Improving Patient Care Program

Learning Session 1
Tucson, Arizona
February 15-16, 2011

The Indian Health Service's 4 priorities:

- To Renew and strengthen our partnership with Tribes;
- In the context of national health insurance reform, to bring reform to IHS;
- **To improve the quality of and access to care**; and
- To make all our work is accountable, transparent, fair, and inclusive.

Challenges for IHS

- Increasing rates of chronic disease
- High prevalence of High BP, Heart Disease, obesity, DM
- Population growth increasing demand for healthcare services
- Providing Health care in the Rural and Urban settings
- Resources to meet demand of services
- Rising health care costs and medical inflation

IPC Program – AIM

The aim of the Improving Patient Care program is to change and improve the Indian Health system. IPC will develop high performing and innovative healthcare teams to improve the quality of and access to care. The results will be a medical home that sets new standards for healthcare delivery and further advances the health and wellness of the American Indian and Alaska Native people.

IPC 2 sites
IHS, Tribal, and Urban Indian health programs

Federal (22)

- Albuquerque Service Unit
- Warm Springs Service Unit
- Chinle Comprehensive Health Care Center
- Wind River Service Unit
- Gallup Indian Medical Center
- Sells Service Unit
- Whiteriver Service Unit
- Rapid City Service Unit
- Clinton Indian Health Center
- Colville Indian Health Center
- Fort Defiance Service Unit
- Fort Peck Service Unit
- Fort Yuma Health Center
- Kayenta Health Center
- Northern Cheyenne Service Unit
- Phoenix Indian Medical Center
- Red Lake Hospital
- Ute Mountain Ute Health Center
- Wagner IHS Health Care Facility
- Wewoka Service Unit
- White Earth Health Center
- Yakama Indian Health Center

Tribal (13)

- Swinomish Health Clinic
- Cherokee Indian Hospital (Eastern)
- Indian Health Council, Inc.
- Cherokee Nation Health Services
- The Choctaw Health Center
- Eastern Aleutian Tribe
- Forest County Potawatomi Health and Wellness Center
- Chickasaw Nation Health System
- Chief Andrew Isaac Health Center
- Chugachmiut
- Fort Mojave Indian Health Center
- Oneida Indian Health Service
- South East Alaska Regional Health Center

Urban Indian health program (3)

- Swinomish Health Clinic
- Cherokee Indian Hospital (Eastern)
- Indian Health Council, Inc.

68 IPC 3 sites

Aleutian Island Service Unit
American Indian Health &Fam. Serv.
Annette Island Service Unit
Blackfeet Service Unit
Bristol Bay Health Corp
Cass Lake Hospital
Catawba Service Unit
Cheyenne River Service Unit: Eagle Butte
Cherokee Indian Hospital: Snowbird
Cherokee Indian Hospital: Cherokee Co.
Cherokee Nation: WW Hastings
Cherokee Nation: Wilma P. Mankiller
Chief Andrew Isaacs Health Center
Chinle Service Unit: Pinon
Chinle Service Unit: Tsaile
Claremore Indian Hospital
Clinton Service Unit: El Reno HC
Colorado Service Unit: Parker
Colorado Service Unit: Peach Springs HC
Copper River Native Assoc.
Colville Indian Health Center
Crownpoint Healthcare Facility
Dena'ina Health Clinic
Elko Service Unit: Southern Bands HC
First Nations Community HealthSource
Fort Belknap Health Center
Fort Defiance Indian Health Board
Fort Hall Service Unit: Not-tsoo-Gah-Nee HC
Fort Mojave Indian Health Ctr.
Fort Peck Service Unit: Vern Gibbs HC
Fort Thompson Health Center
Fort Yuma Service Unit
Gallup Service Unit: Tohatchi Health Center
Hopi Health Care Center
Hunter Health Clinic
Jicarilla Service Unit
Kayenta Service Unit: Inscription House
Ketchikan Indian Comm. Tribal HC
K'ima:w Medical Center
Kodiak Area Native Assoc.
Lassen Indian Health Center
Lawton Service Unit: Anadarko
Lawton Service Unit: Lawton Hospital
Maniilaq Health Center
Menominee Tribal Clinic
Micmac Service Unit
MBCI: Choctaw Health Dept.
NATIVE Health of Spokane
Nebraska Urban Indian Health
Norton Sound Health Corporation
Oklahoma City Indian Clinic
Pawnee Indian Health Center
Phoenix Indian Medical Center
Pine Ridge Hospital
Red Cliff Comm. Health Ctr.
Riverside/SB County Indian Clinic
Sacramento Nat. Am. Health Clinic
San Carlos Service Unit
Santa Fe Service Unit:
Seneca Nation Health Dept.
Shiprock Service Unit: Four Corners Regional HC
Shiprock Service Unit: Northern Navajo Medical Center
Sisseton Service Unit
SouthEast Alaska Regional Health Consortium:
Mt. Edgecumbe Western Oregon Service Unit: Chemawa Indian HC
Wind River Service Unit: Arapahoe
Winnebago Comprehensive Health Care Facility
White Earth Service Unit

