



Best Practices Conference 2009

November 3, 2009



What are we talking about?



- Care Model
- Specific Changes
- Model for Improvement
- Foundations Series
- Indian Health Council story

Changes Represented in Skit

- The Voice of the Community
- The Microsystem
- Assessment
 - The Green book
- The Care Team
- Communication Plan
- Empanelment for Improvement
- Clinical Information System
- Access and Continuity
- The Pre-Visit
- Clinic Efficiency
- Self-Management
- Behavioral Health Integration

Care Model for the Indian Health System



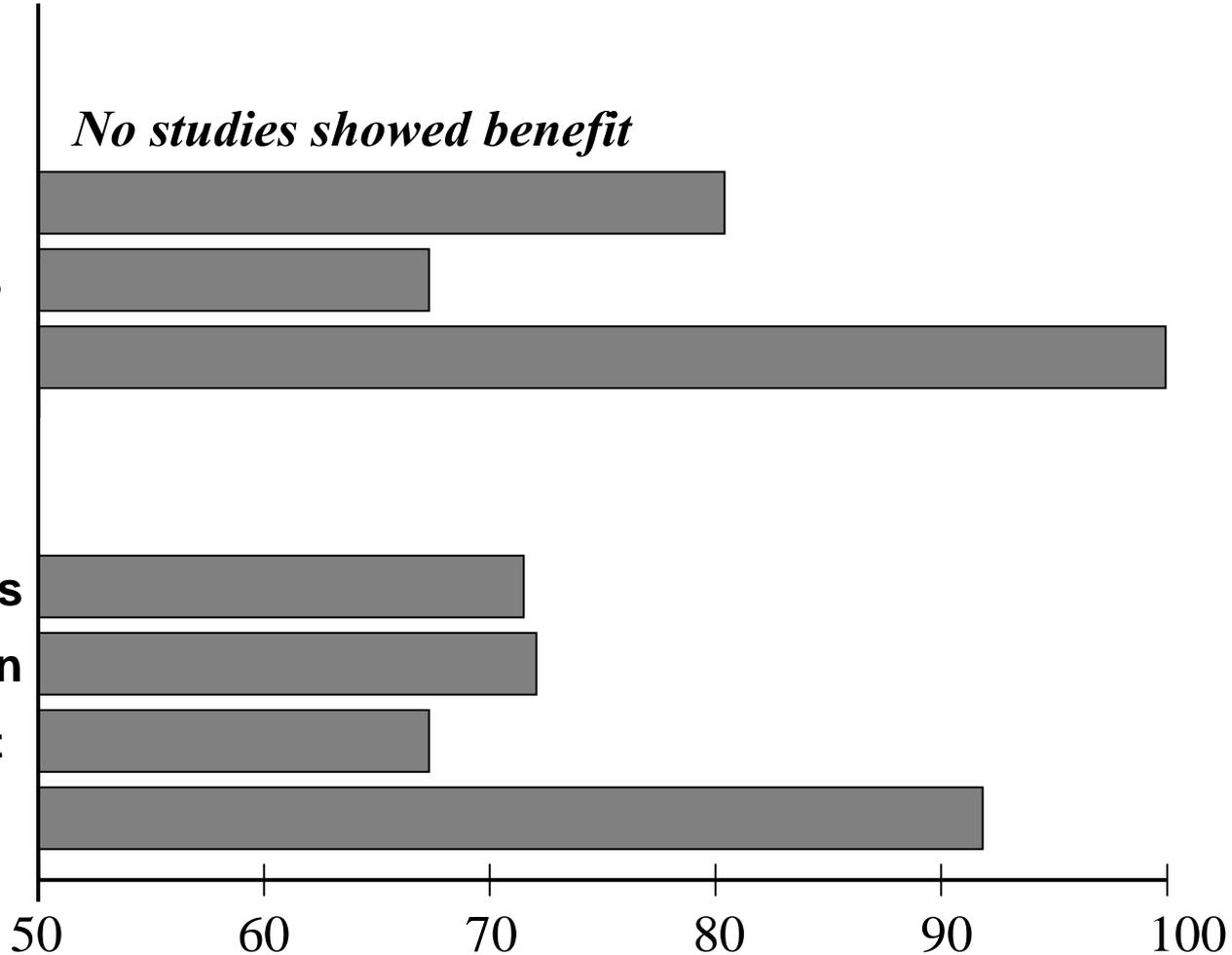
Prewrite/Early	Early-Mid	Later Changes
<p>LEADERSHIP ENGAGEMENT Engage leadership; Identify sponsor who embraces their role</p>	<p>THE CARE TEAM Identify and develop the care team, optimizing the roles of the care team , patients and families, and including the CHR, PHN, DM program in changes to patient care</p>	<p>SPREAD Develop plan for spread</p>
<p>THE VOICE OF THE COMMUNITY Involve and engage the community</p>	<p>COMMUNICATION PLAN Develop mechanisms to keep the community and staff informed</p>	<p>EFFICIENCY Increase value added time of all processes</p>
<p>THE MICROSYSTEM Identify the Microsystem /Target Population</p>	<p>EMPANELMENT FOR IMPROVEMENT Empanel patients to achieve continuity and improve outcomes</p>	<p>CARE BETWEEN VISITS Care management integrated into care team</p>
<p>ASSESSMENT Assess the microsystem, using the Green Book (revisit intermittently)</p>	<p>CLINICAL INFORMATION SYSTEM Optimize the CIS, using it for reminders, prompts, queries, etc</p>	<p>SELF-MANAGEMENT Empower the patient and family members by embedding self-management support processes in care</p>
<p>THE AIM Develop organizational Aim, including some initial plans relating to spread</p>	<p>ACCESS AND CONTINUITY Develop mechanism to ensure access to care and support continuity</p>	<p>BEHAVIORAL HEALTH INTEGRATION Integrate behavioral health</p>
<p>STRATEGIC ALIGNMENT Link IPC aim and goals to the organizational strategic plan</p>	<p>TRANSPARENCY OF IMPROVEMENT Make quality related data available to all (transparency)</p>	

Studies evaluating chronic care model in diabetes

By number of elements

- One element
- Two elements
- Three elements
- Four elements

No studies showed benefit



By type of element

- Clinical information systems
- Delivery system design
- Decision support
- Self-management

Percent of studies showing outcome benefit

Studies on HTN outcomes

A review of quality improvement strategies in hypertension finds that interventions that include **team care** are associated with the greatest improvement in blood pressure outcomes. Here, team care is defined as the “assignment of some responsibilities to a health professional other than the patient's physician.” Other strategies that proved effective include **patient education and self-management support**.

