



# Winston Churchill Travelling Fellowship 2010-11

Exploring different approaches to chronic condition  
management



North Carolina



Alaska



New Mexico



Malta

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## Introduction

In 2009 I was lucky enough to spend a week in Harvard University, USA on a *Women in Leadership* course. This gave me the impetus and motivation to consider applying for a Winston Churchill Travelling Fellowship.

With nearly 30 years experience in healthcare I wanted to have the opportunity to examine different approaches to healthcare, across a number of settings, to see what lessons I could learn to bring back to Wales. In 2010 one of the healthcare categories within the Winston Churchill Travelling Fellowship related to Chronic Conditions. As my role in NHS Wales included responsibility for a programme that was aimed at supporting and reducing the burden of Chronic Conditions on the NHS in Wales, it seemed very appropriate that I should apply for this opportunity.

After a number of selection rounds I was delighted to be informed that I had been successful in achieving a place for a period of four weeks.

My proposal identified my desire to visit North Carolina, Alaska, New Mexico and Malta. These places were chosen as each provided a different and unique environment or type of healthcare delivery in relation to chronic conditions.

## Background

Living with chronic conditions can have far reaching implications on all areas of life and can have a particularly profound effect on the social life and independence of individuals, their families and other carers (Welsh Assembly Government, 2007). The profile of chronic conditions in Wales identifies the extent of the problem, with Wales having a higher proportion of reported limiting long term illness (23%) compared with England (18%), Scotland and Northern Ireland (20%) (Welsh Assembly Government, 2005).

A third of adults in Wales report having at least one chronic condition with two thirds of those over 65 years reporting at least one chronic condition. The most commonly reported chronic conditions treated in Wales are arthritis (14%), respiratory conditions (13%) and heart conditions (9%).

It is estimated that there will be a 12% increase in adults with at least one chronic condition and a 20% increase in those over 65 years by 2012.

Against this background of increasing demand, and diminishing financial provision the focus on health promotion, maintaining individuals within their own homes and preventing admissions to acute hospitals has become paramount.

There is a genuine commitment from Welsh Government and NHS Wales to address these issues with a number of strategic documents and policies having been developed over the past five to 10 years. However, it is also recognised that Wales is not alone in facing these issues.

The Winston Churchill Travelling Fellowship provided me with the opportunity to look, listen and learn from a number of diverse environments and providers to not only enhance my own professional practice but also to contribute effectively and productively to the debate on chronic conditions at an all Wales level.

## Itinerary

**8<sup>th</sup> August 2010 – 4<sup>th</sup> September 2010** – Community Care of North Carolina (CCNC) USA

**5<sup>th</sup> September 2010 – 11<sup>th</sup> September 2010** - Alaskan Native Area Health Service (Indian Health Service) Alaska USA

**30<sup>th</sup> October 2010 – 6<sup>th</sup> November 2010** – Hidalgo Medical Services (HMS) New Mexico USA

**20<sup>th</sup> November 2011 – 27<sup>th</sup> November 2011** - Public Health (Department of Health Promotion and Disease Prevention) Malta



## Community Care of North Carolina (CCNC) USA

The CCNC (<http://www.communitycarenc.org/>) is a demonstration program that began in July 1998 and which aims to build upon North Carolinas' Primary Care Case Management Program - Carolina Access - by working with community providers to better manage the enrolled Medicaid population. The program direction, administration and technical assistance is provided by the Office of Rural Health and Community Care which is the organisation that kindly agreed to host me during the first week of my travelling fellowship.

The Office of Rural Health in Raleigh was the first such office in the USA. It was established in the early 1970's to try and address the health needs of North Carolina citizens, especially those in rural communities, where there were less healthcare providers.

Jim Bernstein (a medic) was previously a member of the Peace Corp and believed that change has to be implemented from the bottom up. He set up not for profit organisations - using members of the community to decide on their priorities and needs. A limited amount of money was available to support them, but his mentality was, that in order to make the service sustainable the community had to match fund any investment - this also meant that the community was far more engaged in any developments as they had personally contributed (communities went from door to door asking for donations). This philosophy became the forerunner of the networks.



Jim also believed in the use of nurse practitioners and practitioner assistants and "fought" his medical colleagues across the State to use these individuals, the concept of which was only just developing. He argued that these individuals, in rural areas particularly, would be able to reach more people (albeit under the arm's length supervision of a clinician in another area). Jim eventually persuaded the local legislators for the State to provide some money for the use of nurse practitioners (but only on the understanding that they would never be able to ask for more). However, the concept proved so successful that more money was eventually found.

Over the years 86 rural health centres have been created, with the State (Office of Rural Health) currently funding 28. This is because as they have expanded there is recognition that there are areas/ communities, due to social deprivation and high health needs, which will never be able to sustain/ fund their own centre. The four main concepts that Jim held were:

- there had to be local ownership;
- the local organisation had to be not for profit;

- support would be provided by the State; and
- ideally the organisation/ centre had to eventually be self funding (so ensuring sustainability).

20 years ago there was a programme in place in North Carolina where Medicaid patients had to register with a Primary Care Provider (PCP), from this Paediatric networks were formed (which were the brain wave of a paediatrician who felt that better care could be provided if PCPs worked together). In 1998 the State asked Practices whether they would be interested in forming networks which would work together to address certain diseases - initially this was specifically for asthma. From the interest received the State decided to form seven networks; they consciously decided not to include everyone, but to test the concept. Over the next five years, the networks grew to encompass the whole State of North Carolina till there are now 14 networks. These have traditionally developed around service provision ie around acute hospitals. Each network has at least one Clinical Director who clinically lead the networks. These Directors meet twice a year as a group, but speak monthly via teleconference.

