

When You've Lost that Loving Feeling Putting the Fun Back into Collaborative Work

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Health Disparities Collaborative (HDC)

- National Effort to achieve strategic system change in the delivery primary healthcare.
- An innovative health initiative that seeks to
 - Improve health outcomes for underserved populations
 - Transform the clinical practice through evidence based models
 - Develop infrastructure, expertise and multi-disciplinary leadership to improve health status
 - Build strategic partnerships to support the care
 - Expectation that changes would spread throughout the entire center and be applied to all chronic care conditions.

HRSA Health Disparities Executive Summary July 2005

National Priorities

- Targeted Disease Conditions are selected on the following criteria:
 - Significant health care cost and human burden
 - Evidence based guidelines exist
 - Best practices or outcomes are measurable
 - Variations in care exist - care is suboptimal
- Practice strategies differ for acute care medicine, chronic care disease management and proactive preventive based medicine.
 - Center's practice systems need to handle every facet of care
 - Move towards total population management

Background

- Started with Diabetes in 1998
- Currently branched into:
 - Cardiovascular Disease
 - Depression
 - Cancer
 - Asthma
 - Pilots – Perinatal, Diabetes Prevention, Prevention, Finance/Redesign

Outcomes at a glance....

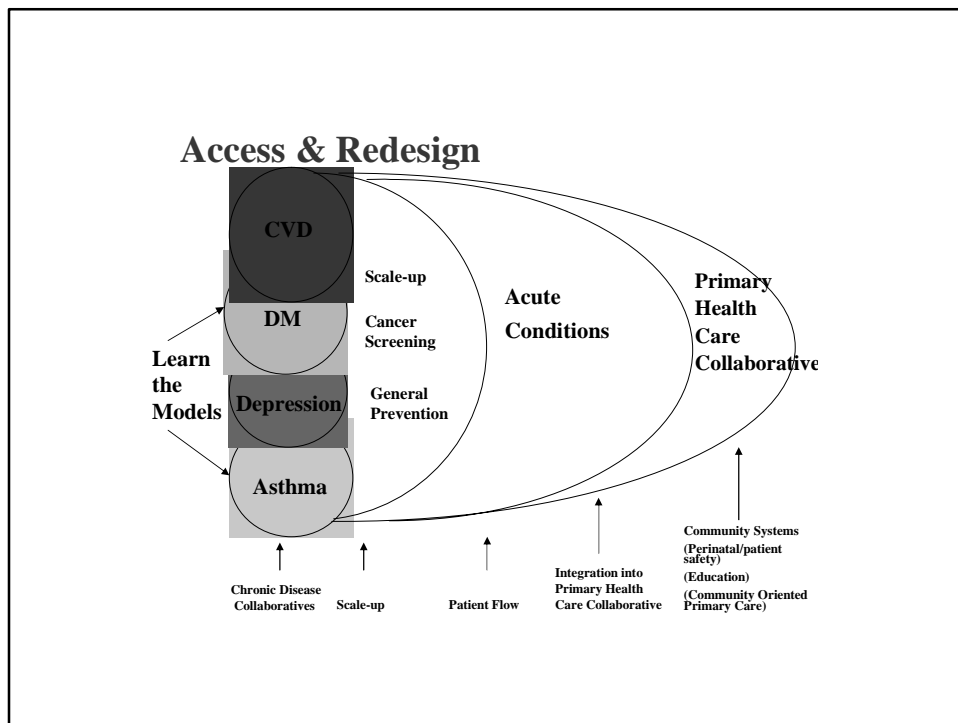
- 350,000 patients in registries to track/manage care
- Major improvement in glucose and blood pressure control
- Appropriate use of drugs for asthma
- High rates of follow-up and improved symptoms for depression
- Significant increase in patient self-management
- No show rates have decreased from 48% to 18%
- Waits and delays for an appointment and during an appointment have significantly decreased while continuity of care has increased.

The HDC Transition

- Six year initiative – 90 million dollars
- Initial chronic care disease focus which utilized the models transform the practice and develop the infrastructure, expertise and multi-disciplinary leadership to improve health status of patients
- Expectation that changes would spread throughout the entire center and be applied to all chronic care conditions.

