rd Avg.

*NHANES III A1c Avg. – 7.7

D-RAP STUDY GROUP

NUMBER OF UNINSURED/INSURED CUSTOMERS
IN THE D-RAP PROGRAM



■ Uninsured ■ Insured

DRAP in the Florida Times Union

One health department program directed at blacks in the city's Northside helps identify at-risk residents in the community and works to make sure they seek medical attention and testing. Those diagnosed receive free diabetes self-management education classes. The Diabetes Rapid Access Program, an outreach program by Shands Jacksonville, allows patients with diabetes to get care at least every three days.

Diabetes: Northside program helping

Continued from D-1

live at or below the federal poverty level — has problems getting good access to primary care, said Tim Lawther, the health department's director of chronic disease prevention.

"Diabetes can be well managed by primary care doctors," Lawther said. "But if people don't have access to such care, they wait until they are really sick and they go to the hospital."

The region's substantial black population, a group predisposed to the disease, also fuels the statistics.

"Jacksonville has the largest percentage of African-Ameri-

coupled with sound eating and living habits, are some ways to gain ground against diabetes.

"We need to continue our outreach and education efforts to get people ... to move more and eat better," Lawther said.

The health department maintains 18 clinics that provide subsidized care to low-income folks. Along with other medical providers, the agency operates programs to identify high-risk residents early and control the spread of diabetes.

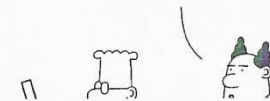
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DILBERT By Scott Adams

I'M PROMOTING
YOU FROM SENIOR
ENGINEER TO LEAD
ENGINEER.



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Review Evaluate And Control Hypertension

Background:

- Recognizes that less than 30% of patients in traditional family practice environments are at goal as specified by JNC 7.
- Active case management of patients within the hybrid, traditional disparity clinic system
- Program implemented June/07
- Offered 7:00am to 5:00pm

Methods:

- Patients are enrolled in the program by encounter data, providers, health fairs, and via HTN registries
- Patients meet with nurse for active management of HTN using established protocols



Protocol- for under and uninsured

- Diuretic → ACE → CCB → (renal consult) → Beta Blocker
Alpha Blocker → ARB → Renin Inhibitor, other
- Disparity Centers used for monitoring and modification of treatment
- Medication assistance provided
- Pharmacy to review medication
- Disease specific education
- Patients contacted via letter/phone
- Registry – 8,000 for quarterly evaluation by Physicians

Renal

- Consult after 3 BP medications
- Half a day clinic at Soutel Wellness and ESFP every other month by Dr. Haider for the under and uninsured
- Allscripts list of patients created to be seen for Renal consult

HY-LIP

Hyperlipidemia

- **Background**

- Recognized as a significant risk for morbidity and mortality
- Decreasing risk of heart attack and stroke by lowering LDLs

- **Methods:**

- Monitor all labs for elevated lipids and triglycerides
- To include women of child bearing age with LDL > 100
- Guidelines based on NCEP/ATP III
- Patients contacted via phone/letter every 2-3 months

HY-LIP

- LDL- 181mg/dl,
- Not taking medications as ordered, stopped stated his last results were normal and felt he did not need medications.
- After education and phone calls, medications resumed
- LDL- 137mg/dl
- Goal of LDL 100

