Applying the Care Model in Statewide Health Disparities Collaboratives

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Evaluation Team

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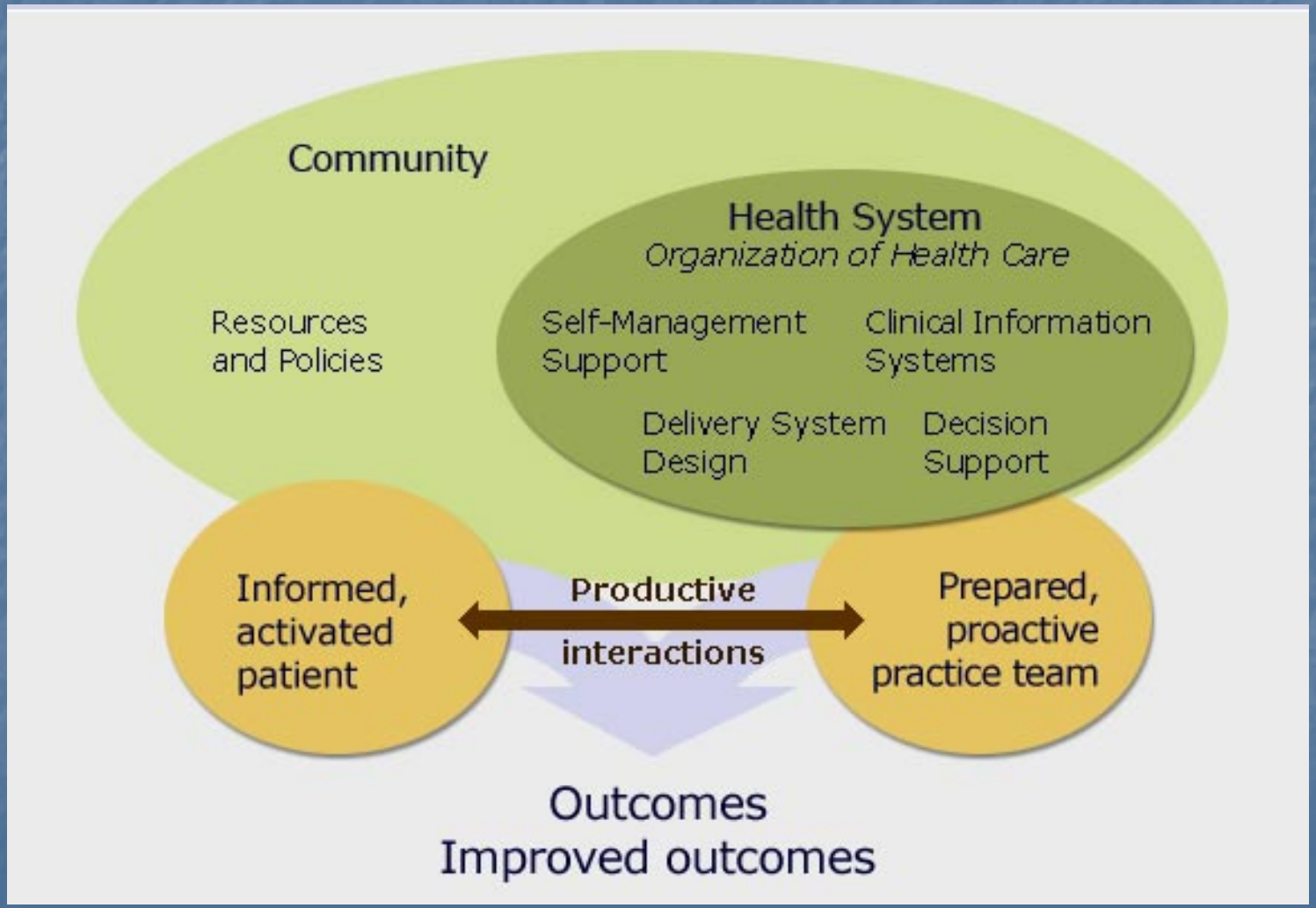
Summary of Collaborative

- Teams from seventeen health centers
- Focus on 100 patients with Type II diabetes
- Patient registry developed
- Rapid cycle improvements
- Learning interventions included:
  - Pre-collaborative training of teams
  - Three two-day learning conferences
  - Monthly telephone calls
  - Monthly progress reports with feedback from program leaders

Built Using the Care Model Framework



Evaluation Components

- Quantitative
  - Patient Survey
  - Clinical Quality Indicators
  - ACIC Key Personnel Survey
- Qualitative
  - Monthly team narratives
  - Site visit in-depth interviews at all CHCs

Overall Organizational Leadership in Chronic Illness Care

D.— does not exist or there is a little interest

C.— is reflected in vision statements and business plans, but no resources are specifically earmarked to execute the work.

B.— is reflected by senior leadership and specific dedicated resources (dollars and personnel).

A.— is part of the system's long term planning strategy, receive necessary resources, and specific people are held accountable.

Improvement Strategy for Chronic Illness Care

D.— is ad hoc and not organized or supported consistently.

C.— utilizes ad hoc approaches for targeted problems as they emerge.

B.— utilizes a proven improvement strategy for targeted problems.

A.— includes a proven improvement strategy and uses it proactively in meeting organizational goals.

Assessment of Chronic Illness Care, Health Disparities Collaborative, Phase I, Start and Finish

Health Center 4	A (9-11) *fully developed*	B (6-8.9) *reasonably good support*	C (3-5.9) *basic support*	D (0-2.9) *limited support*
Organization of Health Care System			**5.6** **4.5**	
Community Linkages			**3.4**	2.9
Self-Management			4.2 **4.1**	
Decision Support			**4.8** 3.8	
Delivery System Design			**4.9** 3.4	
Clinical Information		**6.0**		1.4
Integration System			**4.3**	2.0

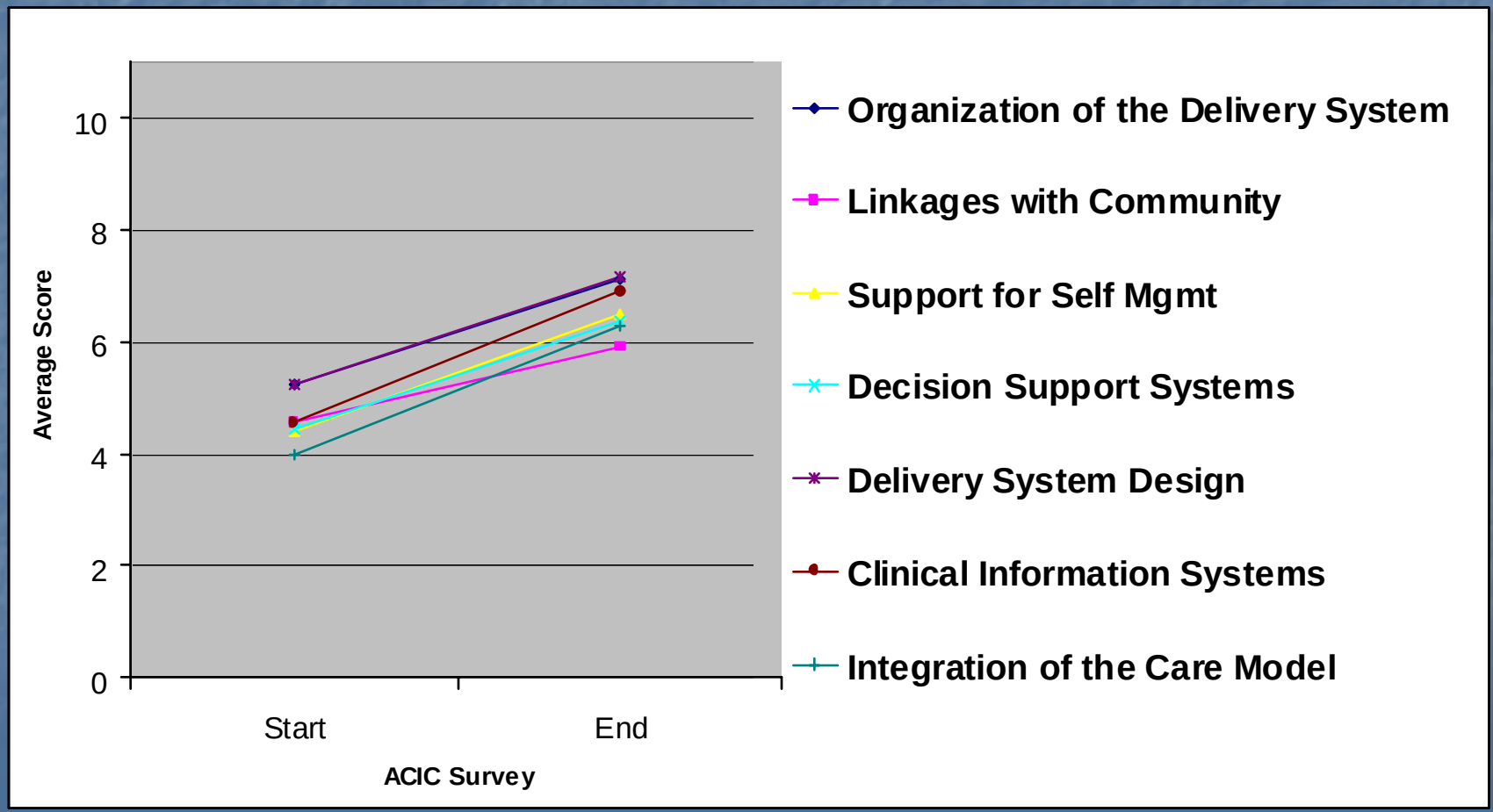
Scores in red represent the team's assessment after one year in the collaborative.

