

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

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San Antonio

- Saint Anthony of Padua, Portugal 1195 – 1231
- Holds the record for fastest canonization – 352 days.
- Portugal donated a large statue of him – now resides along the San Antonio Riverwalk.
- Invoked for the recovery of things lost.

San Antonio

- Also considered the *marriage saint* - look for the marriage island along the Riverwalk.
 - In Latin America single women buy a statue of Saint Anthony and bury it upside down for one week with the threat of only reburying him in the correct position after they have found a good husband.
- Also invoked for issues with starvation, barrenness, patron of amputees, animals, boatman, the elderly, expectant mothers, harvests, mail and people and travelers amongst other things.

What is our Mission?

- To create equity in healthcare.
 - Minorities are disproportionately affected by chronic illnesses and associated complications.
- “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.
 - Ohana – we belong to a collective community – regardless of our station in life – we are family.
- Community Health Centers
 - Safety net providers

Every Starfish in the Sea Matters

“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**

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.

To care for our Ohana.

The Health Disparities Collaborative (HDC)?

- In 1998, Bureau of Primary Health Care, in collaboration with the Institute for Healthcare Improvement (IHI), and other national & strategic partners launched the HDC to address the growing number of health center patients with chronic conditions.
- The ultimate goal of the HDC is to eliminate the health disparities in our nation and to ensure 100% access to quality primary care for underserved and uninsured populations.

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....

- 80,000 patients in registries to track/manage care
- Major improvement in glucose control
- Improved 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 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

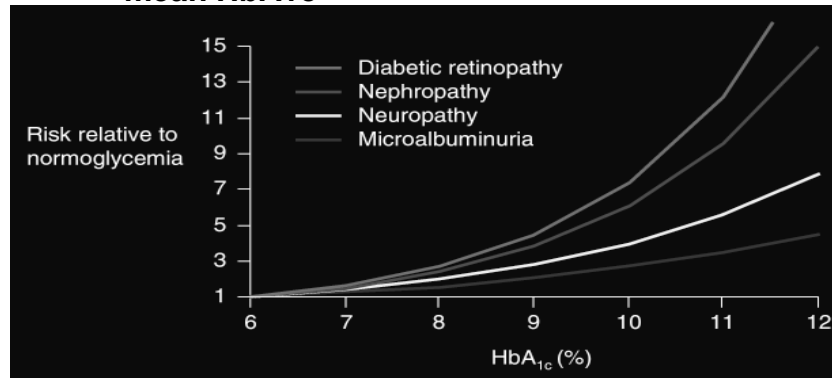
- Prevalence and costs are expected to rise by at least 15% by 2010 and 60% by 2050
- 50% mortality from the ten leading causes of death is attributable to lifestyle behavior

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 HbA1c*

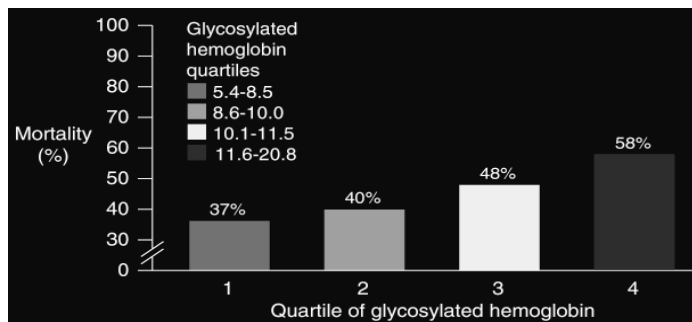


*Extrapolated from DCCT data

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

Wisconsin Epidemiologic Study

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



*Glycosylated hemoglobin =sum of HbA1 fractions HbA1a, HbA1b, HbA1c

P<.005 association of glycosylated hemoglobin with all-cause mortality

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

UKPDS Glycemic Control Study Summary

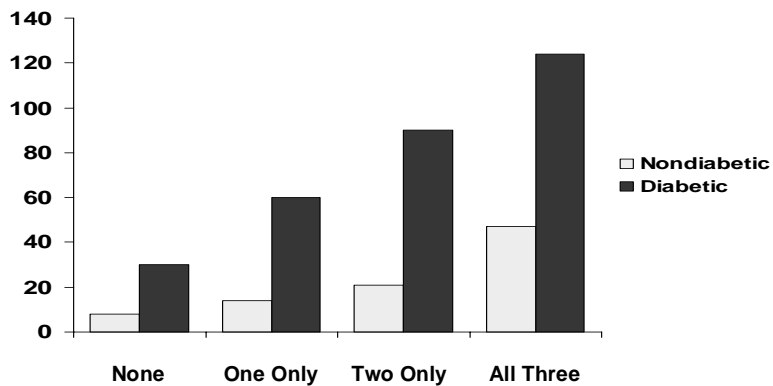
The intensive glucose control policy maintained a lower HbA1c by mean 0.9% over a median follow up of 10 years from diagnosis of type 2 diabetes with reduction in risk of

