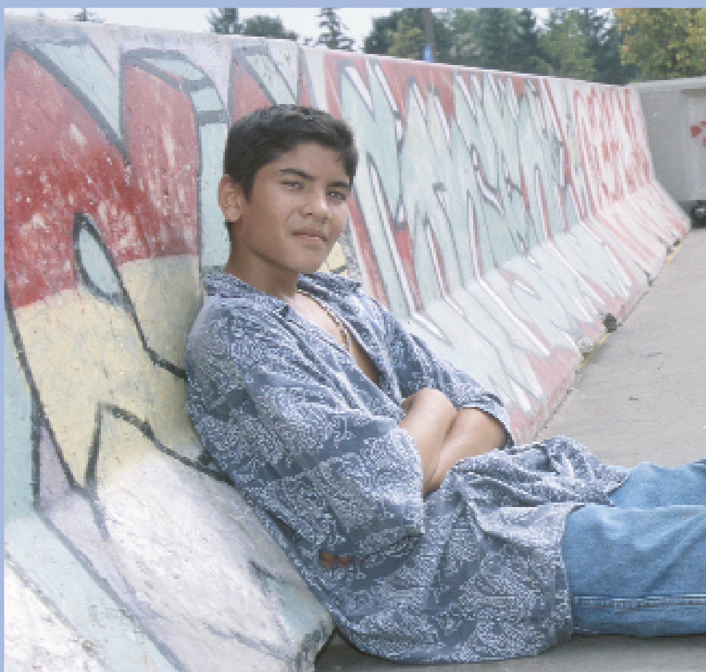
Rural Health Disparities Collaboratives:

Benefits, Barriers and Adaptations for the Future

Focus Group Call
Summary Report
December 1, 2005



Produced for the
National Rural Health Association
521 East 63rd Street
Kansas City, Mo 64110
816/756-3140
www.NRHArural.org

This summary report has been made possible by grant number U30CS00212-04-00 and its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Health Resources and Services Administration (HRSA).

Administrative Office
521 East 63rd Street
Kansas City, MO 64110
816/756-3140

Government Affairs Office
1600 Prince Street, Suite 100
Alexandria, VA 22314
703/519-7910

Rural Health Disparities Collaboratives:

Benefits, Barriers and Adaptations for the Future

Focus Group Call
Summary Report
December 1, 2005

The National Rural Health Association (NRHA) convened a teleconference focus group call on Rural Health Disparities Collaboratives: Benefits, Barriers and Adaptations on December 1, 2005. The purpose of the call was to provide information to the Bureau of Primary Health Care (BPHC) to use in making the Health Disparities Collaboratives (HDC) program more accessible and adaptable to the rural community health center setting.

The focus group participants consisted of 20 individuals from rural HDC health center sites, HDC cluster and primary care association offices, the Training and Technical Assistance Branch and the Clinical Quality Improvement Branch of the BPHC. The call was approximately one hour and 50 minutes in duration. The call guidelines focused on obtaining useful information and used a facilitation process that sought to assure systematic involvement of all participants. The identification of the call participants, a call facilitator, and the arrangements for the call logistics were managed by the NRHA's Minority Health Liaison and Program Services Manager. The call was supported by the BPHC – Division of State and Community Assistance.

The call agenda included a welcome, overview of interaction guidelines, participant introductions, and addressed the following three focus areas:

- Benefits of Participating in the HDC
- Internal Barriers and Adaptations
- External Barriers and Adaptations

In addition, the participants from the BPHC's Clinical Quality Improvement Branch presented questions to seek clarification and additional understanding about points that had been raised during the call. The call concluded with the identification of learning highlights, next steps in processing the call results, a summary of the value of the call to the BPHC, how the findings will be used and, finally, a round of thanks to all for their participation. A copy of the call agenda discussion guidelines, participant list, and call evaluation summary are in Appendix A.

The analysis of the call consisted of a review of the participants' comments contained in the call transcript. The comments were synthesized and edited for clarity and length to produce a summary of the key points for each focus area and of the discussion in response to the questions raised by the BPHC participants at the end of the call. The discussion guidelines presented to the call participants focused on having individuals identify and express key points in relation to each focus area and then on providing other participants an opportunity to add or expand on examples or ask for more details or clarification. There was an emphasis on being concise and not repeating information already given so as to allow as many participants to offer as full a range of information as possible within the time available. There was no mechanism for determining the degree of support or consensus for each point that was raised beyond those instances in which participants spontaneously noted agreement with previous comments or noted a different perception or disagreement regarding a previous comment. Consequently, only the content or substance of the key points that were raised is presented, not their relative strength or importance to the participants.

