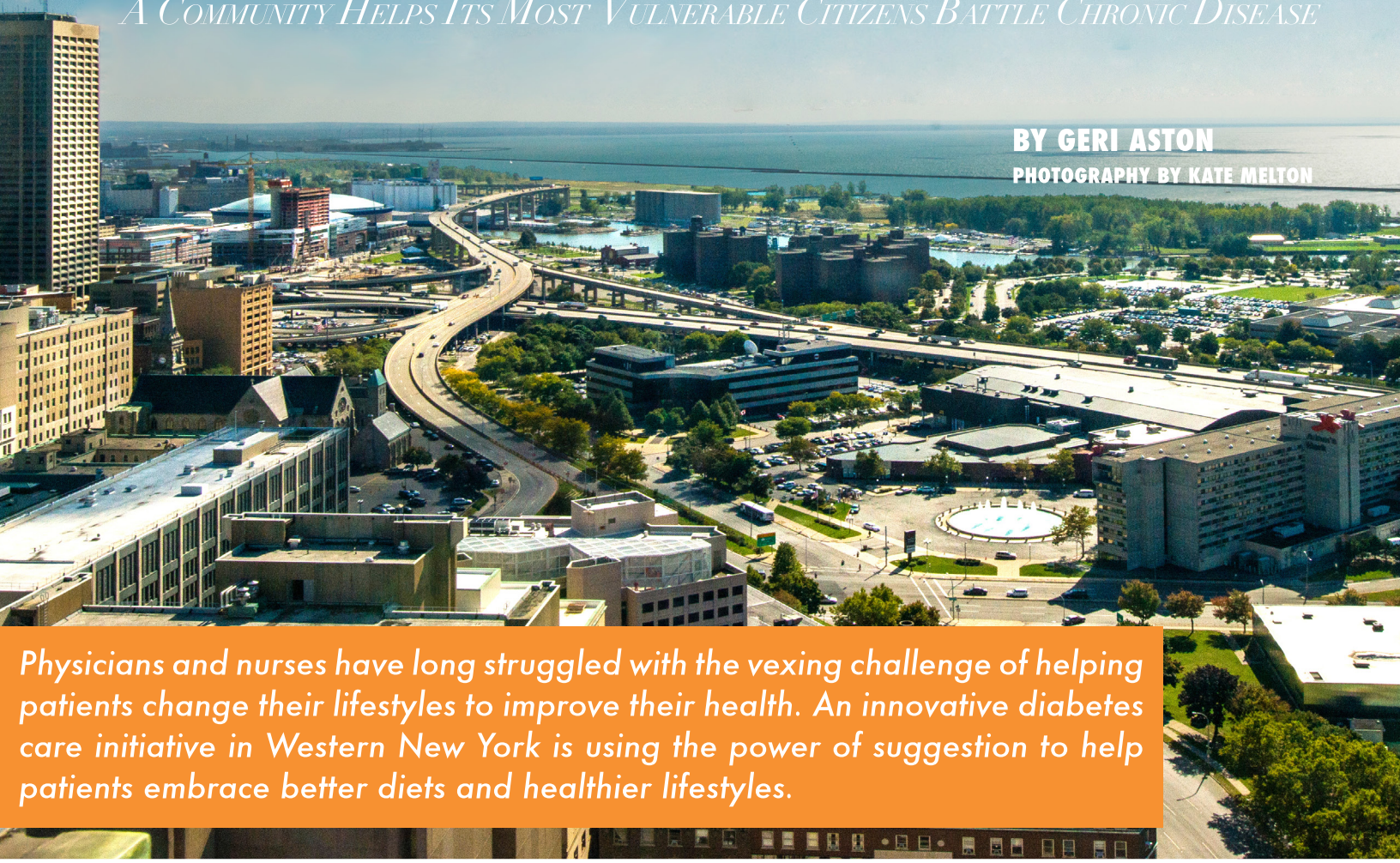
Aligning Forces for Quality | Improving Health & Health Care in Communities Across America
Robert Wood Johnson Foundation

Creating a Health Care Safety Net That Works

A Community Helps Its Most Vulnerable Citizens Battle Chronic Disease

BY GERI ASTON
PHOTOGRAPHY BY KATE MELTON



Physicians and nurses have long struggled with the vexing challenge of helping patients change their lifestyles to improve their health. An innovative diabetes care initiative in Western New York is using the power of suggestion to help patients embrace better diets and healthier lifestyles.

