BREAKING BARRIERS:
Making Community Linkages to Improve Patient Outcomes

IHI National Forum
SL7 Learning Lab
December 9, 2018
1:00-4:30PM
DISCLOSURE STATEMENTS

Shana Scott and Portia Buchongo have no relevant financial or nonfinancial relationships within the services described, reviewed, evaluated or compared in this presentation.

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FACILITATOR INTRODUCTIONS

• Shana Scott, JD, MPH
  *Health Systems Team Lead*
  *Georgia Department of Public Heath*

• Portia Buchongo, RN, MPH
  *PhD Student | Health Services Administration*
  *University of Maryland, School of Public Health*
The Health Systems Team at the Georgia Department of Public Health provides technical support and coaching to health systems, health-focused organizations, and coalitions to build organizational and community capacity to transform and sustain population health.
TODAY’S OBJECTIVES

Community-clinical linkages help to connect health care providers, community organizations, and public health agencies. By the end of the training participants will be able to:

1. Define community-clinical linkages
2. Identify and examine strategies that can support partnerships between health systems and public health entities
3. Identify key factors for successful community-clinical linkages
4. Create systems support maps for facilitating community-clinical linkages
JOIN THE POLL

- Website: PollEv.com/shanascott712
- Text: SHANASCOTT712 to 22333
What one word would you use to describe yourself?
How are you feeling today?
<table>
<thead>
<tr>
<th>Experience</th>
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<tbody>
<tr>
<td>Heard it all before</td>
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<tr>
<td>Could use a refresher</td>
</tr>
<tr>
<td>Newbie - ready to learn</td>
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What is your experience with Community-Clinical Linkages?
Have you ever fallen asleep during a conference?

Yes

No
Setting the Stage for Change

Presenter: Shana Scott
Community-clinical linkages (CCLs) are connections between the community, clinics, and other settings where primary care is provided to improve population health (CDC, 2016).
WHY ARE COMMUNITY-CLINICAL LINKAGES IMPORTANT?

Strategies that improve access to clinical preventive services (such as screening and counseling), community-level activities, and appropriate medical treatments have been shown to reduce and prevent disease in communities.
### WHAT IS PUBLIC HEALTH’S ROLE IN COMMUNITY-CLINICAL LINKAGES?

<table>
<thead>
<tr>
<th>Community Sector</th>
<th>Public Health Sector</th>
<th>Clinical Sector</th>
</tr>
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<tbody>
<tr>
<td>Composed of organizations that provide services, programs, and/or resources to community members in non-healthcare settings.</td>
<td>Composed of public health organizations that can lead efforts to build and improve linkages between community and clinical sectors.</td>
<td>Composed of organizations that provide services, programs, and/or resources directly related to medical diagnoses and/or treatment of community members by healthcare workers in healthcare settings.</td>
</tr>
</tbody>
</table>
WHAT ARE THE GOALS OF A COMMUNITY-CLINICAL LINKAGES?

• Developing partnerships across public health, communities, and health care professionals.

• Promoting healthy behaviors and environments by coordinating health care delivery, public health, and community-based activities.

• Encouraging community engagement in coordinating services and developing linkages.
7 STRATEGIES FOR IMPLEMENTING COMMUNITY-CLINICAL LINKAGES
Community-Clinical Linkages

LINKAGE

Learn about the community clinical sectors
Identify and engage key partners from the community and clinical sectors
Negotiate and agree upon goals and objectives of the linkage
Know which operational structure to implement
Aim to coordinate and manage the linkage
Grow the linkage with sustainability in mind
Evaluate the linkage
Getting Started
CONDUCTING A COMMUNITY HEALTH NEEDS ASSESSMENT

1. Define the community
2. Collect data on the community
3. Identify critical needs and gaps in services and programming in the community
QUESTIONS TO CONSIDER

