

From the Editors

Partnership and Collaboration are two buzz words that continuously swirl around the field of health care. Individual providers and systems are increasingly working together for the shared goal of improving health outcomes. One of the key principles of quality management is the development of interdisciplinary teams to work together on understanding the multiple systems and processes that may contribute to an improvement project. *Progress Notes* chose to feature this edition how partnerships with complementary institutions of care, school health professionals and home care agencies improve outcomes of care. Even if your work does not interface with public schools or home health agencies, we believe

this edition provides valuable insight about processes you can use to work with other institutions that affect the lives and health of your patients. In addition, the newsletter also features a couple of stylistic changes that we hope you will find helpful. We've added a masthead to provide you with contact information about the Massachusetts Asthma Improvement Network and the Diabetes Quality Improvement Network (MAIN-DQIN), as well as an expanded Announcements section. Please take a few moments to fill out the enclosed comment card and let us know how you feel about these new features and the newsletter in general! ■

Tips for
Successful QI
Implementation

Page 3

Potential
Partners in
Massachusetts

Page 1

Coordinating Care with School Health Professionals

A key component of effective collaboration is the development of strong lines of communication between the multiple partners in care processes. Fitchburg Public Schools, with funding from DPH, Enhanced School Health Services Grant, is taking the first steps towards collaboration with health providers by raising awareness of the role of the school health professional in the management of students' health. Janice LeDuc, School Nursing Supervisor, was recently interviewed by *Progress Notes* to learn more about the purpose of what the Fitchburg Public Schools are doing to improve the coordination of care for children with asthma and diabetes.

Lack of Collaboration Among Health Professionals

There are 11 full-time school nurses who serve both the public and parochial schools. These professionals realize that they do not have enough information about medications

(continued on page 2)

Quality Management with Home Health Care

Excerpted from: *Case Studies From the Quality Improvement Support System*, March 1997. Prepared for the federal Agency for Health Care Policy and Research (AHCPR) by David Gustafson, Lisa Risberg, Diana Gering, Ann Schoofs Hundt, Hannah Levine, Steve Excarnilla and Mark Wenneker. To order the complete report for free use the web (www.ahcpr.gov) to request AHCPR document #97-0022.

Introduction

In 1994, this home healthcare group ("the Group") developed and implemented Azmacare, a home healthcare program for asthma patients designed to increase patients' quality of life by teaching them and their caregivers self-management techniques. Subsequently, the Group initiated a clinical study to evaluate the implementation of the Azmacare program. Results from the first 6-month phase of the study indicate that Azmacare successfully reduced emergency room visits, hospitalizations, and school absenteeism. The group is a division

(continued on page 3)

School Health *(continued from page 1)*

and care management plans for school children with chronic conditions to effectively manage care and deal with emergencies. This problem is growing as increasing numbers of students are taking medications to manage chronic conditions, and as students with special needs are becoming more integrated into the infrastructure of the school system. Currently, school health providers rely upon students and parents as their sole source of information about students' chronic conditions and care management plans. There is a need for more effective collaboration between primary care providers and specialists, school health, and families to ensure everyone involved in caring for a student's asthma or diabetes has the same information about managing and monitoring the condition.

Opening the Doors of Communication

Fitchburg School health professionals believed it was important to inform clinicians about the services available through school health units, and to provide information about contacting school nurses. It was also believed that reaching out to community health professionals in this way would also let health providers know that school health professionals did not think it was burdensome to work collaboratively on carrying out students' care management plans.

In order to open the doors of communication, the school nurses in Fitchburg developed and distributed a short brochure on school health services. The brochure features information on:

- Health services available through the public schools
- Names and locations of all public schools
- Name and contact information for each school nurse.

The brochure also asks health providers to obtain the child's school building assignment at subsequent visits with the family, so a connection can be made between the school health professional and the child's care provider.

The brochure was distributed to a list of health providers created by reviewing student health records, going

through their lists of professional contacts, and pulling names from the local telephone book. The brochure was mailed to health providers in Fitchburg and surrounding communities. The brochure, which was translated into both Spanish and Hmong, is also distributed to parents during school registration time as a means of educating families about the role of school health.

Measuring the Effectiveness of Communication

Fitchburg school nurses hope that health providers will be more likely to initiate discussions with them when they are trying to manage the care of school-aged children with chronic conditions. However, there are currently no plans in place to evaluate the impact of the brochure on communication between school health professionals and community-based clinicians. When asked if the brochure has changed the work of the school nurses, Janice LeDuc replied that she is comfortable knowing that school health had reached out to providers in the community.

