



# ***Dallas Area Coalition to Reduce Diabetes and Heart Disease: from Assessment to Intervention***

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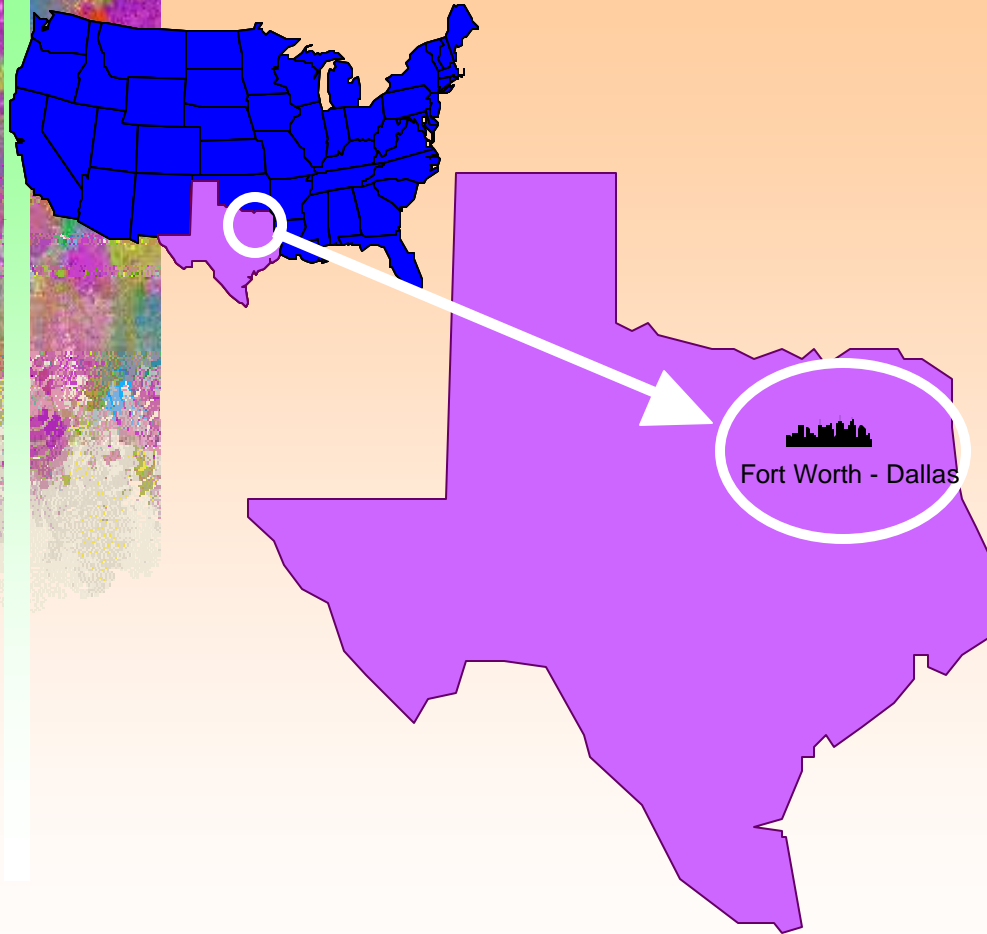
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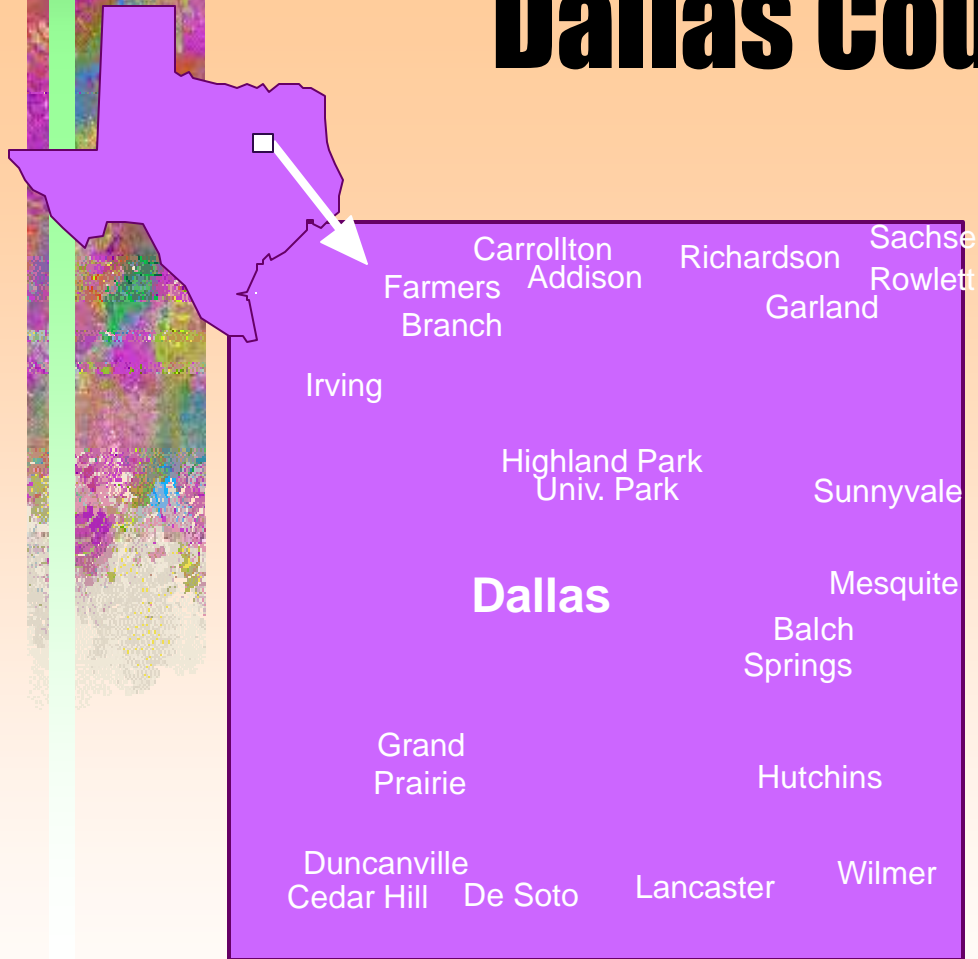
# North Central Texas