• How do you define community?
• What does your community do well?
• Where are some opportunities for growth in resources (e.g. shelters, schools, community centers) within your community?
• What resources are already in place in your community? Do they deal with the health issues about which you and your stakeholders are concerned?
• Is there a lack of health services and programming? If so, what can your organization provide to fill this gap?
• Are there language barriers that influence access and acceptability of available resources?
• Are services and programming offered in a location that is acceptable accessible, and affordable for the community?
IDENTIFY STAKEHOLDERS

PLANNING: IDENTIFY STAKEHOLDERS TO PARTICIPATE IN DEVELOPING GOALS, OBJECTIVES, AND ACTION PLANS
<table>
<thead>
<tr>
<th>Community-Clinical Linkages Stakeholder Examples</th>
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<tbody>
<tr>
<td>Community Partners</td>
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<tr>
<td><strong>Community Centers</strong></td>
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<tr>
<td>(Example: A local recreation center offers cooking classes)</td>
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<td><strong>University Programming</strong></td>
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<tr>
<td>(Example: Extension programs offer nutrition or physical activity programs)</td>
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<tr>
<td><strong>Faith Based Communities</strong></td>
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<tr>
<td>(Example: Faith-based groups offer spiritually-centered stress reduction programs)</td>
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<td><strong>Nonprofit Organizations</strong></td>
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<tr>
<td>(Example: WAGA nutrition programs offer guidance on menu selection)</td>
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<td><strong>Public Libraries</strong></td>
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<tr>
<td>(Example: Libraries offer nutritionist-led classes or collaborative learning sessions about food labels)</td>
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<tr>
<td><strong>Farmers Markets</strong></td>
</tr>
<tr>
<td>(Example: Local WIC agencies work with special coupons or incentive programs to provide healthy foods to communities that lack access to grocery stores and fresh food)</td>
</tr>
<tr>
<td>Stakeholders who are able to provide clinical services in diverse settings</td>
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<tr>
<td><strong>Public Health Government Agencies</strong></td>
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<td>State or Local Health Departments</td>
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<td><strong>Federal Assistance Programs</strong></td>
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<tr>
<td>WIC (Special Supplemental Nutrition Programs for Women, Infants and Children)</td>
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<tr>
<td><strong>Community Pharmacists</strong></td>
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<td><strong>Community Clinics</strong></td>
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</tbody>
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HOW TO PARTNER WITH STAKEHOLDERS?

- Engage stakeholders for the coalition
- Use the community health needs assessment as a tool to develop the coalition
- Identify partners or multi-sector collaborators to join the assessment and subsequent linkage development/implementation
- Use existing frameworks and resources to develop the coalition
- Move toward a model of partnership
- Develop a Memorandum of Understanding among partners
QUESTIONS TO CONSIDER

• Who are your identified partners?
• What are the reflections of each partner regarding the community health needs assessment?
• What will each partner contribute to the linkage and why?
• What resources (e.g., staff, materials, funding) will each partner provide to the linkage?
• What are the goals of the partnership?
• What are the intended short/intermediate/long-term impacts of the partnership?
• At what stages will partners become involved?
• What are some foreseen strengths and barriers to developing this partnership?
SMART OBJECTIVES AND ACTION PLANS

• GOAL
• OBJECTIVE
• ACTION PLAN
IS THE OBJECTIVE BELOW SMART?

• To increase the percentage of new mothers in Baltimore City who improve their access to postnatal care and breastfeeding support post discharge from the hospital.
QUESTIONS TO CONSIDER

• Do the goals and objectives of your organization match the ones of the partnership?

• Did you consider the SMART framework in developing your objectives?

• What activities are needed for the short-, intermediate- and long-term?

• How will you evaluate the program? What data and qualitative information will you need to collect?
IMPLEMENTATION

CREATE A COMMUNITY RESOURCE INVENTORY AND IDENTIFY REFERRAL SYSTEMS
IMPLEMENTATION

CREATING REFERRAL SYSTEMS

1. BI-DIRECTIONAL REFERRAL SYSTEMS
2. FORMAL PROCESSES REFERRAL SYSTEMS
3. INFORMAL PROCESSES REFERRAL SYSTEMS
QUESTIONS TO CONSIDER

Do you have resources available for a formal or informal referral system?