The HDC Transition

- 2006 emphasis is on the institutionalization of QI methodology for total systems change and creation of a comprehensive clinical quality system.
- The work will move from a national to a regional and then ultimately a state level.
- Inclusion of quality into health center grant guidance.
- 2010 goal of scale up to total population management and the creation of the primary health care collaborative.



Overall Strategic Timeline of the HRSA Health Disparities Collaboratives

- 2004: Re-design into PHCC
- 2005: Demos of Integration
- 2006: Integration of All Demos
- 2007: Complete All Health Centers
- 2008: 16 Million Patients in Registry
- 2009: Collect Data - PHC Outcomes
- 2010: Be ready to report as a system on Outcomes Measures on All 16 M

Total Population Management

- Moving away from disease specific sub-populations to total patient initiatives
 - Operational gains need to be made to improve the business considerations for the center
 - Clinical Information Systems and Health Information Technology will play a larger role
- Adoption of a quality driven culture will become essential as the whole center is impacted

Pilots/Demonstrations

- Prevention
- Cancer Screening
- Fiscal
- Access & Redesign
- Perinatal & Patient Safety
- Diabetes Prevention

“Crossing the Quality Chasm”

A New Health System for the 21th Century

Don Berwick, IHI, President & CEO

Report of the Institute of Medicine’s Committee on Quality of Care in America

- “Between the health care we have and the care we could have lies not just a gap, but a chasm.”
- In it’s current form, habits and environment, American health care is incapable of providing the public with the quality health care it expects and deserves.
- Labels the problem as design, not people and then it asks for a change

Defining the Problem

- Complications associated with chronic care diseases can be prevented or delayed.
- Studies in multiple practice care settings demonstrate that care is suboptimal and that a gap exists between recommended care standards and actual practice patterns.
 - The current care systems **cannot** do the job
 - Trying harder **will not** work
 - Changing care systems **will**

It's a System Issue

The Office for Disease Prevention and Health Promotion found that

- There is no correlation between the attitude of the provider and actual practice pattern.
- A system or model of care is needed to ensure that desired clinical care is a routine part of every patient encounter*
- The goal: to *change* the system so that in the future we can do what cannot be done today.

*Leninger LS, Finn L, Dickey L., Deitrich AJ, Foxhall L, Garr D, et al.
Arch Fam Med. 1996;5 108-115

What is our Mission?

- To create equity in healthcare.
 - Minorities are disproportionately affected by chronic illnesses and associated complications.
 - Face unique healthcare challenges
- “Every Single One”
 - The password to pursuing perfection
 - The poorest amongst us have every right to the same level of healthcare that the majority enjoy.
- Community Health Centers
 - Safety net providers

**Every Starfish in the Sea
Matters**

Every Single One

To change the system so that in the future we can do what cannot be done today.

To sow the seeds of social justice and equity of healthcare for all.

Creating a Quality Driven Culture

- Involve the whole healthcare team and leverage their expertise – in every aspect of clinic practice and the change process.
- Define optimal care from current evidence based medicine
- To measure your progress through indicators as a means of driving system change.
- To know who your patients are and what services that they are in need of.

The Burden of Chronic Disease

- Nearly 125 million people in the United States live with some kind of chronic medical condition
- Accounts for 70% of all deaths in the U.S.
- Accounts for more than 60% of nation's medical care costs
- Direct cost of care is \$510 billion per year

Source: Health Disparities Collaborative Pre-work Manual, May 2003; Collaborative Charter Problem Statement