The networks are outcome focused and are allowed/ encouraged to achieve the outcomes in whichever way they wish, as it is recognised by the State that there are different solutions for different communities. The networks have a philosophy which states that if they focus on quality then efficiencies will follow. Whilst the networks were originally set up around specific diseases eg asthma they have now evolved into generic chronic conditions management as they recognised that co-morbidities were so prevalent. Care co-ordinators are all nurses or social workers who are from the area and who know the community and the resources available in that area

All patients involved with the Care co-ordinators have a care plan with specific goals identified. Care co-ordinators also work in hospitals to identify those high risk Medicaid patients who are being discharged. Rather than relying on traditional methods (ie Fax/ letter) to inform the PCP of their discharge the Care co-ordinators actively seek out these patients and ensure that they receive a visit from their own Care co-ordinator on discharge. There are common performance metrics across the whole of the State that are agreed by the Board of Medical Directors. Initially medics were sceptical of the data but now recognise its worth and the part it plays for the Care co-ordinators.

The reason I wanted to visit the CCNC is that they use care co-ordinators/ managers and networks to manage the health of their Chronic Condition (CCM) population. During 2009/10 Wales started to move towards this model and I wanted to see how an established model (of over 10 years) has impacted on the health of the population and also determine what the staff see as the benefits/ disadvantages of this approach.

An independent evaluation that was undertaken in 2002 on CCNC estimated that their asthma programme saved approximately \$3.5 million and their diabetic management programme saved \$2.1 million; so definite food for thought for NHS Wales.

CCNC has identified significant pharmacy savings (\$200 million in the last few years) by the use of generic prescribing and medicines reconciliation. As part of this they have identified 10 drugs which have the most errors in prescribing and also the 10 drugs which if a patient is prescribed indicates that a Care co-ordinator should visit these patients (as often they have health problems that need addressing). Regular audits are undertaken (from both the financial claim forms submitted to Medicaid, but also from paper notes/ case notes within PCP). This is part of the PCP contract and so they have to comply.

They are just starting to look at Mental Health issues, as historically this has been totally separate from Primary Care. They are also just starting to use Motivational Interviewing (they are training all their Care Co-ordinators in this methodology) as they feel that this will help individuals to increase their self management.

Any tools/ documentation that CCNC develops are able to be used by other providers. They recognise that Doctors are not interested in who pays the bills, but if something works and there is evidence of success then Doctors will take this and use it until it becomes accepted practice and this is what CCNC hopes will happen and as a result quality of care improves.

During my stay I visited a number of networks across the State, this included Greensboro, Wake and Johnston and Henderson. All of the networks had slightly different approaches as each network is given the freedom to develop whatever programme they feel will benefit their community the best and keep them out of hospital. Some examples of this included:

- buying children nappies, so that mothers with chronic conditions didn't go without food (and therefore become sicker), bulk buying of hydration salts and making up "glow in the dark" cups with these and instructions which they distribute to all participating Primary Care Practices to prevent children with mild diarrhoea and vomiting being admitted or visiting hospital and making sure patients have medication delivered to their houses if they are unable to collect it.
- a pilot undertaken with Congestive Cardiac Failure patients (CCF). They identified those CCF patients who were constantly being readmitted (about 140 patients within the network) and then hired a nurse (initially for 6 months) who phoned all these patients every week, following an algorithm questionnaire. This focused on areas such as their weight (all patients were provided with a weighing scales), their salt intake, exercise, pitting of legs (oedema) etc. Patients were asked to weigh themselves every day and if during the call the nurse was informed that they had gained more than 2lbs in two days or 5lbs in a week then they were asked to attend the doctors (or the doctor was asked to call) to provide medication prior to them developing pulmonary oedema and requiring hospitalisation. This programme decreased admission rates in these individuals by 24% over the 6 months. This programme is now being spread across North Carolina.
- the need and value of data, and the valuable role that their Quality Improvement Coordinator plays in discussing data with practices, providers and their own staff. She provided an example where the network had the lowest rate of home visits undertaken within 30 days, when compared to all the other networks in the State. To

improve on this they charted (anonymously) all the Care co-ordinators' visits and then distributed to them all. There were significant discrepancies between the various individuals. The provision of this data to the Care co-ordinators has seen the number of home visits within 30 days increase to such an extent that they are now the best in the State. Their approach to this issue has been shared with all the other networks so that others can adopt this methodology if they choose. The network has its own dedicated website: <http://www.ccwjc.com/index.html> which makes available all the tools that both staff and providers require.

Staff at the various networks stressed the need for clinicians to be involved in developing quality indicators and for them to "champion" the way.

The networks have also undertaken a significant amount of work in relation to Medicines Reconciliation. In some networks care coordinators have been trained to undertake medicine reconciliation - comparing the medication that the patient was discharged from hospital on, what has actually been dispensed (they gain this data from the Medicaid claim forms) and then by talking to the patient to find out exactly what they are taking. If there are any discrepancies the Care co-ordinators either contact the PCP or the pharmacist. The care coordinators are also trained to look for five common discrepancies:

1. Discrepancy with known drug allergies
2. Differences in medication/ frequency/dose/direction
3. Unconfirmed discontinuation
4. Not taking prescribed medication
5. Discontinued medication on discharge list but patient still taking

The pharmacists also have a list of five "hot meds" which means that if a patient is taking any of these then a Medicine Reconciliation is undertaken by a pharmacist. These five drugs are: Insulin, Digoxin, Warfarin, Theophylline and anticonvulsants. All patients with eight or more medicines are also reviewed.

