Patient-Centered Care for Underserved Populations: Best Practices

A Case Study of G. A. Carmichael Family Health Center

prepared for

The W. K. Kellogg Foundation

by

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March 2006

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Acknowledgements

The authors would like to thank the W. K. Kellogg Foundation for supporting this research. The W.K. Kellogg Foundation is a nonprofit organization whose mission is to apply knowledge to solve the problems of people. Its founder W.K. Kellogg, the cereal industry pioneer, established the Foundation in 1930. Since its beginning the Foundation has continuously focused on building the capacity of individuals, communities, and institutions to solve their own problems. "To help people help themselves through the practical application of knowledge and resources to improve their quality of life and that of future generations." For more information, see www.wkkf.org

We also thank Eddie Anthony, Executive Director of GACFHC, and Janice E. Bacon, MD, Clinical Services Director, for sharing their time and very valuable insights.

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Case Study: G. A. Carmichael Family Health Center (GACFHC)

Background

G.A. Carmichael Family Health Center, (GACFHC)[1] is a nonprofit community health center agency serving Madison, Yazoo, and Humphreys Counties—a mainly rural area in Central Mississippi. It is comprised of four main health center sites, and 11 school based clinics. GACFHC provides primary care, oral health care, early intervention services for HIV/AIDS clients, outpatient mental health and substance abuse services, some specialty care, patient education, case management, WIC services, and others. In existence since July 1972, GACFHC provides accessible, affordable, quality health care to approximately 23,000 patients, with approximately 98,000 patient encounters in 2004.

GACFHC serves primarily low-income, minority populations. Ninety-six percent of patients are African-American, though the number of Hispanic patients has increased more than 200 percent in 18 months. Forty percent of the Center's patients are uninsured and in the self-pay (sliding fee) category, 35 percent have Medicaid coverage, about 20 percent are covered by Medicare, and the remainder have private insurance.

GACFHC was named after Dr. George Albert Carmichael, who practiced medicine in his hometown of Canton, MS for more than 50 years. His commitment to provide care to the underserved, with "100% access and 0% disparity" became GACFHC's mission.

How GACFHC Practices Patient-Centered Care (PCC)

GACFHC 's commitment to PCC is reflected in its stated values: Quality, Courtesy, Integrity, Responsiveness, Respect, and Teamwork. These values are incorporated into every-day operations. Many elements of PCC grow out of the GACFHC's involvement in national collaboratives, particularly those involving implementation of the Chronic Care Model and Self-management Support, described below.

Patient "Activation" through Decision Support and Self-Management

Dr. Janice Bacon, GACFHC's Director of Clinical Services, defines PCC as "ensuring that a patient is 'activated' – getting them to realize that they are captain of the ship, and we're here to play a role in achieving their goals."

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[1] For more information, see http://gacfhc.org/

GACFHC's major emphasis on patient empowerment and education has its roots in its participation in national collaboratives. With diabetes and obesity at epidemic proportions in Mississippi, and a widespread lack of knowledge among patients (e.g., most patients did not know what "A1c" meant despite that fact that hemoglobin A1c levels, which reflect blood glucose levels, must be monitored and kept low for diabetes patients), GACFHC applied and was accepted to be part of a Health Disparities Collaborative[2] in 1999. GACFHC entered into a 13-month program used to train community health centers in the "Chronic Care Model"[3] and the "Model for Improvement."[4]

At the clinic level, GACFHC focused on the following components of the Chronic Care Model, which are also integral to patient-centered care:

- Self-management support- promoted through Saturday group educational sessions, dental self-management goals, and a self-management contract with goals developed by patient and provider together;
- Delivery system design – uses patient's current needs to plan visits in advance; allows patients to meet with primary care providers and other team members (dentists, nurses, and medical and nursing assistants) with specialists available on a rotating schedule;
- Decision support – integrates evidence-based guidelines into training and practice; uses an acronym for diabetes (developed by GACFHC physician expert, Dr. Debra Rice) outlining the guidelines in flow sheets, self-management contracts, and wall postings in the clinic;
- Clinical information systems – uses a registry of patient and population data (including hemoglobin A1c data over time) that allows the center to plan visits appropriately and to develop proactive care plans;
- Community resource mobilization - encourages patients to participate in effective community programs and formed partnerships with community organizations to support and develop interventions that fill gaps in needed services.

