Trail Guides and Trading Posts on the Journey to Health

Healthy Communities: Networking on the Frontiers

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As we shift from traditional healthcare to thriving health, let's to learn from those who have blazed the trails.

The western frontier of the United States was explored and settled by brave souls who faced existential threats. They were brave and inspired. They also realized a basic truth: they had to survive the journey to reach their destination. For pioneers, often a native trail guide was essential to avoid the known risks and increase the chances of arriving safely. As more people migrated west, trading posts made the journey better for others and laid the foundation for settlements. As many families began to make the journey, their path had to be made clearer, a little safer (although still perilous), in order to benefit from the explorers who went before. An early model of collaboration, but more on that later.

With any journey, if we focus exclusively on the destination, we run the risk of missing what's under our noses along the way. In the journey to become the healthiest nation on earth, what we miss by casting our eyes only ahead is actual current evidence of the change we seek. And the lessons we can learn from that evidence. The territory of health transformation may feel unchartered, but there are explorers and settlers who have established ways to make the journey. We have native trail guides and trading posts. In many cases, "early settlers" have set up shop working with communities under a new paradigm of person-centric and collaborative efforts in service of better health for all. These pioneers don't necessarily see themselves as such and have not garnered much attention.

In this article, we shed a light on the trail guides and trading posts in the journey from healthcare to health. They are known in many quarters by the term "breakthrough collaboratives" and they have been settling the frontier for some time. Keeping a low profile may have enabled them to innovate more effectively. Their story is too valuable to overlook any longer.

Starting with Communities

Health is personal. People live in families and communities. Our national journey to greater health must begin with families and communities. The Folsom Report over 40 years ago called for "communities of solution" to improve national health. Fortunately we have a model for how this works. We have trail guides and trading posts so we can benefit from what others have learned along the way. It turns out that this frontier is more settled than most realize.

Breakthrough Collaboratives are national learning networks that have developed at the grass roots—starting with community-based, federally funded health centers and now extending across the commercial, academic and government health enterprise. They are committed to exploring innovation and research on the creation of health. Funded by the U.S. Department of Health and Human Services (HHS), the Collaboratives evolved within the approximately 9,000 sites of the nationwide network of rural and urban community health centers that are funded by HHS's Health Resources and Services Administration (HRSA) and operated by local boards of directors. The Collaboratives involve health practitioner teams from these different geographies who share insights at the local level on addressing national health challenges, such as obesity, as well as their general learnings about approaches of action that support optimum health.

The Collaboratives exemplify infrastructure that supports wisdom-generation, which is key to our nation's shift from healthcare to health. The Collaboratives generate knowledge from the source: people who are part of a community, part of a family, part of a personal dream. They share knowledge through organizational collaboration, interagency leadership, and virtual communities of practice. Their success demonstrates the potential to accelerate dissemination of valuable solutions through private-public collaboration based on local improvement methodologies in prevention, treatment, and research. They can be characterized as human wisdom-generation efforts that fuel data analytics and networked collaboration to augment human capability.

Moving Toward National Learning Networks

We are a large, diverse nation. Health is a complex challenge. To translate community-by-community learning to national improvement requires a systems approach. How do you address multiple complex challenges and maintain a local focus while making knowledge and best practices available for broad national application? How do we get better at getting better? The story of the HRSA Breakthrough Collaboratives begins to answer those questions. Understanding their genesis and development offers critical insights.

The HRSA Collaboratives started with chronic disease management: the diabetes collaborative, the cardiovascular collaborative, the depression collaborative, the asthma collaborative, and the HIV/AIDS collaborative. They then shifted to a prevention collaborative, as well as a cancer screening collaborative. By combining the chronic disease collaborative with some of the prevention activity, they were able to widen the conversation to a broader framework we call the "expanded care model," and that now has evolved further to another framework we call the "expanded health team framework." The HRSA Collaboratives continually combined lessons learned in the other Collaboratives, ranging from business-case redesign collaboratives to organ transplant collaboratives and healthy weight collaboratives. At each juncture, the social determinants of health are considered as important aspects of improved population health outcomes. The outcomes cannot be improved only by healthcare alone, regardless of the quality of that healthcare. The other aspects of health must come into play. And because the community health centers began with community-oriented primary care (COPC) as a basic framework for their genesis, HRSA has always used a broader framework that combines the efforts of primary

care with public health. The synergies together are important to achieve real improvement for community health and the health of the family and the individual.