### ***Lessons learnt from North Carolina***

- clinicians have to lead the way; identify, catch and keep clinical champions who can engage colleagues!
- focus initially on those practices/ individuals that want to change/ improve (leave those that are "screaming and kicking" to follow; they will eventually);
- focus on the outcomes – not how they are achieved – different solutions are needed for different communities;
- focus on quality then efficiencies will follow;
- care co-ordinators are all nurses or social workers who are from the area and who know the community and the resources available in that area;

- care co-ordinators actively work in hospitals to identify those high risk patients who are to be discharged;
- there are common performance metrics across the whole of the State that are agreed by the Board of Medical Directors;
- CCNC rigorously undertake Medicines Reconciliation. As part of this they have identified 10 drugs which have the most errors in prescribing and also the top five drugs which if a patients is prescribed indicates that a Care co-ordinator should visit these patients (as often they have health issues that need addressing);
- any tools/ documentation that CCNC develops can be used by other providers. They recognise that Doctors are not interested in who pays the bills, but if something works and there is evidence of success then Doctors will take this and use it until it becomes accepted practice and as a result quality of care improves; and
- CCNC use patient specific Emergency Room data to target those individuals who are most likely to re-attend.

## Alaskan Area Native Health Service (Indian Health Service) USA



Historically healthcare for American Indians and Native Alaskans has been provided by the federal government who decided how the money should be spent. However, in the 1970's laws were passed that allowed American Indians and native Alaskans to self determine how they wished to run their health service, although services had to be within federally defined limitations. There are various levels at which this can occur - for the more mature organisations they can self governor, but for those less mature they can self determine healthcare. In Alaska the tribes were very keen to be able to determine their health service, although in other areas of America, they have not been so keen. Over the years tribes in Alaska have taken on more and more programmes and also now have taken on capital facilities. In 1999 a formal compact was agreed where the government handed over the management of the large hospital in Anchorage to the tribes. In order to provide a federal "fail safe" two legal entities were created:

- the Alaskan Tribal Health Consortium (mainly responsible for in patient provision and state wide functions that the Indian Health Service used to provide) - representatives of all the main tribes sit on this Board; and
- South Central Foundation (mainly responsible for all non in patient provision).

(There is some cross over between the two groups for example obstetrics and gynaecology).

Currently there are about 40 tribal health care corporations (which are sovereign entities), with 25 in the more mature position of self governance. Of all the federal health programmes that are run about half are in some form of self governance. Whilst there are some federal priorities that have to be delivered the tribes hold joint discussions of their priorities as although they are separate entities they would not be able to deliver (due to the remoteness) if they did not work in partnership.

Once a year, the Indian Health Service and the tribal representatives sit down and negotiate a common language compact to agree the scope of services. Over the years this has meant that as the tribes take on more programmes the federal "footprint" has shrunk as individuals previously employed by the federal government have moved out with the services. The Indian Health Service (Federally run) has shrunk from about 300 staff to about 36. There are some services that remain inherently federal functions and for which the tribes generally did not want to take on responsibility. The Indian Health Service focuses on facilitation between the federal government and the tribes. They have many partnerships eg department of defence, coast guards as they try and identify areas where they could share resources/ prevent duplication. They also work with other providers such as the Veterans Association (VA) as a percentage of their population are also veterans eg they share consultants.

The system runs on a hub and spoke methodology (due to the rurality). There are six regional hospitals including the tertiary centre in Anchorage. There are also sub-regional clinics/ multi provider clinics with nurse practitioners or physicians aid in place. There are then village clinics (about 170 of these) where there are Community Health Aides.

These are individuals who are from the local community who have agreed to undertake specific health training for them to help the local community. They would not be a qualified nurse or practitioner but would have a pseudo licence as they work under the direction of a physician (this direction would not mean that they were co-located but rather that they would be able to contact the physician for advise should they need to). There are five levels of Community Health Aides and there are now about 500 of these individuals within Alaska. These positions are not mandated, but are encouraged by the tribe elders - as it means there is health care available within the villages. When a patient visits one of the Aides they refer to their "manual" (an enormous tome!) which details questions/ procedures and treatment for many ailments/ conditions. The Aide decides on a course of action, completes a basic form which is then faxed to the integrated team for the doctor to see and confirm that they are content with the course of treatment. Alaska is now currently training Dental Health Aides and also Behavioural Health Aides, with a view to rolling these out. All patients belonging to a team have contact numbers and emails of the staff (including the doctors).



The tribes are able to develop services outside of those defined and agreed federally but if they choose to do this then they take on their own liability. Many of the tribes have chosen to do this and some 40% of income can be from clients such as Medicaid. If they directly employ staff then they have to meet federal requirements for certification etc.

The Alaskan Medical Centre run by South Central Foundation (SCF) is a beautiful building and was specifically designed to reflect the native heritage - with native art and carvings on all walls. There is use of natural light and materials throughout.

The whole philosophy of SCF is to develop a relationship with the customer (patient) so that this can develop over time into a relationship based on trust. To enable this to occur SCF restructured their primary care provision over the past 10 years, so that this is provided by integrated care teams of four individuals - these consist a provider (primary care doctor), a case manager (a nurse), a case manager assistant and a Behavioural Management consultant. This team is responsible for about 1,200 patients and is co located together in one "pod". There are about 4-5 teams in each clinic and these are responsible for building up a relationship with these individuals and encouraging them to look after themselves. All patients are guaranteed a same day appointment - although much of the work is also done over the phone - the philosophy being that the doctor only sees those patients that they really need to see.

