Initiatives at the Community Health Center Level

Dr. Janice Bacon
Clinical Services Director
G. A. Carmichael Family Health Center

G. A. CARMICHAEL FAMILY HEALTH CENTER

- Began l972
- Serve 3 rural counties in Mississippi
  - Canton (Madison county) pop. Approx 12,000
    - 20 miles north of Jackson the capitol of MS
    - Home of new Nissan plant
  - Yazoo City (Yazoo county) pop. Approx. 11, 000
    - Gateway to Mississippi Delta
  - Belzoni (Humphreys county) pop. Approx 3,000
    - In Heart of Mississippi Delta “Catfish Capitol”
- User base >26,000 92% African American
- Community controlled Board of Directors
- 40% uninsured

G. A. Carmichael Family Health Center

- Uniform Data Set (UDS) 2003 data reported to the Bureau of Primary Health Care (BPHC)
  - User base 25,040
  - 88,747 encounters generated
  - 92% of users Black/African American

- Locations:
  - Three main clinics (Madison, Yazoo, Humphreys counties)
  - Eleven School based clinics staffed by midlevel providers
  - One outpatient clinic located on hospital grounds started August 2004 in Canton

GACFHC Services

- Primary care in the fields of:
  - Family medicine
  - Internal medicine
  - Pediatrics
  - Ob/Gyn
- On-site subspeciality care in fields of:
  - Urology/Nephrology/Cardiology

The Environment

BARRIERS TO OVERCOME

COSTS

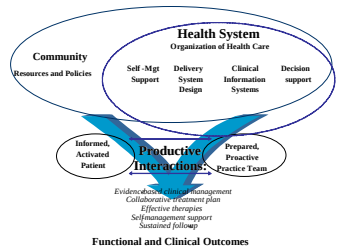
MEDICAID

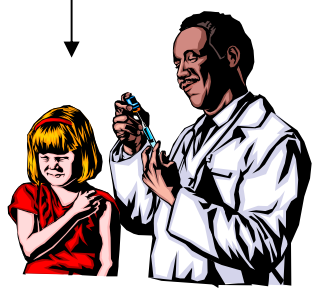
POLITICAL CHAOS

TURNOVER

REIMBURSEMENT DISINCENTIVES

OFTEN WE END UP LAYERING PLANNED CARE ON TOP OF "REGULAR WORK"





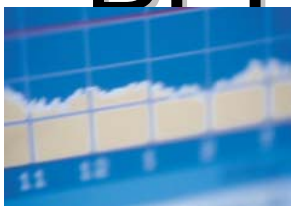
IOM Report: *Six Aims for Improving Health Systems*

- Safe - avoids injuries
- **Effective** - relies on scientific knowledge
- **Patient-centered** - responsive to patient needs, values and preferences
- Timely - avoids delays
- Efficient - avoids waste
- **Equitable** - quality unrelated to personal characteristics

IOM Rules for Care (7 of 10 noted here)

- Base care on continuous healing relationships
- Customize care to patient needs and values
- Patient is source of control
- Share knowledge and information
- Use evidence-based decision making
- Anticipate patient needs
- Cooperation among clinicians

BPHC Quality Improvement Strategy



❶ Division of Clinical Quality

❷ Disease Management Collaboratives

❸ Accreditation

❹ Risk Management

Quality Management Strategy

- Health Disparities Collaboratives as vehicle to:
  - Generate positive health outcomes
  - Build capacity for quality improvement
  - Re-design of clinical, administrative, financial systems
  - Strengthen risk management approach and strategies
  - Indoctrinate performance improvement for accreditation endeavors