Walsh JM, McDonald KM, Shojania KG et al.
Quality improvement strategies for hypertension management: a systematic review. *Med Care* 2006; 44(7):646-57.

Customer/Owner Listening

Not just one method of listening

- Personal interaction with staff
- Group visits
- Comment cards
- Customer Satisfaction surveys
- Organization internet
- Annual Gathering
- 24- hour hotline
- Annual Listening Conference
- Governing board
- Advisory committees
- Focus groups
- Service agreements

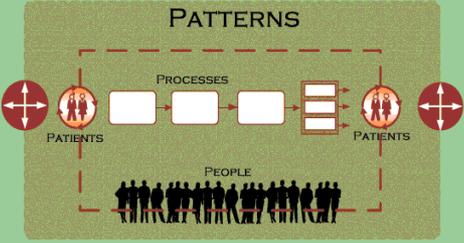
The Greenbook (ADT) & 5P Wall Chart

Greenbook (ADT) (collecting the facts)

5P Wall Chart (summarizing the insights)

 IdealizedDesign™ of Clinical Office Practices
IMPROVING CLINICAL OFFICE PRACTICES AND OUTCOMES

ASSESSING YOUR PRACTICE "THE GREEN BOOK"



PATTERNS

PROCESSES

PATIENTS

PEOPLE

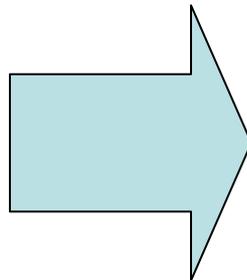
"KNOW YOUR PATIENTS"

"KNOW YOUR PEOPLE"

"KNOW YOUR PROCESSES"

"KNOW YOUR PATTERNS"

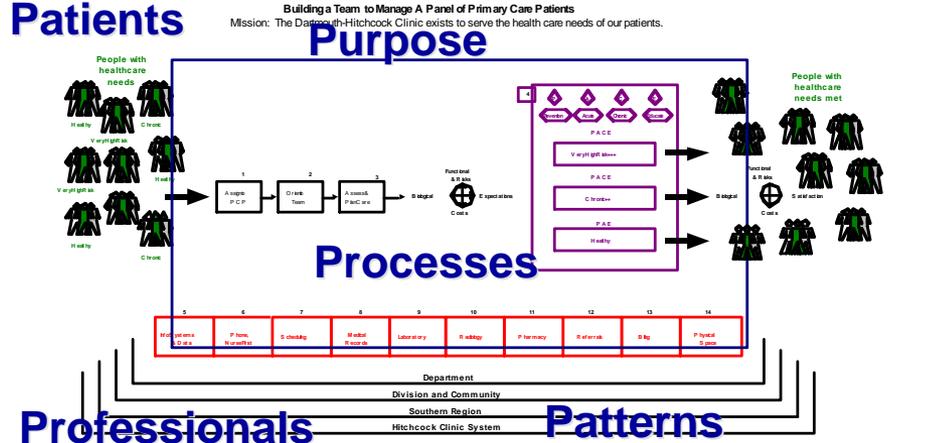
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Building a Team to Manage A Panel of Primary Care Patients

Mission: The Dartmouth-Hitchcock Clinic exists to serve the health care needs of our patients.

Purpose



Patients

Processes

Professionals

Patterns

Measure	Current	Target	Measure	Current	Target
P and A visit			E and A visit		
D and P visit			P and A visit		
N and P visit			A and A visit		
Team visit			S and A visit		

Department
Division and Community
Southern Region
Hitchcock Clinic System

TEAM MEMBERS:

Nashua Internal Medicine		
Sherman Baker, MD	Missy, RN	Amy, Secretary
Leslie Cook, MD	Diane, RN	Buffy, Secretary
Joe Karpicz, MD	Katie, RN	Mary Ellen, Secretary
Deb Unquart, NP	Bonnie, LPN	Kissy, Secretary
Ron Carson, PA	Carole, LPN	Chariene, Secretary
Erica, RN	Nancy, LPN	
Laura, RN	Mary Beth, MA	
Maggi, RN	Lynn, MA	

