How Can a Safety Net Hospital be the Catalyst for Creating a Healthier Community

Ethics Grand Rounds

September 11, 2012

Parkland

Ron J. Anderson, MD, MACP

Special Assistant to the CEO, Parkland Health & Hospital System

The Physician Patient Relationship (Bedside)

- **Beneficence** – Prevention or Removal of harm. A positive action to do good.

- **Non-Maleficence** – "Above all, do no harm." Includes non-intentional harm and risks of harm. Could be a positive action or a withholding of action.

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Fundamentals of Medical Ethics

- **Promotion of Autonomy –** Helping promote wholeness, personhood, and proper decision-making without deploying strong paternalism.

- **Veracity –** A duty to be a truth teller, not a liar or deceiver. (Required for autonomy/trust.)

Confidentiality – Not speaking about what "ought not to be spoken abroad." (Required for respect of person/trust.)

Conflicting Realities

- Beneficence may legitimately conflict at times with our desire to promote autonomy.
- The roots of paternalism run deep in the history and culture of medicine, but the desire to promote autonomy is relatively new (last century).

The Physician's/Health System's Relationship to "Community"

- Communities are made of individuals and they are not to be diminished intrinsically because they are a member of a given populations.
- The bioethical tenets previously discussed are therefore still of fundamental importance and should not be watered down.
- Additionally, the promotion of social justice and the ethical distribution of scarce resources come into sharper focus. (Distributive Justice)

Parkland

Presentation Goals

- Describe size and complexity of Parkland's role as a Safety net teaching hospital.
- Describe Parklands community medicine and population health efforts of the last several decades.
- Describe where Parkland needs to further evolve in preparation for health reform and to help create healthier communities.

Parkland

Presentation Goals

- Describe how the present 1115 Medicaid Waiver could be complementary to the goals of a healthier Dallas County.

- Answer the question as to why we need to evolve beyond the “safety net” apology to become the “change we seek” in a sound and ethical manner.

Parkland

Parkland's Mandate, Mission & Vision

Mandate

To furnish medical aid and hospital care for the indigent and needy persons residing in the hospital district.

Mission

Dedicated to health and well-being of individuals and the community entrusted to our care

Vision

By our actions, we will define the standards of excellence for public academic health systems.

Parkland

Who Is Parkland?

Provider of care for Dallas Country Hospital District

ACC, OPC, HOMES, Women's Clinics, etc.

Acute Care Hospital – Adult and Neonatal only

Primary teaching hospital of UT-Southwestern Medical Center

Level 1 Trauma Center

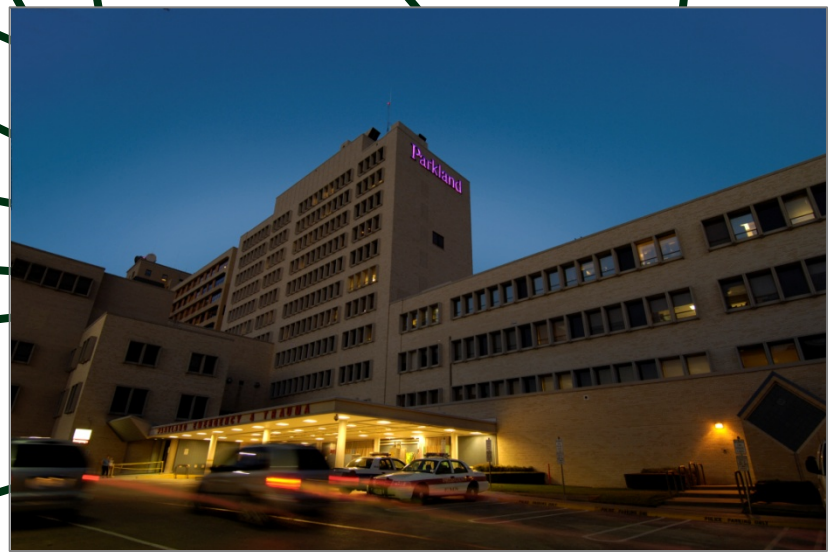
School-Based Health Centers

COPC Network

North Texas Region's Only Burn Center

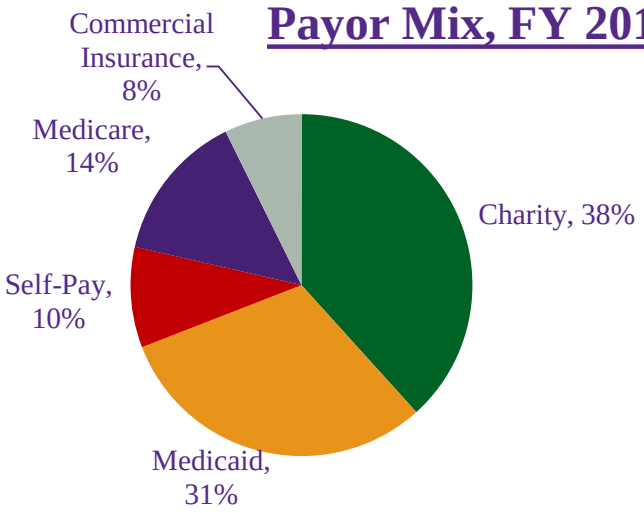
Large OB Service

Jail Health Services & Juvenile Detention



Parkland Health & Hospital System

Payor Mix, FY 2011



System Statistics 2011

- Over 9,300 Employees
- 1,587 Active Physicians
- 1,258 Fellows and Residents
- 2,401 Registered Nurses
- 700 volunteers

Financials (in Thousands) (FY 2011)…

- Tax Base $158,916,261
- Tax (per $100 Valuation) 0,271
- Net Tax Revenue $424,666
- Cost of Uncompensated Care $605,572
- Cost of Uncompensated Care Over Tax Base. $180,906

Other Statistics (2011)

- Prescriptions……..…7,481,398
- Surgeries
  - Main Operating ..……....14,075
  - Simmons Ambulatory,……3,818 Surgery Center
- Pathology procedures…..... 8,933,413

Source: Parkland Health & Hospital System Annual Report, 2012.10

Parkland

Parkland Remains Area's Busiest Hospital System

	1980	1990	2000	2005	2007	2009	2011
Discharges	31,645	39,180	41,679	40,051[1]	42,788	41,364	37,290
Deliveries	8,572	13,585	15,419	15,811	16,252	14,872	12,391
Outpatient	218,283	462,909[2]	401,669[2]	235,708	260,879	295,812	338,245
WISH	---	---[2]	---[2]	177,658	239,647	256,485	256,789
COPC	---	288,909	380,409	452,953	413,516	431,523	445,865
OR Cases	10,879	12,817	13,569	14,846	15,524	16,649	14,705
ER	174,213	145,633	144,510	143,601	142,723	108,717	139,014
Urgent Care	---	---	---	---	---	38,480	54,337

[1]Observation days increased due to chest pain and abdominal trauma protocols, reducing admissions by over 2,000
[2]WISH visits included in Outpatient totals

Source: PHHS Annual Reports

Parkland

"Health Affairs," August 2012 Five Safety-Net Hospitals Utilization and Financial Data

Selected Utilization And Financial Data Of Five Hospitals In The Study Of Safety-Net Hospitals After Reform, 2010

Data type	Bellevue Hospital Center	Denver Health	Parkland Health and Hospital System	San Francisco General Hospital	VCU Health System
Staffed beds	809	404	798	507	719
Discharges	28,764	20,562	41,294	15,403	32,244
Percent Medicaid	57	44	28	35	28
Percent uninsured	8	25	56	25	15
Outpatient visits (number)	649,302	1,038,724	1,330,066	790,269	929,125
Percent Medicaid	45	26	30	28	18
Percent uninsured	31	33	54	35	21
Percent emergency department	18	6	14	7	9
Net revenues					
Percent Medicaid	59	58	46	31	31
Percent Medicare	19	13	21	11	23
Percent commercial	5	21	14	16	37
Percent uninsured	1	3	11	<1	2
Percent other	4	1	7	3	8
Percent state/local payments	12	5	0	39	0

SOURCE National Association of Public Hospitals and Health Systems 2010 hospital characteristics survey (Note 8 in text). **NOTE** VCU is Virginia Commonwealth University.

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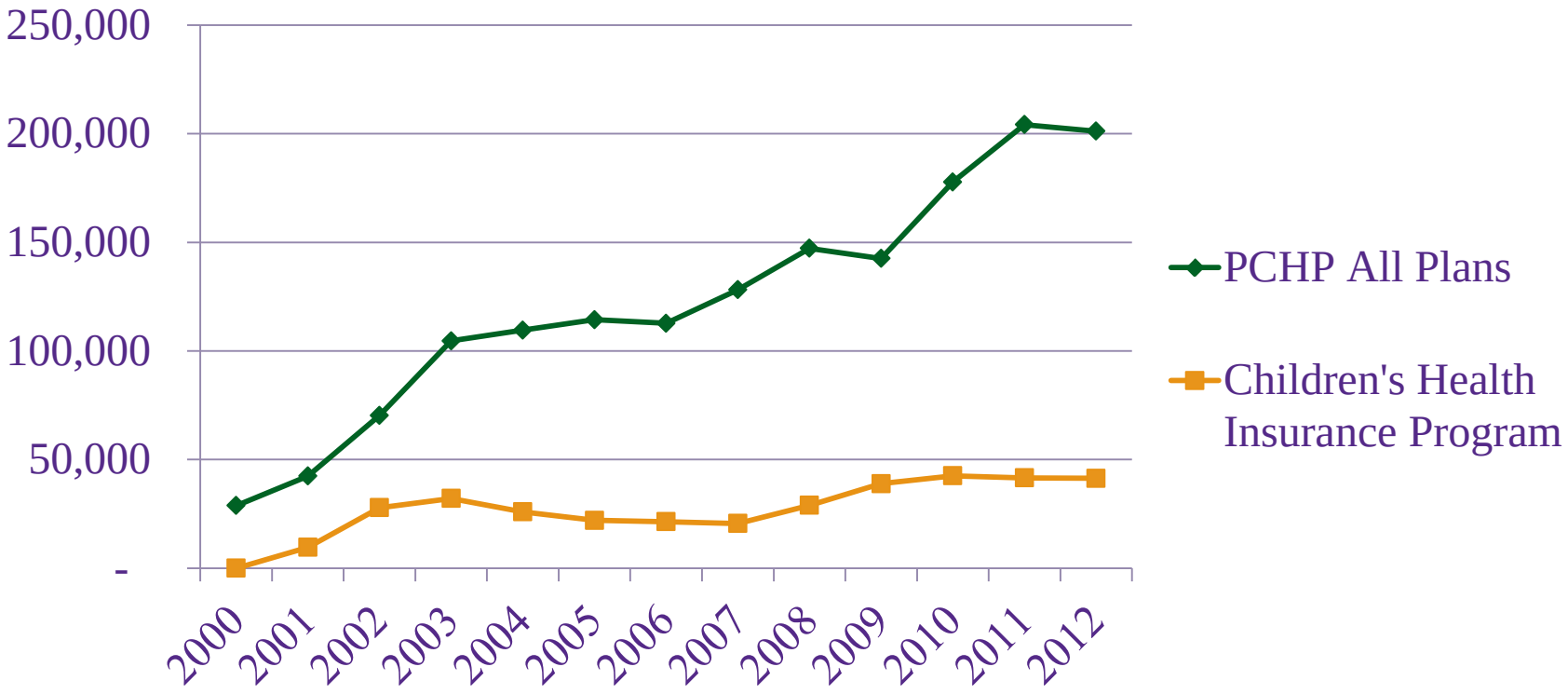
Parkland Community Health Plan

PCHP gives Medicaid and low-income patients more options for care, and keeps an eye on cost and quality.



Parkland

The Parkland Foundation

- The Parkland Foundation is a non-profit organization dedicated to securing substantial financial resources that advance the clinical, educational and research quests of Parkland Health & Hospital System.
  - The Foundation has a separate Board of Directors
  - The Foundation is a dependent non-profit organization
- The Foundation has raised over $100 million to support New Parkland

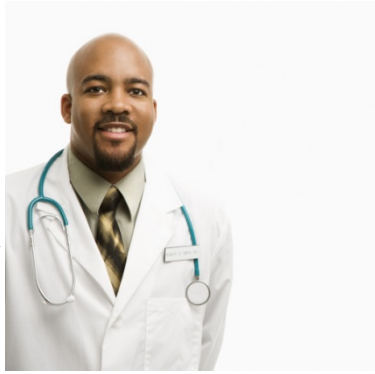
Parkland

Parkland Fills the Gaps for Dallas County

1 in 4 trauma cases go here
6 in 10 for major trauma

Parkland serves a regional referral center for burn and trauma care

4 of 10 HIV/AIDS patients treated here



More than half the county's doctors train here

Parkland serves as the primary teaching hospital for The University of Texas Southwestern Medical Center

Nearly than 1 in 3 residents lack insurance and are likely to seek care here

More than 3 of 10 babies born here

Source: Parkland Health & Hospital System, 5/2009

Parkland

Parkland As Innovator

- **1954:** Parkland became the **first** civilian hospital in Texas to use an artificial kidney machine.
- **1955:** Parkland established its **first** kidney dialysis unit.
- **1955:** Parkland performs the **first** corneal transplant in Dallas.
- **1956:** Parkland develops one of the **first** nuclear medicine labs in the U.S.
- **1959:** Parkland begins Texas' **first** medical service for pediatric infectious diseases.
- **1961:** Parkland opened one of the largest civilian burn units in the U.S., designating four, four-bed wards as a burn treatment area.
- **1962:** Parkland opened the **first** seven-day, 24-hour staffed operating room in North Texas.
- **1964:** A team led by Parkland's Dr. Paul Peters performed Texas' **first** successful kidney transplant.
  - **1966:** The surgery and anesthesiology staffs at Parkland and UT Southwestern published the **first** medical text on trauma.

Parkland

Parkland as Innovator

- **1968:** Parkland opened the fourth Surgical Trauma Unit in the U.S.
- **1968:** Parkland opened its **first** "premature nursery."
- **1971:** Parkland Opened the **first** High Risk Maternity Unit in the U.S.
- **1971:** Parkland opened the **first** Pediatric Burn Unit in North Texas.
- **1973:** Parkland opened the **first** Neonatal Intensive Care Unit in Dallas.
- **1973:** Parkland opened the **first** Neurology/Neurosurgery Intensive Care Unit in Dallas.

- **1973:** UT Southwestern established the **first** and largest clinically oriented skin bank in the nation to provide grafts for burn patients.
- **1979:** Diabetic patients became the **first** in North Texas to use insulin infusion pumps.
- **1983:** Parkland became certified as the **first** Level I Trauma Center in Texas.
  - **1983**: Parkland became the **first** hospital in the Southwest to clinically use nuclear magnetic resonance imaging by evaluating a patient with kidney failure.

