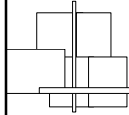


# Changing Practice Changing Lives



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## *The Health Disparities Collaboratives*

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*Colorado Community Health Network (CCHN)*

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## What is a Collaborative?

- A collaborative is an intensive, concentrated effort to facilitate breakthrough transformations in the clinical and operational performance of clinical teams and their organizations, based on what already works.
- The entire effort is an evidence-based approach using ideas that are known to work effectively at the clinical sites, and in the management information systems.



## 4 Types of Collaboratives

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1. **Disease Systems Collaborative**: Chronic and Acute Conditions
2. **Prevention Systems Collaborative**: Diabetes prevention, CA screening, general prevention
3. **Business Systems Collaborative**: Access, patient flow, fiscal, Redefine
4. **Community Systems Collaborative**: Perinatal, patient safety, and workforce development



## Goals of the Health Disparities Collaboratives

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- Generate and document improved health outcomes for underserved populations;
- Transform clinical practice through models of care, improvement and learning;
- Develop infrastructure, expertise and multi-disciplinary leadership to support and drive improved health status; and
- Build strategic partnerships.

## ***Deficiencies In Current Systems***

Health System  
focused on the  
diagnosis and  
treatment of  
acute  
conditions and  
symptoms

- Rushed practitioners unable to follow established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure optimal management and outcomes
- Patients inadequately trained and supported to manage their illnesses

## **History of the Health Disparities Collaboratives**

**IHI (Don Berwick)**

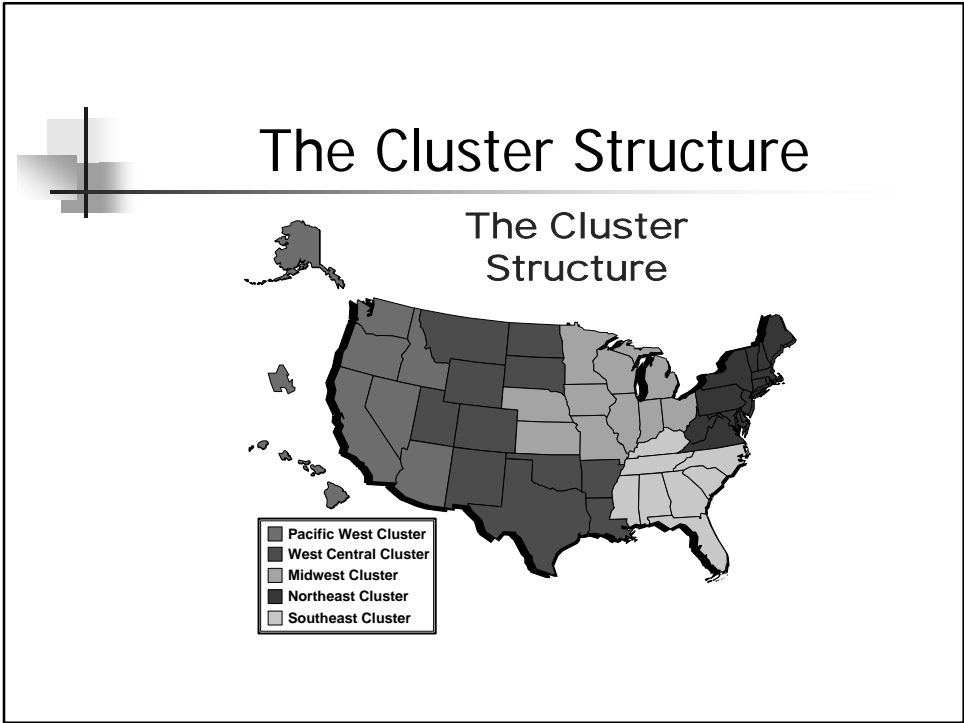
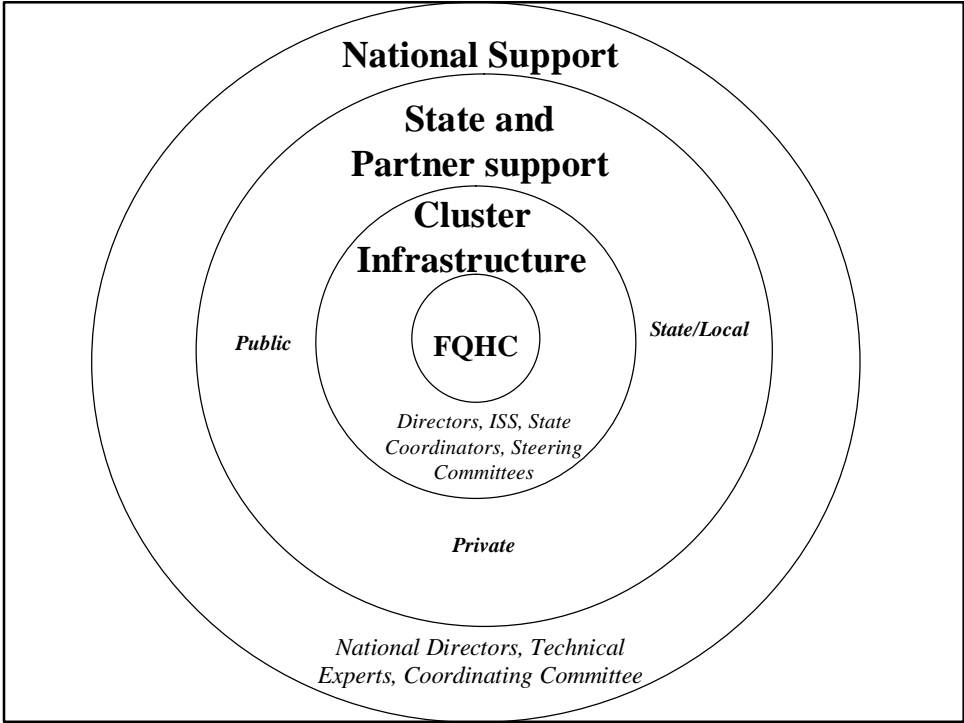
**5 Health Centers**

