Health Disparities Collaboratives

A national effort to improve health outcomes for all medically underserved people with chronic diseases

About Us	Models	Infrastructure	Partnerships	Partnerships	Results	Changes

The Challenge of Systems Change for Secondary Prevention

Heart Disease and Stroke Prevention Practitioners Training Institute
May 14, 2003, Dallas, Texas

Overview/Objectives

- Provide background of the HRSA/BPHC Health Disparities Collaboratives
  - # of health centers participating
  - Conditions addressed
  - What is the vision?
- Describe the three models utilized to accommodate rapid large scale improvements
- Summarize key partnerships and infrastructure and the role they play
- Give examples of population based interventions, goals, measures, and results associated with the Collaboratives

BPHC Primary Care Programs

- 800 Health Centers --community controlled, comprehensive primary care
- 4000 sites
  - Community
  - Migrant
  - Homeless
  - School based
  - Public housing
- Serve 12 million people
  - 85% low income
  - 65% racial/ethnic minorities

Health Center 12 Million Users

- Diverse
  - White: 36%
  - African American: 25%
  - Hispanic: 35%
  - Asian/other: 4%
- Poor
  - 39% uninsured
  - 88% low income with 67% below poverty level

The President's Health Center Initiative

Must give attention to three essential synergistic areas:

1. Managing quality improvement
2. Strengthening existing health centers
3. Managing the growth of new and expanded health centers

Assumptions: Quality Management Strategy

- All health centers complete at least one collaborative, implement and spread the model of care throughout their system, remain engaged in the health center collaborative community of learners, documenting and sharing improvement for underserved people, while improving prevention outcomes and reducing health disparities for the underserved
- Health Disparities Collaboratives are a key vehicle to generate positive health outcomes and build capacity for quality improvement, including risk management, accreditation, and re-design of clinical, administrative and financial systems

HRSA/BPHC Health Disparities Collaboratives

- Number of participating Health Center teams **544**
  - Phase 1 157
  - Phase 2 365
  - Prototypes 22
  - (Cancer, Prevention, Diabetes Prevention)

Health Disparity Collaborative Strategy

- Transform care through care model, improvement model, & learning model
- Infrastructure/Support System
- Strategic Partnerships
- Leadership

Key Elements to Breakthrough Improvement

- *Will* to do what it takes to change to a new system
- *Ideas* on which to base the design of the new system
- *Execution* of the ideas

BPHC Health Disparities Collaboratives

Participants

Select Topic

Planning Group

Identify Change Concepts

Pre-work

Time for setting aims, allocating resources, preparing baseline data leading to the first 2 day meeting.

P D S A

LS 1

LS 2

LS 3

Congress & beyond

Action period 1: Adapt and test the ideas for improved system of care

Action period 2: further develop the system of care at the pilot site and spread the system to other sites

Supports

E-mail Visits Phone Assessments Senior Leader Reports

Care Model

Health System

Community

Resources and Policies

Health Care Organization

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

www.improvingchroniccare.org

Key **Cardiovascular** Change Concepts for the Elements of the Care Model

Self-Management	Decision Support	Delivery System Design	Community	Organization of Healthcare	Clinical Info Systems
Develop culturally appropriate self-management approaches: Promotora/community health worker; Group visits/support groups; Stages of change model/motivational interview	Develop systems/mechanisms to facilitate communication between PCP, specialist, and hospital	Provide alternative patient flow and visits (planned and group visits, drop in visits for BPchecks)	Obtain free or discounted resources from pharmaceutical firms, service groups, health plans for scales, meds, BP cuffs and education programs	Senior leader to identify and allocate resources and remove barriers for implementation of improving chronic care in the system	Develop an electronic registry that can identify the center's CVD patients
Use of culturally/literacy appropriate education and self-management programs and materials (i.e.; smoking cessation and cooking classes)	Provider education: guidelines, BP technique and availability of patient education resources	Use of multidisciplinary care team (Nutritionist, social worker, exercise physiologist)	Promote non-traditional partnerships i.e. parks, transportation, health clubs, schools, YMCA, faith-based organizations, restaurants, barbers & beauty shops for places to exercise, monitor BP, healthy food	Develop partnerships with other health care organizations interested in patient care and outcomes	Cross train staff to enter data and track outcomes
Provide tools for self-management (scale, BP cuff, pedometer, etc)	Integrate guidelines into daily clinical practice (use of flowsheet, etc)	Relevant info available at the time of the visit	Work with homeless shelters, migrant camps to provide education, nutrition, BP checks	BOD and SL receive regular reports	Use of queries and reports proactively to treat patient and plan care
Patient tailored collaborative goal setting with form and follow-up – copy of goals to patient and medical record	Clinical guidelines adopted and used in the organization	Consistent and appropriate follow up including use of telephone, promotora etc.	Use of promotoras, community health workers, and the faith based community to reach out to the community for education and screening	Ensure that the Chronic Care Model is integrated into the strategic organizational plans	Provide information from registry to patient at time of visit
Protocols and training for staff relating to self management support	Provide feedback from population data to providers (results and compliance with guidelines and measures)	Assure clinical case management services for complex patients	Develop relationships with universities and their providers to place students and interns and for community projects	Senior leader is engaged and endorses and communicates content and progress to BOD and staff	Establish real-time data entry process, including back up process
Organize and/or provide access to patient support groups	Use of standing orders and protocols, when appropriate	Identify CVD patient charts and utilize every opportunity to address CVD needs	Reach out to the community with health fairs and community education	Collaborative team is empowered to make changes	Have IS person as part of team
	Inform patients about guidelines pertinent to their care		Hospital and university linkages for specialty care	Incorporate training in the models into the orientation of new employees/staff	Develop mechanism to determine the integrity of the data
		Reminders available and looked at ahead of time	**Partner with state, local and community public health programs**		

