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Morehouse School of Medicine Trained Health Disparities Clinical Scholars to Help Health Centers in Federal Health Disparities Collaborative Program

Preventing and treating chronic disease in safety net populations through a faculty development program

SUMMARY

The National Center for Primary Care at the Morehouse School of Medicine recruited and trained scholars to serve as teachers and advisers for health centers in the federal Health Disparities Collaboratives program between April 2002 and June 2005.

The Health Disparities Collaboratives program of the federal Bureau of Primary Health Care in the Health Resources and Services Administration (HRSA) is aimed at eliminating health disparities and improving health care provided to patients with chronic illnesses at community and other public health centers.

Key Results

- The project recruited and trained 18 Health Disparities Clinical Scholars.
- Some 14 of the 18 scholars supported health centers through presentations and other efforts after the training.
- The project director pilot tested a curriculum to train clinical leaders at health centers in developing quality improvement plans and in managing change.

Funding

The Robert Wood Johnson Foundation (RWJF) supported this *solicited* project with a grant of $272,128.

THE PROBLEM

While research can point the way to effective care for the prevention and treatment of chronic conditions, many Americans do not receive proper care. The gap between best practice and typical care is greatest for poor, underserved and minority populations.

To address this gap, in 1998, HRSA's Bureau of Primary Health Care launched its Health Disparities Collaboratives initiative, designed to improve care for chronic conditions in community health centers and centers serving migrant workers, homeless families and public housing residents.

Each collaborative focuses on a particular condition—such as diabetes, cardiovascular disease, asthma or depression—and participating health centers assign a team of three to five staff members to participate in the collaborative. The program operates in two phases:

- Phase 1 (12 months). This includes four multi-day "learning sessions," covering the Care Model evidence-based standards of care for chronic conditions and the Improvement Model to guide health centers in testing micro-level system change. This year of learning, testing and measurement aids centers' staffs in deciding what changes to incorporate into their center's regular practice.
- Phase 2: Center staff members use the knowledge gained from Phase 1 to sustain the changes they found to be effective and then spread these changes throughout their organizations and measure the impact on their patients.

Federal officials worked with RWJF's national program *Improving Chronic Illness Care* and the Institute for Healthcare Improvement (also funded in part by RWJF through the *Improving Chronic Illness Care* program; see Program Results for more information) in implementing the program. HRSA divided the country into five regional clusters, each with a director who oversaw the collaboratives in the region. The regional clusters were housed at state primary care associations.

In the first three years of the program, more than 300 health centers participated in collaboratives addressing diabetes, cardiovascular disease and asthma.

Data collected on more than 50,000 low-income patients with diabetes, asthma and cardiovascular disease documented significant improvements both in the quality of care the centers provided (e.g., the frequency of blood glucose and blood pressure checks) and in clinical outcomes (e.g., reduced blood glucose levels for diabetes patients and lower blood pressure for those with cardiovascular disease), according to HRSA.

As the collaboratives program expanded, HRSA's Bureau of Primary Health Care found that it needed a growing team of clinical experts in the diseases covered by the collaboratives (expected to include cancer, infant mortality, substance abuse and other problems in future years).

Also needed were experts who could help centers make organizational changes to improve the quality of care and clinical outcomes and address the needs of patients from different cultures. These experts would serve as instructors in the Phase 1 learning sessions and provide technical assistance to participating centers in Phase 2.

THE PROJECT

RWJF funded the National Center for Primary Care at the Morehouse School of Medicine to train 90 experts who would assist health centers in Phase 2 of a collaborative. These Health Disparities Clinical Scholars would:

- Teach at the annual summits held by each regional cluster.
- Serve as consultants to the centers as needed.

While RWJF funds would pay for recruitment and training, the federal government was to provide funds for travel and stipends to support the scholars' work with the collaboratives.

According to RWJF distinguished fellow and senior scientist C. Tracy Orleans, Ph.D., RWJF hoped that the project would recruit a cadre of minority medical faculty. The project director, Elvan C. Daniels, MD, expected to recruit scholars largely from academic institutions. The center designed a curriculum to meet the needs of such scholars, with particular emphasis on the history and purpose of the Health Disparities Collaboratives program.