Suggestions for Working With Your Local School Health Professional

If you have a patient who receives medication through their school, it is important to connect with the school nurse to coordinate treatment.

- Ask your pediatric patients or their families what school they go to and who their school nurse is. If they don't know the school nurse's telephone number, look it up in the telephone book. Put this information in the child's chart.
- Contact the school nurse directly if your pediatric patients need to receive medication or other forms of treatment while in school. Explain the treatment protocol and discuss ways of addressing potential barriers that may be posed by the school schedule or other adherence issues.
- If medications are to be prescribed for administration at school, check with the insurer to learn if they will pay for two prescriptions, one to be kept at home and one to be kept at school. Doing so may ensure the school nurse has a copy of the prescription that has the full set of treatment directions and contact information on it.

Progress Notes is the newsletter of MAIN-DQIN (Massachusetts Asthma Improvement Network- Diabetes Quality Improvement Network). MAIN-DQIN is funded by the Division of Medical Assistance and managed by the MassHealth Access Program in the Office of Community Program at UMass Medical School in cooperation with the Berkshire Area Health Education Center. For information about contributing an article or resource to *Progress Notes*, please call Susan Poulin or Gretchen Kinder at the numbers listed below.

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SUCCESSFUL QI IMPLEMENTATION

Tips on Successful QI Implementation

The case study provided in this newsletter addresses a question being evaluated by caregivers designing strategies to improve care for patients with asthma, diabetes, CHF, and other chronic diseases. A summary of the obstacles encountered by the team along with some ideas about solutions is provided below as an aid to others evaluating similar strategies.

Obstacles	Solutions
Upfront costs	The upfront costs of project development and implementation need to be weighed against future savings from reductions in hospitalizations, ED visits, medication use, and work/school days lost. One big difficulty is that the long-term financial benefits often don't accrue to the entity bearing the implementation costs. To deal with this, you'll have to try to work out creative cost-sharing agreements with managed care providers, which will require you put in place a way to measure the savings you expect to result. While you're working those out, demonstrating a path to improved patient outcomes and the potential for QI project recognition often carries enough weight for project teams to get start-up funding.
Physician resistance	Physician concern over who's bearing the cost of the project, the capabilities of those implementing the intervention, the link between the intervention and better outcomes, and disruptions to their offices and their patients are the primary sources of resistance. Be sure you have adequate forums for understanding the different sources of resistance. The best success can come from clearly showing improvement potential. <i>Physicians need to see that patient behavior can change.</i> They also need to understand that the project will <i>focus on where improvement is needed.</i> In general, physician resistance fades when improved patient outcomes can be validated.
Lack of flexibility	Development of a protocol covering all the steps and timing of a patient education intervention provides a crucial way to collaboratively assess processes of care that will contribute to improved patient outcomes, and can lay the groundwork for a set of criteria for measurement and evaluation. However, care maps/path ways/guidelines often come under fire for their lack of flexibility and inadequate attention to complex patients. Before you've sunk too much time into guideline development, <i>test some basic rules</i> on a small sample of patients. Identify workable options for autonomy in decision-making. And be sure to allocate sufficient time to address guidelines for <i>high-risk patients</i> .
Time to implementation	Everyone's time is at a premium, so a development plan calling for 15 meetings before you even get started helping patients is problematic. Instead, develop a rapid-cycle improvement approach, <i>testing small incremental changes</i> with quick-and-dirty measurement strategies that can enable you to measure whether the change led to improvement. This will make it easier to identify barriers to change and inadequacies of your design.
Finding patients	Even with good physician support, identifying patients for enrollment in education/case management programs is a common difficulty. Be creative in enlisting the help of care givers and community advocates. Word of mouth may be a prime recruitment source, so it is particularly important to do a good job with your first groups of patients. Keep the first groups small and spend extra time with them.
Lack of physician follow-through	Guideline implementation is much more successful when backed by <i>cueing mechanisms</i> such as including follow-up care instructions (medications, referrals) right on standing order sheets and also regular <i>reporting</i> of aggregate results (readmission rate and ED admit trends, for example). Also ensure there is a <i>feedback loop</i> to get patient-specific information (e.g. mechanism to feed back information about the patient's home environment) back to physicians.
Education materials	A range of education materials needs to be developed addressing unique patient needs and cultural and educational differences. Good graphics are key; patient diaries or calendars also help reinforce the lessons. Before you spend a lot of money on printing, test materials out on different patients. Be sure your materials address the interests of the racial, cultural and linguistic needs of your patient population. Prepared by Gina Rogers, Massachusetts Health Quality Partnership (Phone: 617-432-0005)

Home Health *(continued from page 1)*

of a mid-west hospital management company that employs approximately 4,000 people, has 14 offices, and is affiliated with 38 hospitals in cities serving several States.

