

HEALING HANDS



Vol. 6, No. 5 ■ September 2002

Health Disparities Collaboratives: Closing the Gap between Knowledge & Practice

In this issue of *Healing Hands*, Health Care for the Homeless clinicians are invited to take a closer look at the ambitious Federal initiative begun in 1998 to reduce health disparities related to socioeconomic status, ethnicity or gender through the formation of regional Health Disparities Collaboratives. We are grateful to **Laura Gillis, MS, RN**, for sharing her perspective as Collaboratives Coordinator for HCH Clinicians' Network in the following articles. Gillis is a former Clinical Director of Health Care for the Homeless, Inc., Baltimore, Maryland, and was one of the Network's founding members.

Mary Jo Bloominger, PA, first met Paul in May 2000, in a homeless shelter in Davenport, Iowa, where she provides primary health care for the Community Health Center's HCH project. The 49-year-old man complained of a foot ulcer and was diagnosed with type 2 diabetes. His initial hemoglobin A1c test was 13.6% (normal is 6.0%), indicating very poor diabetic control. The HbA1c test correlates with the average amount of sugar in your blood over the past 2-3 months. People with diabetes can avoid serious complications by maintaining an A1c level below 7.0%. Mary Jo explained that Paul would need to change his diet, and how his food choices would affect his diabetes.

At his next visit, when Paul reported having two donuts for lunch, Mary Jo knew she needed to use a different approach. She invited Paul to the Diabetes Group that began when the agency joined the Diabetes Collaborative. Group members share information with Mary Jo and a dietician about how they are managing their diabetes to avoid its worst consequences — stroke, heart attack, amputation, blindness, kidney failure, and death. After his first group session, Paul turned to Mary Jo and remarked, "I've got to watch what I eat!"

Paul still lives in the shelter. His follow-up A1c level in December 2000 was 6.5%; a year later, it was 7.1%.

As clinicians know, there is strong evidence to support maintaining a diabetes patient's hemoglobin A1c below 7%. Research has demonstrated that any reduction in HbA1c is likely to reduce the risk of complications related to type 2 diabetes. For every 1% decrease in A1c, the risk of heart attack is reduced by 14%, the risk of diabetes-related death is reduced by 21%, and the risk of microvascular complications such as serious deterioration of vision and kidney damage is reduced by 37%.¹

But having this knowledge is not the same as implementing it, and closing the gap between scientific knowledge and clinical practice is a primary objective of the Health Disparities Collaboratives. This bold initiative of the Bureau of Primary Health Care is an effort to eliminate health disparities that place ethnic minorities and people living in poverty at much higher risk for chronic disease and death than other Americans. Higher prevalence of heart disease, cancer, stroke

and diabetes — the top four killers in America — among poor, minority and medically underserved populations vividly illustrates these disparities, as do their higher risks for asthma and depression.

For example, African Americans have the highest mortality rate from breast cancer and are twice as likely as white Americans to die from prostate cancer. They are also at greater risk for end-stage renal disease secondary to co-morbid diabetes and hypertension. Hispanics and Native Americans are two to three times more likely than the general population to develop diabetes. Asian Americans are three to five times as 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.²

These 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.²

Public health authorities contend that an important way to reduce health disparities is to change the delivery of health care. The Health Disparities Collaboratives call for a transformation in how providers deliver primary care, how patients understand and participate in managing their own care, and how communities support provider-patient partnerships.

In 1998, the BPHC selected 88 health centers to participate in the first Collaborative, which focused on diabetes. Since then, three more Collaboratives have been added, focusing on asthma, depression, and cardiovascular disease.³ To date, over 400 health centers including almost 30% of the 155 Health Care for the Homeless grantees have joined at least one of these Collaboratives. All BPHC-supported health centers are expected to participate in the health disparities program, including 12 months of intensive, collaborative learning (Phase 1) and continued implementation of the models learned and monthly reporting thereafter (Phase 2).⁴

"Our health center joined the Diabetes Collaborative in 1999. Since then, we have seen significant clinical improvements in our diabetes patients. On average, 80 homeless diabetes patients had lower A1c levels than 80 housed diabetes patients seen by providers at our main clinic – 8.6 vs. 9.2 – compared to much higher levels when these patients were first seen."

*Diana Hobden, CRNP, Thundermist Health Center
Woonsocket, Rhode Island*

How can participation in a Collaborative make dramatic improvements in health outcomes possible, even for homeless clients? Three factors are essential for this to occur: commitment of the health center's administration and providers, support from regional teams of primary care associations and clinical networks, and adherence to three models of change promoted by the Health Disparities Collaboratives.