Assessment of Chronic Illness Care, Health Disparities Collaborative, Phase I, Start and Finish

Health Center 7	A (9-11)	B (6-8.9)	C (3-5.9)	D (0-2.9)
	fully developed	*reasonably good support*	*basic support*	*limited support*
Organization of Health Care System	**9.7**	6.7		
Community Linkages		**6.9**	5.4	
Self-Management		**7.3**	4.6	
Decision Support		**7.2**	4.8	
Delivery System Design		**7.3** 6.9		
Clinical Information		**6.4** 6.0		
Integration System		**6.3**	5.1	

Scores in red represent the team's assessment after one year in the collaborative.

Disparities Teams Assessed Capacity of Organization and Environment More Favorably after 1 Year



Massachusetts Health Disparities Collaborative Patient Survey Results

- Collects data regarding
  - Perceived support from health care team
  - Patient behavior
  - Global health status
  - Demographic information

References :

AHRQ. https://www.cahps.ahrq.gov/content/CAHPSkit/files/ce152ad_engadultmed_mgdcare_3.0.doc, accessed 4 January 2006).

Greene J, Yedidia MJ; The Take Care to Learn Evalutation Collaborative. 2005. Provider behaviors contributing to patient self-management of chronic illness among underserved populations. *J Health Care Poor Underserved* 16(4):808-24.

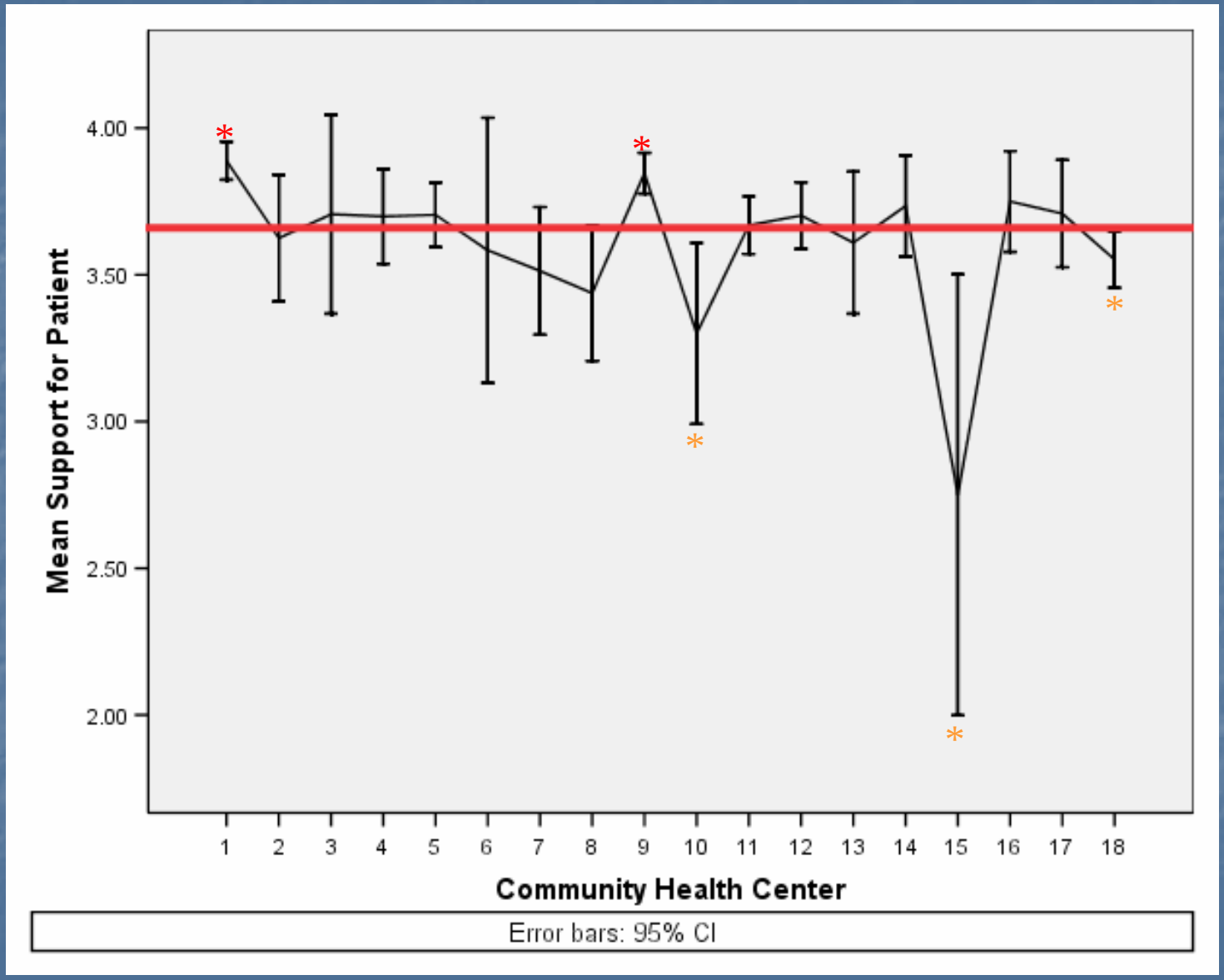
Toobert DJ, Hampson SE, Glasgow RE. 2000. The summary of diabetes self-care activities measure: results from 7 studies and a revised scale. *Diabetes Care* 23(7):943-50.

Patient Survey

Does your health care team involve you in making a plan to care for your diabetes?