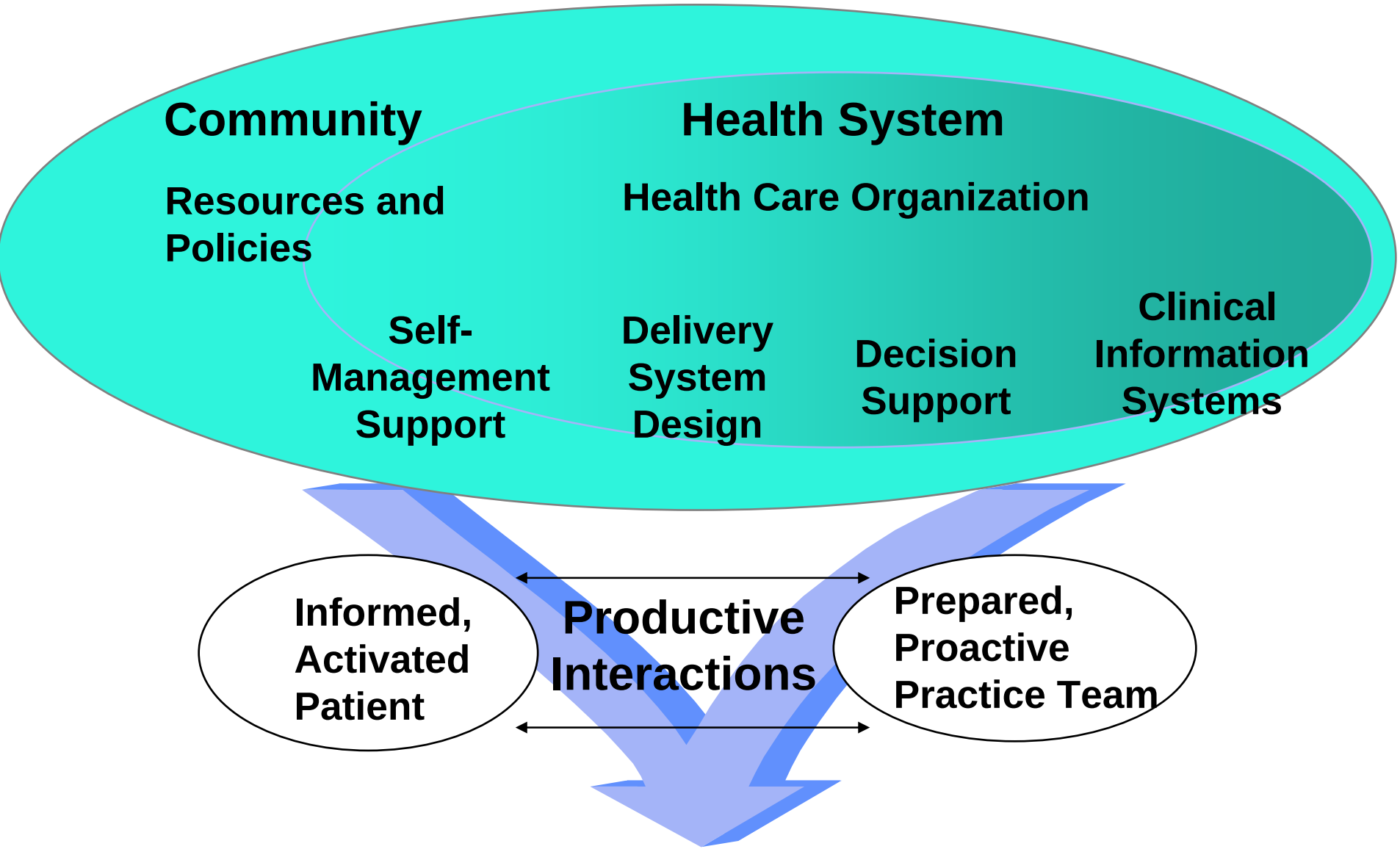
The IOM Quality Report: *Selected Quotes*

- "The current care systems **cannot** do the job."
- "Trying harder will not work."
- ***"Changing care systems will."***

"The model of care for chronic illness is a population-based model that relies on knowing which patients have the illness, assuring that they receive evidence-based care, and actively aiding them to participate in their own care"

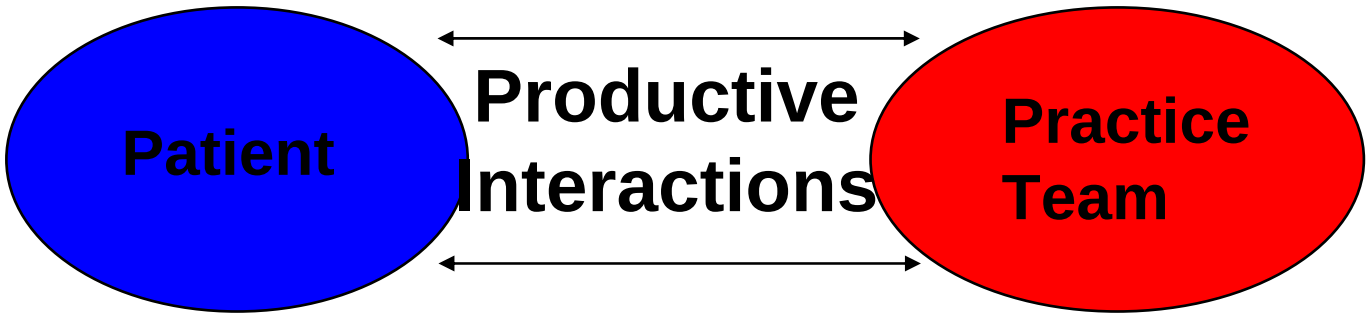
Dr. Ed Wagner

Chronic Care Model



Improved Outcomes

The Goal of System Changes to Improve Chronic Illness (Planned) Care



planned set of interactions
sustained over time
assure delivery
critical clinical and behavioral elements of care

focus
patient-centeredness

Mission of Health Disparities Collaborative (HDC)