The Burden of Chronic Disease

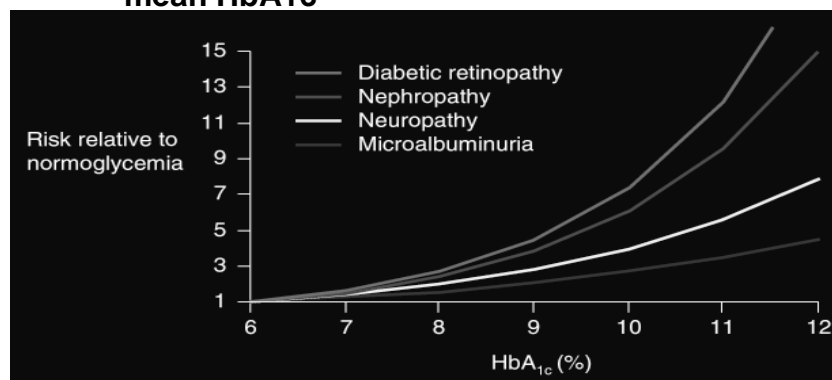
- Prevalence and costs are expected to rise by at least 15% by 2010 and 60% by 2050
- 50% mortality from the ten leading causes of death is attributable to lifestyle behavior

Diabetes – Case Study

- The American Diabetes Association has regularly defined standards of care for patients with diabetes.
- These standards are consistently underutilized.
 - Leading cause of :
 - Blindness
 - Renal Failure
 - Lower Extremity amputation
 - Cardiovascular disease is the major cause of mortality for individuals with diabetes

DCCT

Risk of progression of diabetic complications by mean HbA_{1c}*

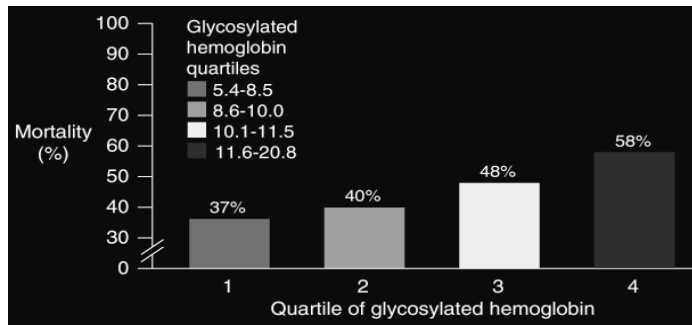


*Extrapolated from DCCT data

Skyler JS. Endocrinol Metab Clin North Am. 1996; 25:243-254.

Wisconsin Epidemiologic Study

10-year mortality by quartile of glycosated hemoglobin* in older onset patients with diabetes (n=1370)



*Glycosated hemoglobin =sum of HbA1 fractions HbA1a, HbA1b, HbA1c
P<.005 association of glycosated hemoglobin with all-cause mortality

Adapted from Moss SE, et al. Arch Intern Med. 1994; 154:2473-2479

UKPDS Glycemic Control Study Summary

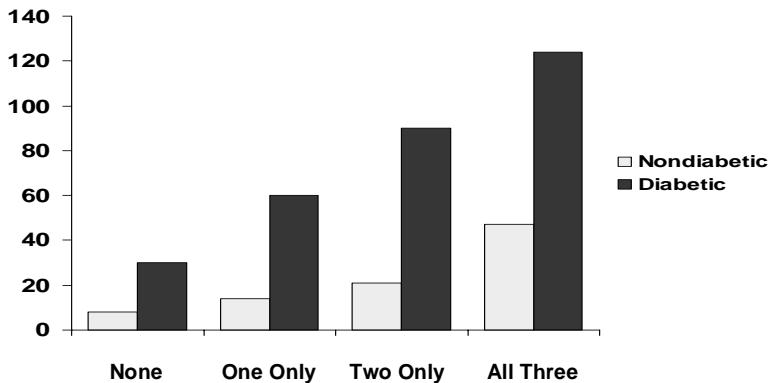
The intensive glucose control policy maintained a lower HbA1c by mean 0.9% over a median follow up of 10 years from diagnosis of type 2 diabetes with reduction in risk of

12%	for any diabetes related endpoint	p=0.029
25%	for microvascular endpoints	p=0.0099
16%	for myocardial infarction	p=0.052
24%	for cataract extraction	p=0.046
21%	for retinopathy at twelve years	p=0.015
33%	for albuminuria at twelve years	p=0.000054

