Environmental Survey Questions for PCEP Summit May 6, 2011

Introduction: The primary care extension program (PCEP) is a model of care that was developed to take advantage of community networks as a means of improving quality of medical care and community health through two mechanisms, namely, local technical support of practices and linkage with community resources. PCEP is a framework of care intended to support a variety of models of practice. Optimal effectiveness is likely to come when PCEP is aligned with primary care practices based on patient-centered medical home model (PCMH). The PCEP model provides assistance for the transformation of primary care to the medical home model. While the medical home model represents an improvement in health care delivery and outcomes, unaddressed social determinants of health often impact a patient's ability to follow through on his or her care plan. Public health programming may be able to impact some of these barriers with the use of lay health workers who straddle the gap between the patient in the community and the medical practice. The PCEP model incorporates Health Extension Agents (HEAs) to perform this outreach function.

There are many projects in Illinois focusing on aspects of these two components of the PCEP model (practice transformation and linkage with community resources). Our goal is to create an environmental survey of the various projects to create a resource database for existing and new projects and enhance the opportunities for synergy. Please complete the following questionnaire:

1. Name of your project**: Aggressive Lipid Management and Cardiovascular Risk Reduction for Primary and Secondary Cardiovascular Prevention**

2. Key project personnel, roles and contact information: **Julie Adkins APN/FNP-BC**

3. Is there information on a website? URL? **None**

4. What is the target population? **Entire patient population of clinic**

5. Provide a short description/overview of project: **My scholarly project for the DNP program is to evaluate the clinical usefulness by incorporating the Lipid and Cardiovascular Risk Reduction Clinics to other sites in Illinois targeting Nurse Practitioners and Clinical Nurse Specialists in Family Practice, Internal Medicine and Cardiology practices.**

6. Describe the elements of practice transformation within your project. Are you using the medical home model? Are you using a standard definition or evaluation tool for medical home model? **I will target the medical home model of the extended clinics. The current clinic incorporates the medical home model for which I am the IHC provider. I am also the sole provider in a satellite clinic in rural Illinois, West Frankfort with a patient population of over 4000. An outcomes study was performed after one year of the lipid clinic to evaluate those patients at aggressive/optimal goals with a result of over 62% in one year.**

7. Describe the elements of community linkages within your project**. Local advertisement of lipid clinic as well as posted on the clinic signs.**

8. Describe key collaborative relationships.
There is a cardiologist from Barnes Hospital, St. Louis who shares office space twice a month and who is my mentor for my scholarly project.

9. Length of time in existence: **Nine Years**

10. Describe the funding of the project.
No funding sought to initiate the clinic. Lipid management certification course taken 9 years ago.
Tracking of patients to assure timely follow-up, adjustments of medications and side effects of medication along with assessment of therapeutic lifestyle changes needed and assessment of Problems/successes.

11. Describe how you intend or are currently evaluating the project. What outcomes are you tracking?
Current outcomes tracked are the evaluation of lipid panels to optimal goals. Blood pressure controls and diabetes controls. The patients are tracked using a software program to be able to print out graphs, diets, risk assessments and metabolic risks. Crucial follow-up of patients to assess lipid and liver panels at initiation of lipid management and if medication is prescribed I use a tracking system to notify patients when their lab is due and sending personal letters to those patients each month. Other tracking includes cardiovascular risk and stroke risk per ATPIII guidelines.

12. What are the results of the project to date?
For the past nine years, I have had no patient with mortality due to cardiovascular disease. Morbidity has been due to other factors and not the cardiovascular reduction/lipid management.

13. Briefly list key challenges and successes?
Key challenges are keeping patients on track with their follow-up bloodwork with reminders. Also medication adherence and side effect reporting. Medication costs adjustments per patient.
Continued education and challenges of therapeutic lifestyle changes.

Successes- I have over 1000 patients in the lipid clinic and would guess their optimal goal attainment to be around 85% at the minimum. I developed a patient education tool 9 years ago and updated 3 years ago for patients to be able to track their lipid numbers as well as descriptions of cardiovascular risks and lifestyle interventions to undertake. No morbidity or mortality related to cardiovascular disease in 9 years.

14. What support or resources do you need in order to expand or replicate your project?
    To be able to extend this project to all primary care offices. Contacts in all primary care Offices to incorporate the project/plan. Serve as a consultant to these practices willing To incorporate the project for questions and problem-solving issues as well as questions Regarding patient treatment strategies.

Julie Adkins APN
406 West St. Louis St
West Frankfort, Illinois 62896
618-937-6300

Please complete by June 1, 2011 and send to Margaret Kirkegaard at mkirkegaard@automated-health.com.