Parkland

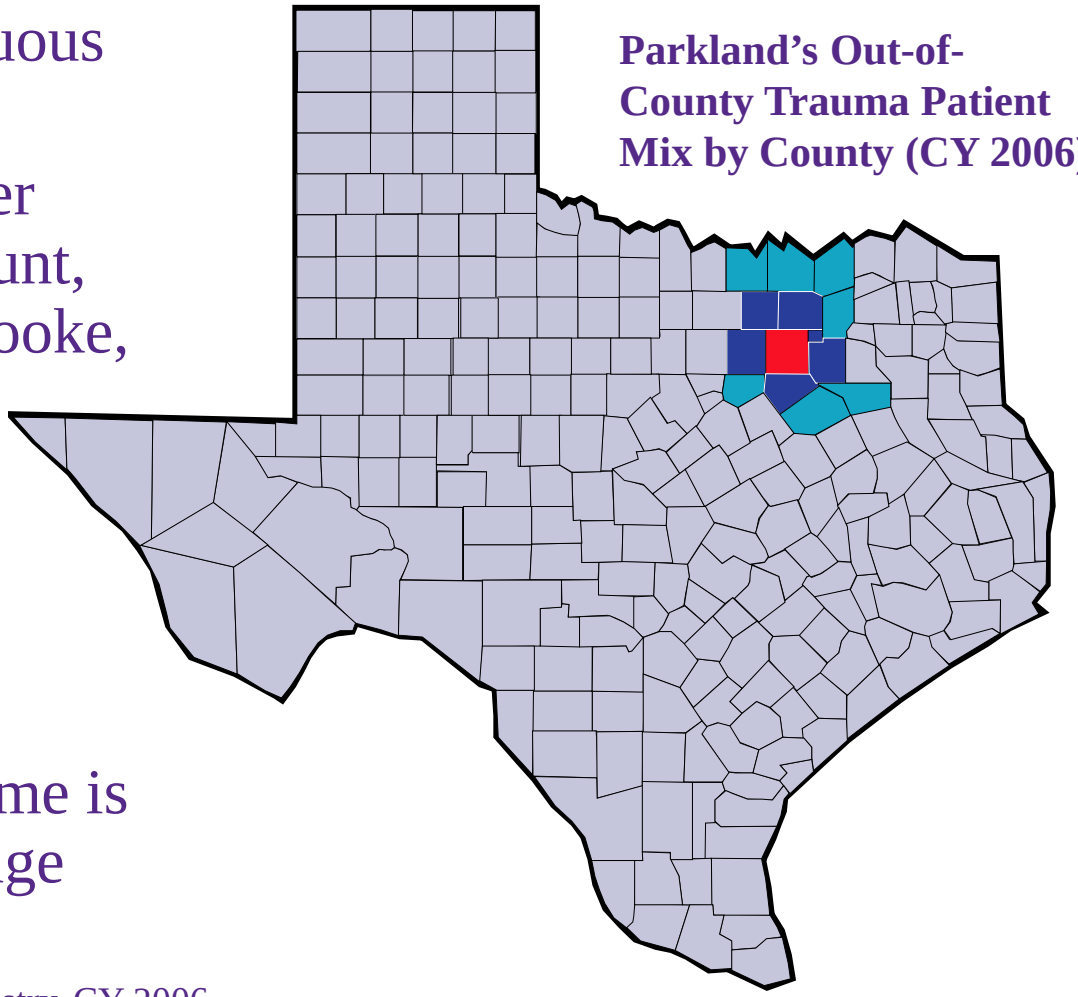
Parkland As Innovator

- **1984**: Parkland opened the Epilepsy Treatment Center as one of a handful of places in the U.S. to do depth electrode studies.
- **1984**: The North Texas Poison Center begins a 24-hour hotline staffed by registered nurse specialists.
- **1986**: Parkland is the **first** hospital in North Texas to establish an Arrhythmia Management Center for heart Patients.
- **1988**: Parkland instituted a Trauma Department to coordinate trauma care from the accident scene through rehabilitation
- **1988**: Parkland began the Community Oriented Primary Care program, with the **first** of a network of neighborhood clinics begin acquired in East Dallas.

- **1994**: Parkland celebrates its Trauma Care and its new Injury Prevention Center.
- **1999**: Parkland Violence Intervention and Prevention Center was established with a $1 million grant from The Harold Stemmons Family Foundation.
  - **1999**: Parkland's HMO, Parkland Community Health Plan, was named the most successful program of Texas hospital plans. PCHP Offered Parkland HEALTHfirst for Medicaid patients and Parkland HEALTH plus for medically indigent Dallas County residents who were not eligible for the Medicaid Managed Care program.

As Level I Regional Trauma Center, Parkland is De Facto a Regional Hospital Funded by a Local Tax Base

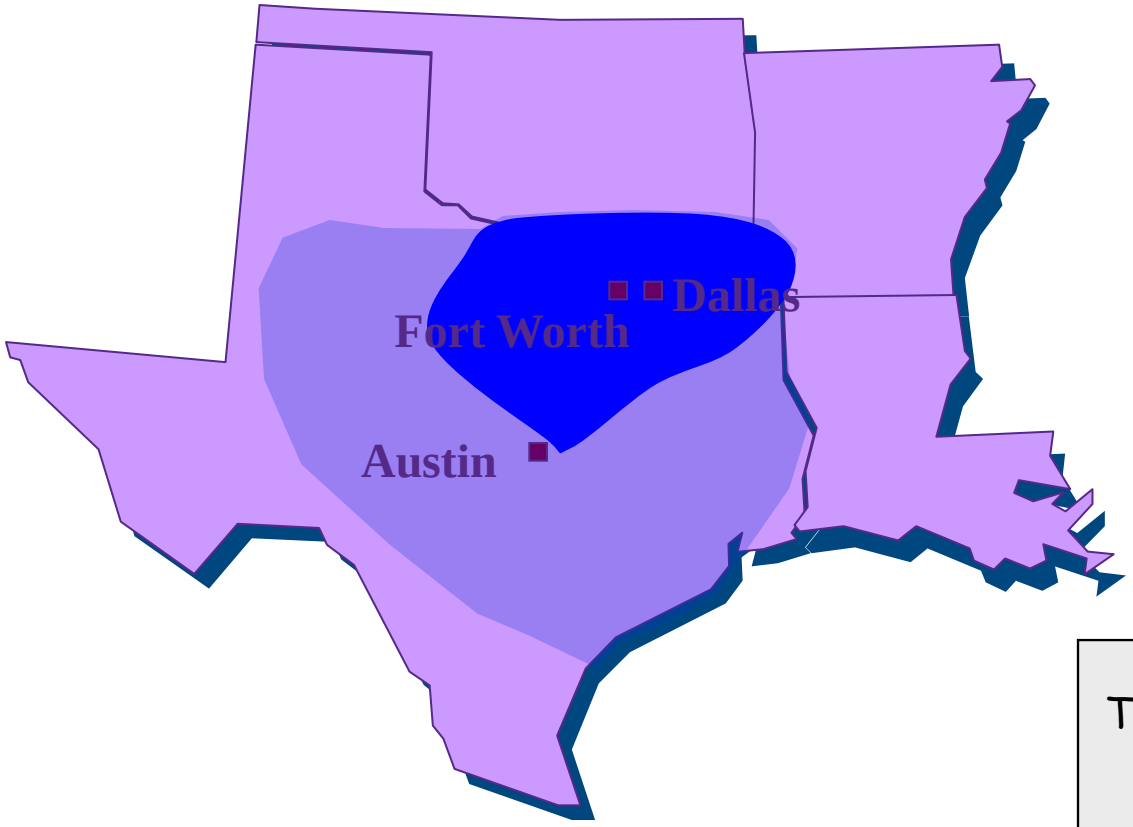
- 60% come from contiguous counties
- 14% come from next tier contiguous counties (Hunt, Henderson, Navarro, Cooke, Fannin, Grayson,
- 25% come from Texas counties, out of state or outside the US
- 1% are unidentified
- Parkland's trauma volume is twice the national average



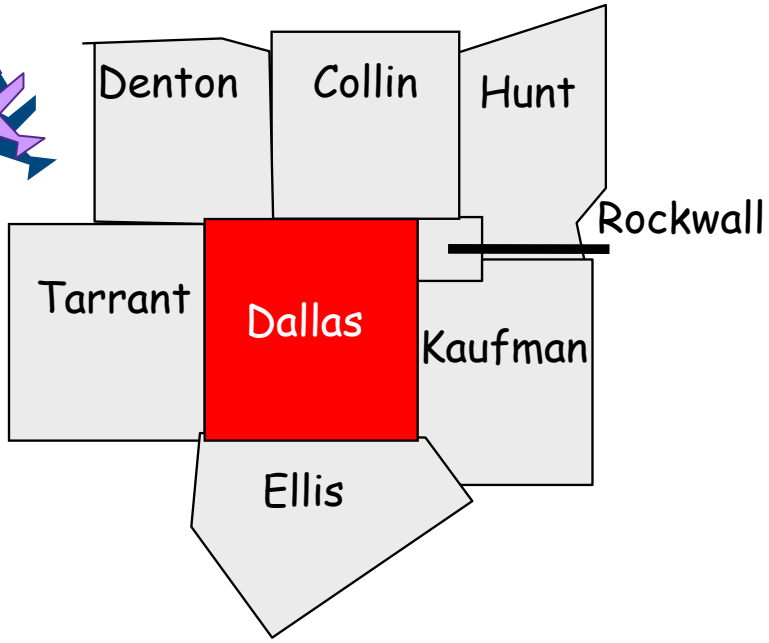
Parkland's Out-of-County Trauma Patient Mix by County (CY 2006)

Source: Parkland data & PHHS Trauma Registry, CY 2006
Source: National Trauma Data Bank, Report 2007 National Average is a 5 year average 2002-2006.

Parkland's Burn Center Serves a Large Area.



- 54.2% come from contiguous counties
- 45.8% come from other Texas counties, out of state or outside the US



Traditional Service Area

Expanded area as a result of Closure of Shriners' in Galveston

Community Medicine

Community Medicine Division

- 522 Employees
- Continuity Clinic for UTSW Pediatric Residency Program
- Patient Demographics for COPC:
  - 54.0% Hispanic, 29.2% African American, 11.7% Caucasian, 3.7% Asian, 1.4% Other

A day in the life of COPC …

- Nearly 37,500 people will be seen at COPC each month
- Over 10,000 babies born at Parkland will be seen at a COPC for newborn care
- Top diagnoses at COPC for the population are Diabetes, Hypertension, and Health Maintenance Exams.

Source: TII data for race/ethnicity FY 2011. Annual Report data FY11 for "a day in the life" (data does not include Women's Health or Family Medicine

Parkland

Community Health Centers

- Community Oriented Primary Care (COPC) – 10 health centers, 1 Employee Physician Office, and 1 Geriatric Center
- Women's Health Centers – 11 Sites 9 of which are co-located in COPC Health Centers
- Family Medicine Clinic
- Youth & Family Centers (Y&F) – 11 school based clinics
  - Wilmer opening in May 2012
- Homeless Outreach Medical Services (HOMES)
  - 4 medical vans
  - 1 dental van
  - Bridge Homeless Clinic
  - 28 Shelters
- Senior Outreach Program
- Refugee Outreach
- Correctional Health Services
  - 5 adult jails
  - 4 juvenile centers

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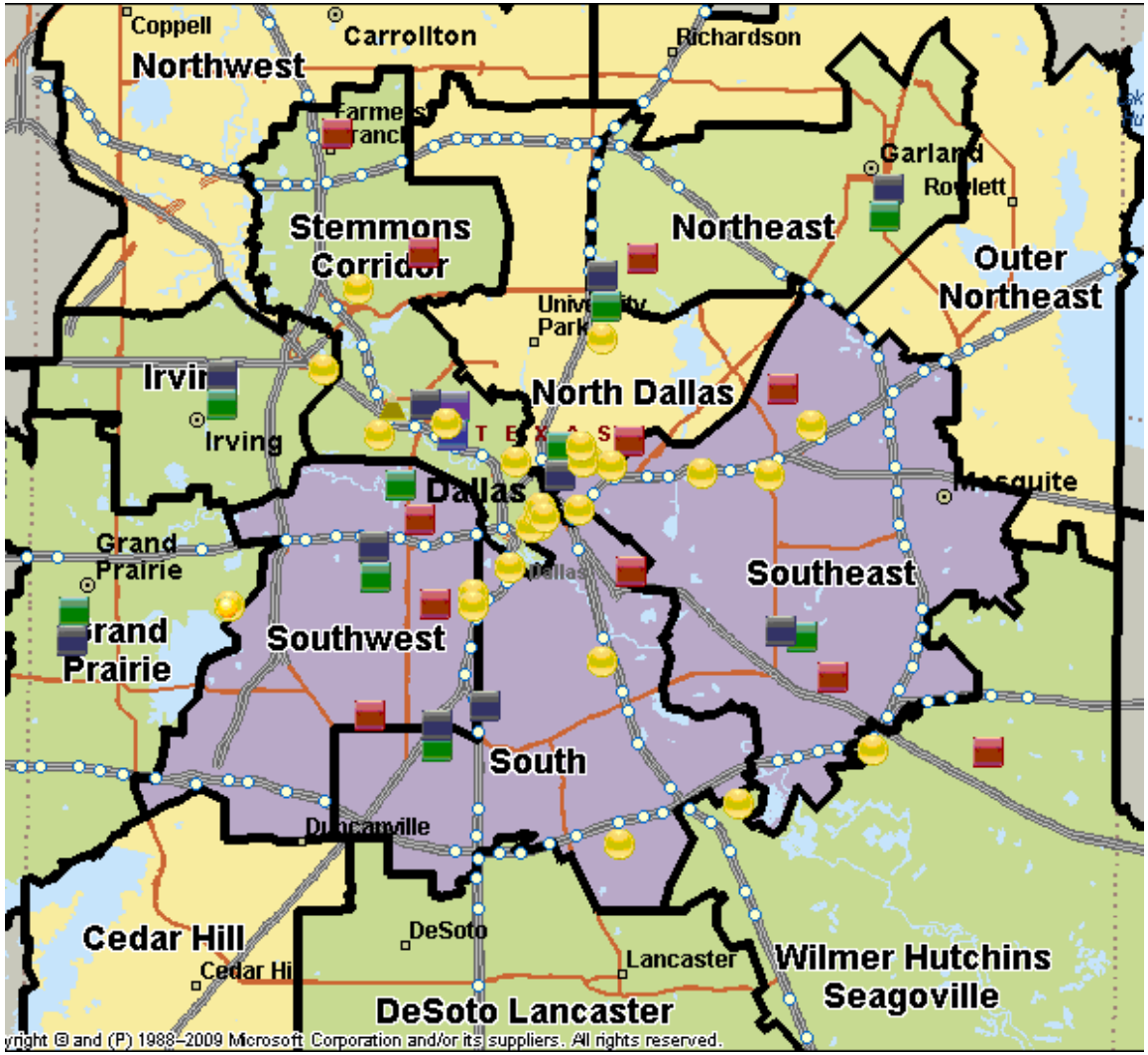
Community Delivery Sites

11 COPC Health Centers Recognized by National Committee for Quality Assurance (NCQA) as Medical Home Level 3



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= Youth & Family Centers ★

- Kiosco
- Lincoln/EBJ
- North Oak Cliff
- Redbird
- Seagoville
- Spruce
- Vivian Field
- West Dallas
- Amelia Flores
- Woodrow Wilson
- Fair Oaks

= HOMES Locations

= Employee Physician Offices (EPO)

= Family Medicine Clinics

= Geriatric Clinic

= COPC Health Centers

- Southeast Dallas
- deHaro-Saldivar
- Garland
- East Dallas
- Pediatric Primary Care Center
- Oak West
- Bluitt-Flowers
- Irving
- Vickery
- Grand Prairie

= Women's Health Centers

- Southeast Dallas
- deHaro-Saldivar
- Garland
- East Dallas
- Lakewest
- Oak West
- Maple
- Irving
- Vickery
- Grand Prairie

★ In partnership with Dallas Independent School District and MetroCare (MHMR)

Parkland

Servant Leadership in the Community

- Patient Advisory Boards, satisfaction surveys keep us in touch with patient needs.
- COPC health centers go beyond primary care:
  - Behavioral health, dental, pharmacies, optometry
  - Strong connections with social service agencies, including ISDs, WIC, Dallas Housing Authority
- Homeless Outreach Medical Services
- Jail Health in the Dallas County Jail system
- Collaborative partner with non-profit agencies, healthcare providers, churches

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Community Involvement

Using COPC Concepts, Parkland Developed Specialty Centers that Work Across Sectors

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Injury Prevention Center of Greater Dallas:

1994 Joint venture among Parkland, 4 local hospitals and foundations, to work to prevent injuries through community collaboration, education, and evaluation (i.e. car seats, seatbelts, bicycle safety, smoke detectors, fall prevention, etc.)