**EXCELLENT HEALTH OUTCOMES**

**657 Health Centers**

**Over 900 Teams**

1998 —————> 2005

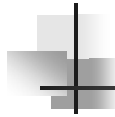




## WCC Goals

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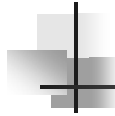
- To assist centers in implementing the Care Model and Model for Improvement
- To establish the capacity and infrastructure to develop, promote, and disseminate positive and lasting breakthrough changes in the primary care delivery system
- To assist centers in the spread and sustainability of positive changes
- To improve the health status of those served by the WCC health centers
- To build collaborative relationships with state, regional, cluster, and national partners



## Training, Development and Special Projects

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- Lead: Connie Sixta
- Development of a performance based training curriculum
- Incubation and dissemination of new models, curriculums and other activities to further spread and sustain
- Development and implementation of special projects such as the Self-management curriculum and Access/Redesign



## Data Management and Technical Support (DMTS)

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- 2 IS Specialist and data programmer
- In coordination with Training and Special projects and Team Support group provide:
  - Support for PECS registries and users
  - Assistance with Measure Graphs Templates
  - Facilitate communication of data and IS issues among project participants
  - Maintain consistency nationwide among Cluster IS Specialists in CIS support
  - Develop staff and team support tools and resources
  - Administer Computer Based Training site
  - Data analysis



## Team Support Group

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- Team leader, 6 coordinators and a program assistant
- In coordination with Training and special projects and DMTS group provide:
  - Comprehensive Phase I and Phase II support
  - Proactive team management to ensure 100% reporting and participation
  - Technical assistance through conference calls, site visits, report feedback, cluster based conferences
  - Assist CHC's across the cluster support implementation, sustainability and spread
  - Foster open, positive relationships with partners to promote active coordination of Collaborative activities
  - Support and implementation of special projects



