

THE COMMUNITY PHYSICIANS' NETWORK (CPN): AN ACADEMIC-COMMUNITY PARTNERSHIP TO ELIMINATE HEALTHCARE DISPARITIES

Introduction: Disparities in health care are maintained by three primary factors: 1) patient factors which include multiple risk factors and comorbidities; 2) healthcare practitioner factors comprising inconsistent application of practice guidelines due to a limited database of clinical trials of effective therapies in African Americans and other underrepresented minorities; and 3) barriers in the healthcare delivery system resulting in poor access to care. The Morehouse School of Medicine Community Physicians' Network (CPN) was established to address disparities in health care by focusing on provider-specific strategies.

Objectives: To: 1) use disease-specific registries to identify treatment gaps and facilitate quality improvement processes among CPN practices; 2) develop practice-specific and guideline-based educational messages to promote quality care; 3) engage and train CPN-physicians for participation in approved NIH, other government, and industry-supported clinical protocols; and 4) develop a data repository of all CPN-sponsored clinical trials that include significant numbers of African Americans and other underrepresented minorities.

Methods: The disease-specific outpatient registries will have the following features: 1) data structures and data elements will use standard database codes and a data dictionary; 2) HIPPA-compliant data abstraction and data transfer tool; 3) baseline chart review to establish practice patterns and provide practice-specific feedback; 4) annual update of registry; 5) data registry and repository maintained on Morehouse School of Medicine's secure servers; 6) registry publications will include only aggregate data, without identification of contributing practices; 7) an electronic medical records platform will be encouraged as the ultimate data management tool for CPN practices. In addition, up to three continuing medical education (CME) programs each year will feature national speakers and promote evidence-based practice guidelines.

Results: Eighty-five primary care and subspecialty practices are actively enrolled in CPN with a total of 385,000 annual outpatient visits. The makeup of insurance status is: HMO/PPO (45%); Medicare only (19%); Medicare HMO (11%); Medicare plus (8%); Medicaid (6%); Uninsured (11%).

Conclusions: The Community Physicians' Network will address specific gaps in the

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INTRODUCTION

Lost in Translation

Major progress in the basic sciences has significantly increased our understanding of disease causation and created opportunities for treatment and prevention. Yet, the enormous growth in the biological, physical, and information sciences over the past several decades has not produced comparable benefits at the bedside. A translational bottleneck continues to impede the transfer of scientific knowledge from the bench to the bedside. This

health care of African-American and other minority patients by promoting quality care among its members and by facilitating participation in approved clinical trial protocols. The unique academic community partnership is consistent with the NIH roadmap goal of eliminating healthcare disparities. (*Ethn Dis.* 2005;15 [suppl 5]:S5-124-S5-127)

Key Words: Practice-Based Research, Quality Improvement

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translational gap is most noticeable for African Americans and other underserved minority patients.

Multiple factors interact to promote and maintain such disparities in health care: 1) patient factors such as risk-factor prevalence and poor adherence to lifestyle or pharmacologic interventions; 2) healthcare practitioner factors such as inconsistent application of clinical practice guidelines due to limited evidence-based, effective therapies for African Americans and other underserved populations; and 3) healthcare delivery system barriers such as poor access to ambulatory care and inconsistent continuity of care plans from inpatient hospitalization to outpatient care.

The influence of race, ethnicity, and socioeconomic status (SES) is recognizably profound, but difficult to measure, due to the complex interactions of human behavior and health outcomes.^{1,2} Race, culture, and SES interact at all levels of the healthcare delivery process from patients' trust, knowledge of, and access to the healthcare system, to patient-provider interactions, and adherence to treatment recommendations.^{1,3} Further compounding these interactions is the history of unethical medical experimentation on ethnic minorities and the institutionalization of race and racial bias in America.⁴ Only recently, a report from the Institute of Medicine confirmed that racial bias plays a major role in the diagnosis and treatment of patients.⁵

The history and economics of medicine also contribute to disparities, given the segmentation of the current healthcare delivery model, such that ethnic

minorities and the poor (sometimes indistinguishable) are generally served by large urban inner city health centers. These centers generally serve as the teaching hospitals for research-intensive institutions. Therefore, much of our knowledge about health disparities is based on data from the teaching centers, the Veterans' Administration hospitals or administrative databases such as Medicare.^{6,7} Such data are central to the formulation of national practice guidelines and treatment recommendations.