The project director formed an advisory committee—including representatives of HRSA, the Institute for Health Improvement and the regional clusters—which helped to recruit faculty and provided feedback on the proposed curriculum for their training. The committee recommended that the project recruit scholars from health centers that had participated in a collaborative already and had achieved some success at eliminating disparities.

At a two-day training October 22–23, 2002, in Dallas, speakers provided scholars with the history and progress of the Health Disparities Collaboratives and background on the Chronic Care Model and Institute for Health Improvement model for changing practice presented by national staff of the HRSA's Bureau of Primary Health Care, staff from RWJF's Improving Chronic Illness Care program and the Institute for Healthcare Improvement.

Faculty from the Morehouse School of Medicine led interactive sessions on cultural competency and skills for working with multicultural health care teams. Sessions also covered teaching and presentation skills, including public speaking and putting together PowerPoint presentations.

Project Challenges

At the time the project was proposed, federal officials had expected the Health Disparities Collaboratives program to continue to expand, with new collaboratives covering different chronic conditions. The scale of the initial project reflected that expectation.

Federal Cutbacks

Early in the project, however, federal officials decided not to expand the number of chronic conditions around which collaboratives would be organized. As a result, fewer scholars were needed, and the project recruited and trained only 18 in the first year, rather than the 44 originally envisioned.

In the second year of the project, federal officials asked the project director not to recruit any more scholars, because they were shifting their emphasis to bringing the rest of the nation's community health centers into Phase 1 of a collaborative and were in the process of developing a new strategic plan for Phase 2. In the interim, they asked the project director to find another way to use the RWJF grant funds to support those centers that were in Phase 2.

In response, the project director conducted several focus groups at health centers and learned that the leaders of health centers who had participated in the Health Disparities Collaboratives program wanted help in developing quality improvement plans and in managing change in their organizations. The project director developed a pilot curriculum addressing these issues.

Limits on Scholar Work

Federal budget cutbacks limited the work the scholars were able to do with health centers. According to the project director, the directors of the regional clusters were supposed to contact the scholars and assign them, with pay, to work with area health centers. However, only the northeast cluster director and, to a lesser extent, the southeast cluster director consistently worked with the scholars, according to Daniels.

Staff Turnover

A final challenge was staff turnover, both at the bureau and in the regional clusters. Daniels said she had less contact with federal officials over time due to a complete turnover of the original Bureau of Primary Health Care National Collaboratives staff, which made it difficult to stay abreast of national changes and communicate these changes to the scholars.

RESULTS

According to the project director, the final report to RWJF and interviews with participants, these were the key results:

- **The project director recruited 18 Health Disparities Clinical Scholars who represented all five regions of the Health Disparities Collaboratives.** Of the group, 15 were from health centers and three were from academic institutions. Ten of the 18 were members of minority groups. Participants included 10 physicians, four

nurses, three physician assistants and one registered dietician. (See Appendix 1 for a list of the scholars.)

- **Fourteen of the 18 Health Disparities Clinical Scholars remained active in supporting Health Disparities Collaboratives activities through the end of the grant period in June 2005.** Twelve of the scholars spoke at national and regional meetings of the Health Disparities Collaboratives. Many also assisted cluster directors in planning activities that included annual cluster meetings. Wanda Montalvo, RN, a former northeast cluster director, said that she has worked primarily with two Health Disparities Clinical Scholars who made presentations at regional meetings. "I've often found their advice to be practical, on target and well received by attendees," she said.

- **The project director pilot tested a curriculum to train clinical leaders in developing quality improvement plans and in managing change.** The director invited teams of medical directors, nursing directors and quality managers from health centers to attend. The director tested the curriculum at three locations: Myrtle Beach, S.C., in November 2004; Nashville, Tenn., in December 2004; and Atlanta in April 2005. In all, about 90 people attended representing 30 health centers. Topics covered included:

  — Overall quality improvement.

