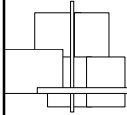


Changing Practice Changing Lives



The Health Disparities Collaboratives

Jessica Sanchez, MSN, FNP

WCC Team Support Manager

Colorado Community Health Network (CCHN)

jessica@cchn.org

303-861-5165 X231



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

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

- 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)

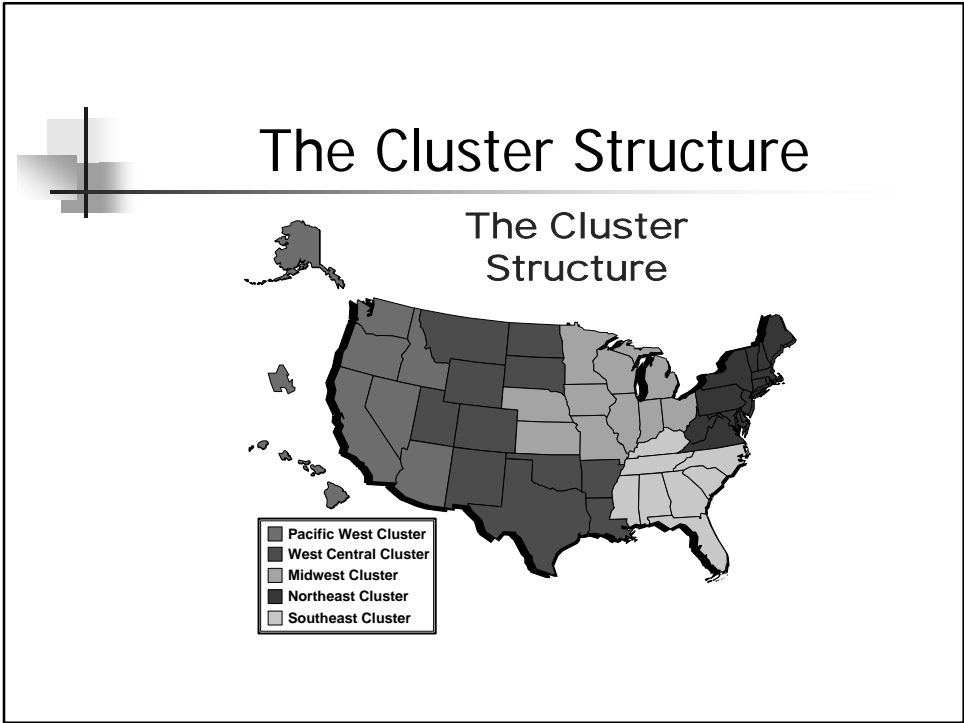
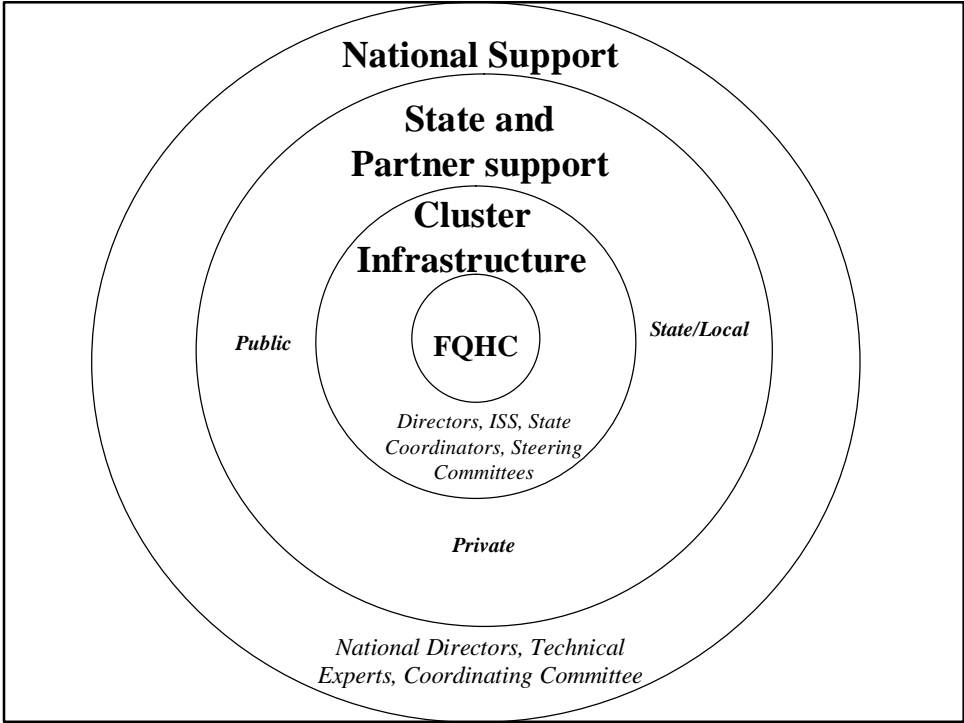
5 Health Centers