IPC 3 AIM

The aim of the Improving Patient Care Collaborative is to **improve health and promote wellness for American Indians and Alaska Natives** and to **support the four agency priorities**. It is a pathway toward a **redesigned** system of care that is **grounded in the values and culture of the community served**. The IPC Collaborative will **focus on strengthening the positive relationships** between the healthcare system/care team and the individual, family and community. The IPC Care Model serves as a framework to guide the creation an *Indian Health Medical Home;* an **accessible and patient-centered system of care that provides safe, timely, effective, efficient and equitable care.**

IPC 3 AIM (continued)

Participating organizations will **show improvement in preventive care, management of chronic conditions and experience of care, while maintaining financial viability**. Within a 12-month period, all engaged sites will achieve a basic level of development of the Indian Health Medical Home. This will be evident by *delivery of care through care teams*, improved *continuity of care*, *partnerships with community and Tribal organizations*, and *integration of improvement into the overall Aim and focus of the organization*. By the end of the 12-month period, successful changes will begin to **spread** throughout the participating site to support and accelerate their ongoing journey of transformation.

IPC 3 Guidance

- Engagement with Tribal leadership and community are essential features of IPC.
- The use and transparency of data to guide improvement is central to achievement of this aim.
- Alignment with organizational priorities and full support of clinical and administrative leadership at all levels within the Indian health system are critical to the success of IPC.
- Meaningful use of the Clinical Information System is important to the successful creation of a Health Home and quality improvement.

Some Goals to Support the Aim

- Improvement in preventive care, management of chronic conditions and experience of care, while maintaining financial viability.
- Achieve a basic level of development of the Indian Health Medical Home.
- Delivery of care through care teams, improved continuity of care, partnerships with community and Tribal organizations and integration of improvement into the overall Aim and focus of the organization.
- Begin to spread throughout the participating site to support and accelerate their ongoing journey of transformation.

22 Quality and Innovation Learning Network Sites

- Rapid City Service Unit
- South Dakota Indian Health Center
- Wagner IHS Healthcare Facility
- Eastern Aleutian Tribes
- SouthEast Alaska Regional Health Consortium
- Albuquerque Indian Health Center
- Ute Mountain Ute Health Center
- Forest County Potawatomi Health & Wellness Center
- Gerald L. Ignace Indian Health Center
- Red Lake Hospital
- Fort Peck Service Unit
- Northern Cheyenne Service Unit
- Cherokee Indian Hospital (NC)
- Chinle Comprehensive Healthcare Center
- Clinton Indian Health Center
- Wewoka Service Unit
- Phoenix Indian Medical Center
- Whiteriver Service Unit
- Swinomish Health Clinic
- Warm Spring Service Unit
- Yakama Indian Health Center
- Sells Service Unit

QILN– AIM

The aim of the Quality and Innovation Learning Network (QILN) is to improve health and promote wellness for American Indians and Alaska Natives across all ages through an active learning and innovation community that provides continued support for IHS, Tribal and Urban programs in achieving changes of the Indian Health medical home:

Key Changes:

- Care Centered on the Patient and Family
- Tribe and Community
- Care Team
- Access and Relationship
- Culture of Quality

QILN– AIM (continued)

Participating sites will spread changes of the Indian Health medical home across their entire sites within 1 year as measured by the Indian Health medical home assessment and serve as mentoring organizations for other Indian Health organizations.