2011 Helped Dallas achieve the International Distinguished Safe Community Award presented by the World Health Organization

Violence Intervention & Prevention (VIP) Center:

1998 Harold C. Simmons Foundation gift established VIP Center, believed to be the first of its kind in the U.S. VIP Center provides support and education about family violence prevention and treatment

2001 Angel of Freedom award by Human Rights Initiative of North Texas for its work in helping people seeking political asylum

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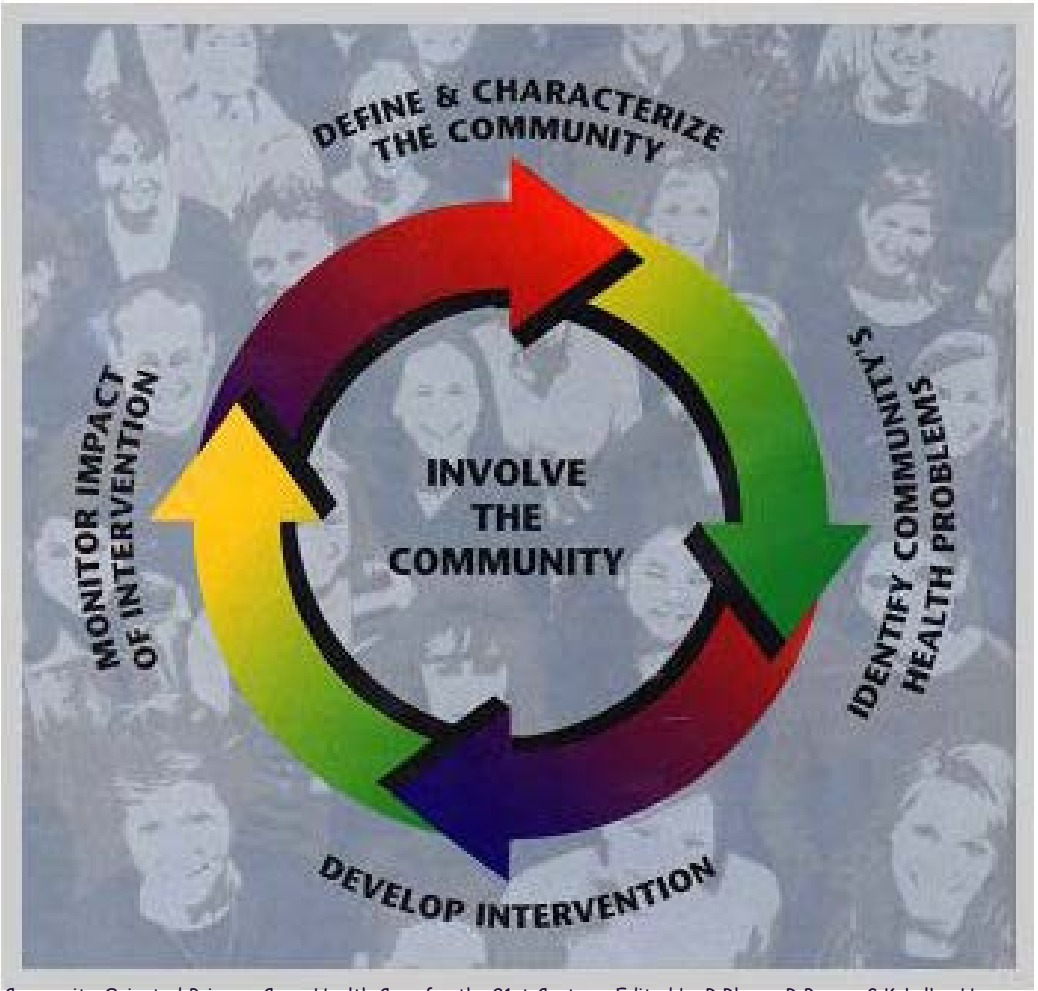
COPC Conceptual Model

"A process by which a defined population's health problems are systematically identified and addressed, combining the principles of primary care, epidemiology, and public health with the community as a partner at every step."

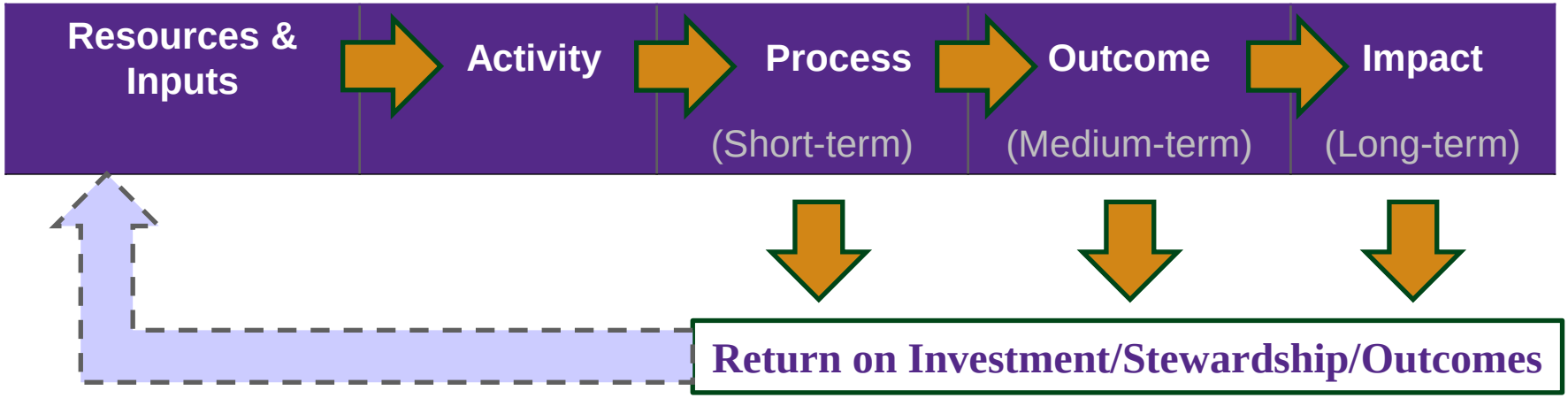


Community-Oriented Primary Care: Health Care for the 21st Century Edited by R Rhyne, R Bogue, G Kukulka, H Fulmer

COPC Provides Substantial Benefits to the Community

- Providing primary care in a lower cost decentralized system
- Increasing patient personal productivity by improving access to early intervention
- Offers opportunity for more appropriate healthcare-seeking behavior by patients (pursuing health maintenance and early intervention rather than delaying care to a point of needing tertiary or quaternary care).

Short and Long Term Feed Back Loops (Logic Model)



Process indicators:
Productivity, Access, Wait times, Satisfaction, Billing, Collections

Outcome indicators:
Improved community health, Improved overall quality of life

Source: Parkland Health & Hospital System in conjunction with the Centers for Disease Control and Prevention

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NCQA Physician Practice Connections®—Patient-Centered Medical Home (PPC-PCMH)

- Recognizes practices that meet the criteria described by the endorsed principles of the Patient-Centered Medical Home
  - Whole Person Focused
  - Coordinated, integrated, comprehensive care
  - Personal clinician, team-based care
- Provides a robust framework for primary care practice development
- Recognition may qualify practices for special reimbursement fees beyond the traditional fee for service
- Defines a practice as a physician or physicians practicing together at a single geographic location
- 4,302 physician practices in the U.S. recognized as 7/10/12.

Source: NCQA

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COPC /PPC-PCMH Relationship

Medical Home Standards

Patient Tracking & Registry
Performance Reporting & Improvement
Care Management
Patient Self Management Support
Access & Communication
E-Prescribing
Advanced Electronic Communication
Referral Tracking
Test Tracking

COPC Scope of Services

Health Maintenance
Quality of Life Advocacy
Illness Intervention
Community Collaboration
Chronic Disease Management

Source: NCQA, "Standards and Guidelines for Physician Practice Connections-Patient-Centered Medical Home," available at: http://www.ncqa.org/tabid/631/Default.aspx, accessed on Aug. 28, 2009; Innovations Center interviews and analysis

Dallas County Jails – Turning a Pigs Ear into a Silk Purse

- 7th largest jail in the United States
- 2nd largest mental health facility in Texas
- 100,000 booked-in per year (275/day)
- Average Daily Census of 7,000
- Average Daily Mental Health Census of 1,336
- Average length of stay 25 days
- 26% female, 74% male

Parkland

A Public Health Concern

- Some people may not care about what happens to the health of prisoners, but the public health ramifications of not providing adequate healthcare to such a large concentrated population would be catastrophic…..
- What would happen to the 1,600 jailers that they come into contact with every day? And their Families? Their children and the children they go to school with? The people they see at church or at the store?

Parkland does: TB Surveillance, STD Surveillance, MRSA management, Chronic Disease Management and connecting those released to a medical home

Servant Leadership & Jail Health

- Providing appropriate health services to local inmates is one of the most complex and difficult challenges in the medical profession

- Inmates are not always the most cooperative. They suffer from high rates of substance abuse and mental illness. They frequently have multiple health problems and are often in the County's care for a relatively short period of time.

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Population Medicine & Health Outcomes

Creating a Commons through Collaborative Dialogue and Partnerships

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Prevention is better than cure.

Desiderius Erasmus
1466-1536

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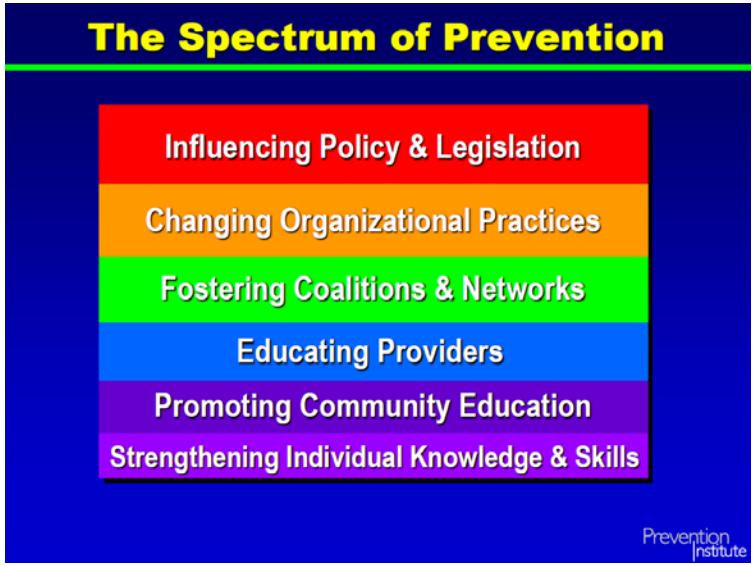
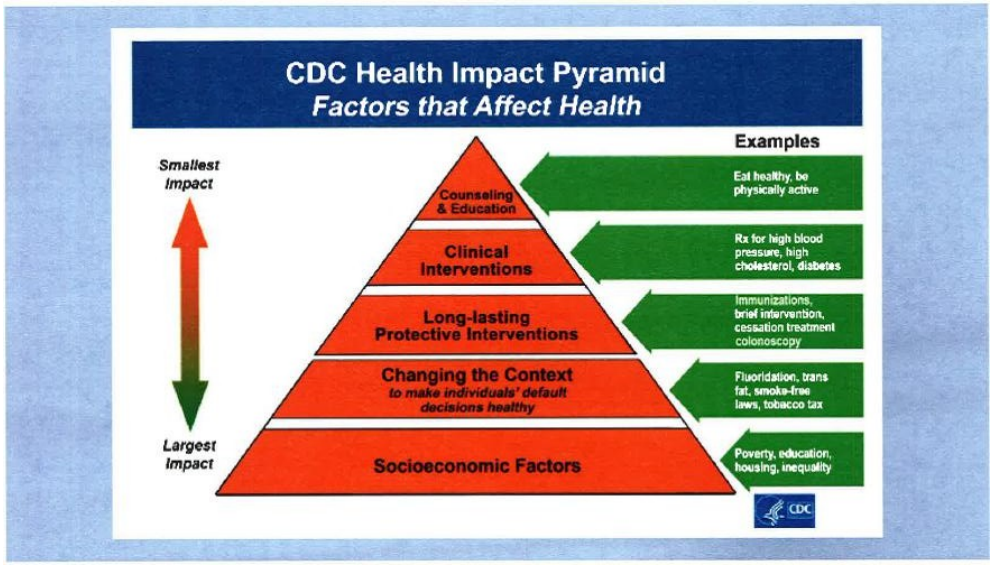
The Spectrum of Prevention



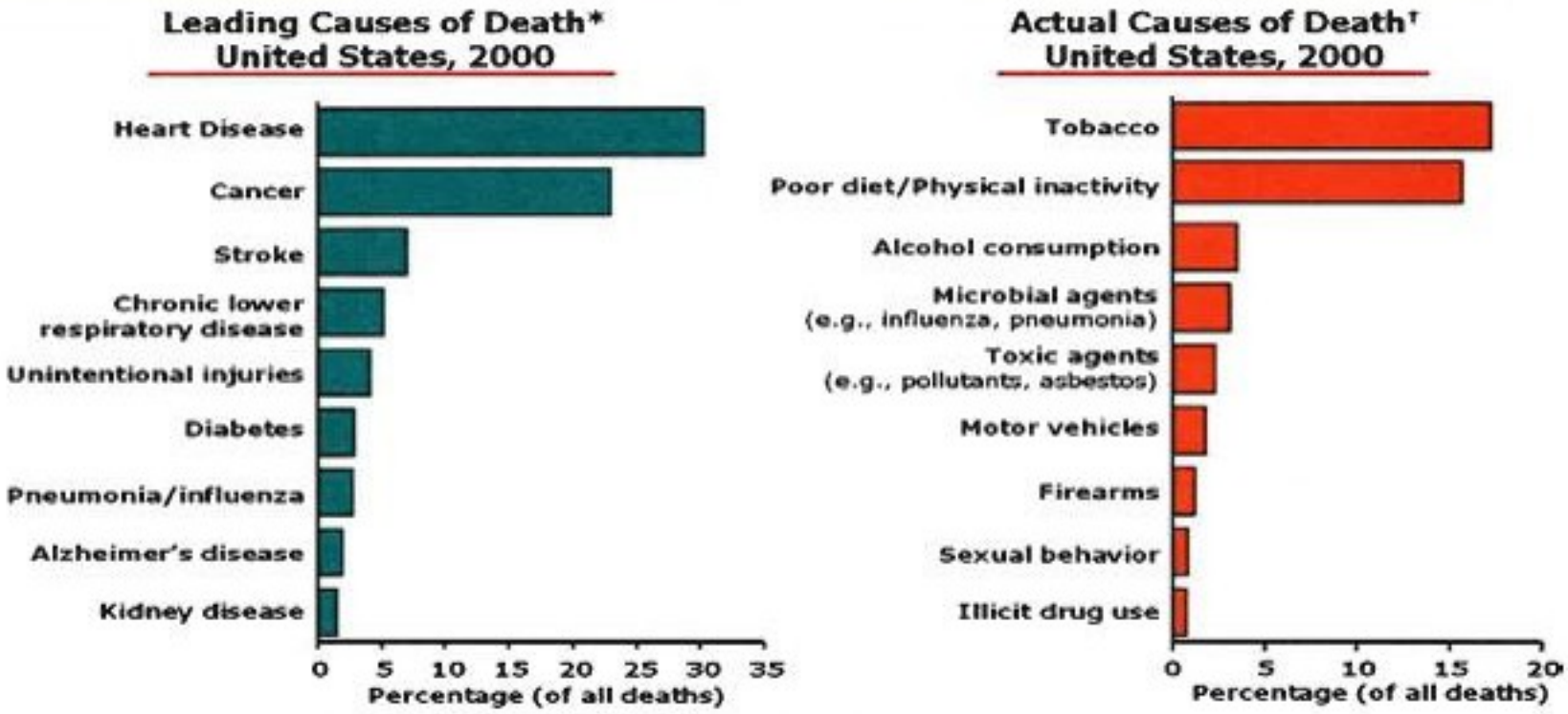


"It is unreasonable to expect that people will change their behavior *easily* when so many forces in the social, cultural, and physical environment conspire against such change."