Who will be in charge of the referral system? Who will refer and who will receive referrals?

How will you monitor the referral system?

Are there opportunities for client feedback on the referrals system?

Could any stakeholder help establish this referral process?
EVALUATION

• Analyze the linkages and identify areas for improvement
EVALUATION RECOMMENDATIONS

- **Establish** short-, intermediate-, and long-term outcomes based on the intervention prior to beginning the formal linkage.
- **Clarify** details about data collection
- **Engage** stakeholders in the evaluation process and consider how they view evaluations and their communication styles
- **Collect** data in both clinical and community settings
- **Focus** on the linkage
EVALUATION QUESTIONS TO CONSIDER

• What information will be collected for evaluation? What resources are needed to facilitate this process?
• Who will collect the data?
• Why is the linkage collecting this data? What purpose and answers will it provide that can lead to quality improvement?
• When will the information be collected?
• How will the information be collected?
• How will the information be collected, recorded and disseminated?
Conceptual Models for Community Clinical Linkages
**Figure 1-1. Linking Clinical Practices and Community Organizations for Prevention: Proposed Model**

**Building Blocks**
- Organizations and inter-organizational linkages
  - Health care system
  - Governmental public health
  - Community

**Intervention/Innovation**
- Practice and/or public health/community interventions in delivery system design, decision support, or information systems, for example:
  - Co-locating services
  - Developing referral mechanisms to prevention resources
  - Coordinating services at different sites

**Short-term (Process)**
- Increased awareness of community resources
- Increased communication across sectors
- Improved referral and tracking mechanisms
- Resource sharing across sectors

**Intermediate**
- Improved coordination of services for individuals (e.g., changes in practice, greater reach, greater efficiency, new services, sustainability)

**Outcomes**
- Improved health behaviors (e.g., improved nutrition, increased physical activity, reduced tobacco use)
- Improved health outcomes (e.g., obesity, cardiovascular disease, diabetes)

**Predisposing, Enabling, and Reinforcing Factors**
- Community context (i.e., politics, funding, policies such as reimbursement for services)
- Organizational capacity (prevention delivery system) (i.e., organization features, practices, and processes; staffing and infrastructure; effective leadership and senior management support; policies; shared decision-making)
- Innovation characteristics (i.e., adoptability/flexibility; compatibility/fit with provider, organization, community)
- Provider characteristics (i.e., perceived need for and potential benefits of the innovation, self-efficacy, skill proficiency)
**Building Blocks**
- Organizations and inter-organizational linkages
  - Health care system
  - Governmental public health
  - Community

**Intervention/Innovation**
- Practice and/or public health/community interventions in delivery system design, decision support, or information systems, for example:
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**Short Term (Process)**
- Increased awareness of community resources
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- Improved referral and tracking
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**Outcomes**
- **Intermediate**
  - Improved coordination of services for individuals (e.g., changes in practice, greater reach; greater efficiency, new services, sustainability)
- **Long Term**
  - Improved health behaviors (e.g., improved nutrition, increased physical activity, reduced tobacco use)
  - Improved health outcomes (e.g., obesity, cardiovascular disease, diabetes)

**Predisposing, Enabling, and Reinforcing Factors**
- Community context (e.g., politics, funding, policies such as reimbursement for services)
- Organizational capacity of the prevention delivery system (e.g., organizations’ features, practices, and processes; staffing and infrastructure; effective leadership and senior management support; policies; shared decision-making)
- Innovation characteristics (e.g., adaptability/flexibility; compatibility/fit with provider, organization, community)
- Provider characteristics (e.g., perceived need for and potential benefits of the innovation, self-efficacy, skill proficiency)
Evidence of Effectiveness

Presenter: Portia Buchongo / Shana Scott
WHAT IS THE EVIDENCE OF EFFECTIVENESS OF COMMUNITY-CLINICAL LINKAGES?