QILN– Guidance

1. The Quality Innovation Learning Network is open to all programs who have participated in the IPC Collaborative and/or have achieved the foundational elements of the Indian Health medical home, as determined by an assessment currently in development.
2. No financial cost for participation; travel support will be provided for teams to attend the Network meetings. Enrollment is annual, for a one-year period.

QILN– Guidance (continued)

3. Core focus:

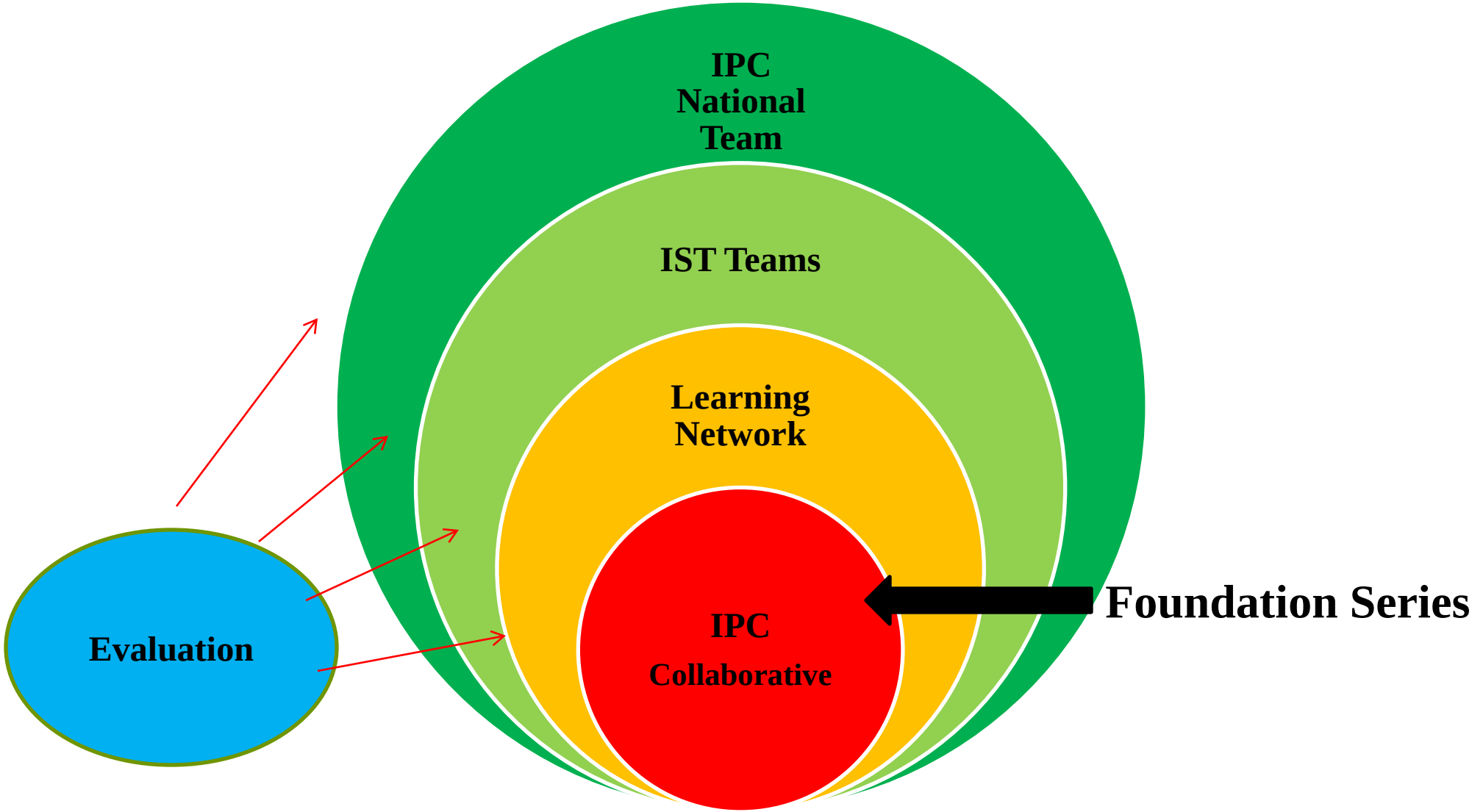
- Spread of changes of the Indian Health medical home to the entire organization, from microsystem to the entire site or facility.
- Testing and implementation of late change of the IPC change package, included Improved Access, Self Management Support, Care Management and Coordination, and Behavioral Health Integration.
- Spread of improvement skills and knowledge throughout the organization.
- Optimization and Meaningful Use of the Clinical Information System. Opportunities to participate in innovation will be integrated into the content of the Learning Network such as:
  - Telehealth tools for improved management of chronic conditions.
  - Tobacco Cessation.