Background

The NAEP and NIH reported after years of study that asthma is an inflammatory disorder and that inflammation is the cause of the bronchospastic constrictions. It is possible for asthmatics to avoid symptoms altogether through modifications in environment and control of the triggers that cause inflammation. In turn, the NAEP/NIH guidelines suggest that with proper management, asthma-related emergency room visits and missed days of school or work are preventable.

Through patient contact and interaction with healthcare providers, the group identified two opportunities for improvement. First, some physicians did not know about the NAEP/NIH guidelines. This was especially true of family physicians and pediatricians who, because of the volume of literature, sometimes remained unaware of newer recommendations and continued to follow traditional standards of practice. For example, the new guidelines suggest that effective asthma therapy should target prevention of inflammation rather than treatment of symptoms. However, the Group found that many physicians continued to prescribe medication to treat bronchospasms, rather than self-management techniques to prevent symptoms from recurring.

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Home Health *(continued from previous page)*

Second, even when hospital staff or physicians educated asthma patients on how to manage their disease, patients frequently did not comply with the instructions at home. Furthermore, no one assessed patients' home environments for conditions that were likely to trigger asthma symptoms.

Project Teams

The program director organized quality improvement teams in each office. Team members included experienced home care nurses and sales representatives. Sales representatives' involvement was crucial because of the need to market Azmacare to physicians, managed care companies, and other healthcare payer sources. Sales representatives received specialized education about the clinical nature of asthma, as well as how to present Azmacare advantages to physicians and payers in a non-threatening way.

Because the Group fosters a total quality management, team-oriented culture, approximately half of the team members completed basic training on quality improvement philosophy, tools, and group processes before participating on the Azmacare teams. Each city had a designated team leader and team facilitator, and the Azmacare program director coordinated efforts throughout the system.

Initial Development

An internal focus group met to develop the foundation of the Azmacare program. Representatives from Marketing, Respiratory Therapy, and Nursing met approximately 15 times.

The focus group engaged in extensive discussion and shared observations from their personal practices to develop a preliminary protocol. Another focus group comprising physicians and staff from an area pediatric hospital convened to comment on the original group's

ideas. The primary Azmacare protocol components are presented below:

1. A licensed respiratory therapist/registered nurse instructs patients on all therapies. A follow-up telephone call will be made within 48 hours, and a follow-up visit will be made in 1 week.
2. A visit includes instruction on taking medications, using equipment, and modifying the home environment.
3. The Group's recommendation for asthma patients is to ask physicians to order peak flow meters (an easy-to-use device that measures how forcefully a patient can exhale).
4. The physician can order a peak flow range and prescribe medications according to the peak flow. This is a simple, practical method for prevention of severe asthma attacks and assessment of a patient's response to therapy.
5. Educating the patient about asthma, identifying current or past triggers, instructing the patient regarding treatments, and measuring peak expiratory flows help in the management plan and the decision for hospitalization.

To accommodate patients with different needs, the Group also developed options for patients who had either controlled or complex/uncontrolled asthma. They defined a controlled asthmatic as an individual with the means and capabilities to manage his or her disease. The services provided to patients with controlled asthma concentrate on educating the patient regarding proper use of equipment and medications and how to deal with environmental factors. Complex/uncontrolled asthmatics require more intensive education and follow up to understand how to manage their disease. These patients receive more visits, which include assessment and monitoring, as well as education. The services provided to patients for both options are displayed in Figure 1.

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Figure 1. Asthma management

Option 1: Controlled asthma

- Case conference telephone call with Case Manager.
- Initial patient visit.
- Mail patient assessment to the attending physician if there is a need to change patient orders).
- 48-hour follow-up telephone call.
- Second patient visit after first week of care.
- Follow-up telephone call every month for 4 consecutive months.
- Third patient visit during the 6th month of patient care.
- Patient discharge summary sent to Case Manager.

Option 2: Complex/uncontrolled asthma

- Case conference telephone call with Case Manager.
- Initial patient visit.