Partner with state, local and community public health programs

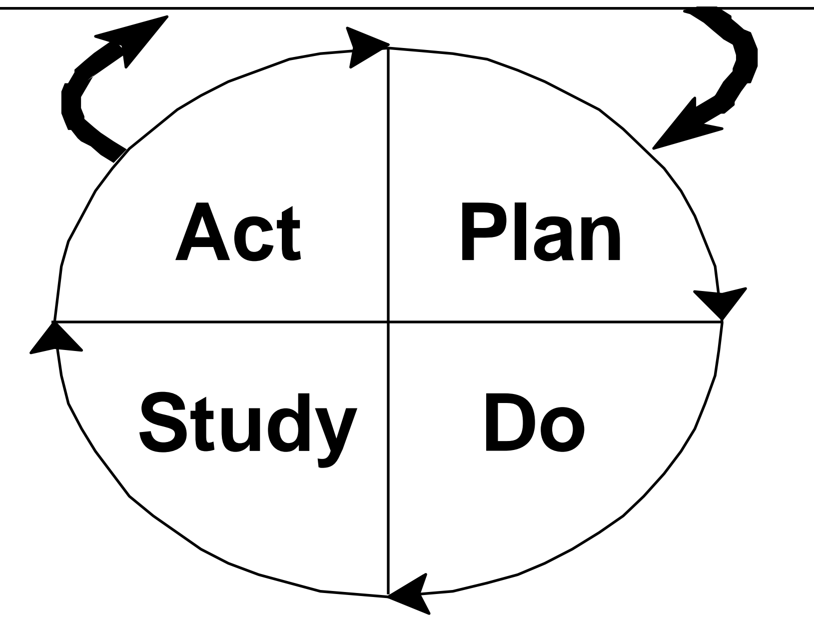
- *Collaboration with state of WI CVD representative Mary Jo Brink also State Diabetic Representative We have received a large number of glucometers to give to those patients (<u>Marshfield</u>)*
- *Wisewoman contract signed ,which is a CV program for woman age 40-64 through the local health department.(<u>UP</u>)*
- *Public Health will provide our organization with nutritional support to assist our patients with self-management goals and educators to assist with smoking cessation program (<u>Palmetto</u>)*
- *American Heart Association Provides educational materials for patients concerning heart disease and risk factors (<u>Palmetto</u>)*
- *Partnership with Utah Department of Health – have new cholesterol testing machines (<u>Green River</u>)*
- *New funds from Utah Division of Mental Health to support behavioral health and modification (<u>Green River</u>)*
- *Utah State Primary Care Grant Program to support collaborative integration and ASHES (<u>Green River</u>)*

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Associates in Process Improvement

Supporting Sustain/Spread INFRASTRUCTURE

- Multi-State (5 clusters) and State infrastructure
  - Cluster Directors, Cluster Coordinators, Information Systems Specialists
  - Support to 30 State PCA's
  - State Diabetes and Cardiovascular programs
- Leverage of national content experts (NCI, EPA, CDC)
- National Clinical Networks: HCH, MCN, NAOHA

