

Improving Health With Our Community

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***A Presentation for Panel #4: Community Engagement
Public Forum on Best Practices for Community Health Needs
Assessments and Implementation Strategies: A Review of
Scientific Methods, Current Practices, and Future Potential
July 11-13, 2011 Centers for Disease Control and Prevention***

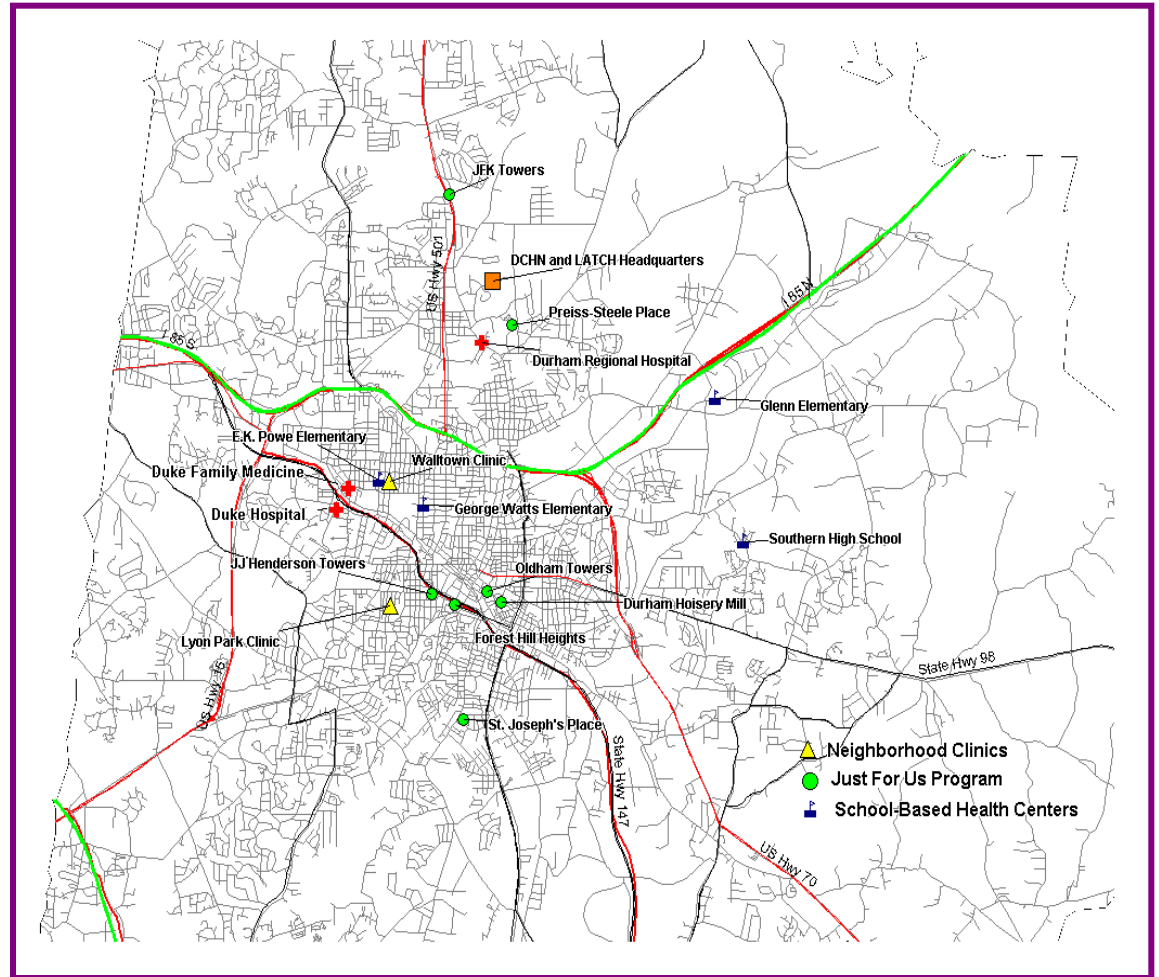
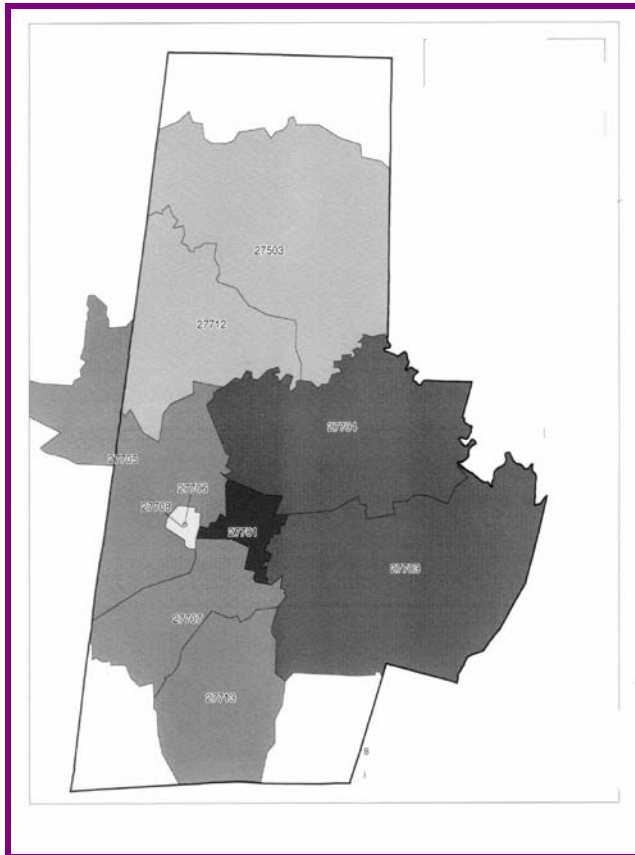
DUKE CONNECTED CARE