SWH Mx MDs 28 RNs 68 NP/PAs 2 MA 44 LPN - SECs

Micro-System Approach 6/17/98
Revised: 1/27/00

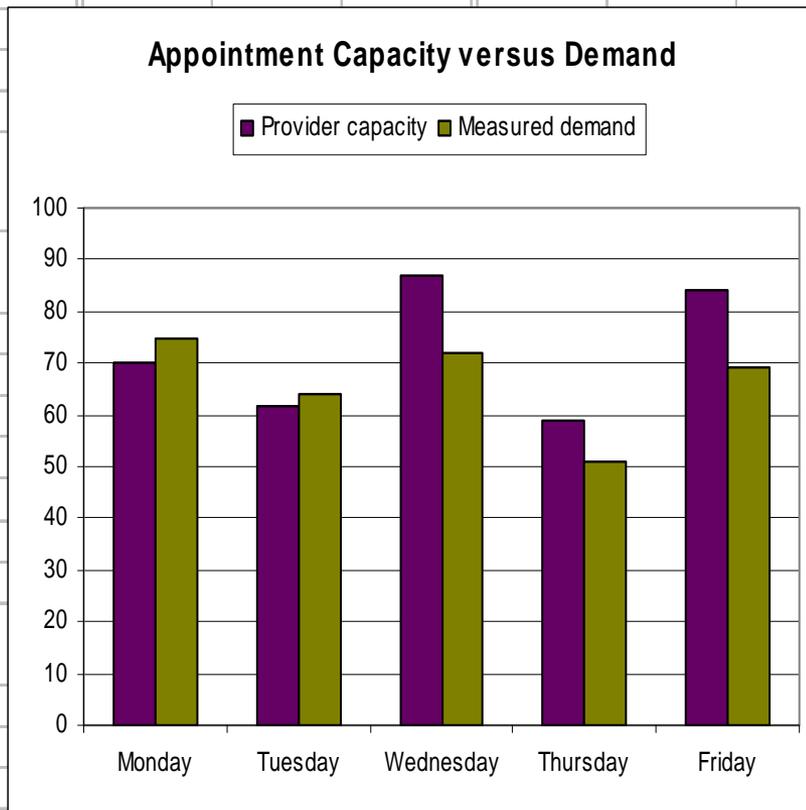
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Measured demand	Calls for visits	Other external demand	Internal demand	# appt per day
Monday	44	2	29	75
Tuesday	34	5	25	64
Wednesday	29	8	35	72
Thursday	30	3	18	51
Friday	37	1	31	69

Provider capacity	# appt per day
Monday	70.125
Tuesday	61.5
Wednesday	87
Thursday	58.875
Friday	84

VISIT RATE	Visits per hour
Provider A	3
Provider B	3
Provider C	2.25
Provider D	3
Provider E	3
Provider F	3

HOURS per session	Mon AM	Mon PM	Total	Tues AM	Tues PM	Total	Wed AM	Wed PM	Total	Thu AM	Thu PM	Total	Fri AM
Provider A	3.5	4	22.5		4	12	3.5	2	16.5		4	12	3.5
Provider B			0	2.5	3	16.5	2.5	3	16.5			0	2.5
Provider C	2.5	4	14.625			0		4	9	3.5	4	16.875	



If Demand is Greater than Supply

Four Options

1. Work harder ?
2. Delay the work ?
3. Buy more supply ?

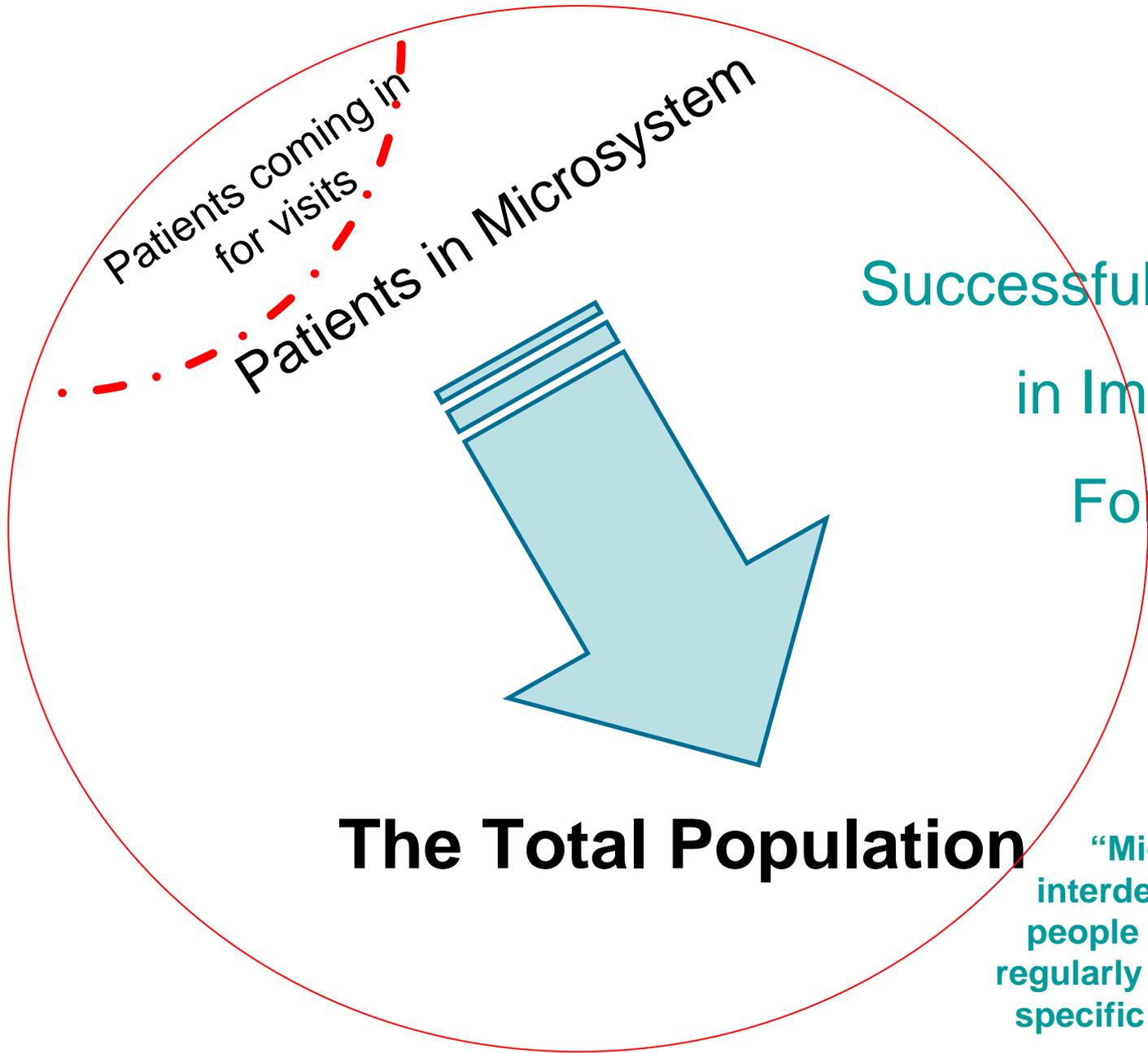
4. Do the work differently

- Shape Demand
- Eliminate duplicate visits
- Care Team development
- leverage the work
- Extend visit interval
- Promote Continuity
- Max Pack
- Simplify Appt types and times
- Nurse Appts
- Phone Appts
- Improve Access to reduce No Shows and capture that Supply
- Spread