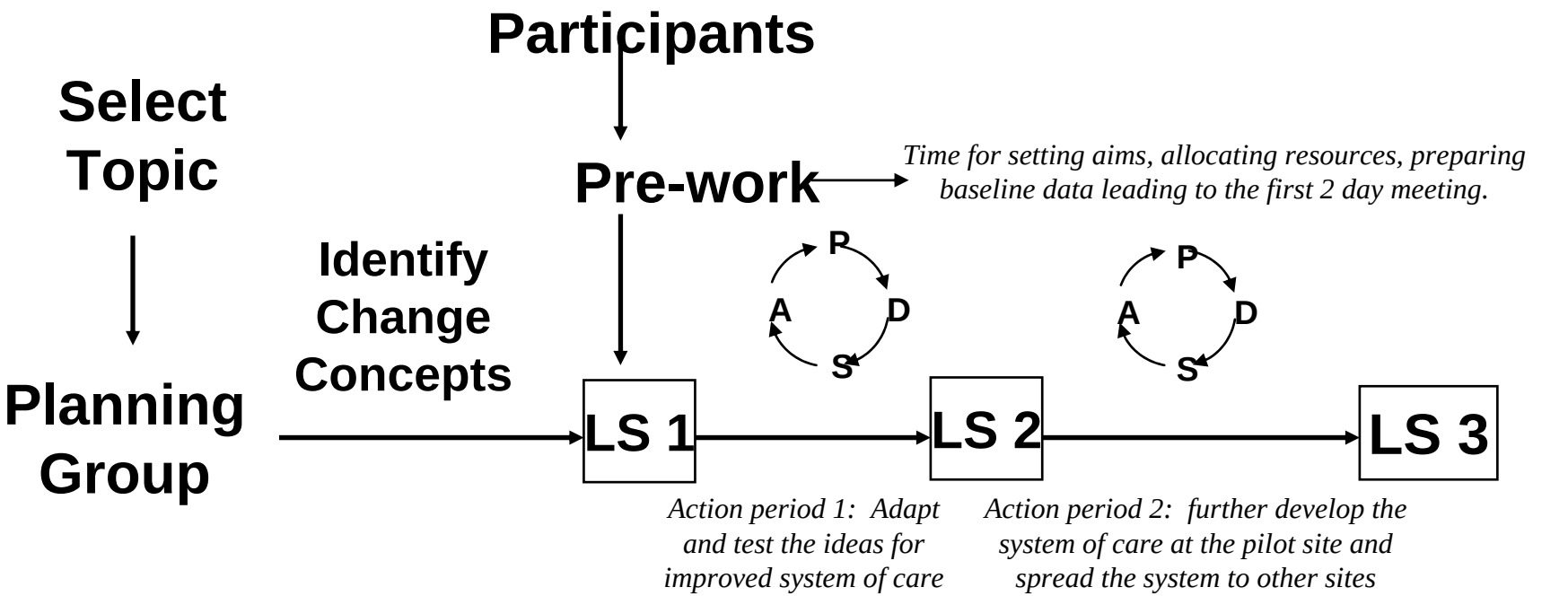
- To achieve excellence in practice through the following goals

1. To generate and document improved health outcomes for underserved populations
2. To transform clinical practice through models of care, improvement and learning
3. To develop infrastructure, expertise and multi-disciplinary leadership to support and drive improved health status
4. To build strategic partnerships

Advantages of a General System Change Model

- Applicable to most preventive and chronic care issues
- Once system changes in place, accommodating new guideline or innovation much easier
- *Participants in Health Disparities collaboratives using it comprehensively*

The IHI Learning Model



Supports

E-mail Visits

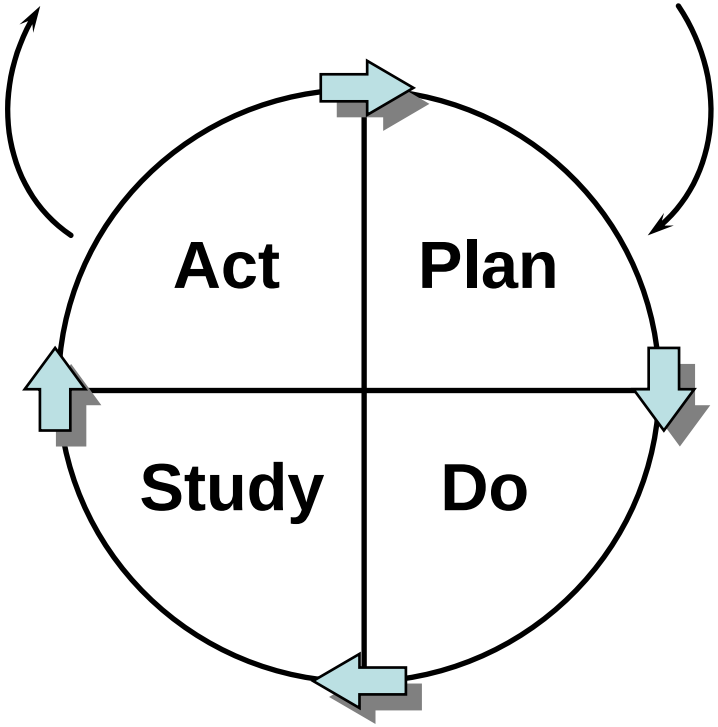
Phone Assessments Senior Leader Reports

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?



What is reality?

- MS CHCs in HDCs are making a business case as a result of implementing the (chronic) planned care models
- ***We are utilizing Collaborative work to reexamine all of their systems supporting care delivery***

