Changing Practices/Changing Lives: The Health Disparities Collaboratives

David M. Stevens, M.D.
Center for Quality Improvement & Patient Safety
Agency for Healthcare Research & Quality

From Clinical Trials to Community: The Science of Translating Diabetes and Obesity Research
National Institutes of Health
January 12-13, 2004

New AHRQ Mission Statement

To improve the quality, safety, efficiency, and effectiveness of health care for all Americans

HRSA Health Resources and Services Administration

The access agency, HRSA is an important part of America's health care safety net:

- Strategy of moving toward:
  - **Eliminating barriers to care**
  - **Eliminating health disparities**
- Expands access to high-quality, culturally sensitive health care;
- Improves health outcomes among America's vulnerable and underserved communities

HRSA/BPHC Supported Federally Qualified Health Centers

- Community controlled
- Comprehensive Primary Care
- 768 organizations
- 3,552 sites: rural & urban

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HRSA/BPHC supported Federally Qualified Health Centers

Health Center 10.3 Million Users

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

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HRSA/BPHC Strategy for Health Centers

Key Strategic Elements In Health Disparities Collaborative

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

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Health Disparities Collaboratives: Focus Areas

- Diabetes, Depression, Cardiovascular Disease, Asthma, Cancer
- In development: Prevention, Diabetes Prevention, perinatal/patient safety, finance/re-design
- HIV: HIV/AIDS Bureau Collaboratives

www.healthdisparities.net

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National Strategic Partnerships

- ***Current:***
  - **DM/Cardiovascular: CDC,SAMSHA, IHI**
  - **Asthma : EPA,CDC, IHI**
  - **HIV: HIV/AIDS Bureau**
  - **Depression : SAMHSA, IHI**
  - **Cancer: NIH(NCI), ICIC, CDC, IHI**
  - **Evaluation: AHRQ**
- ***In Development*:**
  - **Diabetes Prevention: CDC, NIDDK, IHI, Medstar**
  - **Prevention: NCI, CDC, MCHB, IHI, RWJF**

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Care Model

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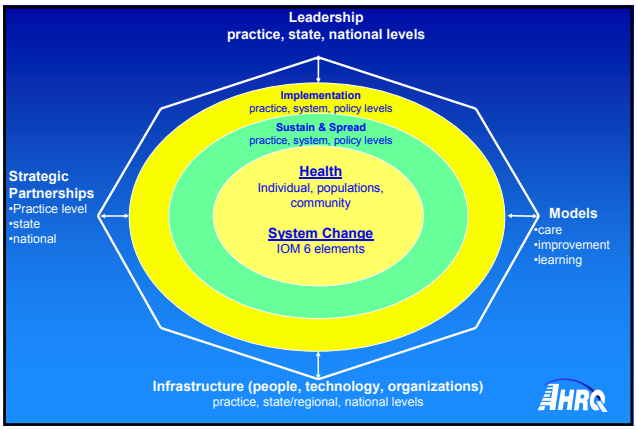

Diabetes Measures 2003-2004

- Core Measures
  - Average HbA1c
  - Two HbA1c's in last year
  - Documentation of self-mgt. goal setting
  - Cardiac Risk Reduction: ACE/ARB & Statins
  - Dental Exam is have dental practice

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Diabetes Measures 2003-2004

- Additional Measures
  - **Depression Screening in past 12 months**
  - **Patients with LDL <100**
  - **ASA or other antithrombotic agent**
  - **Current smokers**
  - **Dilated eye exam**
  - **Foot exam**
  - **Microalbuminuria screening in past year**
  - **Vaccination: influenza, pneumococcal**
  - **Dental exam in last year**

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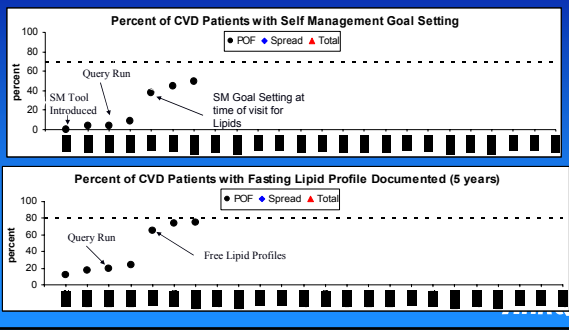
Improvement Model: Impact on National Measures