IPC 2

- Care Team





Successful Progression
in Improving Care
For Populations

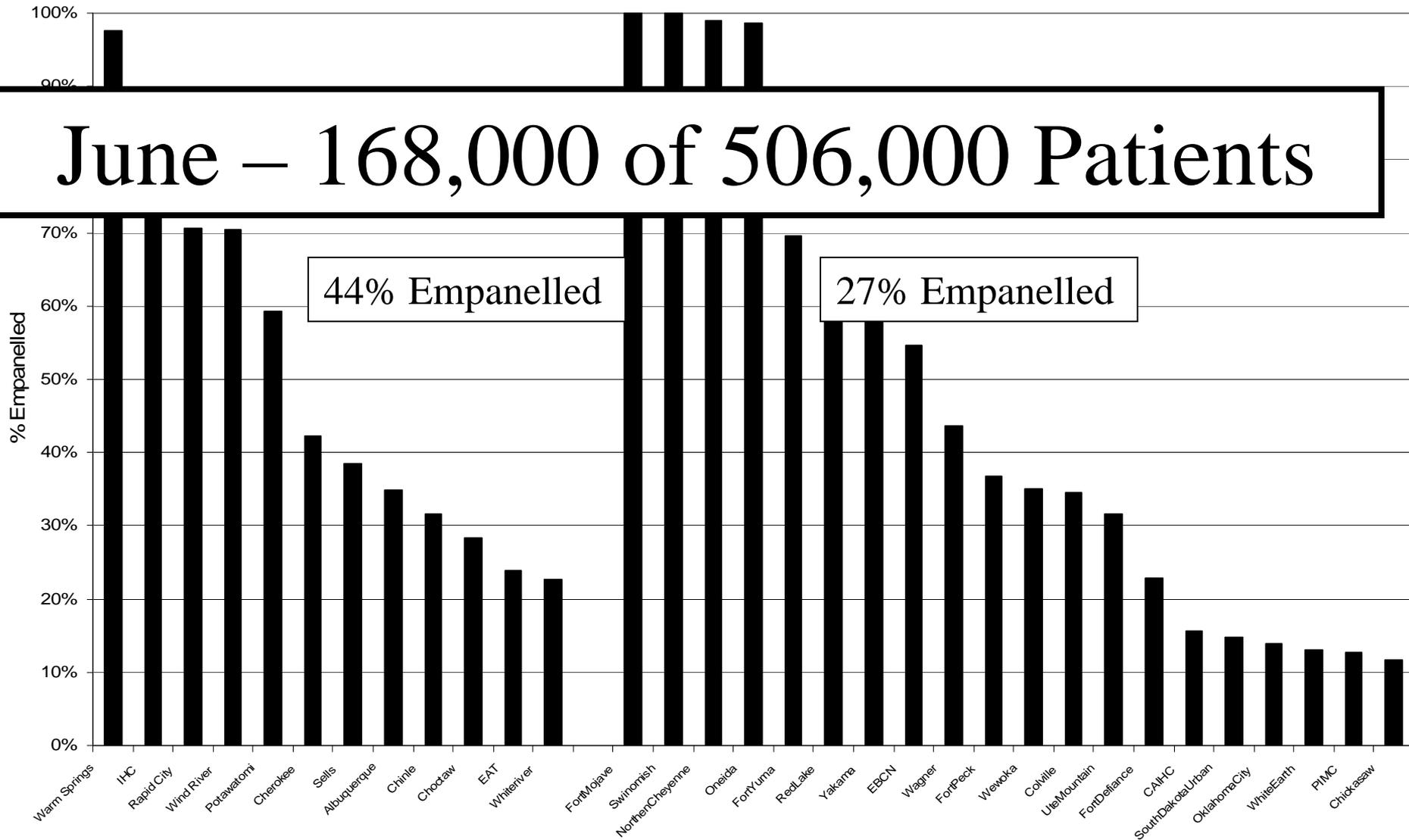
The Total Population

“Microsystem”: small, interdependent groups of people who work together regularly to provide care for specific groups of patients