For years, 70-year-old Buffalo resident Rafael Wence, a native of Guadalajara, Mexico, was in the habit of eating just one big meal of mainly junk food each day. Eighteen months ago, Wence was overweight, his blood sugar was too high, his daily insulin dose was on the rise, and he admits he had little idea how to manage his diabetes.

Around that time, Wence was introduced to Barbara Hilton, RN, diabetes care coordinator at Jericho Road Community Health Center in Buffalo, N.Y. Together, he and Hilton set goals to get him on the path toward controlling his diabetes. Once they reached one goal, they'd set a new one.

Hilton introduced Wence to vegetables, and helped him give up donuts and other sweets. She even shared recipes with him, including his new favorite—shrimp and vegetables. Wence started walking for exercise and eating four small meals a day.

Those little changes over time have paid off in a big way, says Wence, who has lost 25 pounds since he began working with Hilton. His blood sugar level, as measured by the hemoglobin A1C test, has dropped from 9.5 to 7.2 at the last reading. Now it's likely below 7, he says. Optimal A1C value for most diabetics is 6.5. Plus, his daily insulin dose has dropped from 40 units to 15 units.

"I save a lot of money, because the insulin is expensive," Wence says. "I feel a lot better, more energetic. If it wasn't for [Hilton], none of this would have happened."

Hilton's job is made possible with funding from the P² Collaborative of Western New York, one of 16 communities participating in the Robert Wood Johnson Foundation's signature *Aligning Forces for Quality* initiative. The Collaborative's Safety Net Care Coordination Initiative provides funding and

support to eight Buffalo-area practices to help them use care coordination to improve outcomes for their diabetic patients.

The program focused on helping safety net practices reduce disparities in the care received by Medicaid patients, says Glenda Meeks, the P² Collaborative's manager for clinical care coordination. The group settled on diabetes care because the disease is a concern across Buffalo's safety net practices, and the Collaborative had experience with the condition from previous projects.

As part of the initiative, the Collaborative collects monthly data reports from the safety net practices' electronic medical records (EMRs), analyzes them, shares the results with the practices, and helps them identify opportunities to improve, Meeks says. The collaborative meets regularly with the practices' care coordination teams to discuss possible improvements and helps them conduct small tests of change. The meetings give the care coordination teams a chance to share challenges and successes and to learn from one another.

At the Jericho Road clinic, the initiative brings diabetes care to a new level, even as the disease burden has grown, says Brett Lawton, director of clinical operations. In the past five years, the number of diabetic patients at the center has almost doubled, from 450 to more than 850.

"You find that the more hands on deck, the more you can effect change," Lawton says.