Intensive glucose median =HbA1c level of 7.0% vs. 7.9% p<0.001

Influence of Multiple Risk Factors* on CVD Death Rates in Men With and Without Diabetes

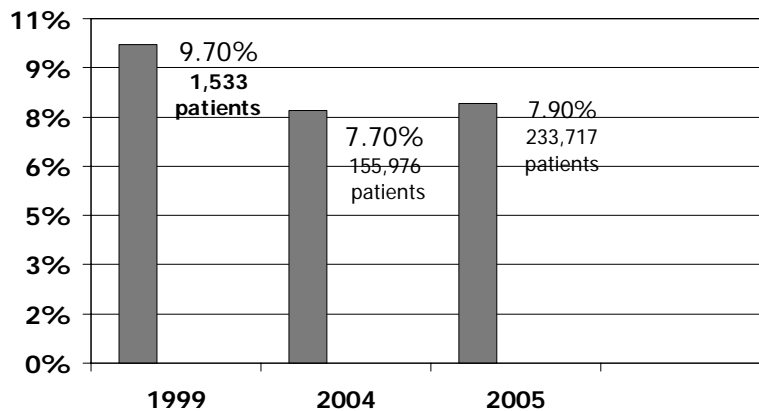
CVD Death Rate Per 10,000 Person Years



* Serum cholesterol >200 mg/dl, smoking, SBP >120 mmHg

Stamler et al, Multiple Risk Factor Intervention Trial, Diabetes p. Care 1993, 440

Average HbA1c Results (HDC National Goal < 7.0%)



Average HbA1c: <7.0%

- WCC Cluster (January 2006)

7.9%

Registry Size 36,380

- Nationally (June 2005)

7.9%

Registry Size 233,717

Patients w/2 HbA1c's: > 90%

- WCC Cluster (January 2006)

34%

- Nationally (June 2005)

33%

Registry Size 233,717

**Patients with Blood Pressure
< 130/80 > 40%**

- | | |
|------------------------------|-----|
| ■ WCC Cluster (October 2005) | 34% |
| ■ Nationally (June 2005) | 37% |

**Patients with LDL < 100;
> 70%**

- | | |
|------------------------------|-----|
| ■ WCC Cluster (January 2006) | 56% |
| ■ Nationally (June 2005) | 49% |
| Registry Size 233,717 | |