DukeMedicine



Our Context: A Strong History of Collaboration



Duke Medicine Strategy for Community Engagement

Together with community partners, we...

- Ask and listen
- Analyze health care utilization and costs
- Explore barriers to appropriate care
- Identify partner needs and resources
- Plan/redesign services
- Track outcomes, share accountability



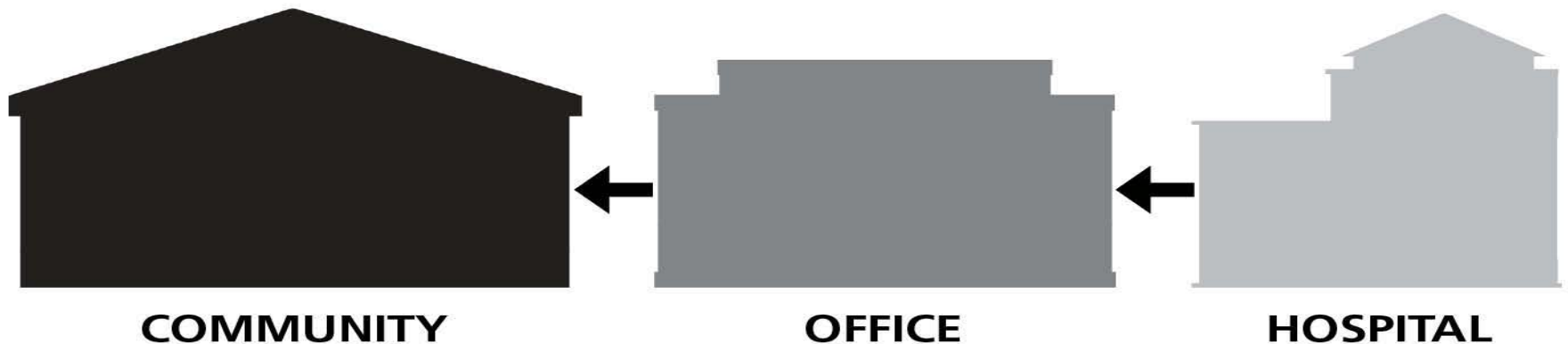
A Few Examples of Collaboration...

- Neighborhood clinics
- School-based clinics
- Home care for elderly and/or disabled
- Care management teams
- Specialty Access
- Durham Health Innovations
- Educating the Next Generation and New Variations of Clinicians



Questions....

1. How do we assess disease risk and burden, and health status at the individual and population level?
2. What are the best practices of community engaged approaches to population health? Where, how, and by whom can interventions be delivered most effectively?
3. What are the key metrics? How will we know if we succeeded?





