

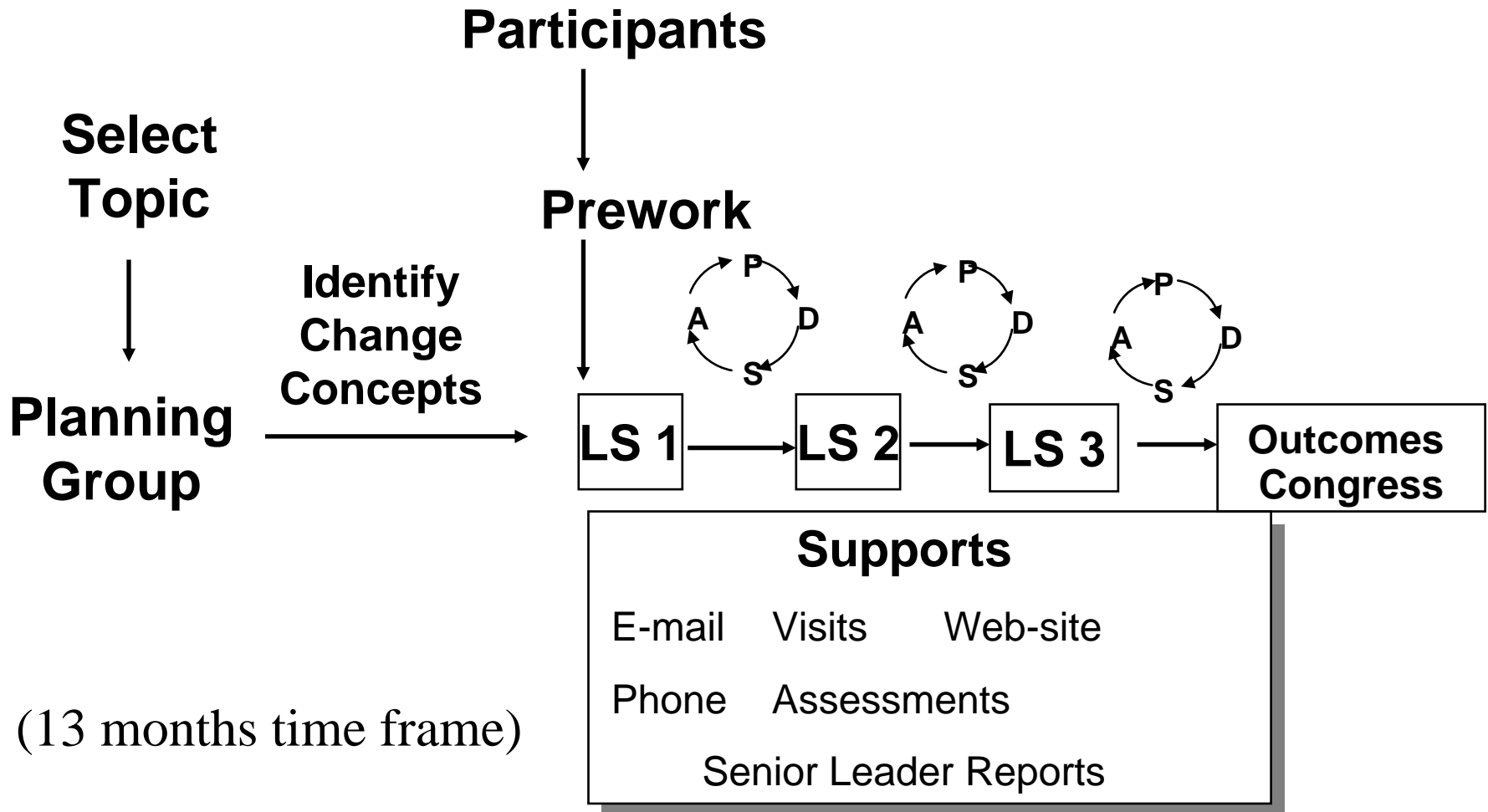
# How to Develop A State Health Care Collaborative Using the Planned Care Model