Pharmacy

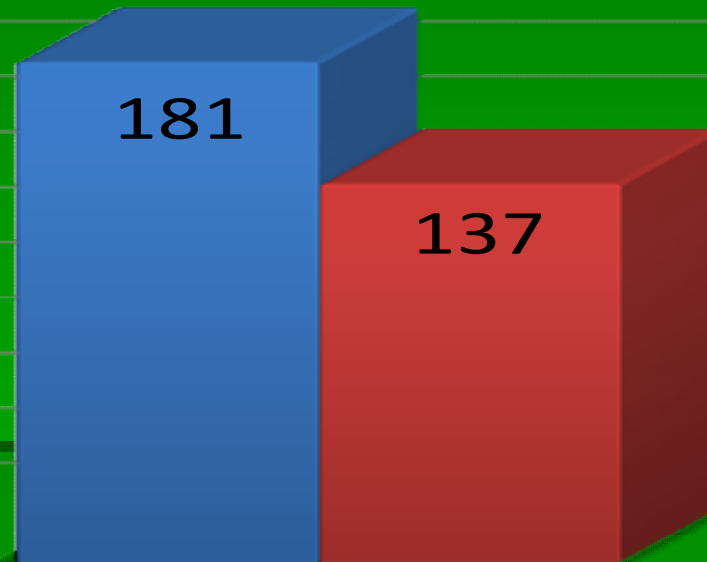
HY-LIP

- CK is greater than 300, Pharmacy consulted for possible discontinuation of medication and referral to Cardiology generated

HY-LIP Study Group

AVERAGE LDL RESULTS

200
180
160
140
120
100
80
60
40
20
0



HY-LIP

■ 1st Avg. ■ 2nd Avg.

CARE

COPD/Asthma, Respiratory Enhancement

- **Background:**

- In 2001, approximately 12.1 million adults older than 25 years of age were diagnosed with COPD in the US
- Asthma is estimated to affect 300 million people worldwide and 11% of the US population

- **Method:**

- Query claims for pt. dx. with COPD or asthma / Referral for PCP / Baseline Spirometry
- Provide medication and education / Pt call every 2 months

- **Results:**

- Decrease overall morbidity/mortality
- Enhance patient quality of life
- Decrease ER visit for COPD and Asthma
- 321 patients in program