Behavioural Management Consultants (BMC) have been included within the team to deal with those patients who do not require specialist mental health support, but who are anxious, depressed etc. Their involvement frees up the doctor to see the patients that they really

need to see. This also means that if the doctor identifies someone as requiring Behavioural Management support then he/she can go and get a BMC who will see that individual immediately - this reduces waste and inefficiency. 80% of appointment slots are kept free to enable this to occur.

Every time a patient phones they will automatically be connected with their team. Prior to this system care used to be provided on a "design and deploy" basis (ie coercion) SCF now engage in an "enquire and spread" approach which assumes that some work has already been done somewhere and that someone has figured out the problem, so everyone can learn from it. This approach has apparently changed the focus of conversations - in that now people want to work together as they all want to improve. Providers are not happy if they see red on their score card (although these are not used punitively) and they want to take control of moving it into the green/ blue. In addition staff are encouraged to share their ideas and as long as they reflect the philosophy of the company will be trialled.

SCF is working on integrating other members of the Primary Health Care Team into teams eg pharmacist, midwife etc - although they recognise that there will be a level when they can go no further. When they initially considered this concept they did not think that they would have enough staff to enable same day appointments and to meet the needs of all patients- but they then realised that was because they couldn't continue to work how they had always worked and implement the new system, so they stopped seeing all those patients who did not require appointment time. Some staff were very resistant to the change and indeed even today they have some who are described as "false advocates".

Data is used to motivate individuals and whilst there is a central data hub where all the information is collated (about all the individuals who are American Indians or native Alaskans) SCF produce a balanced score card for each of the providers (primary care doctors) which identifies their position, based on outcomes, against the mean (based on Statistical Process Control Charts) these are colour coded for ease:

- Red = below 50th percentile
- Amber = just below expectations
- Green = meeting expectations
- Blue = over 90th percentile

These measure such things as: immunisation rates, Smear rates, number of appointments booked at the same time, number of patients seen etc. Each area within the scorecard is shown with its denominator and the case manager/ provider is able to drill down to identify those patients that are "outstanding" eg immunisations/ BP check/ foot check etc. These "red" areas are then actioned to try and move them into green and ideally blue.

Lists of target patients are generated by an IT system of those requiring care/ screening etc. so that they can be targeted by the case managers. They try and "Max - Pac" the patients ie: if a patient visits the clinic then they will do all they can for that patient in one visit, so if they are due screening then they will undertake that during the visit. SCF also looks at those

patients who are high users of the Emergency Room (ER) - as they state they should not be attending ER if they are adequately supported by the integrated primary care team. They are also just starting to look at those individuals (the top 5%) who have accessed the primary care team the most during the last year - as they view these individuals as having chronic conditions (the drivers usually being psychosocial economic) to determine what help they can offer to these individuals. They feel that doctors often perpetuate these problems by trying to find a disease for these individuals that they don't actually have (ie running test after test). They want to take a different approach with these individuals and approach them stating "we're obviously not meeting your needs - what can we do better"?

During the week I visited a number of different tribes including the Chugach Native people of Alaska and the Yukon-Kuskokwim Health Consortium – involving a one hour flight as the place we visited (Bethel) is only accessible by sea or air!

Some of the main health issues facing the Alaskan natives are diabetes, cancer, poor nutrition, asthma and arthritis. Smoking/ tobacco produces contribute significantly - as 62% of the natives smoke (and this is by self report so is actually likely to be higher) and they have a large programme educating about the dangers of smoking. Due to the rurality of many of the villages the Community Health Aides are vital to providing health. Dental care is a real issue for many of the rural areas however in the past couple of years lots of work has been undertaken in this area with the development of Dental Aides. The impact of these is that there are now a number of villages that are totally decay free.

One of the challenges of providing health care in Alaska is that when native Alaskans travel in from surrounding villages for treatment they need often to be accompanied by an escort - and these escorts have to be housed somewhere (people would not be able to afford accommodation, and it is very limited). This has led to the creation of hostels to enable tribes to house escorts or families accompanying patients. Individuals are usually charged for these on a sliding scale dependant on income.



Travel is also a major issue for the more rural areas of Alaska as tribes have to get patients (and escorts to and from the hospital) often from communities which can only be accessed by boat or plane. There is a whole department in the Alaskan Tribal Health System that deals with just travel.

The Community Health Aide Programme (CHAP)

(<http://www.anthc.org/chs/chap/index.cfm>) which Alaska relies so heavily on for its healthcare was started unofficially in the 1950's where villages were required to administer Tuberculosis drugs. It was adopted officially by the federal government in the 1970s. Villages usually decide which individuals they would like to undertake the programme and the Tribal consortium/ corporation hires the individual. There are four training centres (Anchorage, Bethel, Nome and Sitka) who all work from the same standards and use the same manual (the Community Health Aide Manual - CHAM) so all technically teach the same thing. There

are four levels of CHA with the fifth being practitioner status. The training is designed to take between 2-3 years for individuals to complete all the levels (if they wish to). They also gain university credits although the programme is not dependant on this. Each Community Health Aide also has to achieve their First Responder Certificate as they have to respond to many emergencies.

