Anna: *You're listening to Changing Minds: Transformative Talks for Healthcare Improvement. Grab a coffee or tea and join our team as we chat with leaders in the academic detailing space. For more information on academic detailing, visit us at narcad.org.*

Anna: Hello and welcome back to *Changing Minds*. I'm your host, Anna Morgan-Barsamian, and we are excited to be here today. I am joined by Jacki Travers. Jacki is a clinical pharmacist with Pharmacy Management Consultants, a division of the University of Oklahoma College of Pharmacy.

Since 2015, she has led the team in their academic detailing work, and her AD efforts are primarily in service to Oklahoma Medicaid providers, who in turn care for some of the state's most vulnerable populations. She has also served as a training facilitator for the NaRCAD Academic Detailing Techniques trainings since 2019. Jacki, welcome to our podcast. How are you today?

Jacki: I'm doing well. Thank you so much for having me.

Anna: Of course. Let's dive right in with our first question. Can you provide an overview of your new public health detailing project that your team has been working on, and tell us a little bit about what inspired this initiative?

Jacki: Absolutely. I would love to. This is a five-year project, and it is in partnership with the Oklahoma State Department of Health. The overarching goal is to reduce health disparities and to address some of the underlying contributors that lead to some of our poorer outcomes for diabetes and cardiovascular disease specifically. It's a very collaboration-focused project, and we have six main strategies that are our areas of focus.

The first being to increase social drivers of health screenings. You might have heard those called social determinants of health in the past, just synonymous naming, same acronym and everything. SDOH is how you might hear me refer to those during this podcast today.

One of the specific areas that we're leaning into is having standardized processes in place, validated processes. We are encouraging everyone who's doing these kinds of screenings to use the PREPARE tool. It's a national tool. It's available in 25 different languages. It was built and promoted by the National Association of Community Health Centers. Just a great, great tool out there.

We are also tasked with increasing the number of community health workers, or CHWs. This is where our libraries and faith-based groups that you'll hear about a little bit later are coming into play.

We are promoting team-based care. Basically, what that means is for folks who have diabetes and cardiovascular disease, there are some non-primary care needs that they have, things like dental screenings, podiatrists, optometry screenings. Helping them get access to those points of team-based care for those screenings.

Additionally, we are creating community clinical linkages in order to better identify where those SDOH needs are. Again, faith-based groups and libraries are the main focus there. Like I said, I'll go into more detail about that later.

Also, we're partnering with the American Heart Association. There are also different multiple ECHO groups. Shout out to all the lovely ECHO opportunities available throughout the United States. Love, love, love the ECHO. Then almost last, but certainly not least, promoting self-

monitoring of blood pressure. Here is where our American Heart Association partnership, they are just our rock stars in this, they're helping us put devices in the hands of people. Just buying a blood pressure cuff, buying a blood pressure monitor, can sometimes be a barrier to doing self-monitoring of blood pressure. They're helping us put blood pressure monitors and devices in the hands of people who otherwise might not get to have them.

They're also partnering with us to share some drug resource cards, basically a flip book for folks so that they can understand how their drugs work, what they should be looking for, what they should be concerned about, those kinds of things.

Our last strategy is actually referring folks with cardiovascular disease and diabetes for those resources. Get them screened and then do the next step, help them access the resources. One of the things that we're doing there is we are in talks with MyHealth, which is the closest thing in Oklahoma that we have to a universal health information exchange. It's not through the entire state, but it's getting pretty close. About 80 percent of the healthcare points of contact share their information with MyHealth.

They are actually using the PREPARE tool, and part of what they do currently is it's a provider-driven piece right now so that if someone has an appointment, then they are prompted to complete the PREPARE tool. Then based on what they answer, they will be in real time given access to three different resources that will meet whatever needs they've expressed during their screening. Two of them are going to be zip code based, so very local, and then one is going to be a statewide resource.

If they don't have something local, then they would get more statewide resources and things like that. Part of what we're doing with MyHealth is we are working on getting a more patient-initiated survey. Think QR codes posted in libraries, QR codes included with the blood pressure kits, possibly posted on a worship space bulletin board.