QILN– Guidance

4. Expectations for Participants:

- Actively participate in biweekly Action Period Calls.
- Attend two in-person Learning Network Meetings each year.
- Participate in Leadership calls.
- Report and share the small set of measures.
- Share tools and ideas.
- Serve as mentoring organization to other organizations.

Improving Patient Care Program



“Break Through Series”Model

Major activities of all IPC sites:

- Teams will receive extensive training and support in attaining the skills and knowledge in applying methods for improvement
- 5 group learning sessions
  - 2 Face to Face sessions
  - 2 Virtual WebEx based learning sessions
  - Knowledge gathering session
- Action orientated initiative that provides the foundation for continued improvement

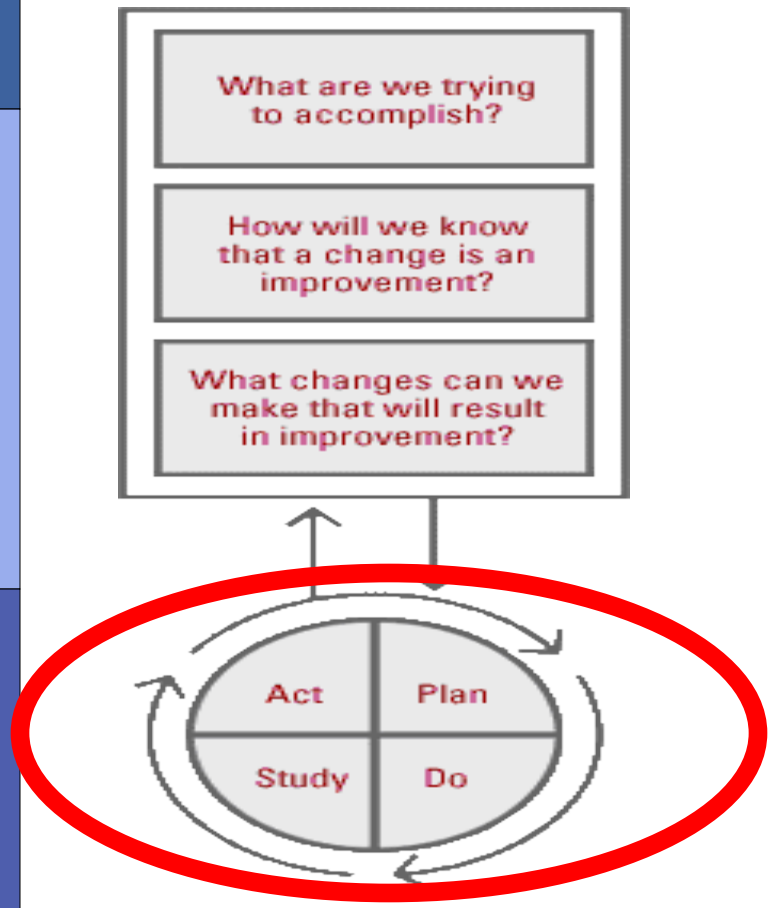
Action orientated activities of IPC

- Aim Statement aligns with the mission and strategic plan
- Care Team “Micro-system”
- The “Green Book” Clinic Self Assessment and Processing mapping- staff/clinical design and flow.
- Through “The Patients Eyes”; Clinic assessment from the Patient’s perspective
- Model for Improvement – PDSA with Rapid Cycle
- Empanelment assignments
- Data reporting