  — Change awareness and management (utilizing a curriculum developed by Spencer Johnson, MD, based on his book *Who Moved My Cheese?).*

  — Risk management.

  — Assessing improvement data.

The Scholars' Perspective

In interviews, six of the 18 clinical scholars reported mixed feelings about the training and follow-up—from enthusiastic to critical:

- Saint Anthony Amofah, MD: "What this did was give me the credentials to do this work. I put this on my resume—Clinical Scholar for Health Disparities. Once I was able to do that, the process came alive." See Profile for more details on his experience.

- Janice Bacon, MD: "It sharpened my public health focus. At one point I would have said that I was just interested in my patients, but I'm realizing now that with a population-based focus it's good to start with your patient—but actually the community is your patient." See Profile for more details on her experience.

- Kathleen Reims, MD: "When you're off on your own it can look good in your setting. But I didn't have the confidence to take it on the road. Talking to people who were doing similar things and being able to assess and judge my experience in doing it helped launch me." See Profile for more details on her experience.

- David Rollason, physician assistant: "I think there is value in teaching clinicians how to teach. [But] you can't do that in a day and a half…. At the time it seemed very peripheral to the Health Disparities Collaboratives. It wasn't integrated with the collaborative work." See Profile for more details on his experience.
- Daren Anderson, MD: "The people who trained us didn't have any idea of our competencies or what we were supposed to do…. The biggest problem was the lack of follow through and the lack of a clearly defined mission." See Profile for more details on his experience.
- Jada Bussey-Jones, MD: "I used the information for my practice but if it's supposed to be used to spread to the masses then there could have been a better plan to lay out how the information is going to be used once you have it and how to spread it." See Profile for more details on her experience.

LESSONS LEARNED

1. **Conduct a needs assessment with your audience when planning a curriculum.** When planning the training, the project director relied on her advisory committee and the belief that most of the participants would be from academic institutions, and so she included a basic course on the Health Disparities Collaboratives model. As it turned out, most of the participants came from health centers and were already familiar with this model. A needs assessment was sent to scholars prior to the training, but only 20 percent of these assessments were returned before the training. A thorough needs assessment can assist project directors in better tailoring their training to meet the target audience's training needs. (Project Director/Daniels)
2. **When tying in a project with a federal program, get enough funds so that you do not rely on the federal program to complete your work.** The project director relied on HRSA to provide funds for travel and stipends for the Health Disparities Clinical Scholars to work with community health centers. But the federal agency underwent budget cuts and programmatic changes. It ended up providing little of the funding to clusters to support the scholars once trained, as the director had expected. Scholars were left feeling unengaged and unaware of how they fit into the cluster infrastructure of which they were to be a part. It would have made more sense to include in the budget all of the funds needed to complete the project. (Project Director/Daniels)
3. **When a project is working with a federal program it is critical for it to have an ongoing, working relationship with staff of that program.** In this case, the project director was not part of the ongoing work of the Bureau of Primary Health Care's Health Disparities Collaboratives so she could not direct the bureau to direct collaborative staff (national and regional) to communicate changes in the collaborative program to the Health Disparities Clinical Scholars or truly recognize them as part of the regional cluster infrastructure supporting the Phase 2 activities. (Project Director/Daniels)

AFTERWARD

The Morehouse School of Medicine received a $1.8 million grant from HRSA for its Healthy Communities Access Program (HCAP) demonstration project. It is designed to enhance both the research infrastructure at this historically African-American institution and that of its federally qualified health centers partners.

The one of three major projects within the HCAP Demonstration Project supports four health centers in Georgia to sustain changes made through the collaboratives. Researchers at Morehouse School of Medicine anticipate that by measuring the impact of state-of-the-art quality improvement interventions at the practice level and also community-level measurement of clinical outcomes for the uninsured and Medicaid segments of the population, they can demonstrate the impact that these health centers are making in their communities.