Practicing physicians are often faced with conflicting recommendations on treatment strategies in minority and underrepresented populations, due to limitations of these data.⁸ The recent landmark AHEFT trial,⁹ which enrolled more than 1100 African-American patients and showed dramatic survival advantage of a nitric oxide enhancing therapy, compared usual heart-failure care among participants and points to the value of bold new strategies in clinical trial implementation.

Further research, as well as potential solutions, must shift to the community, where a socioeconomically, ethnically, and culturally diverse patient population receives care.

Although community practitioners are starting to participate in multi-center clinical protocols, the data usually remain with the sponsoring agency, most often pharmaceutical companies, and are therefore generally not accessible for analysis. Additionally, there is no incentive for longitudinal follow-up beyond the confines of the clinical trial. Most importantly, ethnic minorities—including patients and physicians—remain severely underrepresented in these clinical protocols.

Strategies to improve healthcare disparities must, therefore, involve a fundamental paradigm shift to a process of care that encourages and tests systems that will facilitate such inclusion. A major objective of the NIH roadmap is to increase the participation

of community-based physicians in clinical research, in order to develop regional and national networks that will support clinical trials in diverse populations.

The Morehouse Community Physicians' Network (CPN) is a consortium of primary care and multi-specialty community-based healthcare practitioners in partnership with Morehouse School of Medicine. The CPN goal is to eliminate health disparities through innovative educational programs, practice-based interventions, and clinical research participation. The mission of CPN is to promote evidence-based medical care through participation in quality improvement programs and to foster the highest standards of clinical research and good clinical practice.

The consortium will promote equity in health care by expanding the African-American practitioner base in clinical research, increasing participation of African Americans and other ethnic minority patients in clinical trials, and supporting "best practices" by actively promoting quality care of minority patients. By bringing together the science of academic medicine with the real world practice of the community where most patients receive their health care, CPN has a tremendous opportunity to positively influence health outcomes for African Americans and other under-served minority patients.

The objectives of the network are to: 1) use disease-specific registries to identify treatment gaps and facilitate quality improvement processes among CPN practices; 2) develop practice-specific and guideline-based educational messages to promote quality care; 3) engage and train CPN physicians for participation in approved NIH, other government, and industry-supported clinical protocols; and 4) develop a data repository of all CPN-sponsored clinical trials that include significant numbers of African-American and other underrepresented minorities.

METHODS

CPN Governance, Organizational Structure, and Membership

The network is governed by the policies of Morehouse School of Medicine (MSM) and membership criteria include:

- Full-time MSM clinical faculty member with active clinical practice at Morehouse Medical Associates.
- Part-time or volunteer clinical faculty member licensed to practice medicine or surgery in the State of Georgia. Non-MSM employed private practitioners, including alumni, whose practice demographics includes at least 30% ethnic minorities (African Americans, Hispanics, Asians, Native Americans, Pacific Islanders, and Alaskan Natives).
- Member of the Southeast Regional Primary Care Consortium.

Volunteer clinical adjunct faculty appointment with MSM is encouraged but not mandated for non-MSM faculty.

Volunteer partner organizations include local hospitals, state and local professional organizations and academic centers that have pledged support and participation in network research and education initiatives.

Hospitals and professional associations include: Association of Black Cardiologists (600 members); Atlanta Medical Association (250 members); Consortium of Southeastern Hypertension Control (COSEHC); Georgia State Medical Association (375 members); American Heart Association; Atlanta Medical Center, South Fulton Hospital, South West Hospital.

Academic partners include Duke University, University of Alabama Birmingham, and Medical University of South Carolina. Each will work with MSM to establish the database and registries of CPN.

The advisory board advises the steering committee on the prioritization of the research agenda based on clinical practice relevance and potential impact on healthcare disparities. The advisory board has four CPN members and a chair who serve up to two-year terms as elected by members of the CPN. The chair of the MSM CRC Community Advisory Board and the director of the Information Dissemination Core of the Health Disparities Center also serve on this board. The at-large member is a community physician. By helping to shape the research agenda, this board ensures ties to the community for participant recruitment and dissemination of research findings. The board meets once each year on the MSM campus.

The steering committee has four members including the PI or director of the network consortium, the research director of the Morehouse CRC, the director of the Biostatistics and Data Coordinating Center (BDMC), and the chair of the CPN advisory board. The steering committee oversees the design of study protocols and the preparation of data for publication.

The database committee includes four members from participating professional societies and/or academic partners and the chair of the Duke University Clinical Research Institute (DCRI). The database committee provides advice and consultation to MSM database and informatics personnel on the necessary elements of the data registries and clinical trial repository. This committee also advises the steering committee on issues related to data integrity, compliance with privacy regulations, data analysis, and dissemination and publication of results.