Words and Deeds: Quick and Effective Dissemination of Ideas

The Collaboratives developed out of experiences and needs of people working on the front lines of health, enabling them to quickly share information and reach solutions. For example, a clinician might notice an adverse drug effect and learn that others had similar observations. That could lead to a study group, where one person scans the literature, another person investigates how the drug is produced, then they aggregate their experience and research to share with all the Health Centers. The key is having a network built on trust and whose participants were willing to share with each other openly and transparently.

Starting with this type of knowledge sharing, the HRSA Breakthrough Collaboratives have specialized in true dissemination. Participants look for the positive deviants— new ideas that work— so they can quickly expose others in the national network, who then apply the learnings in their local communities, facilities, and local networks. The Breakthrough Collaboratives have managed to combine classical interventions that are doable at the tactical level to make a difference in outcomes. They have effectively married at least three models together:

> One model (the Chronic Care Model) is organizing multiple different system-level supports for each person: at the self-management level, at the team level, at the clinical organizational level, at the community level, and then connecting that with learnings at the national level.
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> The second model teaches how to change something systematically, called PDSA (Plan, Do, Study, Act) Change Cycle Model, or rapid cycle improvement science model. The PDSA Model tests small changes at the micro-system level. The data from a small test is used to analyze and track repercussions in order both to scale it up within the organization and to share it more widely within the organization or with the national dialogue.
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> The third model is the National Learning Community approach, wherein community centers come together through the Collaboratives to share ideas at meetings and in interactive virtual communities of practice at a regional or national level.

The Collaboratives have become an exemplar for leveraging a community's positive results to teach and inform health workers across the country. They have developed the capacity to disseminate best practices for immediate implementation, as opposed to merely publishing in academic journals and then becoming passive about dissemination in any other active approach, which research has demonstrated only results in 15 to 17 year lag in implementation of something that is known. Traditional academic publications can take months to years with no guarantee that the people who need the information will read the journal. In stark contrast the

Community Health Centers have been working together online for 15 years in a peer-to-peer network of communities:10,000 people are members drawn from the full spectrum of people at the Health Centers: CEOs, CFOs, IT, front office, back office, medical officers, nurses, and other staff from all over the nation learning from the Breakthrough Collaboratives.[1]

These communities of practice engage not only people in the Health Centers but also subject matter experts. These are "communities of trust" enabling practitioners to collaborate with transparency. In addition, the sites have a public domain to enable citizens to access the knowledge. They leverage the feedback tools from social media and social marketing to understand how to disseminate information as well as to learn from the communities ("Did vaccinations work?") and to share experiences ("Was it better to send a teacher out to a poor neighborhood?").

The Copernican Revolution: People (not Providers) at the Center

Insights from this collaborative approach have been fascinating. For example, to work in the new collaborative approach to health, practitioners have had to change their mindset. The teams have had to shift the center of focus away from the traditional clinical-provider-perspective to that of the person who wants to be healthy. This has been the equivalent of a Copernican revolution: the entire universe does not circulate around the earth; in fact the solar system circulates around the sun. Health does not revolve around the providers; in fact the providers should circulate around the person. The doctor has to come to grips with the idea that the outcome of health does not depend on him or her, it depends on the person, with the expanded health team's support, and the person as a member of the health team. It is surprising to many to realize that the patient was not part of most models of healthcare until Ed Wagner at the MacColl Institute published the Chronic Care Model in the mid-1990s. Most models of healthcare were doctor-centered, speaking about what the doctor would do to the patient. Today, in going from "healthcare to health" we are going well beyond the traditional term "patient," and shifting to using the term "person."

