



The Health Disparities Collaborative

Laura M. Gillis, MS, RN

A major goal of the US Public Health Service and the Bureau of Primary Health Care is the elimination of health disparities, particularly for minority populations, people living in poverty, and, in some cases, women. These health disparities refer to differences in deaths from the four top “killers” (heart disease, cancer, stroke, and diabetes), as well as other chronic illnesses.

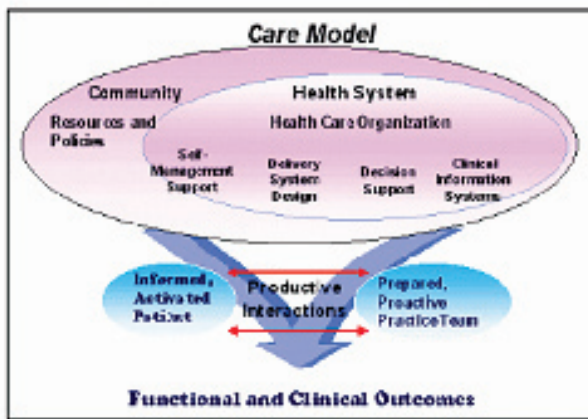
- African Americans have the highest mortality rate from breast cancer, are twice as likely as white Americans to die from prostate cancer, and are at greater risk for end-stage renal disease secondary to comorbid diabetes and hypertension.
- Hispanics and Native Americans are 2-3 times more likely than the general population to develop diabetes.
- Asian Americans are 3-5 times more likely to suffer liver cancer associated with untreated hepatitis.
- Inner city children and youth living in poverty have a higher incidence of asthma than those residing in less populated areas.

Health disparities are explained by four primary factors: limited access to appropriate health care; insufficient or ineffective treatment of mental

health problems; exposure to higher levels of environmental pollutants; and lifestyle factors such as use of addictive substances, poor diet, and physical inactivity.

Scientific research and clinical practice have produced strong evidence concerning the successful management of chronic diseases such as diabetes. However, the implementation of this knowledge remains a challenge for all clinicians, and closing this gap between scientific knowledge and clinical practice is a primary objective of the Health Disparities Collaboratives. To eliminate health disparities and improve functional and clinical outcomes, health care organizations must be willing to change the way care is delivered. The Health Disparities Collaboratives thus call for a fundamental transformation in the service delivery model of care in the USA. This transformation affects not only how clinicians, such

Dr. Stefan Kertesz of BHCHP examines a patient at the BHCHP clinic at Saint Francis House. Photo by Jessie McCary MD



as doctors, nurse practitioners, physician assistants, dentists, nurses, and social workers deliver care, but also how patients participate in their own care and how communities learn to strengthen the provider-patient partnership.

The Health Disparities Collaboratives strive to achieve excellence in practice and improve the health of all Americans through the following goals:

- 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.

The Health Disparities Collaboratives were developed by the Bureau of Primary Health Care (BPHC) in order to improve the health care provided to everyone and to eliminate health disparities. BPHC, a part of the U.S. Department of Health and Human Services, is responsible for funding programs to expand access to high quality, culturally and linguistically competent, primary and preventive care for underserved, uninsured, and underinsured Americans. To achieve this mission, BPHC funds community, migrant, homeless, and public housing health centers that care for over 3,500 communities and 12 million people, including 7 million minority individuals.

In 1998 BPHC funded one state Primary Care Association and one regional Clinical Network in each of five regional clusters to begin the first Collaborative. In addition, National Clinical Networks, created to focus on oral health, migrant farm worker health care, and homeless health care, began to work with the Institute for Healthcare Improvement (IHI) to develop the infrastructure to support the Health Disparities Collaboratives.

The first Collaborative in 1998 focused on

diabetes, with 88 health centers selected to participate. Additional Collaboratives have since been initiated, concentrating on asthma, depression, cardiovascular disease, HIV, and cancer, with plans for prevention, diabetes prevention, finance, and office redesign. As of December 2003, over 500 health centers have participated in at least one of these Collaboratives, including almost 30% of the over 160 Health Care for the Homeless Projects. All BPHC-supported health centers are expected to take part in the Health Disparities Collaboratives.

How can participation in a Collaborative make dramatic improvements in health outcomes possible, even for homeless patients? Three factors are essential for this to occur: 1) commitment of the health center's administration and providers; 2) support from the regional infrastructure comprised of primary care associations and clinical networks; and 3) adherence to three models of change promoted by the Health Disparities Collaboratives. These three models of change are the Learning Model, the Care Model, and the Improvement Model.

The Learning Model involves 12 months of intensive learning during the implementation phase, called Phase I, of a Collaborative. The Learning Model is adapted from the IHI's Breakthrough Series. The following components comprise the Learning Model.

- Health center leadership selects the staff team to work on the Collaborative. The team does initial pre-work to gain an understanding of the Collaborative and the issue being studied (diabetes, asthma, cardiovascular disease, or depression).
- The team participates in three Learning Sessions with teams from other centers and with expert advisors. At these sessions, change ideas and results are shared among all teams.
- Each Learning Session is followed by an Action Period, during which each center develops, tests, and implements trial runs for their change ideas, using the PDSA model (described below under Improvement Model).
- After the final Learning Session, each health center works on ways to move the new model into other clinical areas or other sites.