EXCELLENT HEALTH OUTCOMES

657 Health Centers

Over 900 Teams

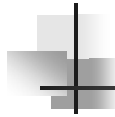
1998 —————> 2005





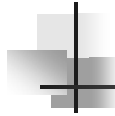
WCC Goals

- 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

- 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)

- 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

- 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



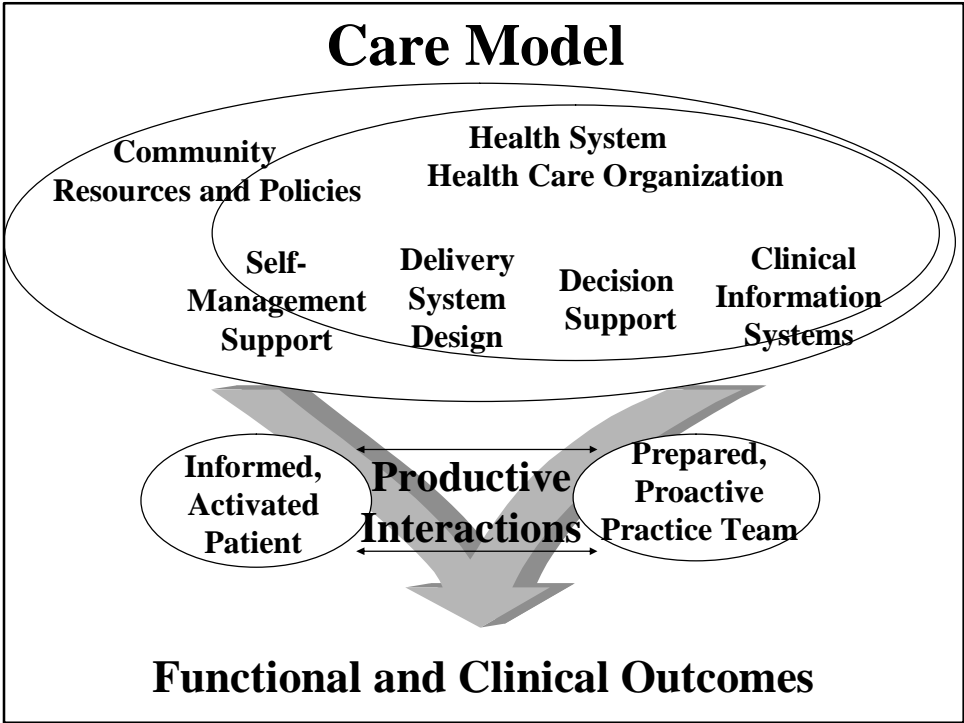
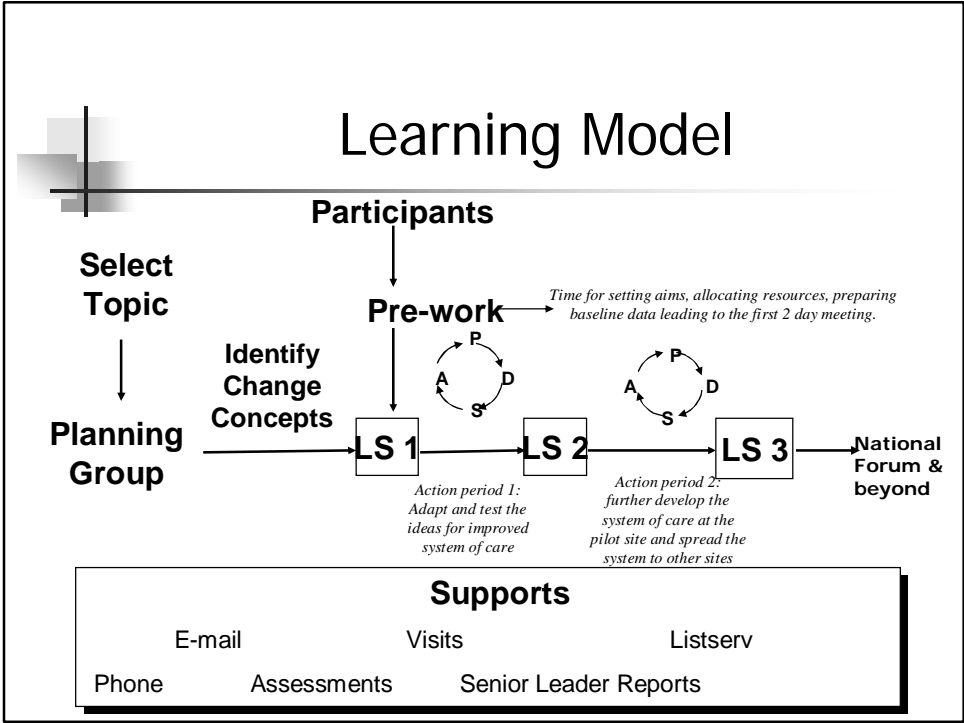
WCC Leadership