- **6.5 million people**
- **4.5 million in large metropolitan area — the Dallas-Fort Worth metroplex**

*Source: US Census Bureau*

# Dallas County



- **2.2 million people**
- **880 square miles**
- **City of Dallas, 22 suburban cities, & a few rural areas**
- **14% poverty rate**
- **29% uninsured**

# Dallas County Is the Second Fastest Growing County in Texas

- 19.8% growth from 1990 to 2000
- Growth in Hispanic and African American population largely outside the city boundaries
  - 118% growth outside city boundaries
  - 41% growth inside city boundaries
- Dallas County expected to grow to 2,401,474 by the year 2005

*Source: Steve Murdock, Ph.D. Texas State Data Center and U.S Census Bureau*

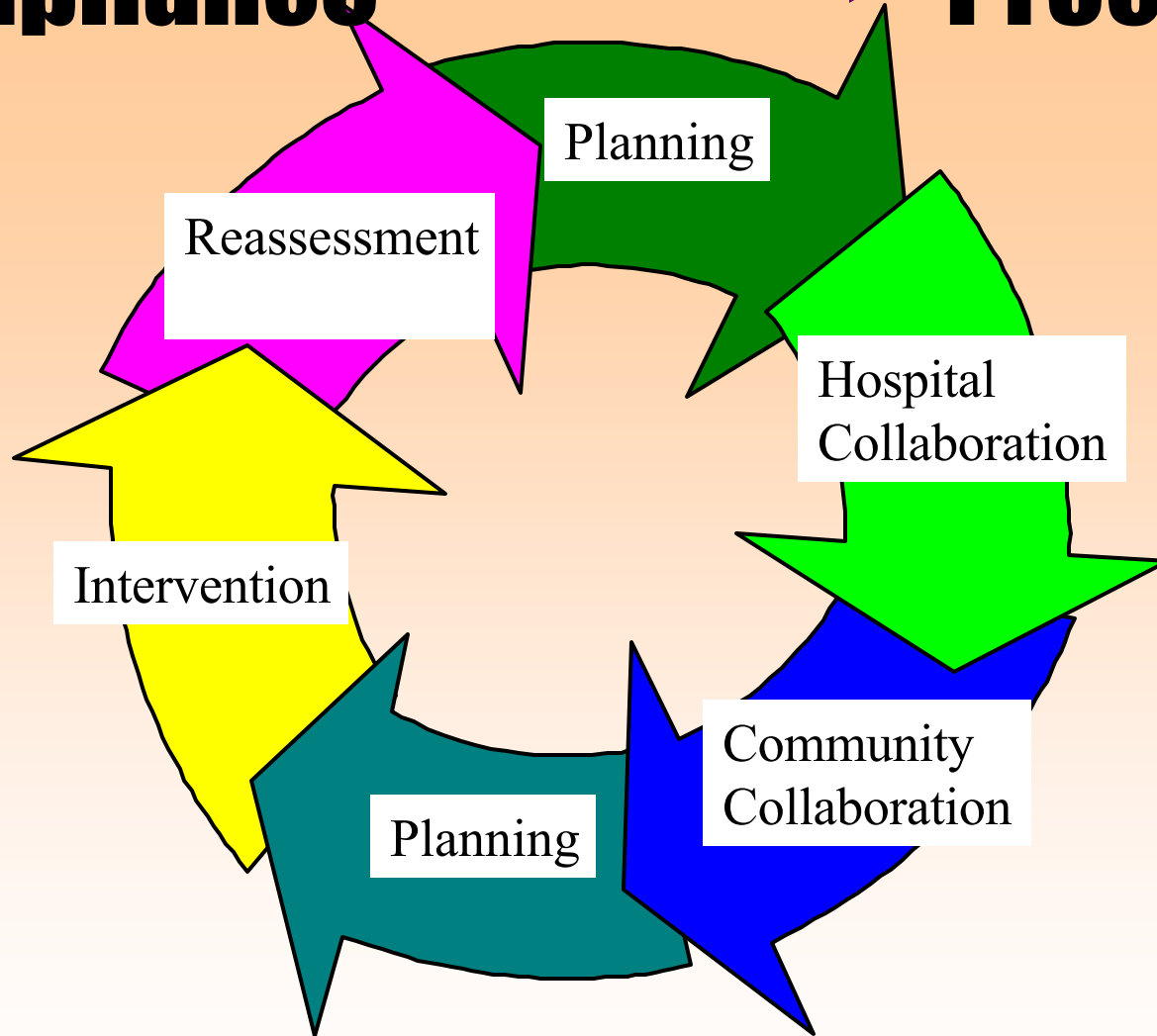


# **Texas - Dallas**

- **No State Income Tax**
- **Little support for the indigent**
- **Right to Work State**
- **Wide open spaces**
- **Beginnings of a mass transit system - we don't walk places - we drive**
- **city and county named for relatives**
- **Stiff competition between Dallas and Fort Worth - County line is a barrier**

# Compliance

# Process



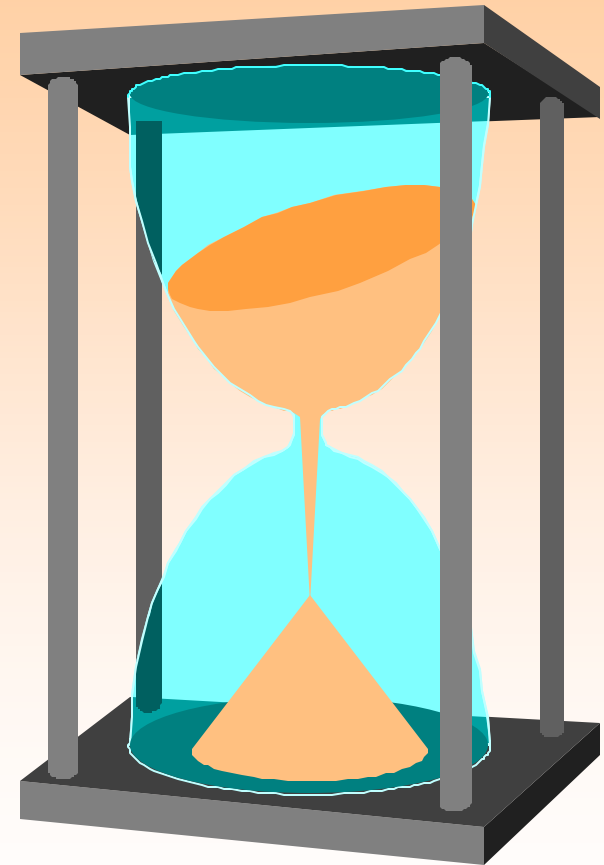


# **Community Benefit in Texas is mandated through legislation.**

- **Senate Bill 427, passed in May 1993, defines tax exempt status of non-profit hospitals**
- **1997 legislature expanded law to include:**
  - ⇒ **public hospitals**
  - ⇒ **disproportionate share hospitals**

# **Time for compliance was limited.**

**Law went into effect in  
September 1993 and  
required submission of a  
needs assessment by  
December 31, 1993**




# Immediate action was needed

- **Dallas-Fort Worth Hospital Council (over 70 hospital membership) established ad hoc Needs Assessment task force to explore areas of possible collaboration Parkland Health & Hospital System offered its existing community assessment (a Management Tool for its Community Oriented Primary Care Health Centers) with the stipulation that, in subsequent years, other hospitals would support production and share in costs.**



## **14-16 hospitals have been working together for 7 years**

- **Effect of a common community assessment:**
  - **Reduced costs to each institution**
  - **Standardized information**
  - **Agreed standard for the community**
- **Not-for-profit health care system can:**
  - **identify county's health needs and assets**
  - **plan in a unified way**