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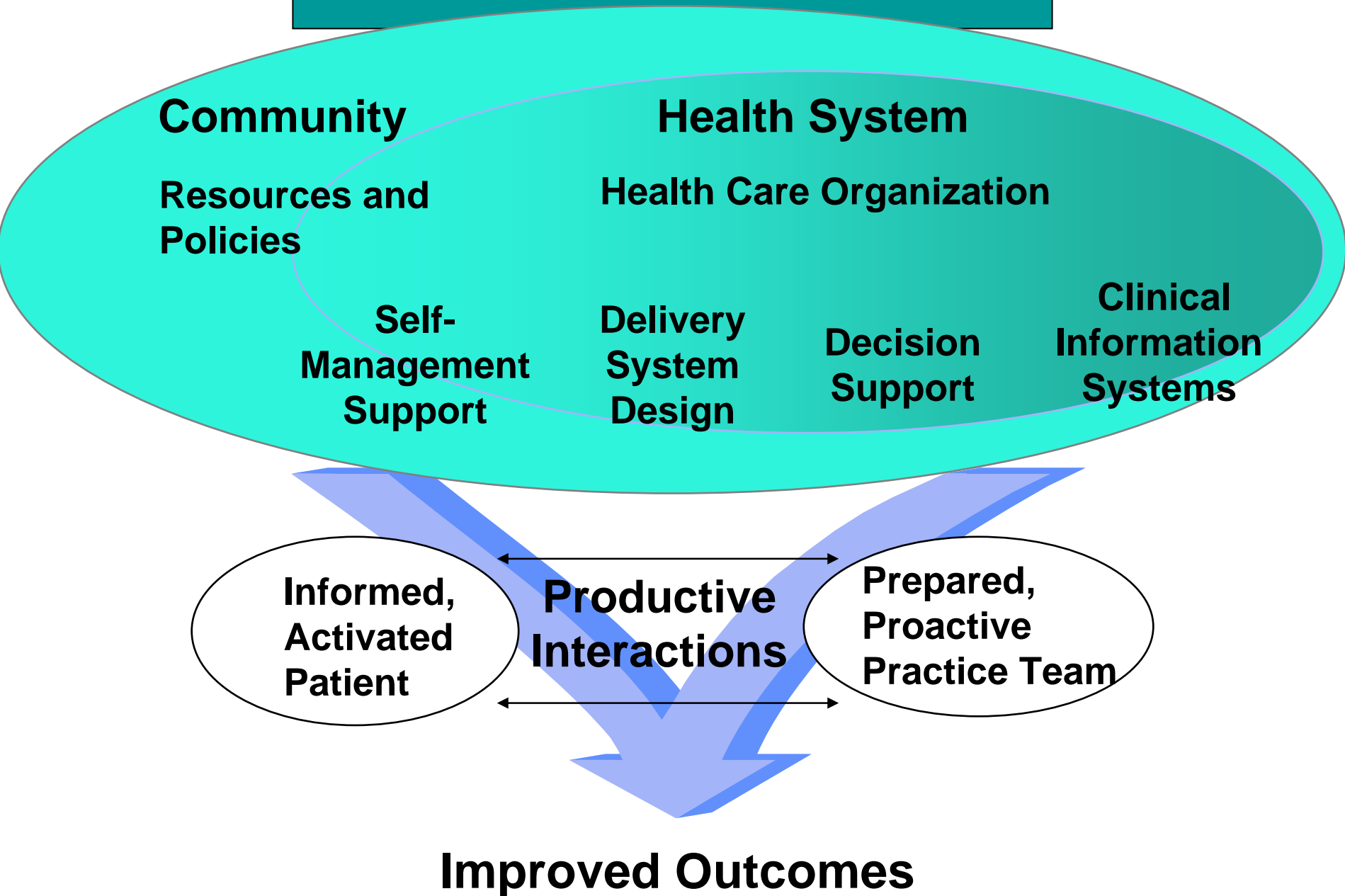
# Collaborative Process