The individuals can be aged 18 to 60+ women or men and all races (although preference is given to Alaskan natives). They have to be literate in English and basic Maths. The faculty train six students at a time as the level of support is very intense as some of the individuals require support re basic maths and English. The hours of training are long; typically 7.30am - 7pm (or 10pm) 6 days a week. Following the completion of a session (3-4 weeks) the faculty will take a week off for preparation and then a new lot of students will start, so there are 10 cohorts/ year. All the professionally qualified staff (nurses/ nurse practitioners/ medic) all maintain practical sessions to enable them to keep their skills and also to allow students the opportunity for practical application of their learning.

A pre-session is run for students where the training is described and they can decide whether they wish to proceed to the full training - it also provides the faculty a chance to see if the students are suitable. The students then undertake a four week training on basic examination skills. Following this they return to their villages to gain practical experience where they are under observation from their licensed practitioner who is responsible for their supervision. A few months later they return for the second session which again focuses on basic examination skills. These two sessions are the minimum requirement which enables them to see patients and act under "standing orders" ie prescribe medication. Regular time is set aside each day for them to speak to their supervising medic via phone, email or more recently via telehealth. During their training all the students are accommodated in Anchorage (which is included within the price of their training - which the Tribal organisations pay for). All Community Health Aides are required to work a minimum of 200 hours (this is usually based on a 6 hour a day basis). Session 3 (should they choose to undertake it) relates to child and maternal health and takes three weeks to complete the training (they are then required to complete additional practical hours).

Once a year clinical updates are undertaken so that the Community Health Aide can refresh their skills. The CHAM (which is an enormous book comprising four different volumes) <http://www.akchap.org/CommunityHealthAideManual.cfm> was first written in 1976 and has since been rewritten/ updated a number of times. The production of this document has never been specifically funded but they have managed to find funds to enable this to occur. When updates are required eg drugs or practices changes then these are issued and circulated to all the Community Health Aides. Updates are also available on the website (as is the CHAM available for sale).

The programme has been so successful that it has been spread to dental health aids (who are able to do preventative work and some preparation) and also behavioural health aids (although these are less in number as this is a fairly new initiative).

Another initiative is the Dental Technician Programme, which is the first in the USA and allows individuals to fill and drill teeth and in certain circumstances undertake extractions.

The programme has been going for four years and it takes two years for the students to qualify. They spend 40 weeks of the year training and are funded by their tribal consortium/ corporation on the agreement that for the two years of training they give the community back four years. To date there are nearly 40 of these individuals who are trained and working within the villages. I was shown around the facility and met one of the students from Bethel (see photo) who is just completing her 1st year. The programme focuses on building relationships with the families and children as they want them not to be frightened of coming to the dentist. This is a great programme, not only improving the dental health of the population but training individuals from their own communities - so encouraging them to stay and serve their community.

### ***Lessons learnt from Alaska***

- the improvement approach has to start small and spread organically;
- the value and importance, placed by staff, on their relationship with the patient;
- the focus on providing care as near to home as possible, which is determined by local people;
- the will to continually improve services and provision, despite the difficulties caused by distance etc;
- the use of Community Health Aides; this is such an innovative way of addressing the rurality issue;
- the great feeling of respect and compassion that all the staff I met had for the elders of their population;
- allow others to take responsibility so that trained staff only work at their highest level;
- guaranteed same day appointment - with YOUR doctor...! 80% of appointment slots are kept free for this;
- measures/ data are provided for information and are not punitive - the staff force the improvements themselves;
- Enquire and Spread model adopted, as opposed to Design and Deploy;
- integrated teams that sit together so that they can all work together to support patients to keep them at home;
- the importance placed on dedicated and continual workforce development;
- the value of true partnership working. Despite all the issues with funding streams/ private companies etc.....things still manage to get done;

- the impact that a true commitment to improving health can achieve eg two dental cavity free villages; and
- consideration by the tribes of the whole family's needs (re hostel) and recognition of the difficulties many of the villagers face in travelling and living away from home.

## Hidalgo Medical Services Silver City New Mexico USA

Hidalgo Medical Services (HMS) is a non-profit Health Care & Community Development Organisation that improves the quality of life of the people of Hidalgo County and Southwestern New Mexico: <http://www.hms-nm.org/about-hms/hms-history.html#>. New Mexico is one of the most culturally distinct states in the US with a population of nearly 2 million of which just over 43% are Hispanics. Diabetes in Hispanic Americans is a major health challenge due to:



- a higher prevalence in this population
- a high number of risk factors for diabetes in Hispanics
- high incidence of several serious diabetic complications
- the growing number of people of Hispanic ethnicity in the US

Over 10% of all Hispanic Americans have diabetes, almost double the rate for non Hispanic whites. Residents earn significantly less than those living in many other states.

Historically medical provision in Hidalgo County was poor, with no provision between 1986 and 1995, which meant people had to travel a significant distance if they needed health care. In 1994, the Hidalgo County government applied for and received funds from the New Mexico Department of Health, Primary Care Bureau to try and establish health care provision in the area. The \$35,000 in funds allowed the county to hire a clinic director and support staff to begin developing the infrastructure for service delivery. In late 1994, the Department of Health, Rural Health Office staff (Charlie Alfero) and the Director of the Family and Community Medicine Department travelled to Lordsburg with two family practice residents to discuss how everyone could work together to initiate services in Lordsburg. On July 1, 1995, Hidalgo Medical Services (HMS), opened its doors in a wing of an old hospital and began providing services, using four physicians from Silver City, Southwest Family Medicine. Each one rotated to Lordsburg one day every other week, providing a two day per week clinic in Lordsburg. From these humble beginnings Charlie Alfero (currently CEO of the organisation) has built HMS up into an organisation that operates in seven facilities, employs over 100 staff and has a budget in excess of \$6 million. The main HMS clinic is based in Silver City which is one of the oldest frontier towns with massive kerbs (due to very occasional flooding!).