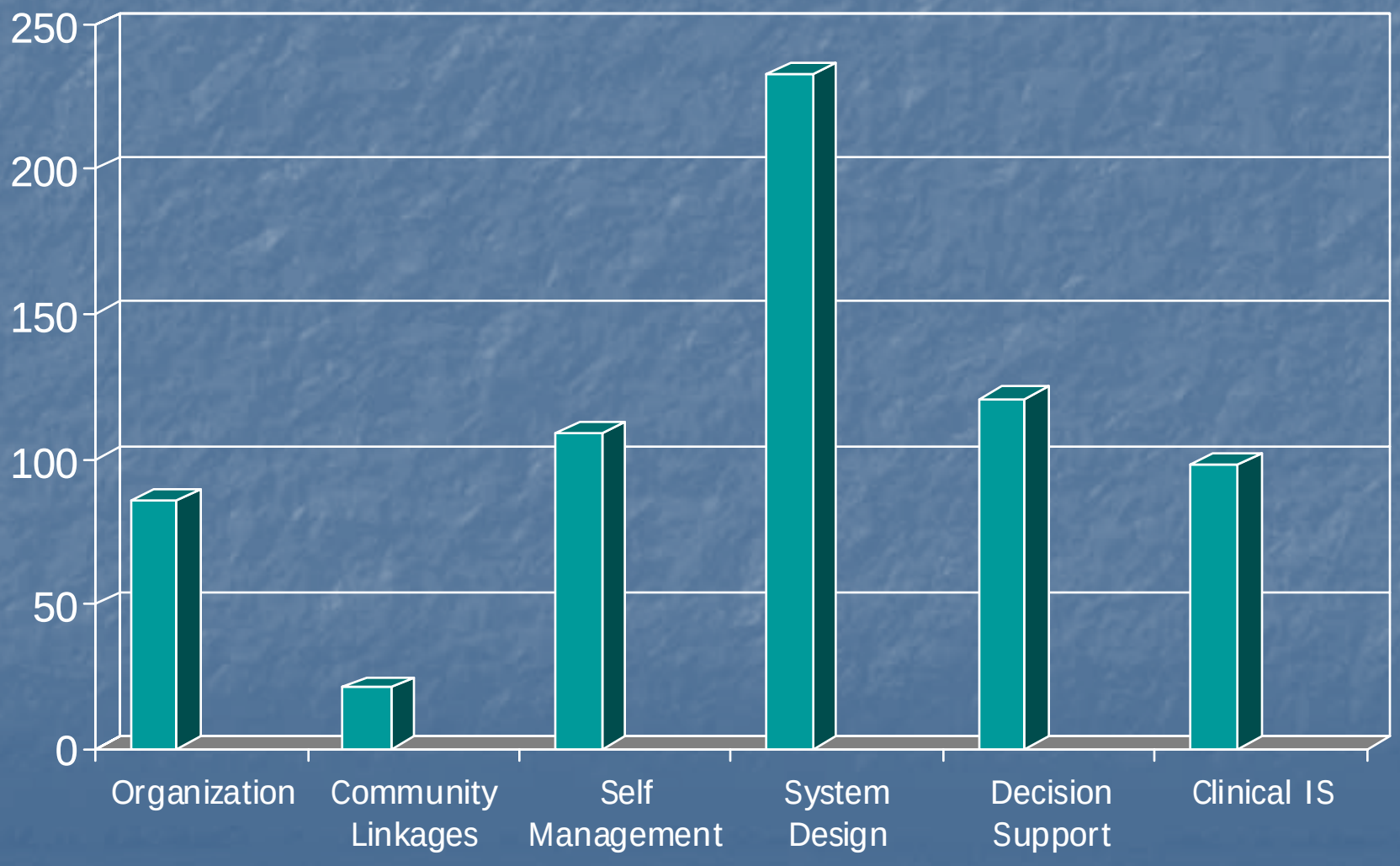
Overall, how helpful is your health care team in making you feel you can take care of your diabetes?

Patient Surveys: Average Support Score

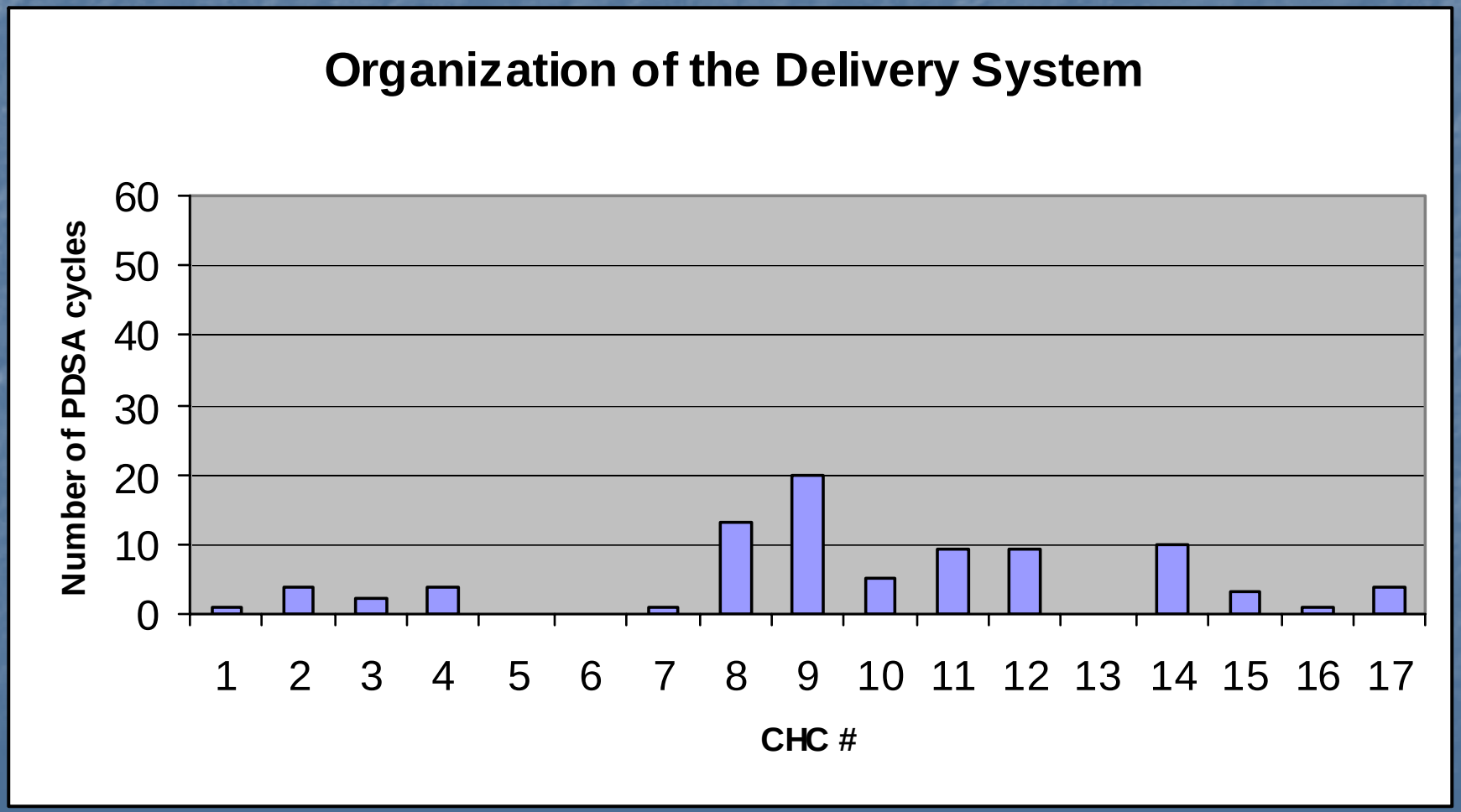


Range from 1 (Never) to 4 (Always)