## WCC Leadership

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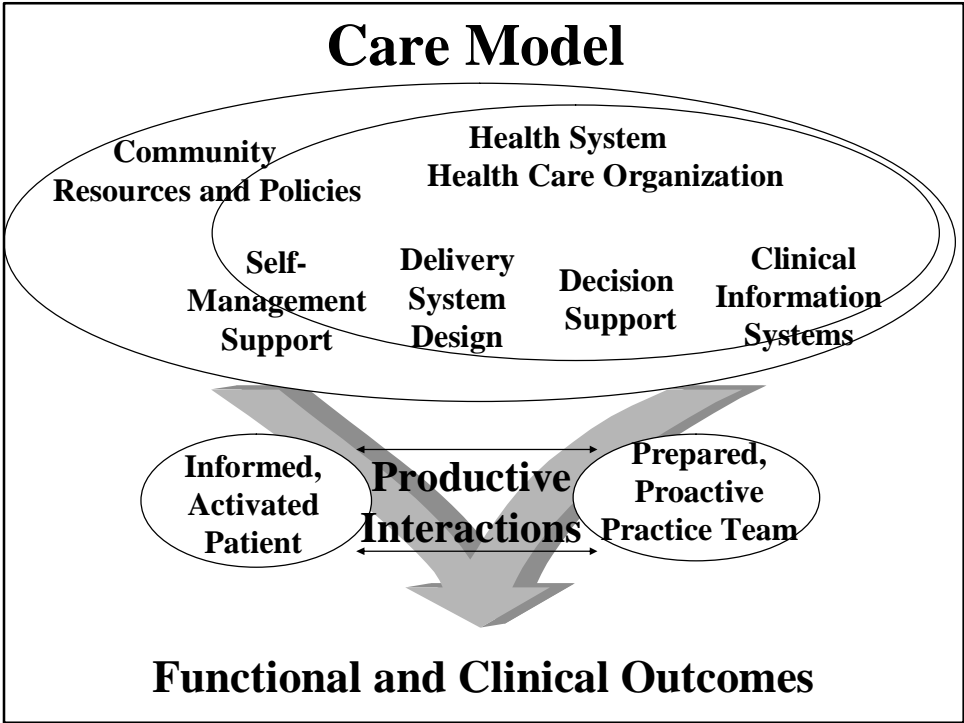
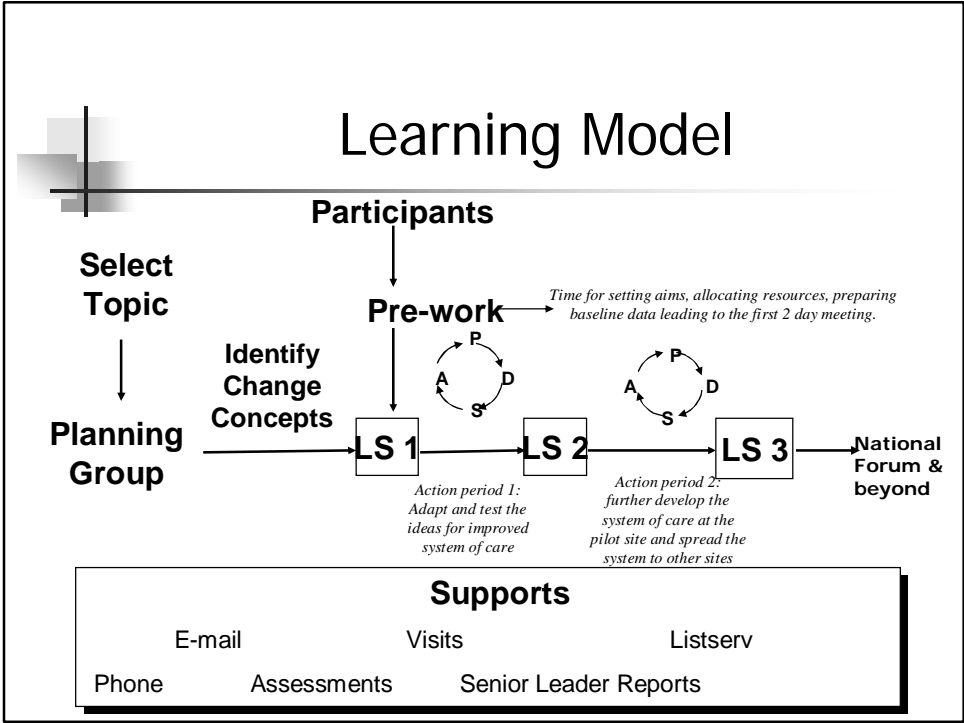
- Steering Committee: Advisory group of clinicians, CHC senior leaders, PCAs, network affiliates
- WCC PCAs: Participating partners that support cluster infrastructure and state based activities
- Clinical Network: Assists with the linkage of clinical resources



## Three Models of the Health Disparities Collaborative

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- ❖ ***Learning Model:*** A performance-based learning method that supports a community of learners to apply, adapt, share, and generate knowledge, and spread positive change
- ❖ ***Chronic Care Model:*** A population based model that relies on knowing which patients have the illness, assuring that they receive evidence based care, and actively aiding them to participating in their own care.
- ❖ ***Improvement Model:*** (AKA: PDSA Cycle) How to test changes in a system of care in a fast & efficient way, ensures that changes are an improvement, and expands the changes throughout the practice





## Organization of Health Care

- Make improving chronic care a part of the organization's vision, mission, goals, performance improvement and business plans.
- Make sure senior leaders actively support the improvement effort by removing barriers and providing necessary resources.
- Board education packets and monthly updates.