- Mail patient assessment to the attending physician (case nurse will contact attending physician if there is a need to change patient orders).
- 48-hour follow-up telephone call.
- One weekly visit for 3 consecutive weeks (during this time the caregiver will assess the asthma triggers and educate the patient and caregivers to identify and avoid triggers).
- Two visits during the following month of care (during these visits the caregiver will monitor the patient's compliance with the prescribed care).
- Follow-up telephone call every month for 2 consecutive months.
- Seventh patient visit during the 6th month of patient care.
- Patient discharge summary sent to Case Manager.

Home Health *(continued from previous page)*

The protocol and options described above served as a consistent set of criteria for measurement and evaluation of the Azmacare program and also provided managed care companies and other interested parties with a guideline of specific services that the Group intended to provide. As negotiations proceeded with payers and providers to accept Azmacare services for their subscribers and patients, these guidelines proved crucial as a means of describing the program.

To standardize care for the new asthma program across multiple implementation sites, the focus group also developed a care map. The focus group studied the hospital pathways and customized a home-based care map for the Azmacare program. The first page of the care map outlines procedures the nurse should follow for each home visit and is used to record patient progress with the protocol. The second page addresses changes in patient outcomes, including respiration and vital signs, physical status, activity level, and ability to demonstrate correct use of equipment. Nurses track variances from the protocol on the care map, which then serves as an ongoing record of the success of Azmacare for a specific patient. The Group submitted the finalized care map to the Quality Improvement Coordinator at the corporate office, which suggested minor adjustments and approved the care map for implementation.

Finally, the focus group approved educational materials for distribution to patients. These included such handouts as "Tips for Allergy-Proofing Your Home" and "How To Use a Peak Flow Meter."

Team Review and Revision

Although the official clinical study did not begin until fall of 1994, teams began meeting together to test the protocols and devise a plan for full implementation in the spring of 1994. Team meetings were managed autonomously within each city and were held no less than once a month and as often as once a week. During these meetings, members reviewed current individual patients, discussed successful educational techniques, and evaluated ways to improve the protocols. Teams continued to provide the program director with feedback. The program director maintained communication with all teams, promoted consistency in implementing the protocols, received input from team meetings, and visited each team at least monthly.

Based on teams' recommendations, some changes were made to the program. For example, visiting nurses claimed that the teaching tool for allergy-proofing homes were not working well. Their suggestions for improvement resulted in redesigning the teaching tool into a graphic that resembles a house that includes a living room, bedroom, kitchen, bathroom, and basement. In the living room, a checklist reminds patients to vacuum twice a week, wear masks while cleaning, and cover the floor with low pile carpet or no carpet at all. In the bedroom, some of the guidelines include keeping pets out of the room,

covering things that collect dust, covering pillows and mattresses with plastic, and washing bedding weekly in hot water. The kitchen section suggests that patients clean and dust the back of the refrigerator, use exhaust fans while cooking, and watch for mildew around the refrigerator drip pan.

Azmacare Implementation

The group conducted the first phase of a two-phase clinical study between September 1, 1995, to evaluate the impact of the Azmacare program on patient outcomes. To assess patients consistently, a questionnaire was developed to measure a predetermined set of objective criteria based on the NAEP/NIH guidelines for asthma diagnosis and management. Visiting nurses completed the questionnaire when first assessing a patient and then again for each subsequent patient visit. Because the questionnaire was identical for every visit and for every patient, data analysis identified trends or changes in patient status over time.

After initial assessments of patients, staff provided home assessment and education during visits to patients' homes. Experienced respiratory therapists and specially trained Azmacare nurses worked closely with physicians to develop detailed plans of care, addressing unique patient needs and cultural or educational differences as well as medical necessities. Staff provided physicians with information concerning the patient's home environment that might affect the appropriate care for the patient and that physicians normally could not easily access.

Where gaps in patient knowledge existed, staff educated patients regarding the disease process, medications, and recommended environmental changes. Nurses showed patients how to graph their peak flow readings and how to record medications and symptoms in a diary. When they found it difficult to schedule a patient visit. Staff followed up over the telephone. Some asthma patients had difficulty complying with suggested guidelines because of limited financial resources. To assist this group of patients, staff introduced them to community resources. For example, if parents of a child with asthma could not afford to air-condition their home, staff identified local churches or community groups who were willing to donate second-hand window air conditioners for use in the child's room.

Although the staff were well trained and fully prepared to implement the Azmacare program, teams encountered unexpected resistance from physicians and managed care companies. Physicians who were unfamiliar with the NAEP/NIH guidelines for asthma care were not easily convinced that asthma patients needed the home care services the group wanted to provide. They also resisted the intrusion of home care staff into their patients' homes. Payers were uncertain about agreeing to authorize services without specific information on cost and duration of treatment, despite the potential savings from reduced emergency room visits and other costs related to care. Furthermore, even if a managed care company approved the program for a patient, preferred providers affiliated

(continued on page 6)

Home Health *(continued from previous page)*

with the managed care company did not always agree. Azmacare teams were forced to rethink their marketing strategy and place more emphasis on physician and payer education.