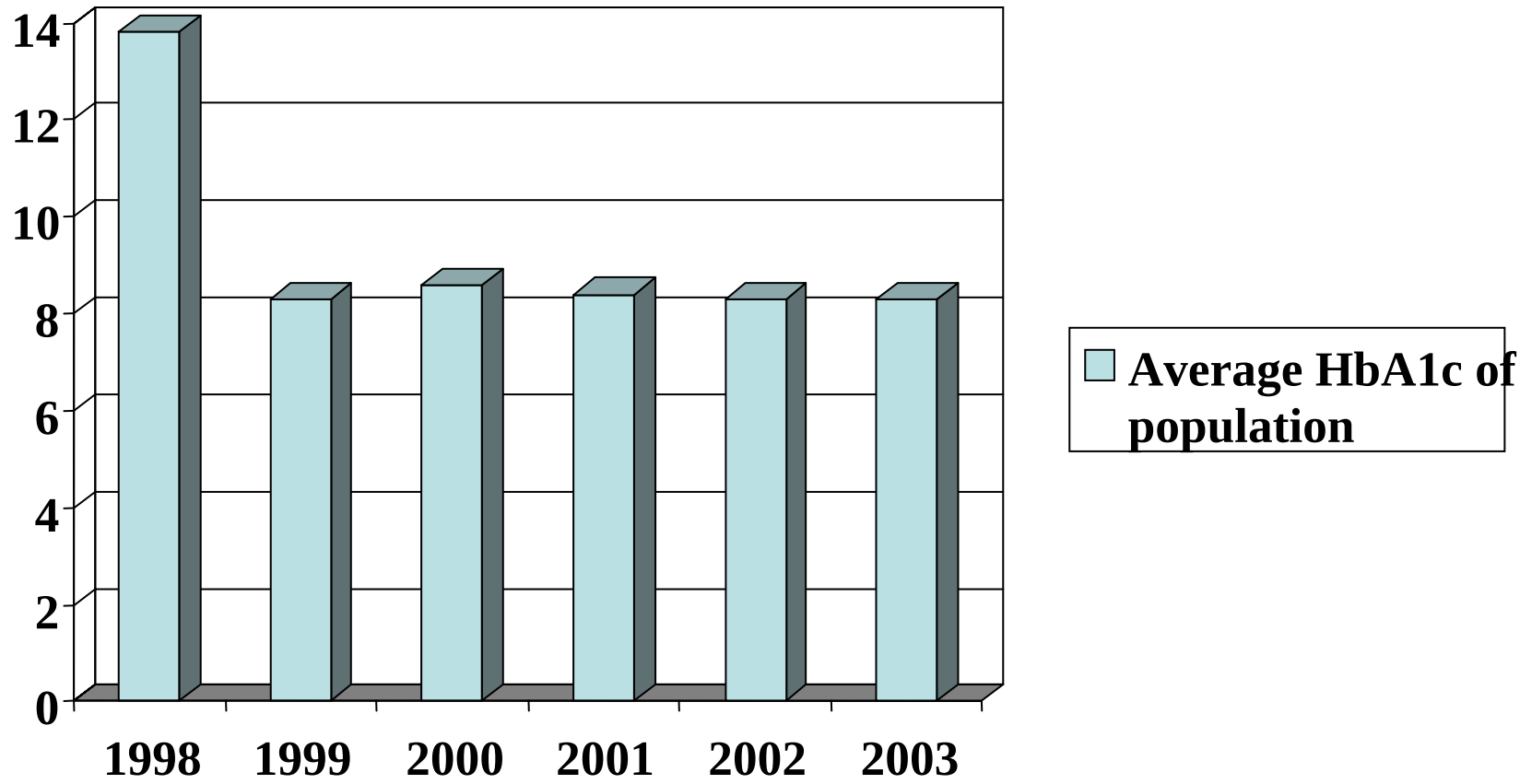
GACFHC HDC

Able to generate and document improved health outcomes for underserved populations

GACFHC HDC

- Participant in Diabetes I (1999-2000)
- Participant in Asthma I (2000-2001)
- Participant in Self-Management Pilot Collaborative (2003-2004)
- Participant in Perinatal/Patient Safety Collaborative 2004-2005

GACFHC DIABETES DATA



Community

Janice Bacon, G. A. Carmichael FHC

Implemented into our Delivery System

- ***Solid Relationship with State Diabetes Prevention and Control Office***
- ***Solid relationship with State Department of Health Cardiovascular Division***
- ***Partnered with eye care providers in all three counties to obtain retinopathy exams for diabetic clients***
- ***Mayors along with elected officials attend each Stepping Out Campaign and greet attendees***
- ***Ministerial Alliance support: Self-Management sessions at Family Life Centers***
- ***On-site evaluation of clients with Diabetes by Nephrologists, Cardiologists***
- ***Recipient of Miss. Qualified Health Center (MQHC) funds of approx.$170,000 a year to cover costs of Diabetic foot care, Diabetic shoewear, laboratory testing (hemoglobin A1c, lipid panel), glucometers, lancets, strips (entering 6th year of funding 2005) MS State House Bill 1048***
  - ***Staff supported from funds: Diabetic foot care specialist, certified Diabetic educator***
- ***Plans underway to establish state of the art "DIABETES" center in partnership with local hospital in Madison county***