# Learning Sessions

- Conduct Three Learning/Training Sessions
- Time Frame
  - 13 Months for 3 Sessions – Two Sessions per grant cycle
  - 2 Day Sessions – Friday/Saturday
  - Overnight Stay – 1 Room per two participants
  - Meals Provided– Breakfast/Lunch
- Follow the National Health Disparities Collaborative Guidelines/Agenda

# Planned Care Model

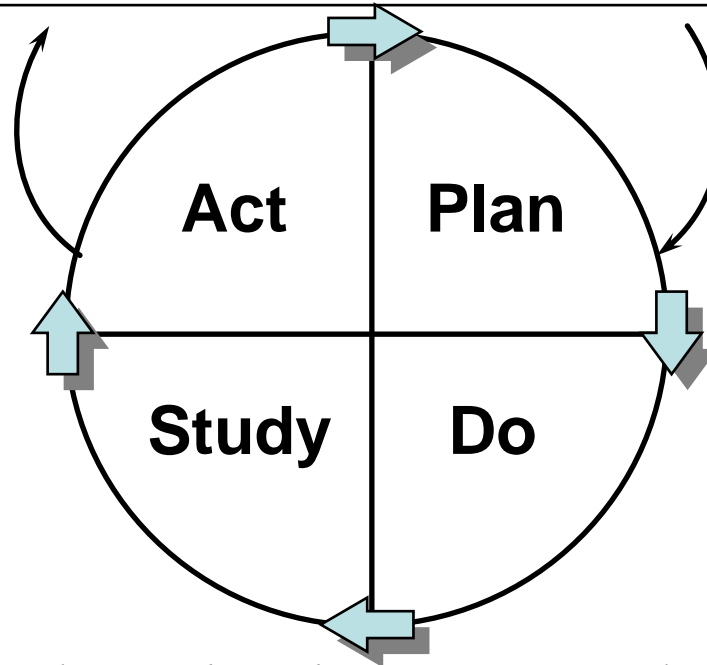


# Model for Improvement

What are we trying to accomplish?