Supporting Sustain/Spread INFRASTRUCTURE

- National Directors, Improvement Advisors
- HRSA, IHI, NACHC, ICIC
- PECS development, training and maintenance. PECS Advisory Group
- Clinical Faculty and Planning Groups

Supporting Sustain/Spread PARTNERSHIPS

- Centers for Disease Control & Prevention
- National Cancer Institute
- Environmental Protection Agency
- Agency for Healthcare Research and Quality (multi-year evaluation)
- HRSA-IHI-NACHC-ICIC
- Morehouse School of Medicine (Clinical Scholars)

CVD Goals

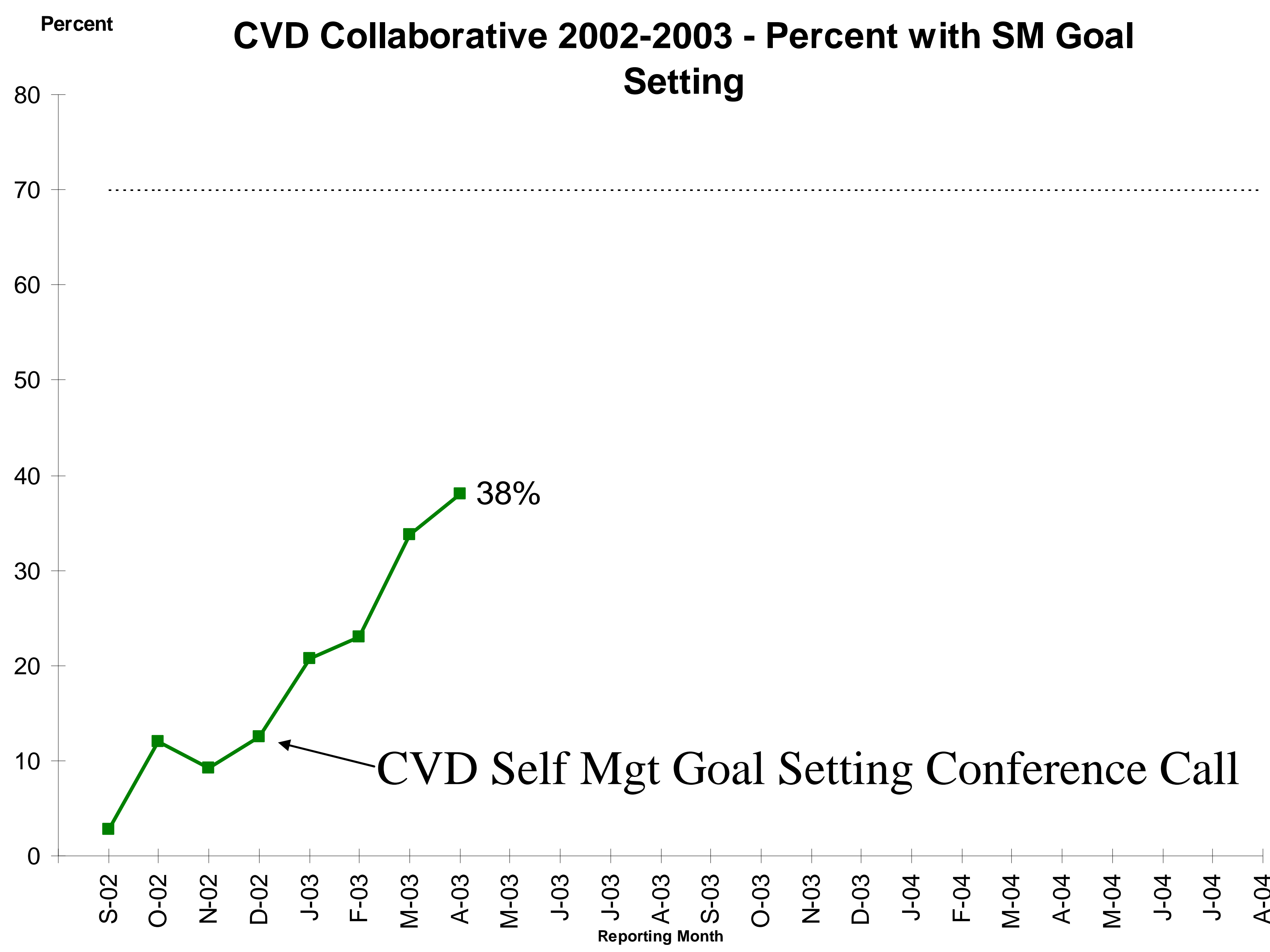
1. To delay or decrease the complications of cardiovascular disease by excelling in patient self-management, clinical decision support, positive delivery system re-design, clinical information systems, and strong partnerships with local community organizations
2. >50% of hypertensive pts having BP < 140/90 mm Hg
3. >90% of patients having BP documented > 2 times/year
4. >80% of patients having fasting lipid profile documented
5. >60% of patients with CAD or DM with LDL cholesterol <100 mg/dl
6. >70% of patients having self management goal setting
7. >90% of patients with CAD taking ASA or antithrombotic agent