With the right celestial body at the center (the person), we have begun to use social networks to complete our health solar system. Although person-centric in approach, we realize that health occurs within a social environment. People gain weight and lose weight as a network of friends and family; they do not do it as an individual. For example, a 12-year-old obese child is not obese because he or she is trying to be obese, it is because he or she happens to live in a location that has a lot of fast food available, and the family or community system makes that the easier choice. It does not matter how strong the person feels that his or her character is, or how good his or her doctor is, it has much more to do with the systems aspect at the local level of network or community. Changing behavior requires a social network of support. We have to shift to addressing health at the community and family levels. People cannot usually achieve optimum health by themselves. An "expanded health team," as opposed to a traditional healthcare team within the hospital or ambulatory facility, is necessary to account appropriately for the social determinants of health.

Busting Silos – How Leaders Work Together to Support Transformation

The federal agencies responsible for healthcare are models of both the current problem and the real potential promise of transformation. Federal agencies and departments engaged in health have been operating in what many have called "Cylinders of Excellence" with separate leadership and funding streams. A budget crisis for some can be a rallying cry for others to break down these silos. The Collaboratives provide a blueprint for how to work across boundaries to improve health, lower cost, and improve population outcomes, and they are consistent with national policies and working groups, including the National Quality Strategy (NQS) and the Federal Working Group on Health Care Quality (IWG); as well as the Partnership for Patients (PfP)).

9,000-Plus Community Health Centers Learning Together

Across the United States, there are some 9,000 geographically disseminated HRSA-funded Health Center sites, each with different issues, challenges, and organizational cultural experiences related to their particular communities. Together, the Health Centers currently serve over 21 million people, the poor and the underserved, many of which historically have had no health insurance, but have a place where they can receive care. Each of these health center sites is known as a Federally Qualified Health Center (FQHC).

Beyond providing healthcare, these centers promote health in a broader sense by working on multiple levels, including prevention, lifestyle, and social determinants of health. The Centers serve as community hubs, supporting people to live happier, healthier, and more productive lives. Responding to the unique needs of the local community and the individuals who walk through their doors, Community Health Centers may provide employment support, skills training, exercise classes, farming advances, help with transportation, and a variety of other forms of support to individuals and families. People from within communities step up to help others, facilitated by the center's local leaders.

The HRSA Health Centers are supported about 20 percent by federal grant funding, and the remainder of funding comes from the local community and business agreements. The Health Centers have been a relatively inexpensive way for the Federal government to deliver primary care. The Health Centers can serve their unique communities because in order to become an FQHC, more than 51 percent of each board is required to be comprised of community members who are active patients of the facility. The board sets direction and hires the executive director and staff.

In providing preventative care, the Health Centers have demonstrably reduced the impact on other health care services. For example, Duke University operates community clinics in North Carolina that, after more than a decade of operation, have reduced the need for hospitalizations from their local communities, so the hospital can focus on attracting patients with more complex

illness from a larger geographic area. Prevention in community and primary care settings helped people stay healthy, and kept their illnesses under better control, so they could live healthier and more active lives.

This kind of change does not come from policy-setting. It emerges from a massive number of people on the front lines exploring what works and sharing the insights with each other as "communities-of-practice." Or "Communities of Solution" as the Folsom report urged.

Historically, the collaboratives have been facilitated by the Institute for Healthcare Improvement (IHI)—to allow them to work on common problems. They now are on autopilot; often funded by many other organizations such as private foundations. The collaborative model can be found in the approaches used in many places across the health landscape, including the Mayo Clinic, the Public Health Institute, the Partnership for Patients, and others.