Because patients obtain insurance from a variety of payer sources, the group worked with private payers, commercial insurance companies, and managed care companies. The sales and customer service staff worked diligently to explain the benefits of Azmacare to case managers. They explained how, compared with conventional treatment, the Azmacare program utilized resources more appropriately and resulted in improved patient outcomes.

Some teams met with resistance when managed care companies in their area refused to pre-approve multiple home visits or wanted to modify another component of care specified by protocol. For example, one managed care company interpreted the protocols literally and expected team members to identify the exact number of visits a patient required after an initial assessment and then to conduct the number of visits in precisely the timeframe suggested by the protocol. However, the affected patient population consisted of mainly low-income Medicaid patients, many of whom did not own telephones and were difficult to reach.

To resolve the conflict, the team formed a focus group that included representatives from the managed care company and Azmacare team members. The team presented their initial data, including the money they already saved the managed care company, and illustrated additional improvements in patient care and cost-effectiveness that were possible with more flexibility. After a few meetings, the focus group reached a compromise that allowed the team additional autonomy in their assessment of the number of visits a patient required and the timespan in which they could schedule those visits. In return, the Group agreed to change some of their documentation so they were better able to tell case managers the reasons for their decisions.

Physicians also required extensive education. After enlisting financial support from pharmaceutical companies and the cooperation of the medical directors for several large managed care companies, team members offered seminars and dinners to community physicians and their office staff, introducing them to the NAEP/NIH guidelines and advantages of Azmacare. Specialists, such as allergists or pulmonologists, were scheduled as speakers so physicians who attended the seminars could earn continuing medical education credits. Afterwards, the program director for Azmacare or members of the local Azmacare team addressed the audience. Team members felt these seminars were successful, since they increased physicians' willingness to allow their asthma patients to participate in the Azmacare program. Seminars were also well received by physicians' office staff, since they learned additional tools for assisting asthma patients. For example, nurses learned valuable approaches to take with

parents who call about their child's asthma, such as asking them to note their child's peak flow meter reading so the nurse can assess the severity of the child's condition.

Results

At the completion of Phase 1 of the clinical outcome study, results suggested that patients improved their ability to manage their own disease process. The study followed 49 patients who had completed the 6-month Azmacare self-management program as of March 1, 1995. Study outcomes were compared with patients' histories before implementation of the program. Azmacare generated up to an 80 percent reduction in emergency room visits, hospitalizations, and missed school days for asthma patients in all age groups (*Figures 2, 3 and 4*).

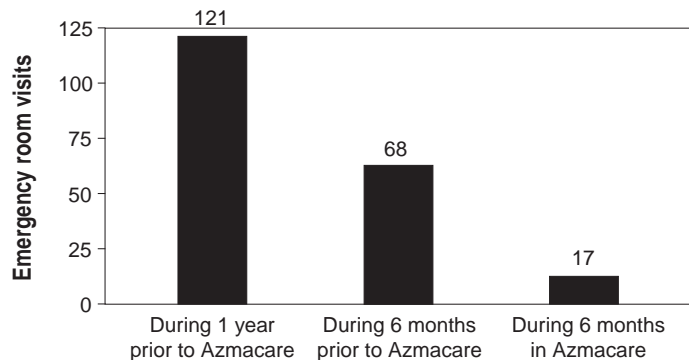


Figure 2. Emergency room visits

Note: The total emergency room visits are for all 49 patients but do not include those resulting in hospital admission.

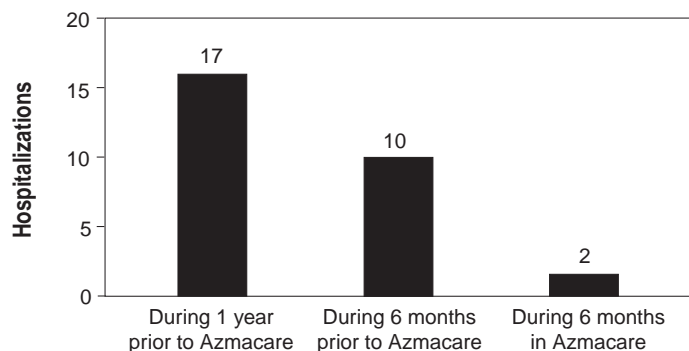


Figure 3. Total hospitalizations

Note: The total hospitalizations are for all 49 patients. Inpatient days per admission ranged from 2 to 6 days