- Clinical Conditions
  - Blood Pressure
  - Prediabetes
  - Diabetes
- Behavioral Changes
  - Nutrition
  - Physical activity
  - Diabetes self-management behaviors
OBJECTIVE: TARGET UNINSURED AND UNDERINSURED INDIVIDUALS AT RISK FOR DIABETES AND CARDIOVASCULAR DISEASE

Program Components:

- UTILIZATION OF NURSE PROTOCOLS
- Early detection and outreach activities
- Provision of self-management support
  - Diabetes and Hypertension
- Tobacco cessation
- Guidance on medication adherence

Funding:

Preventative Health and Health Services Block Grant
Annual Allocation for Annex 170: $690,000.00*

Allocation Method: Based on costs for comprehensive physical exam, Patient follow-up, lab diagnostics, pharmaceuticals, and case management

*Includes salaries
PROGRAM OPERATIONS

Background Information:
• The Georgia Stroke and Heart Attack Prevention Program
  • Across 72 counties in 12 public health districts

Participants:
• Across 43 counties in 5 public health districts

Partners:
Local Health Districts, Emory Diabetes Training and Technical Assistance Center (DTTAC), FQHCs
Model for improving the diagnosis and quality of care for chronic conditions in health systems

Aims to create a uniform and systematic approach to improve the control and management of hypertension, diabetes and related chronic conditions

Collaboration with health systems

- **Commit** to participating
- **Assess** your practice or system
- **Training**
- **Activate** your community resources
- **Plan** of Action
- **Utilize** your plan
- **Leverage** data
- **Test** and implement approaches
CATAPULT

- Offers several Quality Improvement (QI) plans:
  - Improve management of patients with hypertension
  - Identify patients with undiagnosed hypertension
  - Improve management of patients with diabetes
  - Identify patients at risk for diabetes
  - Implement diabetes prevention lifestyle change programs
• Framework incorporates evidence-based strategies for quality improvement
  • Use of Health Information Technology and Clinical decision-support systems
  • Self-measured blood pressure monitoring interventions
  • Team-based care to improve blood pressure control
  • Self-management support and education
  • Diabetes Prevention Program
CATAPULT COMPONENTS:

Commit to Participating

• Why?

• What Do I Need to Do?
  • Sign commitment statement
  • Identify internal support team

• How can DPH help?
CATAPULT COMPONENTS:

Assess your practice or system

- Why Assess?
- What do I need to do?
  - Complete the Georgia Health Systems Assessment
  - Consider developing logic model
  - Define main project objectives
- How can DPH help?
CATAPULT COMPONENTS:

*Training*

- Why?
- What do I need to do?
  - Review assessment results
  - Partner with DPH for training opportunities
- How can DPH help?
CATAPULT COMPONENTS:

Activate Community Resources

• Why?

• What do I need to do?
  • Identify a team member
  • Partner with CBOs

• How can DPH help?
Setting Aims
Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

Establishing Measures
Teams use quantitative measures to determine if a specific change actually leads to an improvement.

Selecting Changes
All improvement require making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.

Testing Changes
The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the result, and acting on what is learned. This is the scientific method used for action-oriented learning.
Hypertension AIM Statement Example

Three month AIM Statement:
By July 2011, Neighborhood Health Clinic will implement preventative changes to improve the management of hypertension based on the Hypertension Change Package. This will provide measurably improved care for our patients with hypertension.

Our population is defined as:
Patients of participating healthcare providers who have a diagnosis of essential (primary) hypertension as defined by the clinic, over 18 years of age, and who have been seen at the clinic at least two times in the last year.

We expect that:
- The percentage of patients with a most recent blood pressure of less than 140/90 will be five percent above baseline within three months.
- The percentage of patients with diabetes or CKD with blood pressure of less than 130/80 will be five percent above baseline within three months.
- The percentage of patients with documentation of self-management goals will be 20 percent above baseline within three months.
- The percentage of patients who use tobacco – who have been offered tobacco-cessation counseling in the past 12 months – will be 20 percent above baseline within three months.