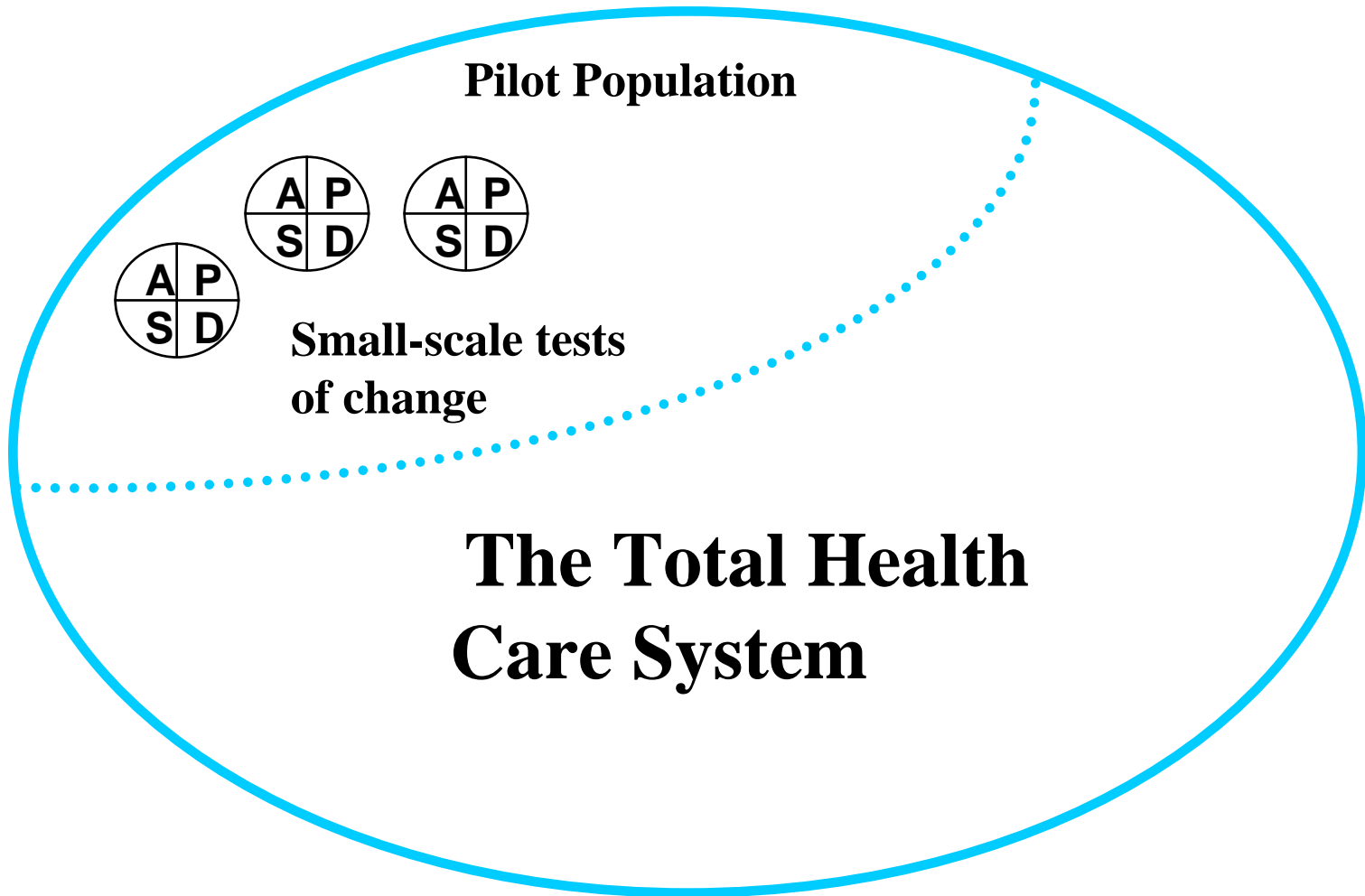
How will we know that a change is an improvement?

What change can we make that will result in improvement?



# Rapid Cycle Change

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# Partners/Resources (WA)

- Washington State Department of Health
  - Heart Disease and Stroke Prevention
  - Diabetes Prevention and Control
  - Tobacco Control
  - STEPS to a Healthier Washington
- Qualis Health
- Improving Chronic Illness Care
  - Robert Wood Johnson National Program

# Partners/Resources (WA) – cont.

- DOH
  - Faculty/staff for 3.0 FTE
  - Scholarships for teams \$360,000
    - 10K per team awarded through an RFP
    - Administered through an outside foundation
- Qualis Health
  - Faculty/staff for 3.0 FTE
- Improving Chronic Illness Care
  - Technical Support



# Partners/Resources (NC) - cont.

2004-05 Chronic Disease Management Collaborative  
Cost approximately \$170,000 plus additional "in kind"

- Kate B. Reynolds Charitable Trust: \$75,000
- CDC - NC Diabetes Prevention and Control Branch:  
\$25,000 + in kind (~\$20,000)
- CDC - NC Heart Disease and Stroke Prevention Branch:
  - State \$21,000 + in kind (~\$10,000)
  - Local ~\$7,000 + in kind (self-management materials)
- Medical Review of North Carolina: \$6,000 + in kind (CMEs)
- NC Community Health Care Association: \$6,000 + in kind

# Partners/Resources (AR)

## **Planning Committee Partners:**

- Arkansas Foundation for Medical Care (QIO organization)
- Arkansas Diabetes and Control Program
- Arkansas Health Education Centers
- Community Health Centers of AR, Inc.
- Arkansas Cardiovascular Health Program