Rapid Cycle QI: *Plan Do Study Act*



PDSAs in 17 Community Health Centers



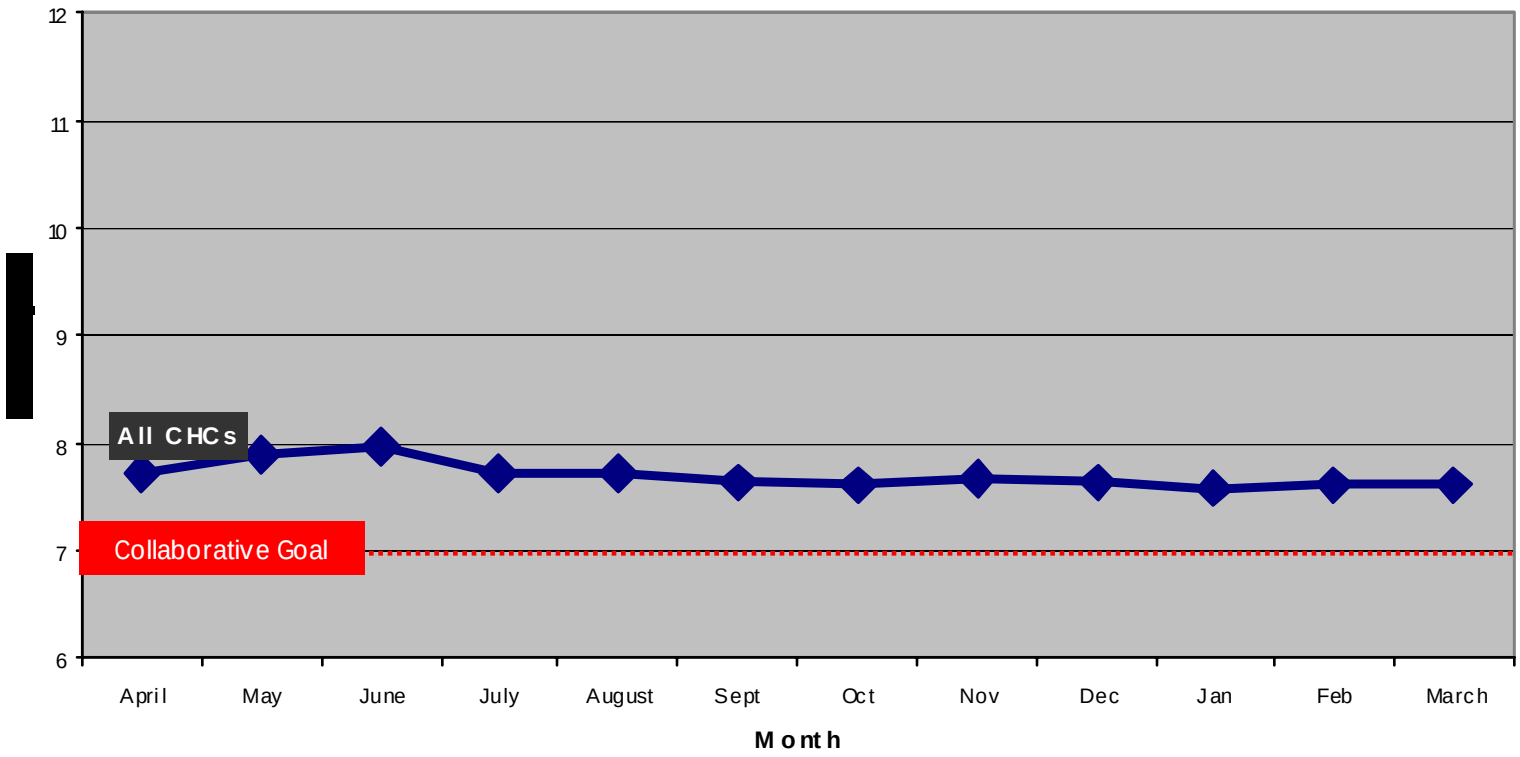
Main Success Stories over the course of Phase 1

1. Spreading information regarding the collaborative
2. New hire or new team member added
3. PECS up and running
4. Collaboration with agencies/organizations
5. Regular Team meetings

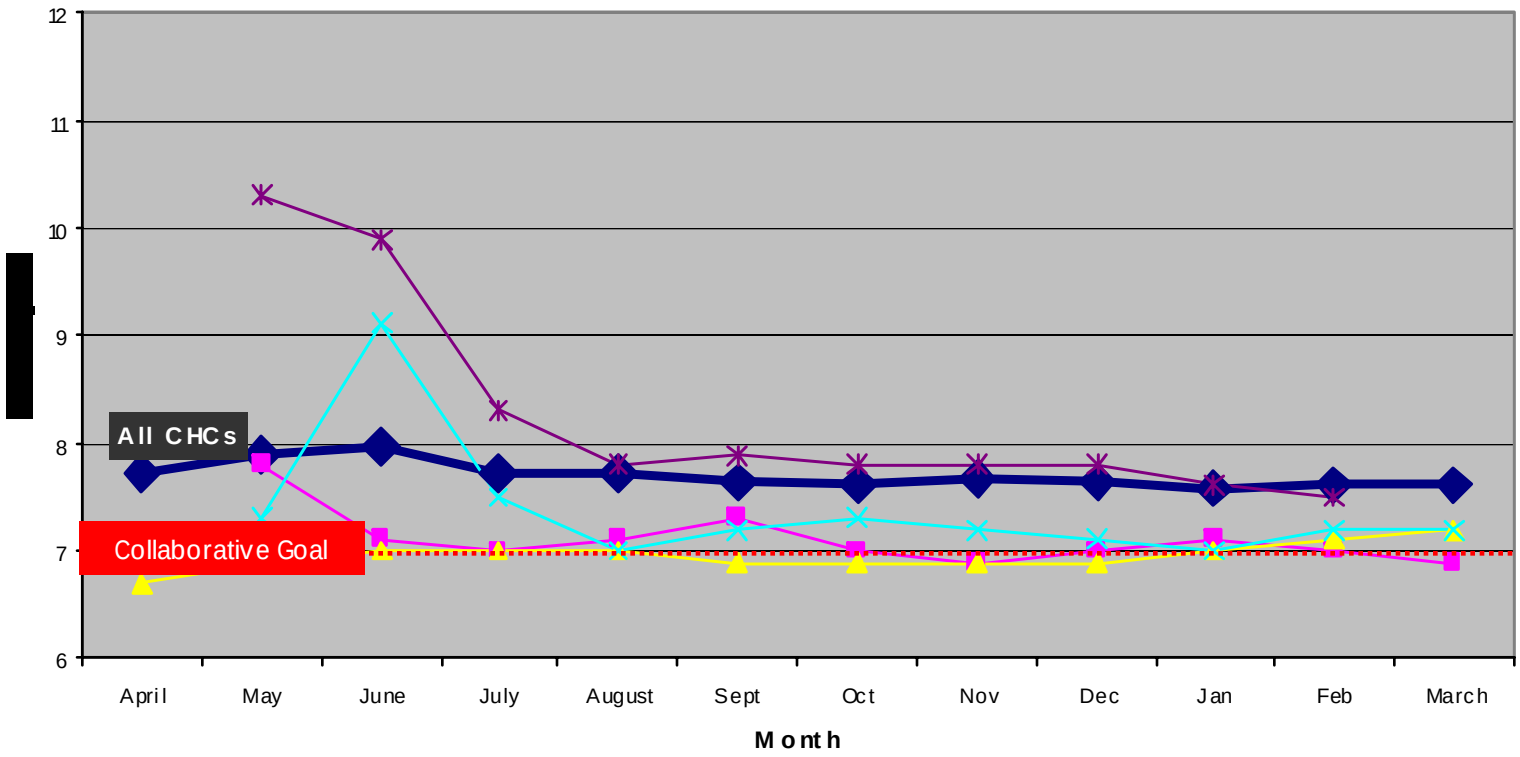
Major Barriers over the course of Phase 1

1. IT/PECS/EMR problems
2. Time constraints
3. Staff turnover/loss
4. Decreased or no team meetings
5. Locating sources of care/supplies