Charlie, who is my host for the week is a really driven individual who is obviously passionate about improving health care in New Mexico, he survives on about 4 hours sleep a night! Charlie is really focused on trying to make health care provision easier and wants to pilot the Hidalgo Medical Services as an Accountable Care Organisation (ACO) which would be the first in the US following Obama's new health reforms. This would mean that instead of HMS getting paid on a per patient basis, there would be an agreement between HMS, Medicaid/Medicare and the state government that they would get paid a lump sum so they could then determine the care they wanted to provide for their population (currently 5,000 individuals). This would be at no additional cost to the service currently provided, but Charlie would then

be able to contract with providers in the acute sector and incentivise them to keep individuals out of hospital.

The week comprised many visits including a number at New Mexico University, Albuquerque. One of these was to Arthur (Art) Kaufman (Vice President of the Community Health School of Science). Charlie and Art have obviously known each other a long time and have worked to promote rural health in New Mexico. Art described their vision called Vision 2020 which sets out how an academic institute can practically affect the health of a population. He described how a year ago they shut down the whole of the Health Sciences department and spent the day learning off each other as to how they could improve the health of New Mexico. They all agreed that every ones Personal Development Plan would contain objectives as to how they personally would contribute to improving health in the State. They agreed that they would look at the determinants of health and health outcomes and focus on these as an institution and monitor their outcomes. Working with organisations within the communities, such as HMS, they have started to make a difference. They hope to use a website to track their impact on the health determinants which will be available to the public. <http://hsc.unm.edu/community/>.

Art shared how New Mexico is one of the poorest states in relation to food insecurity - this means that just under 20% of the population do not know where their next meal is coming from. There are significant areas of New Mexico that do not have access to fresh food. There was a poster on Art's wall which showed the communities that are 20 miles from the nearest food store...there were massive areas that do not have any coverage.

Art also described their "Health Extension" programme which he said was inspired by Charlie, who was always visiting the University and the Rural Health Office to lobby for support for his community. Charlie succeeded in this because he knew what his community needed and secondly had the relationships with people to enable him to ask for support. Art started thinking about the impact that a "Charlie" in every county within New Mexico could have on the health of that area and they developed a Health Extension programme which now has links with individuals across New Mexico. They have succeeded in getting this model into the new health law (5405) and are hopeful that additional money will be found to enable them to continue to expand this service.

Meetings at the University were also held with the School of Dentistry where Charlie discussed the possibility of HMS having residencies for family practice medicine (our equivalent of GPs) and Dentists. Students who are doing their residencies visit HMS, but these "belong" to other institutions and are not trained by HMS. Charlie has recently been awarded money to enable them to set up their own system (albeit they have to conform to numerous regulations) to enable them to train their own doctors/ dentists, which they ultimately hope will then remain within New Mexico. HMS has three years to set up this service - two years to plan and a third in which they have to implement. A meeting with senior clinicians at the University school of medicine then followed to have the same conversation about doctors. This also focused on what experience junior doctors require during their training and if HMS can't provide this eg cardiology - how could the University medical school meet this need. Again Charlie got an "unofficial" agreement that they could work together going forward...what a master!



Within Hidalgo County I was taken on a tour of HMS providers/ clinics. We started off with a visit to the main clinic in Silver City which hosts family medicine, mental health, dental and family support services. HMS have just been awarded \$10 million to build a new clinic next to the existing one to enable services to be expanded. Here I had a chance to meet some of the Family Support Workers or Promotoras as they are known locally (lay people employed from the community to support individuals with chronic conditions). This was my main reason for visiting HMS; to find out about this role. The Promotoras were initially employed to support individuals with diabetes by helping them with social economic factors eg housing, finance, nutrition, which affects their health.

HMS employs eight of these individuals who are recruited from the local community. The programme started by focusing on diabetes (La Vida programme) and whilst the individuals still look after diabetic patients they also now see other patients. Anyone can see a Promotora and they are available at all the clinics at different times. Much of their work focuses on the La Vida programme (diabetic programme) which comprises 11 one to one sessions which cover such areas as healthily diet, exercise etc. One of the main areas they help families with is claiming money or resources that they are entitled to eg food stamps - this also helps with gaining family's trust. The Promotoras check that patients are able to take their blood sugar correctly and if required they can refer the patient back to the primary care provider and onto other agencies such as other support agencies. All the Promotoras' contacts are recorded onto a data base so that HMS can run reports to illustrate how many people they have seen and what interventions they have undertaken.

Every Wednesday the Promotoras have two hours of professional development or a staff meeting. This is where individuals or agencies can be invited in to talk to the Promotoras to educate them about their service or for them to discuss policies/ procedures. The number of patients seen by the Promotoras varies depending on location and individuals but external evaluation has shown that they have had a significant impact on the control of diabetic patients. It truly is a wonderful programme that supports individuals by using people from their own community.