According to Dr. Bacon, this process was effective in getting the agency "out of the accepted modes of doing business." The models "get the staff energized" and empower staff members to break out of traditional roles (see Staff Empowerment, below). GACFHC staff joined faculty from other organizations to learn about and create improved processes in the specific disease areas—first diabetes, then asthma, and finally perinatal care. The ultimate goal is to incorporate elements of the models for all patients, across the entire organization.

To help promote "informed, activated patients" through self-management support and decision support, GACFHC has also been involved in a pilot collaborative on Self-management Support through the Health Research and Educational Trust of the American Hospital Association. This 8-

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[2] Health Disparities website (www.healthdisparities.net)

[3] The Chronic Care Model was developed by Dr. Ed Wagner, national program director of Improving Chronic Illness Care (ICIC). ICIC is a national program supported by The Robert Wood Johnson Foundation with direction and technical assistance provided by Group Health Cooperative's MacColl Institute for Healthcare Innovation.

[4] The Model for Improvement, developed by Associates in Process Improvement, is a tool for accelerating change in organizations that are trying to improve health care processes and outcomes. It has two parts: 1) setting aims, establishing measures, and selecting changes; and 2) the Plan-Do-Study-Act (PDSA) cycle, which involves planning the change, trying it, observing the results, and acting on what is learned. See: http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/

month collaborative effort is designed to increase delivery system capacity of the participating organizations, and create stronger links to community resources to provide self-management support for patients.[5]

A critical element of these various collaboratives involves recognizing that patients are making decisions about their care (even if this results in poor adherence to recommendations from clinicians), and helping those patients make better-informed choices. AT GACFHC, it required moving away from a paternalistic relationship in which the doctor and nurse dictate a care protocol (which is often disregarded), and toward a partnership in which the patient plays a major role in decision-making and self-care management.

Specifically, GACFHC tries to change behaviors by jointly setting goals through a Patient Action Plan, and continually assessing how confident the patient feels about reaching those goals. With some guidance, the patient sets self-management goals during a visit, and staff members follow up with phone calls and/or written correspondence. During each subsequent visit, a "team" member (described below) looks over the goals with the patient, and assesses progress toward the goals as well as the patient's confidence about reaching the goals. The confidence level is assessed on a scale of one to ten. When a patient's confidence is low, further intervention is required to identify and address the problem. This generally involves inquiring about barriers, and helping patients acknowledge that other issues in their lives may be interfering. It involves understanding – and helping the patient understand—the specific circumstances that influence health-related behaviors, making referrals to other community support services, and encouraging the patient to renew their efforts.

According to the center's executive director, the best way to activate patients is by first helping them to understand their diseases, and *then* teaching them the "do's and don'ts". This can be a long process. It involves both one-on-one interactions between the patient and his/her health provider, with reinforcement by a chronic care coordinator and other members of the care team (described below). GACFHC also uses classes to as an educational tool. There are monthly classes for diabetes patients, exercise classes for obese children and teens, educational materials that high school students can access via computer, and even cooking classes to help young mothers, diabetes patients, and others to learn how to prepare healthy meals. There is also a one-week summer camp for children with asthma to help them learn how to control their condition.

Socio-cultural competence

There are many ways that GACFHC tries to understand a patient's individual, educational and cultural circumstances. For example, if it appears that a patient can not read a form (e.g., if it is held upside down), a staff person brings the patient into another room to assist him/her. This addresses the patient's literacy issues while maintaining his/her dignity.