That's basically the overview of the project. Then as far as our inspiration, we've really had a great long-standing history with the state health department. We have done medication therapy management services for them at the local pharmacy level. We have trained federally qualified health center pharmacists and retail pharmacists to then also deliver medication therapy management or MTM services. We've done academic detailing to some primary care practices to help them refer out for that MTM. This particular grant, the CDC gave Oklahoma the funding, the opportunity to start working on the social drivers of health. It was a natural pivot for them to include us just because we've had such a great history working with them.

Anna: Wow, what stands out the most, Jacki, is this collaborative approach that you're speaking about. Your team is so involved with other community initiatives. That's such a great approach to take for academic detailing because I really think that the intervention can be amplified when you join forces with other groups and interventions.

How does this project fit into the broader mission and goals of your detailing program?

Jacki: Yeah, I agree 100 percent. The reach of detailing is just so much stronger when we get those community linkages in place. I just cannot emphasize that point enough. We're stronger together for sure.

Anna: Definitely.

Jacki: In terms of fitting into our current detailing program, so this is new for us. We have historically been focusing much more specifically on medication-focused detailing, things like antibiotic stewardship, appropriate care for attention deficit hyperactivity disorder, ADHD, appropriate care for asthma, initiating smart therapy, the single maintenance and reliever therapy for kiddos with asthma. It's a little bit of a natural offshoot.

Our program has historically been funded through CHIP, the Children's Health Insurance Program funding, which flows through Medicaid. That piece is still continuing. Most of the members that are covered by Medicaid are dealing with these SDOH factors.

It's a lot of times the folks with the highest need and the folks that are the most frequent utilizers of the resources that we're talking about, so food banks, utility assistance, SNAP benefits. Let me define SNAP there for you. I don't want to speak too much in acronyms. The Supplemental Nutrition and Assistance Program.

A lot of the folks that are already covered by Medicaid are in need of these very resources that we're trying to close the gap on. A lot of them are from an adult space, but what we do know is that when adult needs are met, then the children benefit too. The kiddos whose parents have their transportation needs met can get to their healthcare appointments. When food needs are met, then kiddos are better able to focus in the classroom. They're less prone to the kinds of behaviors that may lead to teachers possibly misidentifying a diagnosis and really just be medicating the effects of poverty rather than what's actually a true mental health condition.

If we can move forwards towards lessening the effects of poverty rather than medicating the effects, that's all to the good of both children and their parents.

Anna: Oh, 100%. How did you decide to partner with public libraries and faith communities for this project? I'm interested in learning more about that.

Jacki: So for those not necessarily familiar with Oklahoma, we are a fairly rural and trending towards poor state, definitely poor in terms of resources. We have multiple types of care deserts in Oklahoma. We have maternal care deserts. We have primary care deserts. Some of the recent reports say that less than a third of all of the or about a third of all the counties in Oklahoma have less than 11,000 people. And so that number typically can't support a hospital, maybe not even a clinic.

But one thing that every county, all the 77 counties in Oklahoma do have is we have pharmacies, public libraries, and faith-based groups. And so that's kind of where we started looking at where do we get the most access. Maybe we're not able to have folks that get in for their primary care appointments, but they can get in. They're coming to worship services on Saturdays, Sundays, Wednesdays, Thursdays, you name it. And they have daily access to the public library.

There's a different group, a different College of Pharmacy that's focusing on the pharmacy side of things. And so I want to shout out to them that that need is particularly being met by Southwestern Oklahoma State University College of Pharmacy, yay.

But we're focusing on public libraries and the faith-based groups. And so for me, full disclosure, I had a little bit of an inside track to know about all of the great public health work already being done by the libraries. My daughter Zoe is part of the communications team for the Oklahoma City Metropolitan Library System. And so I've kind of seen behind the scenes the kinds of things that they're doing. And so at the public library, you can borrow gardening

supplies, you can reserve HIPAA compliant booth for your telehealth appointments. You can access broadband internet services that maybe you don't have in your home. They offer Tai Chi classes, they have a mobile market that shows up with fresh produce. You can take a free GED class in order to qualify for a job that you've seen at the job postings at the library.

