Description

Open Cities Health Center (OCHC) provides primary medical, dental, behavioral health, chiropractic, eye care, podiatry, and outreach services to those in need. OCHC programs use case management, support group, and community outreach approaches focused on:

1) detecting breast and cervical cancer earlier through a coordinated/integrated process; and 2) improving the health status of people with diabetes through providing case management on all aspects of disease management.

Project Rationale

Our clinic’s target populations, particularly African American and Hmong women, do not receive much needed screenings, follow-up and coordinated services for breast and cervical cancer. Of the 16,000+ patients OCHC served in 2012, 1,049 were diabetic. Diabetes is one of the most devastating and complicated diseases. For the many barriers OCHC target populations face in accessing care, they face even more in trying to manage a disease like diabetes. OCHC is utilizing case management and support group strategies in reducing the disparity among our community members.

Population Served & Geography

African/African Asian/Pacific Islanders in the 7 County Twin Cities metro area; Ramsey County; Summit-University, Thomas-Dale, North End, Payne-Phalen neighborhoods in St. Paul.

Project Partners

None.
Successes

- Full implementation of monthly diabetic support group - feedback form implementation
- Targeted diabetic in-reach for recommended eye-care treatment
- Provision of family planning and spacing education given for women of child-bearing age
- Targeted clinic in-reach for breast/cervical cancer screening
- Implementation of daily reports which allows for audits of past mammograms and Pap smears leading to reminders placed in patient’s electronic medical record
- Recruitment of high-risk women for breast/cervical screening events
- Policy changes which call for HNC Access to St. Paul Radiology portal for results retrieval

Challenges

- Coordinating processes among OCHC departments requires involvement from Outreach, Medical, Front Desk, IT, and Billing departments
- Communication and workflow adjustment among providers.
- The health navigator issued reminder cards to patients re: CBEs with the appropriate code number for the CBE so the provider could enter it into EMR. This continues to be a challenge to track but it has improved with the reminder cards.

Cost Savings

According to the Minnesota Department of Health Fact Sheet “Diabetes in Minnesota,” there are 294,000 Minnesotans with diabetes and that the annual cost of diabetes in Minnesota is estimated at over $2.3 billion, or an annual average cost per diabetic patient of $7,823. In 2012-2013 OCHC provided case management for 597 diabetic patients. If those same 597 patients received care elsewhere, it would have cost the system $4,670,331.

Key Evaluation Findings 2012-2013

Breast/Cervical

- 74 health fairs attended where flyers and brochures were distributed
- 2 mammogram screening events
- 360 total women received mammograms; 75% of total mammograms were to women in target populations
- 620 total women received cervical cancer screenings; 74% of total cervical cancer screenings were to women in target populations

Diabetes

- 12 Diabetic support groups
- 85 total participants at diabetic support groups
- 74 health fairs attended where diabetic flyers/brochures were distributed
- 597 African American and Asian diabetic patients received case management
- 77% of diabetic support group participants report learning about disease management and healthy lifestyle behavior

Infant Mortality

- 173 of women in target populations receive OBG education sessions in-clinic
- 100% of (173) OBG participants receive family planning, spacing education, and have access to case management.
- 75% of assessments that show areas of high-risk and barriers receive case management from a Health Navigator

Utilizing Partners and Screening Events to Address Breast Cancer Disparities

OCHC partnered with MDH Sage and American Cancer Society (ACS) to coordinate screening events for patients who are high-risk and/or SAGE eligible. We generated clinic reports of patients who were uninsured/self-pay or underinsured and sent out a bulk mailing along with conducting recruitment calls to these patients. In total, OCHC completed two screening events (October 2012 & February 2013), and effectively screened 43 women, provided education and necessary follow-up. Each woman also received assistance with barriers if needed, such as transportation assistance. Cancer has been detected as a result of these events and Health Navigators have helped guide necessary follow-up and treatment. OCHC has continued these screening events and views them as a valued part of our patient-centered care.

This activity is made possible by a grant from the Eliminating Health Disparities Initiative (EHDI) of the Minnesota Department of Health’s Office of Minority & Multicultural Health, through an appropriation from the Minnesota State Legislature.