Required Measures

- BP < 140/90 mm Hg
- Documentation of self-management goal setting
- BP documented > 2 times/yr
- Fasting lipid profile documented (5 years)
- LDL Cholesterol <100 mg/dl
- Aspirin or other antithrombotic agent
- Registry Size

Examples of Additional Key Measures

- ACE inhibitor use
- Beta blocker use
- Depression screening
- Weight reduction $\geq$ 10 lbs
- Regular exercise (3Xweek @ least 20 minutes)
- Smoking cessation


Percent
CVD Collaborative 2002-2003 - Percent with SM Goal Setting
80
70
60
50
40
30
20
10
0
38%
CVD Self Mgt Goal Setting Conference Call
S-02
O-02
N-02
D-02
J-03
F-03
M-03
A-03
M-03
J-03
J-03
A-03
S-03
O-03
N-03
D-03
J-04
F-04
M-04
A-04
M-04
J-04
J-04
A-04
Reporting Month

Tips for Good Blood Pressure Control

To prevent cardiovascular complications that may result in heart attack and stroke follow these tips:	
	1. Doing something you enjoy will help keep your blood pressure down. It also helps if you can talk to someone when you feel stressed out. You can talk to a friend, a clergy or a family member.
	1. Once you are cleared to exercise, walk 30 minutes at a rapid pace every day. 2. If you notice chest pain, shortness of breath, or tightness in the chest, stop and seek medical attention.
	1. Salt makes your body retain water which can make your blood pressure go up. Avoid foods that are high in salt, such as potato chips, pickles, and peanuts. Cook with little or no salt, and do not add salt to your food on the table.
	1. **DO** eat lean meat, fruit, and vegetables. 2. **DO** eat multigrain food,, such as whole wheat breads. 3. **DO** drink 6-8 glasses of water every day. 4. **EAT** 2-4 servings of fruit per day. Bananas, cantaloupe, and oranges are good fruits to eat. 5. **LIMIT** your carbohydrates to 3-4 servings per day. Carbohydrates include bread, tortillas, rice, potatoes, noodles, lima beans, sweet peas, corn, etc.
	1. To achieve good blood pressure control, obtain and maintain your ideal body weight. Weigh yourself every day.
	1. If your doctor has put you on medicine, you need to take them as ordered. To prevent blood clots, take a baby aspirin every day.
	1. If you smoke, **STOP SMOKING**. Smoking is not good for your lungs, it can make your blood pressure go up and is expensive. Try chewing sugarless gum when you feel like smoking. There are classes, medicines or patches, available, to help you stop smoking. Ask your provider.
	1. To protect your vision, visit an eye specialist every year or as instructed.
	1. Limit alcohol to 1 glass per day. Beer and wine are considered alcohol.
	1. Diet, exercise, relaxing activities, and taking your medicines as ordered are all important in controlling your blood pressure.

Cardiovascular Self-Management

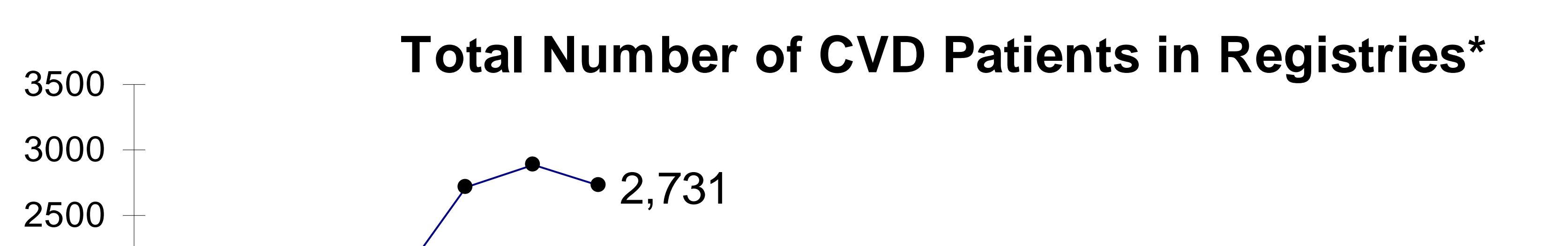
Note: To achieve good control of your blood pressure it is important to have practical goals for yourself. Set one goal now and after you have achieved it, move on to another. Know your risk factors and decide what you are willing to change. Feel good about one change before making another. Make your health a priority in terms of your time and energy. Consider your health provider at the Sicily Island Medical Center, a partner in your health.