# Partners/Resources (AR) – cont.

- UAMS Department of Family and Preventive Medicine CME

## **Resources**

- AR Tobacco Prevention & Education Program (\$50,000)
- AR Cardiovascular Health Program (\$27,000)
- AR Diabetes Prevention & Control Program (\$12,000)

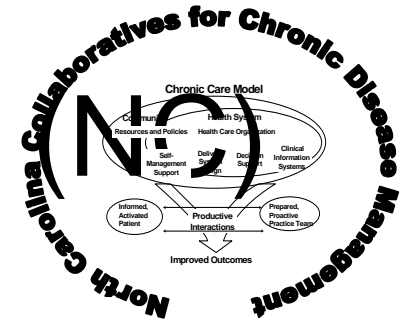
# Marketing/Recruitment (WA)

- Mass mailing to all PCPs in WA with postcard mail back
- Follow up phone calls
- Face to face presentations with marketing packet
- Fact sheets on what the Collaborative is
- Word of mouth from previous teams

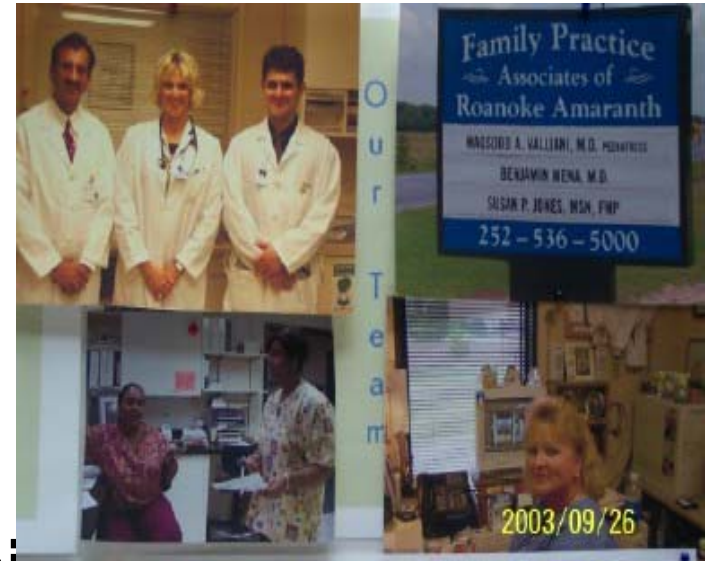
# Marketing/Recruitment (WA) – cont.

- Scholarships to assist with cost to attend
  - Tuition, abstraction, travel, staff replacement
- Health plan contacts to providers
- Public health partners outreach to providers

# Marketing/Recruitment



- Community & Rural Health Centers
- Local Health Departments
- Free Clinics
- Private Physician Offices
- Health Plans
- Hospital-Based Outpatient Education Programs



**21 teams recruited, 18 participating (10 were given \$1,000 sponsorships; most paid own travel)**

# Marketing/Recruitment (NC) – cont.

- Direct Mail Letters, Brochures, Newsletters, Websites and Face to Face Presentations
  - Community & Rural Health Centers
  - Local Health Directors
  - Primary Care Providers
  - NC Medical Society
  - Old North State Medical Society
  - NC Association of Health Plans, Inc.
  - NC Academy of Family Practice
  - Blue Cross Blue Shield Chronic Disease Managers

# Marketing/Recruitment (AR)

- Committee Partners Recruit Clinic Teams for the Arkansas Chronic Illness Collaborative
- Minimal PEC Software Support (\$1,500)
- UAMS Department of Family & Preventive Medicine markets to health care professionals using current mailing/registration list and promotional postcards

# Marketing/Recruitment (AR) – cont.

- Developed informational brochure targeting private clinics
- Provide \$3000 per clinic for technical assistance to establish cardiovascular and/or diabetes patient registries
- Promote the Collaborative utilizing the nationally produced video tape “Changing Practice, Changing Lives”