Institute of Medicine

Parkland

Clinical Prevention and Public Health: Actual Causes of Death



* Miniño AM, Arias E, Kochanek KD, Murphy SL, Smith BL. Deaths: final data for 2000. National Vital Statistics Reports 2002; 50(15):1-120.
† Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA. 2004;291(10):1238-1246.

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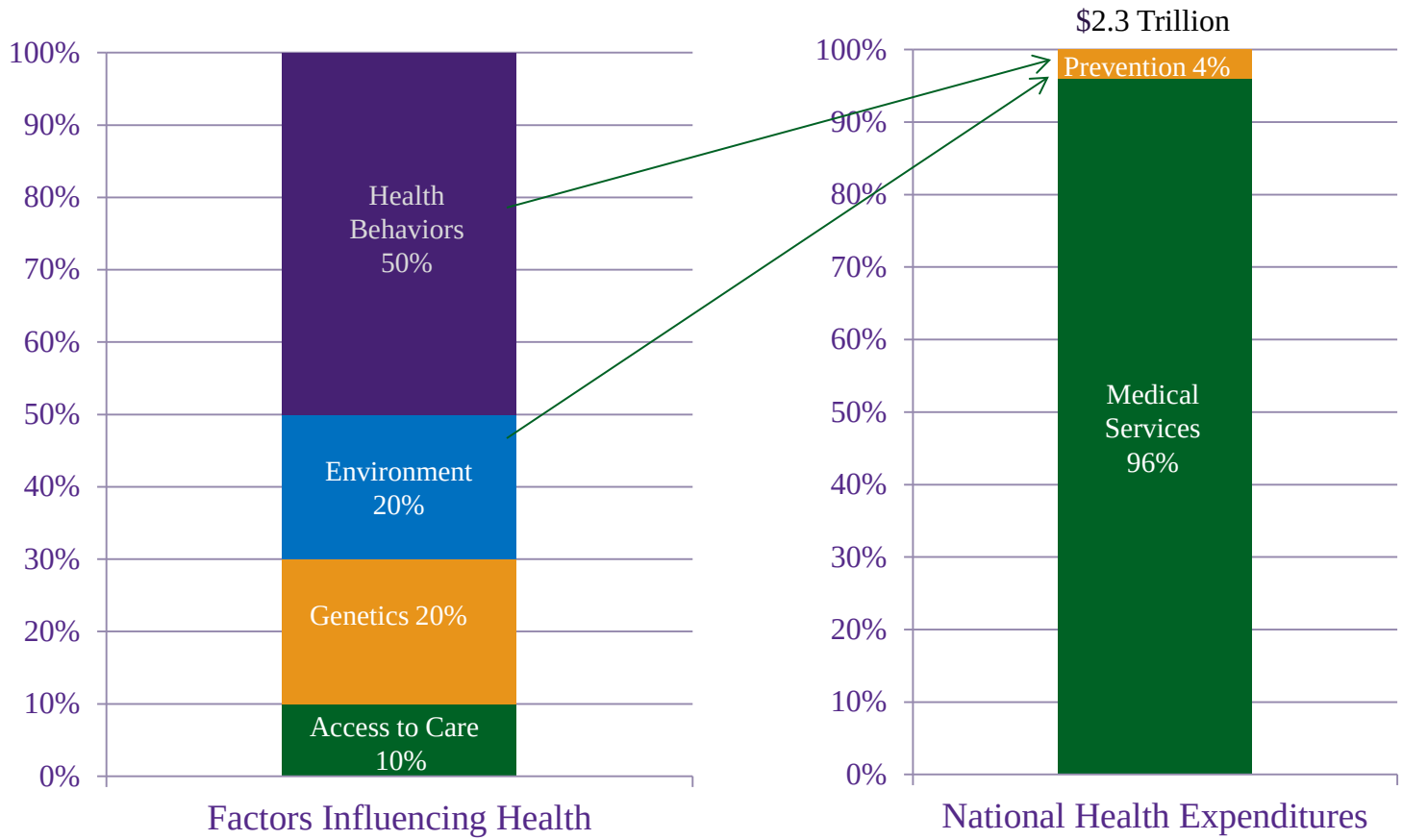
Discrepancy Between Health Determinants & Spending

Health care can moderate the effects of these factors, but its contribution to prevention of premature death is much smaller – only about 10%



Lambrew JM. A Wellness Trust to Prioritize Disease Prevention. The Hamilton Project, Brookings Institution. 2007. discussion paper 2007-04: 1-36. University of California at San Francisco, Institute of the Future, 2000

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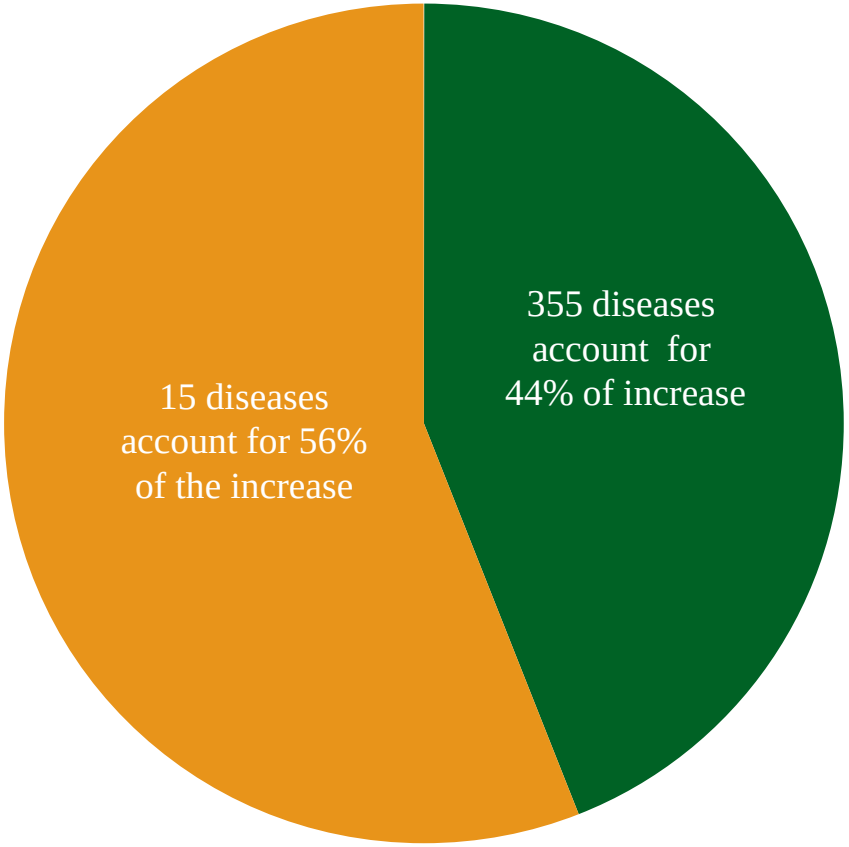
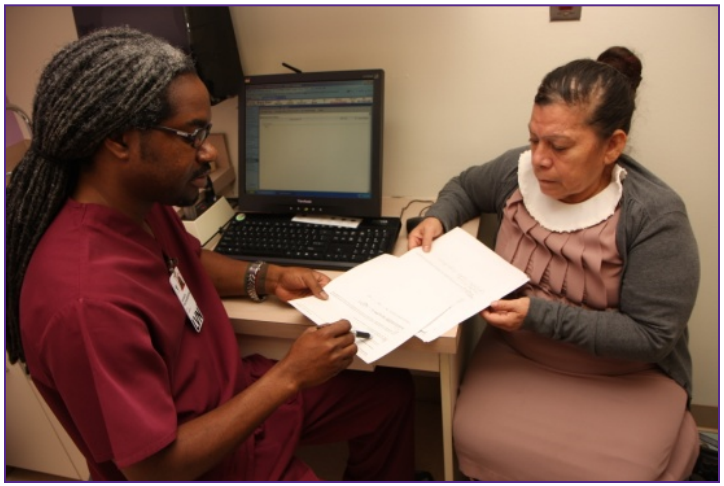
Cost Savings from Prevention

Percentage of health care cost increase attributed of specific disease, 1987 – 2000



Diseases that Account for Majority of Cost Increase

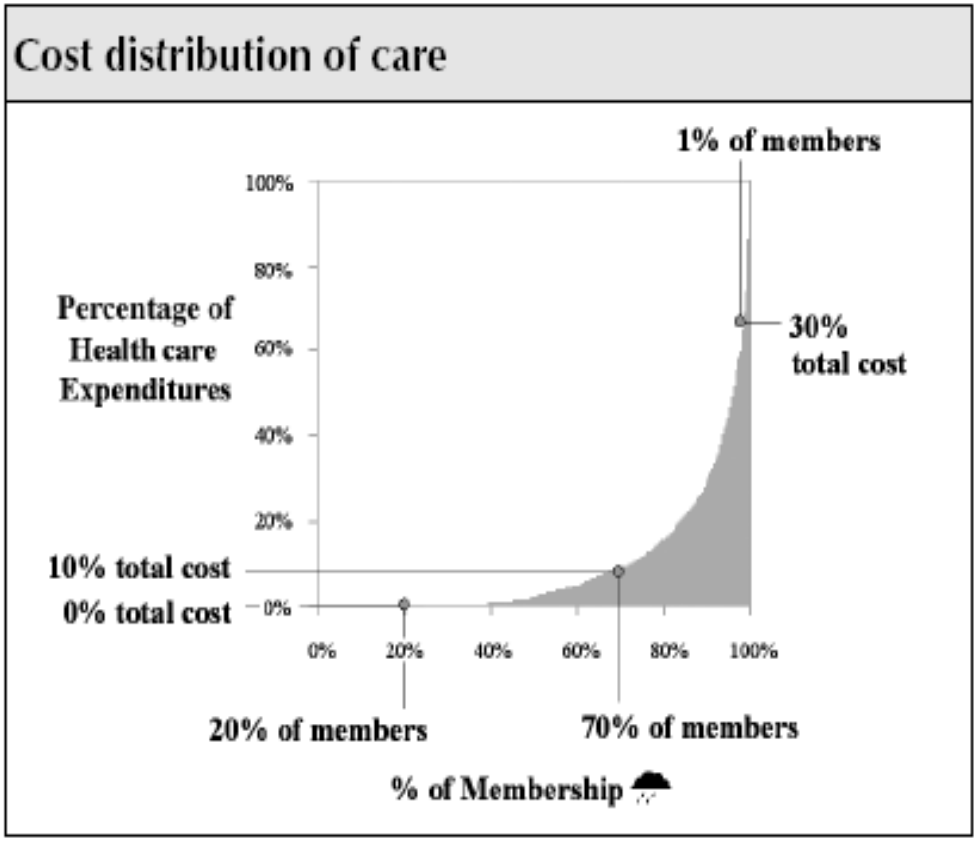
- Ischemic heart
- Motor vehicle accidents
- Acute respiratory infection
- Peripheral vascular disorders
- Cerebrovascular Disease
- Cardiac dysrhythmias
- Congestive Heart Failure
- Respiratory Malignancies
- Hypertension
- Diabetes
- Arthropathies
- COPD
- Asthma
- Mood disorders
- Back problems



Thorpe KE, Florence CS, Joski P. Which Medical Conditions Account for the Rise in Health Care Spending? Health Affairs, 2004.

Most of Cost Can Be Attributed to a Small Number of Patients

- Pareto's Distribution suggests that 20% of patients will consume 80% of care resources
- Data from a 2001 study cited by Kaiser Permanente suggests that estimate is close



Typical pattern of health care expenditures among a health plan's membership

Adapted and reproduced by permission of the publisher and author from: Halvorson GC, Isham GJ. Epidemic of care: a call for safer, better, and more accountable health care. San Francisco (CA): Jossey-Bass; 2003.[1p41] *(This figure was based on data obtained from the Milliman 2001 Health Cost Guidelines-Claims Liability Distributions.)*

Kaiser Permanente Journal. 2005 http://xnet.kp.org/permanentejournal/spring05/highrisk.pdf

Results – Parkland Provides Excellent Care

Research shows that Parkland's outcomes are better than other hospitals when it comes to providing care to different populations.

Decreased Preterm Births in an Inner-City Public Hospital

Kenneth J. Leveno, MD, Donald D. McIntire, PhD, Steven L. Bloom, MD, Miriam R. Sibley, RN, and Ron J. Anderson, MD

OBJECTIVE: To examine preterm births among African-American and Hispanic women delivered at an inner-city public hospital in the context of contemporaneously increasing rates in the United States.

METHODS: The rates of preterm birth, defined as birth before 37 weeks of gestation, for singleton neonates with birth weights of 500 g or higher delivered to women who had prenatal care at Parkland Hospital between 1988 and 2006 were compared with similar births in the United States from 1995 to 2002. Preterm birth rates also were compared for white, African-American, and Hispanic women as were disparity in these rates using white women as the referent.

RESULTS: The Parkland Memorial Hospital cohort included 260,197 women, of whom 70% were Hispanic, 20% African-American, and 8% white. The U.S. cohort

births was the result of a public health care program specifically targeting minority pregnant women.