The four-member data and safety monitoring board provides oversight of all study protocols within the CPN consortium in order to ensure protection of human subjects per institutional and NIH guidelines and compliance with the Health Insurance Portability and Accountability Act (HIPAA). The chair of

the MSM institutional review board or designee and the research subjects advocate from the CRC also serves on this board, along with two at-large community members, one of which is a non-physician lay person.

Operational Strategies

A regional educational strategy focuses on practice-based disease-specific registries. Through initial pilot funds from the National Center for Minority Health to the MSM's Center of Health Disparities, and a subsequent award from the Medtronic Foundation, CPN has initiated hypertension and heart failure registries. The hypertension and heart failure outpatient registries have the following features:

1. Data structures and data elements that use standard database codes and a data dictionary.
2. HIPAA-compliant data-abstraction and data-transfer tools.
3. Baseline chart review to establish practice patterns and to provide practice-specific feedback.
4. Annual update of registry.
5. Data registries maintained on MSM's secure servers.
6. Quarterly confidential reports on quality improvement and process-of-care measures to each participating practice.
7. Registry publications including only aggregate data, without identification of contributing practices, as approved by the steering and database committees.
8. An electronic medical records platform encouraged as the ultimate data management tool for CPN practices.

The hypertension and heart failure regional registries will inform practice-specific educational efforts and drive regional or national educational initiatives in collaboration with CPN organizational partners.

Up to three continuing medical education (CME) programs per year will feature national and regional speakers.

Continuing medical education (CME) programs use aggregate analysis from the registries to inform the workshops and tutorial sessions, thus ensuring relevance and practicality to CPN member practices.

A national clinical research strategy focuses on training and certification of CPN physicians and their study coordinators for participation in NIH, other government, and pharmaceutical-sponsored clinical protocols.

Clinical research training manuals include standard modules such as human subjects protection, the role of the institutional review board, good clinical and laboratory practices, and the role of FDA and other regulatory agencies in the clinical trials process. The manuals also include sessions on the history of experimentation on African Americans and other minorities, as well as sessions on the legacy of the Tuskegee syphilis studies.

Other unique features of the CPN clinical research training program include simultaneous training of study coordinators and the use of trained and certified site-management teams in order to ensure protocol compliance.

RESULTS

Eighty-five primary care and subspecialty practices are actively enrolled in CPN, with a total of 385,000 annual outpatient visits. Of patients seen in the practices, the insurance status has been reported as follows: HMO/PPO (45%); Medicare only (19%), Medicare HMO (11%), Medicare plus (8%), Medicaid (6%), Uninsured (11%).

The hypertension and heart failure registries have a total of 800 patients enrolled; target enrollment of 2000 will be completed by December 2005. The heart failure registry alone has 350 patients currently enrolled; recruitment of new practices is underway.

CPN-conducted, CME, interactive, practice-based workshops were conducted and well-attended in December

2004 and April 2005; a third workshop is planned for October 2005.

CONCLUSIONS

The Community Physicians' Network will address specific gaps in the care of African-American and other minority patients by promoting quality care among its members and by facilitating participation in approved NIH, other governmental, and industry-supported clinical trials.

CPN is a unique program designed to reduce disparities in the care of African-American, Hispanic, and other under-served minorities by focusing on two key strategies: quality care and clinical research participation. This unique academic community partnership is consistent with the NIH roadmap goal of eliminating healthcare disparities through research participation. Finally, CPN and its organizational partners are positioned to lead the effort for appropriate risk adjustments to ensure that the current calls for 'pay for performance'

and other quality improvement initiatives will indeed lead to improved health care for minority patients.

ACKNOWLEDGMENTS

The Morehouse Community Physicians' Network is supported by NIH grants # 5P20RR11104 to the Clinical Research Center; grant# 5P20MD00272 to the Healthcare Disparities Center; grant # 5U54RR14758 to the Center of Excellence in Clinical Research; and The Medtronic Foundation. Sanofi-Synthelabo Inc has provided an unrestricted educational grant toward partial support of CPN physicians' training. CPN also acknowledges its organizational partners and hospitals: the Association of Black Cardiologists; the National Medical Association; the Georgia State Medical Association; the Atlanta Medical Association; the Consortium of Southeastern Hypertension Control and Grady Memorial Hospital. CPN thanks the many practices that have completed practice demographics for inclusion in the registries.

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