


Laying The Foundation For Change

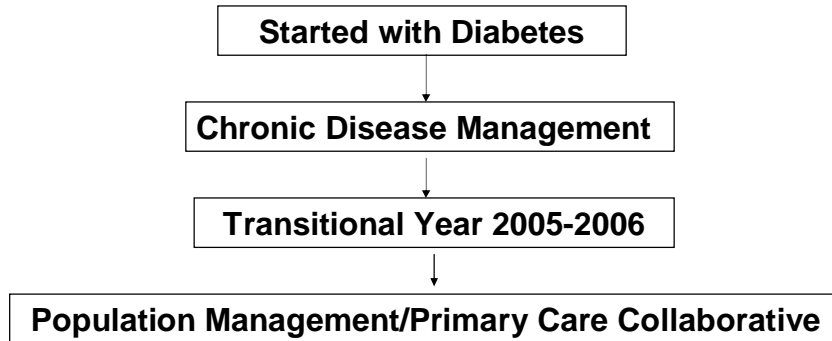
Wendy Latham, WCC Director
WCC Regional Summit #2



- Historical Perspective
- Current Situation
- Transition/Evaluation
- The Future

2

Evolution of the HDC



3

One Condition Focus

- In 1999, BPHC, 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.
- 5 pilot centers focusing on diabetes

4



3 Models

- **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 need care, assuring that they receive evidenced-based care and actively aids them to participate 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

5



The Framework

- 4 Learning Sessions (Kick-off through Congress) for Phase I teams at the cluster level supported by monthly calls, reporting and site visits
- Senior Leader forum supported by monthly calls
- Phase II supported at the cluster level with one summit, quarterly reporting and calls

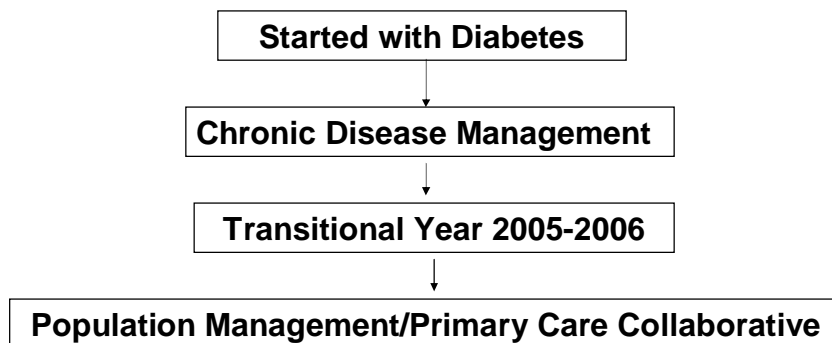
6

Initial Assumptions Regarding The Business Case

- Reduce Costs (Generally defined as being more efficient)
- Improve Productivity (Defined as more visits)
- Enhance Revenues (Defined as a higher charge per visit - RVUs)

7

Evolution of the HDC



8



Expanded Focus

- **Four Types of Collaboratives**
 - **Disease Collaboratives:** Acute and Chronic conditions
 - **Prevention Collaboratives:** Diabetes Prevention, Cancer Screening, General Prevention
 - **Business Collaboratives:** Fiscal and Access/Redesign of Patient Flow
 - **Community Systems Collaboratives:** Perinatal and Patient Safety Collaborative

9

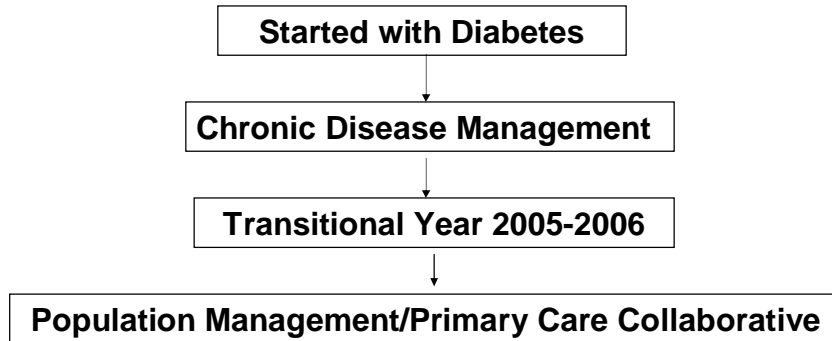


Expanded Framework

- Phase I supported through 4 national learning sessions, run by national faculty. Multiple conditions available
- Multiple opportunities to participate in pilot collaboratives
- Phase II supported at the cluster level through one summit, quarterly reporting and calls