# Faculty/Staffing (WA)

- Director (DOH)
- Coordinator (Qualis)
- Improvement Leaders (Qualis)
- Systems Leader (DOH)
- Chair (contract \$5K per specialist)
  - CVD
  - Diabetes

# Faculty/Staffing (WA) – cont.

- Lead faculty for each of the model (6)
  - DOH staff or former clinic participants
- Event planning (Qualis Health)
  - Registration
  - Materials development
  - Facility arrangements
- Invited national speakers















# Measures/Tracking (NC) – cont.

- Hypertensive patients with BP < 140/90
  - <130/80 if Diabetes or Renal Disease
- Patients with 2 BP's in last year
- Patients with fasting lipids documented
- LDL Cholesterol <100 mg/dl (CAD & DM)
- Document Self Management Goal Setting
- Aspirin or other antithrombotic agent use
- Patients who are Current Smokers

# Measures/Tracking (AR)

## Registry Tracking

- Started with CV/Dems
- CHC currently using PECS
  - Cost to purchase from NHDC <\$500
- AHEC using Logician
- Collect the same data regardless of software
- Collaborative Sessions
  - Monthly registry reports
  - 2<sup>nd</sup> year - quarterly registry reports

# Measures/Tracking (AR) – cont.

- Cardiovascular Key Measures
- Patients with 2 BP's in Last Year >90%
- Hypertensive Patients with BP<140/90 >50%
- Fasting Lipid Profile Documented (5Yr) >80%
- LDL Cholesterol <100 mg/dl >60%
- Documentation of Self-Mgmt Goal Setting >70%
- Aspirin or Other Antithrombotic Agent  
>90%

# Cardiovascular Registry Report

## Demographics

- Gender, Age, Ethnicity, Insurance, Type of CVD, Special Populations

## Visit Information

- BMI, Blood pressure, Meds, Health Profile, Specialty Care Received

## Test Information

- Lipid Profile, Creatinine, Potassium, NYGA Class, Electrocardiogram, echocardiogram, exercise stress Test, Cardiac Cath, Revascularization

# Sustainability (WA)

- Ongoing data requests monthly for the first year then quarterly
- Repeat Collaborative experience to support spread to new sites in system
- Train new staff in chronic care model and registry support
- County-wide Collaboratives developing
- Push to implement EHRs by QIOs
- Maintain email list for communication

# Sustainability (WA) – cont.

- Developing Sustaining Change Initiative
  - *To assist organizations who have been through the WSC to sustain and spread planned care through providing tools and a supportive interactive experience that builds skills, confidence, competencies and infrastructure to improve the care of all patients*
  - *18 months, no tuition, modest travel support*
- *Develop and implement a spread plan*
- *15 teams enrolling for a Sep 29<sup>th</sup> launch*



# Sustainability (NC) – cont.

- Ideas for Phase 2 (life after Year 1):
  - “Membership” Status (associated fee)
  - List-serve Communication
  - Report collection 2xs year
  - Yearly Summit
  - Specialty Collaborative (Medicaid Providers, etc.)

# Sustainability (AR)

- Diabetes Program starts Collaborative in 2002
- ACIC established in 2003
- Targeted Clinics
  - Community Health Centers, Inc.
  - AR Health Education Centers
  - Private Clinics (2 currently participating)
- Funding
  - \$90,000 per year
  - considerable in-kind staffing support

# Sustainability (AR) – cont.

- Tied to Funding
- Tied to Clinics continued interest in participating
- Tied to increase in private clinic participation
- Tied to increased awareness of Planned Care Model
- Tied to Care Model accepted as the quality of care standard for system change in clinics

*Developing A  
State Health Care  
Collaborative*



Improving  
Quality of  
Care is Hard  
Work . . . . .  
Providers Do  
Not Have to  
Do It Alone!

**Grant me the serenity to accept the things I cannot change,  
the courage to change the things I cannot accept, and the  
wisdom to hide the bodies of those people who were unwilling  
to participate in my test of change!**