The following sections of this report provide a summary of key points expressed in each focus area and highlights of the discussion that occurred in response to the questions posed by the BPHC staff.

BENEFITS OF PARTICIPATING IN THE HDC

The first focus area was "Benefits of Participating in the HDC." The introductory prompt to this focus area was as follows:

A specified set of participants will identify a condition or characteristic that changed for the better within their organization as a result of participating in the HDC program. There will be a few minutes for the larger group to add examples or explain the importance.

The following focus question was presented and the facilitator called upon a set of four participants, who had previously been identified on the agenda as the Initial Respondents for this focus question, and who represented health center management and medical perspectives:

What is the single most beneficial change to your organization or your patients as a result of participating in the HDC?

Eight key points emerged from the discussion of the benefits of participating in the HDC:

- **Participation in the HDC has resulted in an increased practice and appreciation of teamwork in improving the delivery of care.**
- **It has changed how individual providers look at their roles in the organization and provided opportunity to take people out of their routines.**
- **The learning model and PDSA have encouraged broader thinking including looking at business functions internally and out into the community to re-think possible partnerships.**
- **The Collaborative listserv and websites to go to have provided access to knowledgeable contacts nationwide and to evidence-based guidelines, self-management forms and other invaluable tools.**
- **Use of a patient registry has been an important and powerful tool in enabling both the providers and patients to understand what's going on.**
- **Participation has brought a perspective of empowering and enabling patients and an understanding of the real power of teaching self-management.**
- **Participation has definitely resulted in improved patient care and outcomes including helping patients at an earlier stage and decreasing devastating side effects.**
- **Having the data to back up the improved patient outcomes that come from participation in the HDC raises the status of community health center health care itself and is politically very good for everyone.**

INTERNAL BARRIERS AND ADAPTATIONS

The second focus area was "Internal Barriers and Adaptations." The introductory prompt to this focus area was as follows:

We will have an initial round-robin response by a small group of participants followed by full group discussion of (a) factors internal to a Center's organization and patient population that hindered participation or achieving success, and (b) adaptations or changes that address the barriers that were encountered.

The following focus question was presented and the facilitator called upon a set of four participants, who had previously been identified on the agenda as the Initial Respondents for this focus question, and who represented a mix of health center administrative and medical perspectives and HDC cluster and primary care association perspectives:

What is the single most detrimental internal barrier to achieving success that you encountered and what adaptation or change was made, or do you think could be made, to address the barrier?

Four organizational and three patient population-related barriers emerged as key points in the discussion of internal barriers and adaptations.

Organizational Culture

- The lack of an existing culture of quality and of prevention made it difficult to get buy-in and to spread the program throughout a health center's staff or among multiple Centers. Indicators included:
  - Staff sincerely believed that they already were doing a good job even though they don't document it.
  - Staff questioned whether the outcomes would be worthwhile relative to the additional time, effort and expense which might cut down overall encounters.
  - Individuals initially came to team meetings with problems to have fixed but no solutions to propose.
  - Responsibility for information gathering kept building for the initial team instead of new sites taking on that responsibility for themselves.

- Adaptations to address problems involving organizational culture included:
  - Offering good natured, relatively easily attainable challenges to the perceived performance that can be checked with audit or other data and going over the results with the individual(s) to illustrate discrepancy in perception and performance.
  - Making the HDC part of the job descriptions to make clearer that this is the way that the health center does business.
  - Creating sub-teams to work together on a more individual basis to try Plan-Do-Study-Act (PDSA) cycles to produce more involvement and have possible solutions to bring back to meetings.
  - Offering incentives to new sites for taking on ownership as shown by monthly monitoring on improving their criteria.

Leadership

- Lack of HDC program buy-in and support by the executive director and other health center leadership limits success.
- Adaptations to address the importance of leadership included:
  - Addressing the importance of leadership when Centers apply.
  - Openly attend to the need for leadership at regional meetings.
  - Having cluster personnel work directly with health center leadership on this challenge throughout the year.