GIVING A GENTLE TOUCH TO MOTIVATE PATIENTS

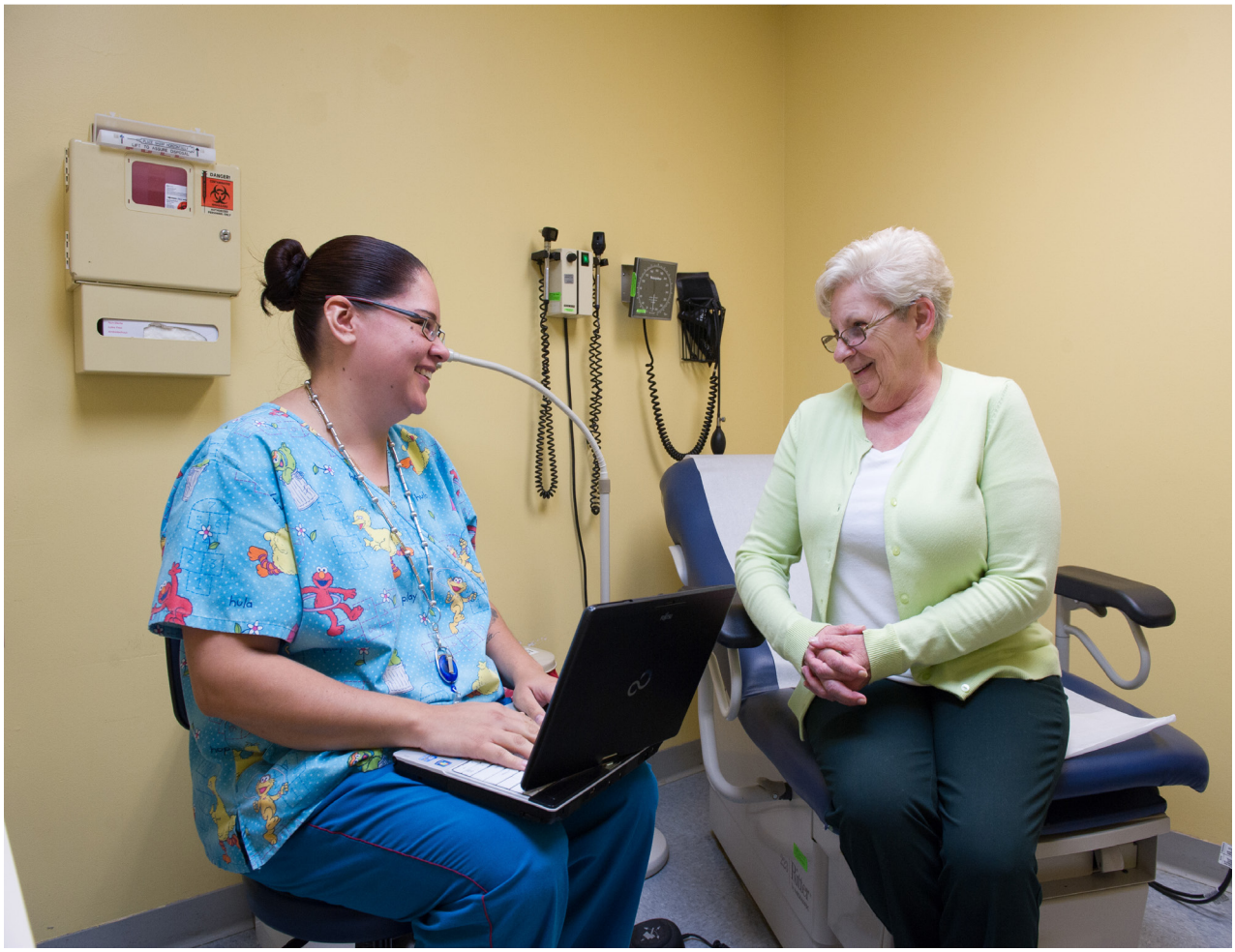
In her role as care coordinator, Hilton goes through the center's diabetes patient registry to create a list of patients who are one or two weeks away from an appointment. She then goes through their charts to find out if any needed tests or exams are missing, before following up with patients by phone.

Sometimes the problem is a missing order, in which case Hilton asks the physician to fill it. She uses the registry to identify patients whose blood sugar levels are out-of-range and asks their physicians if they'd like her to work with those patients. They always say yes, she says.