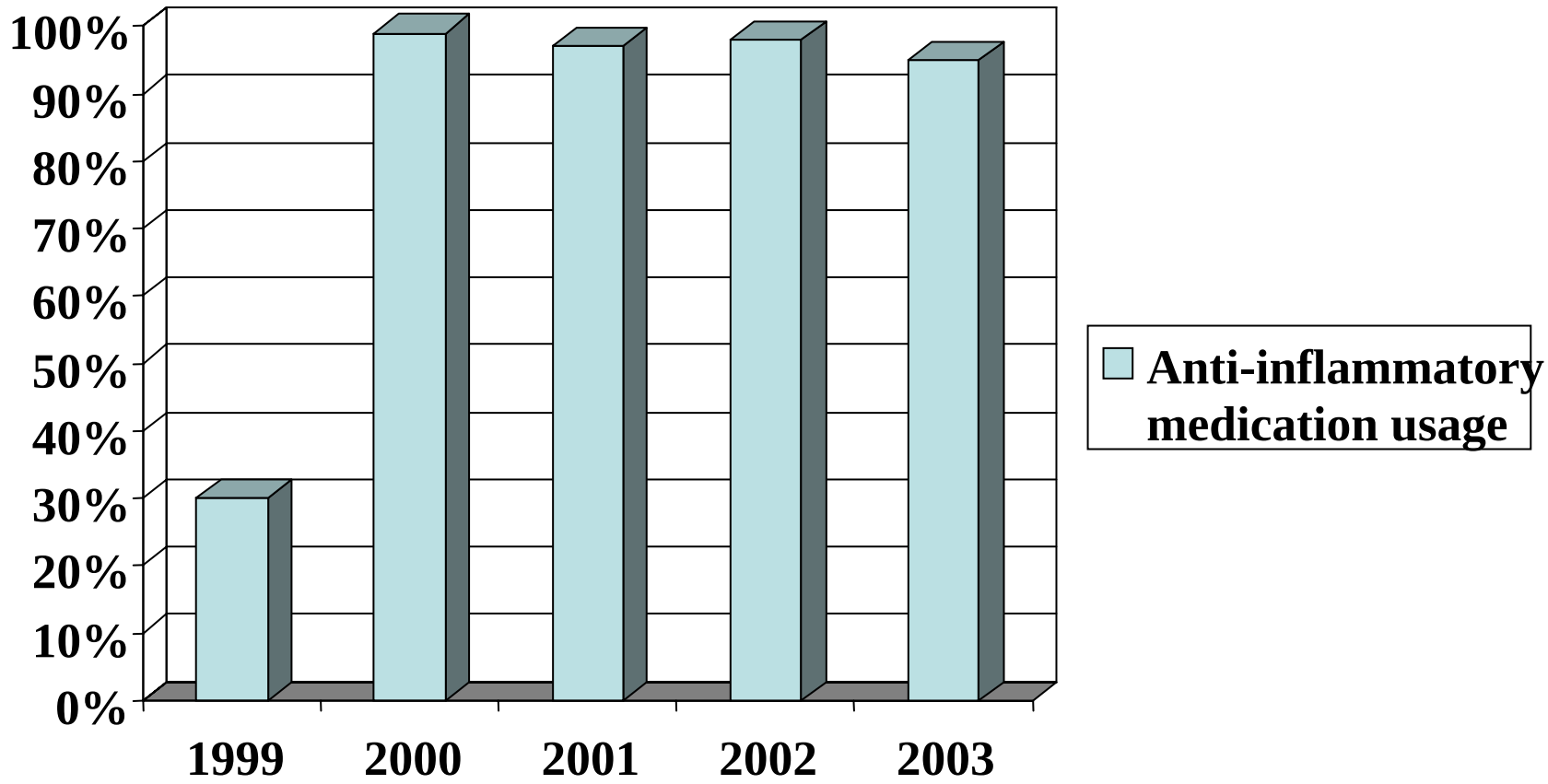
Aim and Key Measures (Asthma)

Aim: To implement components of the chronic care model in our asthma program to show the key measures listed below.

Key Measures:

1. Symptom free days will increase by at least 40%.
2. ER visits will decrease by 50%.
3. 90% of patients with persistent asthma will be treated with anti-inflammatory meds.
4. 90% of patients will have a written asthma action plan. (Self-management strategy)

GACFHC Asthma



A PUBLICATION OF THE AMERICAN LUNG ASSOCIATION OF MISSISSIPPI AND ITS MEDICAL SECTIONS, THE MISSISSIPPI THORACIC SOCIETY AND THE MISSISSIPPI ASTHMA COLLABORATIVE

AMERICAN LUNG ASSOCIATION® of Mississippi

Breathing Easy

When you can't breathe, nothing else matters®

WINTER 2002

ANNUAL REPORT ISSUE

Canton schools are focus of asthma therapy study

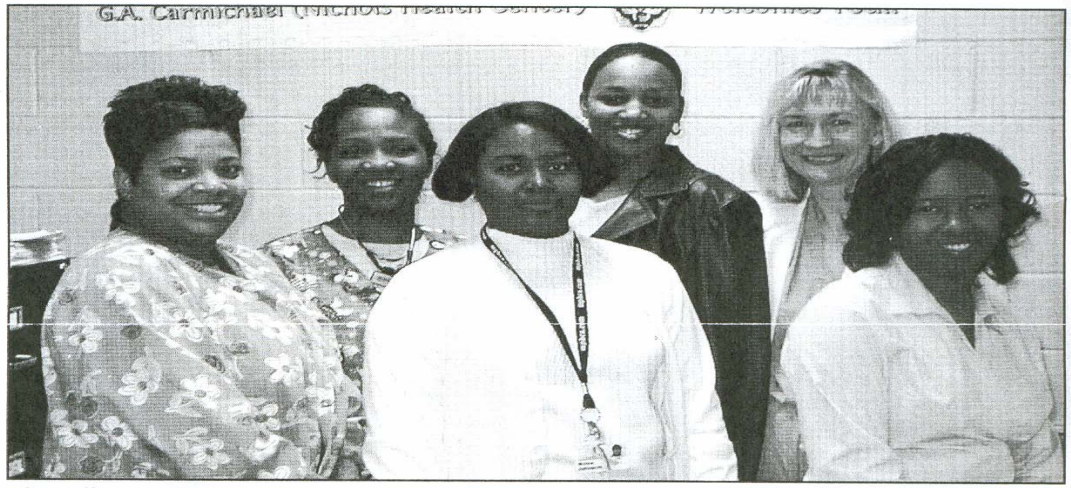
Students miss fewer days when therapy is administered at school

A pilot program at two Canton, Miss., schools shows promise for the management of asthma among students, particularly those from lower-income families.

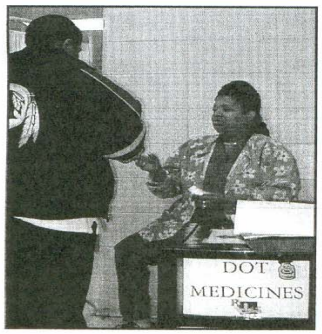
The program involved "directly observed therapy" by school staff, the results of which are compared with a control group where students received their asthma therapy traditionally, at home.