DURHAM

Health

INNOVATIONS



DURHAM
Health
INNOVATIONS

Oversight Committee

Co-chairs:

Rob Califf, MD, Director, DTMI and Vice Chancellor for Clinical Research, Duke Medicine

Gayle B. Harris, MPH, Director, Durham County Health Department

MaryAnn Black, MSW, LCSW, Associate Vice President, Office of Community Relations, DUHS

Jackie Brown, Community Advocate

William Fulkerson, MD, Senior Vice President, Clinical Affairs, DUHS

Catherine L. Gilliss, DNSc, RN, FAAN, Dean, Duke University School of Nursing and Vice Chancellor for Nursing Affairs

Ellen Holliman, Director, The Durham Center

J. Lloyd Michener, MD, Chairman, Department of Community & Family Medicine and Director, Duke Center for Community Research

Marie Lynn Miranda, PhD, Director, Children's Environmental Health Initiative, Duke University Nicholas School of the Environment

Earl Phillips, Assistant Director, Community Engagement, City of Durham

Gerri Robinson, Director, Durham County Department of Social Services

Pilar Rocha-Goldberg, Executive Director, El Centro Hispano



DTMI

Transforming Medicine

GOAL: Improve health in Durham County

- **Develop innovative approaches to translate best practices into community settings**
- **Develop a community model using advanced informatics and health services redesign**
- Leverage collaborative Durham – Duke teams
- Over 500 people, 90 community groups



Final Teams

Life Stage

- Maternal/Fetal Health
- Adolescent Health
- Seniors' Health

"Hard medical"

- Cardiovascular
- Cancer screening/survivors
- Asthma/COPD

Behaviors

- Substance abuse/pain management

Medical/Behavioral

- Obesity
- Diabetes
- STDs





DURHAM
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Technical Assistance Cores

Community Engagement

Co-Chairs:

Michelle Lyn (Duke)
Earl Phillips (City of Durham Housing and Development)

→ Modeling engagement

→ Facilitating conversations

→ Connecting to other teams

Data and Analysis

Co-Chairs:

Marie Lynn Miranda (Duke)
Becky Freeman (Durham County Health Department)

→ DSR and other linked data

→ Business data

→ Data from teams

→ Geospatial mapping

Plan Development

Co-Chairs:

Krishna Udayakumar (Duke)
Casey Steinbacher (Durham County Chamber of Commerce)

→ Alternative models of care

→ Business plan development

Analysis

Data confidentiality issues



DTMI

Transforming Medicine

Current Focus

- Classify patients' health risks
- Use information technology
- Create a “web” of options:
 - 1) Specialist and primary-care
 - 2) PAs and NPs
 - 3) Care coordinators
 - 4) Alternative care arrangements



RESULT: Care is ...

CLOSE To home, neighborhood, school, workplace...

CONNECTED Individuals to health providers
Health providers to each other

ACCOUNTABLE Measurable performance
with consequences

IT IS A FUNDAMENTAL REDESIGN – NOT A SUBSTITUTION MODEL,
NOT A “LESSER” MODEL



What have we learned?

1

Physicians need to do what only they can do

- Complex care
- Unknown illnesses
- System redesign

2

We need more than doctors

PAs, NPs, nurses	Physical therapists
Psychologists	Case managers
PharmDs	Health educators
Social workers	IT designers
Dietitians	

3

We need to train teams to work together

4

We need to start now



What will this require?

Practice what we teach; teach what we practice; research how to do better

University

- Coordinated placement/pipeline programs

Professional Schools

- Training and practice in teamwork
- Primary care leadership

PA, NP, PT

- Expansion of program size; teamwork

Residency

- Restructured FM residency around improving population health
- Masters in Clinical Leadership

Faculty and Staff

- Classes, Grand Rounds, online training in community engagement
- Shift practice and research to improving community outcomes



Duke Family Medicine Residency

- Shift to ambulatory specialist.
- Longitudinal model with daily clinic
- Curriculum completely restructured
 - Team based care
 - Chronic disease management
 - Community engagement
 - Leadership skills
 - Quality measurement and improvement

Community focus

- 2-year continuity experience in innovative community care delivery
- Measurement of health status of the community as a whole
- Reduce health disparities



Conclusions

- Health requires more than medicine
- Health care requires more than physicians
- Improving health requires teams in the office and in the community
- Community partners add expertise and resources
- Needs vary; one size does not fit all
- **We can do better...**

