National Medical Association & Sepracor Collaboration Offering Updates in Patient Management

NEW VOICES
IN PATIENT MANAGEMENT

a highlights newsletter developed from educational information presented at the National Medical Association 2003 Meeting

TABLE 1 Bridging the Gap: Recommendations for Improving Access and Quality of Health Care for the African-American Population

- Increase the number of African Americans in clinical trials
  - Ensure clinical trials involving medications for the treatment of asthma include a percentage of African Americans representative of the actual population
- Improve and expand educational opportunities for primary care physicians practicing in inner cities (eg, better assessment skills, medication use, effective use of specialty care when appropriate)
- Increase the number of providers and specialists dealing with asthma
- Improve assessment tools – focus on time-sparing/easy administration for busy primary care physicians
- Make physicians accountable for outcomes
- Develop and enhance physician outreach programs, such as the Zero Action Asthma Mortality Program, which aspires to reduce the incidence of asthma to zero by 2010
- Increase the use of media, particularly TV and radio, as educational tools

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In coordination with the National Medical Association

National Medical Association

Asthma in minority communities has become a healthcare crisis. While asthma rates have steadily increased among all age groups, genders, and racial groups since the 1980s, recent reports show the greatest increase among African Americans, Hispanics, and the underserved inner-city population. In fact, African Americans are 3 times more likely than whites to be hospitalized from asthma and 3 times more likely to die from the disease. These increases have occurred despite improvements in medical treatments. One underlying factor is lack of knowledge by physicians in the inner cities about asthma and its effective treatment. Greater asthma prevalence, morbidity, and mortality among minorities is highly correlated with poverty, urban air quality, indoor allergens, lack of patient and physician education, inadequate medical care, misuse of medications, and lack of resources in the communities. It is with these facts in mind that the symposium entitled *Health Disparities in the Community*, which was supported by a grant from Sepracor, was conducted at the NMA 2003 Annual Convention and Scientific Assembly. This newsletter contains highlights from the conference.

Concerns and goals for improving respiratory healthcare within the African-American population were outlined as an introduction. Data obtained from HMO plans reveal disturbing trends; people of different ethnic groups with identical living situations are not receiving the same quality of healthcare for asthma. Specifically, African Americans more frequently end up in the emergency room, do not get the same medications, and are not referred to specialists at the same rate as other patient populations. We have to "figure out ways to bridge that gap."

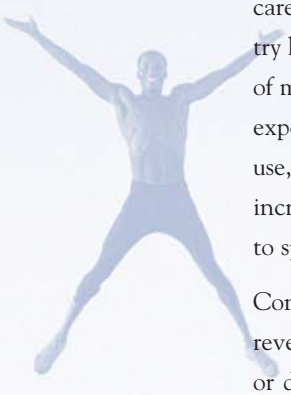
To improve access and overall quality of health care, the points listed in Table 1 were emphasized.

MANAGED CARE AND THE MINORITY PHYSICIAN

Despite dissimilarities that exist between policies throughout the country, managed care may significantly impact physician practices, particularly for minority practitioners. For example, managed care corporations

generally prefer large medical networks, healthy patient populations, and large corporate contracts, which may work against minority physician practices in urban communities.

Dr Cheryl L. Walker, Allergist at Emory University, is currently involved in a large study intended to evaluate the impact of managed care on physicians, including minority physicians. This study will examine the influence of physician practice parameters on asthma management. Qualitative interviews with 100 healthcare experts and 200 physicians from across the country have been completed. Some of the positive aspects of managed care identified by the respondents include expenses for preventive care, oversight of healthcare use, and cost control, while negative factors include increased paperwork and limitations on patient access to specialists and treatment plans.



Concerns specific to the minority physician were revealed in the survey. Some physicians report delayed or decreased access to managed care contracts, while some feel managed care plans reject their claims, reimburse at low rates, and do not allow adequate access to specialists.

TABLE 2 Managed Care Study: Interpretation of Qualitative Survey Results

- Managed care organizations may not impact physician behaviors as much as initially anticipated
- Resources that focus on protocol and guideline development may not be the most effective way to manage asthma or improve asthma care in minority communities
  - Use national organizations to enhance direct communication with primary care physicians in order to address specific issues (eg, how to grade asthma severity)
- Specific indications for using spirometry for objective assessment still need to be identified
- Creative methods are warranted to influence physicians to provide care that is more consistent with national guidelines

To determine whether differences exist between physicians within managed care systems in terms of diagnosis and treatment, objective measurements of asthma severity and medication use were assessed. The assumption was that doctors in managed care systems would be influenced to provide care based upon procedural guidelines. Preliminary data indicate asthma severity rating is highly subjective. When physicians were presented with a case vignette, responses about the severity of the patient's asthmatic condition ranged from mild intermittent to moderate persistent. In addition, inconsistencies were noted in in-office spirometry use. Although the decision to use certain asthma drugs was influenced by access to medications on managed care formularies, maintenance medications were chosen based on grading of disease severity. Conclusions drawn from these findings are listed in Table 2.

Dr Walker summarized the results of the initial data by emphasizing that managed care may influence access to certain resources and medications, but the impact of managed care on actual asthma management by all physicians, not just minority physicians, does not appear to be as significant as previously thought.

HARLEM CHILDREN'S ZONE ASTHMA INITIATIVE: FROM HOME TO SCHOOL TO HOSPITAL

The prevalence of asthma in elementary school children living in Harlem is estimated to range from 10% to 15%. Asthma is the leading cause of admission to Harlem Hospital, accounting for 25% to 30% of all admissions. To further quantify the problem of respiratory disease and address the issues through more extensive resource allocation, a comprehensive children's asthma program was started in September 2001. The site for the project encompassed a 24-block area in central Harlem called the Harlem Children's Zone. Various organizations and establishments, such as the New York City Department of Health and Mental Hygiene and Columbia Hospital, which includes Harlem Hospital, were committed to the project.