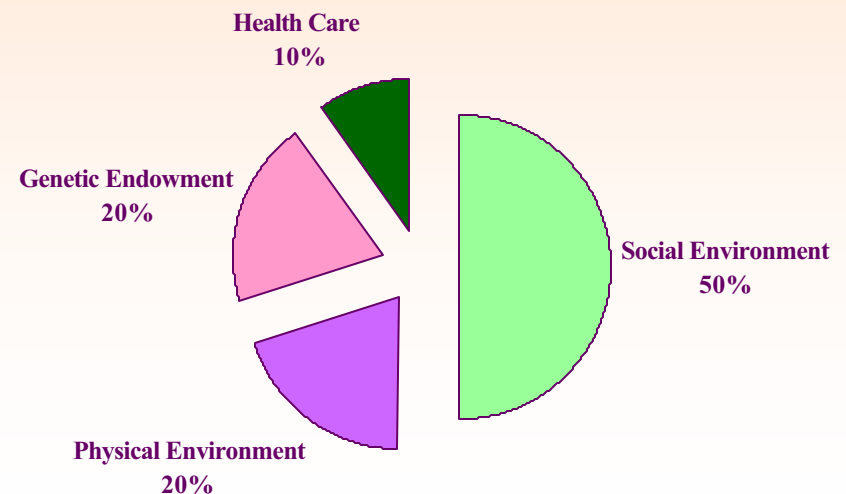


# **Dallas County's assessment is the “gold standard” for the Texas Department of Health**

- **Refined each year**
- **Identifies:**
  - **needs and deficiencies**
  - **assets---at least equally important!**

# Health care delivery market in D/FW has shifted

- **Managed care penetration, increasing uninsured, and a changing demography (aging and increasing number of minorities)**
- **The participating institutions realize that, to survive in the new health care market, they need to deal with “upstream” issues--determinants of health:**
  - **social environment**
  - **physical environment**
  - **genetic endowment**
  - **medical care**





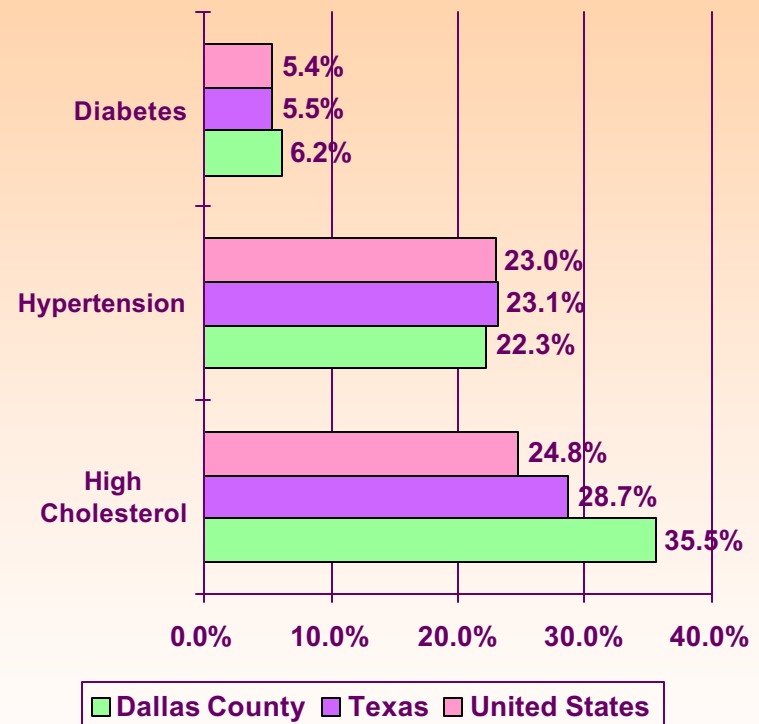
## **Multitude of needs requires cooperation, focus.**

- **Participants agreed to identify one issue for collaboration:**
  - **Significant problem**
    - ⇒ **morbidity**
    - ⇒ **mortality**
    - ⇒ **cost**
  - **Amenable to early intervention, management**
  - **Available Assets**
  - **Significant to all levels of the community**

# Needs Assessment Task Force selected diabetes, hypertension and high cholesterol as the first issue to address.

- **Four surveys indicated higher rates for Dallas County than Texas and the US.**

- **1995 Greater Dallas United Way Survey**
- **1996 repeated questions to validate result**
- **1998 BRFSS conducted in Dallas CO.**
- **1999 NRC Market Guide study**





## **Key strategy was to involve both public and business leaders in the coalition.**

- **Co-chairs**

- **Judge Lee Jackson, Dallas County's highest elected official**
- **Sue Nelson, president of the Dallas-Forth Worth Business Group on Health**

- **Involvement from broad spectrum of community life---businesses, schools, churches**