% of Patients with a Primary Care Provider designated in CIS

June – 168,000 of 506,000 Patients



Clinical Information Systems

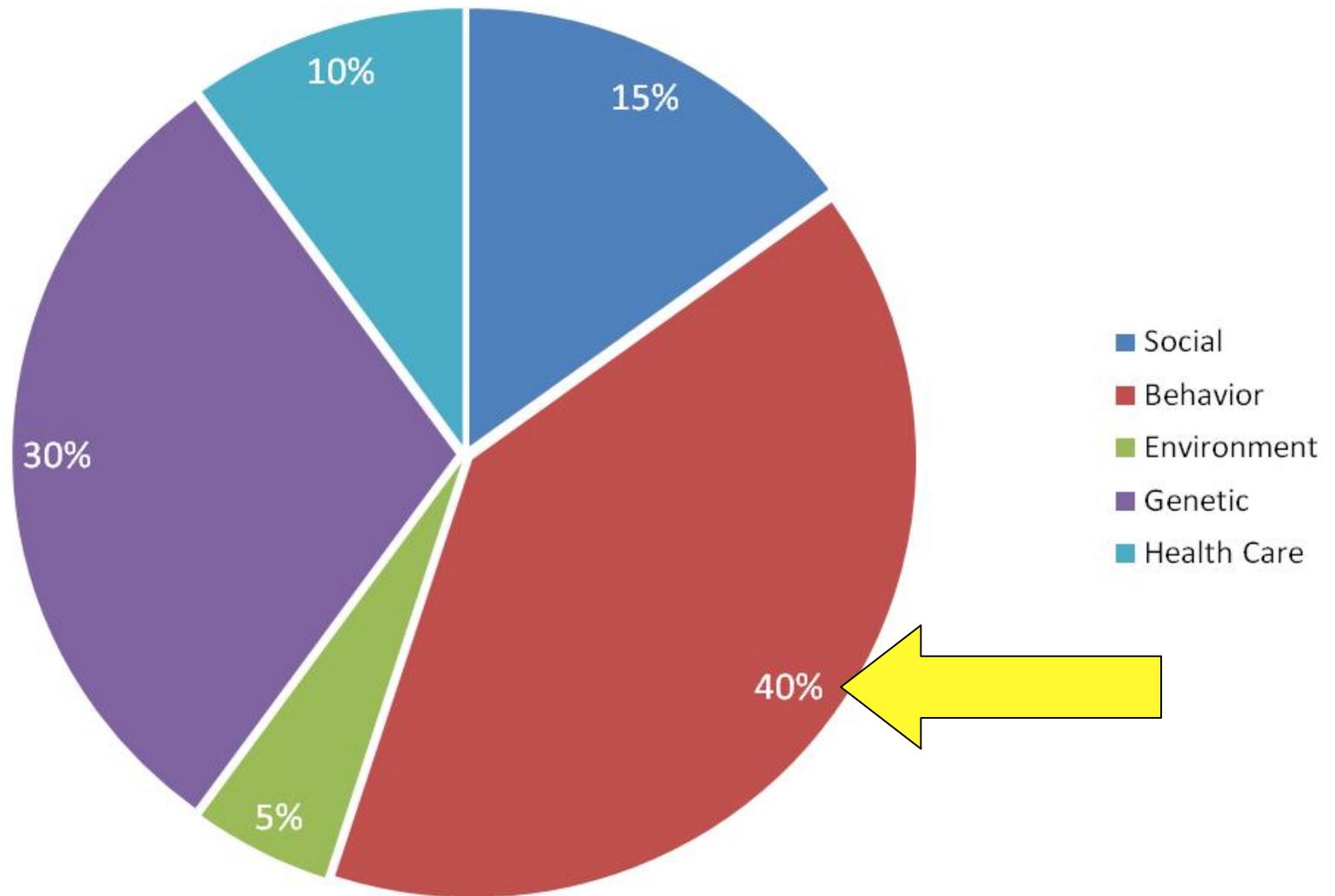
- General principles of using CIS for patient care quality improvement
 - Whole patient proactive care planning
 - Planning for population based care
 - Improvement methods for care teams, PCPs, QI

What is Self-Management Support ?

“The assistance caregivers give *patients* so that they can manage their conditions on a day-to-day basis and develop the confidence to sustain healthy behaviors for a lifetime.”

T Bodenheimer, et al. Helping Patients Manage their Chronic Conditions. Available at <http://www.chcf.org>