Staff also try to understand a patient's individual and family context in order to find out the underlying causes of the presenting problem. Over time, the patients get used to being asked questions. When taking a family history, the staff member looks for pertinent facts, such as other fam-

[5] For more information, see: http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/ImprovementStories/PilotCollaborativeonSelfManagementSupport.htm

ily members with similar conditions. Also, when an intake nurse obtains a history for a patient with hypertension, she looks for underlying causes and risk factors, such as weight gain, alcohol consumption, or salt intake. She then conducts follow-up with the patient to try to address the specific issues, calling upon established internal and external referral systems. For example, if the patient has increased weight gain, an internal referral may occur to the center's nutritionist. If the patient expresses concerns about payment of a utility bill, a referral is made internally to the social work department. Follow up may also entail referral to specialists or appropriate community-based organizations.

Many elderly patients, particularly those in rural areas, use home remedies to treat their conditions. GACFHC clinicians always ask what else a patient is taking, including such alternative treatments. The physicians understand the psychological importance of home remedies that have been used for generations, and do not try to stop such practices unless they are detrimental to the patient's health. Rather, they let the patient know that their home remedy is all right, but they should *also* take the appropriate (medically necessary) medication.

As noted above, there is a small but quickly growing population of Hispanic patients. So far, the Center has managed with forms translated into Spanish, one provider with a certain level of Spanish fluency and a contract with a Texas based company to provide a cordless interpreter line for use in the intake and examination rooms. GACFHC's strategic plan includes acquisition of bilingual staff members for receptionists, outreach, and community education, and clinical staff positions.

Easy access to care

GACFMC tries to promote easy access to services, with late night and Saturday clinic hours for those who work normal business hours. Also, if a mother comes in with children in addition to the one for whom she has an appointment, the clinician will check all of the children --- realizing that the family may have barriers such as limited transportation and not return for subsequent visits.

To address poor outcomes for the school based population GACFHC saw the need to "go where the kids are." Proposals were submitted to the school boards in districts within GACFHC's service area, making the case to establish school-based clinics. There are currently 11 such sites, staffed by GACFHC nurse practitioners. The local school districts have assisted with operation of the facilities by supporting the salaries for key clinical staff including licensed practical nurses and medical receptionists. The clinics allow students to be seen during the school day, while their parents are working. One of the sites is open to non-student community members as well. The students receive acute and preventive medical services; the nurse practitioners are able to diagnose and prescribe medications. This ability to effectively treat the students is a significant asset: GACFHC's school-based operations have greatly improved the average daily attendance for the school districts, largely by addressing asthma, the chronic illness that causes the most missed school days among students.

Community outreach

GACFHC is governed by a volunteer Board of Directors that includes patients and representatives of local community organizations and businesses. According to federal requirements, at least 51 percent of the board members must be clients of the Center; during 2004-2005, about 84 percent of the board are users clinic services. In this way, the Center's activities are highly influenced by patient values and priorities.

GACFHC also interacts with the community by conducting health fairs and screenings at Senior Citizen complexes, religious organizations, and other sites. GACFHC has a partnership with a Ministerial Alliance that includes ministers in the area. The Alliance helps the health center design outreach and health education programs, which are often held in community churches. Elected officials including the Mayors and members of law enforcement are invited to GACFHC health fairs to emphasize the importance of the health issues.

Institutional Supports and Processes that Allow CHA to Practice PCC

There are numerous organizational structures and processes that facilitate the practice of PCC at GACFHC, described below.

Staff Empowerment and Teams

Integrating the Chronic Care Model and its PCC mechanisms into daily operations involved a significant shift in focus and approach to care delivery. It involved "re-engineering" to make sure all staff members – from front desk and medical records personnel to clinical staff – to feel part of the GACFHC "team." In addition, the center uses interdisciplinary teams that follow and monitor patients. Each patient is assigned a team that generally consists of: a nurse practitioner or physician; an RN or LPN; a certified nurse assistant; a chronic care coordinator; and a social worker if necessary; a pregnant patient's team would include an obstetrician or midwife. The team "huddles" to discuss patients' needs (incorporating the patient's preferences as assessed through a patient survey and ongoing communications with the patient), and how those needs are being met.