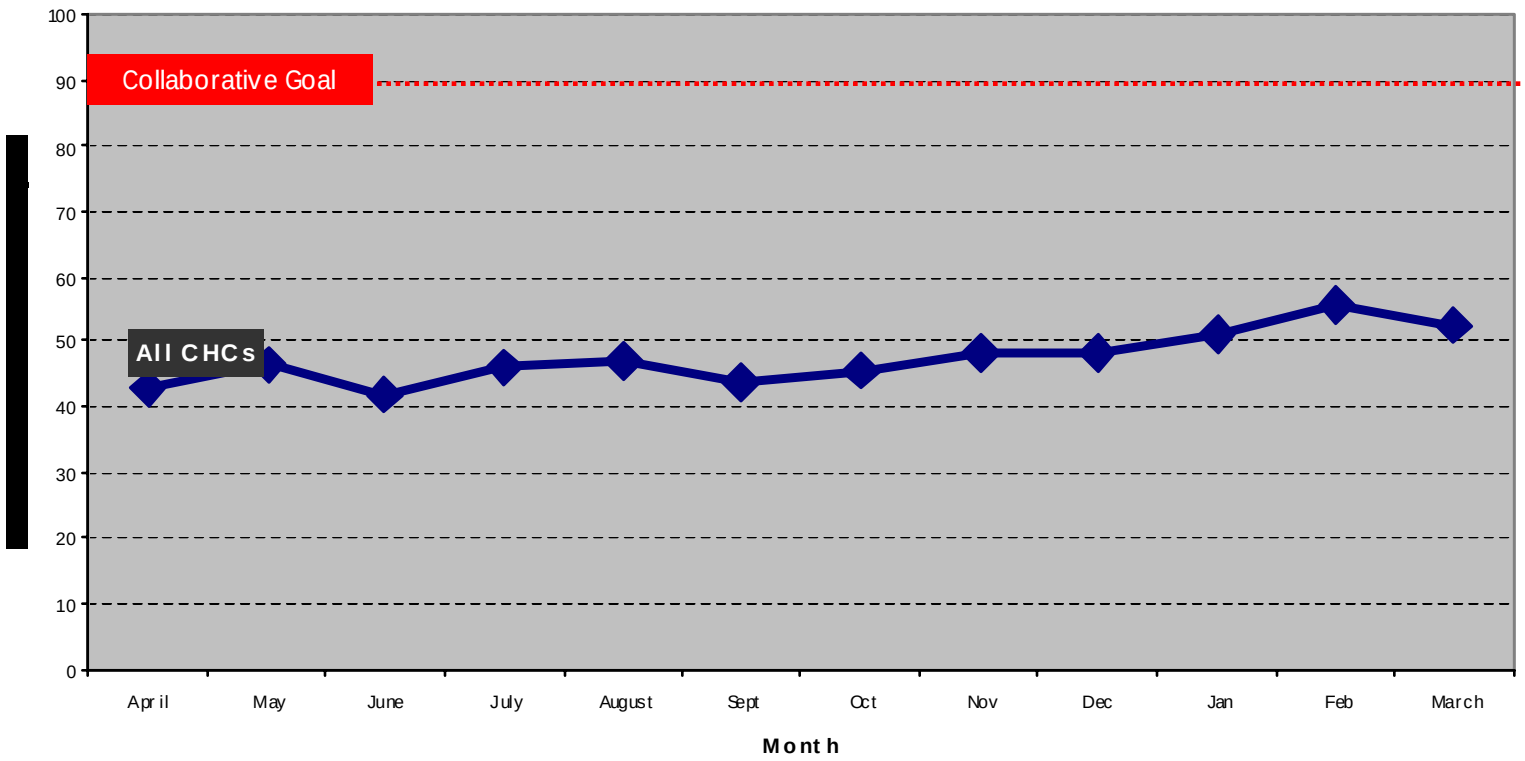
Average HgA1c



Average HgA1c



Two HgA1c Tests