Example: The PSPC Collaborative

The Patient Safety and Clinical Pharmacy Services Collaborative (PSPC), sponsored by HRSA, is comprised of 368 teams from 570 organizations across the nation, driving to improve the health outcomes and safety for high medication populations through patient-centered, cost-effective medication management. Team members represent community health centers, poison control centers, hospitals, colleges and schools of pharmacy, Ryan White HIV/AIDS program grantees, primary care associations, state health departments, and rural health clinics. Care delivery organizations partner with both private and public community based entities.

A key partner is the Center for Medicare and Medicaid Services (CMS) Quality Improvement Organizations (QIOs). QIOs establish relationships with PSPC teams to mutually support and document medication therapy management and thus help to disseminate the Collaborative's systematic delivery of care to the Medicare, Medicare Advantage and the *dual eligible* population, a key focus for PSPC's: those high risk, high cost, complex patients whose needs are beyond the reach of the traditional delivery system.

By focusing on small panels of patients who are at the highest risk for poor health outcomes and adverse drug events, the teams are able to accomplish two goals. First, ***identify the pertinent challenges for the population of focus***, allowing teams to systematically address issues related to providing high-quality, patient-centered care. Second, ***conduct small-scale testing*** that enables them to refine and implement practices that meet their unique organizational needs, ensuring that systematic changes made are accepted and sustained by the expanded healthcare team. This allows teams to detect improvements, over time, in this complex patient population.

PSPC operates in cycles using a fast-paced, iterative improvement method designed to support teams in testing and spreading leading practices, which are drawn from organizations that have achieved outstanding results with an identified population of focus (PoF). Within an intensive cycle of Learning Sessions and Action Periods, teams learn the leading practices from expert national faculty and from observing the progress of other teams. During the Action Periods, which occur between each Learning Session, teams test, refine, and implement changes within

their health care organizations. Teams track and share progress monthly on multiple improvement measures, which include health outcomes and adverse drug events. Improvements are quickly shared throughout the Collaborative learning community.

After five PSPC cycles, five tiers of performance provide a stair-step improvement pathway for all teams, recognizing and rewarding accomplishment at each step. The pipeline of teams' progress as of August 2013 is shown below. Waiting in the wings are 121 teams in formation who have not yet received their initial assessment

New York	North Carolina	Arizona	New Jersey	New Mexico	Oregon	Texas	Puerto Rico	Alabama	California
5	5		2	2	2	2	2	1	1
Indiana	Iowa	Kentucky	Maryland	Massachusetts	Minnesota	New Hampshire	Ohio	Pennsylvania	Virginia
1	1	1	1	1	1	1	1	1	1

Gold-Certified Team with over 80% of high risk population under appropriate review and care regimes.

Figure 1: Locations of the Gold and Gold-certified PSPC teams

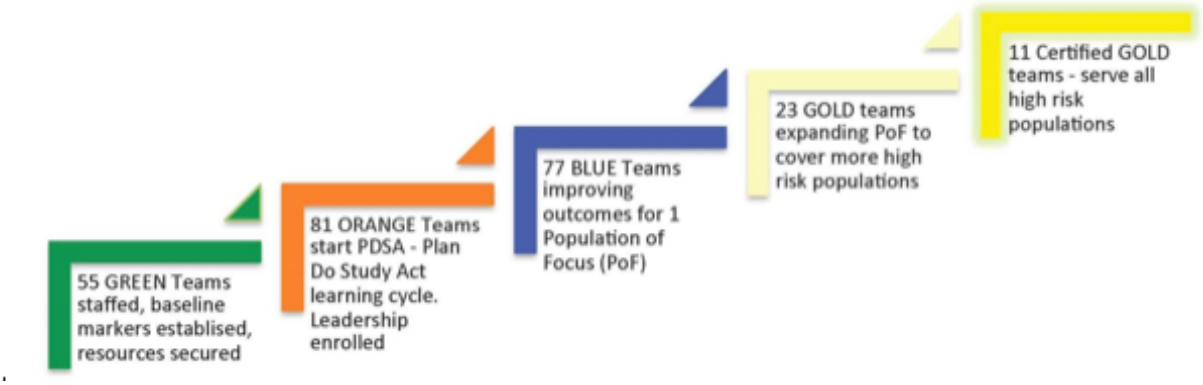

Figure 2: The Five Tiers of Performance

Looking to the Future

The next step on this journey is to scale the impact of the Collaboratives on the health outcomes of the nation.