Computer Systems

- The lack of adequate computing capacity in relation to patient registry requirements creates a sense of stumbling, frustration and sometimes wanting to quit right at the beginning. Indicators include:
  - Not realizing how large the registry software program will be.
  - Frequently losing information while working with the software and having to maintain files on a disk.
  - Realizing the need for a computer at each site.
- Adaptations to address the lack of computing capacity included:
  - Seeking small grants for new computers.
  - Hiring a computer services director.
  - Proposing that future HDC initial agreements include resources for computers and other needed technology.

Turnover

- Turnover of staff, especially a champion staff or champion provider results in a very difficult transition time until the responsibility is shifted and/or the position is filled and the HDC skills are re-established.
- No adaptations were identified.

Transportation

- Lack of transportation prevents patients from being able to come for their appointments.
- Adaptations to address the lack of transportation included:
  - Resuming transportation services once the negative impact on keeping HDC appointments was clear.

Literacy

- Many patients either can't read or read at about a sixth grade level.
- Adaptations to address literacy problems of patient population included:
  - Acquiring educational tools and booklets that use pictures instead of writing.
  - Sitting more with patients and learning about their reading level.
  - Using analogies such as driving a car to represent having control of their diabetes.
  - Presenting potential educational solutions at the PDSA and actively involving patients in the PDSA process to test the improvements.

Language

- There is a lack of Spanish language skills and interpretation services to address the increase in the Hispanic population in rural areas.
- Adaptations to address the need for Spanish language skills and interpretation services included:
  - Seeking interpretation services.

EXTERNAL BARRIERS AND ADAPTATIONS

The third focus area was "External Barriers and Adaptations." The introductory prompt to this focus area was as follows:

We will have an initial round-robin response by a small group of participants followed by full group discussion of (a) external factors pertaining to the HDC program or tools that hindered participation or achieving success, and (b) adaptations or changes that address the barriers that were encountered.

The following focus question was presented and the facilitator called upon a set of four participants, who had previously been identified on the agenda as Initial Respondents for this focus question, and who represented a mix of center administrative and medical perspectives:

What is the single most detrimental external barrier to achieving success that you encountered and what adaptation or change was made, or do you think could be made, to address the barrier?

Travel

- Time required to travel to and attend Collaborative events causes a hardship on smaller rural clinics particularly in Phase I with four conferences that year. Indicators included:
  - Sometimes having to close the whole clinic to enable participants to come to a conference.
- Adaptations to address the impact of time required to travel and attend Collaboratives events included:
  - In Phase II move from a single summit conference to regional and state-based conferences to take the show to where the audience is.

Resources

- Rural settings face a chronic shortage of resources to meet basic ongoing programmatic and administrative needs. Indicators included:
  - Lack of computers and data entry capacity (identified earlier in internal barriers).
  - Lack of patient transportation to clinic appointments (identified earlier in internal barriers).
  - Need to provide food in sessions.
  - Constantly having to shift to new sources to keep middle school exercise class for obese students going.
  - No payment/funding for specialty referrals for underinsured and uninsured.
- Adaptations to acquire resources to meet basic ongoing programmatic and administrative needs included:
  - Seeking small grants from a variety of sources.
  - Working with a variety of state agencies to fund or provide staff for specific projects related to their mission.
  - Work with state legislature to allocate tobacco settlement funds to community health centers.

Mixed or Unclear Messages

- At times health centers, especially in rural areas, perceive there to be mixed or unclear messages about the direction of Collaboratives and are concerned about what the lack of clarity might mean for their HDC efforts. Indicators included:
  - Differences in perspective of what the timeline actually is to involve all patients in all clinics in the primary care collaborative.
  - Skepticism about getting all patients involved in the primary care collaborative given the amount of resources needed and when some clinics are struggling just to get a few people into the registry
  - Concern about how much to put into this Collaborative given a sense of uncertainty about the financial ability of the BPHC to have programs.
  - An uncomfortable sense that the longevity and ultimate direction of the Collaboratives are still questionable.
- Adaptations to improve the clarity of messages and reduce the sense of uncertainty regarding the direction of the Collaboratives included:
  - Involving the state primary care associations and clusters on a routine basis to try to assure that senior leadership of the Collaboratives is on the same page.