## Community Linkages

- Raise community awareness through networking and education
- Use of lay workers to link to communities and as resource to health center community
- Community assessment performed to determine strengths and needs



## Self-Management Support

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- Create a self management goal sheet for set and document SM goals.
- Group visits formatted to educate and provide support.
- Culturally competent patient education materials
- Train staff to set self management goals



## Decision Support

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- Embed evidence-based guidelines in the care delivery system.
- Establish linkages with key specialists to assure that primary care providers have access to expert support.
- Educate patients about guidelines.



## Delivery System Design

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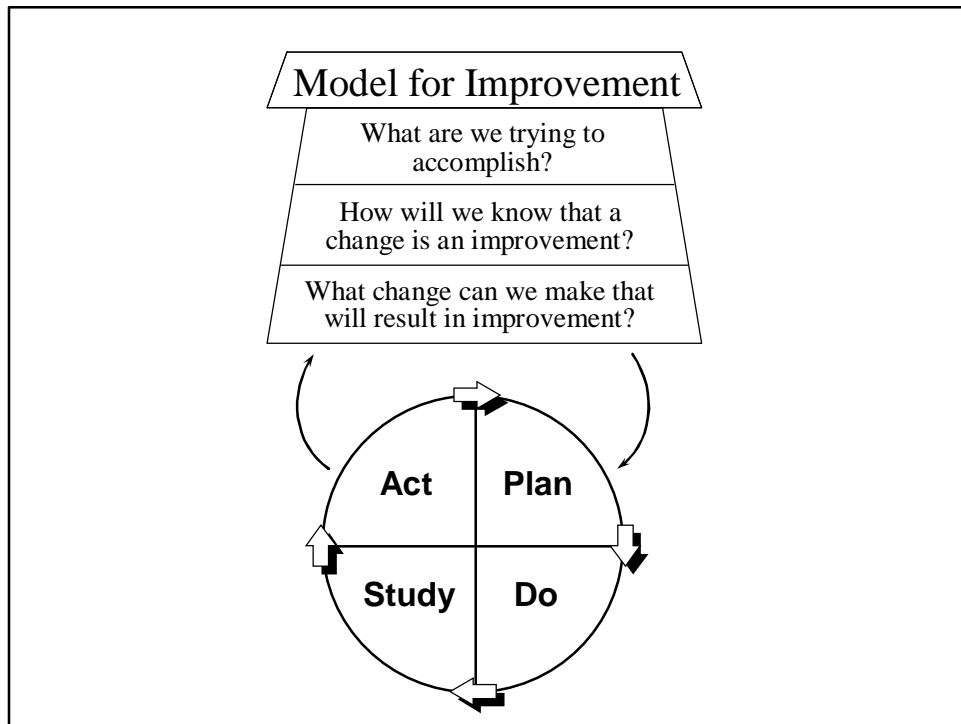
- Assign roles, duties, and tasks for planned visits to a multidisciplinary care team. Use cross-training to expand staff capability.
- Make designated staff responsible for follow-up by various methods, including outreach workers, telephone calls, and home visits.



## Clinical Information System

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- Develop processes for use of the registry, including designating personnel for data entry, assuring data integrity, and registry maintenance.
- Use the registry to generate reminders and care-planning tools for individual patients.



## What Are We Trying to Accomplish?

- ✓ Focus on System-Wide change
- ✓ Implementation of the Care Model
- ✓ Measurable Component

## How will we know that a change is an improvement?

A collaborative is about changing a participating organization's approach to the topic of the collaborative

**It is not about measurement. But .....**

- Data base management and measurement are key components of the Care Model.
- Key outcome measures are required to assess progress on a team's aim.
- Specific measures are required for learning about the components of the Care Model.