Improving Patient Care

Developing ***care processes*** that apply across multiple clinical and management conditions. Best practices, improvement strategies and methodologies will be developed, tested, and integrated into the health care services provided to be spread throughout the Indian health system.

Model for Improvement



The Plan-Do-Study-Act (PDSA) cycle is a process for testing a change:

(Plan) –develop a plan to test the change,
(Do)- carry out the test,
(Study) – observe and learn from the consequences,
(Act) – determine what modifications should be made to the test.

Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*.
http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Literature/The+Improvement+GGuid+A+Practical+Approach+to+Enhancing+Organizational+Performance.htm

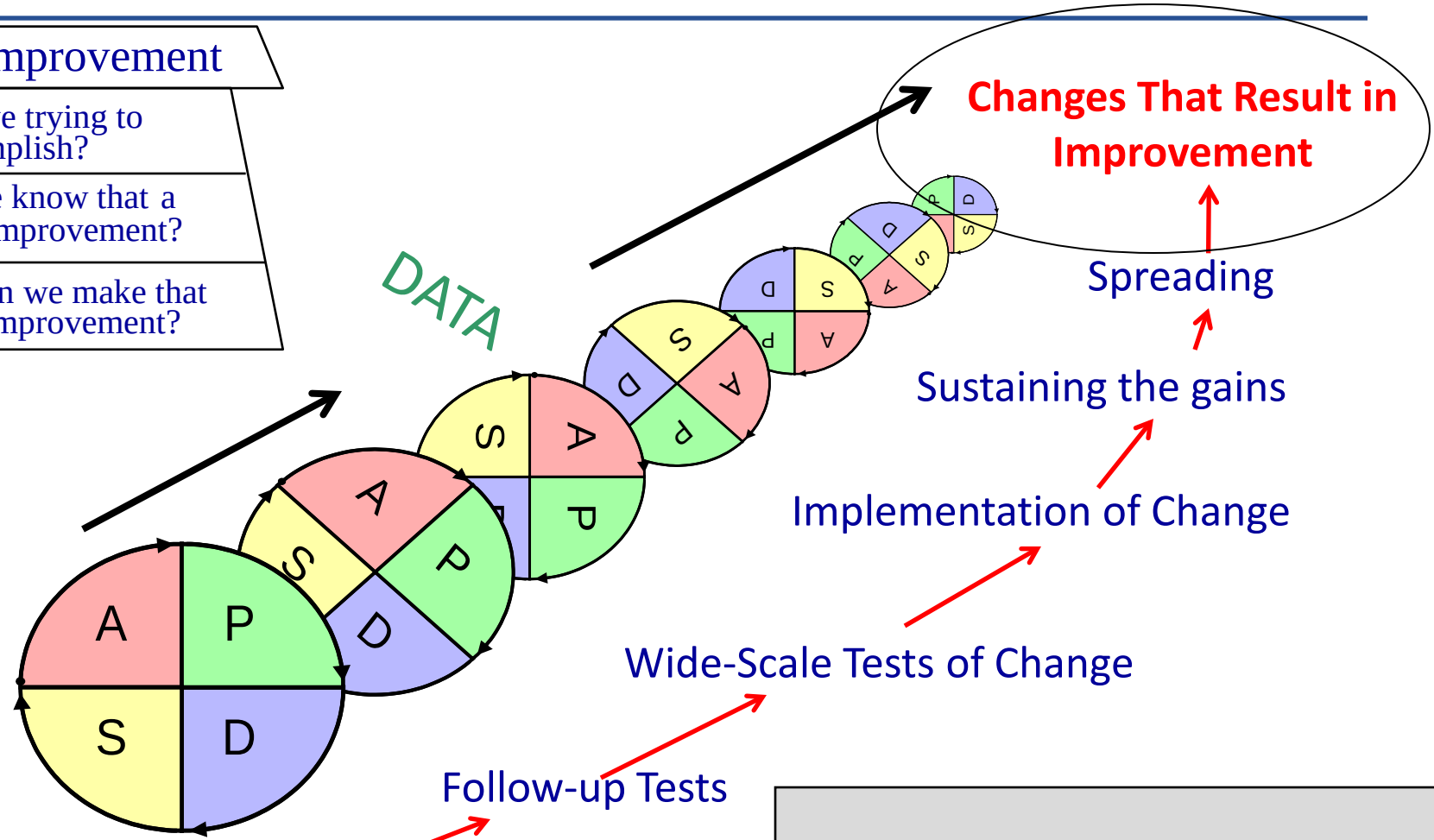
PDSA Cycle for Testing

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Sequential building of knowledge under a wide range of conditions

IPC Indian Health Medical Home

- **Care Centered on the Patient and Family**

  Health programs design their services to put the patient and family at the center of care, to provide great customer service and to support them as they strive toward wellness.

- **Care Team**

  Everyone works in a coordinated way as members of highly functioning teams meeting the needs of the patient.

- **Access and Continuity**

  Every patient has a relationship with a provider and care team, and has consistent and reliable access to that provider and care team.

- **Community Focus**

  Renew and strengthen partnerships with Tribal and community-based health services.

- **Quality and Transparency**

  Everyone in the system has the skills and tools for making improvement, and uses measurement and data to build better care.

Assure Quality of Care

- **Health Care Organization:** Create a culture, organization and mechanisms that promote safe, high quality care among all I/T/U health programs.
- **Community Resources and Policies:** Mobilize community resources to meet needs of patients among all I/T/U health programs.
- **Self Management Support:** Empower and prepare patients to manage their health and health care.
- **Delivery System Design:** Assure the delivery of care is effective, efficient for all care teams.