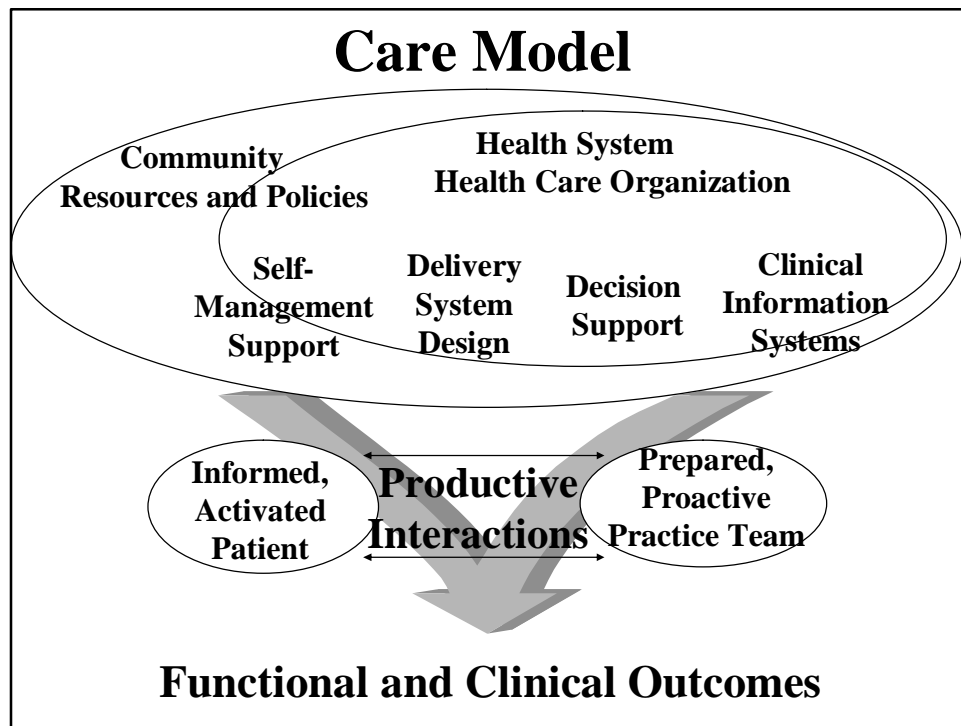
Self-Management Goals

Documented: > 70%

- | | |
|------------------------------|-----|
| ■ WCC Cluster (January 2006) | 30% |
| ■ Nationally (June 2005) | 39% |

Chronic Care Disease Model The Center for Health Studies

- Organizes the care of a population of patients with chronic diseases
- Addresses a mix of effective interventions to improve office performance
- Care becomes proactive rather than reactive, where there are missed opportunities to improve overall care and/or meet care goals



What characterizes a “prepared” practice team?

Prepared Practice Team

Patient information (i.e. lab data) is organized and readily available to the team. The team utilizes evidence-based guidelines to manage care and prevent illness. The team has time to teach the patient , provide self-management support, and follow-up on Outcomes.

Clinical Information System: Registry

A registry defines your total population of patients
– know who your patients are.

- Provide reminders for care that is due at the time of the visit and remind the provider who is due for a visit.
- Provides feedback for providers and patients.
- Identify relevant patient subgroups and provide proactive care. (Those that are in need of better management)
- Facilitate individual patient care planning through the registry.

Clinical Information System: Examples

- Populating PECS for your center.
- Running monthly reports
 - Patients who haven't been seen in the past year.
 - Patients who have an HbA1c > 9.
 - Practice level reports - where is the gap?
- Using those reports to verify data integrity:
Identify 5 patients and do a chart review to see if what is in PECS is accurate.

Decision Support

- Embed evidence-based guidelines which describe stepped-care into daily clinical practice.
- Integrate specialist expertise into primary care.
- Defines what the standard of care is.
- Inform patients about guidelines pertinent to their care.

Delivery System Design

- Define roles and delegate tasks amongst team members.
- Use planned visits to support evidence-based care.
- Integration of standing orders.
- Build “effective” case management functionality into practice
- Assure continuity by the primary care team.
- Assure regular follow-up.

What characterizes a “informed, activated” patient?

**Informed,
Activated
Patient**

Patient understands the disease process, and realizes his/her role as the daily self manager. Family and caregivers are engaged in the patient’s self-management. The patient manages his own care according to guidelines. The provider is viewed as a guide on the side, not the sage on the stage!