There's just so many different points of the SDOH needs that are already being touched by the libraries. And so it's a really great way to not duplicate efforts, but to capitalize on the great work that's already being done.

And then so for the faith-based groups, the Oklahoma Faith Network is one of our partners there and they're an ecumenical group. So that just means that they have partners that are part of the Islamic community. They have partners that are traditional Christian mainline denominations. They have non-denominational, they have Jewish organizations, lots and lots of different faith groups that they represent.

So it's a wonderful cross-section of the community. And they also are already doing some great healthcare work. They have some areas that they are particularly focusing on, criminal justice, poverty, health, anti-discrimination, anti-racism, immigration, environment, just kind of goes on and on. But specifically, one of the things that they have as their focus is that only seven counties in Oklahoma have the recommended number of primary care physicians. And so there are six counties, even in Oklahoma, with less than 0.5 primary care positions per 10,000 patients.

So I talked about those counties earlier that have less than 11,000 people. They have a halftime primary care for all of those people for all the time. So you can just kind of see where the needs are there. They also have a really great history of providing opioid and stimulant outreach, focusing on stigma, providing naloxone to the community. And they've also had a previous partnership with the Oklahoma Department of Mental Health and Substance Abuse Services. So again, just really kind of looking at what work is already being done out in the community that maybe hasn't typically been thought of as healthcare, but it 100% is healthcare. They're meeting sometimes direct healthcare needs and sometimes going through the SDOH pathway to improve the healthcare for people around.

Anna: Wow. And I mean, you've clearly done your research, Jacki, and I appreciate all that you shared about Oklahoma, as well as how you utilized your network with your daughter working in the communications department. Having that inside scoop is so helpful. And I hope that people who are listening will be able to use their networks as well, and maybe not in the traditional sense that they might think of when you say, hey, use your network to get your AD work promoted and out there. But thinking outside of the box, I really appreciate you sharing all of that.

You mentioned community health workers earlier in our conversation. What specific training will the volunteer community health workers be receiving?

Jacki: Yeah, that's a great question. That's probably the area where I personally have felt the most stretched, I guess you could say, because I am not a CHW. I don't have a public health background. And so we needed to bring someone on for this. And so it was really our first team expansion. We doubled our workforce in our little AD program from just me. And then it became me and Yajaira. And so Yajaira Valdez, shout out to her. She's a complete rock star, great background in community health.

She has her degree, her training in that area. She's working on advancing her training with an additional degree in that area. And she has just put together this really great training for the folks that maybe don't have any background at all in community health.

It's about a 16-hour long training, and we're providing it either online or in person. And it's addressing things like stigma, cultural competency, how do you educate and promote health in the community? How do you help folks connect with social support, that super important social support? And then just a smattering of disease prevention and control, focusing mostly on diabetes and cardiovascular kinds of things. And then also how do you help folks navigate the healthcare system? So like I said, it's about a two-day training on all of those particular topics.

Anna: How do you envision that these community health workers are going to impact or improve access to community resources that exist?

Jacki: So a lot of it is probably going to be serving as a repository for the information. Really just how do people get the services? Who do they need to call? What are the hours that the particular resources are open? Is it every Tuesday from two to five? Is it only on the weekends? So it's just very kind of practical things to help folks get access to the services that they're most in need of.

We envision them also assisting some bit with the application processes, sort of like case management for folks who wouldn't otherwise qualify for case management. So how do you help them apply for Medicaid? How do you get the paperwork completed so that they can get the utility assistance that they're needing? Those kinds of things. But one of the main advantages for having the community health workers be already in the communities is that they're part of the history. They bring an intuition. They bring a shared lived experience. They know when a community has had a shutdown of a distribution center. And so 200 people have lost their jobs. Those kinds of things. They know what's impacting the community and they know what works in their community.

So it's very much a situation where it can help address the nothing for us without us mindset there. There's a lot of great literature out there about the importance of already being a part of the community and then receiving the training in order to impact community health, rather than being someone from the outside who comes in and says, here, let me tell you how to fix this thing that you already know is existing in your community.

Anna: Yep. Really getting the community members involved in the work is so important. I want to talk a little bit about the content that you're going to be covering with your detailing. What are the primary health disparities associated with diabetes and cardiovascular disease that your project is focusing on?