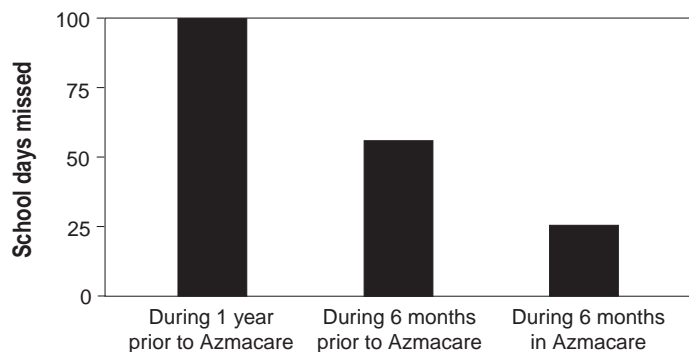


Figure 4. School absenteeism

Note: The data used for reporting school absenteeism were obtained from the parents and/or caregiver of the asthma patients. The number of days in some cases was estimated by the person being interviewed. Therefore, the total numbers are approximate.

Potential Partners in Massachusetts

One of the primary reasons for collaboration in today's health care environment is a need to maximize the use of dwindling health care dollars. However, it is often difficult to identify local partners who have resources and expertise that will enhance your project. Listed below is information about some of the many organizational partners in Massachusetts that are interested in working with asthma and diabetes providers to improve their clinical outcomes and enhance their quality programming. Contact them for more information about working with them. Be sure to mention you learned about their organization through MAIN-DQIN!

American Diabetes Association (ADA)

The American Diabetes Association is organized regionally. The regional office for New England can be reached at 508-786-9520.

American Lung Association (ALA)

There are several chapters of the American Lung Association in Massachusetts. These include:

Southeastern Branch, Middleboro, 508-947-7204

Essex County Branch, Beverly, 978-524-7770

Central Branch, Worcester, 508-756-5749

The main office is in Brighton and can be reached at 617-787-5864 or by email at alamass@juno.com.

Each ALA office offers different education programs and resources for dealing with asthma. Examples include:

- Open Airways, a school-based program designed to teach elementary school health professionals how to teach asthma management to children
- Living with Asthma and Better Breathers Club, a monthly asthma education and support group for families and consumers.

All programs have educational materials they are interested in distributing through local health providers. More information about each office can be found on the internet at www.lungusa.org/local/programs.

Asthma and Allergy Foundation of America (AAFA)/ New England Chapter

For further information, please contact AAFA/New England Chapter at 617-965-7771, toll-free at 877-2-ASTHMA, email at aafane@aol.com or look to their national website at www.aafa.org.

The Asthma and Allergy Foundation of America/New England Chapter has available for clinical providers a broad range of patient education materials and programs including books, pamphlets, videos, CD-roms, bulletins and the acclaimed *You Can Control Asthma* workbook (available in both English and Spanish), which was created and tested with young, low-literacy patients and their families. The New England Chapter also provides leader training for packaged educational programs for children and *Power Breathing* for teenagers. The Foundation's Resource Catalogue includes *Meetings in a Box*, a resource

that provides slides, a script and handouts for health providers to run four different meetings to train patients, their families, schools and caretakers.

In addition, the New England Chapter has developed a checklist and training sessions to help daycare providers have "asthma-friendly" settings. The chapter also provides exhibits and information booths at health fairs, and sends speakers on asthma and allergies to conferences of teachers, coaches, school nurses, parents and community meetings, as well as offering yearly accredited Asthma Training Programs for Allied Health Professionals. It also publicizes and sends a free lending library to support groups that have become affiliated with the organization by signing a simple form, agreeing to comply with NHLBI guidelines.

Area Health Education Centers (AHEC)

AHECs were established by the federal government more than 25 years ago to address primary care shortages in medically underserved areas of the country. AHEC provide a variety of services at the community level in an effort to enhance primary care providers' capacity to meet the needs of the local population. Each AHEC provides some combination of the following programs:

Professional development and continuing education programming developed in partnership with local health providers and systems to meet the continuing education needs of local provider community.

- Education, training and technical assistance around building cultural competence in clinical care.
- Coordination and provision of interpreter services
- Community-based learning experiences for health professions students
- Community health coalition development and support
- Health careers counseling and training for minority teens

Contact the AHEC office in your region to learn how your program or institution can partner with them for any of the functions listed above.