Health Disparities Collaboratives: Diabetes, 2001-03

Measure	January, 2001	July, 2003
Number of Health Centers	88	335
Persons with DM in registries	13,387	102,260
Two HbA1c per year	55.8% (7,470 patients)	36% (36,814 patients)
Documented patient self-mgt	39% (5,221 patients)	40% (40,904 patients)
Average HbA1c	8.46%	8.00%

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Repairing the Schism: Clinical Medicine & Public Health: Diabetes Control Programs

- 1999: 15 partnerships between DCP and health centers in the health disparities collaborative
- 2003: 48 partnerships between DCPs and Health Centers in the health disparities collaborative

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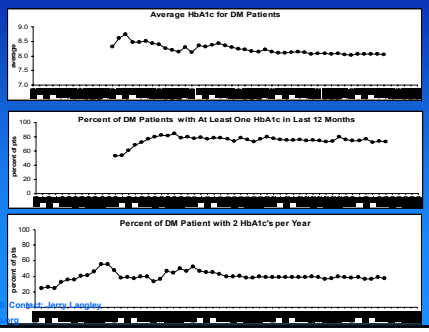
Summary Measures DM Collaboratives

Feb 1999-July 2003



Source: HRSA/BPHC/IHI Collaboratives
Contact: leroy.t.eagles@hrsa.gov

Summary Measures DM Collaboratives
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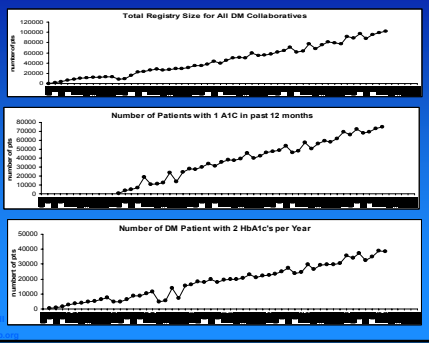

Source: HRSA/BPHC/IHI Collaboratives
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UKPDS Applied to 65,000 patients in Collaborative DM Registries

- Avoidable hospital admissions: 14,950
- Deaths avoided: 221
- Savings: Cardiovascular Disease hospital costs associated with diabetes: $19,638,043
- Savings: Cerebrovascular Disease hospital costs associated with diabetes: $697,361

Based on N.J. Dept of Health 2001data; UKPDS;
Mutual of Omaha data 2001from *Current Trends in Health Care and Dental Costs Utilization: Groups Benefit Services Annual Report*

CareSouth Data Profile
State Budget and Control Board
State Health Plan Claims for January 1, 2000-December 31, 2001
Patients with Diabetes (primary and secondary diagnosis)

	CHC trained in Planned Care	CHC Uninitiated to Planned Care	Other Community Providers	Specialists
Patient Average Age	54	55	59	60
Office Visits Per Patient	3.27	2.95	3.09	3.12
% patients > 1 visit	68.75%	81.08%	77.96%	78.26%
Average # days between office visits	68	69	68	68
% patients with a hospitalization	2.08%	8.10%	7.89%	9.52%
Average Payment Per Inpatient	$3,545.62	$39,264.06	$10,894.45	$12,024.79
Average Days Stay	3	10	5	5
Average Payment Per Office Visit	$67.42	$66.55	$65.62	$67.35
Average Total Annual Cost Per Patient	$343.41	$4,542.14	$1,591.03	$1,882.95

Revised March 14, 2003

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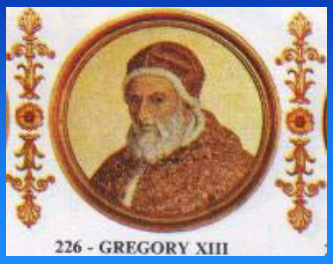
Pope Gregory XIII



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Translating Science Into Practice: A Long Time Comin'

- Pope Gregory XIII: modern calendar introduced 1582
  - German states accepted it 1700
  - England 1752
  - Sweden 1753
  - Russia 1918