Fastfood Culture

- The culture of eating the quickest, fastest, most processed foods available in the social environment creates a significant barrier to improvements in HDC patients. Indicators include:
  - Presence and easy access to high-fat, high-sugar, high-carbohydrate and high-salt foods.
  - Ignorance and lack of understanding about what should be eaten.
  - Not wanting to cook after coming home from work.
  - Difficulty getting patients to comply with a healthy diet.
- No adaptations were identified.

Payment for Specialty Referrals

- There is a lack of payment mechanisms in the private sector to cover specialty referral services for indigent patients. Indicators include:
  - Identifying a need for referral to optometrist, ophthalmologist or gastroenterologist in screening and then not able to get necessary treatment.
- Adaptations to address lack of payment to cover needed referrals included:

- In the case of cancers, work with national organizations to seek resources.
- Encourage community leadership to speak out for underserved on the lack of access to care once screening has identified a problem.

Perceived Liability

- The perception of potential liability in regard to Stark-type liability hinders some organizations from collaborative sharing of resources. Indicators included:
  - Local hospital legal counsel advised against providing health center indigent patients free access to hospital diabetes self-management program.
- Adaptations to address Stark-type liability included:
  - Looking to propose safe harbor legislation that would protect centers in such instances.

BPHC QUESTIONS REGARDING ADDITIONAL INSIGHT INTO PARTICIPANT COMMENTS AND DISCUSSION

The facilitator opened the agenda to questions that BPHC personnel might have regarding the participants' comments and discussion that occurred in addressing the three focus areas. The reasons for adding this agenda item were to make good use of the remaining time, to assure that the BPHC personnel wouldn't leave the focus group event with misunderstandings of what was said and to have the information that they need.

Four questions were posed by the BPHC participants that resulted in direct responses and follow-up questions of a clarifying and exploratory nature by the health center, cluster and primary care association participants.

Collaboratives Stop Tomorrow

- What if the Collaboratives were to stop tomorrow, no Phase 1, no Phase 2, no dollars, no infrastructure aboard, nothing, would the health centers continue on their quality improvement work using these methods or completely just drop it? Responses included:
  - There has been a transition over the years from "that diabetes thing you guys are doing" to the way that we practice now. We don't have to go to learning sessions or do monthly phone calls to continue, I don't think it would change at all.
  - One of the most exciting things was that someone had gone out and found literature and research and summarized it and processed it until it was understandable. If the funding and the infrastructure support from the clusters and state people stopped we would lose a whole lot of ground, the strongest health centers would continue and others would become discouraged and fall off.
  - Without the cluster infrastructure and the IT infrastructure, many teams that haven't spread past their 250 patient focus – population focus- would fall off within a year or two.
  - As a small clinic, we've seen massive impact in our patients and have gotten the basics to build on so we know it works. So should it stop today, we wouldn't be able to improve so rapidly and dramatically without the assistance and tools, but I don't see our group just dropping off.
  - Without the infrastructure and without the data input from all over the country we would lose that political power of knowing what we're doing in community health centers and would no longer be able speak to the quality that's happening in our health centers.

Incentives Program

- What if there was an incentive grant program associated with submission of the data or base adjustments? Would that stimulate more engagement from even the health centers that might not have been scaling up for whatever difficulty or complexity, or that just haven't committed to that next leap yet? Responses and exploratory questions included:
  - Would that be a competitive process?
    - Let's say health centers were paid on a capitation basis for the number of people in the registry that they're recording quality care being delivered on.
      - That would be wonderful.
  - Is there talk of tying this registry and its data with what is currently reported on the UDS report?
    - Yes, but it would require interoperability at the level of the health center and HRSA as a whole. The current labor intensive, volunteering time after-hours practice of manually entering data into the registry would be replaced with automatic, electronic entry of data from the lab or practice management system. And similar interoperability would be true for the various databases within the BPHC and within HRSA as a whole.
    - Ultimately, making these improvement models work in this way for the business case would be a major implication for the whole community of health centers. To the extent this can be moved along coherently, the program probably will be able to exceed some of the expectations that HRSA has made.