- 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

- ❖ ***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.



Community Linkages

- Link to community resources for defrayed medication costs, education, and materials.
- Provide a list of community resources to patients, families, and staff.



Self-Management Support

- Use group visits to support self-management.
- Set and document self-management goals collaboratively with patients.
- Follow up and monitor self-management goals.



Decision Support

- 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.



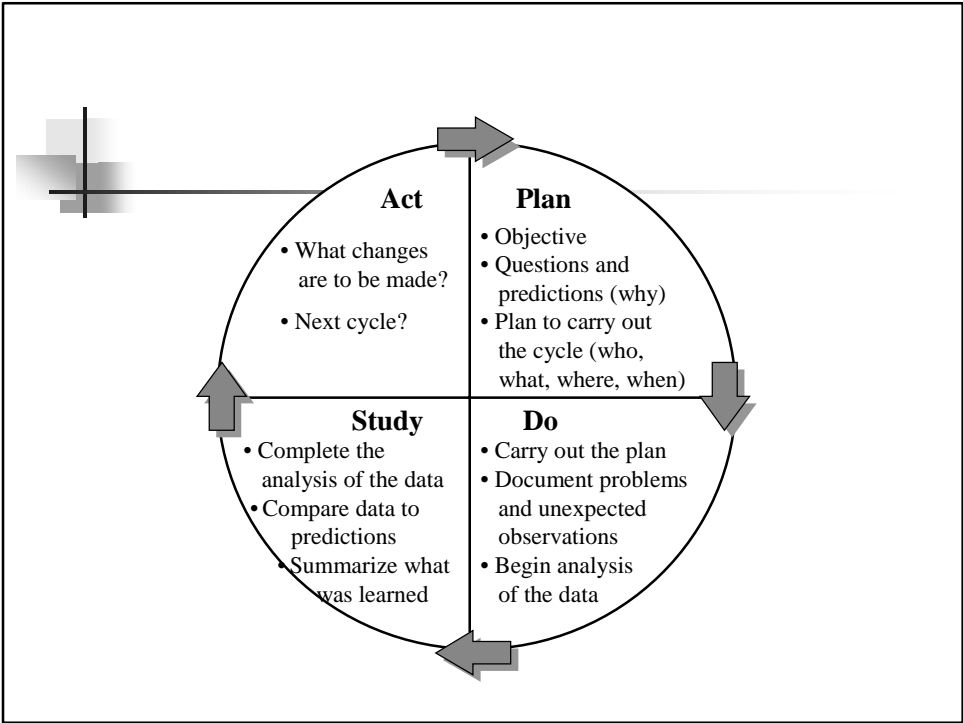
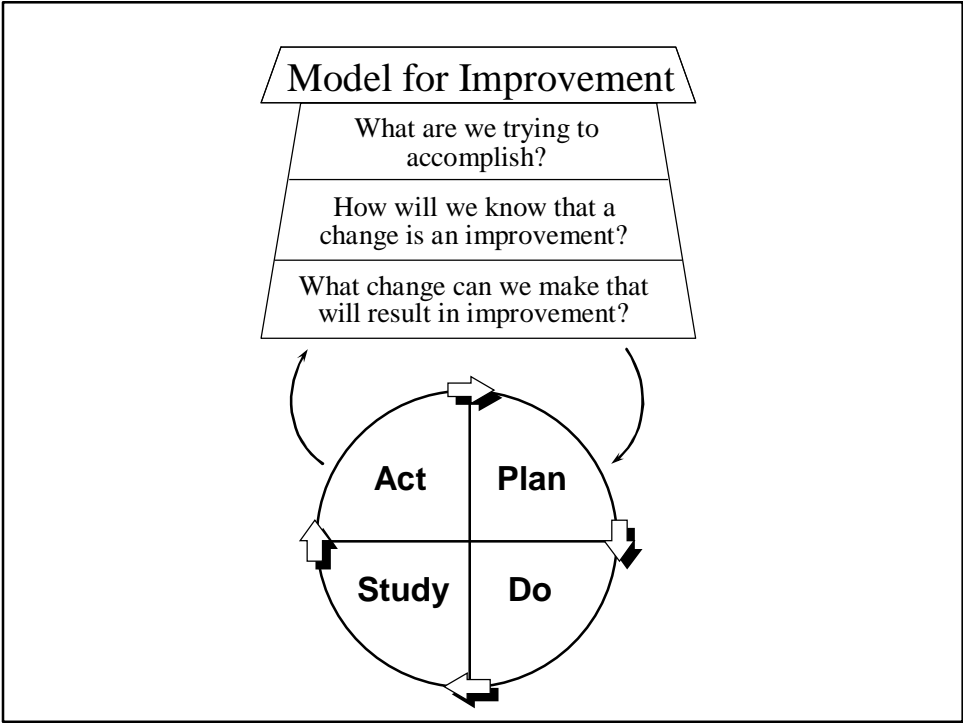
Delivery System Design

- 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

- 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.

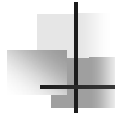


Why Test?

- 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.

Implementation vs. Testing

- Requires standardized form
- Requires standardized procedures
- Requires formal training
- Requires explicit orientation and definition of job roles and responsibilities



PDSA 101 Exercise

- 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?

- 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
- Mindfulness



Challenges and Avenues to Overcome Them

- Team huddles
- Setting ground rules
- Staff members calling in sick, vacation, etc., need for “cross-training”
- The belief that the HDC is “additional” work
- Integrating the work of the HDC into the daily routine and job descriptions
- Buy-in
- Avoiding “burn out”



Reporting Process

- Reports are uploaded to the HDNR Website
 - www.hdnr.org
- Senior Leader Narrative Submitted Quarterly
 - (Jan 1st, April 1st, July 1st, Oct. 1st)
- Data Reported Monthly:
 - Excel Measure Graphs
 - Registry Summary Reports



Conference Calls

- Monthly Condition Specific Conference Calls
 - Diabetes
 - Cardiovascular Disease
 - Depression
 - Cancer
- Quarterly WCC Phase 2 Conference Calls



Who You Going To Call?