An Essential Shift in Chronic Care Disease Management

Putting the patient back into the center of their care

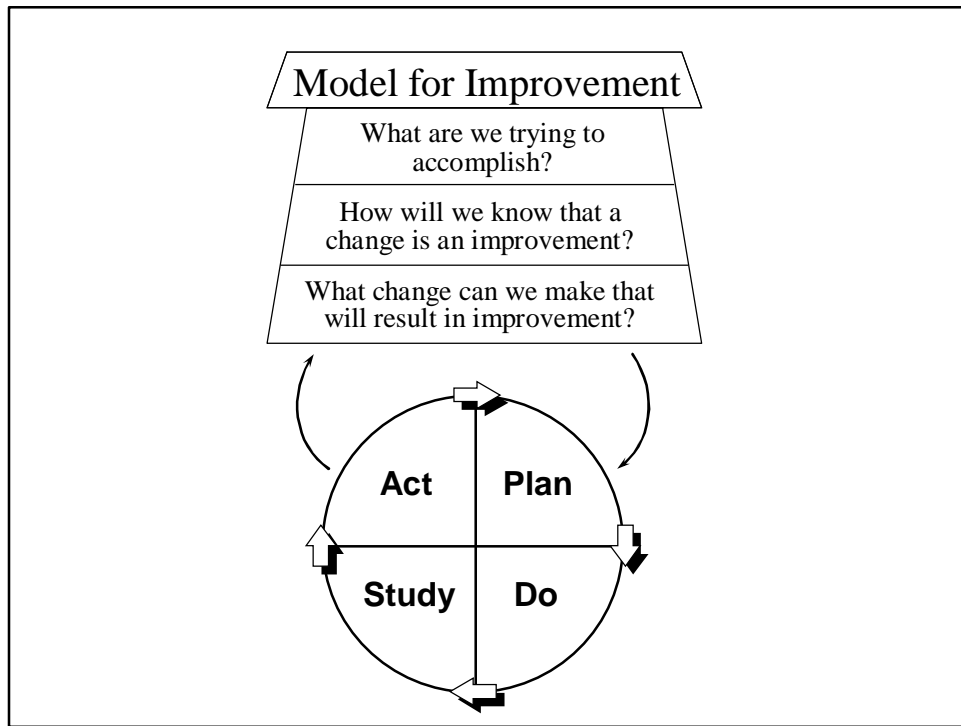
- Between 95-99% of chronic care illness care is delivered by the patient who has the illness.
- **Noncompliance** can be defined as the doctor and the patient working toward different goals.
- Acknowledges their place on the health care team.
- A team is a group of people that work together to achieve a common purpose and are mutually accountable to each other.
 - Share responsibility for the ultimate outcome.
 - The work could not be accomplished independently.

Community

- Create linkages with existing community resources
- Use of state based partnerships such as the state health department
- Educational materials from pharmacy reps.
- Working within the community to help patients meet self management goals.

Health Care Organization Concepts (from BPHC)

- Accepted part of the work of the organization.
- Upper management visibly supports the work through dedicated time and resources
- Part of the center's annual goals
- The board understands and supports the work.
- Population based disease management is an expectation for all who work at the center.
- Duties of staff are in job descriptions and evaluations.



Principles of the Improvement Model

- All improvement requires change
- Not all change results in improvement
- Organized and deliberate change can and does lead to improvement

Characteristics of the Improvement Model

- Action oriented – “What are you going to test by next Tuesday?”
- Rapid-cycle of testing changes
- Evaluation and revision of all changes before implementation
- Testing and implementing the changes in small populations, then spreading to the larger population
- Impact evaluated using annotated run charts.
- Monthly reporting of tests and outcomes

Befriending Change

To change the system so that in the future we can do what cannot be done today.

Of Mice and Men

Who Likes Change?

- **Early Adapters**
 - *Drivers* of new innovations
- **Middle Adapters**
 - *Riders* - eventually will ride along with new trends
- **Late Adapters**
 - *Draggers* - still don't want to use a word processor or fax machine.

Relationships to Change

Early Adopters

- An estimated 10-20% of American society.
- Naturally curious, self-motivated, seek new experiences and like to explore.
- Is inner-directed; motivated by an innate curiosity, and is likely to be among the first to try anything new, often for the fun of it.

Relationships to Change

Middle and Late Adopters

- Represent 80% of American society.
- Are outer directed – motivated primarily through the direction of others.
- Wait to try something new until they feel its safe, and accepted, for them to try it too.
- “Playing it safe” for them is just common sense.

Diffusion of Innovation

- There is a bell curve of diffusion of innovations.
- Most effective means of spreading change is when some type of gain can be foreseen with the change.
 - Show case the benefits
 - Lead the horse to the water and then drink the water while he looks on.
- Change imposed is change opposed.
- There is a natural tipping point – 100th Monkey.

Four Stages of Internalization of Innovation

1. Awareness and Uncertainty
 - Shallow awareness of benefits and low self-efficacy
 - To overcome - keep changes small, achievable and with high probability of success.
2. Insight and Adoption
 - The change seems within reach, self confidence rises and benefits of change emerge.
3. Internalization/Adaptation
 - The change is widespread and - it has become the norm.
4. Enlightened Expectations
 - Excitement is apparent and new possibilities associated with the change can be imagined.

WHY CHANGE???

Unless things change – they are likely to remain the same.