Jacki: Yeah. Another great question. A lot of the specific factors that we're focusing on were predefined by the state health department for us. And so we have kind of some very specific metrics that we're going to be measuring, but a lot of these are based in the Healthy People 2030 initiatives.

And so I would really, really encourage all your listeners to go and just check out what's happening there in that Healthy People 2030 space. There's a lot of things that are associated with health disparities that you don't even necessarily think about. One of the things that I learned in this process is that one of their objectives is to increase voting. I never really thought of voting as a health promoting activity, but obviously how we vote changes the healthcare that we receive. And so one of the Healthy People 2030 initiatives is to increase

the percentage of people who are voting. So that's just a little bit of an aside thing that I learned in this process.

But one of the things, again, it's part of the Healthy People 2030 piece is to increase the social and community connections, helping people get the social support that they need in places where they are. Where are they born? Where do they live? Where do they learn? Where do they play? Where do they worship? Where are they with people of their same age peers? And so helping facilitate those connections. And I think it's a natural kind of offshoot, especially with the faith-based groups to increase the social and community connections.

It just helps people be healthier members of the community if they are engaged in the community. And then the next specific disparity that we're working on is healthy foods, fresh produce, and a lot of that comes through the library space as well as accessing food banks and those SNAP benefits that I mentioned. There's a double-up program that we have in Oklahoma where the SNAP dollars go twice as far if you purchase healthy produce. And so just letting people know that, hey, did you know that you get more bang for your buck when you go this pathway with it?

And then transportation is another one of the specific needs that we're focusing on. And so helping people understand where the free transportation options are. A lot of changes have happened in our state recently. We just made the transition to managed care for Medicaid. And so a lot of those managed care organizations are now offering multiple times per month where they can utilize, where people can utilize transportation options, not just necessarily for healthcare. Sometimes it's for job applications, sometimes it's to go to the grocery store.

And so there's a lot more options out there that people may not realize they have available to them. And then reducing stigma just across the board, specifically poverty-focused stigma is another one of our health disparities that we're focusing on. And then increasing health screenings.

So I talked about blood pressure screening and diabetes screenings is another one. Part of, again, the Healthy People 2030 is to increase the number of community organizations that provide prevention and screening services. And so you can kind of see that through line with the national priorities to the state priorities, to the local priorities.

Anna: As I'm hearing you and listening to you explain this, I'm wondering when your team is thinking about evaluation, how are you going to measure the project's success with reducing these health disparities, especially for outcomes that maybe are a little more difficult to measure?

Jacki: Yeah. It's not a small question. How are we going to figure out if we're doing what we think we're doing? How are we going to know what impact we're having? And so we spent quite a bit of time thinking through what that looks like and how exactly are we going to collect the information that we want to collect? Because there's going to be a lot of subjective kinds of reports, data, if you will, reflections from the community health workers. What have people told them? What have they defined as their successes? So kind of a narrative approach with a lot of the community health workers.

From more of an objective kind of standpoint, we're going to look at the number of screenings. So the number of clinics that are using the PREPARE tool, the number of healthcare systems that are using the PREPARE tool. We want to also look at from an objective standpoint, the number of team-based care loop referrals that are closed. So how many folks that have been

diagnosed with diabetes now have had a retinal scan when they didn't have one in the past year, two years, what have you? How many folks have been screened for chronic kidney disease if they have a diagnosis of diabetes? And so some of that comes from our existing partnership with Oklahoma Medicaid.

So we happily have access to paid claims on that side of things. And so we're able to identify some of those pieces and then figure out how to specifically target the very folks that are with the most need and then to measure those loop referral closures. We're also going to be reporting on the number of blood pressure screenings.

And so part of the way we're going to track that is the number of blood pressure devices that we're handing out. And so how many of those American Heart Association blood pressure devices are being used. For the community health worker survey piece, there's going to be, I mentioned having them address their narratives, but we also want them to do some self-reflecting.

What do they think about their role as community health workers? What do they think about how they're impacting the community and things like that? And then just raw numbers also of the number of community health workers changed or trained in the community. How are they engaging with which specific community care organizations? So that kind of will lead towards collecting the number of community partnerships developed. And then ideally the number of adults that are impacted.