- State Coordinator – Arkansas
 - Mary Gupton (MGupton@chc-ar.org)
 - (501) 374-8225 X108
- State Coordinator – Portions of West Texas
 - Celeste Frangeskou (cfrangeskou@tachc.org)
 - (512)329-5959
- State Coordinator - Texas:
 - Juanita Lambie (jlambie@tachc.org)
 - (512) 329-5959
- IS Specialist
 - Lisa Revelett (lrevelett@tachc.org)
 - (512) 329-5959
- WCC Team Support Manager, Oklahoma and Louisiana Coordinator
 - Jessica Sanchez (jessica@cchn.org)
 - (303) 861-5165 X231



Listservs

- WCC Phase 2 Team Listserv- Contact your State Coordinator to be added
 - wccphase2@tachc.org
- Health Disparities National Web Page:
www.healthdisparities.net



Websites

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

Questions/Comments



PDSA Form		
Date:	Initiated by:	Cycle
This cycle is for:		Other purpose: _____

CARE MODEL COMPONENT: OrgHC Comm DelSysD DecSupp SelfMgt CIS

Purpose of this cycle:

PLAN the change, prediction(s) and data collection	
THE CHANGE:	
What are we testing?	
On whom are we testing the change?	
When are we testing?	
Where are we testing?	
PREDICTION(s):	
What do we expect to happen?	
DATA:	
What data do we need to collect?	
Who will collect the data?	
When will the data be collected?	
Where will data be collected?	
DO: Carry out the change/test, collect data, and begin analysis	
What was actually tested?	
What happened?	
Observations:	
Problems:	
STUDY: Complete analysis of data: Summarize what was learned and compare to prediction.	
ACT	
<i>What adjustments to the change or method of test should we make before the next cycle?</i>	
<i>Are we ready to implement the change we tested?</i>	
<i>What will the next test cycle be?</i>	

Example: (Courtesy of Pat Willis, Big Sandy Health Care Inc.)

Big Sandy Health Care, Inc.	PDSA Form
Date: 03/16/04 Initiated by: Pat Willis	Cycle #8
This cycle is for: CIS	Other purpose:

CARE MODEL COMPONENT: OrgHC Comm DelSysD DecSupp SelfMgt CIS

Purpose of this cycle: To develop health center infrastructure to support spread.

PLAN the change, prediction(s) and data collection	
THE CHANGE:	
What are we testing?	The capability of the network (WAN) to efficiently handle PECS data from another site and back-up the files. We will be entering data for 10 patients. Data enter will be completed by members of the Mud Creek staff.
On whom are we testing the change?	We are testing the change over WAN.
When are we testing?	March 16
Where are we testing?	Mud Creek Clinic
PREDICTION(s):	
What do we expect to happen?	We expect the system to accurately capture the data and back-up the files.
DATA:	
What data do we need to collect?	Accuracy of the reports.
Who will collect the data?	Pat Willis and Nate Hager
When will the data be collected?	March 17
Where will data be collected?	Central Office
DO: Carry out the change/test, collect data, and begin analysis	
What was actually tested?	Same as above
What happened?	No problems with the system accurately capturing the data. The Mud Creek staff entered the data without any difficulty.
Observations:	
Problems:	Back-up FAILED!!!
STUDY: Complete analysis of data: Summarize what was learned and compare to prediction.	
ACT	
<i>What adjustments to the change or method of test should we make before the next cycle?</i> IS to assure back-up procedures are in place to assure successful back-up of files.	
<i>Are we ready to implement the change we tested?</i> Yes. Mud Creek will begin entering for all DM patients seen at that site.	
<i>What will the next test cycle be?</i> None at this time.	