- Being paid based on how many people are in a registry is one thing but what sort of accountability criteria would be built in?
  - Although we're speaking hypothetically at this point, we're not just talking about the number of patients in a registry, we're talking about demonstration of improvement of outcome over time for a cohort of patients.
  - Health centers would address this in their evaluation plan in terms of moving from some particular percent controlled diabetic to some greater percent controlled diabetic in a certain time frame.
  - There should be incentives involved and be based on information integral to what health centers do.

Business Case

- What about the information at the recent learning session showing that some of the business implications were much more important than people had realized in terms of dollar outcome and real business case? Are there some positive business case implications for these kinds of activities?
  - We've definitely seen it. In our rural area we are consistently seeing patients twice a year for their diabetes, and that wasn't done before. It was like the earlier example, where a provider believed 100 percent of diabetic patients were seen but it actually was only 12 percent. By seeing patients more frequently, we not only provide better access and better outcomes but we get paid for seeing those patients.
  - We are doing a better job of looking at all of our business functions around supporting increased access for patients and better outcomes.
  - At the recent learning experience, there were clinics from small rural places that incorporated clinic redesign or reengineering into their first year and spoke very positively about the success they've had.
  - We found that our ability to effectively code and track key items is important to making our business case, but we can't translate between external codes like ICD-9 and CPT and our current system for reimbursement as a FQHC. Does anyone have solutions or experience with that?
  - We're participating in a study regarding group visits to help understand how efficacious group visits are and a larger study to work toward getting group visits approved as charged.

Turnover

- Does being in a macro program and having interaction with other providers, at least four times a year, increase staff remaining in rural areas? Or is there more or less turnover from participating in the Collaborative?
  - I don't think we've observed any change.
  - We have less turnovers in certain positions and actually been able to attract certain staff, nursing and medical assistance staff, for example based on being part of a pediatrics department and being able to do a variety of things like working with kids with asthma, showing how to use devices and possibly doing sessions at the school.

CALL HIGHLIGHTS AND TAKEAWAYS

The wrap-up of the call included the identification of call highlights and takeaways by the NRHA and BPHC call participants. Those highlights and takeaways are combined and presented below.

- The call discussion revealed an unmistakable buy-in by health centers of teams and registries and other basic concepts and tools of the HDC program.
- The Collaboratives process has involved for everyone the notion of a democracy of conversation about all aspects of the Collaboratives on the listserv.
- The idea of health centers being on the cutting edge of improving quality is a new and different role than traditionally thought about and something that is underestimated and under-discussed.
- The acknowledgement of a business case has been increasingly recognized and the instruments and details of improved access, efficiency and fiscal impact are closer to being packaged, getting feedback from the infrastructure and getting the word out to the whole network.
- There indeed have been mixed messages and a part of the solution to that can come from a gathering in 2006 of learning and lessons of all variety of pilots and demonstrations to help define next steps and commitments.
- The model can't be just a cookie cutter, and with everyone's involvement we can continue in ways that are not just generic but very specific to all kinds of communities.

APPENDIX A

CONFERENCE CALL AGENDA

Rural Health Disparities Collaboratives:
Benefits, Barriers and Adaptations for the Future

December 1, 2005 ***11:00 am – 1:00 pm (CST)***
Call-in Number: 877-358-8255 ***Conference ID: 7999310***

Please call in 5-10 minutes in advance of the starting time to assure proper connection and a timely start with all participants on board

Purpose: To provide information to the Bureau of Primary Health Care (BPHC) to use in making the Health Disparities Collaboratives program more accessible and adaptable to the rural Community Health Center setting.

5 min **Welcome and Purpose**

Rosemary McKenzie, National Rural Health Association
Ahmed Calvo, MD, Clinical Quality Improvement Branch, BPHC

A welcome to all to this important event for rural America and a brief statement of our purpose for being together today

15 min **Review of Interaction Guidelines and Participant Introductions**

J. Patrick (Pat) Hart, PhD, Call Facilitator
Rural HDC Call Participants

The interaction guidelines will be highlighted and participants will provide a brief statement of their current position, location and a tidbit on their background

20 min **Focus Area 1 – Benefits of Participating in the HDC**

Call Facilitator and Participants

A specified set of participants will identify a condition or characteristic that changed for the better within their organization as a result of participating in the HDC program. There will be a few minutes for the larger group to add examples or explain the importance.

Focus Question: What is the single most beneficial change to your organization or your patients from participating in the HDC?