We visited a school based clinic, which focused on providing services for all the children in the high school. Any child can access them and they will provide sexual health information, contraception, immunisation, drug support etc. These clinics provide confidential advice which is not shared with their parents or family doctor. My tour also included visiting a clinic in Cliff, which was basically a two roomed clinic run by a Physician's aid. This is an individual who is able to do most things for patients ie. diagnose, prescribe, refer. The clinic was very remote and obviously provided a much needed local service to that area.

HMS also runs a Senior Citizen Centre in Lordsburg, which I was lucky enough to visit. Apparently the centre has been in operation for over 40 years and last year the Board of Directors decided that they could no longer afford to keep it going. The people of the town

went to Charlie and asked him whether he could help retain the centre. This resulted in HMS taking over the centre, which they now intend to expand. The reason Charlie supports the centre is that he believes in helping the community and by doing so believes that he helps keep individuals well. The centre feeds about 40 individuals a day and if you are over 65yrs, this is free. In addition they deliver 50 meals a day to the house bound (breakfast and lunch). What an amazing thing! The centre had a lovely atmosphere and was very homely. Another area where Charlie is working in this way is in relation to community gardens. He is currently negotiating the purchase of land on which the community can build gardens, and grow vegetables that can then be used to benefit the local community.

### ***Lessons learnt from New Mexico***

- don't underestimate the impact that one determined person can make on achieving something. Know what you want and keep going for it...however much people say it can't be done;
- the value of building relationships and keeping communication open cannot be underestimated. If you believe in something - go for it!
- always keep looking for the next development/ improvement;
- the role and use of Physician's Aids – why don't we use them in the UK?
- the use of lay people from the community to support individuals with chronic conditions. These individuals know the area and the individuals are able to support them in much more than just health issues; and
- individuals and the community need to be looked at holistically, not as individuals with diseases. Health is not always addressed by just dealing with medical needs, the Promotoras/Family Support Service help individuals address those issues that affect their health eg. help them to complete forms to get money or food to which they are entitled.

## Department of Non-Communicable Disease Public Health Ministry of Health Malta

The Public Health Department of Malta sits within the Ministry of Health and sets out its aim as that of “sustaining service and efforts so that the population of Malta can live healthier and more rewarding lives”. There are two parts to the Department for Health - those responsible to the Chief Medical Officer and those responsible to the Superintendence of Public Health; which Health Promotion and Disease Prevention sit under.

My host for the week is a Public Health Consultant with the Ministry of Health (Mariella). Mariella and another consultant are responsible for the non-communicable disease element of Public Health in a department that was only established in April 2010. Their remit is to try and make health promotion more mainstream in relation to chronic conditions as opposed to just "fire fighting". There are eight Health Centres around the island and people who live near them can visit these GPs, although they are not registered to a specific GP (which they feel is a disadvantage). Health care in Malta is traditionally free at the point of delivery although there is a thriving private practice (approximately 30% of care received) as Government waits for surgery are very long (eg. cataracts about 2-3 years).

There is one acute hospital in Malta (built three years ago) and this also acts as a tertiary centre. If there is someone that requires additional services then a specialised consultant is either flown in or they fly the patients out (they have agreements with local countries). They are moving towards a de-centralised service, where the Government has less involvement with the health providers. Recently the providers have appointed CEOs who are responsible for delivering services eg mental health. The aim is to increase autonomy of the providers so the government can move towards a commissioning framework and model (albeit that they acknowledge there is limited competition due to a lack of providers).

During my time in Malta I spent time with various individuals in the department and also visited a number of providers. Public Health staff explained a number of their projects/programmes to me which are aimed at preventing chronic diseases in later life. One of their recent projects is targeted at school children (both primary and secondary) and is aimed at preventing osteoporosis and promoting bone health. Staff are working with Personal Social Education (PSE) teachers to get children to eat more fruit and vegetables and drink less fizzy drinks. Following a successful pilot the programme is now being rolled out across Malta. The level of obesity in children over 10 years is 40%, so much of the public health work is focused in this area.

One of my visits was to the Richmond Foundation in St. Venera. The Richmond Foundation is a Non Government Organisation that was set up in 1993 by a group of people who felt that more should be done for individuals with Mental Health (MH) problems. They decided that their first project would be to start a community based service for rehabilitation and this dream was realised in 1995 when they opened a house called Villa Chelsea to house 12 individuals (male and female). The house was to provide a yearlong programme of rehabilitation; based on the principle of a therapeutic community. However, once the first



group of individuals left the house in 1996 they realised that there needed to be some ongoing support for these individuals so a home support service was established to support people in their own homes. The Foundation has now grown so that it is providing a variety of support (not just Villa Chelsea), a home support service; counselling, supported accommodation, a 24 hour manned hostel, an IT suite, a Kids Residential Programme and self help groups. The service is only open to

those who are 17-65yrs and these individuals are generally referred by a psychiatrist. Staff told me that within Malta there is still great stigma attached to having mental health problems and this is reflected in the services available, with the Richmond Foundation being the only specific mental health provider in Malta. Unfortunately this means that the Foundation now has a waiting list for their services which they are trying to address. The Foundation also acknowledges that it needs to think about provision for the over 65 years.

One of the programmes that the Foundation provides is KIDS. This is a three year residential programme for children aged 5-10 years with disruptive behaviour. I found it difficult to comprehend that children of this age would be put in residential care - although staff explained that these were generally children from a care background. Staff explained that the first three year programme had finished in 2010 but that they were now left with trying to place the children who had finished the programme. Some of the children returned to their homes, while others returned to care. This has resulted in the Foundation considering developing an additional programme to support children from the age of 10 years.