Learning Model: During the first 12 months, participants select a staff team, do preparatory work on a disease topic, and participate in three learning sessions with teams from other centers and expert advisors. They develop and test a change idea and plan its broader implementation in other clinic areas and sites.³

"I was impressed by the quality of clinical updates provided in learning sessions for the Diabetes and Cardiovascular Disease Collaboratives. These are excellent opportunities for professional growth."

*Ed Farrell, MD, Medical Director, Stout Street Clinic,
Denver, Colorado*

Chronic Care Model: Each health center team identifies which patients have the illness, assure that they receive evidence-based care, and actively aid them to participate in their own care. The team works on changes in each of six components: the health care organization, community resources and policies, self-management support, decision support, delivery system design, and clinical information systems.³

"The most important thing we achieved from participating in the Collaboratives was the Self-Management component of the Chronic Care Model. We assumed our clients couldn't set their own self-management goals because they were trying to meet basic needs. We were wrong. All of our patients set their own goals, and the majority achieve them."

*Paula Gonzalez, CRNP, Birmingham Health Care for the Homeless
Birmingham, Alabama*

Improvement Model: To improve the quality of care at an accelerated pace, health center teams respond to three basic questions in the following ways:

1. **What are we trying to accomplish?** Specify aims, focus on measurable actions to be accomplished within a specified time, and select patients and providers who will participate.
2. **How will we know that a change is an improvement?** Specify the desired improvement and data needed to determine whether it has been made.
3. **What changes can we make that will result in any improvement?** Plan a change, try it out on a small scale, observe the results, and refine the change as necessary. This Plan, Do, Study, Act (PDSA) cycle enables teams to test changes quickly to see how they work. PDSA cycles should be short and quick, typically requiring only hours, days or a few weeks to complete.³

Measurement is essential to ensure that changes made in clinical practice are leading to desired improvements. All health center 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 education sessions; and generate reminders and guidance for patient care. Health centers are expected to track and report monthly 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).

Health Care for the Homeless, Baltimore, is participating in the Diabetes IV Collaborative that began in July 2002. MIS coordinator **Carla Flaim** reports that the new PECS is "easy to use and very powerful because you can track labs, specific diseases, past individual visits and medication history. You can also customize the registry to meet your project's needs and generate reports on a particular group of patients. We are excited about the possibilities that PECS offers."

"Participation in a Collaborative is doable and worth doing, even for small HCH projects. Our project wouldn't have the resources to establish this kind of outcomes-based QI program without the help we receive from participating in the Cardiovascular Collaborative.

Everything is free and set up for you — software, staff training, benchmarks and evidence-based standards."

Adele O'Sullivan, MD, Medical Director, Maricopa County Health Department HCH project, Phoenix, Arizona

If you would like to participate in a Health Disparities Collaborative, your health center must complete a formal application to clarify reasons and goals for participation, and an interview must be conducted with the Executive Director or Medical Director to assure commitment of the agency's leadership to the project.

What's New?

- **Adding HCH clinicians to Cluster Steering Committees.** The Cluster Steering Committees set strategic directions and approve applications for each Health Disparities Collaborative. They are comprised of representatives of regional primary care associations, clinical networks, senior leadership and clinicians from participating health centers, and HRSA field offices. Recently HCH clinicians were invited to represent participating HCH projects in each regional cluster on the steering committees. Besides having expertise in providing primary care to homeless persons, these HCH representatives are currently participating in a Collaborative.
- **Planning for a Substance Abuse Collaborative.** In response to a request from the HCH Clinicians' Network to begin a Collaborative on substance use disorders, a pilot project will be initiated in 2003 to test clinical measures. Five

HCH teams and five community health center teams with experience in another Collaborative will be invited to participate. If your HCH project has successfully completed Phase 1 of a Collaborative and is interested in participating in this pilot project, beginning in the summer of 2003, please contact HCH Collaboratives Coordinator Laura Gillis at lgillis@nhchc.org.

- **Adapting clinical guidelines for homeless populations.** In June 2002, the Network adapted the American Diabetes Association's standard clinical guidelines to optimize care for patients experiencing homelessness. Currently we are developing recommendations for several more health conditions frequently seen in homeless patients including asthma, otitis media, hypertension, HIV/AIDS, and other sexually transmitted diseases. The completed guidelines will be available online at www.nhchc.org. ■

The steering committee in your regional cluster is responsible for selecting Collaborative participants in your geographic region. For more information about the Health Disparities Collaboratives and how to submit an application online, see: www.healthdisparities.net/apply.html.