PLEASE CHOOSE ONE OR MORE OF THE FOLLOWING GOALS

Yes	No	Goals		
		Goal 1	I will help myself to reduce stress by doing something I enjoy, exercising or meditating. When I feel stressed out, I will find someone to talk to.	
		Goal 2	I will walk 30 minutes ___day(s) a week. If I notice chest pain, shortness of breath, or chest tightness, I will seek medical attention.	
		Goal 3	I will decrease the amount of salt that I use every day.	
		Goal 4	I will follow my low fat diet, low cholesterol diet to reduce my cholesterol and reach or maintain my ideal weight.	
		Goal 5	I will try to reach my ideal body weight. I will lose ____ pounds by _______________	
		Goal 6	I will take all medications properly every day. To prevent blood clots, stroke or heart attack, I will take an aspirin a day.	
		Goal 7	I will stop smoking.	
		Goal 8	I will visit the eye specialist every year or as indicated.	
		Goal 9	I will limit alcohol to 1 glass per day.	
		Goal 10	I will lower my blood pressure to ___/___ by _________________.	

Patient's Name: ____MR# ______________________

Patient's Signature: ____Date: ______________________



Total Number of CVD Patients in Registries*
3500
3000
2500
2000
1500
1000
500
0
2,731
S-02
O-02
N-02
D-02
J-03
F-03
M-03
A-03
M-03
J-03
J-03
A-03
S-03
O-03
N-03
D-03
J-04
F-04
M-04
A-04
M-04
J-04
J-04
A-04
LS1

Data from 90% of teams

Average Number of CVD Patients in Registries
National average for all conditions = 116
160
140
120
100
80
60
40
20
0
152
Range = 77 - 276
S-02
O-02
N-02
D-02
J-03
F-03
M-03
A-03
M-03
J-03
J-03
A-03
S-03
O-03
N-03
D-03
J-04
F-04
M-04
A-04
M-04
J-04
J-04
A-04

Percent of CVD Patients with Fasting Lipid Profile Documented (5 years)

In November of 2002, query from PECS "Pts with no lipid profile documented". From that list, patients were contacted and scheduled to come in for a one time free lipid profile. The SM tool was also given to patients at that visit.