We will achieve this by:
Starting with small steps of change in two areas of the Change Package and progressing to performing small steps of change in all eight components of the Change Package. Changes that have been shown to be effective will then be implemented.
The team will meet weekly to track what is being learned and to monitor progress.
WHAT DOES COMMITMENT ENTAIL?

• Implement 1 or more of the 5 Plans of Action.
Plan of Action

- Plan of Action I: Improve management of patients with hypertension
- Plan of Action II: Identify patients with undiagnosed hypertension
- Plan of Action III: Improve management of patients with diabetes
- Plan of Action IV: Identify patients at risk for prediabetes
- Plan of Action V: Identify patients with Nicotine Addiction
Plan of Action I

- Plan of Action 1: Improve management of patients with hypertension
- Option: Hypertension Management Program
  - a. Practices will identify and designate a healthcare provider lead
  - b. Practices will use their EHR to identify undiagnosed hypertensive patients to enroll in the Hypertension Management Program
  - c. Each hypertensive patient recruited will be evaluated and treatment will be recommended based on the Joint National Committee
  - d. Practices will identify a case manager to encourage appointment and medication therapy management and a case management strategy (to include self-management plans). Self-management plans may include:
    - i. Medication Adherence
    - ii. Self-Monitoring of blood pressure levels
    - iii. Increased consumption of nutritious foods and beverages
    - iv. Increased physical activity
    - v. Maintaining medical appointments
Plan of Action 2: Identify patients with undiagnosed hypertension

Option 1: Hypertension Improvement Initiative

Option 2: Health Information Technology Improvement
Option 1: Hypertension Improvement Initiative

• The health system or clinic will partner with internal provider practices to complete the following:
  • 1) Identify patients with undiagnosed hypertension:
    • a. Search an electronic medical record or clinical data system to identify patients not diagnosed with hypertension with two or more elevated blood pressures, and recall those patients using telephonic, written or email reminders to be rescreened for hypertension, and provide: a) an aggregate number of patients identified for recall based on the search of the records system; b) the percentage of those patients who return to be rescreened; and c) the total number of those patients diagnosed with hypertension, if available; and d) a plan detailing how the patients will be recalled and the health system’s strategy on enrolling the patients in a hypertension management plan for disease management.
  • 2) Use a Plan-Do-Study-Act approach to test at least three (3) changes in practice, policy, patient management, and/or patient education in an existing panel of patients to improve control of hypertension.

Option 2: Health Information Technology Improvement

• The health system or clinic will complete the following:
  • i. Conduct an initial organizational capacity/readiness assessment of the providers to determine: electronic record capacity, functionality, electronic health record certification status and existing organizational workflows (using a DPH created assessment tool)
  • ii. Offer educational sessions about electronic health record adoption, certification and reporting of healthcare quality measures (includes National Quality Forum (NQF) measure 18 and NQF 59) with the providers
  • iii. Identify and share “Best Practices” tools, protocols and processes for Hypertension control that promote system changes with the providers
  • iv. Assist the providers with developing protocols for retrieving healthcare quality measures data from reports to identify patients with undiagnosed hypertension, diagnosed hypertension (controlled/poorly controlled) and diagnosed diabetes (Controlled/poorly controlled)
  • v. Incorporate into EHR systems content such as: treatment protocols, algorithms, workflow templates, electronic health record prompts and reminders, and Hypertension and Diabetes (where applicable) Clinical Decision Support alerts (to alert the provider of any abnormal or significant values and prompt provider to implement a protocol utilizing the most current guidelines approved by his/her organization).
Plan of Action 3:

- Improve management of patients with diabetes
- Option 1: Diabetes Management Program
- Option 2: Diabetes Self-Management Education and Support
PLAN OF ACTION 4

Option: Implement Diabetes Prevention Lifestyle Change Program (DPP)

Identify patients at risk for prediabetes
The health system will collaborate with physician practices to identify tobacco users with the goal of managing nicotine addiction in patients.