The Care Model is a population-based model predicated upon knowing which patients have the target illness, assuring that care is based upon scientific evidence, and actively aiding each patient

to participate in all aspects of care. This model was developed by a national program of the Robert Wood Johnson Foundation, called Improving Chronic Illness Care, at the MacColl Institute in Seattle, Washington. It is recommended that a subgroup of the entire patient population be the focus of change for the duration of the Collaborative.

The Care Model has six components:

- the health care organization;
- community resources and policies;
- self-management support;
- decision support;
- delivery system design;
- clinical information systems.

The change concepts associated with each of the six components of the Care Model are described below.

Health Care Organization

- Goals to improve chronic care are part of the organization's business plan.
- Senior leaders visibly support improvement in chronic illness care.
- Benefit packages designed by the health care organization promote good chronic illness care.
- Provider incentives encourage better chronic illness care.
- Improvement strategies that are known to be effective are used to achieve comprehensive system change.

Community Resources and Policies

- Effective programs are identified and patients are encouraged to participate.
- Partnerships with community organizations are formed to develop evidence-based programs and health policies that support chronic care.
- Health care organizations coordinate chronic illness guidelines, measures, and care resources throughout the community.

Self-Management Support

- Providers emphasize the patient's active and central role in managing chronic illness.
- Standardized patient assessments include self-management knowledge, skills, confidence, supports, and barriers.
- Effective behavior change interventions and ongoing support with peers or professionals are provided.

- The care team assures care planning and assistance with problem solving.

Decision Support

- Evidence-based guidelines are embedded into daily clinical practice.
- Specialist expertise is integrated into primary care.
- Provider education modalities proven to change practice behavior are utilized.
- Patients are informed of guidelines pertinent to their care.

Delivery System Design

- Team roles are defined and tasks delegated.
- Planned visits are used to provide care.
- The primary care team assures continuity.
- Regular follow-up is assured.

Clinical Information Systems

- A registry contains clinically useful and timely information.
- Care reminders and feedback for providers and patients are built into the information system.
- Relevant patient subgroups can be identified for proactive care.
- Individual patient care planning is facilitated by the information system.

In addition to the Care Model, the Collaboratives use an Improvement Model developed by the Associates in Process Improvement and tested and used in many IHI-sponsored Collaboratives. When used with the Care Model, the Improvement Model provides a process to improve the quality of care at an accelerated pace. The Improvement Model is based on the following three fundamental questions.

What are we trying to accomplish?

This question is meant to establish an "aim statement" that focuses the organization's effort for improvement. This aim statement helps focus on specific actions or elements of the Care Model and defines which patients and providers will participate. The aim statement should be time-specific, measurable, and as concise as possible. A few trials that test an aim statement may be required before it becomes truly focused.

How will we know that a change is an improvement?

Measures and definitions are necessary to

answer this question. Data is needed to assess and understand the impact of changes designed to meet an aim statement. When shared aim statements and data are used, learning is further enhanced in sharing with other organizations in the Collaborative. Superior performances and best practices are more quickly identified and disseminated through benchmarking.

What changes can we make that will result in any improvement?

Testing and re-testing are necessary to conclude that a result is an improvement. The PDSA (“Plan, Do, Study, Act”) Cycle is a trial-and-learning method to discover effective and efficient ways to change a process. The “study” part of the cycle is the key to learning which changes lead to improvement. “Study” compels the team to learn from the data collected and to assess the effects of any changes on other parts of the system, as well as on patients and staff. Changes can also have varying effects under different conditions, such as different practice teams or different sites. Most importantly, the “study” phase is an ideal time to think through how the Care Model can help generate new ideas and new approaches to positive change. PDSA cycles should be short and quick, requiring only hours, days, or a few weeks to complete.

Measurement is essential to ensure that changes made in clinical practice lead to desired improvements. All teams use national measures determined by a panel of clinical experts. In addition, each team selects at least one additional measure to use in assessing clinical outcomes. An electronic registry is used to collect data, schedule office visits, labs, and educational sessions, and generate reminders and guidance for patient care. Health centers are

expected to track and provide monthly reports on the core measures used by all Collaborative participants as well as the additional measure(s) they have selected. The Bureau of Primary Health Care provides free software for the electronic registry to all health centers that participate in a Health Disparities Collaborative. The latest version, released in July 2002, is called the Patient Electronic Care System (PECS).

The Health Care for the Homeless Clinicians’ Network is one of three national clinical networks that provide support and technical assistance to teams in the Health Disparities Collaborative. The Network’s role in the Collaboratives is to increase the understanding of the special needs of homeless people, partner with Collaboratives’ staff at the national and regional levels, serve as a resource and mentor to health center teams, and participate as faculty at Learning Sessions.

The Health Care for the Homeless Clinicians’ Network, founded in 1994, is a national professional association of clinicians from many disciplines who are dedicated to the prevention of homelessness and strive to improve the health and quality of life of homeless people. Organized to provide peer support to clinicians from various disciplines, the Network has many goals and objectives, including: actively sharing information and experience to enhance clinical practice; promoting clinical research; educating clinicians, communities, homeless people, and policymakers on the interrelationship between homelessness, health, and public policy issues; and collaborating with other clinical networks, professional associations, and groups who work with our homeless neighbors. ■

Reference

Sam, C. Eliminating US health care disparities among racial and ethnic groups. Presentation at the Society of General Internal Medicine 24th Annual Meeting, May 2001.