percent

100
90
80
70
60
50
40
30
20
10
0

PECS query F/U

Percent of CVD Patients with Self Management Goal Setting

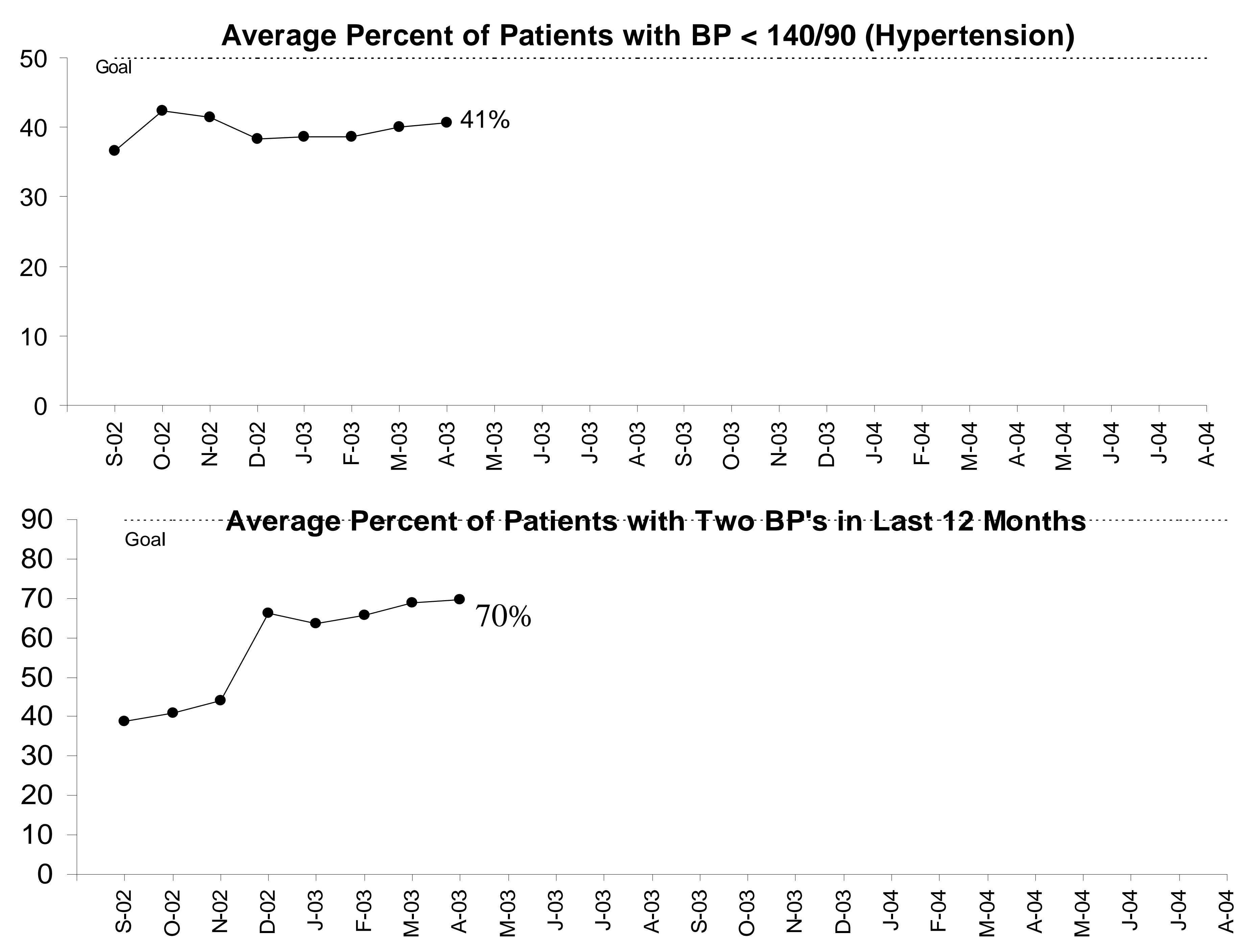
percent

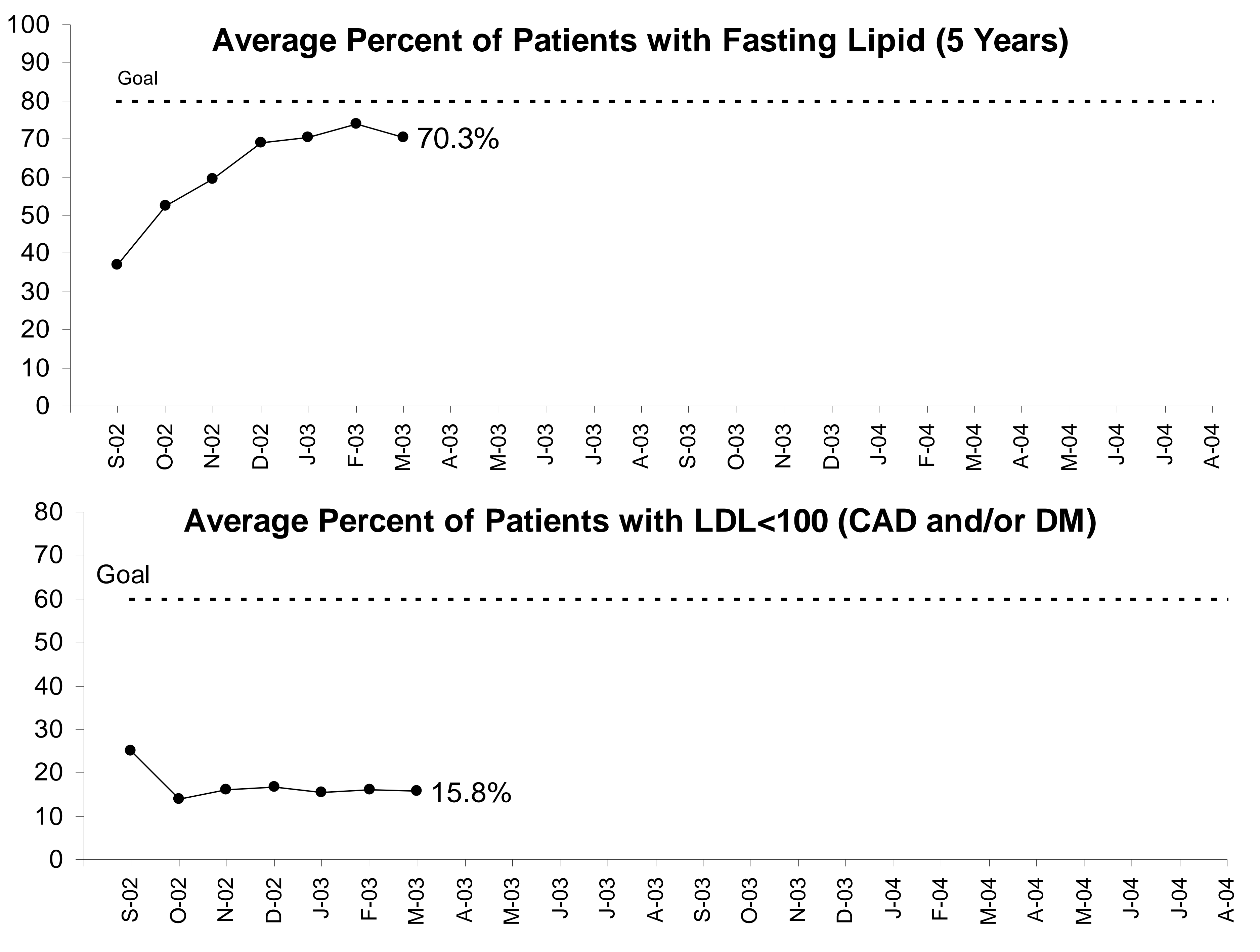
100
90
80
70
60
50
40
30
20
10
0

50%

PECS query F/U

S-02 O-02 N-02 D-02 J-03 F-03 M-03 A-03 M-03 J-03 J-03 A-03 S-03 O-03 N-03 D-03 J-04 F-04 M-04 A-04 M-04 J-04 J-04 A-04


Average Percent of Patients with BP < 140/90 (Hypertension)
Goal
41%
50
40
30
20
10
0
S-02
O-02
N-02
D-02
J-03
F-03
M-03
A-03
M-03
J-03
J-03
A-03
S-03
O-03
N-03
D-03
J-04
F-04
M-04
A-04
M-04
J-04
J-04
A-04
Average Percent of Patients with Two BP's in Last 12 Months
Goal
70%
90
80
70
60
50
40
30
20
10
0
S-02
O-02
N-02
D-02
J-03
F-03
M-03
A-03
M-03
J-03
J-03
A-03
S-03
O-03
N-03
D-03
J-04
F-04
M-04
A-04
M-04
J-04
J-04
A-04