10

Evolution of the HDC

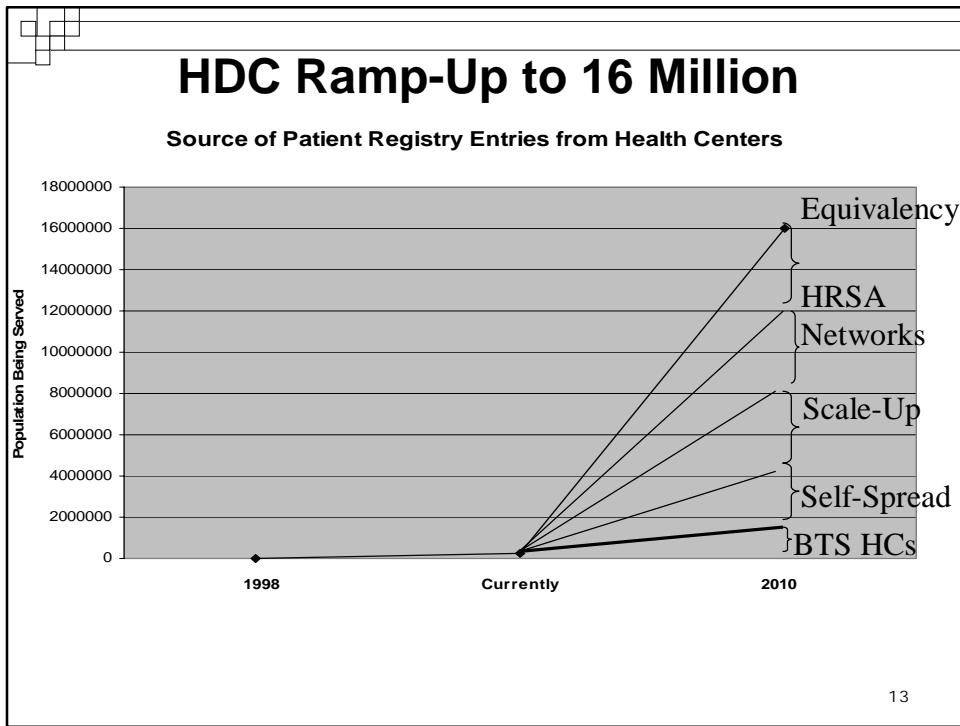


11

HRSA Draws a Line in the Sand: Overall Strategic Goal of the HRSA HDC

- Exceed All HP2010 Measures with all 16 Million HC Patients and have the data to prove it.
- Reference: Healthy People 2010

12




- ## HRSA HDC – Long Term Goals
- To improve the quality of care delivered to the medically underserved
 - Improve the efficiency and management of health centers
 - To improve health outcomes
 - To eliminate health disparities
- 14



Evaluation – Where are We?

- HDC Impact on patient, provider, CHC and HRSA
- The numbers – what have we actually accomplished?
- The Framework: How Has WCC Begun to Adjust?
- Re-aligning the business case

15



HDC Impact on the Patient Population

- Improved follow-up and outcomes for patients who are included *in the registry*
- Ongoing issues:
 - Difficulty accessing provider appointments
 - Waits during a visit
 - Lack of continuity with a Primary Care Provider

16



HDC Impact on the Provider and the Community Health Center

- Learned how to improve performance (PIM)
- Learned the use of evidence-based guidelines
- Learned components of population management
- Ongoing issues
 - Experienced costs related to HDC participation
 - Struggled to manage the data
 - No financial incentives related to “Quality” outcomes
 - Failed to realize financial gain from the downstream impact of “Improved Outcomes” (e.g. decrease in hospitalizations)

17



HDC Impact on the BPHC

- Strong cluster infrastructure to support population management
- Improved clinical outcomes for patients *in the registry*
- Growth of CHC capacity and related access to care has not improved
 - The number of total visits has increased, but the growth in number of patients served has not kept pace.
 - The spread of chronic disease management is lower than anticipated (WCC data).

18

The Numbers? National Population Comparison USD vs HDC Registry

Patient Groups	National UDS Chronic Disease Totals	National HDC Registry Totals	National HDC Registry Totals as a Percentage of National UDS Chronic Disease Totals
Asthma	418,256	31,589	7.55%
Diabetes	778,628	250,540	32.18%
Heart Disease (selected)	230,596		
Hypertension	1,257,930		
Cardiovascular Disease	1,488,526	81,172	5.45%
Depression (and other mood disorders)	402,148	25,386	6.31%
All Patients With Chronic Disease	3,087,558	388,687	12.59%
All Patients in the UDS	13,127,811		
Percentage of UDS Patients with Chronic Disease	23.52%		

19

Adjusting the Framework During the Transition

- Shift to Phase II Regional Summits
- Broader summit curriculum
- Decentralize WCC staff support (the staff moving closer to the teams they monitor)

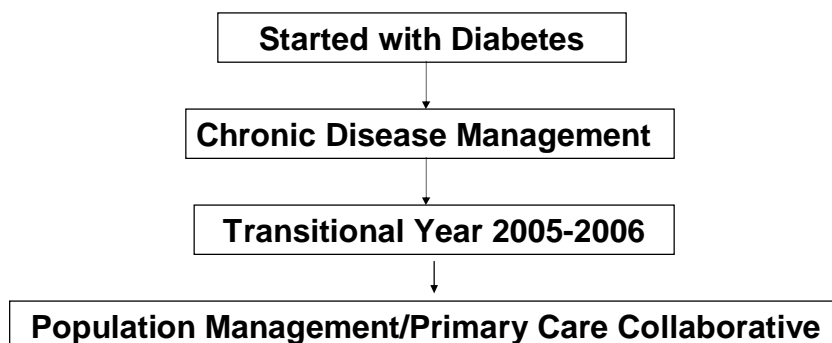
20

The Emerging Business Case for Population Management


- Reduce Costs (Defined as improved access, continuity of care, decreased cycle time, use of provider-led team)
- Improve Productivity (Defined as provider panel management)
- Enhance Revenues (Payment needs to be realigned from visit to panel)

21

Evolution of the HDC



22



The Future is now – Shift From Project to the “Work”

- Increased focus on spread/Institutionalization of the HDC
- Rapid sharing of innovation
- Aggressive exploration of alternative models for doing the business of the HDC
- Expansion of the cluster support


23



Institutionalization of the HDC

- Merging of Phase I and Phase II curriculum
- State based summits, increased contact with state PCA
- Increased focus on strengthening the business case for the centers
- Focus on assisting centers to increase capacity and refine panel management
- Universal tracking of a group of core measures

24



Wendy Latham, WCC Director
W: 512.329.5959
C:512.970.6690
wlatham@tachc.org

25