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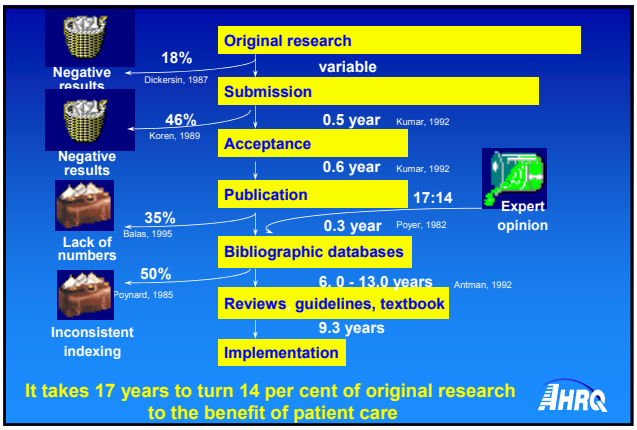

Diabetes Prevention Collaborative Prototype

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Diabetes Prevention : What the Studies told us--

- Finnish Diabetes Prevention Study
- Diabetes Prevention Program

Weight loss & ↑physical activity = delayed/prevented onset of diabetes among pre-diabetes populations.

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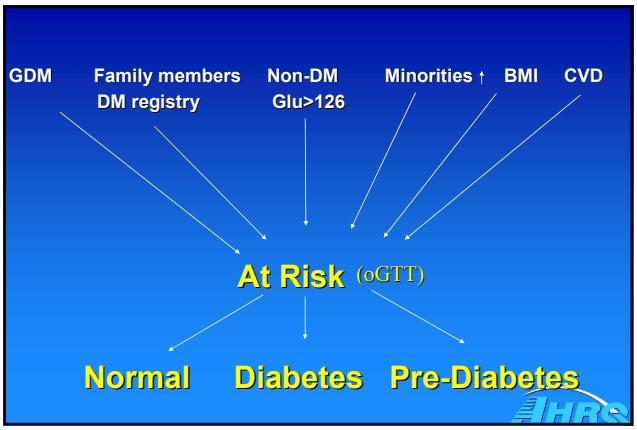
Prevention Prototype Aim

- To redesign the system of care by implementing the Chronic Care Model--

  so community- based identification and interventions can be implemented ---

  based on evidence from DPP & the Finnish Study.



Diabetes Prevention (January 2004)

- 3434 patients identified as high risk
- 1223 (35.6%) patients screened via (oGTT)
- 452 (36.9%) patients identified with pre-diabetes
- 172 (14.0%) patients identified with diabetes

Early Results
January, 2004

- 313 (69.2%) of patients with pre-diabetes have self-mgt goal
- 98 (21.7%) of patients have over 150 minutes of exercise per week
- 78 (17.3%) have 7% or greater average weight loss.

From Research Into Practice
From Knowledge to System Change

Spreading Innovation
Aim: Change & improve practice

Methods:
- **Transformational models**
- **Tests observable**
- **Stable bias**
- **Just enough data**
- **Changing hypotheses**
- **Sequential Tests**
- **Changing population**

synergy

Publishing Research
Aim: Truth

Methods:
- **Explanatory/predictive models**
- **Blinded tests**
- **No bias**
- **All possible data**
- **Fixed hypotheses**
- **One large test**
- **Stable cohort(s)**

Source: adapted from T. Nolan

Translation or Cultural & System Change?
A *complex circular process*

- **Formal Attitudes**
  - **E.g. Patient plans to see clinician; health system doesn't plan visit and its content**
- **Informal Attitudes**
  - **E.g. If the patient doesn't follow documented advice, it is no longer a problem for the health system**
- **Technical Attitudes**
  - **E.g. Implement evidence-based guidelines for diabetes prevention**

Edward T. Hall, The Silent Language, 1959

Modest Proposals
Two cultures of research & quality improvement

- Methods
  - Involve decision makers, quality improvement, public health & community expertise in development of hypotheses, study design, and implementation, e.g. Canadian Health Services Research Foundation
  - Study system change and interactions in complex systems – idea that behavior of system is product of the system itself, not its individual pieces
- Communication, generation & implementation of new ideas
  - peer review journals (science community) vs. networking, conferences (Quality improvement community & decision makers)
  - Redesign funding opportunities to support programs that integrate research with system change
  - Results inform policy debates

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Clinica Campesina:
Barriers We Overcame

- The belief that our patients cannot change and that little changes don't matter
- The idea that we need consensus to change anything
- The concept that improving care means more work
- That we cannot improve without more FTE
- The belief in a provider oriented rather than patient oriented care system

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