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

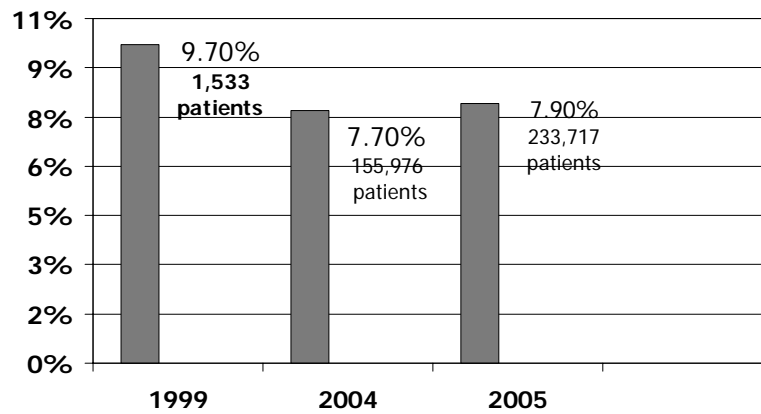
CVD Death Rate Per
10,000 Person Years



* 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 (October 2005)
7.9%
Registry Size 74,206
- Nationally (June 2005)
7.9%
Registry Size 233,717

**Patients w/2 HbA1c's:
> 90%**

- WCC Cluster (Dec. 2004) 35%
Registry Size 74,206
Patients with one HbA1c 68%
- Nationally (June 2005) 33%
Registry Size 233,717

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

- WCC Cluster (October 2005) 35%
Registry Size 74,206
- Nationally (June 2005) 37%
Registry Size 233,717

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

- | | |
|------------------------------|-----|
| ■ WCC Cluster (October 2005) | 32% |
| Registry Size 74,206 | |
| ■ Nationally (June 2005) | 49% |
| Registry Size 233,717 | |

**Self-Management Goals
Documented: > 70%**

- | | |
|------------------------------|-----|
| ■ WCC Cluster (October 2005) | 30% |
| Registry Size 74,206 | |
| ■ Nationally (June 2005) | 39% |
| Registry Size 233,717 | |

Definition of Quality “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.

To care for our Ohana

CHANGE???

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!

Here are some of the 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., and only 144 miles of paved roads.
- The maximum speed limit in most cities was 10 mph

What a Difference a Century Can Make!

- The average wage in the U.S. was 22 cents per hour.
- The average U.S. worker made between \$200 and \$400 per year.
 - A competent accountant could expect to earn \$2000 per year,
 - a dentist \$2,500 per year,
 - a veterinarian between \$1,500 and \$4,000 per year, and
 - a mechanical engineer about \$5,000 per year.

What a Difference a Century Can Make!

- More than 95% of all births in the U.S. took place at home.
- Ninety% 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."

What a Difference a Century Can Make!

- Crossword puzzles, canned beer, and ice tea hadn't been invented yet.
- Two out of every 10 U.S. adults couldn't read or write and only 6 percent of all Americans had graduated from high school.
- Marijuana, heroin, and morphine were all available over the counter at the local corner drugstores.
 - Back then pharmacist said, "Heroin clears the complexion, gives buoyancy to the mind, regulates the stomach and bowels, and is, in fact, a perfect guardian of health." (Shocking!)
- Eighteen percent of households in the U.S. had at least one full-time servant or domestic help.

Definition of Quality “Every Single One”

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

The Need for Redesign

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 system needs to be able to handle the unique barriers specific to each clinic setting.

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

Goal of the Collaboratives

- To close the gap between what we know and what is actually done for every patient in the practice.
- To provide a framework for implementing changes into the practice and ultimately consistency in practice.
- To restructure the care delivery system to successfully handle the complexity of care for chronic illness and improve the delivery of preventive services.
- To ultimately improve patient outcomes and delay or prevention complications associated with chronic care diseases and improve office efficiency.

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

The Essential Shift in Quality Improvement

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.
 - Relationships cross organizational boundaries

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

The 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

Shifts in Quality Improvement

- Center processes cannot be looked at in isolation – their relationship to the whole must be examined.
- The relationship between different processes is as important as the processes themselves.
 - What impact would changing one process have on the whole?
 - Maintains that the whole of the organization is responsible and accountable to each other and responsible for the ultimate outcome.
 - Prevents silo efforts as the team works across organization 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.

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).

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.