# **Key community organizations were invited to participate.**

- **Dallas-Fort Worth Hospital Council**
- **Parkland Health & Hospital System**
- **Baylor Health Care system**
- **Dallas County Medical Society**
- **American Heart Association**
- **Prudential Healthcare of North Texas**
- **American Diabetes Association**
- **Texas Diabetes Council**
- **Coalition for Health Care Quality**
- **City of Dallas Health Department**
- **The Quality Edge**
- **Dallas Concilio**
- **La Raza**
- **Texas Instruments and the Dallas-Fort Worth Business Group on health**
- **Dallas County commissioners Court Judge**
- **Dallas Public Schools**
- **Greater Dallas Community of Churches**
- **Greater Dallas Restaurant Association**
- **Texas Agricultural Extension Service**
- **Pfizer Pharmaceuticals**
- **Aventis Pharmaceuticals**
- **Smith-Klien Beecham**
- **Eli Lilly**
- **Merk**

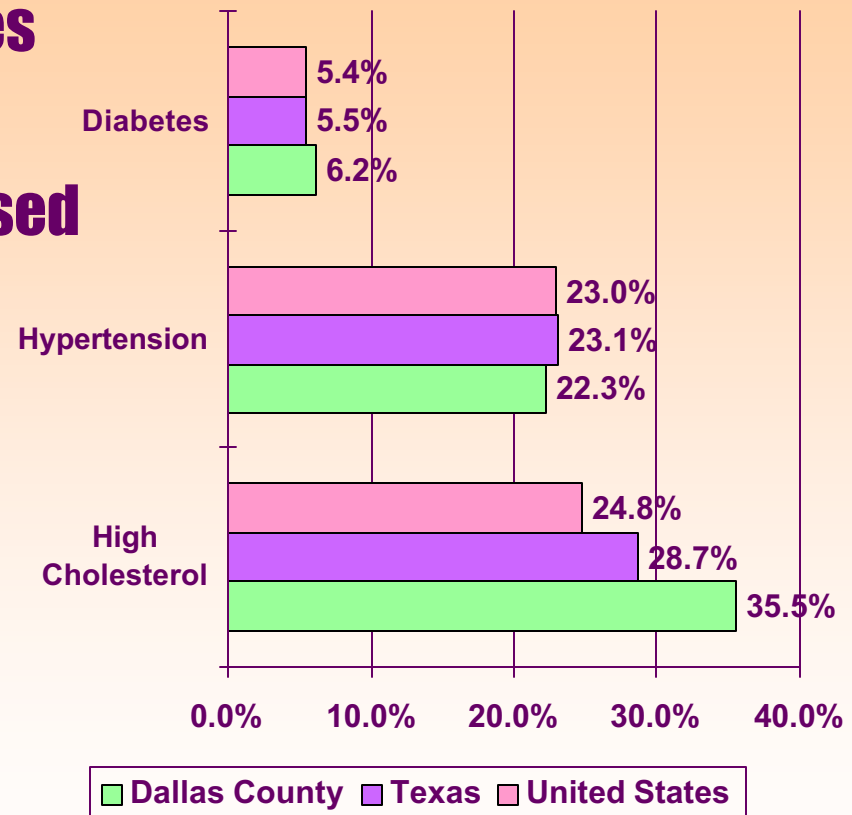
# **Briefing sessions provided common background and framed the issues.**

- **Coalition staff (D/FW Hospital Council and Parkland Health & Hospital System) arranged four briefing sessions, at the request of coalition Chairs, Judge Jackson and Ms. Nelson**



# First briefing included core members of coalition.

- **Introduced themselves**
- **Discuss basic issues**
- **Principle item discussed was chart**
  - **prevalence of diseases**
  - **economic impact**
    - ⇒ **healthcare costs**
    - ⇒ **lost productivity**