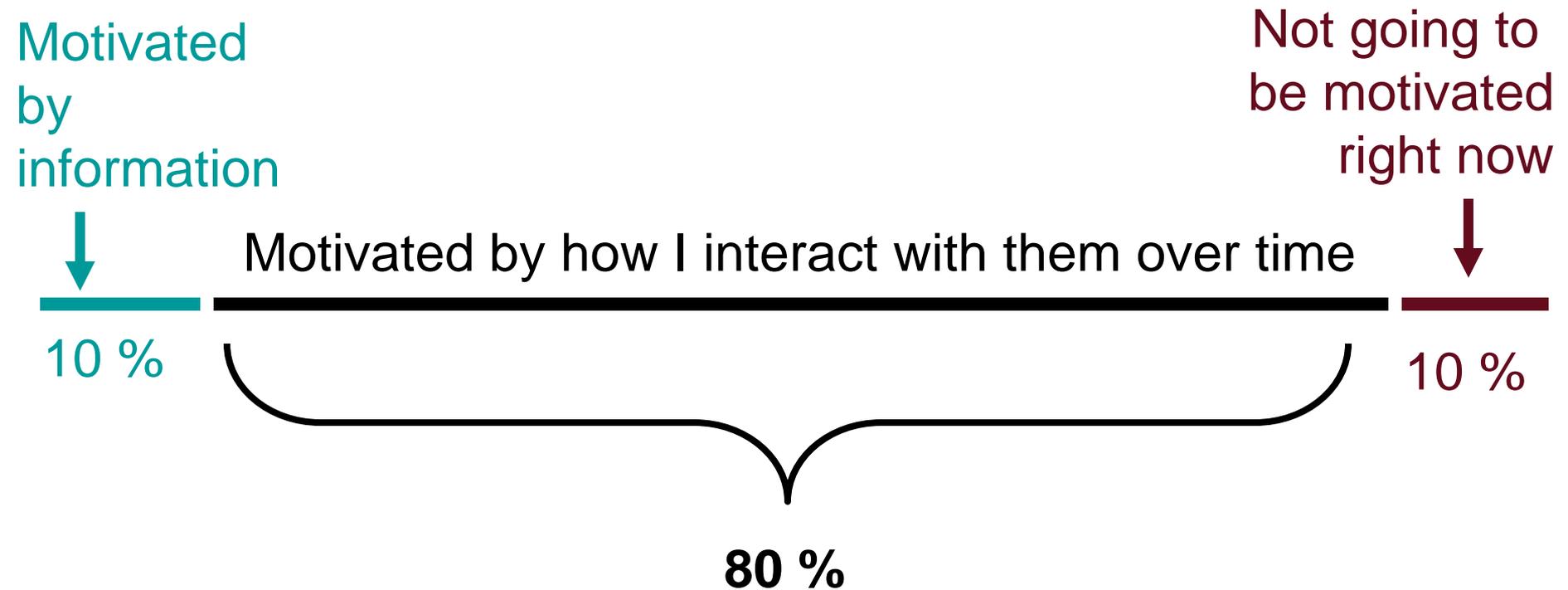
The Leading Determinants Of Health



Slide courtesy of IHI

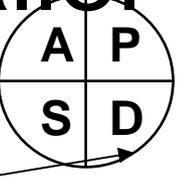
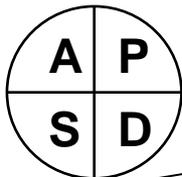
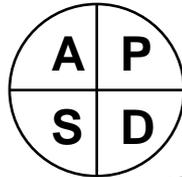
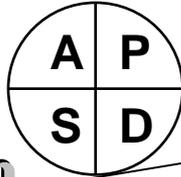
Source: McGinnis, JM et al Health Affairs
Apr2002

The truth about motivation...

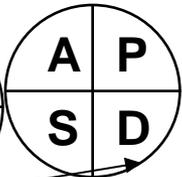
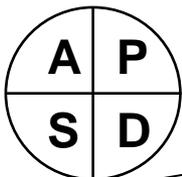
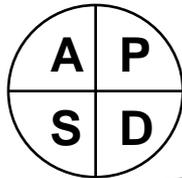
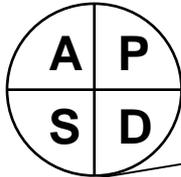


Testing in Parallel

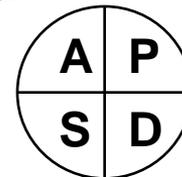
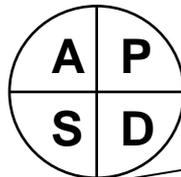
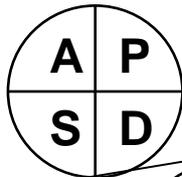
Care Team



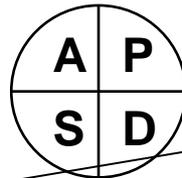
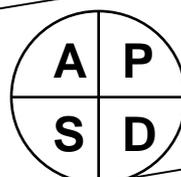
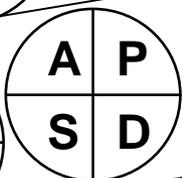
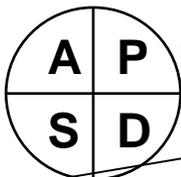
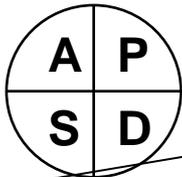
Cycle Time



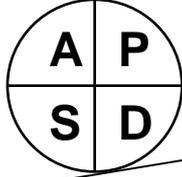
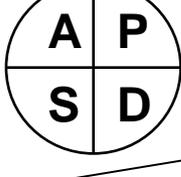
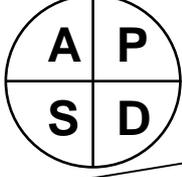
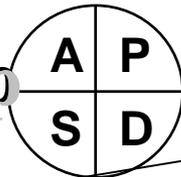
Self Mgt