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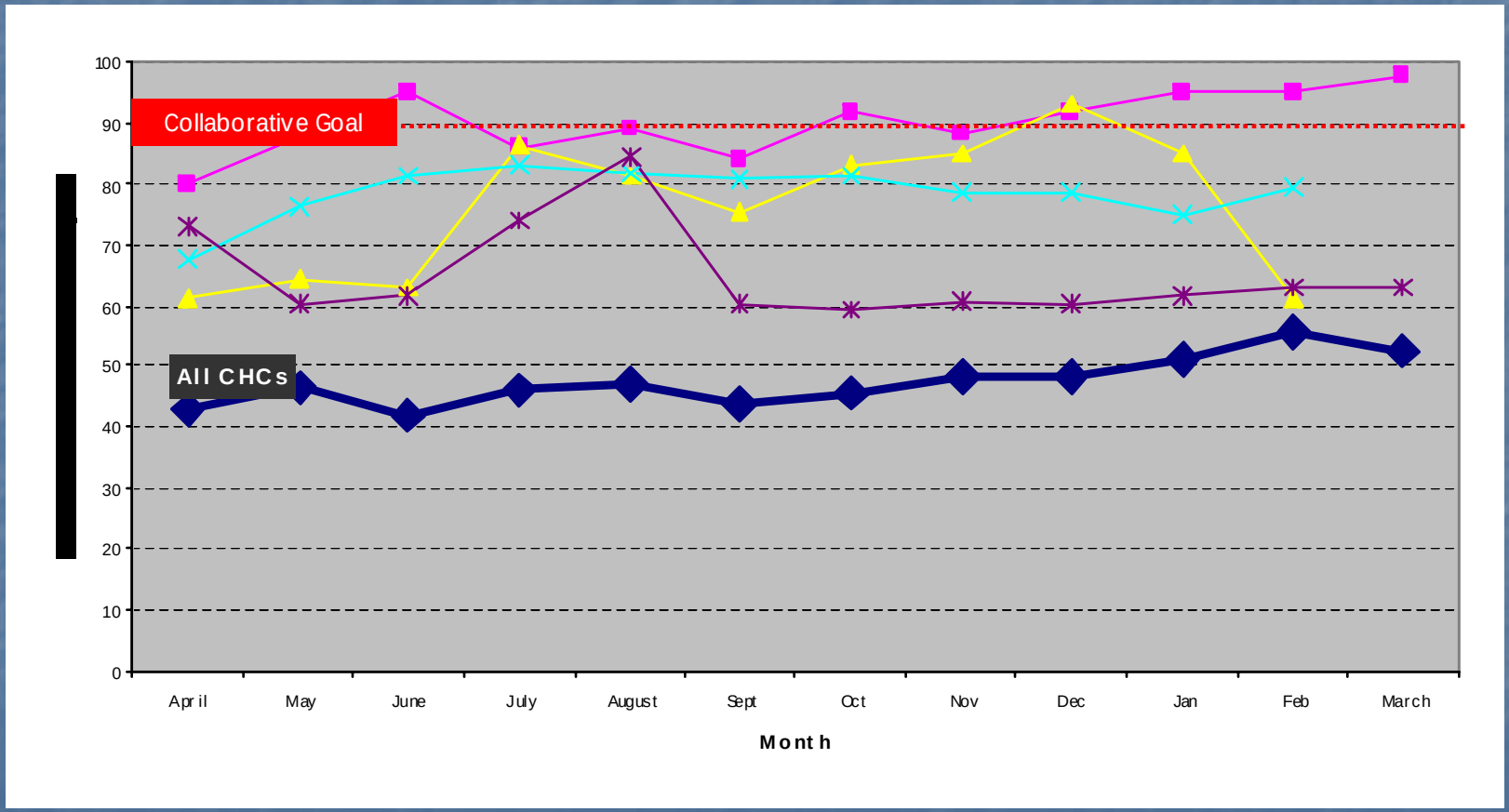
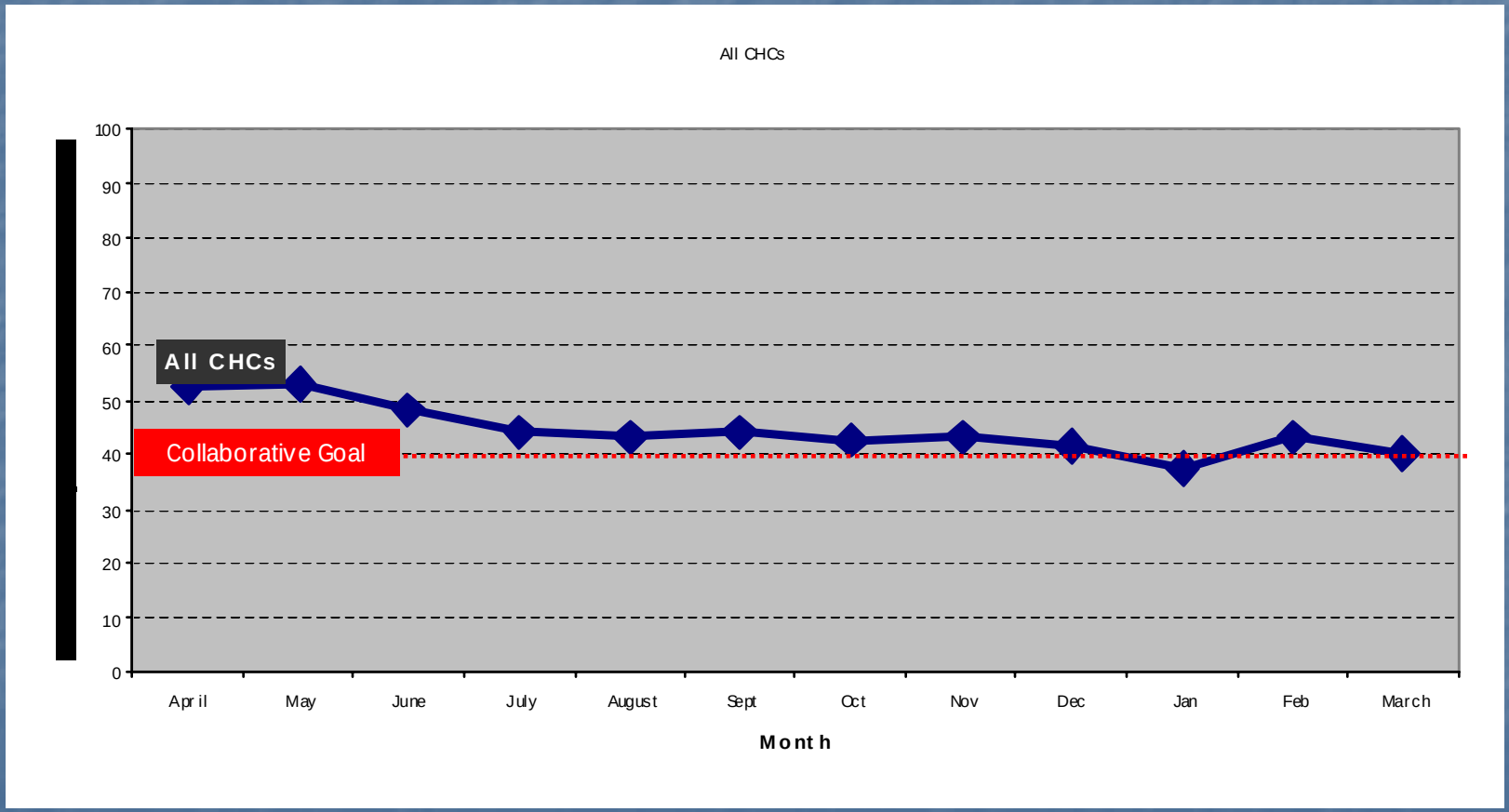