SOURCES:

1. Stratton IM et al. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. *BMJ* 2000; 321:405-412 (Aug 12): www.bmj.com/cgi/content/full/321/7258/405.
2. Sam, Colleen. Eliminating US health care disparities among racial and ethnic groups. Society of General Internal Medicine 24th Annual Meeting, May 2001: www.medscape.com.
3. Health Disparities Collaboratives website: www.healthdisparities.net.
4. BPHC. Excellence in Practice: Health Disparities Collaboratives Expectations, January 8, 2002; PIN 2002-12: www.bphc.hrsa.dhhs.gov/pinspals/#2002PIN. ■

CONTACT YOUR HCH REPRESENTATIVE

Northeast Cluster

Diana Hobden, CRNP
Thundermist Health Associates, Inc.
Woonsocket, Rhode Island
DianaH@thundermisthealth.org

Southeast Cluster

Paula Gonzalez, CRNP
Birmingham HCH
Birmingham, Alabama
zom42855@aol.com

Midwest Cluster

Mary Jo Bloominger, PA
Community Health Center
Davenport, Iowa
mbloominger@davchc.com

West Central Cluster

Darcie Meierbachtol, FNP
Colorado Coalition for the Homeless
Denver, Colorado
darcie@coloradocoalition.org

Pacific West Cluster: to be determined

Frequently Asked Questions

- **What evidence do we have that participation in the Health Disparities Collaboratives results in clinical improvements for homeless populations?** No national database currently provides this information. In FY 2003, Laura Gillis will create a database to enable the aggregation of data submitted to the regional Clusters by participating HCH projects. Her plan is to track homeless clients' progress on key clinical measures.
- **How can this model work in smaller clinics with few personnel?** Smaller clinics can choose outcome measures that are easier to document. For example, the HCH project in Phoenix, Arizona, initially decided to document serum creatinine at least once annually as an optional measure for the Cardiovascular Collaborative. This year, they are also measuring lipids. Most important is the philosophical commitment of agency leadership, however large the clinic may be.

■ **What are the advantages for HCH projects that participate in a Health Disparities Collaborative?** Five reasons why Health Care for the Homeless providers should join a Collaborative:

1. Work with colleagues in a new way that promotes teamwork.
2. Learn how to make rapid changes in the delivery of health care that lead to measurable clinical and functional improvements in your patients.

3. Free access to the PECS Registry, a database that can be used to track patient care and health outcomes.
4. Share tools and resources among health teams across the country to keep you from reinventing the wheel.
5. Free technical assistance from clinical experts and health information systems specialists, and a health care delivery system that enables continued improvements in patient care. ■

Steal Shamelessly and Share Senselessly

“Steal shamelessly and share senselessly” is the motto of the Health Disparities Collaboratives, which reflects the cooperative, noncompetitive spirit of this national initiative. All participants in a Collaborative are on a listserv with other health teams in their region. Teams share clinical protocols and flow sheets developed in response to questions such as “Does anyone have a patient education sheet on diabetic foot care in Vietnamese that you could share?” or “What depression screening tool are you using in your clinics?” Best practices are communicated quickly, so teams can learn from each other. In that spirit, we offer the following resources.

■ **Adapting Your Practice: Treatment & Recommendations for Homeless Patients with Diabetes Mellitus** by Brehove T, Bloominger MJ, Gillis L, Meierbachtol DA, Richardson VJ & Strehlow AJ, June 2002. Available online at: www.nhchc.org/Publications/clinical_guidelines_dm.pdf

■ **Diabetes & Homelessness: Overcoming Barriers to Care** by Ridolfo A and Proffitt B, April 2000. A rich and varied collection of clinical tools, self-management and educational materials, outreach protocols, nutrition information and other resources for clinicians serving diabetes patients who are homeless. Three-hole punch suitable for binder, \$15. To order: www.nhchc.org/Publications/

■ **Diabetes Personal Care Cards**, available in \$15 packets of 100, folded and shrink-wrapped for your convenience; *first set free* plus shipping. To order: www.nhchc.org/Publications/

■ **Nylon Wallets** (4 1/2" x 5") with zippered pockets and a clear plastic sleeve; navy with the Network logo in white; nylon cord with visible ID card stating, I Have Diabetes; \$2.25 each plus shipping. To order: www.nhchc.org/Publications/

■ **Health Disparities Collaboratives website:** www.healthdisparities.net. Click on “Resources” for more tools and helpful information. ■

Communications Committee

Adele O'Sullivan, MD (Chair); Jan Caughlan, LCSW-C; Lisa Cunningham Roberts, MA, NCC; Abby Hale, PA-C; Lorna Hines, CMA; Karen Holman, MD, MPH; Scott Orman; Pat Post, MPA (Editor)

Healing Hands is a publication of Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council. P.O. Box 60427, Nashville, Tennessee 37206-0427 ~ For membership information, call (615) 226-2292 or visit www.nhchc.org.



HCH Clinicians' Network
P.O. Box 60427
Nashville, TN 37206-0427