Initial Respondents: Holmes (SC), Wilson, (MO), Miller (AR), Bacon (MS)

35 min **Focus Area 2 – Internal Barriers and Adaptations**

Call Facilitator and Participants

We will have an initial round-robin response by a small group of participants followed by full group discussion of (a) factors internal to a Center's organization and patient population that hindered participation or achieving success, and (b) adaptations or changes to address the barriers that were encountered

Focus Question: What is the single most detrimental internal barrier to achieving success that you encountered and what adaptation or change was made, or do you think could be made, to address the barrier?

Initial Respondents: Ericson (ND), Thiel (MI), Cross (WI), Latham (TX), Ferguson (SC)

35 min **Focus Area 3 – External Barriers and Adaptations**

Call Facilitator and Participants

We will have an initial round-robin response by a small group of participants followed by full group discussion of (a) external factors pertaining to the HDC program or tools that hindered participation or achieving success, and (b) adaptations or changes to address the barriers that were encountered

Focus Question: What is the single most detrimental external barrier to achieving success that you encountered and what adaptation or change was made, or do you think could be made, to address the barrier?

Initial Respondents: Anthony (MS), Kroll (WI), Zuroweste (PA), Kordsmeier (AR)

10 min **Wrap-up, Next Steps and Thanks**

Rosemary McKenzie, National Rural Health Association
Ahmed Calvo, MD, Clinical Quality Improvement Branch, BPHC

Learning highlights and how and when the results of the work will get to the participants. What the Bureau hopes to come of the work, and thanks to all.

Adjourn

CONFERENCE CALL GUDELINES

Thank you for agreeing to share your valuable time, experience and perspective in this call to identify and explore barriers and opportunities related to rural health center participation in the Health Disparities Collaboratives (HDC). You will be part of a group of about 20 people from across the country representing clinical, administrative and educational roles at the local, cluster and national levels of the HDC program who will be discussing how the Bureau of Primary Health Care can make the HDC program more accessible and adaptable to the rural Community Health Center setting.

This document will provide you with background on how the call will be conducted, some straightforward interaction guidelines for making the call productive, and what you can do to prepare for the call. Please have this document, the call agenda and the participant list with you during the call.

Call Format

The call will be conducted in a focus group-like manner directed at getting as much useful information as we can in a relatively short period of time. Following the opening of the call we will proceed to address three focus areas. The opening will include a welcome and brief statement of the purpose of the call, highlights of the interaction guidelines, and participant introductions. The introductions will serve as a sound check to be sure we can hear everyone and a recognition check to begin recognizing our call partners. The three focus areas are: 1) Benefits of participating in the HDC; 2) Factors internal to a Center's organization and patient population that presented barriers and actual or potential adaptations to address the barriers; and 3) Aspects of the HDC Program and its tools that presented barriers and actual or potential adaptations to address the barriers.

In order to get input from all participants we will use a facilitation technique in which for each focus area a small group of the participants will be specified in advance on the agenda to provide concise comments in relation to the focus area question that is posed by the facilitator. The larger group will then have the opportunity to add examples, expand on examples via their experience, or ask for more details or clarification. Please check the agenda to see where you will be participating in a small group. The facilitator will provide the transition from the small group's comments to the larger group discussion by opening the topic for comments, calling on participants by role such as executive directors, medical directors, or cluster directors, or calling on particular individuals (especially if you aren't in one of the small groups).

Interaction Guidelines

Here are a few guidelines that are offered to move this call toward a high performance and productive call.

- One of the main things to keep in mind is that this call is intended to generate information. Consequently, it's important to think of every observation or idea as useful and a good one (avoid evaluation or criticism of other's comments.
- When it is your turn to speak as a small group contributor make the points you are asked to address keeping your comments as concise as you can while still getting your experience or idea communicated (don't carry on with marginally related ideas that happen to come to mind as you speak).
- We will make use of a round-robin technique asking for additional input so if you have more than one observation or idea that pertains to a topic we are discussing you will very likely have the opportunity to express it.
- If there is a relevant observation or idea that pertains to a focus area that you think of as the call proceeds and the timing or lack of time prohibits covering it on the call, you can e-mail it to Rosemary McKenzie at rmckenzie@NRHArural.org to include in the report.
- Keep track of the times you talk with a check ( ) next to the agenda items where you participate. Ask yourself if the group is losing out because you are not contributing or if you are dominating the time and adjust your participation accordingly.
- The facilitator will signal when he needs you to wrap-up or he needs to make a process comment or ask questions (probe) to get at more detail or get clarification. Please be as responsive to these requests as you can so that we can proceed on time and on goal.