Average Percent of Patients with Fasting Lipid (5 Years)
Goal
70.3%
100
90
80
70
60
50
40
30
20
10
0
S-02
O-02
N-02
D-02
J-03
F-03
M-03
A-03
M-03
J-03
J-03
A-03
S-03
O-03
N-03
D-03
J-04
F-04
M-04
A-04
M-04
J-04
J-04
A-04
Average Percent of Patients with LDL<100 (CAD and/or DM)
Goal
15.8%
80
70
60
50
40
30
20
10
0
S-02
O-02
N-02
D-02
J-03
F-03
M-03
A-03
M-03
J-03
J-03
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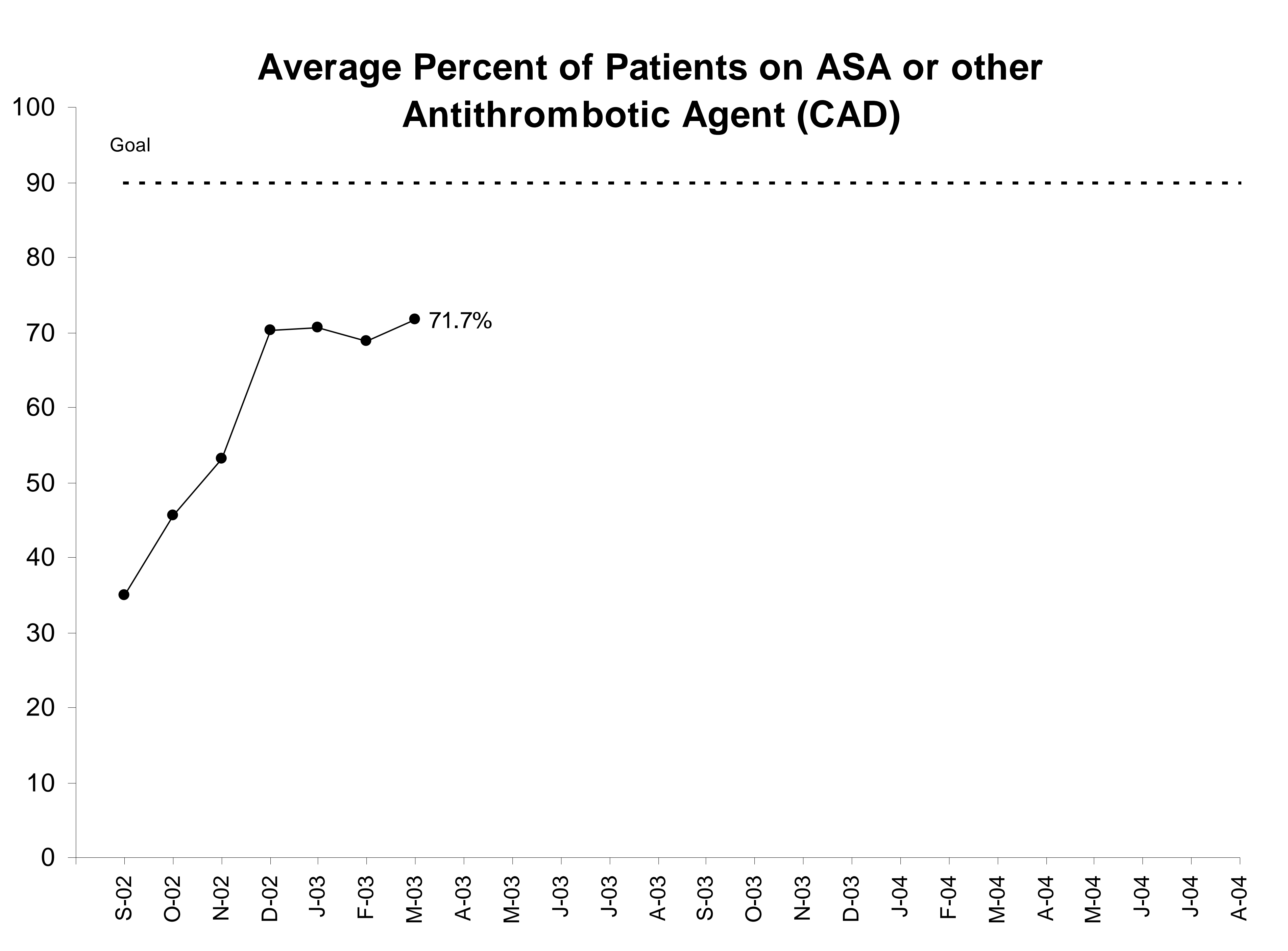
Average Percent of Patients on ASA or other Antithrombotic Agent (CAD)
Goal
71.7%
100
90
80
70
60
50
40
30
20
10
0
S-02
O-02
N-02
D-02
J-03
F-03
M-03
A-03
M-03
J-03
J-03
A-03
S-03
O-03
N-03
D-03
J-04
F-04
M-04
A-04
M-04
J-04
J-04
A-04

One Health Center's Journey toward depression integration

February

Development of Behavioral Health Consultant role and redesigning the mental health services in Family Practice.

Jan

Determining feasibility of program that will address mental health needs of our CV patients. In the long term, hope to offer these services to all patients with chronic disease.

Dec

Nursing staff initiating PHQ and found 50% of those rating depressed. Referral is then made to social services for further eval. Goal is to address and treat depression in patients with chronic disease. Have an independent psychiatrist and psych NP part time.

Nov

Began testing CV patients for depression using the PHQ. 24/74 registry patients tested as they came in for appt. Any patient > 5 is referred to SW for further evaluation.

Oct

Return from Learning Session #2 identifying the importance of testing and treating chronic condition patients for depression

Prevention Pilot

- Focus for prevention:
  - **Healthy Weight**
  - **Tobacco**
  - **Cholesterol**
  - **Blood Pressure**
  - Immunizations
  - Oral Health
  - Blood Lead Test

Vision: a summary

- By 2005, model of care implemented in all HCs
- Core set of clinical prevention, chronic disease measures
- BPHC supported programs form a learning and improvement community in their state working on a core set of aims/measures
- State based and national infrastructure, leadership and partnerships to sustain and spread model and accelerate improvement
- Major improvement in health status among underserved people

QUESTIONS?