- **Decision Support:** Promote clinical care that is consistent with scientific evidence and patient preferences.
- **Clinical Information Systems:** Organize patient and population data to facilitate efficient and effective care.

IPC Levels of Measurement

Measurement Domain	Measure Indicators
Adult: **Clinical Process Measures**	**Adult GPRA Measures:** Diabetes Comprehensive Care Cancer-related screenings Immunizations* Health Risk Assessments*
Management and Prevention of Chronic Conditions	**Control Measures:** Control of Blood Pressure Control of Lipids Control of A1c Tobacco Cessation Treatment* Diabetes Care Obesity assessment
Access to Care	Continuity of Care ER/UCC visits 3rd to Next Available
Patient Experience of Care	Customer/Provider/Staff satisfaction survey Single question: *"They give me exactly the help I want (and need) exactly when I want (and need) it."*

Measurement Domain	Areas of Focus/Coverage	Core Measure(s)	Goal	Notes
inical Prevention	Keeping current on preventive screenings	**Health Risk Screening Bundle:** BMI, Tobacco Screening, DV/IPV Screening, Depression Screening, Alcohol misuse screening, Blood Pressure.	80%	
	Keeping current on cancer screening	**Cancer Screening Bundle:** Colorectal Cancer Screening, Cervical Cancer Screening, Breast Cancer Screening.	70%	
anagement and Prevention of hronic Conditions	Control of Blood Pressure Control of Lipids Control of Diabetes	**Outcome Bundle:** Control of Blood Pressure. Control of Lipids, Control of Diabetes.	70%	
	Diabetes Care	Diabetes Comprehensive Care	70%	
	Chronic illness and Cancer Prevention	Tobacco Users (18 and older)		Meaningful Use
		Tobacco Users Cessation Visit in last 2 years	70%	Meaningful Use
osts	Workforce	Staff Satisfaction		Survey Quarterly
atient Experience	Experience and Efficiency	Average Office Visit Cycle Time	45 minutes	
		Patient Experience: Single question with site specific questions		
	Building Relationships for Care	Percent of Patients Empanelled to a Primary Care Provider	90%	
		Number of patients in the Microsystem	See guidance	
		Continuity of Care to a Primary Care Provider	80%	
	Access	Third Next Available Appointment to a Medical Provider	0 days	Weekly
	Patient Activation	Percent of Patients with Self Management Goal Set	70%	