The grant runs from September 2004 to February 2007. The project director is also refining the curriculum that she pilot tested.

As of August 2006, she planned to begin rolling out the curriculum to health centers state by state. The curriculum is not backed by funding, so the project director planned to ask state primary care associations to sponsor the curriculum training or to charge for it directly.

In another follow-up project (ID# 055278), running from September 2005 to March 2007, RWJF supported key components of the national Academic Chronic Care Collaborative that have been developed as a partnership between the Association of American Medical Colleges' (AAMC) Institute for Improving Clinical Care and RWJF's *Improving Chronic Illness Care* program (see Program Results).

Project staff at the Association of American Medical Colleges provided education and coaching to teams at 22 academic health centers that were implementing the Chronic Care Model—a system to improve the care of chronically ill patients. The key results of this project were:

- Teams that focused on diabetes showed improvements in process measures that correlate with quality diabetes care, such as giving patients regular eye and foot exams. Improvement in clinical patient outcomes, such as lowered LDL (bad cholesterol) or lowered hemoglobin A1C (blood sugar count), was mixed.
- Most of the teams were able to make changes to their educational programs in chronic illness care that also aligned with teaching the competencies required by the Accreditation Council for Graduate Medical Education (ACGME). For more information see Program Results.

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APPENDIX 1

Health Disparities Clinical Scholars

(Current as of the end date of the program; provided by the program's management; not verified by RWJF.)

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APPENDIX 2

Health Disparities Clinical Scholar Profiles

"A Defining Moment"

Saint Anthony Amofah, MD, medical director of the Helen B. Bentley Family Health Center in Miami, came to the training for the Health Disparities Clinical Scholars shortly after his center joined the Health Disparities Collaboratives. He called the training "a defining moment for me."

Amofah used the tools he gained to assist other health centers in undergoing and sustaining collaborative changes. For example, he developed a "readiness assessment" tool to help health center staff plot whether they are ready to undergo changes in how they care for patients with chronic illnesses.

He said he also helps health centers understand how change can be threatening and suggests ways to bring people on board. He has assisted center staff in setting up

electronic patient records as well. Amofah estimates that he has made presentations to about 20 health centers since the training.

He said his skills in change management also helped him to become a surveyor for ambulatory care centers for the Joint Commission on Accreditation of Healthcare Organizations, which evaluates and accredits health care organizations. In recent years, the Joint Commission has focused on quality management and ways to implement change.

"What this did was give me the credentials to do this work," he said. "I put this on my resume—Clinical Scholar for Health Disparities. Once I was able to do that, the process came alive."

Broadening to a Population-Based Perspective

As clinical services director of the G.A. Carmichael Family Health Center, a community health center in Canton, Miss., **Janice Bacon, MD,** has her hands full.

The daily struggles of her patients-from a 9-month old baby who weighs only 9 pounds to older diabetic patients who weigh 400 pounds and only take their medications when they are about to see their doctor-take up almost all her time.

But her participation as a Health Disparities Clinical Scholar helped her see her work as going beyond her individual patients.

"The Clinical Scholars project sharpened my public health focus," said Bacon. "At one point I would have said that I'm just interested in my individual patient, but I'm realizing now that with a population-based focus it's good to start with your patient, but actually the community is your patient. You need to expand your horizons.

"That's what I learned from the program. It's the community perspective that we need as a provider that you don't always get through medical school and training…. It is impossible to solve such difficult problems as obesity and diabetes without looking to community partners for help.

"We have developed a lot of initiatives to partner with other agencies…. We have to maintain and continue our work as a true public health center. We are part of Mississippi Primary Health Care Association. We have [been on] a task force with the Mississippi Department of Health."

Since completing the Clinical Scholars project, Bacon has worked at G.A. Carmichael to develop her staff as expert faculty in diabetes, cardiovascular disease and asthma. She is also starting a patient self-management project that her staff will oversee.

Bacon also has worked with or given presentations to other health centers in Alabama, Tennessee, Louisiana and Florida.