Southeastern Mass, Marion, 508-748-0837

Merrimack Valley, Lawrence, 978-685-4860

Central Mass, Worcester, 508-756-6676

Pioneer Valley, Springfield, 413-787-6756

Berkshire, Pittsfield, 413-447-2417

Boston, 617-534-5258

Massachusetts Department of Public Health Regional Prevention Centers

There are ten regional prevention centers located around the state to provide resources and technical services to any community organization interested in working on the following issues:

- Organization Building (project planning, implementation, resource development, changing health attitudes and behaviors, coalition building)

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Potential Partners *(continued from previous page)*

- Training (community leadership development, health and prevention conferences and workshops for community members).

Prevention centers are equipped to work with any community organization interested in health and prevention programming in their community.

Contact the prevention center in your region to learn how you can partner with them to meet your community education and prevention programming needs

Boston Region, 617-423-4337

Greater Western Mass, 413-584-3880

North Shore Region, 978-777-2121

Lower Pioneer Valley, 413-732-2009

Southeast Upper Region, 508-583-2350

Southeast Coastal Region, 617-624-5070

Merrimac Valley Region, 978-688-2323

Metrowest-West Region, 508-875-5419

Metrowest-East Region, 617-441-0700

Central Mass Region, 508-752-8083

Massachusetts Health Quality Partnership (MHQP)

For more information about working with MHQP, contact Barbara Rabson or Gina Rogers at 617-432-0005 or find them on the web at www.mhqp.org.

MHQP is a coalition of health care providers and purchasers working together to improve health care quality in Massachusetts. The Partnership can serve as a resource for those seeking strategies to facilitate improvement, offering insight on topics such as conducting focus groups, implementing and evaluating rapid-cycle improvement initiatives, learning from benchmark performers, and promoting improvement within and between organizations.

MHQP's activities include:

- **Statewide Patient Survey Project:** provides public release of comparative measures of inpatient hospital care
- **Data Coordination:** reduces hospital reporting requirements to health plans through the development of a standard set of quality measures and framework for reporting on hospital-selected QI initiatives

Guideline Collaboration: will promote preventive care guideline development and dissemination, include strategies for measurement of adherence to the guidelines, and lay the groundwork for future guideline development activity tackling clinical guidelines related to AMI (post-acute care, secondary prevention) next.

"MAIN-DQIN to Launch Clearinghouse"

A web-based clearinghouse is being developed by MAIN-DQIN to help you access information, resources and colleagues in Massachusetts with expertise in successfully improving patient care outcomes through the use of quality improvement processes. This clearinghouse will catalogue quality improvement projects and resources in New England. Staff from MAIN-DQIN will be contacting you to learn about your quality initiatives and the resources your organization uses in its asthma or diabetes care so you can be included in the clearinghouse. The web-based clearinghouse will also be a source of continuing education programming and a gateway for other web-based information about using quality improvement processes in caring for patients with chronic illness. The Project Team at MAIN-DQIN is working collaboratively with the Department of Library Services at UMass Medical School to develop criteria for screening related websites to ensure web-links are up-to-date and provide you with cutting edge, practical information and resources you can apply directly in your practice. The web-based clearinghouse is expected to be completed by Winter. You will be notified of the progress of this initiative through this newsletter and special mailings.

Special thanks to the Commonwealth Medicine Group at UMass Medical School and the Office of Clinical Affairs at the Division of Medical Assistance for approving funding for this project.

Announcements



Grants

Childhood Asthma and Hazardous Substances Applied Research and Development

ATSDR has \$185,000 for one or two grants to be made to state agencies or state colleges and research centers. Money will be awarded for the exploration of the impact of hazardous substances on childhood asthma. Submission deadline is 7/16/99. Call 888-472-6874 and request announcement #99059 to receive a copy of the RFP. If you have questions, contact Nelda Godfrey at 770-488-2722.

The Juvenile Diabetes Foundation International and the Diabetes Research Foundation has \$25 million to support research in five areas:

- Modulation of the immune system
- Beta cell replacement/islet transplantation
- Genetic engineering/gene therapy
- Hypoglycemia
- Complications

The Foundation will accept applications for research, career development, fellowships, innovative practice, or conferences. Application deadline is 9/1/99 for funding in 1/00. More information about this initiative may be found on the web at www.jdfcure.org/research/



Awards

Premier, the nation's largest healthcare alliance, is looking for nominations for the 8th annual Monroe E. Troutman Premier Cares Award. This Award

recognizes efforts that have made health services more accessible to the medically underserved as shown by health outcomes. Programs may be nominated if they (a) improved access to health services in an underserved part of the U. S., (b) are collaborative, (c) are a non-profit entity, (d) can show measurable outcomes for two-years prior to 7/3/99, (e) and can be replicated. Applications, available through, www.premierinc.com, are due on 7/30/99.