Measurement Domain	Areas of Focus/Coverage	Core Measure(s)	Goal	Notes
Clinical Prevention	Keeping current on immunizations	Pediatric immunizations defined by Meaningful Use (MU: for 2 Year olds 4-3-1-3-3-1 PLUS 4-PCV; 2 Hep A; 2-3 RV and 2-Flu.)	90%	Meaningful Use***
	Prevention of early childhood caries	Fluoride Applications in Pediatric population		
	Physical Activity Level	Physical Activity Screening	70%	
Management of Chronic Conditions				
Costs	Workforce	To be developed: retention		
	Revenue Generation	Revenue Generated by patient visits		
	Productivity	To be developed: Relative Value Units based productivity measure		
	Preventable hospitalizations	AHRQ hospital admission diagnoses as “preventable with optimal primary care” (Prevention Quality Indictors = PQ1, PQ3, PQ5, PQ7, PQ8, PQ10, PQ11, PQ12, PQ13, PQ15)	50% decrease	Data Collection through RPMS
Patient Experience	Building Relationships for Care	Continuity of Care to a Care Team	80%	
	Access	Oral Exams for Diabetes	70%	
		Number of ER and Urgent Care Visits	50% decrease	
	Patient Activation			

Quality of Care

Clinical Process Measures:

Adult Diagnostic and Preventive Care
- Colorectal Cancer Screening (Ages 50-80)
- Breast Cancer Screening (Ages 40-69)
- Cervical Cancer Screening (Ages 21-64)

Immunization rates
- Pneumovax
- Influenza Vaccination

Heart Disease and Cholesterol Mgt.
- Cholesterol Screening Test in CVD

Diabetes Comprehensive care
- HgA1c testing
- Chol (LDL-C) screening Test
- Blood Pressure screening
- Retinopathy exam
- Monofilament foot exam
- Screen for Kidney Disease

Health Risk Screening:
Depression + Alcohol + Tobacco + DV/IPV + BP + BMI

Key Changes

Identified Care team members
Raise the level of workforce development
Evidence Based guidelines
Percent empanelled
Disease specific registries
Reporting Results of change
Sharing of Best practice
Cross train staff
Order sets/protocols
Pre-visit planning
Percent productivity change

Organized Effectiveness of Care teams

"Breakthrough Series"
IPC –"Microsystems" multidisciplinary care team
PDSA rapid cycle
Clinical Flow design
Clinical Decision Support Reporting
Partnership with community based health programs
Delivery system design
Clinical information systems

Access to Care-Intended Outcomes

Access to care Indicators

Improve Continuity of Care
Reduce ER/UCC visits
Reduce No Show rates
Improve Access w/PCP same day
Reduce 3rd to next available
Follow up of care team after Hosp discharge
Reduce re-admission rates
Improve Patient satisfaction

Key Changes

Reduce Back log
Sharing of Best Practices (IPC)
Measure Supply and Demand
Optimize care team
Continuity of Care*
Create contingency plans
Decrease demand for appointments
Managing panel size
Anticipate patient needs
Reduce scheduling complexity
Improve work flow and eliminate waste

Organized Effectiveness of Care teams

"Breakthrough Series"
IPC –"Microsystems" multidisciplinary care team
PDSA rapid cycle
Clinical Flow design
Care mgt
Clinical Decision Support Reporting
Partnership with community based health programs
Delivery system design
Clinical information systems

Patient Experience of Care

Short term Outcome:

Improve cycle times
Reduce waiting times
Improve access to primary care
Increase patient satisfaction
Increase staff satisfaction
Increase health literacy
Patient experience of care score