She has incorporated several insights from her training into her work, including the importance of getting everyone at a health center to support a project to improve chronic care.

"For medical providers that might be improving quality care," she said. "However, chief financial officers and others are going to want to know how it is going to enhance and improve the center's revenues and not be a barrier or stress or drain on their resources."

Project Builds Confidence for National Work

Kathleen Reims, MD, was medical director at a community health center in Boulder, Colo. when she underwent the training. She had already implemented two Health Disparities Collaboratives projects in diabetes and mental health and saw the value in the approach.

She now works for Patient Infosystems, a Rochester, N.Y., health services company. There, part of her job is to oversee a project with the national YMCA. She is helping the YMCA use some of the processes she learned in the Health Disparities Collaboratives projects to change their organization so they have more of an impact on the health of their members.

Reims said that the main advantage of the training was that it built her confidence in this area.

"I needed to feel that I was competent to go out there and do what I was doing," she said. "It happened at a very critical time for me. When you're off on your own it can look good in your setting. But I didn't have the confidence to take it on the road. Talking to people who were doing similar things and being able to assess and judge my experience in doing it helped launch me."

Participant Incorporates Adult Learning

Physician assistant **David Rollason** had already served as a national faculty member for the Health Disparities Collaborative for asthma when he became involved in the training. As national faculty, he met often with his colleagues around the country either through regular conferences or monthly telephone calls.

That consistent sharing of information was something that he wished the Health Disparities Clinical Scholars project had done. Once the training was completed, there was no ongoing follow-up with the other scholars. Because of that, the scholars could not exchange information or learn about the latest developments nationally in health disparities work.

He said that he learned more about adult learning styles from the training, and has subsequently modified his teaching to include more active, participatory learning.

"I think there is value in teaching clinicians how to teach," he said. "[But] you can't do that in a day and a half…. At the time it seemed very peripheral to the Health Disparities Collaborative. It wasn't integrated with the collaborative work."

Useless Training for One Participant

Daren Anderson, MD, said that his training as a Health Disparities Clinical Scholar was disappointing. He began working with the Health Disparities Collaborative at its

inception in 1998 as medical director at the Community Health Center in Middletown, Conn.

He called his earlier work with the Health Disparities Collaborative a "wonderful experience" and said that the program has led to a transformation of care in health centers. But he was less enamored of the training he participated in through the RWJF-funded project.

"The [Health Disparities] Clinical Scholars training project was completely useless," he said. "It was a one-shot deal…. The people who trained us didn't have any idea of our competencies or what we were supposed to do."

He said that the training felt like a rehash of information that most participants already knew. If the Health Disparities Clinical Scholars were supposed to serve in a mentoring capacity or as coaches it would have been helpful to learn more about leadership and the academic basis behind the quality improvement and change methodology, Anderson said.

He had hoped that he and his colleagues would become scholars and leaders working regionally to help health centers improve their chronic illness care. But he said that officials did not use the scholars once they had gone through the training.

"The biggest problem was the lack of follow through and the lack of a clearly defined mission," Anderson said. "They had a good idea [but] when you looked to do the service there was nothing there."

Impetus for Change at Health Center

The information on the Chronic Care Model and how to quickly test ideas was mostly new for **Jada Bussey-Jones, MD,** an assistant professor of medicine at Emory University School of Medicine in Atlanta. She is also director of one the largest community health centers in Georgia, the General Medical Clinic in Atlanta, which serves more than 120,000 patients a year.

She said the Health Disparities Clinical Scholars training helped motivate her and her colleagues to implement changes at the health center. Among those changes that have shown the most promise is giving physicians information on their results in meeting certain goals, such as lowering the hemoglobin A1c levels for patients with diabetes. Physicians can compare their rates with those of their colleagues and the overall goals for patients.

While she has used the training for her own health center, Bussey-Jones said that there was little follow-up after the training and she has not worked with any other health centers since then.

"I used the information for my practice but if it's supposed to be used to spread to the masses, then there could have been a better plan to lay out how the information is going to be used once you have it and how to spread it," she said.