If you have an announcement about upcoming meetings, resources or information you would like to share with other members of MAIN-DQIN, please contact Gretchen Kinder. Send all announcements to her either by email to gkinder@nt.dma.state.ma.us or fax them to 508-856-4850.



Call for Papers

Papers on health education promotion and practice, policy and professional issues are being solicited for "Health Promotion Practice," the new peer-reviewed journal being produced by the Society for Public Health Education (SOPHE). Specific subject areas of interest are:

- Program development
- Professional skills development and new contributions to practice
- Administration and policy
- Future developments in health care/health promotion.

For more information, contact editor Randy Schwartz at the Maine Bureau of Health by telephone (207-287-5385) or email (randy.h.schwartz@state.me.us). The first issue of this new journal is scheduled to be published in January 2000. Sample issues of the journal may be obtained for free by calling Sage Publications at 805-499-9774 or through email at jsamples@sagepub.com.

The "Practice Notes" section of the journal "Health, Education and Behavior" is looking for short articles on great health education programs of all types. Lisa Lieberman, Editor of "Practice Notes" asks "Are you involved in a health education program that you want to share with your colleagues? Have you found a unique way to reach a particular audience, provide special services, or meet an unusual challenge? Can you write a brief description of your program, including its objective, assessment of needs, program strategies, and implications for other health educators?" Call Lisa Lieberman with questions about submissions at 914-638-1619 or email liebermn@icu.com.

"Health Affairs" Seeks Contributors for Personal Essay Section
The journal "Health Affairs" is seeking contributors for its new personal essay section, "Narrative Matters: Beyond the Data." This section will provide the human context and perspective on research and policy as told from the perspective of health providers, caretakers, patients and others who are closely involved with health care issues on a personal level. Contact Fitzhugh Mullen, Editor of "Narrative Matters" at fmullan@projhope.org. Dr. Mullen can be reached by phone at 301-656-7401.



Conferences

Taking on Diabetes: Care in the New Millenium, co-sponsored by the American Association of Health Plans, the American Diabetes Association and the Health Care Financing Administration, will take place August 3-5 at the Capital Hilton in Washington DC. Each conference registrant will receive a compendium of best practices and intervention tools as part of their conference packets. For more information or to register for the conference call 202-778-3629 (press 1), or look on the internet at www.diabetes.org/takingondiabetes. For information about CME credit contact Shirely Ash at 703-549-1500 (ext. 2214).

New Statewide Diabetes Guideline

New Statewide Diabetes Guideline Developed Collaboratively

After reviewing national and state data indicating the people with diabetes do not receive recommended levels of preventive care, the Massachusetts Department of Public Health Diabetes Control Program and its Advisory Board recommended developing state diabetes guidelines as an opportunity to improve diabetes care in the state. The Guidelines highlight and summarize essential components of quality diabetes management and offer accompanying tools to use in the primary care setting.

The *Massachusetts Guide for Adult Diabetes Care* was developed by a workgroup convened by the Diabetes Control program. The workgroup was comprised of clinicians and representatives from managed care organizations (MCO), the Division of Medical Assistance, and MassPRO. A grid was developed comparing the American Diabetes Association (ADA) Standards of Medical Care to the diabetes clinical practice recommendations of several MCOs in Massachusetts. Where differences existed, the group reviewed ADA guidelines, other literature, and expert opinion to reach consensus. The Medicaid Managed Care Medical Directors and the Massachusetts League of Community Health Centers each assigned a physician to a second workgroup to review and comment on the draft. Their recommendations were incorporated into the final version of the *Guidelines* that was then reviewed and approved by each partner organization.

In July 1999 the Diabetes Control Program will mail the *Guide* to all primary care physicians, endocrinologists, nurse practitioners, physician-assistants and certified diabetes educators in the Commonwealth. Electronic copies of all materials will be available on the Massachusetts Department of Public Health website at www.state.ma.us/dph/diabcon.htm.

If you have questions about the Guideline, please call Kate Alich at 617-624-5403.

MAINE/DIIN
Massachusetts Asthma
Improvement Network/
Diabetes Quality
Improvement Network

Summer 1999

Progress Notes

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