CARE

Results

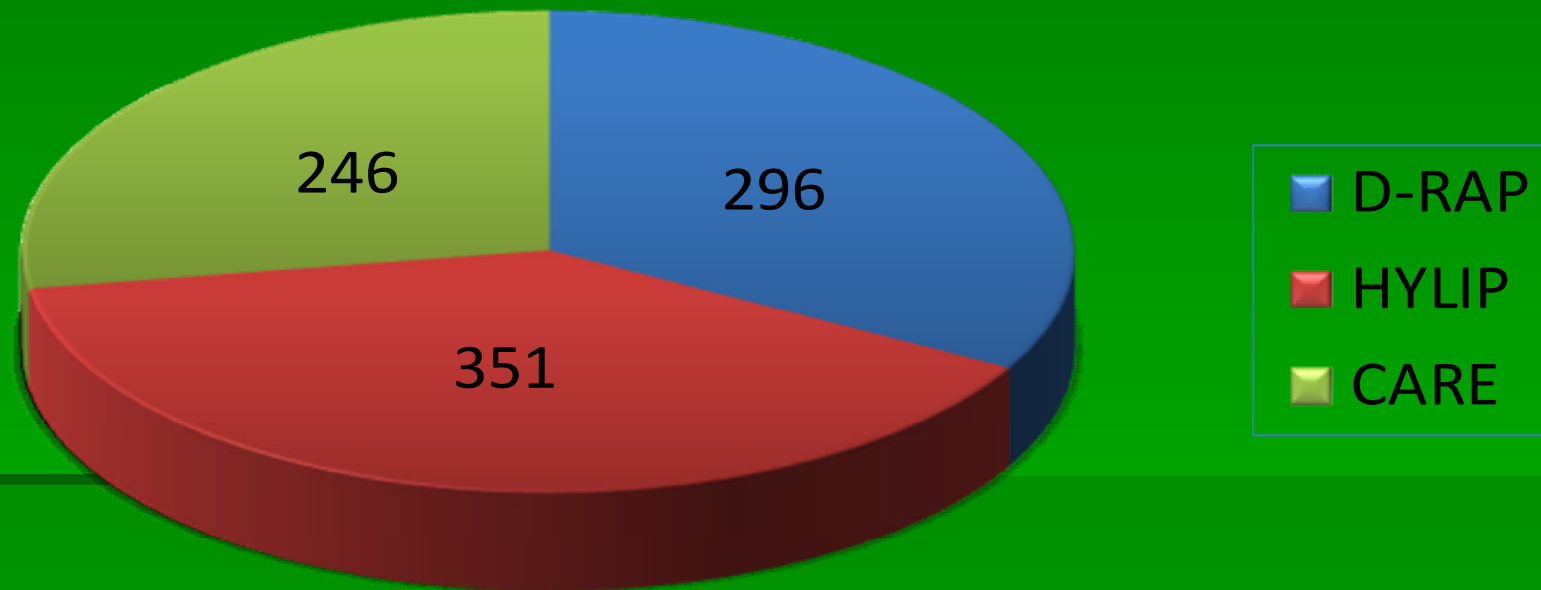
Pt's comment

“I can now walk to my mailbox without getting short of breath”

Pt's able to increase activity level

D-RAP, HY-LIP AND CARE

NUMBER OF CUSTOMERS IN THE STUDY GROUP



Free Script

- **Background:**

- To provide certain medications to disparity patients with no means of paying for their medications
- Two drug stores participating in the program; Osteen's and Walmart on Lem Turner

- **Results:**

- To date, Osteen's has provided 282 prescriptions at a cost of \$1,129.00
- To date, Walmart has provided xxx dollars in medications, xxx prescriptions
- ARBs will be added to the Free Script program for patients who need ARBs— anticipate Micardis

Pharmacy Initiative

- Shands Pharmacy to be available Wednesday morning
- Review pharmacy protocols
- Case management for patients with Diabetes, Hyperlipidemia, Hypertension, who also has been identified with liver, renal, heart disease, etc.,
- Telephone line available to the Dept. 8-4:30 for patient questions (244-4700)

Pharmacy

Anti-Coagulant clinic

- Patients lab drawn at Soutel Family Practice
- No co-pay
- Follow-up visit at Soutel Wellness with Pharmacist
- Letter sent for patient to be seen at Soutel Wellness

Pharmacy

Review all charts periodically and make recommendation to protocol

- HY-LIP
- REACH
- D-RAP
- CARE

Registry Specialist

- Letters are mailed on a continuous basis for patient to come in and follow-up on labs and PCP visits
- Patient on registry are assessed quarterly through the registry program

Hispanic Initiative

- Health fairs at Hispanic Churches
- Third sundays; 1st Heal Thy people in February
- Serving the Hispanic populations of Duval County

Registries

- FCA
- Humana
- Medicaid
- Uninsured
- City Contract
- Query of ER encounters on above patient population
- will receive letter offering community affairs clinics as alternative

Food services

- Collaborative effort with Shands chaplain services to offer meals for those who are financially challenged and whose love ones have extended inpatient stays

JUDI

Jacksonville Urban Disparity
Institute

JUDI

Was formed to help reduce health disparities identified by the US center of Disease Control and prevention that adversely impact low socioeconomic individuals in Jacksonville and Duval county.

JUDI

- Exclusively for:
 - A.) promoting health care
 - B.) Educating
 - C.) scientific and related charitable purposes

JUDI

- Governed by an Executives Committee
- Input from the Advisory Board which will meet quarterly
- The institute is currently located at Soutel

Future Initiative

Childhood Obesity

- Scientific common sense approach to Childhood metabolic obesity
- Reducing Childhood Obesity through early identification of DM, Hy-Lip, Thyroid disease and dietary consult

Core Principal

ACCESS

- Results:
- Decreased ER utilization by the Uninsured approximately 10,000/year
- Decreased bed days
- Decreased length of stay
- Improved A1c, blood pressure and lipid profiles
- Decreased ER utilization for asthma/COPD