That's probably going to be the hardest to kind of put a number to is exactly how many people did this touch. But those are some of our non-stretch goals. And then that last one's a bit of a stretch goal for us.

Anna: I mean, your team clearly has put in a lot of thought into how you're going to prepare for this project and run this project and evaluate it. So I'm looking forward to seeing the results. And it's always a stretch to want to see how many people that academic detailing has impacted. And it's a hard thing to measure.

Can you share any early successes or challenges that you've encountered in implementing this project so far?

Jacki: Yeah, we're still kind of early on in the process. The biggest successes I would say we've had is what I would characterize as an actually pretty easy buy-in from the Oklahoma United Methodist Church, from the Oklahoma Faith Network.

And then the, well, let me backtrack just a little bit. The Oklahoma United Methodist Church is a part of the Oklahoma Faith Network. But independently of their relationship with the Oklahoma Faith Network, they have decided that they want to have a community health worker in all of their churches across the state.

And so that was, yeah, we were just a little bit blown away by just how readily that was accepted. And so one of their key pillars that they're focusing on is improving health and reducing the effects of poverty. And so it was just kind of a natural sort of relationship that developed there. So like I said, they intend to roll this out for all of their churches. And so that's about 300 community health workers across the state, ideally.

And as I mentioned, Oklahoma Faith Network, and then really the American Heart Association, that was another one. It just almost kind of dropped in our lap. We had someone on our team that was on a Project ECHO and the person on the ECHO just happened to mention that we

were doing this project. And so then the Heart Association team, shout out to Megan, reached out to us and said, hey, what are you doing? Can I help? What can I do? And we were like, hey, you got some blood pressure cuffs. We'd love to have some cuffs. And she was like, done, done, and done. Okay.

Yeah. And then of course the library, you know, just can't say enough about all the great things. We had such an initial embracing of the topic from the library. It's just, those particular partnerships really went very seamlessly. And so we're in the process of getting feet on the ground for those groups. And then we'll kind of see where else it goes.

The My Health space is in more of the initial phases and it probably has a little bit more challenge associated with it. Because we're talking about people's data and particularly sensitive data in some cases, you know, has someone been incarcerated? Are they dealing with job insecurity? What's their income? Those are more sensitive issues than whether or not someone has a diagnosis of something different and potentially has the impact to cause people a little bit of discomfort. And so that's been one of our challenges is who has the data? How are they collecting it? How willing are they to share it? And then what happens during the sharing process so that everyone's information is preserved, nothing is shared outside of their consent and those kinds of things. So that's probably our biggest challenge is the area of the data management.

Anna: That's definitely a challenge that I've heard other folks working on different detailing projects that has come up quite a bit - managing data and especially health data and sensitive topics as the ones that you're working on.

I have one more question for you, Jacki. What advice would you give to other organizations looking to launch similar public health detailing projects?

Jacki: Oh, wow. That's such a great question. I think a lot of it is very state specific and so I would say look at the goals of your state. Where are the drivers of change looking in your state? Are they looking at insulin? Access to different pieces of care? Are they looking at childhood poverty? School lunches? Whatever it is that is happening in your state, start looking there and see where your team can find a gap that they feel like they can fill.

And it may mean thinking outside of the box. It may mean that you hire someone with a public health background when everyone else that works there is a pharmacist. So maybe you start thinking down some different lines that you maybe you weren't thinking about before.

And then you can look broader, look nationally, like I mentioned a few times, Healthy People 2030. An amazing amount of areas of focus there so if you start thinking about how can my organization impact whatever this particular need is that I didn't even know was out there can really get the wheels turning and help you realize that maybe you have some skills and resources that you didn't even know you had that could come to play in some areas that you didn't even know existed.

Anna: Thank you, Jacki, that is great advice and thank you so so much for joining us today. Your insights have been incredibly valuable and I am sure that our listeners will take away a lot from this conversation. Thank you again, Jacki, for being here and we look forward to catching up with you after you get this project moving in the field.

Jacki: It has completely been my pleasure. Thank you so much – I really enjoyed it!

Anna: Thank you!