This shift meant allowing certain staff members to get out of their traditional roles, and to develop new skills. Nursing assistants, for example, were trained to move beyond conducting intakes or taking vital signs, and became team leaders, or experts on such topics as asthma care and helping patients set goals. Front desk staff were trained to become chronic care coordinators – to introduce patients to the concepts of self management, and to make follow up calls to ask about the patients' goals and how confident they are about reaching their goals. The telephone operators now take the lead in contacting patients who haven't been seen in a while.

In general, patient-centered care is emphasized at staff meetings, where it is made clear that "you're here because of the patients, and everything revolves around those patients." The leadership relays the message that "we will let you go if you do not provide the same quality of care for 'non-paying' patients as for paying patients." Both hiring and training are designed around the mission, which stresses serving the uninsured and underinsured with "compassion and professionalism." New staff undergo an orientation and training on what self-management actually

means, and how to use the self-management tools described above. Training in the chronic care model has included role playing and performing skits.

Like the patients, most staff are African-American and are from the surrounding communities, and they encourage their neighbors to come in to the clinics. It is expected that staff members greet patients warmly and let them know that they are "very glad you're here."

Measurement and feedback

Patient survey results and other comments collected through a Suggestion Box and patient satisfaction surveys are compiled and reviewed at the monthly board meetings. It is then up to the Board and staff to address the issues raised.

GACFHC has seen a reduction in emergency room utilization and hospitalizations in recent years, particularly among its asthma patients, and they attribute this to the techniques implemented through the Disparities Collaboratives. But financial constraints limit the degree of evaluation of other PCC-related strategies (discussed further below). Participants in the Disparities Collaboratives now have access to a Patient Electronic Care System (PECS). This electronic registry contains a section on self-management goals that can be tracked over time. GACFHC adds confidence levels to the system as well.

Involvement in Collaboratives and Pilots

As noted above, GACFHC's involvement in outside programs, such as the Health Disparities Collaboratives and Self-Management Support project, have been invaluable in patient-centered care best practices to rural Mississippi. The clinics received technical assistance and training from experts at the Institute for Healthcare Improvement, the MacColl Institute for Healthcare Innovation, the Bureau of Primary Care, and others organizations. GACFHC leaders emphasize the importance of these opportunities to learn and improve, and they would like to find additional pilot projects and opportunities to interact with outside sources. They also stress, however, the need to adapt the models to the specific culture and needs at GACFHC.

Challenges

GACFHC has faced some challenges in pursuing PCC. Implementing the diabetes and asthma collaboratives meant institutional change, and "change is hard." According to the director, there are "early adopters and laggers." A key to bringing the staff along was to include them in the team, as described above. Further, it has been important to recognize members of the teams that perform well. GACFHC also struggled with changing the mindset of the patients; it has been important to gain their trust, and to encourage them to take greater control of their health, but this process can be slow.

Other challenges are related to lack of resources. GACFHC has four social workers that cover eleven school-based clinics and four main sites. Administrators are frustrated that they are not nearly able to meet the needs of all of their patients. Educational and decision-support technology is also limited. Although there is access to the internet for staff and patients at certain clinic sites, GACFHC, like most clinics, lacks adequate web-based tools for all patients and staff. Ad-

ministrators expressed that they would love to set up kiosks in the waiting rooms that would make health-related materials available on-line. Currently, they are trying to set up a Personal Action Plan in the discharge portion of a clinician's progress note but are struggling with how to best track this information.

Financial constraints also limit evaluation of the various PCC mechanisms. For example, the Clinical Services Director would like to do a pre/post test of hemoglobin A1C levels among diabetes patients actively involved in self-management goal setting, to assess the self-management techniques that have been adopted. Also, the center's director would like to build up psycho-social services, which are currently lacking. Unfortunately, resources do not permit such efforts on a consistent basis.

Conclusion

The efforts being made by GACFHC to develop practices that encourage active participation by patients in their own care should reap long-term benefits in quality, cost-effectiveness, and overall satisfaction among patients and staff. Their experience illustrates that it is possible for rural community health centers to adopt and refine "best practices" in PCC.