# **Economic impact directly related to healthcare services is high.....**

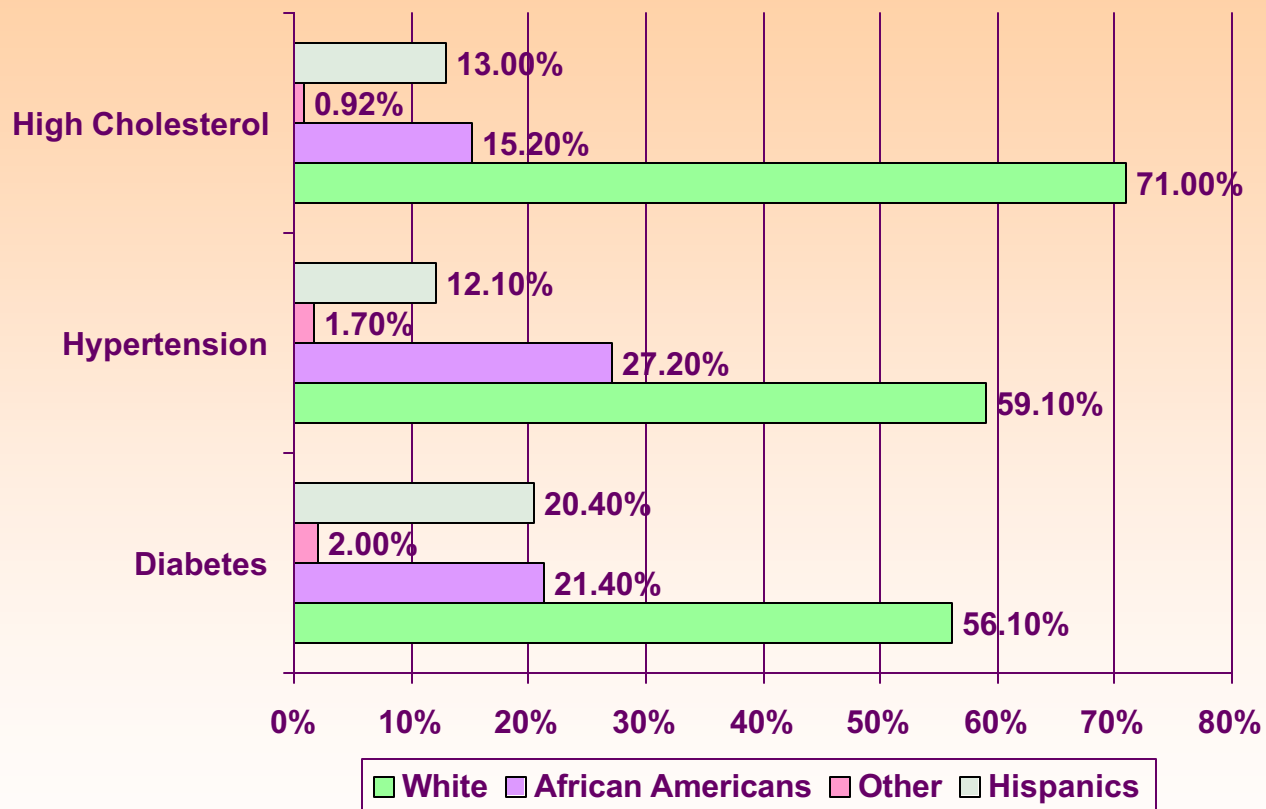
- **Charges to D/FW hospitals in 1999**
  - **Heart Disease** **\$65 million**
  - **Diabetes** **\$35 million**
- **Cost to insurers for covered diabetics in 1995**
  - **Prudential/North Texas** **\$30 million**
  - **Texas Instruments** **\$9 million**



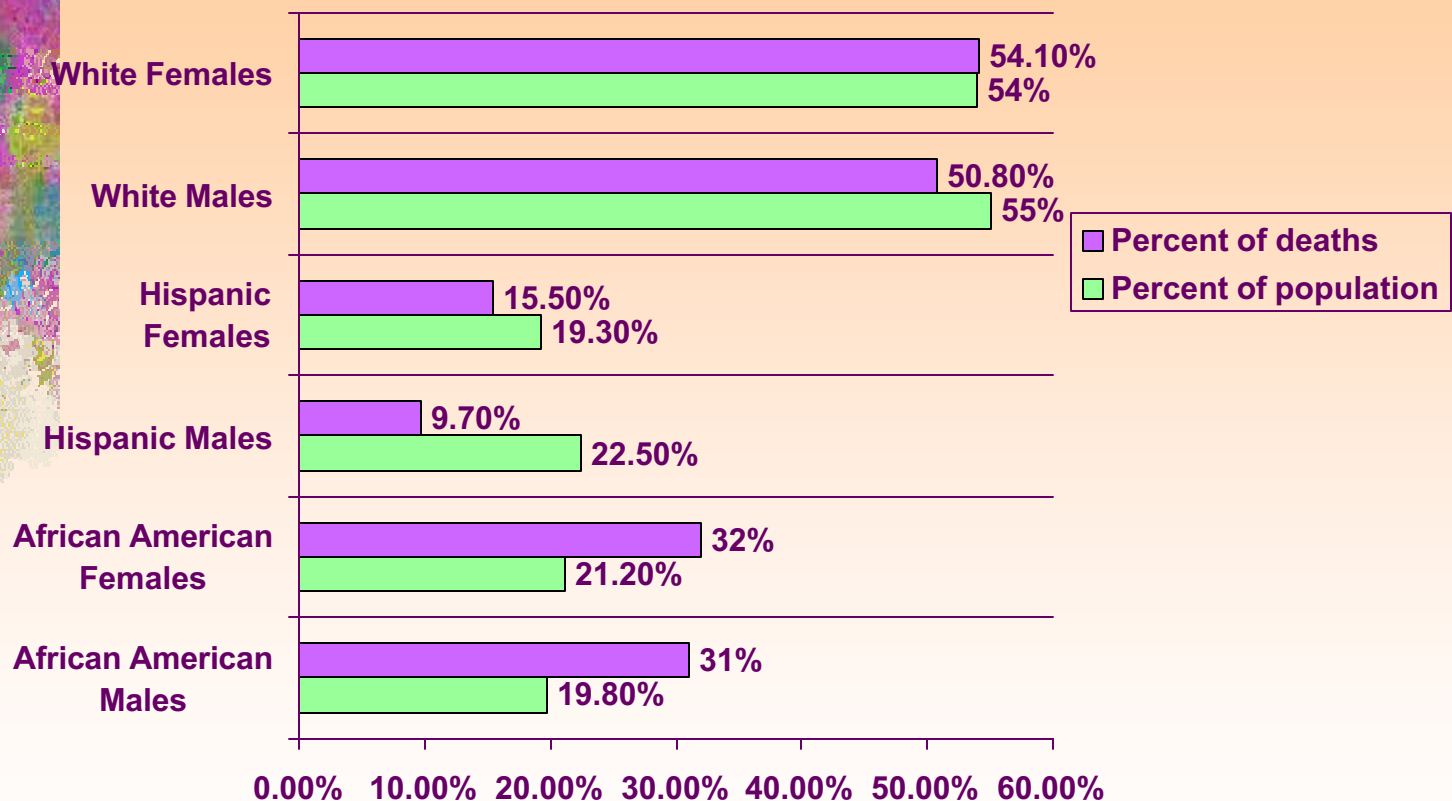
## **Second briefing addressed specific questions from first briefing**