In the beginning:

- Call 5 to 10 minutes in advance to be ready to go at start time.
- Remember to speak directly into your phone handset or speaker phone and be close enough to make it count.
- Try to keep the background noise at a minimum (including side conversations, typing and heavy breathing). Use the mute on your speaker phone if necessary.

Call Preparation

- Take a few minutes to review the agenda and simply think back on your experience and the lessons you've learned as a participant in the HDC program.
- Think of an interesting factoid or tidbit about yourself that you can use in the introduction to help people know you beyond your name, job and organization.
- Identify where in the agenda you will be a part of a small group that kicks off the comments and discussion of a focus area. Think through how you can best give concise but meaningful information.
- Identify documents that you would like to have handy that would help you feel comfortable and could serve as prompts for your comments and discussion (but keep it spontaneous, not scripted).

Thanks again for sharing your time and talent to improve the accessibility and adaptability of the HDC program to its rural participants. We sincerely hope that the information shared on this call will result in value not only to the HDC program overall but to every one of its participants.

PARTICIPANT LIST

Janice Bacon, M.D., Clinical Services Director
G.A. Carmichael Family Health Center
Asthma I, Diabetes V, Perinatal and Prototype
1668 West Peace Street, P.O. Box 588
Canton, MS 39046
601/859-5213
janicebaconwest@aol.com

Mona Dawar, Ph.D., M.S., M.Ed.
Associate Director of Case and Disease Specific Management
National Health Services, Inc.
Diabetes, Asthma, Depression and Cardiovascular
659 South Central Valley Hwy., P.O. Box 1060
Shafter, CA 93263
(661) 459-1911
mdawar@nhsinc.org

Sharon R. Ericson, CEO
Valley Community Health Centers
Diabetes and Cardiovascular
P.O. Box 160
Northwood, ND 58267
701/587-6000
sharon.ericson@valleychc.org

Mary LaFrance Ferguson, Medical Director
Beaufort Jasper Hampton Community Health Service, Inc.
Diabetes II and Prototype
721 Okatie Hwy., P.O. Box 357
Ridgeland, SC 29936
833/987-7448

Marianne Holmes, F.N.P., C.D.E., HDC Team Leader
Beaufort Jasper Hampton Community Health Service, Inc.
Diabetes II and Prototype
721 Okatie Hwy., P.O. Box 357
Ridgeland, SC 29936
833/987-7448
mholmes@BJHCHS.com

Phyllis Kordsmeier, CEO
Cabun Rural Health Service, Inc.
Diabetes II and Cardiovascular II
403 Highway 167 South, P.O. Box 1
Hampton AR 71744-1196
870/798-4064
cabunchc@aol.com

Rhonda Kroll, R.N.
Northern Health Centers, Inc.
Diabetes and Cardiovascular III
15397 Highway 32
Lakewood, WI 54138
715/276-6321
rhondak@nhcmedden.com

Wendy Latham, B.S.W.
West Central Cluster Director
Texas Association of Community Health Centers
5900 Southwest Parkway, Bldg. 3
Austin, TX 78735
512/329-5959
wlatham@tachc.org

Sandra Miller, R.N.
Cabun Rural Health Service, Inc.
Diabetes II and Cardiovascular II
403 Highway 167 South, P.O. Box 1
Hampton AR 71744-1196
870/798-4064

Denise Rigcen, Team Leader
Family Health/La Clinica Diabetes
400 South Townline Road
Wautoma, WI 54982
920/787-5514

Trease Riley
Chronic Care Coordinator
Northwest Health Services, Inc.
Diabetes III, Depression II, Pilot beginning cardiovascular
3110 Karnes Road
St. Joseph, MO 64506
816/271-8263

Fay Thiel, Chief of Clinical Services
Michigan Primary Care Association
2525 Jolly Rd., Suite 280
Okemos, MI 48864
517/381-8000
fthiel@mpca.net