- Practices will identify and designate a tobacco cessation lead and team to oversee and implement the inclusion of the Georgia cAARds Ask, Advice Refer Program.
- Practices will establish procedures to identify patient’s tobacco use during patient in-take.
- Practices will identify the readiness to quit of each patient who identifies as a tobacco user.
- Practices will establish a protocol to refer the patient wishing to quit within 30 days through a case manager.
  - Practices will identify a case manager who can consult with the patient, complete the referral form and send it to the Georgia Tobacco Quit Line (GTQL) by fax or through the organization’s electronic medical record.
- Receive and monitor the patient outcome report from GTQL
- Review progress with patient and assess the need for continued treatment in patient treatment plan.
- Each provider will refer ready to quit patients to the Georgia Tobacco Quit Line through the Georgia cAARds Program.
- Tools and resources will be developed, and protocols will be recommended by DPH.
- DPH will provide technical assistance to include education and training. Best practices, successful strategies and lessons learned will be reported to DPH.
CATAPULT COMPONENTS:

Utilize Your Plan

• Why?
• What do I need to do?
• How can DPH Help?
CATAPULT COMPONENTS:

Leverage Your Data Systems

• Why?
• What do I need to do?
• How can DPH Help?
CATAPULT COMPONENTS:

Test and Implement Your Approach

• Why?
• What do I need to do?
• How can DPH Help?
WHO CAN PARTICIPATE?

• Any health system is encouraged to utilize the CATAPULT framework

• Priority systems:
  • Federally Qualified Health Centers (FQHCs)
  • Public Health Districts
  • Hospital-based health system with affiliated primary care practices (HPCP)
  • Health Plans and Health Maintenance Organizations (HMO)
  • Rural Health Centers (RHCs)
  • Care Management Organizations (CMO)

• Current implementation: 40 systems in Georgia
BREAK
EVIDENCE INTO ACTION

FACILITATOR: PORTIA BUCHONGO
COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

- Community health needs assessments (CHNA) and implementation strategies requirement for tax-exempt hospitals as a result of the Patient Protection and Affordable Care Act (ACA). These assessments and strategies create an important opportunity to improve the health of communities. They ensure that hospitals have the information they need to provide community benefits that meet the needs of their communities. They also provide an opportunity to improve coordination of hospital community benefits with other efforts to improve community health. By statute, the CHNAs must take into account input from “persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.” -ASTHO
COMMUNITY-CLINICAL LINKAGES

L earn about the community clinical sectors
I dentify and engage key partners from the community and clinical sectors
N egotiate and agree upon goals and objectives of the linkage
K now which operational structure to evaluate
A im to coordinate and manage the linkage
G row the linkage with sustainability in mind
E valuate the linkage
COMMUNITY-CLINICAL LINKAGES

Learn about the community clinical sectors

➢ Identify and engage key partners from the community and clinical sectors

Negotiate and agree upon goals and objectives of the linkage

➢ Know which operational structure to evaluate

Aim to coordinate and manage the linkage

Grow the linkage with sustainability in mind

➢ Evaluate the linkage
INTRODUCTIONS

- Name
- What organization do you work with?
- What is your current role?
PART 1: IDENTIFY RESOURCES AND PARTNERS
Who are your partners/resources?
PART 2: GOALS AND STRATEGIES FOR PARTNERS
DISCUSSION

What gaps can be filled with partnership?

What other partners should be considered?

What might facilitate collaboration?
PART 2: BARRIERS
DISCUSSION

What barriers did you identify?