- **Why address both diabetes and heart disease?**
- **What is the extent of the problem?**
  - **Mortality**
  - **Morbidity**
  - **Utilization**
- **Who is at risk?**
- **What is already being done across the US? (best practices)**

# Ethnic Distribution of Dallas County Residents with Diabetes, Hypertension and High Cholesterol



# Deaths due to Diabetes, Dallas County, 1996



Total Deaths are 342. 155 were male and 187 were female

# Populations of Focus

- **African Americans are over represented in the deaths due to diabetes.**
- **Whites are over represented in heart disease deaths.**
- **Hispanics are under represented in deaths due to diabetes and heart disease deaths.**
- **Target the whole community with specific programs targeting African American adults and older whites.**
- **Areas of focus**





## **Different members saw the problem from different perspectives**

- **Business: economics and productivity; interested in data**
- **Political: issues of the common good; interested in “stories”**
- **Education: how can we grow healthy people**
- **Health Care: quality of care and positive health outcomes**



## **Coalition members described existing community programs addressing these issues.**

- **Tremendous resources already being spent, but no coordination**
- **Wanted to know:**
  - **Who's doing what?**
  - **What assets are available?**
  - **What are possible areas of collaboration?**

# Third and fourth briefings developed asset matrix to answer these questions

	Greater Dallas Restaurant Association	Dallas County Medical Society	Prudential Healthcare of North Texas
Current Programs			
Activities/Services			
Reason Began Program			
Audience/ # impacted			
Monetary investment/funding source			
cunsultant/contractor			

# Process: Gap Analysis Impact of Existing Programs



- **Matrix constructed by service provider, age and ethnicity**
- **Quantified the availability of current services**
- **Validated scores**



# Findings from Gap Analysis

- **Taken qualitative data and quantified it**
  - **Verified data with partners**
- **Mile wide and an inch deep**
- **Many programs are event oriented and not sustained**
- **Little coordination between timing and messages**
- **Messages are not reinforced**

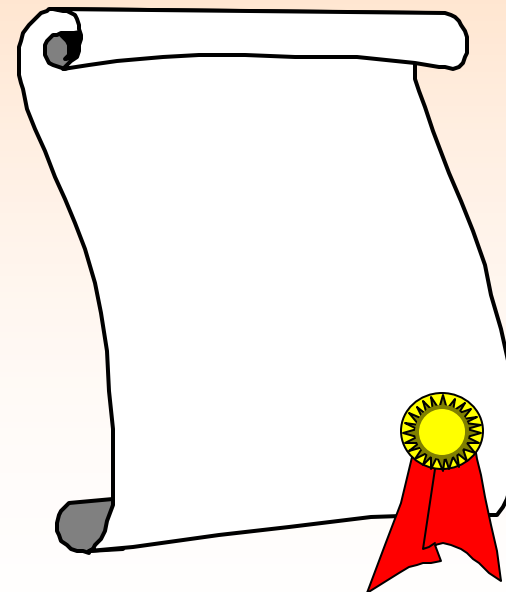


# **Vision**

**The Dallas Area Coalition to Reduce Diabetes and Heart Disease seeks a healthier community through collaborative efforts by making the entire community aware and involved in managing and reducing the incidence of diabetes and heart disease, resulting in a national reputation for healthy citizenry and workforce. (approved April 17, 1998)**