"It's been an excellent program to enable the child to manage their asthma and stay in school," said Dr. Janice Bacon, clinical services director for the G.A. Carmichael Health Center, and a partner in the study.

The study, which ran from September to December 2002, focused on 40-plus students at Canton Elementary School and Nichols Middle School. The most important finding, Bacon said, was that school-administered therapy was in many cases more effective than home. "It improved the average daily attendance and increased symptom-free days," she said. "It's an excellent tool to enhance self-management."



The staff of the G.A. Charmichael Clinic at Nichols Elementary School in Canton includes, pictured left to right, Sharica Harden, nursing assistant; Sharetta Donalson, LPN; Monica Johnson, LPN; Tamika Curtis, Outreach Counselor; Betty Lang, Family Nurse Practitioner; Kenda Graham, Social Worker. Not pictured: Sandra Tate, medical records/receptionist, and the Canton Elementary staff.



Nurse Assistant, Sharica Harden, administers asthma medications to a student participating in the Canton asthma study.

"There's little doubt this study will be repeated, if we can demonstrate the effectiveness of the program," said Dr. Jim Haltom, with the Mississippi Asthma and Allergy Clinic, another participant. Demonstrating the effectiveness will require close evaluation of the data, which is being done now, he said. "This may be a simple way to get at a chronic health problem that causes a tremendous amount of school absence. Asthma is the number-one health problem causing school absences."

There are myriad problems with home management for some students, Bacon said. Particularly for lower income students, "In addition to the medical regimen, there are issues of exposure to environmental triggers," she said. Such students also tend to be under-insured, live in homes where roaches are common and which are poorly ventilated, and have parents who may not be able to leave work to respond to an asthma attack.

"Say the mother works on the line at a chicken processing plant," Bacon said. "If the child has a problem, it takes an act of Congress to get through to her, and then she may have to walk home, and she may get demerits from her employer for leaving."

Schools, on the other hand, are in a position to respond immediately, she said. The program also enabled school officials to ensure that the students got their medication daily, and it gave them an opportunity to observe them more closely.

The study was a joint project of the American Lung Association of Mississippi, Canton Public Schools, the Mississippi Asthma Coalition and the Carmichael center. It was funded by the Mississippi State Department of Health, and Merck and Co. Astra Zereca donated all of the medications.

"I'd love to expand it," Bacon said of the program. The biggest hurdle, she added, is that each school would have to have a nurse practitioner to

Pilot Collaborative on
Self-Management Support

Eight Month Collaborative with three learning sessions

“Healthy Foods/Healthy Moves”

G. A. Carmichael FHC

Aim

To redesign our clinical practice so that patients with Diabetes and or Obesity will have an effective knowledge base, ability to address lifestyle changes and manage crises. Our approach will integrate measures to overcome psychological, social, economic, and cultural barriers.