Dr Vincent Hutchinson, Assistant Director of Pediatrics and Chief, Division of Allergy and

Immunology at Harlem Hospital Center, New York, described the program. He explained that the clinical team consists of principal investigators, allergists, general pediatricians, nurse clinicians, social workers, and community health workers. The multiple phases of the program are presented in Table 3.

To date, 1901 patients have been screened; 494 (26%) have been identified as asthmatic, twice the prevalence estimated at the inception of the project. In terms of baseline characteristics for the 1901 patients screened, 90% have health insurance and 21.7% were exposed to tobacco. Two years into the study, investigators have determined that rates of tobacco exposure are approximately 30% higher for individuals diagnosed with asthma compared with patients without asthma. Furthermore, specific apartment buildings with large numbers of asthmatic patients were identified. Additional findings reveal that large percentages of asthmatic patients visit the emergency room or doctor's office, suffer sleep disturbances, and miss school. Most are under-medicated; only 24% take daily medications.

The program is ongoing. Of the 494 screened patients with asthma, 247 are now enrolled. Data thus far show the rate of asthma in Harlem is 4 times the national average (26% versus 6%). Although data are still being generated, the prevalence of asthma in the first group of patients screened, coupled with the findings of substantial undertreatment, indicates the need for additional efforts to improve environmental and healthcare practices in inner-city communities.

TABLE 3 Harlem Children's Asthma Project: Multilevel Program Design

STAFF TRAINING AND RECRUITMENT

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SCREENING PHASE
- Questionnaire for each child to take home: Request information about demographics, asthma diagnostic history, insurance coverage, physical examination history
- Examination of lungs: Evaluate for wheezing and perform peak flows
  - Children who are wheezing are put on priority list to enroll in program
  - Identify those not yet diagnosed with asthma, but who are symptomatic

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ENROLLMENT PHASE
- Obtain approval and consent

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EVALUATION
- Home assessments: Examine rooms for dust, mold, tobacco exposure, pests, vermin, and pets. Evaluate basic infrastructure of the building
- Interviews every 3 months for first year and twice a year for the next 3 to 4 years
- Record clinical symptoms and hospitalizations

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EDUCATION
- Direct education: Provide information about asthma triggers and medication. During home visits ask patients/parents to point out asthma triggers and discuss what they can actively do about them
- Indirect education: Send letter to the primary care physician with information about specific asthma triggers found in the patient's home, severity of symptoms, and medication recommendations

BRIEF UPDATE ON ASTHMA TREATMENT: β_2 ADRENERGIC RECEPTOR AGONISTS

The 4 key components in the management of asthma are: (1) Maintain control with the smallest amount of medication. (2) Maintain a normal, healthy lifestyle. (3) Avoid exacerbations. (4) Incrementally increase or decrease treatment based on asthma severity.

Acute exacerbations are mainly treated with a short-acting bronchodilator, such as albuterol. FDA-approved in 2002 for use in children ages 6 to 11 years, levalbuterol is the R isomer of racemic albuterol. Its current indication is the treatment or prevention of bronchospasm in adults, adolescents, and children with reversible obstructive airway disease. Studies demonstrate that lower doses of levalbuterol are required to increase FEV_1 compared with racemic albuterol. Preliminary data reveal decreased rates of hospitalization with administration of levalbuterol.

SEPRACOR AND THE NATIONAL MEDICAL ASSOCIATION

The National Medical Association (NMA), along with other national physician groups, is working on independent approaches to overcome the growing problem of asthma in minority communities. Sepracor understands the importance of developing and integrating solution-oriented strategies and has partnered with the NMA in an effort to effectively address mutual concerns by establishing the following goals:

- Exchange scientific information and create an environment of open communication to increase respiratory knowledge within the NMA and discuss key educational priorities within Sepracor
- Identify specific opportunities and initiatives to decrease asthma severity, morbidity, and mortality in the African-American and Hispanic populations
- Facilitate a better understanding of problems caused by limited access to medication
- Create and reveal evidence-based medicine findings appropriate for NMA physicians and their patient populations

This partnership has had a positive impact on many sections within the NMA. Dr Anne M. Staveren, Allergy and Immunology, says, "In the midst of an allergic pandemic it is crucial to educate clinicians on state-of-the-art asthma therapy. The partnership between Sepracor and the NMA's Allergy and Immunology Section has provided invaluable education for primary care practitioners taking care of asthmatic patients. The intense Asthma Certification Course allows a positive discourse between physicians and provides academic and practical medical education. Sepracor has facilitated the National Medical Association being in the forefront of continuing medical education and erasing health disparities in underserved communities." Dr Christopher Ervin, Emergency Medicine, comments, "Asthma is a primary cause of visits to the emergency department. Often the visits are a result of inadequate or relapsing treatment. This reality is most prevalent in African-American communities. Sepracor's involvement with the Emergency Medicine Section and the NMA will help address these issues. By bringing together the relevant stakeholders in the treatment of this still devastating disease, our partnership with Sepracor should advance the treatment of asthma in a manner that is truly needed." Finally, Dr Gideon Adegbile, Family Practice, believes that a good relationship has begun between Sepracor and his section, as well as the NMA as a whole. "The Sepracor-sponsored Respiratory Symposium, part of the Family Practice Section Scientific Program in Philadelphia this past summer, was a great success. Future collaboration has unlimited potential. I believe the community at large is the ultimate beneficiary of this relationship." □

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