Zella Van Natta
Family Health/La Clinica
Diabetes and Depression
400 South Townline Road
Wautoma,WI 54982
910/787-5514
Zella@famhealth.com

Susan Wilson, CEO
Northwest Health Services, Inc.
Diabetes III, Depression II, Pilot beginning cardiovascular
3110 Karnes Road
St. Joseph, MO 64506
816/271-8263
susanwilson@nwhealth-services.org

Ed Zuroweste, M.D.
HDC National Partner – SE/NE Cluster
Medical Director
Migrant Clinicians Network
878 North Allen Street
State College, PA 16803
814/238-6566
kugelzur@migrantclinician.org

Facilitator

J. Patrick Hart, Ph.D., Hart & Associates
Rural2Ruarl Consulting
1166 Madison Lane
Pisgah, IA 51564
712/456-2055
jpathart@iowatelecom.net

Federal Representatives

Jay Anderson, D.M.D., M.H.S.A.
Chief Dental Officer, Health Disparities Collaborative Dental Lead
Clinical Quality Improvement Branch
Bureau of Primary Health Care/Division of Clinical Quality/HRSA
5600 Fishers Lane, Room 17C-26
Rockville, MD 20857
301/594-4295
janderson@hrsa.gov

Fred Butler, MPH, MBA
Health Disparities Collaborative Program Manager
Bureau of Primary Health Care/Division of Clinical Quality/HRSA
5600 Fishers Lane, Room 17C-26
Rockville, MD 20857
Phone: (301) 594-4483
fbutler@hrsa.gov

Lori Butler, Public Health Analyst
Training and Technical Assistance Branch
Division of State and Community Assistance
Bureau of Primary Health Care/HRSA
5600 Fishers Lane, Mail Stop 15C-04
Rockville, MD 20857
301/594-0287
lbutler@hrsa.gov

Ahmed Calvo, M.D., M.P.H., F.A.A.F.P.
Chief, Clinical Quality Improvement Branch
Bureau of Primary Health Care/Division of Clinical Quality/HRSA
5600 Fishers Lane, Room 17C-26
Rockville, MD 20857
301/594-4293
acalvo@hrsa.gov

Harriet McCombs, Ph.D.
Health Disparities Collaborative Mental Health Lead
Bureau of Primary Health Care/Division of Clinical Quality/HRSA
5600 Fishers Lane, Room 17C-26
Rockville, MD 20857
Phone: (301) 594-4483
hmccombs@hrsa.gov

NRHA Staff

Rosemary McKenzie
Minority Health Liaison and Program Services Manager
National Rural Health Association
1 West Armour Blvd., Suite 203
Kansas City, MO 64111
816/756-3140
rmckenzie@NRHArural.org

EVALUATION SUMMARY

With regard to the call on Rural Health Disparities Collaboratives:

1. (+) What went well?

- Conference was well run. All participants sounded confident in responses and were open in discussion.
- I thought the whole call went well. I always learn so much from people who have done this longer.
- I thought everything went well. Everyone was polite and didn't try to talk over each other. The subjects discussed were covered thoroughly.
- Frank discussion was good. I appreciated having the BPHC and HRSA staff on the call.
- Learning how we are all in the same boat as far as benefits and barriers.
- There was a good representative group of individuals on the call and everyone had sufficient time to express their opinions on the topics presented.

2. (--) What went poorly?

- Some voices were difficult to hear due to background noises.
- I thought it ran too long. We stayed on the phone after we had exhausted the subject.
- I didn't sense anything that was truly "poor". Perhaps we didn't get as much overall participation as we could have because people like me talked/dominated more than we should have.
- Not able to say what I wanted to say when called upon I was rudely cut off.
- Nothing went poorly but again it is unclear to me, and I am sure to other participants on the call, what direction the BPHC is going in the future activities of the HDC.

3. (△) What would you change if we were to do the call again?

- Make the time an hour and a half, rather than two hours.
- I wish the facilitator had waited just a little longer for answers to his questions. I was prepared for the "prepared" questions, but wanted to think a bit longer on the spontaneous topics that came up.
- To have a power point to follow along with.
- Nothing dramatic, I believe it was a good call for the information that was requested and I believe that there was an honest discussion of the issues.
- Thanks to Rosemary and the NRHA for hosting the discussion.