## What Change Can We Make That Will Result in Improvement ?

- The Care Model describes concepts that, if implemented, will improve care.
- Previous chronic care collaboratives have developed additional ideas that have worked in practice.

## To Be Considered a PDSA Cycle

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- The test or observation was **planned** (including a plan for collecting data).
- The plan was **attempted**.
- Time was set aside to **analyze** the data and study the results.
- Action was rationally based on what was learned.

## Why Test?

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- Increase your belief that the change will result in improvement.
- Document how much improvement can be expected from the change.
- Learn how to adapt the change to conditions in the local environment.
- Evaluate costs and side-effects of the change
- Minimize resistance upon implementation.

## Testing on a Small Scale

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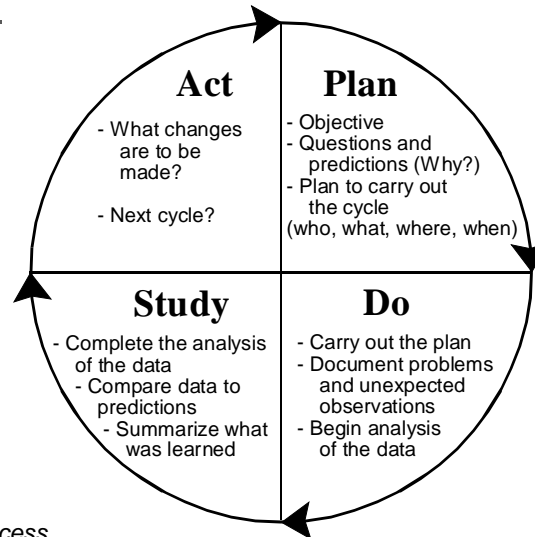
- Test the change on the members of the team that helped developed it before introducing the change to others.
- Incorporate redundancy in the test by making the change side-by-side with the existing system.
- Conduct the test in one facility or office in the organization, or with one patient.
- Conduct the test over a short time period.
- Test the change on a small group of volunteers.

## Suggestions for Measurement and Data Collection During PDSA Cycles

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- Collect useful data, not perfect data. The purpose of the data is learning, not evaluation.
- Use a pencil and paper until the information system is ready.
- Use qualitative data rather than wait for quantitative.
- Record what went wrong during the data collection.

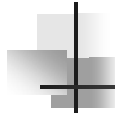
## The PDSA Cycle for Learning and Improvement



*Associates in Process*

## Jessica's PDSA: THE PLAN

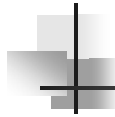
- Purpose of this cycle/what am I testing? :
  - To increase my activity by parking at a distance from stores when running errands.
- Prediction: I expect to increase my activity by at least 500 steps by parking far away from the store, cleaners, and post office.
- Data: I will need to collect the number of steps I walk while running errands. I will use a pedometer to count the steps and review it after I am finished running errands.



## Jessica's PDSA: DO, DO, DO!!!

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- What was actually tested? The increase in activity by parking at a distance from stores, post office, and cleaners.
- What happened? I went to three stores, the pos office, and the cleaners – all different locations. I parked as far away as possible in the parking lot, when I returned home, my pedometer read 3,250!
- Observations: It didn't seem to add a lot of time to my errands overall. It was VERY easy to find a parking space.
- Problems: When I had to carry bags, it go a bit tiring at times. Also there was a thunderstorm in the afternoon and I got a bit wet.



## Jessica's PDSA: How am I going to ACT on this Plan?

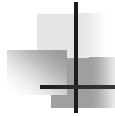
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### What Did I Learn?

- My test to increase my activity by parking at a distance worked! I didn't realize how much of a difference that a simple change could make. I will remember to carry my raincoat from now on, and maybe even consider bringing a small backpack if I know I am going to be carrying multiple packages.

### What changes should I make before my next test cycle?

- Put my raincoat or umbrella in the car



## PDSA 101 Exercise

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- Identify an area that needs work to assure implementation of a change in your health center.
- Apply the model for improvement to this area
  1. Write a PDSA cycle
  2. What barriers might keep you from carrying out an initial cycle "by next Tuesday?"



## What Are We Learning?

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- Health Centers can generate knowledge on improving primary & preventive care at the practice and system levels
- Collaborative learning processes generate results faster than individual consultation – but this cannot be done on a volunteer basis.
- A business case for all the activity needs to be shared with all of the Health Centers so we can understand the impact of the cost.
- Improvements can be accelerated by using State and National infrastructure, leadership, and partnerships.