Percent of Patients with BP < 130/80



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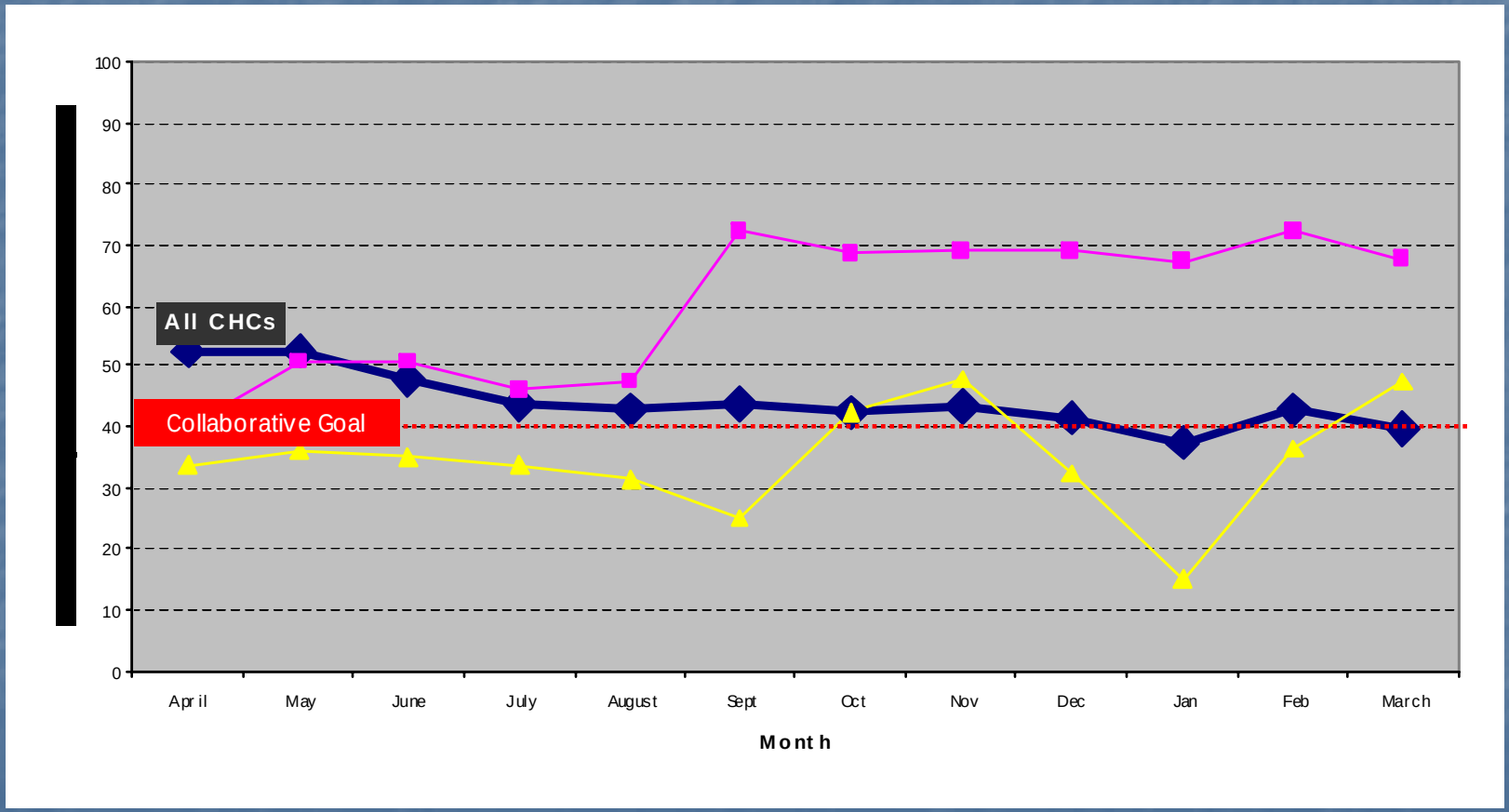
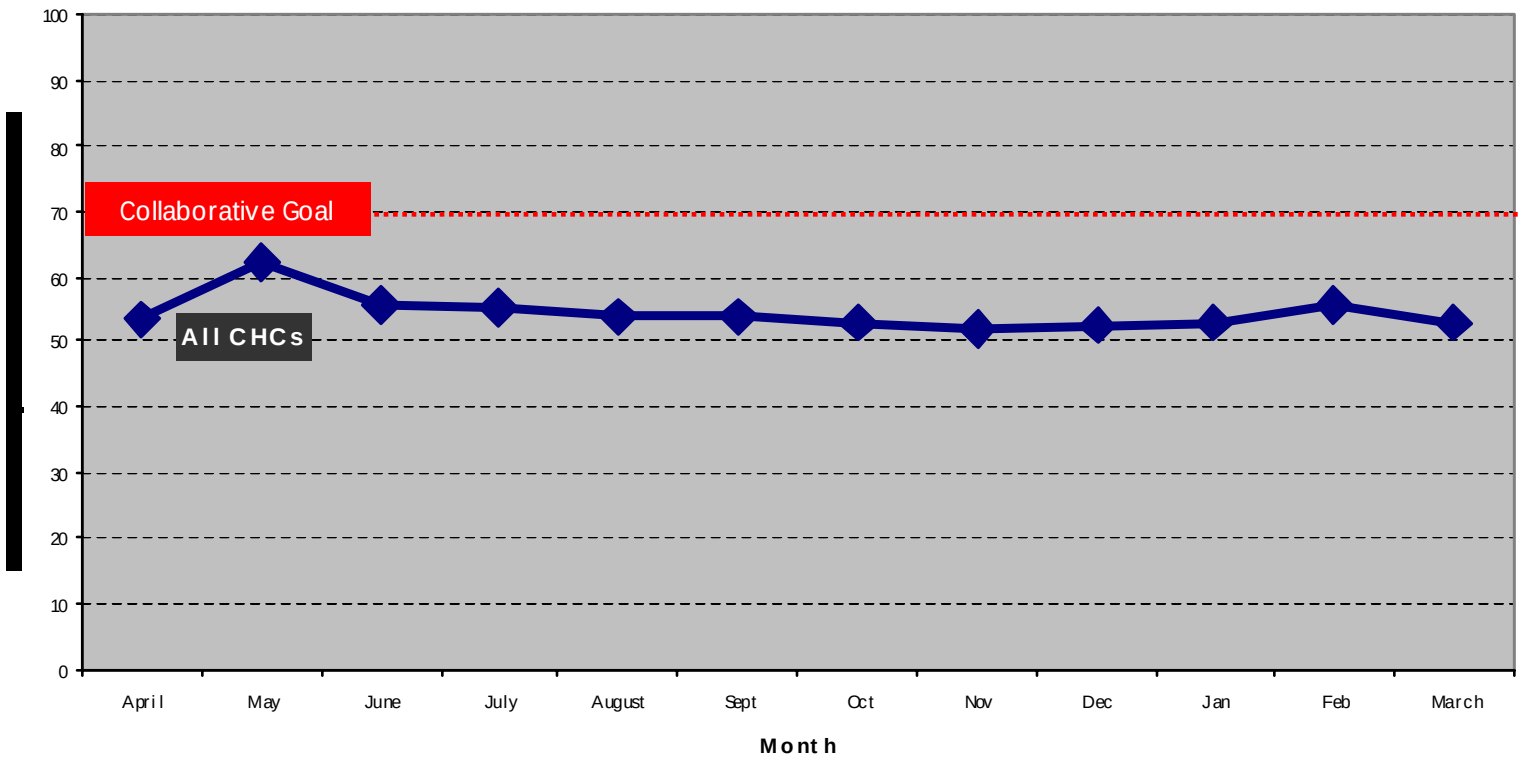
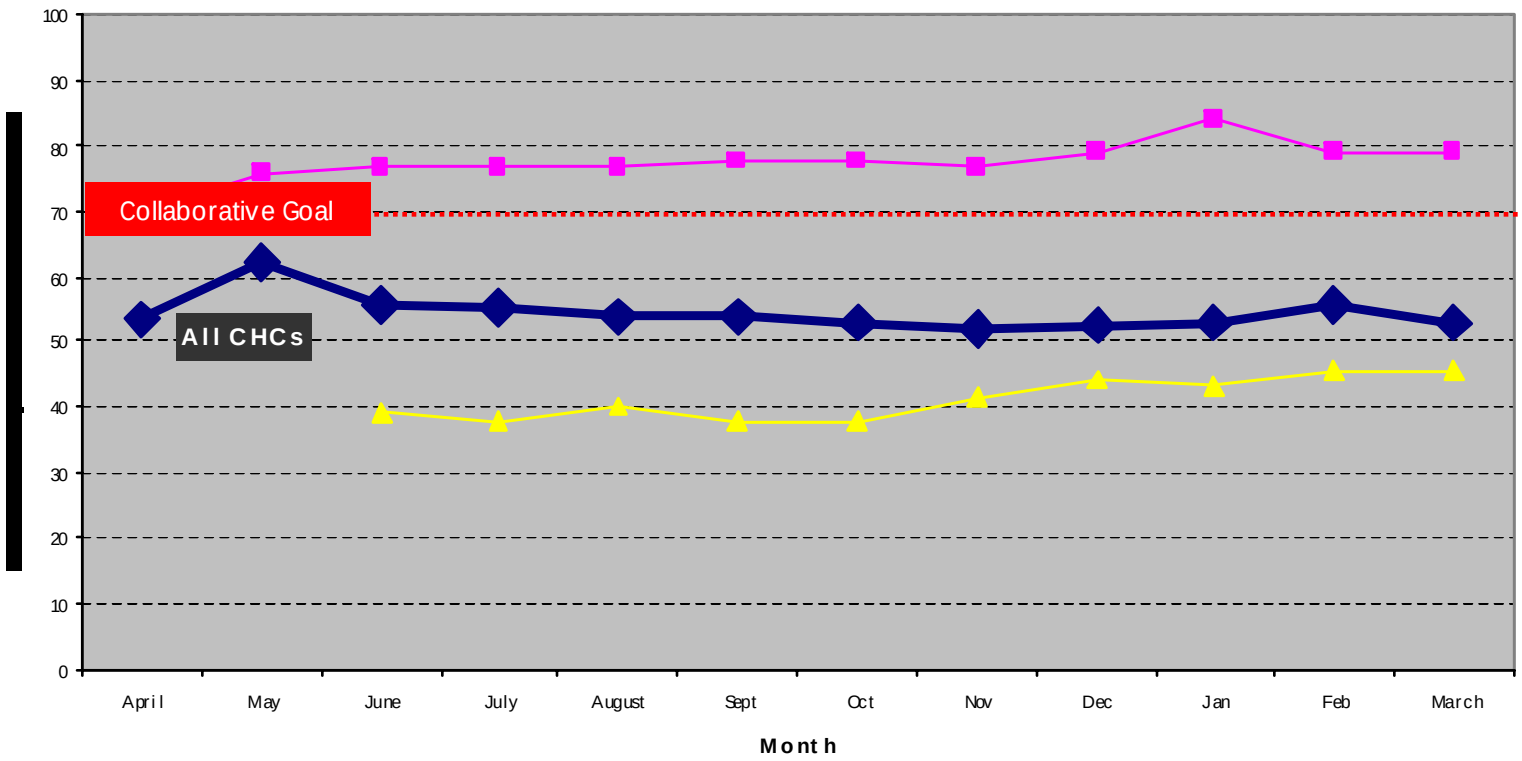