(Obstet Gynecol 2009;113:1–1)

LEVEL OF EVIDENCE: III

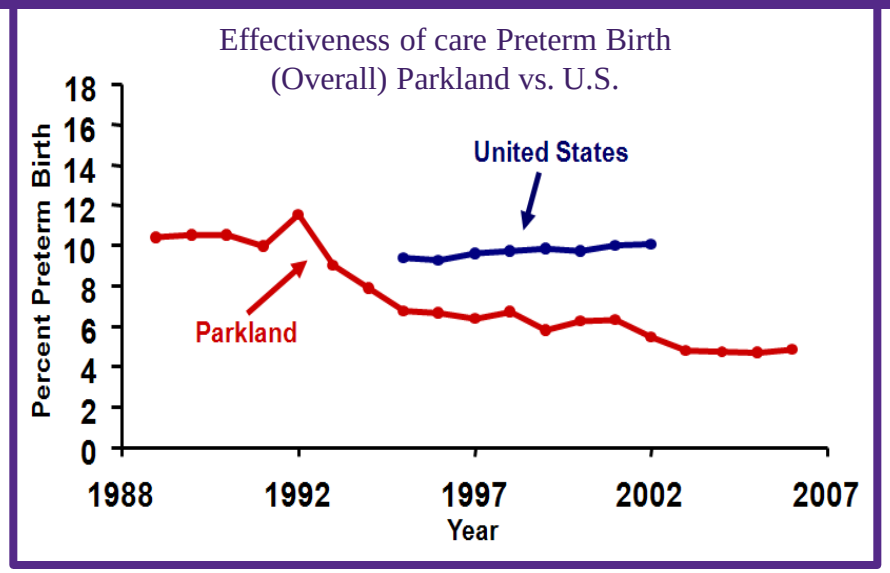
In 2000, the U.S. Department of Health and Human Services, in its publication Healthy People 2010, reaffirmed its goal to improve the health of mothers and infants.[1] Since such goals first were promulgated in 1990, preterm birth continues to be a major source of perinatal morbidity and mortality as well as having an important economic effect. In its recent report, the Institute of Medicine[2] states that the incidence of preterm birth actually has increased during the past two decades. Specifically, preterm birth–defined as

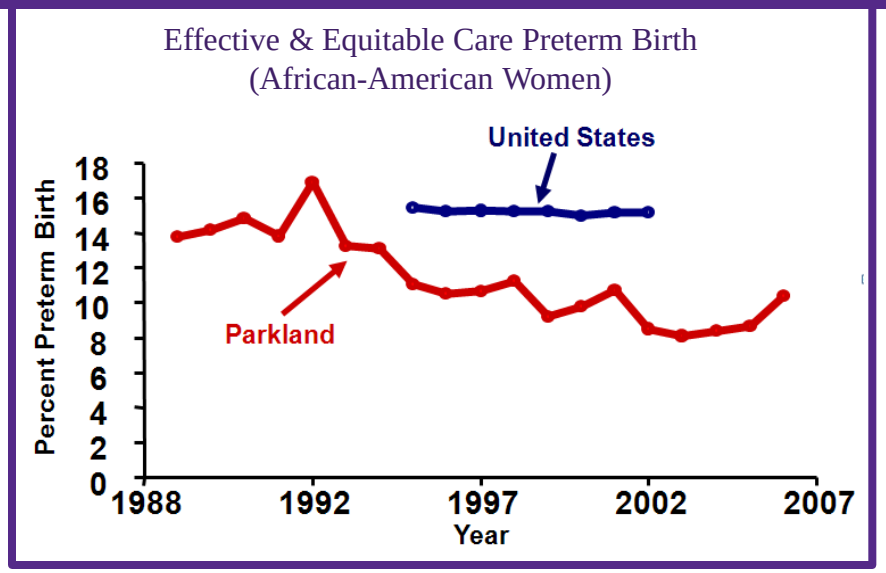
- "Preterm birth significantly decreased in minority women delivered at an inner-city public hospital. We hypothesize that the reduction in preterm births was the result of a public health care program specifically targeting minority pregnant women."

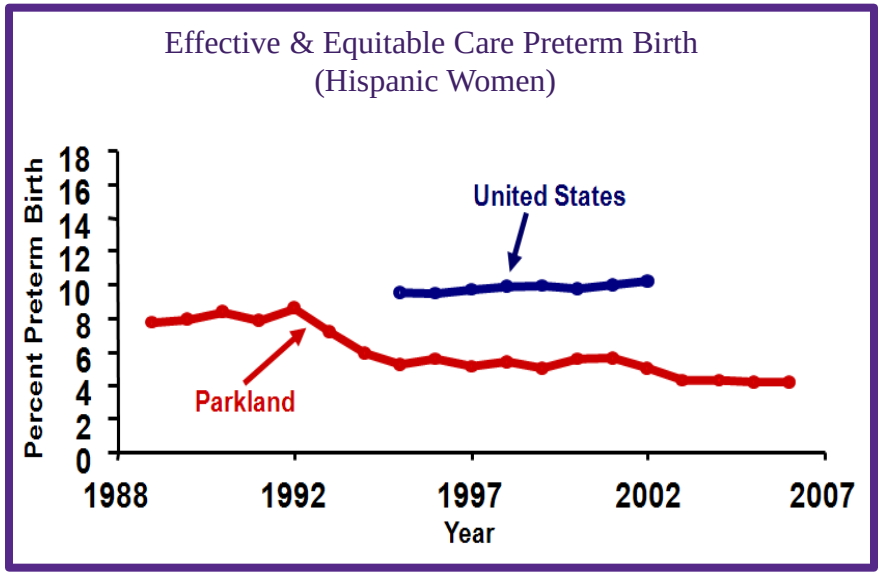
(Obstet Gynecol 2009;113:1-1)

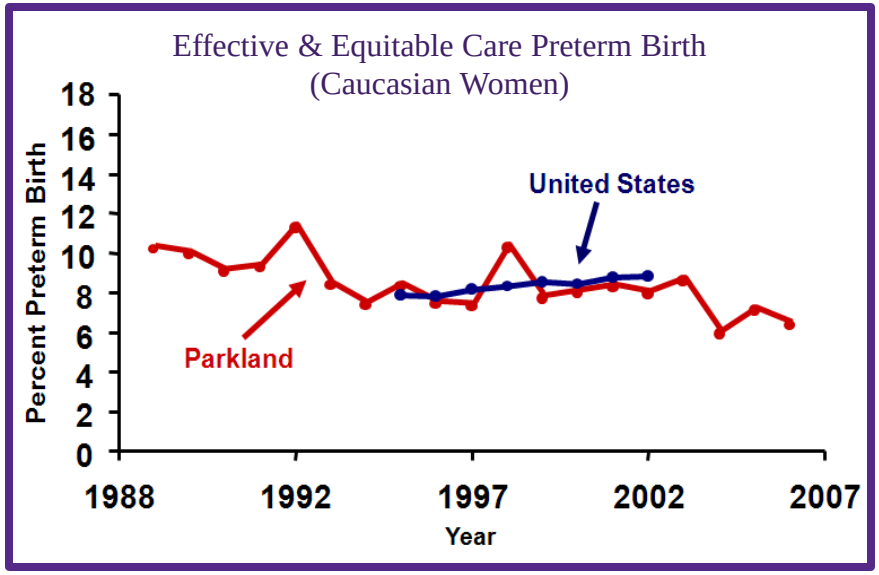
Parkland

Results – Better Outcomes for All Women



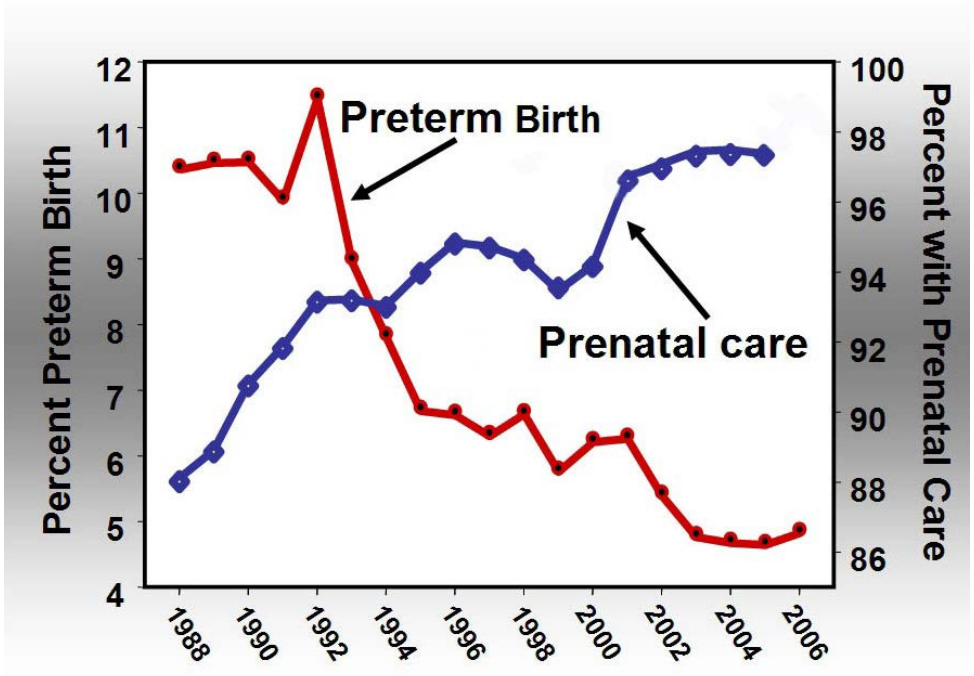






Parkland

Effectiveness of Care at Parkland



Parkland Birth Outcomes (per 1,000 live births)	No Prenatal Care	Prenatal Care	P-value
Stillbirth	13.0	5.6	<.0001
Neonatal death	11.4	3.7	<.0001
Neonatal Intracranial Bleed	14.6	5.2	<.0001
Admission to NICU	62.7	25.9	<.0001

Parkland

Statistics = Human Tragedies!

Quality Initiatives of Parkland's Clinical Innovations Center

Disability and severity of illness drive change not medicine

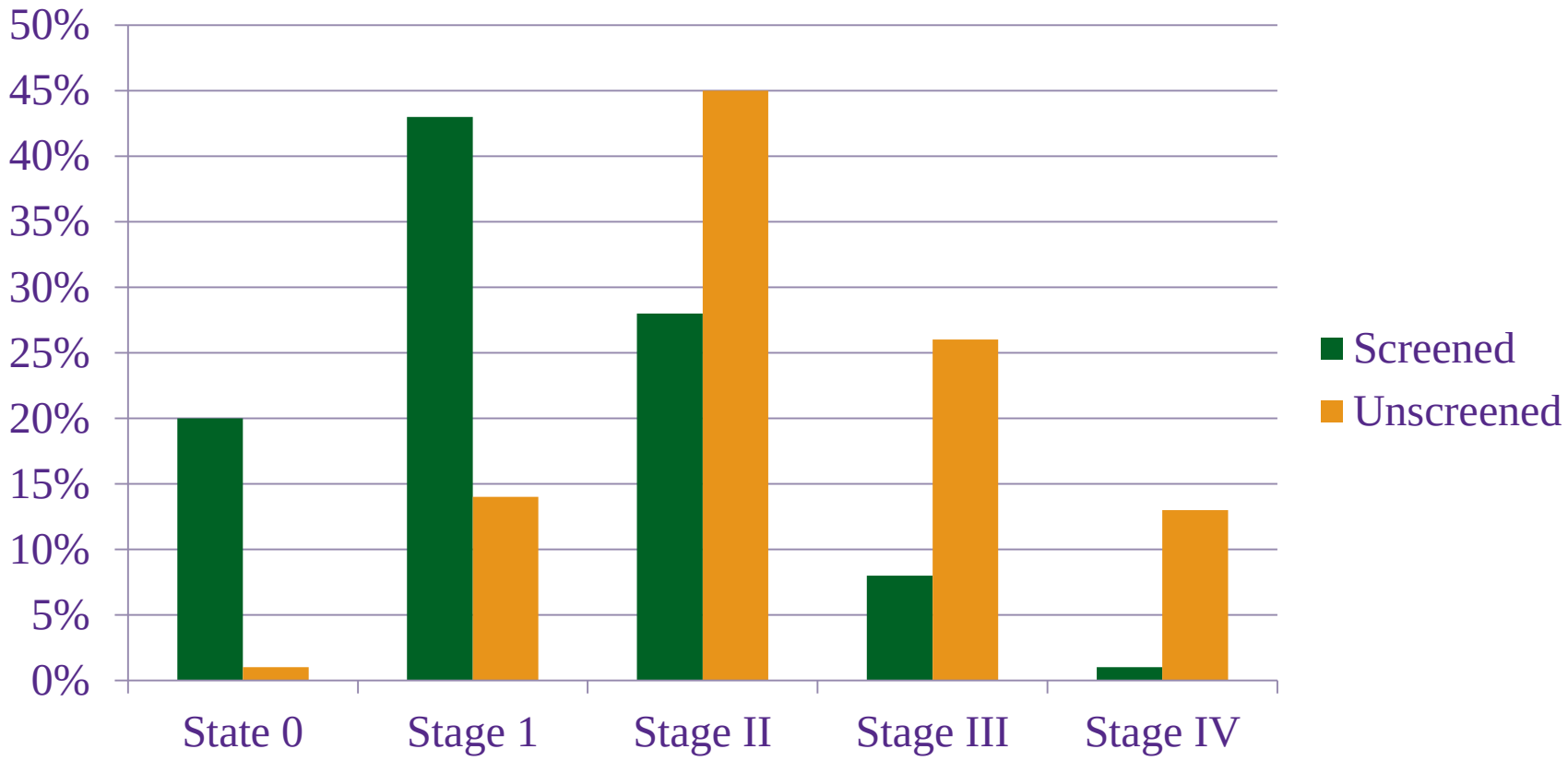
Predictive Algorithm:

- Algorithm to predict CHF 30-day readmission using clinical variables and non-clinical socio-demographic risk factors
- Uses real time, present on admission data
- Socio-demographic factors were better predictors of CHF re-admissions than commonly used clinical measures
- Identified high-risk patients from this algorithm were triaged to special hospital services, intensive case management, and home visits
- Resulted in a 26% risk adjusted reduction in re-admission to any DFW hospital for patients originally admitted to Parkland and a 40% risk adjusted reduction for Medicare patients.

Amarasingham R., Moore B.J., Tabak Y.P., Drazner M.H., Clark C.A., Zhang S., Reed W.G., Swanson T.S., Ma Y., Halm E.A.: "An Automated Model to Identify Heart Failure Patients at Risk for Readmission or Death Using Electronic Medical Record Data." *Medical* Care 2010; 48(11):981-8.

Parkland

Screened and unscreened breast cancer cases, Parkland Hospital, 1992



Source: Adapted from : A. Marilyn Leitch, MD, and Ronald F. Garvey, MD, MBA. Breast Cancer in a County Hospital Population: *Impact of Breast Screening Stage of Presentation*. The Annals of Surgical Oncology , Vol. 1, No. 6, 1994, pp: 516-520.

Special Article

DEATHS AND INJURIES FROM HOUSE FIRES

GREGORY R. ISTRE, M.D., MARY A. MCCOY, B.S., LINDA OSBORN, JEFFREY J. BARNARD, M.D., AND ALLEN BOLTON, M.P.H.

ABSTRACT

Background We sought to define the factors associated with house fires and related injuries by analyzing the data from population-based surveillance.

Methods For 1991 through 1997, we linked the following data for Dallas: records from the fire department of all house fires (excluding fires in apartments and mobile homes), records of patients transported by ambulance, hospital admissions, and reports from the medical examiner of fatal injuries.