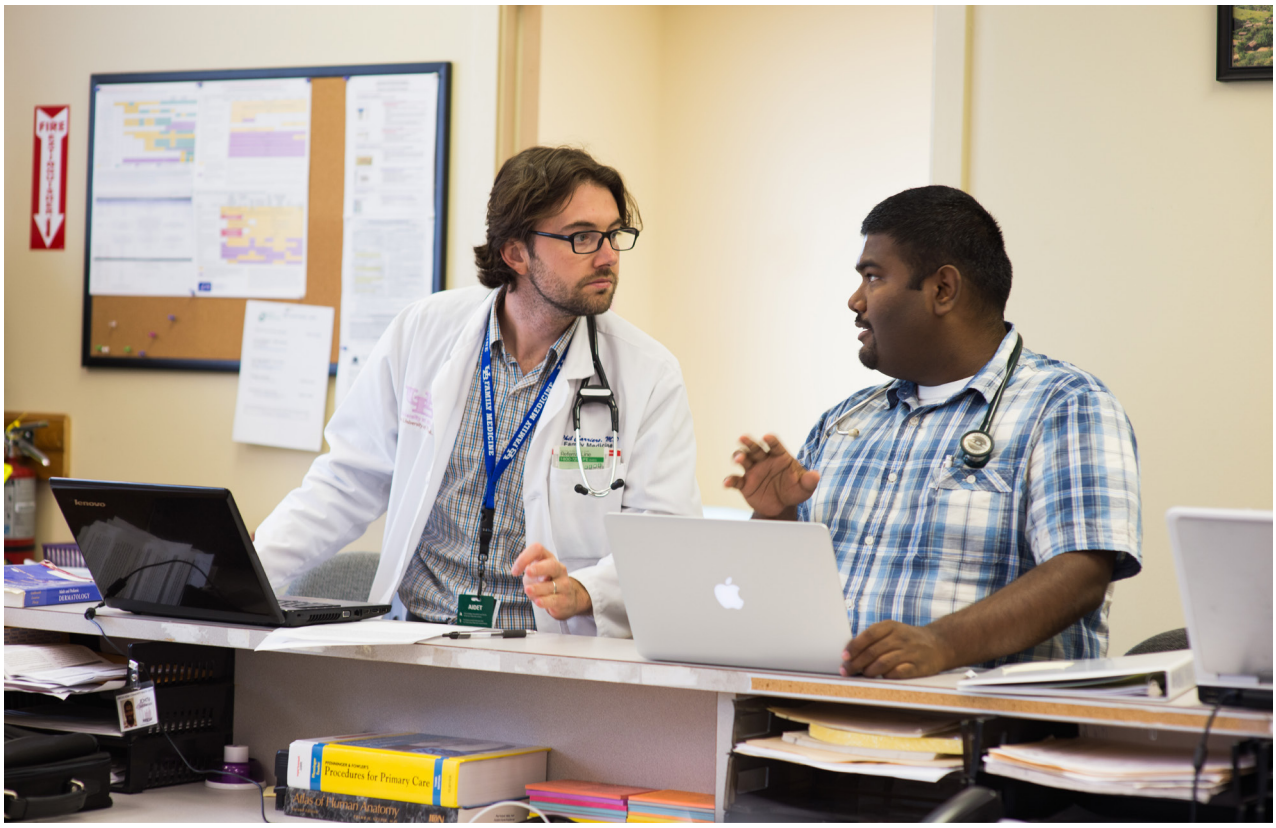
"The doctors can tell patients, 'this is what you need to do,' but they have such a patient load that they can't take the time to set these baby-step goals that I do. I can take that more in-depth approach to diet and exercise."

Jericho Road has two sites. Most patients at the east Buffalo location are low-income African-Americans, while most patients at the west-side office are refugees from countries in Asia and Africa. English is the primary language for less than half of the center's patients.

When Hilton meets one-on-one with patients, she uses a motivational approach to helping them make lifestyle changes,



(Left to right) Felicia Velez, RN, talks to Mary Lou Flaminic during a patient visit at the Elmwood Health Center in Buffalo.



(Right to left) Rohith Saravanan, MD, a family physician at Jericho Road Community Health Center in Buffalo, discusses patient care with Phillip Carriere, a medical resident working at the center.

instead of dictating what they should do to get their diabetes under control. This technique works well with patients of all backgrounds, Hilton says.

At first, Hilton worried how the clinic's diverse populations would react to her suggestions to modify their diets. Today, she suggests making practical changes to traditional dishes to make them healthier—instead of recommending they eliminate those dishes entirely.

"I thought, here's a white woman coming in to tell them how to eat," she says. "But once I got patients to see that I'm not going to sit here and tell them what to do, I was more accepted. If you use a sense of humor and some teaching, it goes a long way."

Within the refugee population, Hilton notes that the patients who have adopted Western diets are often in the most need of help.

"We Americans have taught them well how to become diabetics," Hilton says. "Our cheap foods are the unhealthy foods, like white rice, white bread, white potatoes and white pasta. All that starch turns into high sugar in the blood after it's digested. When refugees come here and they don't have a lot of money, what are they going to buy?"

The clinic's small army of interpreters, who are often refugees themselves, help patients find healthy foods from their shared culture. They also help the diabetes team to contextualize recommendations for the different cultures.

"You can't talk about portions on plates when their culture is used to sharing plates from the middle of the table," Lawton says. "The interpreters explain how to talk about portion sizes in other cultures."

The time Hilton spends planning for appointments and one-on-one time with patients makes work easier for the center's physicians, says Rohith Saravanan, MD, a family physician originally from southern India. "There is only so much you can do in a 15-minute visit with a patient," he says. "Diabetes isn't a 15-minute disease. You need a full-team approach."