Guidelines



Leadership Support

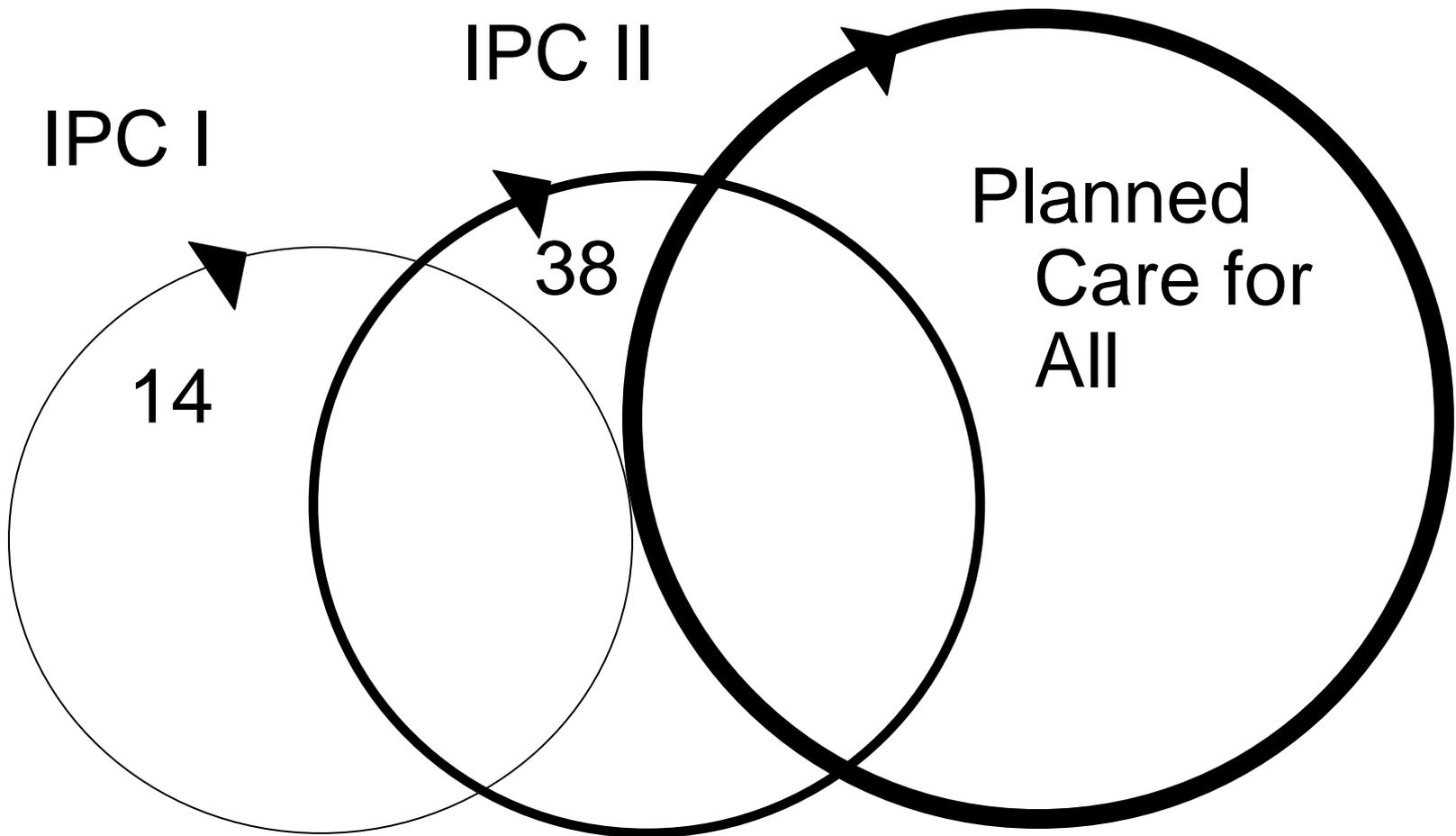


Testing Implementation..... Spread

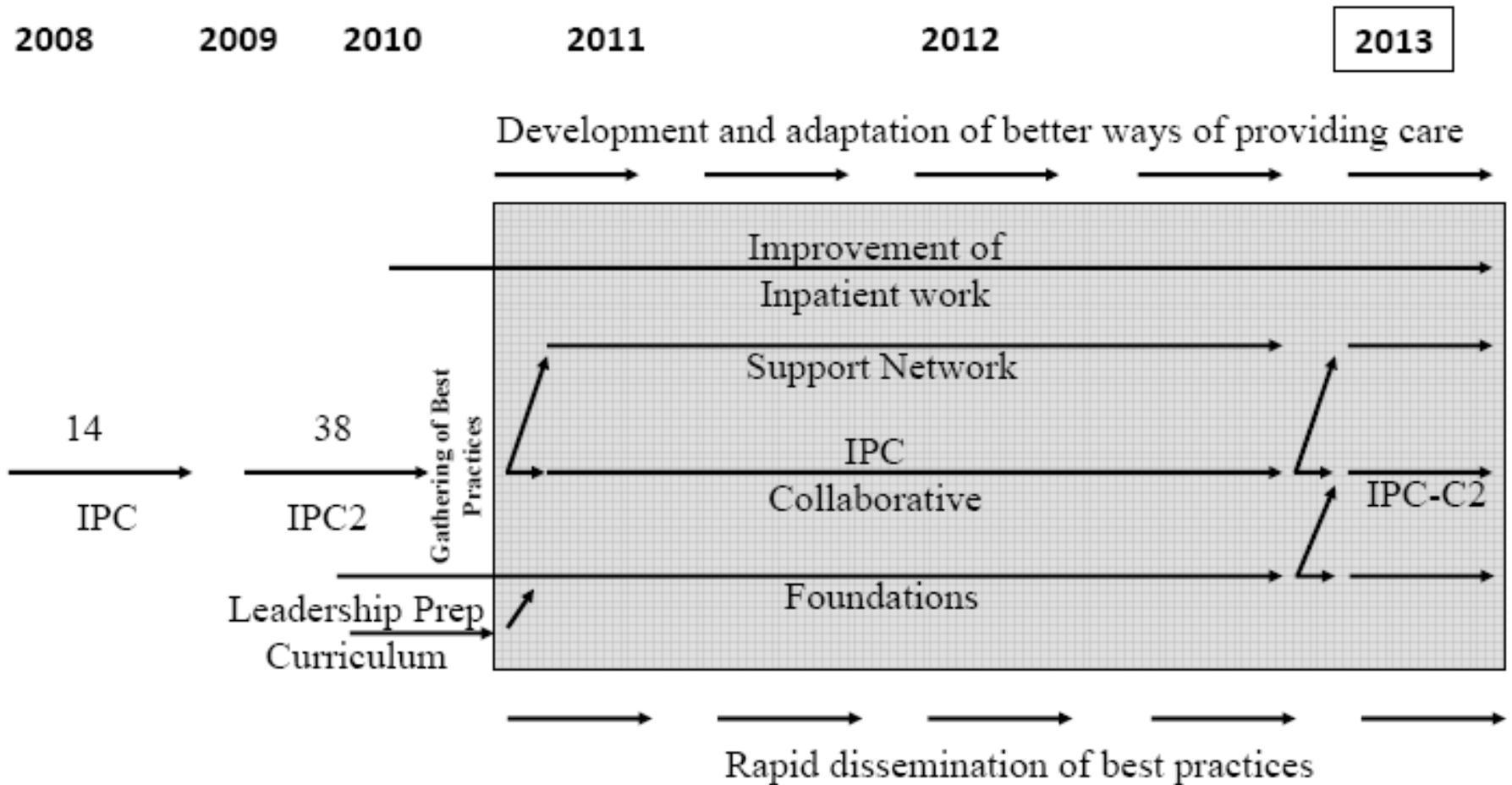
Aim:
Improve
Health,
wellness
of
AI/AN
people



Improving Patient Care Initiative



Improving Patient Care Initiative



IPC Foundations Series

- Series of Web-based seminars to lay the foundation for engagement in the Improving Patient Care collaborative.
- hands-on learning
- prepare participants with tools and approaches that they can use in their outpatient settings.
- Built on the learning of the IHS, Tribal, and Urban pilot sites in the IPC Collaborative
- 3 crucial topic areas:
 - Understanding the experience of care for our patients and community
 - Working toward the health of a defined group of patients
 - Leadership for high quality health care

Improving Team Communication Experiences of Indian Health Council



Objectives

- Identify the value of effective and efficient team communication and its impact on access, processes, and outcomes.
- Describe the key elements of optimizing communication within the care team.
- List important information to have available at the time of your team huddles.