Results There were 223 injuries (91 fatal and 132 nonfatal) from 7190 house fires, for a rate of 5.2 injured persons per 100,000 population per year. Rates of injury related to house fires were highest among blacks (relative risk, 2.8; 95 percent confidence interval, 2.1 to 3.6) and in people 65 years of age or older (relative risk, 2.6; 95 percent confidence interval, 1.9 to 3.5). Census tracts with low median incomes had the highest rates of injury related to house fires (relative risk as compared with census tracts with high median incomes, 8.1; 95 percent confidence interval, 2.5 to 32.0). The rate of injuries was higher for fires that began in bedrooms or living areas (relative risk, 3.7); that were started by heating equipment, smoking, or children playing with fire (relative risk, 2.6); or that occurred in houses built before 1980 (relative risk, 6.6). Injuries occurred more often in houses without functioning smoke detectors (relative risk, 1.5; 95 percent confidence interval, 1.0 to 2.4). The prevalence of functioning smoke detectors was lowest in houses in the census tracts with the lowest median incomes (P<0.001).

Conclusions Rates of injuries related to house fires are highest in elderly, minority, and low-income populations and in houses without functioning smoke detectors. Efforts to prevent injuries and deaths from house fires should target these populations. (N Engl J Med 2001;344:1911-6.)

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HOUSE fires remain an important cause of death and injury, accounting for more than 3000 deaths and 17,000 injuries each year in the United States.[1] Interventions such as programs for the distribution of smoke detectors to prevent injuries related to house fires are most efficient when directed to the groups at highest risk.[2,3] In public health, obtaining accurate data to identify high-risk groups requires surveillance,[4,5] which is as important for the prevention of injuries as it is for the prevention of infectious diseases.[6]

Surveillance for injuries related to house fires was accomplished in some locations by making burn injury a reportable condition.[3] However, in Dallas we had neither the statutory authority conduct surveillance for injurie stead, we attempted to use exist institutions and to link individu detailed picture of injuries and d fires in our community. The C Prevention and Control of the has encouraged the use of data li of injuries.[6] Data linkage has b to study motor vehicle–related knowledge a linked data set has n itor house-fire–related injuries.

METHOD

Sources of Data

Relevant data sets had been collected b and contained various types of informa injuries and deaths related to house fire available for the years 1991 to 1997: re medical services for all patients transport hospital admissions at Parkland Health only hospital with a burn unit in Dallas; the office of the medical examiner; and n Department of all house fires in Dallas. Fire Department contained details abou cluding information about the source a age and type of the residential structure, ing or nonworking smoke detector. Th tector was determined by fire-inspection interviews and inspection of the home af contained information about injured per injuries.

Definitions and Linkage of Data

An injured person was defined as any ed by emergency medical services or ad and Hospital System for a burn or smo been identified by the medical examine related injuries; in addition, the injury by a fire in a residential structure. Injuries or smoke (e.g., falls or lacerations) were related.

We defined a house fire as one report partment in an inhabited, nonmobile res

From the Injury Prevention Center of Gre A.B.); PID Associates (G.R.I.); the Dallas Fir Office of the Chief Medical Examiner of Dalla las; and the Comprehensive Cancer Center, Un ham, Birmingham (A.B.). Address reprint req Prevention Center of Greater Dallas, P.O. Bo

Reprinted from THE NEW ENGLAND JOURNAL OF MEDICINE (ISSN 0028–4793) Vol. 344:1911-1916 (June 21, 2001).
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Taylor & Francis

The "Unintended Pedestrian" on Expressways

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Objective. *To explore the epidemiology of pedestrian deaths in Dallas County, Texas, and to compare* *with pedestrian deaths on expressways versus those that occurred on other roadways.*

Methods. *We studied all pedestrian deaths among persons 15 years of age or older in Dallas County, to 2004 by linking data from Medical Examiner's office, the Fatality Analysis Reporting System, and hos Univariate and multivariate analysis compared various factors associated with death on an expressway.*

Results. *Among 437 pedestrian deaths who were 15 years of age or older, 197 (45%) occurred on proportion that occurred on expressways was highest among 15- to 29-year-olds (65%) and was lower w group ($p < 0.01$, chi square for trend). At least 56% of these expressway-related pedestrian deaths were k "unintended pedestrians," who had exited a vehicle after being on the roadway, compared with 11% of on surface streets (OR 4.6, 95% CI, 2.7–8.1), and this was also highest among younger age groups. Ped an expressway, compared with deaths on surface streets, remained strongly associated with having bee pedestrian" (OR 6.2, 95% CI, 3.1–14.0), after controlling for several other variables, including age, sex, crash, and alcohol involvement.*

Conclusions. *Expressways are the predominant site of fatal pedestrian crashes among young adults i Since many of these deaths were "unintended pedestrians," procedures for management of occupants of on expressways could have a large impact on pedestrian deaths in young adults.*

Keywords Injury; Pedestrian; Unintended; Expressway; Freeway; Trauma; Epidemiology; Prevention

Pedestrian injuries resulted in more than 4800 traffic deaths in the United States in 2005 with a rate of 1.7 deaths per 100,000 population, accounting for about 12% of all traffic-related deaths (Department of Transportation [DOT], National Highway Transportation Safety Administration [NHTSA], 2006). This was the highest level of pedestrian deaths since 2001 (DOT, NHTSA, 2006). More than two thirds of pedestrian deaths occurred on urban roadways, and in many cities, pedestrians account for >20% of traffic-related deaths (DOT, NHTSA, 2003). For many years, "Sunbelt" states in the southern United States have had higher pedestrian death rates than other areas (Paulozzi, 2006).

Received 20 March 2007; accepted 14 July 2007.
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Presented, in part, to the American Public Health Association Annual Meeting, San Francisco, November 2003, and to the Injury and Violence in America Conference, Denver, May 2005.

A better understanding of the epi deaths is essential to designing preve United States and around the world. pedestrian deaths for a large urban are the goal of identifying patterns, circum tors, and potential avenues for prevent problem. Our linked data allowed us related deaths and some of the circ deaths, including the reason that the pe way, and to compare expressway-relat those that occurred on other roadways

METHODS

Background

Dallas County, Texas, had a populati according to the 2000 census. The po or older was 1.7 million: 49% were w were black, non-Hispanic; 22% were

Downloaded from injuryprevention.bmj.com on 7 November 2007

ORIGINAL ARTICLE

Childhood injuries due to falls from apartment balconies and windows

G R Istre, M A McCoy, M Stowe, K Davies, D Zane, R J Anderson, R Wiebe

Injury Prevention 2003;9:349–352

Background: Falls from balconies and windows are an important cause of childhood injury. This study investigated the circumstances around such falls and attempted to identify possible measures for their prevention.
Population: Children <15 years living in Dallas County, Texas.
Methods: Each child treated because of a fall from a building in 1997–99 had information about the injury collected, and a parent was contacted to obtain further information. For apartment related falls, an attempt was made to visit the apartment to measure windows and balcony rails.
Results: Ninety eight children were injured in falls from buildings during the three year period; 39 (40%) were admitted to hospital. Seventy five of the falls (77%) involved apartments, and most occurred around noon or evening meal times. Among apartment falls, 39 (52%) fell from windows, 34 (45%) from balconies, and two (3%) from unknown sites. For more than two thirds of balcony related falls, the child fell from between the balcony rails, all of which were spaced more than 4 inches (10 cm) apart. On-site measurement showed the rails were an average of 7.5 inches (19 cm) apart; all of these apartments were built before 1984. For more than two thirds of window related falls, the window was situated within 2 feet (61 cm) of the floor.
Conclusions: Two factors are important in falls from apartment windows and balconies: balcony rails more than 4 inches (10 cm) apart, and windows positioned low to the floor. Current building codes do not apply to older apartments, where most of these falls occurred. Nevertheless, these factors may be amenable to environmental modifications that may prevent most of these falls.

See end of article for authors' affiliations

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Falls account for significant morbidity and mortality among young children, and are one of the most common reasons for emergency department visits.[1 2] Since the early 1970s, falls from buildings have been recognized as an important cause of injuries and deaths,[1 3-6] and a program in New York City that installed window guards in tall apartment buildings led to a dramatic decline in childhood deaths from building falls.[7] However, in many other parts of the United States, falls from windows and balconies of apartments are not as likely to result in death,[8-10] possibly because apartments are less likely to be as tall in other parts of the country. Nevertheless, these fall related injuries might result in substantial morbidity, if not mortality.[7] In addition, we could find no recent studies that included on-site visits and review of pertinent environmental aspects that may contribute to such a fall.[10] We attempted to determine the circumstances around childhood falls from apartments in the Dallas County area, including inspection of the pertinent environment in order to identify whether interventions may be developed to prevent these injuries.

METHODS

Between 1 January 1997 and 31 December 1999, we asked the emergency department from each acute care hospital in the Dallas, Texas metropolitan area to report cases of injuries in children <15 years of age due to falls from heights associated with buildings. The Texas Department of Health provided support by requesting hospitals to participate in the investigation. Basic demographic data, diagnosis, and disposition were obtained from the emergency department log, and at least three attempts were made to contact by telephone the parents of each case to administer a standardized questionnaire. The questionnaire elicited specific information about the circumstances of the fall.

It became apparent early in the investigation that apartment balconies and windows were the main locations for the fall associated injuries in this population. Therefore, for cases for which a telephone questionnaire was completed, we also attempted to make a visit to the location of the fall. This allowed us to view the site of the fall and to obtain measurements of windows and balconies, including the height of the window sill or the distance between slats of the balcony railing.

Denominator data for rate calculations were obtained from the 2000 census data for Dallas County, Texas. Data were entered into a database and analyzed using Epi Info version 6.02b, from the Centers for Disease Control and Prevention. Dichotomous variables were compared using χ^2 or Fisher's exact test. To determine whether there had been any fall related deaths in children for the time period in question, we also reviewed log books of the Dallas County Medical Examiner for 1997–99.

RESULTS

Overview

For the three years of the investigation, 108 children <15 years of age were seen in emergency departments for injuries due to falls from buildings. Ninety eight of these were residents of Dallas County (annualized rate: 6.2 per 100 000 Dallas County children age 0–14 years). Ages were known for 97 injured children, and ranged from 1 to 12 years (mean 2.7 years). The highest rate of these fall related injuries occurred in children 0–4 years (15.6 per 100 000), and was considerable lower in 5–9 years (1.5 per 100 000) and 10–14 years (0.8 per 100 000) (table 1). Fifty seven children (58%) were male. Rates of injuries were not significantly different by race or ethnicity (table 1). Seventy four of the cases (76%) were seen at the Children's Medical Center of Dallas, which had the

Parkland

Operation Installation

Joint Effort:

Dallas Fire Rescue Department

Red Cross

Injury Prevention Center

Hospitals

Volunteers

Donors

Began in 2000

Supplements efforts of DFR to install Smoke Alarms

Plan:

Install 50,000 smoke alarms in high-risk neighborhoods.

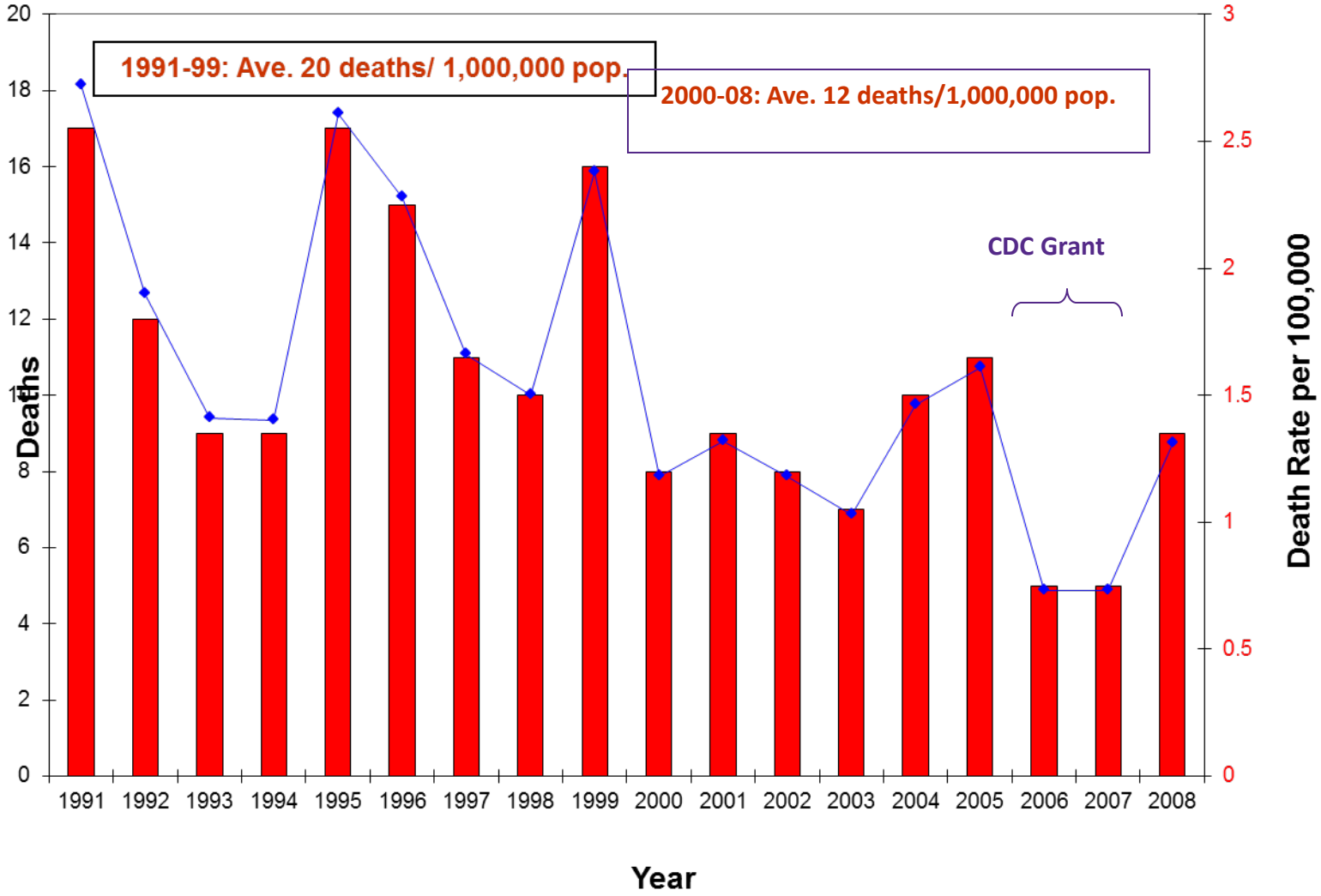
Provide education about fire prevention, escape, etc.

FIRE STATION NO. 44
DALLAS FIRE-RESCUE
44

Parkland

House Fire-related Deaths and Death Rates,

Dallas, TX 1991-2008



"Inner City Asthma Study: relationships among sensitivity, allergen exposure and asthma morbidity."

SOURCE: University **of Texas Southwestern Medical Center at Dallas, 75390-8859, USA. Rebecca.Gruchalla@utsouthwestern.edu**

Gruchalla, R.S., Pongracie, J., Palut, M., Evans, R. 3rd, Visness, C.M., Walter, M., Crain, E.F., Kattan, M., Morgan, W.J., Steinbach, S., Stout, J., Malindzak, G., Smartt, E., Mitchell, H.: "Inner City Asthma Study: Relationships among sensitivity, allergen exposure, and asthma morbidity." *J Allergy Clin Immunol*. Vol 115, No. 3, 2005, pps. 478-485.

