Wetmore Comprehensive Center : Fostering TB Patients for Establishing Primary Care. A One-stop Care Coordination Model. Initial Analysis of A Pilot Process Improvement Program.

Priyanka Jadhav, Ph.D., Gabrielle Boudoin, MPH, Regina Miles, FNP-Bc, Amy Wolfe, MD.

Section of Pulmonary /Critical Care/ Allergy and Immunology, LSUHSC, New Orleans, LA.

INTRODUCTION

Background

- For over 50 years, the Wetmore Tuberculosis clinic in New Orleans has been providing TB care to the area residents through adult and pediatric pulmonary and infectious disease faculty from LSUHSC and Tulane University Health Sciences Center.
- It has also served as a teaching site for medical and public health students, residents and fellows; providing them unique experiences in evaluating and managing TB in long term.
- The Louisiana Dept. of Health charges us to evaluate patients for active or latent TB as a referral site and provide medical and nursing follow up and management of TB.
- Managing other co-morbidities and care coordination in this TB clinic has always been challenging.

Program Vision

- To build a pilot model, local Center of Excellence for comprehensive TB care coupled with structured primary care coordination.

OBJECTIVES

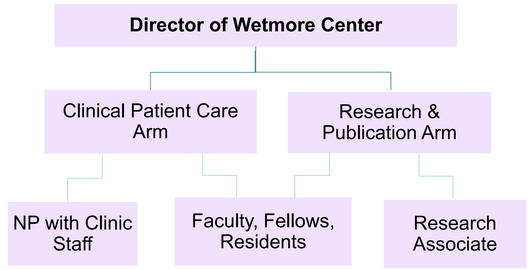
1. To provide care to all patients with TB by establishing pathways of primary and specialty care and specially focusing on indigent, uninsured, underserved, and underinsured patients.
2. To create a long-term platform for collecting data, conducting research and publishing manuscripts with the collaboration of Office of Public Health (OPH) and Academic Centers.

METHODS

To implement objective No. 1, we adopted following methods:

The work on the project started through the Wetmore Grant in November 2022.

ORGANIZATIONAL STRUCTURE OF PROGRAM



- In the subsequent 5-months, a total of 110 TB patients were seen and interviewed regarding their PCP information and follow-up.

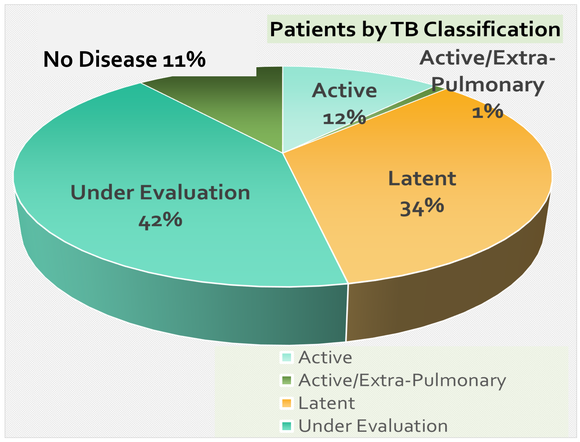


Fig. 1. Patients categorized based on TB type

- We tracked total number of Wetmore TB patients encountered with MD/clinic or nurse evaluation visit and divided them in 3 groups based on Primary Care Follow up (PC):

Group 1: Those with a robust established PC
Group 2: With Intermittent/sporadic PC
Group 3: Those with no PC at all.

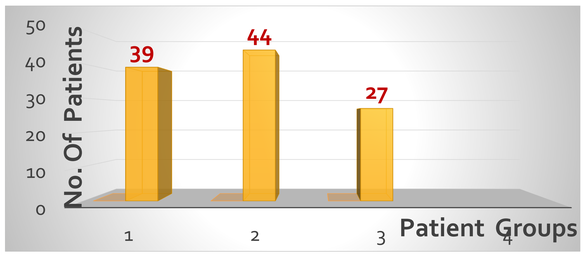


Fig. 2. Patient groups based on PC tracking

- **We further assessed patients based on :**
  - HIV and other comorbidities: HTN, DM and COPD
  - Shelter History/Homelessness
  - History of Incarceration
  - History of previous TB treatment
  - Country of origin/ Immigration Status.
- **We identified following Barriers to PC**
  - Language barrier
  - Transportation to/from PCP appointments
  - Health literacy and awareness
  - Family support (especially for elderly or pediatric patients)
  - Prescription drug access or lack of pharmacy and cost of non-TB meds
  - Work schedule/childcare challenges
  - Lack of adequate insurance.

RESULTS

The action Items undertaken to eliminate challenges:

- Language barriers: iPad, internet-based video-translator device and referrals to the Latino Health Clinics at West Jefferson and other health systems were implemented.
- Family support (elderly/pediatric patients): The coordination with local and social services and charities was intensified.
- Transportation to/from PCP appointments: Some shelters and clinic offer transportation, and this was further explored.
- Health literacy: Onsite education with information brochure was provided.
- Prescription drug access or lack of pharmacy and Medication cost: Our NP put together a list of low-cost medications either through coupons/patient assistance programs or supporting Charity programs.
- Specialized care/Dental care: Partnership and connections with health systems like LCMC/UMC and Healthcare for the Homeless through the City of New Orleans Medical Director's office are being reconfigured and strengthened.
- Patients in Group I were encouraged to "stay the course" and continue their regular follow-up with close communication with the Wetmore clinic. Patients in Group II were encouraged to re-establish regular visits and contact with their physician of choice and those clinics were informed of these patients with records exchanged for future reference. Patients in Group III were directly referred to providers, including UMC and Healthcare for the Homeless Clinics, if they were amenable to that referral.

CONCLUSION

- We will continue to adapt our resources to our ongoing patient needs and present our follow up report in one year with more evaluation and outcome data. As we move forward with this concept, we hope to enumerate research projects and publications which may emanate from this approach as part of the research and quality improvement arm of this project.
- If successful, this model could be adopted by other TB units in the country.
- The upcoming plan is to create an Evaluation Tool to see how this program works.

ACKNOWLEDGEMENT

1. Wetmore Clinic Faculty and Staff.
2. Office of Public Health.
3. Wetmore Trust.
4. Healthcare for Homeless.
5. Dr. Juzar Ali, (Mentor).

REFERENCES

1. Baluku, J.B., *et al.* Prevalence of cardiovascular risk factors in active tuberculosis in Africa: a systematic review and meta-analysis. *Sci Rep* 12, 16354 (2022).
2. Jesus, Gabriela S et al., The effect of primary health care on tuberculosis in a nationwide cohort of 7·3 million Brazilian people: a quasi-experimental study, *The Lancet Global Health*, Volume 10, Issue 3, e390 - e397, (2022).