PRACTICES CRAFT TAILORED APPROACH TO CARE COORDINATION

Each practice participating in the P² Collaborative's initiative takes a different approach to care coordination because each has different needs, resources and patient populations. At Elmwood Health Center, half of the patients have developmental disabilities, and many of those patients live in group homes. Care Coordinator Jennifer Sander, RN, works closely with the group homes' staff to support residents with diabetes.

"If there's a problem, the group home staff will call me," she says. "They're very good advocates for the patients."

Sander also does appointment pre-planning, diabetes education and one-on-one patient sessions. Using the practice's EMR, she monitors patients' test results and reaches out to them when they have a problem.

Sander's position wouldn't have been created without the initial P² Collaborative funding, says Frank Azzarelli, Elmwood's director.

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Rohith Saravanan, MD
Family Physician
Jericho Road Community Health Center

"Jennifer has been able to keep her fingers on the pulse of diabetic patients and has been able to bring them in when they need to come in, rather than them showing up in an ER," Azzarelli says. "We were managing crises; now we're not. We were reactive; now we're proactive."

THE OVER 8 CLUB

Moving forward, Sander plans on adapting an idea from another center—called the Over 8 Club—because it's for patients with A1C levels above 8—and launching it at Elmwood. She envisions Elmwood's club as a support group, because patients have expressed a need for help coping emotionally with diabetes. Members could talk about their frustration at having a chronic disease, discuss the difficulty of finding affordable, healthy food, and swap tips. The initiative's data collection and dissemination component allows the practices to see how their results compare with the average and best performers on diabetes process and outcomes measures.

Changes in results are difficult to accomplish quickly. One reason is because the program only began in May 2013 and changing patient behavior enough to see outcomes improvements takes a long time, especially in patients with severe disease, Meeks says.

Using different metrics could be valuable, notes Christine Kemp, the P² Collaborative coordinator for community health improvement. For example, instead of measuring the percentage of patients with A1C levels less than 9, measuring the change in individual patients' A1C levels over the course of a year could provide useful information while avoiding the skewed results patients with extremely high blood sugar levels produce.

Changes in results on the two process measures are difficult to accomplish quickly. For example, a practice that recently adopted appointment pre-planning won't see its full impact on the percentage of patients getting their A1C and cholesterol levels checked in the past year until an entire year has passed.

Through the initiative, participating practices are developing care coordination techniques that eventually will result in better patient outcomes, Meeks says. But those care coordination processes, such as appointment pre-planning and workflow redesign, aren't formally measured and reported.

Because each practice implemented care coordination in its own way, it's challenging to make broad conclusions about what techniques are best, Kemp notes.

"The practices needed flexibility to develop the interventions that work best within their workflow and their business plan, so it's at a cost to consistency and ability to make solid scientific claims about what happened," she said.

However, because practices were able to create their own solutions and modify any ideas they borrowed from their peers to meet their own needs, the interventions are more likely to last throughout the initiative and beyond, Kemp notes.

"They really value their autonomy and their ability to adapt the resources we can bring to this project to their own practices," Kemp says.

SUSTAINING MOMENTUM AFTER 2015

With the 2015 conclusion of AF4Q funding nearing, the P² Collaborative and the participating practices in the Safety Net Care Coordination Initiative are working together to determine how the care coordination effort can be sustained. The Collaborative views the monthly funding practices receive under the initiative as seed money to build care coordination into their practice in a lasting way.

"The practices are committed to retaining care coordination services and finding a way to pay for it," Kemp says. "That doesn't make it easy, but there is a strong resolve among them because they see the value of these services."

The Collaborative has also hired a consultant, recommended by RWJF, to help the practices build a business case for the sustainability of care coordination through reimbursement. From there, practices would take their business cases to Medicaid managed care plans and other payers to convince them to invest in diabetes care coordination. For Jericho Road Community Health Center patient Wence, the case for Hilton's care coordination work is clear.

"There are a lot of [diabetic] people out there who don't know what they're doing," he says. "The way she helped me, she can help somebody else." □

Geri Aston *is a long-time health policy writer whose work has appeared in the* Economist, *the* St. Louis Post-Dispatch, American Medical News *and* Hospitals & Health Networks *magazine. Her ongoing coverage of clinical management in* H&HN *has earned her several awards from the Association of Healthcare Publication Editors and the Society of Business Publication Editors.*