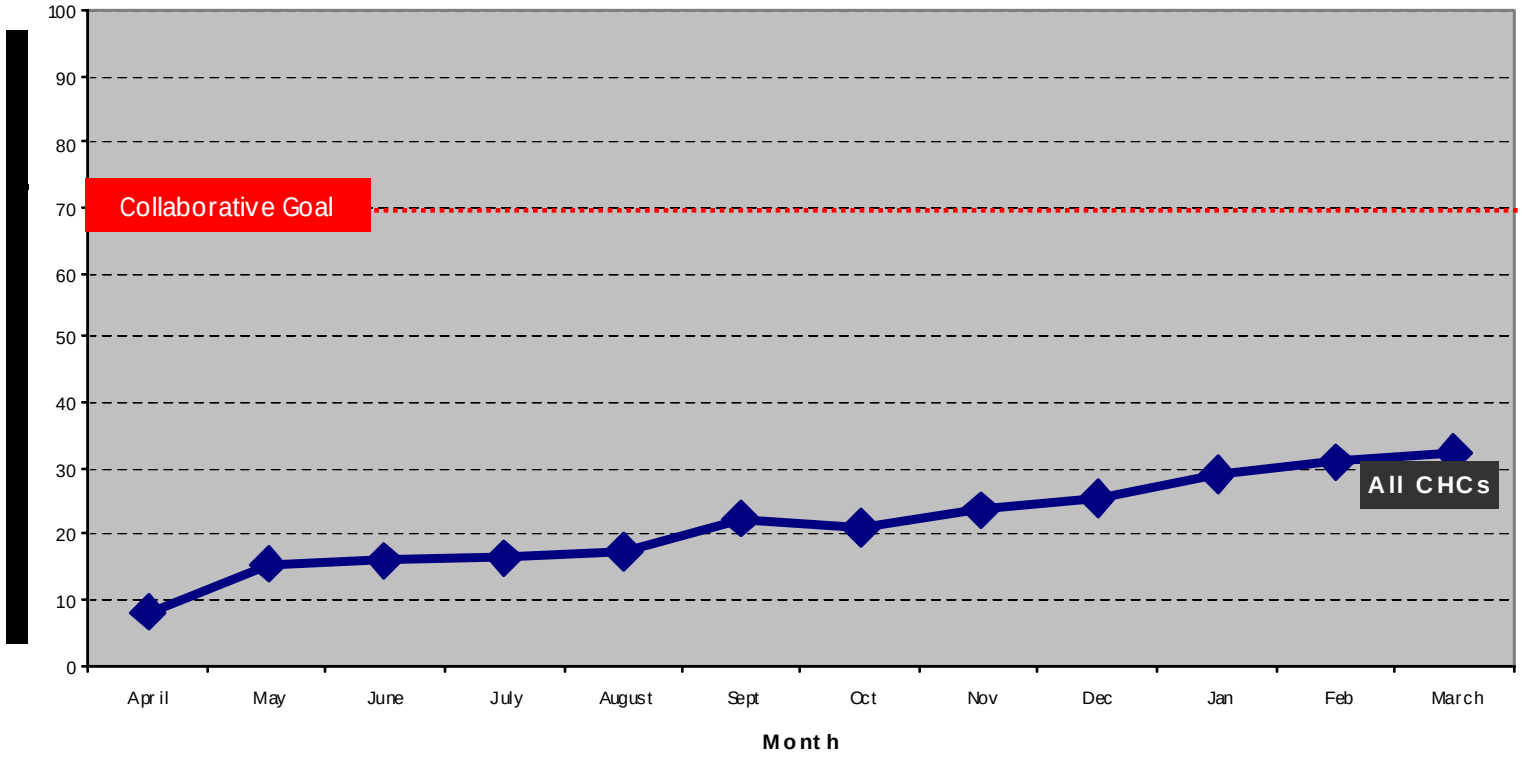
Percent with LDL < 100



Percent with LDL < 100



Percent with Documented Self-Management Goals



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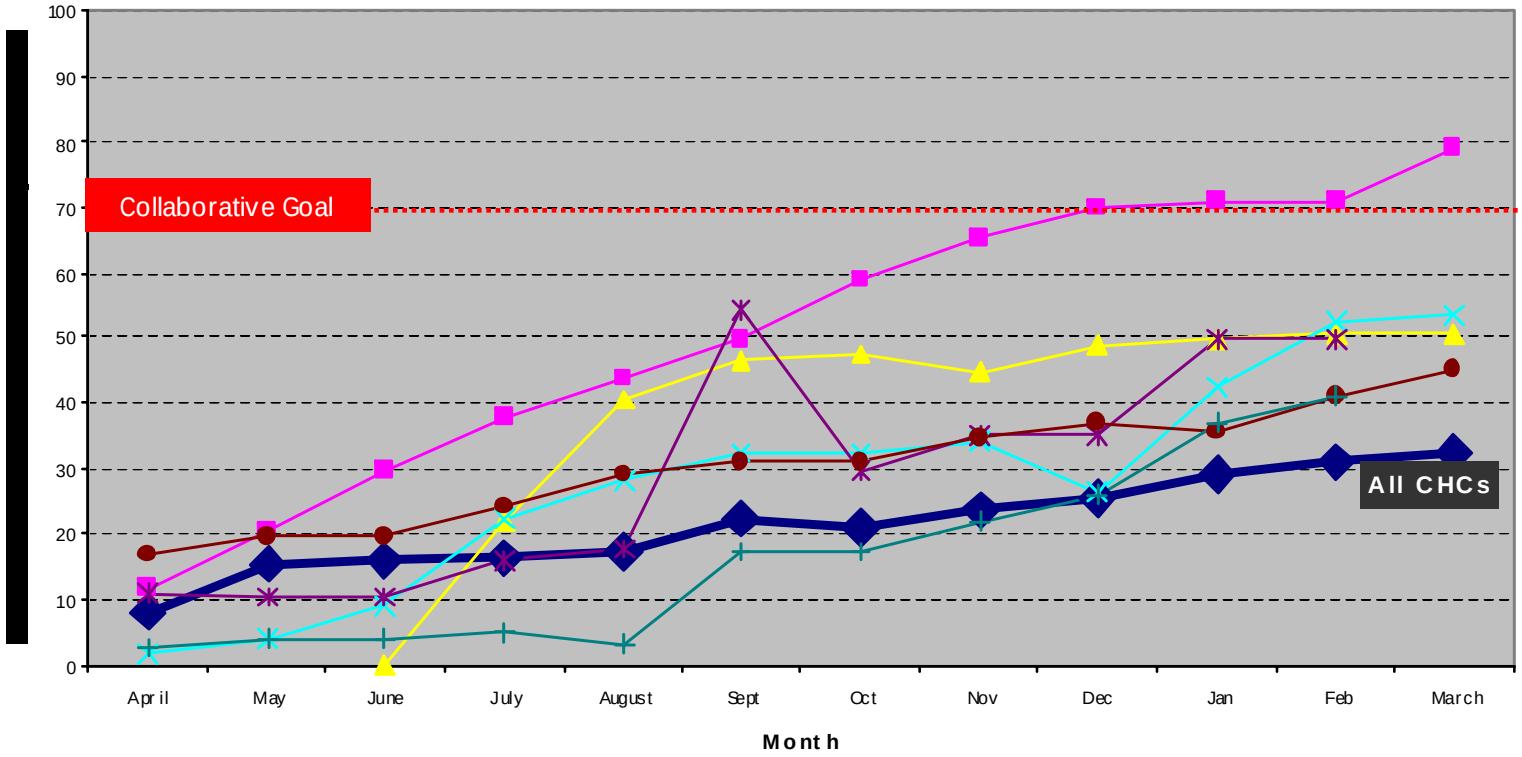

Sites with improvements: Common themes

- Multi-pronged, targeted approach
  - Example, additional support from other CHC teams with same goal or a grant supporting change
- Assigned responsibility for specific tasks
  - Example, for SM goal setting, MA gets the forms, the provider discusses SM goal setting and then refers to RN who sets the goal
- Provider Champion interest
  - Example, PC was aggressive about putting people on ACE inhibitors, ASA, and statins. This was an area the PC was very interested in

Take Home Messages

1. Health centers gained confidence in using the Care Model.
2. In aggregate, the only significant change among core measures was documentation of a self-management goal.
3. Nevertheless, several health center teams increased performance for a core measure.
4. Overall, surveys suggest that patients feel supported by the diabetes teams.
5. Transforming care, developing patient registries and monthly reporting, as well as testing change continuously requires perseverance, strong organizational leadership and resources.