Abstract.

BACKGROUND: Asthma-associated morbidity is rising, especially in inner city children.

OBJECTIVE: We evaluated the allergen sensitivities, allergen exposures, and associated morbidity for participants in the Inner City Asthma Study. We also determined geographic variations of indoor allergen levels.

METHODS: Nine hundred thirty-seven inner city children 5 to 11 years old with moderate to severe asthma underwent allergen skin testing. Bedroom dust samples were evaluated for Der p 1, Der f 1, Bla g 1, Fel d 1, and Can f 1.

Parkland

"Inner City Asthma Study: relationships among sensitivity, allergen exposure and asthma morbidity."

RESULTS: Skin test sensitivities to cockroach (69%), dust mites (62%), and molds (50%) predominated, with marked study site-specific differences. Cockroach sensitivity was highest in the Bronx, New York, and Dallas (81.2%, 78.7%, and 78.5%, respectively), and dust mite sensitivity was highest in Dallas and Seattle (83.7% and 78.0%, respectively). A majority of homes in Chicago, New York, and the Bronx had cockroach allergen levels greater than 2 U/g, and a majority of those in Dallas and Seattle had dust mite allergen levels greater than 2 microg/g. Levels of both of these allergens were influenced by housing type. Cockroach allergen levels were highest in high-rise apartments, whereas dust mite allergen levels were highest in detached homes. Children who were both sensitive and exposed to cockroach allergen had significantly more asthma symptom days, more caretaker interrupted sleep, and more school days missed than children who were not sensitive or exposed.

CONCLUSION: Geographic differences in allergen exposure and sensitivity exist among inner city children. Cockroach exposure and sensitivity predominate in the Northeast, whereas dust mite exposure and sensitivity are highest in the South and Northwest. Cockroach allergen appears to have a greater effect on asthma morbidity than dust mite or pet allergen in these children.

Parkland

Fence or Ambulance?

The poem "Fence or Ambulance?" by Joseph Malins that was published in the 1913 Bulletin of the North Carolina State Board of Health opens this way:

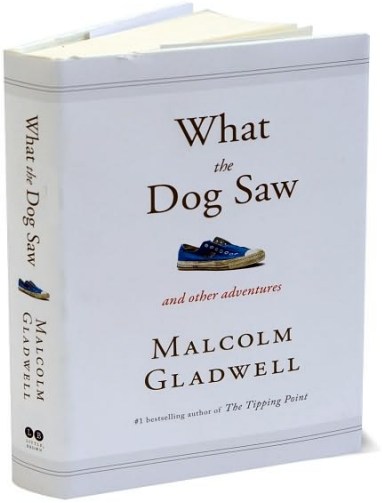
- "Twas a dangerous cliff, as they freely confessed,
- Though to walk near its crest was so pleasant;
- But over its terrible edge there had slipped
- A duke, and full many a peasant;
- So the people said something would have to be done,
- But their projects did not at all tally.
- Some said, "Put a fence around the edge of the cliff";
- Some, "An ambulance down in the valley."

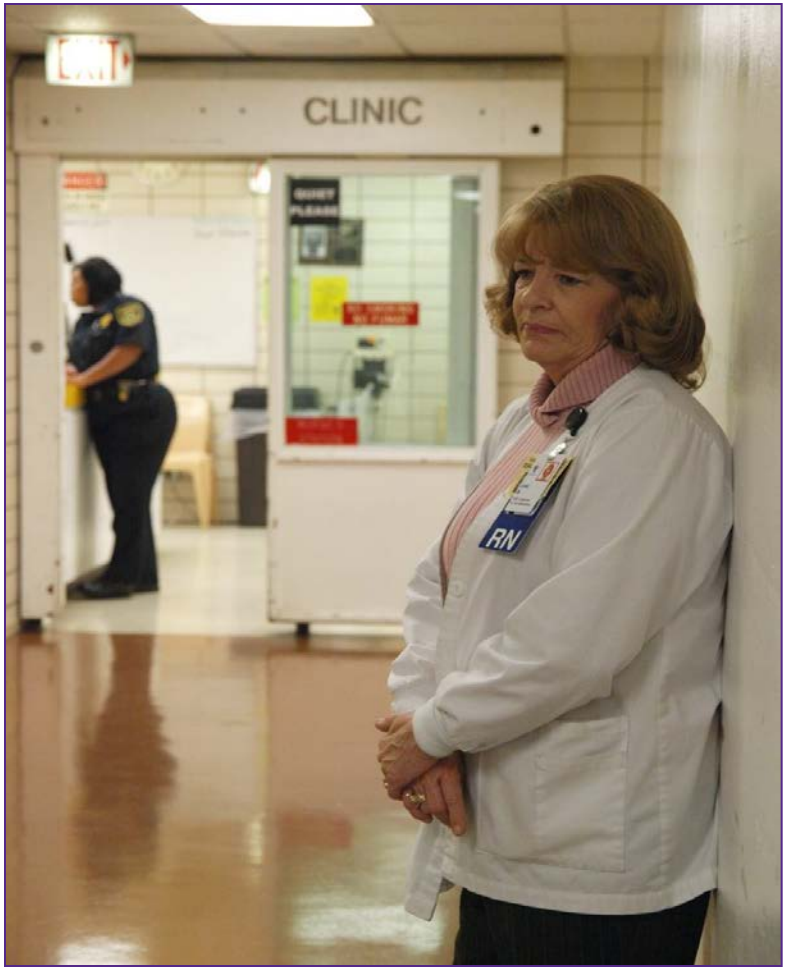
Better guide well the young than reclaim them when old,
For the voice of true wisdom is calling;
To rescue the fallen is good, but 'tis best
To prevent other people from falling;
Better close up the source of temptation and crime
Than deliver from dungeon or galley;
Better put a strong fence 'round the top of the cliff,
Than an ambulance down in the valley.

Malins J. Fence or ambulance? Bulletin of the North Carolina State Board of Health 1913;27(10):16
Available at: http://www.archive.org/stream/bulletinofnorthc27nort#page/16/mode/1up.

Moral Ambiguity

- Substance Abuse
- Mental Health
- Family Planning





Parkland

Dallas County Hospitals with Psychiatric Capacity, 2010

There was an increase of 12 beds in 2010 from 2008. However, Dallas County has a bed to population ratio of 1.8 compared to the U.S. at 5.4 beds per 10,000 population.

Hospital	Total Beds	Psych Beds	Alcohol /Drug Beds	Dual Diagnosis Beds	Dedicated Child/Adol. Psych Beds	Trauma	Total Mental Health
Methodist Richardson	205	30	12				42
Green Oaks **	106	78		20	8*		106
Hickory Trail ** (formerly The Cedars)	86	28	14		30*	14	86
Timberlawn **	144	56	16		55*	17	144
Parkland	672	18					18
Children's MC	487				12*		12
UT SW University Hospital	422	18					18
THR Presbyterian Dallas	895	50					50
Total:	------	278	42	20	105	31	476

* Pediatric and adolescent capacity
** Psychiatric Hospitals (other hospitals are general acute care with a psychiatric unit)

Texas DSHS Annual Survey, State Licensing DB as of 6/1/2010 and telephone interviews with facility representatives on services (6/8-9/2010 and 9/15/2010)

Parkland

Psychiatric Bed/ Population Ratios

Country*	Beds per 10,000 Population
Australia	4.1
Canada	19.0
Denmark	15.1
France	12.1
Germany	7.6
Ireland	11.5
Japan	28.4
Netherlands	18.7
United Kingdom	5.8
USA	5.4

Region	Beds per 10,000 Population
Texas**	2.1
Dallas County Adult***	1.8
Dallas County Child/Adolescent***	1.7

* World Health Organization, 2001.Accessed 10/30/2006. http://www.who.int/mental_health/evidence/atlas/PDF/Atlas%20final%20vol%202.pdf

** Texas Sate Data Center Population Projections 100-2007 scenario. Accessed 06/08/2010. http://www.dshs.state.tx.us/chs/popdat/ST2010.shtm

*** Texas DSHS Lic. Data, Hospital Association Annual Survey, 2008, and local interviews with the facilities

Mental Health Care in Dallas County

- Dallas Area NorthSTAR Authority or DANSTX is North Texas Behavioral Health Authority (NTBHA)
- NorthSTAR is the only local health authority for 7 counties in the North Texas Region
- Oversees managed behavioral health care service delivery system which serves persons eligible for Medicaid and/or public behavioral health funds in the region
- NorthSTAR provides an integrated system of care with mental health care and chemical dependency services to designated priority populations
- Priority populations include severe/persistent mental illnesses (schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders) which require crisis resolution or ongoing and long-term support /treatment

- Texas is 43rd in the per capita mental health funding in the country
- NorthSTAR gets lowest per capita funding in Texas
- Since 1999 number of patients has grown 90% versus funding 60%
- Behavioral Health Leadership Group (BHLG) created to develop a cohesive mental health delivery system in Dallas County

Parkland

Impact of Family Planning Program – Births Averted

Family planning began as a joint effort between Parkland and UT Southwestern. In 2005, the program was in danger of ending. Parkland took over to ensure these services are available for women in need.

Access to family planning services prevents unplanned Medicaid births.

Parkland Family Planning offers much more than the opportunity for patients to control the timing of their pregnancy. The program encompasses preventive health care services as well - particularly for women.

Serves 35,000 women each year with services such as screenings, tests, education and counseling.

- From September 2009 to August 2010, Parkland's family planning program averted a total of 6,609 births:
  - Adolescents (19 and under) = 1,125
  - Adults (20 and over) = 5,484
- Estimated by outcome:
  - Births = 2,858
  - Abortions = 2,887
  - Miscarriages = 864
- 99.4% of these averted births would fall at or below 185% of FPIL (eligible for Medicaid coverage for delivery and newborn care)

Parkland

Elements Needed in the Changing Environment

- New delivery models are as important as insurance reform
  - Rationalizing delivery models
    - Primary medical care homes
    - Care management
    - Addressing socioeconomic determinants of health
    - Addressing disparities adequately
  - Shift from volume-driven to value-driven (outcomes vs. thru-put)
- Access is as fundamentally important as coverage
- Evidence-based practice and policy are critical
  - Must deal with variations in practice that are not bringing value
  - Must promote comparative effectiveness research and its applications
  - Must balance “sticks and carrots”

Safety Net in the Changing Environment

- Needs to expand upstream and deal with the determinants of health at the community level:
  - Prevention
  - Health promotion
  - Care management
  - Population-driven medicine
- The Safety Net may need to be redefined:
  - More adaptable and flexible
  - More accountable
  - More upstream interventions

Parkland

Safety Net in a Changing Environment

- Investment in public infrastructure may be the best way for many urban areas to provide the elements necessary for reform to succeed, especially in these areas:
  - Physician, nurse and other provider training
  - Outcomes studies for comparative effectiveness and disparities
  - Population medicine
  - Provision of regional tertiary/quaternary services
- Rethinking the health delivery model, moving from individual medicine to population health
- Need incentives to improve collaboration among hospitals, public health and community-based services
- Meet as a community to determine how to harvest the synergy of education, housing, police, fire, etc.

Parkland

Recreate “the Commons”

- Restore our sense of community
- Re-tap our energy to solve our own problems
- Rediscover the strengths of ad hocracies
  - De Tocqueville — early 1800s
- Effects will be seen in areas other than health care

Parkland

Managing the In-Betweens

- We must manage the In-Between, or the Common Ground that benefits the whole infra-structure but is not managed by any one part
- Important for accountability, stewardship and outcomes
- Promotes synergism with one success building upon another

Parkland

Call to Action

- To improve quality, safety & access:
- Goals for Dallas to bring us together – Healthy Dallas Goals for United Way Strategic Plan
- Collaborative Dialogue
- Community Driven Process
  - (Managing the In-Betweens)
- Regional Health Partnerships –
  - Planning for Health Among Competitors
  - (1115 Medicaid Waiver)

Parkland

Planning for the Future

Parkland

Guiding Principles

Extraordinary Provider

Learning & Research Leader Public Health Innovator

Organized • Equipped • Focused • Achiever

By our actions, we will define the standards of excellence for public academic health systems

QUALITY	CARE SYSTEM	STEWARDSHIP	PEOPLE
Leading performer in all quality and safety measures at all sites of care	Patient and academic centered integrated system of care	Financially strong and innovative leader in population-based efficiency, effectiveness	Highly engaged workforce; loyal patients who choose the Parkland system
Top decile performance on peer and public scorecards	*Right care, right place, right provider, right time*	*Moody's A performance; top quartile per capita costs*	*Top engagement and satisfaction scores*

The Triple Aim

S T E E E P

Parkland

STEEEP

- **S**afe— Primum non Nocere
- **T**imely — No Unwanted Waiting
- **E**ffective — Improve the Patient's Health
- **E**fficient — No Waste of Resources
- **E**quitable — No One Left Out
- **P**atient-Centered — The Patient's Needs Supersede all Others

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Triple Aim

The IHI Triple Aim

Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs

Institute for Healthcare Improvement, 2007

- 3 critical objectives:
  - Improve the health of the population
  - Enhance the patient experience of care (including quality, access, and reliability)
  - Reduce, or at least control, the per capita cost of care

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Community Health Institute

Determines the Parkland System Public Health Priorities with the aim of improving the health and wellness of the community through:

- *Professional education and community health training*
- *Health services research and policy development*
- *Population Medicine*

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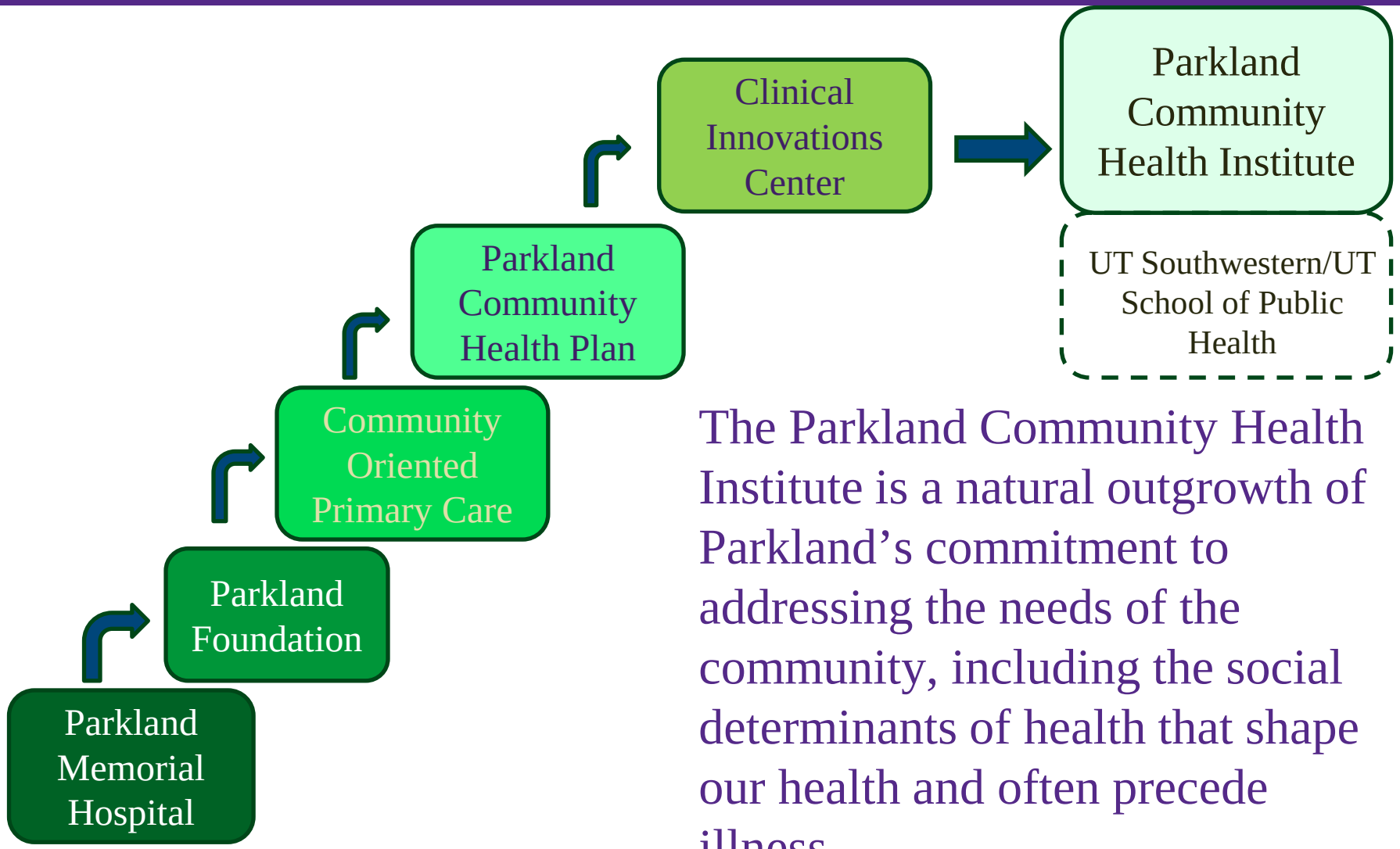
Growth of the Parkland System



The Parkland Community Health Institute is a natural outgrowth of Parkland's commitment to addressing the needs of the community, including the social determinants of health that shape our health and often precede illness.