One approach is to create a "Healthy Community Collaborative," which intentionally and purposefully links primary care and public health interventions. The PSPC (focused on the person-centered team delivery of healthcare), which is making steady progress up the stairway of health, could combine with the Healthy Weight Collaborative (focused on the public health factors and social determinants that together help address obesity).

We will be much faster at coming to a solution concerning the nation's health if we all do this together, as a combination of communities, the aggregate of communities adding up to the nation. We have all the pieces, with the Collaboratives collecting the innovation practices that are needed to address specific issues (Trail Guides). We have emerging public-private partnerships collaborating together (Trading Posts). Now we need an evolving structure to translate our findings into health outcomes.

Darwin has taught us the strength of the forces of evolution that allowed nature to improve over millions of years. Can we learn from nature to capture those unhealthy habits and practices in an effective and efficient manner? The spider has learned to weld a web that captures its prey, without it having to expend the effort of chasing after the prey.

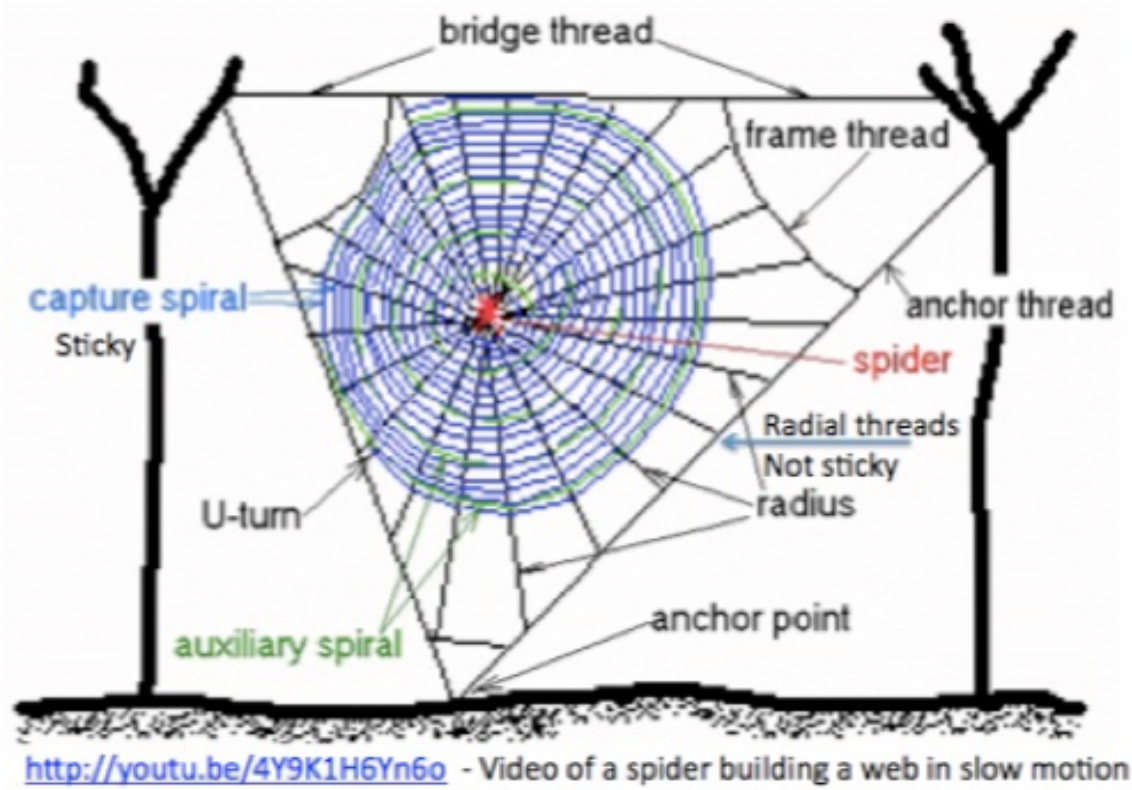

Figure 3: How a spider builds a web

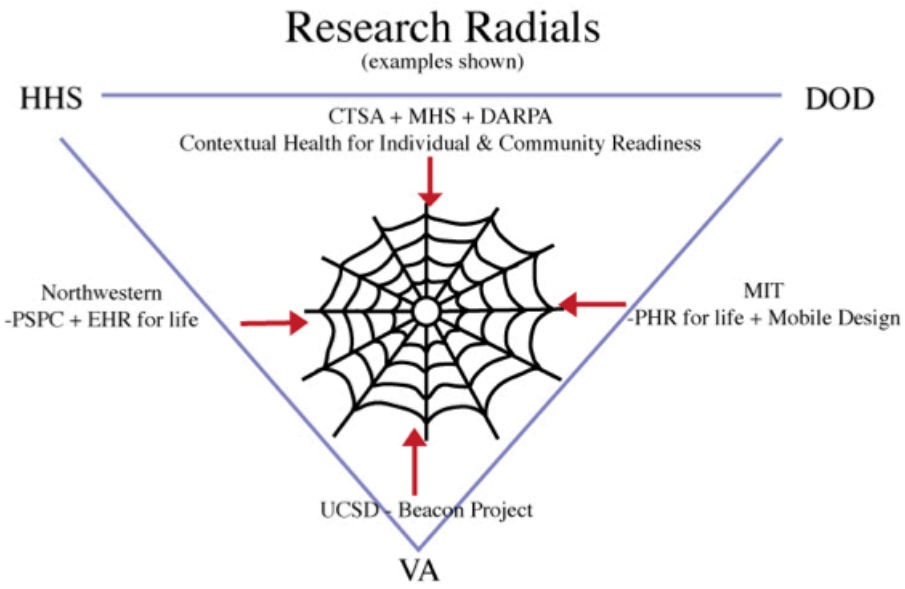

Figure 4 – Set up Healthy Community Research Radials

The joining together of three of the major players in health policy and spending in the US: The Departments of Health and Human Services, Defense, and Veterans Affairs could provide the structural framing of the Healthy Communities Collaborative. The Center for Translational Awards (CTSA) in HHS could join forces with the military Services and DARPA to provide the "Bridge Thread" of the spider web, to foster healthy communities.

The VA could be the Anchor Point, the beneficiary and testing ground for working with Breakthrough Collaboratives and the 9,000 Community Health Centers throughout the country. For Research radials, the Navy is actively collaborating with the VA in Chicago, San Diego (Navy), and this collaboration can be expanded to include the Community Health Centers, the Army and the Air Force. Northwestern University has been supporting the research thrust of the PSPC collaborative, and MIT is a leading center for looking at the future of digital health records and the use of the cell phone for health service delivery. Other research radials can be readily connected in.

The Radial Threads are the potential intersection points of practical innovation and evidence-based research focus where increased attention and recognition to accelerate the rapid dissemination of leading breakthroughs.

National repositories of data - already evolving separately within the FQHCs, CMS, CDC, VA, each of the military services, TMA and many more locations
Healthy People 2020 - nationwide initiative by HHS
Public Health Service - network of the Medical Response Corps and HOSA/Future Health Professionals

The Healthy Communities Breakthrough Collaborative will be a testing ground for the shift from costly Healthcare to Thriving Health.

[1] Examples can be found at: **healthcarecommunities.org collaborateforhealthyweight.org hrsa.gov/quality/toolbox hrsa.gov/publichealth/clinical/patientsafety**