How might barriers be addressed?
PART 3: CLINICIANS, PATIENTS AND COMMUNITY CHARACTERISTICS
DISCUSSION

Key organizational roles that must be filled at community organizations.
ROADMAP

- Linkages between primary care clinics and community resources for preventive services.
EVALUATION RESOURCE*

- Clinical-Community-Patient Relationships
- Organizational processes
<table>
<thead>
<tr>
<th>Domain</th>
<th>Element/Relationship</th>
<th>Patient</th>
<th>Community resource</th>
<th>Clinician/clinician – patient</th>
<th>Clinician/clinician – community resource</th>
<th>Patient – community resource</th>
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<tbody>
<tr>
<td>Ability to access primary care</td>
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<td>Ability to access community resource</td>
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<td>Assessment and goal setting</td>
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<td>Capacity for self-management</td>
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<td>Communication and follow through/follow-up</td>
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<td>Cost efficiency</td>
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<td>Delivery of service</td>
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<td>Delivery system design</td>
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<td>Information technology infrastructure</td>
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<td>Informed and activated patient</td>
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<td>Knowledge of and familiarity with community resources</td>
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CATAPULT SUCCESSES

• Barnes Health Care Services
• Coastal Community Health Systems
• WellStar Health System
• Floyd Regional Medical Center
A BIT ABOUT QI
QUALITY IMPROVEMENT

Plan Strategy
- Prepare for change: Create team and establish/confirm goals
- Investigate potential interventions

Reassess & Respond
- Use CAHPS data to assess what worked, what didn’t
- Spread successful innovations

Develop, Test Strategy
- Select measures to monitor progress
- Develop changes
- Conduct small tests of change
- Adapt changes to organizational context
- Identify and deal with barriers

Monitor Strategy
- Implement changes and hold the gains
- Evaluate progress against criteria
ORGANIZING IMPROVEMENTS

• Use quality models
  • Care Model
  • FOCUS PDSA
• “The Model for Improvement”
  • Accelerate improvement
  • Encourages small, rapid-cycles tests of change
The Chronic Care Model (CCM) identifies essential elements of a health care system that encourage high-quality chronic disease care:

- The community
- The health system
- Self-management support
- Delivery system design
- Decision support
- Clinical information systems
Evidenced-based change concepts under each element foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise.

The Model can be applied to a variety of chronic illnesses, health care settings and target populations.

The result is healthier patients, more satisfied providers and cost savings.
The Chronic Care Model was developed by Ed Wagner, MD, MPH, Director of the MacColl Institute for Healthcare Innovation, Group Health Cooperative.
THE EXPANDED CARE MODEL

Created by: Victoria Barr, Sylvia Robison, braida Marie-Link, Liam Underhill, Anita Dots & Darlene Revensdale (2002)
A CHANGING PARADIGM

• Improving the U.S. health care system requires simultaneous pursuit of three aims:
  • Improving the experience of care
  • Improving the health of populations
  • Reducing per capita costs of health care
THE TRIPLE AIM

- Improving the experience of care
- Improving the health of populations
- Reducing per capita costs of health care
## The Business Case for Quality Improvement

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<tr>
<td><strong>Improve</strong></td>
<td>Improve staff satisfaction and retention</td>
</tr>
<tr>
<td><strong>Enhance</strong></td>
<td>Enhance patient satisfaction and loyalty</td>
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<tr>
<td><strong>Position</strong></td>
<td>Position clinics to capture pay-for-performance and quality improvement bonuses and grants</td>
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<tr>
<td><strong>Streamline</strong></td>
<td>Streamline workflow and maximize the use of staff</td>
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<td><strong>Improve</strong></td>
<td>Improve efficiency</td>
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ADDITIONAL RESOURCES

• Association for Community Health Improvement’s Community Health Needs Assessment Toolkit offers a nine-step pathway for conducting a CHA and developing implementation strategies.

• CDC’s CHANGE Action Guide provides step-by-step instructions to assist with community assessments and developing action plans.

• CDC Tools for Community Health Improvement includes needs assessment materials.

• The National Association of County and City Health Officials’ Resource Center provides practical, customizable tools and resources for local health departments (LHDs) and their partners in completing community health improvement processes.

• CDC Making the Case for Collaborative Community Health Improvement Stories provides hospitals examples of how they might engage in collaborative public health efforts.

• Community Commons, is a web-based tool, is designed to assist stakeholders in understanding the needs and assets of their communities, identify vulnerable populations, and map health indicators.
REFERENCES

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