The Parkland Community Health Institute

The Parkland Community Health Institute (PCHI) will track the health status of our patient populations

- Outcomes research – How do patients fare when they get back home? Are we intervening early enough, effectively, and in ways that patients feel comfortable with?
- Self-Management – Are patients able to do at home what we advise them to do? Can we find and remove barriers to optimal self-management of chronic diseases?
- Utilization – Are patients using the system the right way? Can we accomplish the same goals through lower-intensity interventions?
- Patient-Centered Medical Home – Are our clinics being responsive to patient needs and preferences? Are people falling through the cracks?
- Population Medicine – What emerging disease trends can we predict and prevent?
- Education – How can we train new generations of doctors, administrators and other healthcare workers to look to communities as an ally in healthcare?
- Health Policy – Can we help Parkland and area leaders formulate policies that optimize health for all?

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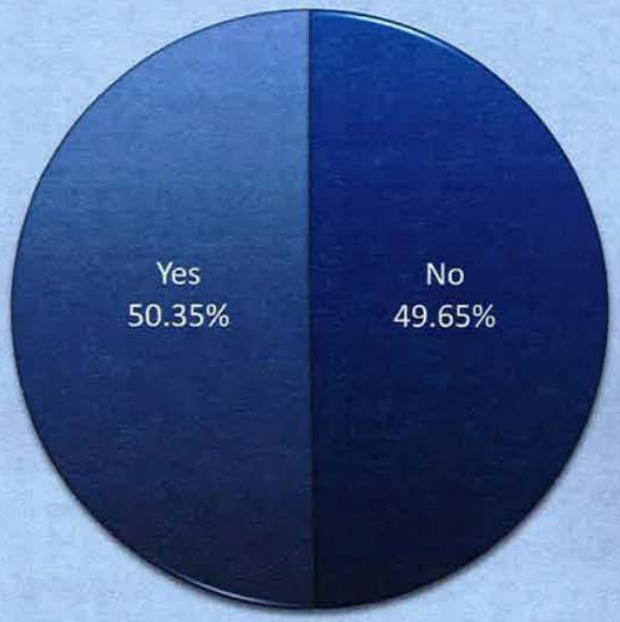
Would you be interested in an "MD with Distinction" that incorporates Principles of Public Health and Prevention, Community Service Learning, and Community Based Participatory Research?



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Becoming the System of Choice, Not of Last Resort

- In 2000, WHO suggested some essential elements for reforming health care:
  - Support a paradigm shift toward integrated, preventive health care
  - Promote financing systems and policies that support prevention in health care
  - Equip patients with needed information, motivation, and skills in prevention and self-management
  - Make prevention an element of every health care interaction
  - Make chronic disease management a priority across the healthcare system

Source: World Health Organization. 2000. http://www.who.int/mediacentre/factsheets/fs172/en/index.html Accessed 12/03/07

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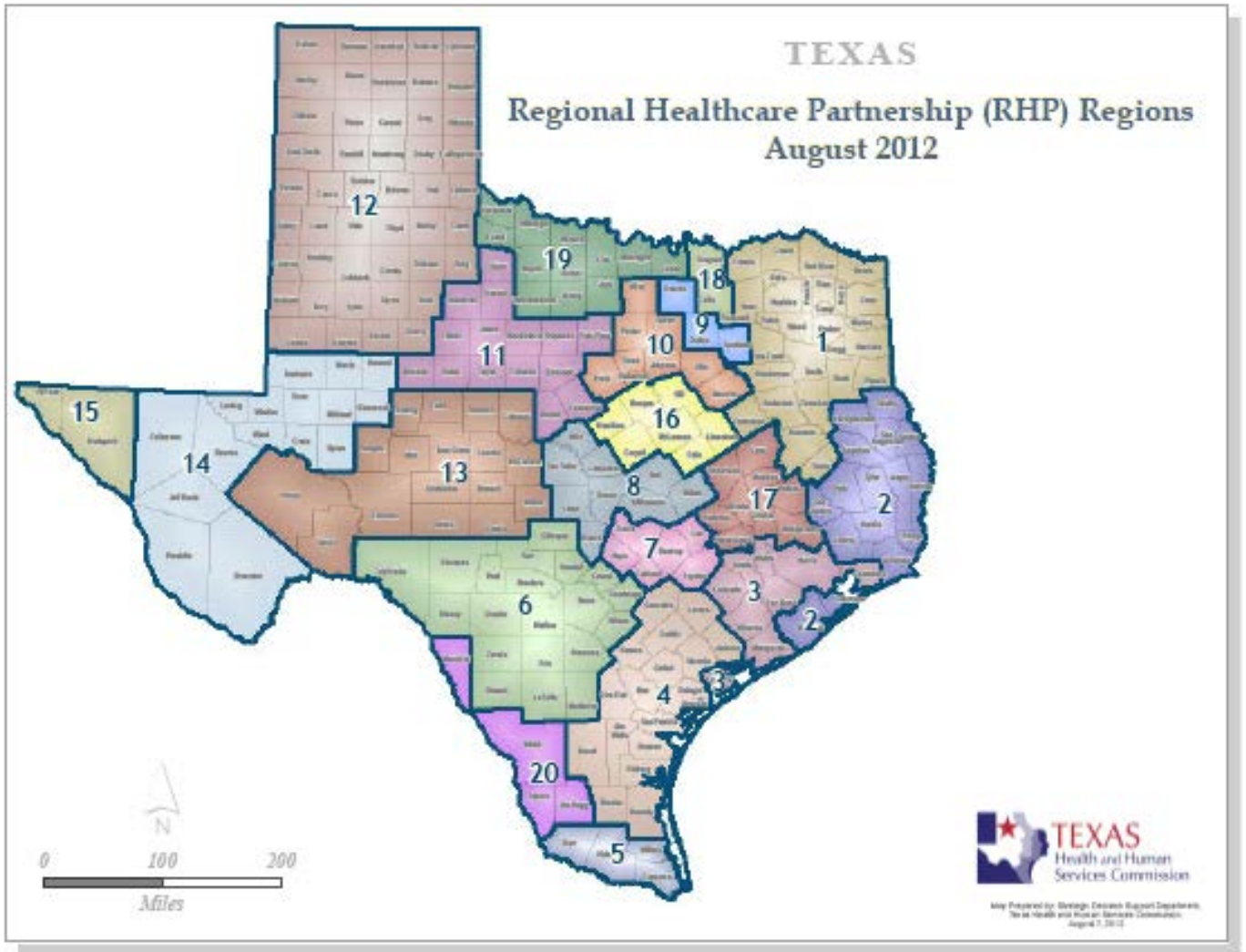
1115 Waiver

- Waiver's impact is state and local, rather than federal
- Works whether the healthcare reform law remains intact or not
- Milestones
  - Expansion of primary care
  - Behavioral health goals
  - Specialty care access goals
- DSRIP and UC more than doubles the former UPL annual payment

Proposed RHP Map



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RHPs and DSRIP

- RHP Plans include:
  - Regional health assessments
  - Participating local public entities
  - Identification of hospitals receiving incentives and of yearly performance measures
  - Incentive projects by DSRIP categories

- RHPs and RHP plans do not:
  - Require four-year local funding commitments
  - Determine health policy, Medicaid program policy, regional reimbursement, or managed care requirements

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DSRIP Category 1: Infrastructure Development

Category 1 Projects
1. Expand Primary Care Capacity
2. Increase Training of Primary Care Workforce
3. Implement a Chronic Disease Management Registry
4. Enhance Interpretation Services and Culturally Competent Care
5. Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities
6. Enhance Urgent Medical Advice
7. Introduce, Expand, or Enhance Telemedicine/Telehealth
8. Increase, Expand, and Enhance Dental Services
9. Expand Specialty Care Capacity
10. Enhance Performance Improvement and Reporting Capacity
11. Expand Behavioral Health Care Capacity (not yet inserted by state)

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DSRIP Category 2: Program Innovation and Redesign

Category 2 Projects
1. Enhance/Expand Medical Homes
2. Expand Chronic Care Management Models
3. Redesign Primary Care
4. Redesign to Improve Patient Experience
5. Redesign for Cost Containment
6. Implement Evidence-Based Health Promotion Programs
7. Implement Evidence-Based Health Disease Prevention Programs (new)
8. Apply Process Improvement Methodology to Improve Quality/Efficiency (e.g., Rapid Cycle, Management Engineering, and Lean Technology)
9. Establish/Expand a Patient Care Navigation Program
10. Use Palliative Care Programs
11. Conduct Medication Management
12. Implement/Expand Care Transitions Programs
13. Expand Behavioral Health Capacity (not yet inserted by State)

DSRIP Category 3: Quality Improvements

Improvements in prevention and/or management of:

- Patient Satisfaction
- Appropriate Care, Appropriate Setting
- Improved outcome for identified disparity group
- Reduction in population specific PPA/PPR for Congestive heart failure, Asthma, Diabetes, COPD, BH/SA
- Improved Clinical Outcomes
- Third Next Available Appointment
- Reduced ED utilization
- Perinatal Health (Birth trauma rate)

DSRIP Category 4: Population-focused Improvements

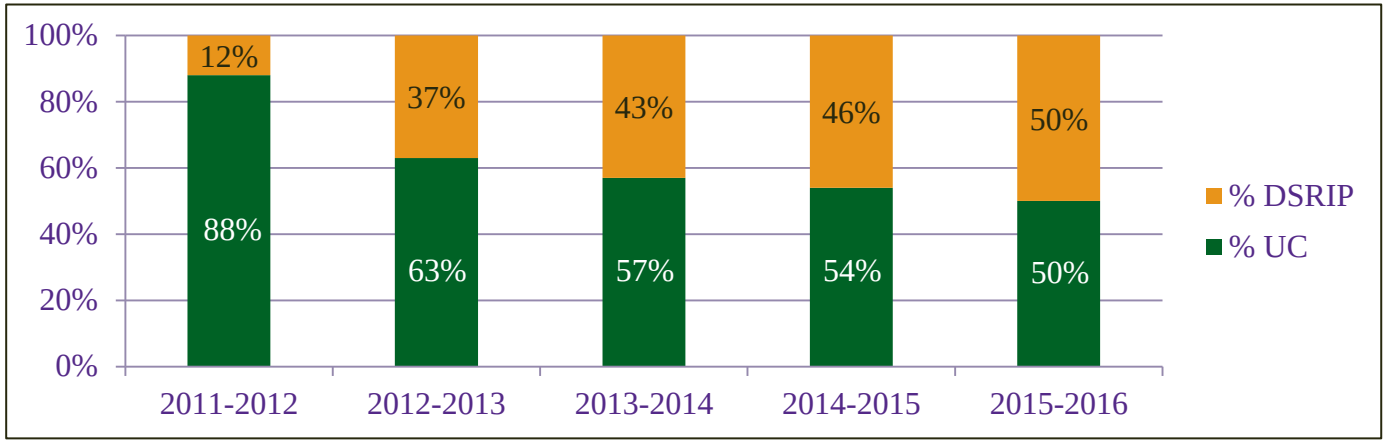
Reporting Results Required:

- Potentially preventable admission
- 30-day readmissions
- Potentially preventable complications
- Patient satisfaction (HCA HPS_?_)

Pool Funding Distribution

Pool Funding Distribution in Billions

Pool Type	DY* 1 (2011-2012)	DY 2 (2012- 2013)	DY 3 (2013- 2014)	DY 4 (2014-2015)	DY 5 (2015-2016)	Totals
UC	$3.7	$3.9	$3.534	$3.348	$3.1	$17.582
DSRIP	$0.5	$2.3	$2.666	$2.852	$3.1	$11.418
Total/DY	$4.2	$6.2	$6.2	$6.2	$6.2	$29
% UC	88%	63%	57%	54%	50%	60%
% DSRIP	12%	37%	43%	46%	50%	40%



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Advice to a Sojourner in Health Policy

- Be a student of “unintentional consequences”
- The admonition “first do no harm” is still relevant.
- Recognize that reform is young, just making its first steps
- Don’t let perfection become the enemy of “good and getting better every year” (not every institution starts in the same place)
- Controlling costs will require:
  - Addressing social determinants of health
  - Reducing consumer demand
  - Payment for value, not volume
- Practice cultural humility (sensitivity is important but not sufficient and competence can be illusive.)
- Try to have bipartisan dialogue to help with incremental improvements

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Final Comments

Parkland certainly is facing serious regulatory challenges as this Grand Rounds is being presented.

But on a more positive side:

Parkland will have a new, larger, more patient-centered, adaptable, and flexible hospital, capable of serving many decades into the future. The hospital system has invested in an electronic medical record system to improve patient care, but also to improve the ability to do outcomes research, or quality and safety interventions. Parkland has its own non-profit HMO foundation, and clinical innovations center. It would be well served to invest in a Community Health Institute to incorporate health promotion, disease and injury prevention, participatory community-based research, and to cultivate deeper community dialogue and action toward the resolution of problems that previously may have been labeled “insolvable.”

There is every expectation that Parkland can, and will, serve in an even more robust manner going forward if the path outlined in this talk is pursued in a spirit of servant leadership.

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Be the change you want to see in the world.”

Mahatma Gandhi

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