## **Everyone Needs to be Aware of the HRSA Strategic Goals (2005-2010)**

- GOAL 1: Improve Access to Health Care
- GOAL 2: Improve Health Outcomes
- GOAL 3: Improve the Quality of Health Care
- GOAL 4: Eliminate Health Disparities
- GOAL 5: Improve the Public Health and  
Health Care Systems
- GOAL 6: Enhance the Ability of the  
Health Care System to  
Respond to Public Health Emergencies
- GOAL 7: Achieve Excellence in  
Management Practices

## **Overall Timeline of the HRSA Health Disparities Collaboratives**

- 2004: Re-design into Primary Health Care Collaborative (PHCC)
- 2005: Demos of Integration
- 2006: Integration of All Demos
- 2007: Complete all Health Centers
- 2008: 16 Million Patients in the Registry
- 2009: Collect Data on PHC Outcomes
- 2010: Be ready to report as a system on outcome measures on all 16 million



## Reaching 16 Million by 2010

- Systems Change with improved process/outcomes in preparation for P-4-P Health Care Industry Market Reality  
**Example: California HMOs bonus payments to medical groups if they could document the quality of their care (reputation no longer good enough in this incoming context).**
- Providing outcome based care across the life span: prevention, acute care and chronic disease.
- Focus looking at the care delivery mechanism and maximizing efficiency to provide patient centered comprehensive care when needed and where needed.




## What's In It For Me? (Or, Why Do We Do The Collaboratives?)

- Some Benefits....
  - Improved practice – the same models can affect every diagnosis
  - Eliminate Clinical Outcomes – reporting to BPHC and HRSA
  - Meet BPHC directive to participate by 2006
  - Obtain additional grants by promoting participation and outcomes
  - Provides a tool for documenting successes
  - Enhance recruitment of new patients and patient satisfaction
  - Enhance recruitment and retention of providers and staff
  - Assist with Accreditation compliance (JCAHO, NCQA, AAAHC)
  - Opportunity to publish findings/data about HDC outcomes
  - Basis on which to build organizational performance improvement plan and Health Plan



*“A Day In the Life of a  
Team Member”*



Day to Day Tasks of Team Leaders  
& Supporting Team Members

- Education!
- Engagement of clinic staff and providers in the HDC
- Organizational Skills
- Team meetings and/or huddles
- Reporting: Monthly and quarterly reports



## How Does the WCC Support You?

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- Quarterly Team Conference Calls
- Site Visits
- Staff training
- PECS Registry Support
- Community Linkages
- Web Based Trainings
- Annual Conferences



## Who You Going To Call?

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- State Coordinator – New Mexico and portions of West Texas
  - Celeste Frangeskou ([cfrangeskou@tachc.org](mailto:cfrangeskou@tachc.org))
  - (512)329-5959
- State Coordinator - Utah:
  - Kimberly Mueller([ccc@auch.org](mailto:ccc@auch.org))
  - (801) 974-5522
- IS Specialist
  - Dan Martin ([dmartin@cchn.org](mailto:dmartin@cchn.org))
  - (303) 861-5165 X231
- WCC Team Support Manager, Colorado, Oklahoma and Louisiana Coordinator
  - Jessica Sanchez ([jessica@cchn.org](mailto:jessica@cchn.org))
  - (303) 861-5165 X231
- Program Assistant
  - Margaret Mills ([mmills@cchn.org](mailto:mmills@cchn.org))
  - (303)861-5165 X225



## Listservs

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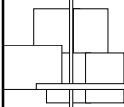
- WCC Phase 2 Team Listserv- Contact your State Coordinator to be added
  - [wccphase2@tachc.org](mailto:wccphase2@tachc.org)
- Health Disparities National Web Page:  
[www.healthdisparities.net](http://www.healthdisparities.net)



## Websites

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- Texas Association of Community Health Centers (TACHC)
  - [www.tachc.org](http://www.tachc.org)
  - <http://www.tachc.org/HDC/Overview.asp>
- Institute for Healthcare Improvement (IHI)
  - <http://www.ihc.org/>
- Health Disparities Collaboratives (HDC)
  - <http://www.healthdisparities.net>



## Questions/Comments

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