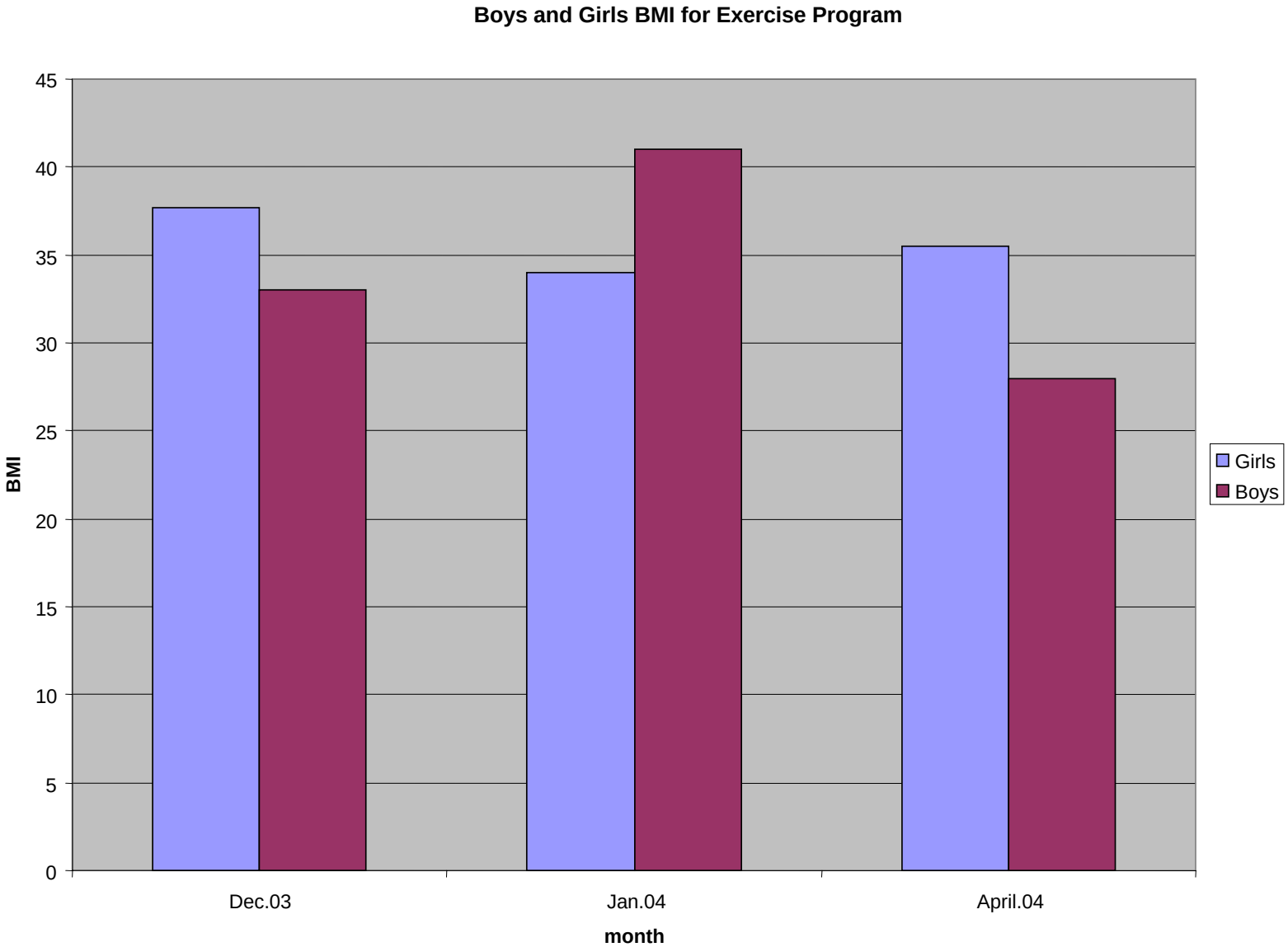
Key Partners

- Canton Public School District
  - Superintendent
  - Principals for elementary and middle schools
  - PTSA of school

✓ **Local Daycare Facility**

❑ Canton Ministerial Alliance

❑ Trigger for endeavor to create community based fitness facility for children and parents

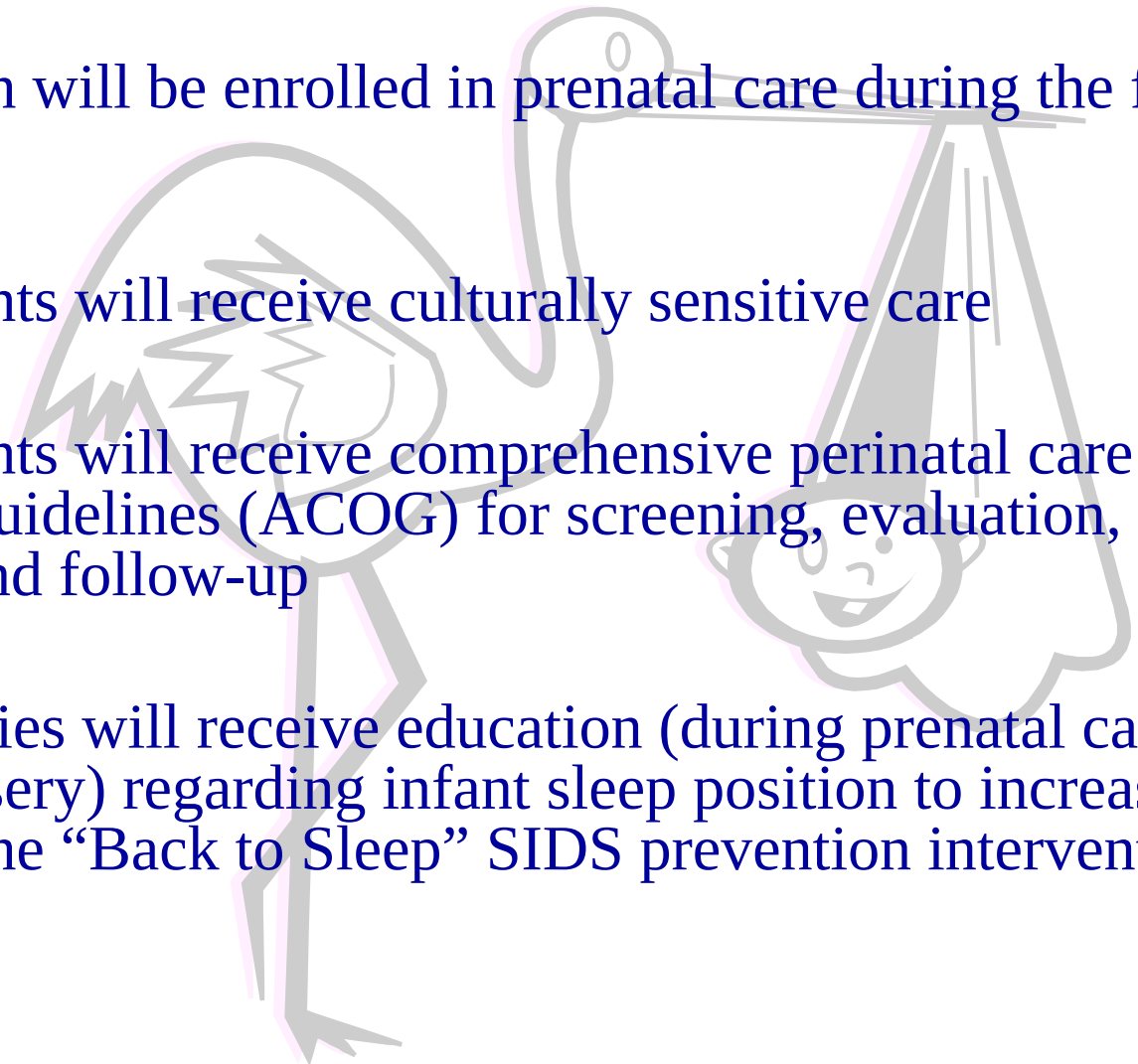

Boys and Girls BMI for Exercise Program
45
40
35
30
25
20
15
10
5
0
BMI
Dec.03
Jan.04
April.04
month
Girls
Boys

Aim

G. A. Carmichael Family Health Center in conjunction with Madison County Medical Center and Mallory Community Health Center will develop and implement a comprehensive and coordinated effort to improve processes and healthcare outcomes.