# The Plan

- **Goal 1: To create a continuum of care to decrease morbidity and mortality of the African American Population with diabetes and hypertension, and the elderly Caucasian population with heart disease by 2005.**
- **Goal 2: Increase the level of awareness and knowledge of risk that would lead to behavioral change, especially in high-risk populations.**





# The Plan Continued

- **Goal 1: Strategy 1:** To create a continuum of care
- **Goal 2: Strategy 2:** Engage in a social marketing campaign
- **Strategy 3:** Explore incentives with insurance companies to develop a primary care provider education program to improve the coordination and delivery of primary care.

# Coalition solicited focus group input

- **Results of focus groups:**
  - **Need for clinical support, i.e. accurately & honestly identifying the problem (a little sugar or borderline)**
  - **More clinical education available for patients**
  - **Community education**
  - **Support groups**





## **Key programming gaps identified**

- **Primary-care physicians**
  - **continuing education**
  - **involvement in patient management**
- **Continuum of care among all providers within the County**
- **Public education including**
  - **Restaurants offering more low-fat and heart-healthy foods**
  - **Outreach to surrounding counties**
  - **speaker bureau**
  - **Elementary school education**



# **Intervention**

- Physician/nurse CME program”Diabetes Mellitus: The Epidemic in our Backyard (Tools for Community based Practices)**
- Targeted to primary care practices serving minority at risk populations**
- Primary Goal to impact physician office practice management of diabetic patients - included office nurses**

# **Putting the intervention together**

- **Task force established from larger coalition**
- **Brought in additional expertise from partners**
  - **THR Continuing Education Department**
  - **Medical Directors,**
    - **Presbyterian PrimaCare and**
    - **Parkland COPC**
  - **American Diabetes Assoc., etc.**
  - **Drug Companies**

# Financing

- **Sponsors**
  - **Presbyterian Hospital of Dallas**
  - **Baylor Health care System**
- **Joint-sponsors:**
  - **American Diabetes Association**
  - **Coalition for Health Care Quality**
  - **Dallas/Fort-Worth Hospital Council**
  - **Parkland Health & Hospital system**
- **Corporate Sponsors**
  - **Pfizer**
  - **Aventis**
  - **Eli Lilly**
  - **Amira**
  - **SmithKlien Beechm**
- **Space and AV equipment donated by Texas Scottish Rite Hospital**
- **Nominal charge of \$25 per participant**



# **Crafting the Program**

- **Primary Care office practice partners**
- **Highly qualified and entertaining faculty**
- **Offered highly sought after Medical Ethics CME credit**
  - **strategically place late in the program to ensure attendance throughout the day**
- **Nominal fee**
- **Educational and vendor booths**

# Results

- **Attended by over 200 physicians and nurses - standing room only**
- **80% stayed all day**
- **Ran out of Educational and Vendor Booth materials**
- **Evaluation score of 4.6 on a 5 point scale**

## **Results (2nd Program)**

- **Attended by over 350 physicians and nurses - standing room only**
- **80% stayed all day**
- **Ran out of Educational and Vendor Booth materials**
- **Evaluation score pending**

# **De-Briefing and Next Steps**

- **Presented results to Coalition**
- **Next Steps**
  - **Institutionalize CME program**
  - **Develop resource directory (made available at the (2nd annual CME)**
  - **Implement a list serve for professionals and advocates**
  - **Support REACH program being developed by La Raza**
  - **Public education campaign**

# Lessons Learned

- **Coalition members committed to improving health**
- **Coalition members wanted to have an impact on the identified areas**
- **Trust is essential for any for of collaboration**
- **Buy-in from all coalition members key to accomplishment of goals**
- **Takes a significantly longer period of time to build a working coalition.**
  - **Analysis paralysis**
  - **Set time for accomplishing tasks**
  - **One facilitator the group is comfortable with**
- **A lot of community initiatives without evaluative framework lead to a lot of activity with little concrete results.**
- **Focus efforts necessary to be able to establish measurable interventions**
- **Longer period of time to effect improvement in community health.**



# **Ideas of interventions**

- **Give us ideas of interventions to take back to our coalition**
- **How do we activate non health care partners**
  - **Fire Department**
  - **School District**
  - **Churches**
  - **Restaurant Assoc.**



# Gap Analysis Worksheet