Part of my visit to the Richmond Foundation involved a visit to Villa Chelsea. It is a big, imposing house which the Foundation rent off the Government. I was shown the communal areas and the garden, but not the bedrooms which are apparently shared. I was also shown the list of activities for the week which included chores, shopping, cooking, various classes (eg self grooming), outings, group therapy and individual therapy sessions. The whole building was being overseen by two girls who looked about 18yrs (I must be getting old!). The Foundation's work with mental health patients is significant and enables many of them to return to their own homes or supported living.

Another visit focused on diabetes, when I visited a clinic in Gzira where I met the Clinical Lead (Dr Mario) responsible for delivering diabetes clinics. The clinical lead explained how three years ago Malta had no diabetes register and most people with diabetes were seen in the acute setting. He explained that he didn't think this was right and after talking to a colleague in Ireland he decided that as President of the GP Society in Malta he should tackle this issue. He met with his consultant colleagues in the hospital and persuaded them that there should be a shared care protocol between primary and secondary care - he proudly

showed me this document - which had apparently taken lots of negotiation to produce and was a first for Malta.

Diabetic patients see a consultant once a year and a GP twice a year. Documents have been produced for these visits that record ophthalmology and podiatry information. If any concerns are identified the patient can be referred back to the consultant. To date, across Malta 3,000 patients' care has been shifted back into primary care. Dr Mario explained that for free drugs (for which diabetic patients qualify) the prescription has to be signed by a consultant. Dr Mario has agreed with the consultants in the hospital that the GPs can initially sign the forms (so the patients can get the drugs) and then the consultants will counter sign the forms). This means that patients don't have to wait or don't have to buy their own drugs while they are waiting. This has been seen as a massive triumph for all the staff and a real benefit to patients. I was then shown around the clinic - which was very busy (and noisy!). Dr Mario then showed us the IT system they use to record the diabetic patient visits on. This contains information about height, weight, BMI, HBA1C, history etc. This information can also be accessed in the hospital. He explained that clinical audits are run on the system every 6-8 weeks to ensure quality. There is currently no provision for clinical audit within primary care within Malta. It is hoped that the shared care protocol and way of working will be adopted for other conditions such as hypertension.



Another day saw a visit to a local primary school to watch a dental technician, and the Chief Dental officer, give a talk to the children on dental hygiene. I had a great couple of hours listening to the talk (which was in Maltese, but which contained enough English words for me to follow eg dental floss and plaque!) - the childrens' ability to be bi-lingual was phenomenal.

I also visited a clinic in Mtarfa where I met the Senior GP and a nurse who have a Health Promotion Clinic. The idea started from a nurse who was undertaking her PHD and who had an interest in health promotion. She developed a "Check up" clinic, with an accompanying questionnaire so that the results could be used for her PHD. However, nurses and other members of the multi - disciplinary team

who were aware of the clinic thought it was an excellent idea and wished to continue it. They developed the work further into a "Health Needs Assessment", focusing on risk factors eg family environment, health risk factors (eg smoking), genetics etc which is undertaken by the use of an in-depth questionnaire.

The Health Needs Assessment clinics are self referral clinics and each appointment takes about 45 minutes. During the appointment the nurse also takes the individual's BMI, HBA1 (if required) and BP. The purpose of the clinic is to identify the health risks and then work with the individual to reduce their risks. The nurses use Motivational Interviewing Techniques during these meetings. Every encounter also requires the patient to see the doctor – apparently this is due to the fact that the Malta Society for GPs had insisted that nurses were not able to see patients on their own. To me this seems such a shame as if nurses were

given the autonomy to see patients in their own right they would be able to support the GPs much more and free up their time to be able to see other patients.

The GP and the nurse explained how they use established guidelines in relation to low fat diets and they encourage patients to keep a food log. However, they feel that if they were to have some formal nutritional qualification this would enhance their service. This is an area that Public Health is considering offering support. The project was originally started as a pilot within a small village however, people now travel from a fair distance to attend and they would like to roll out the service across the island. In the first year of running the clinic - 90 patients were seen (there are only four appointments available every two weeks). The clinic has undertaken some evaluation of the programme but this focused mainly on numbers through the clinic, as opposed to outcomes for patients, although there was evidence that patients had lost weight.

### ***Lessons learnt from Malta***

- we are very fortunate in Wales with our financial allocation for health. In Malta non-communicable disease prevention have been allocated no money for 2012;
- despite a lack of allocated budget - Malta is doing great work in relation to non-communicable diseases and health promotion;
- there are many people passionate about improving health in Malta;
- health care in Malta remains medically directed - despite there being highly qualified nurses and Allied Health Professionals;
- Malta has worked hard in the last 10-15 years to improve their Mental Health services;
- culture can play a significant part in whether something is accepted or not (Malta's sexual health strategy has taken 10 years to publish due to population's disquiet with its content); and
- there are many similar issues in relation to health between Wales and Malta eg diabetes prevalence and childhood obesity...these are areas both countries continue to struggle with!

## Conclusion

I have had an amazing four weeks of my Winston Churchill Travelling Fellowship. I have had the opportunity to travel to places I may never have seen (North Carolina, Alaska, New Mexico and Malta) and met people who have truly inspired me.

I have taken so much from this experience, not just for my area of work, but also for me as an individual. I hope that in some small way I have also left knowledge behind for the people who were kind enough to host me and spent time sharing their knowledge and experience with me.

The lessons learnt during my travels have been shared with my own organisation, wider members of NHS Wales and with key individuals, responsible for health, within Welsh Government.

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