What a Difference a Century Can Make!

U.S. statistics for the Year 1905

- The average life expectancy in the U.S. was 47 years.
- Only 14 percent of the homes in the U.S. had a bathtub.
- Only 8 percent of the homes had a telephone.
- There were only 8,000 cars in the U.S.
- The maximum speed limit in most cities was 10 mph.
- More than 95% of all births in the U.S. took place at home.
- 90% of all U.S. doctors had no college education.
 - Instead, they attended so-called medical schools, many of which were condemned in the press and by the government as "substandard."

An Essential Shift in Quality Improvement

- Putting those that perform the key clinic processes in the core of the improvement process team.
- Team members consist of those that do the work:
 - Acknowledges that they are the experts of the particular process that contributes to the whole.
 - Can create a shared vision of the end goal of the change with equal participation.
 - By participating in the change process – self discovery is possible and tangible benefits are seen earlier on and

The Healthcare Team

A team is a group of people that work together to achieve a common purpose and are mutually accountable to each other.

- Share responsibility for the ultimate outcome.
- The work could that they do together cannot be accomplished independently.
- Relationships cross organizational boundaries.

I Have to Work with WHO??!!

**...but they are different than
me**

**...but we're all different from
each other and that's a good
thing**

4 Personality Types

- **Analytical**
- **Expressive**
- **Solid**
- **Dominant**

We Have to Work Together?

The FIVE desirable functions of a TEAM

- #1 Trust in team members
 - Confidence that team intentions are good - vulnerability is fostered.
- #2 Productive Ideological Conflict
 - Open discussion of ideas is present.
- #3 Commitment
 - Decisions are clear and the team is able to move forward with complete buy in from everyone.
- #4 Accountability
 - Team members hold each other accountable for their actions.
- #5 Attention to Results
 - Focus is on specific goals and defined outcomes.

The FIVE dysfunctions of a TEAM

Patrick Lencioni

- #1 Absence of Trust
 - Lack of openness with one another.
- #2 Fear of Conflict
 - Veiled discussions and guarded comments.
- #3 Lack of Commitment
 - Lack of buy in to decisions or goals that the team makes.
- #4 Avoidance of Accountability
 - Don't check and balance team members actions.
- #5 Inattention to Results
 - Individual needs take precedence over team goals.

Overcoming the FIVE dysfunctions of a TEAM

- #1 Absence of Trust
 - Identify and discuss individual strengths and weaknesses.
 - Spend face to face time in working sessions.
- #2 Fear of Conflict
 - Acknowledge that conflict is a good thing.
 - Establish ground rules for engaging in conflict - limit discussion to the issues at hand, etc.
 - Understand individual team members conflict styles
- #3 Lack of Commitment
 - Review commitments at the end of each meeting to ensure alignment.
 - Adopt a "disagree and commit" mentality.
- #4 Avoidance of Accountability
 - Agree to standards and goals for behavior.
 - Discuss team performance
- #5 Inattention to Results
 - Stay focused on tangible goals.
 - Reward individuals based on team goals - not individual ones.

Achieving the Goal

- Move from a provider oriented system to a patient/family/community oriented system.
- Embrace care and improvement models to improve health outcomes for underserved people and to eliminate health disparities
- Utilize goals and measures that are evidenced based and congruent with national measures.
- Use the learning model as a means to reorganize the center practice.

The 10 New Rules for 21st Century Healthcare

- Base Care in healing relationships (not just visits).
- Customize care to the individual patient (avoiding unhelpful variation).
- Regard the patient as the source of all control (rather than beginning with control in the system).

The 10 New Rules for 21st Century Healthcare

- Share knowledge and make information flow freely (including unfettered access by patients to their medical records).
- Base decisions on evidence (rather than habit).
- Improve safety as a system property (rather than exhorting individuals).

The 10 New Rules for 21st Century Healthcare

- Embrace transparency (not secrecy).
- Anticipate needs (rather than reacting).
- Continually reduce waste (of time, supplies, space, information, ideas, spirit, etc.).
- Cooperate (as the highest professional value).