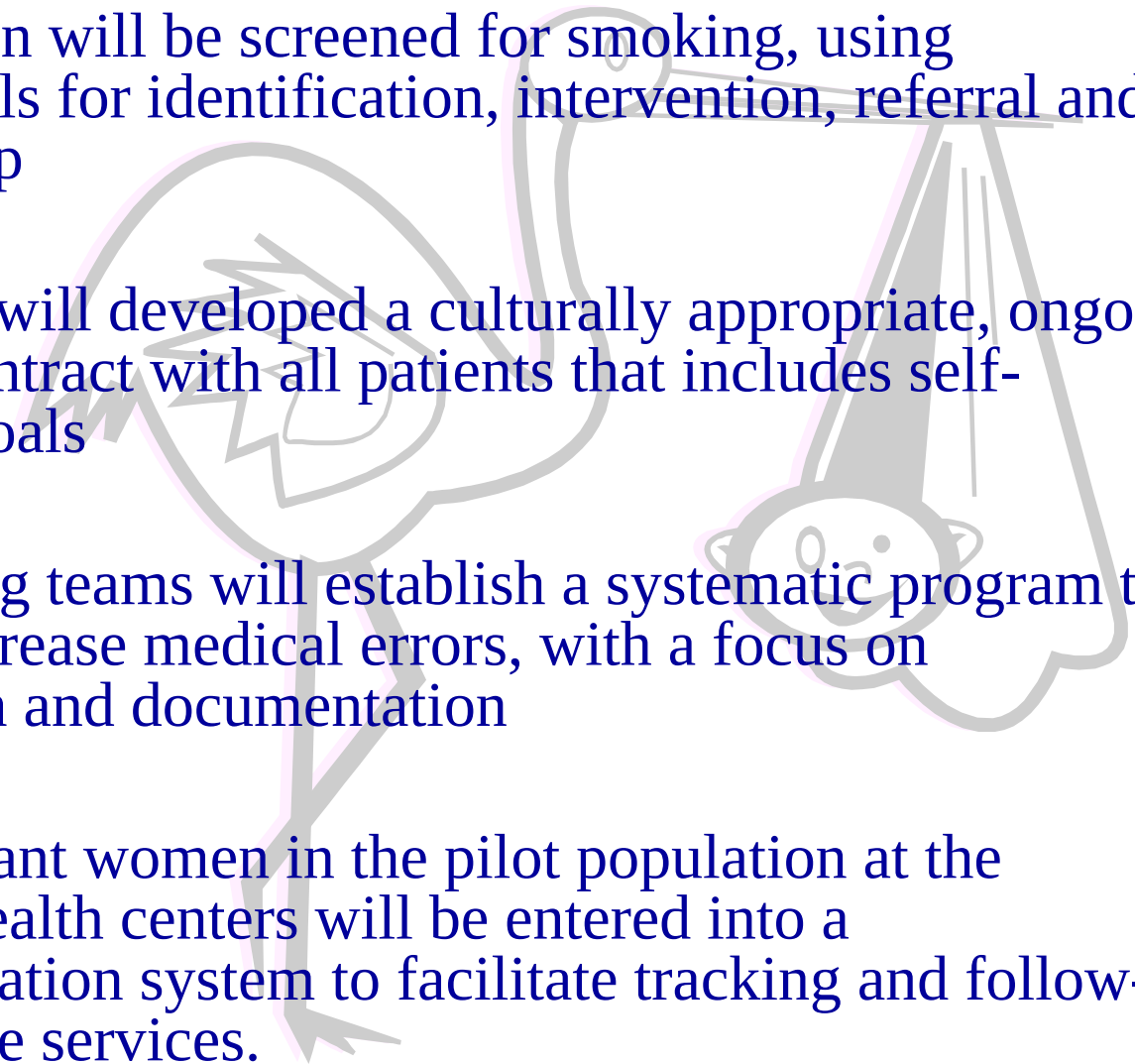
Goals

- 75% of women will be enrolled in prenatal care during the first trimester
- 100% of patients will receive culturally sensitive care
- 100% of patients will receive comprehensive perinatal care according to guidelines (ACOG) for screening, evaluation, intervention and follow-up
- 100% of families will receive education (during prenatal care and in the nursery) regarding infant sleep position to increase adherence to the “Back to Sleep” SIDS prevention intervention



Goals

- 100% of women will be screened for smoking, using appropriate tools for identification, intervention, referral and on-going follow-up
- Health centers will developed a culturally appropriate, ongoing plan of care/contract with all patients that includes self-management goals
- All participating teams will establish a systematic program to review and decrease medical errors, with a focus on communication and documentation
- 100% of pregnant women in the pilot population at the participating health centers will be entered into a registry/information system to facilitate tracking and follow-up of perinatal care services.



Community Partnerships/Linkages

Madison County Medical Center located in Canton, Ms.

Approx. 40% of clients deliver at this location

Strengths/Challenges:

Strength--community linkages very good
Challenges: cultural issues related to repeat pregnancies

Target strategies: Use of social services staff and outreach counselors

Mallory Community Health Center: Employs Ob-Gyn providers on staff at Madison County Medical Center