Key Changes

Patient survey
Interpreters at POV
Link pts to community based health programs- CHR, PHN, DM-program, wellness programs
Self mgt strategies
Educational material=health literacy
Patient wellness handouts
Integration of traditional/Western medicine

Organized Effectiveness of Care teams

"Breakthrough Series"
IPC –"Microsystems" multidisciplinary care team
PDSA rapid cycle
Cultural competency
Self management support
Delivery system design
Decision support

Improvements to IPC Measurement Process

- **IPC Measures Instruction Guide**
  - Step by step guide to generate improvement data
- **Several Measures now programmed into RPMS**
  - Continuity of care (PCC Mgt Reports)
  - Empanelled population (PCC Mgt Reports)
  - CA screening bundle (CRS/iCare)
  - Health Risk Screening Bundle (CRS/iCare)
  - Physical Activity screening (CRS/iCare)
  - PCC Management Reports IPC tab!
- **CRS and iCare**
  - Makes generating improvement data easy!

Future plans for IPC Measures

- Alignment with Meaningful Use Measures
- Measurement set near finalized for IPC3 and IPC Learning Network
  - Reduce measurement complexity for improvement teams
- Move all measures into iCare
  - Run charts to plot data over time

Quality and Innovation Learning Network (QILN)

- Continue to spread the change improvements across site.

- Participate in one or two of the following intensive;
  - Care Coordination
  - Advanced Access
  - Mobilize Tribal and Community based health programs
  - Behavioral health integration within the primary care setting
  - TeleHealth Blood Pressure monitoring to improve control
  - Self Management support

Improvement Support Teams (ISTs)

- Expansion of the IPC Program to 100 sites in the next 3 years will require a National infrastructure for improvement in care.
- The 12 Area IST's were created to strengthen the capacity and infrastructure of the Areas to support spread and sustain improvement among the IPC sites throughout the Indian health system.
- ISTs will engage frontline staff in the work of IPC sites and provide leadership support to enhance their capacity to support improvement in the field.

Improvement Support Team Expectations and Goals Part 1

Provide annual plan-identify members and leadership sponsor; including

- Plan to support participating Tribal IPC sites.
- IPC Knowledge and skills self assessment of IST members and composite team assessment
- Address resources and support needs identified by participating IPC sites.

Balancing measure; IST to incorporate into plan from IPC

- Participating IPC sites will assess the support provided by Area IST.
- National IPC team will track participating IPC sites from each Area.
- National IPC team will track and report on the spread of IPC Medical Home within Area.

Improvement Support Team Expectations and Goals Part 2

Through the course of the year, Area ISTs will be asked to:

- Assess the progress of all IPC on a quarterly basis with a standard assessment process that uses IPC team reporting as the primary data source.
- Provide these assessments to the IPC National Team and Tribal Health boards.
- Provide support for the spread of the IPC Medical Home from micro-system to all of the departments and health program services within the facility and Area.
- Support recruitment participation of new sites into IPC and spread of IPC improvement methods among I/T/U health programs within your respective Area.

Improvement Support Team Expectations and Goals Part 3

Through the course of the year, participation/representation of IST members in:

- Web-Ex seminars: 1-hour action period calls every two weeks
- Attend IPC learning sessions of new participating sites
- Participate in IST trainings
- 1 hour IST leadership calls twice a month
- As IPC faculty in improvement and engage in areas of subject matter expertise

Foundation Series Purpose

- To provide an avenue of web-based educational opportunities highlighting the knowledge gained from former IPC teams who have joined our quest to change and improve the Indian Health system.
- To provide the groundwork necessary for active engagement in the IPC Collaborative.

Foundations Series Goals

- To share new ideas and methods useful in the improvement of healthcare delivery.
- To provide innovative practices designed to change the way healthcare is experienced by patients, families, and communities.
- To prepare Indian Health system organizations for participation in the IPC Collaborative.

Foundation Series

- The content of the IPC Foundations Series is organized within three fundamental areas:
- Comprehending the experience of care for our patients, families and communities;
- Engaging leadership in high quality healthcare processes;
- Working toward further advancement of health for all American Indian and Alaska Native people.

IHS National IPC Team

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