High Leverage Changes for Office Efficiency

- Balance capacity and demand for all processes
- Synchronize patient, provider, and information
- Predict and anticipate needs
- Optimize rooms, equipment, technology
- **Optimize the care team**
- **Listen to your community – what do they want and expect!**

Optimize the Care Team

Changes for Improvement

- Cross Train Staff
- Reduce Variation in Provider Styles – Standardize!
- **Use Team Communication Methods**
 - Walkie Talkies
 - Electronic Tasking
- Ensure that Clinicians and Staff Work to Their Highest Level of Experience, Skills, and Licensure
- Establish Standard Protocols to Move Work Away from the Provider

IHC Before Huddle

- No Teams/No Empanelment
- Providers, Nurses and MA's all housed in separate areas
- Poor communication between staff within the medical department and intradepartmental
- No continuity of care
- Community frustration – repeatedly having to tell their story
- Lack of interdisciplinary integration
- Staff reluctance
- Resulted in missed opportunities to CARE for the client

Huddles: Getting Started

- Start huddles with a small goals and grow the work as the huddling team gains proficiency.
 - For example, in their huddles, teams can discuss:
 - what patients on the schedule are unlikely to come (in the hospital, just called, were just seen last week)
 - what equipment will be needed in the room
 - What screening and testing is due
 - what extra things can we do for the patient today to make a re-visit less likely.
 - Identify which members of the team can perform various tasks and testing
 - By working as a team – huddle becomes the platform to anticipate needs and improve patient care.

IHC Huddle Development

- Move staff – IHC created Care Teams (1,2,3) – despite space constraints - Creativity a must!!
 - Teams moved together to improve communication and to use all resources to top to their license.
 - Everyone brings their expertise to the huddle!!
 - Everyone is trained to look for ways to improve standards of care (Mammography, Paps, labs etc.)
 - **Now the work Begins**



Care Team Huddle At IHC

- Team One

Mary Jo Strom, FNP

Cindy Adriano, PA

Regin Baysa, RN

Valarie Boyle, MA

Irene Garcia, MA

Aliesha Hulett, MA-Xray

Community Health Rep

Behavioral Health

Integrati



The Huddle Expands and Dental Gets on the Bus



What Tools Can We Use?

- Manual Huddle Sheet
- RPMS Health Summary
- iCare – Electronic reminders for those without EHR
- EHR Reminders
- Check Out Reminders (With practice – staff become comfortable in new rolls– there is less reliance on the tools – as chart review becomes the standard)

CONFIDENTIAL PATIENT INFORMATION - [10/12/2008 12:22 PM] - [N] Reminders for: DEMO,FEMALE ('111111-HIC)

Category	T	Next Due	T	Reminder Date	T	Due Date	T	Next Due	T	Last Due On	T
HEALTH SUMMARY / General	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y
GENERAL	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y
WEIGHT	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y
IMMUNIZATIONS	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y
BEHAVIORAL HEALTH / DEPRESSION SCREENING	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y
GENERAL	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y
BLOOD PRESSURE	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y
DIABETES RELATED	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y
BEHAVIORAL HEALTH / ALCOHOL USE SCREENING	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y
ELDER	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y
DIABETES RELATED	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y
BEHAVIORAL HEALTH / BONE DENSITY SCREENING	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y	10/11/08	Y

Page 1

Please go to the front desk and make the following appointments before you leave the clinic today:

Podiatry / P.T. / Ultrasound—Dr. Tran
 Acupuncture—Ann Baily
 Chiropractor—Dr. Vertrees
 Ophthalmology
 Optometrist—Leanne Aguilar
 Social Worker—Nancy Spence
 Cardiology—Dr. Smith
 Dental
 Lab Work—Fasting / Non-fasting
 Mammogram
 OB/GYN
 Nutritionist—Jina Mitchell
 Exercise—Angelina Renteria
 General Physical / WCC / Immunizations
 CPE w/ Pap / Pelvic
 Peripheral Artery Disease Clinic—Dr. Allison
 Regular Follow-up reason _____

Sent by: D. Calac E. Calac Moses Venegas
 Pallante Davidson McFerran Smith
 Allison

Date _____

Patient Name _____ Date of Birth _____

Huddle Sheet

Routine Health Maintenance	Date	Date
Physical exam		
EKG		
Pap / Pelvic exam		
Breast exam		
Mammogram		
Rectal exam / guaiac		
Ophthalmology?		
Dental?		
Podiatry? (Please INSPECT feet)		
Screen for Neuropathy		
Labs		
Accu✓ / HgbA1c		
TSH / LFTs		
Serum Creatinine		
UA (if +, do micro)		
Microalbuminuria		
Cholesterol profile		
Pregnancy test / Depo		
Immunizations		
Flu D/TaP Hep A / B HIV IPV MMR PCV PPD Td Varicella		
Special Aspects of DM Care		
SBGM?		
Depression?		
Anti-platelet therapy?		
Tobacco use ETOH use Drug use DV		
Classifying DM		
Self care education/Referral		
Nutrition Diabetes Ophthalmology Podiatry		
Foot Inspection Ed. Glycemic Control Ed. Dental		
Comm. Health Human Svcs. Outside Referral		
Name: _____ DOB: _____		

GPRA Huddle Sheet

Routine Health Maintenance	Date	Date
Physical exam (exam, see notes)		
EKG (exam, see notes)		
Pap / Pelvic exam (exam)		
Breast exam (exam)		
Mammogram (exam, see notes)		
Rectal exam / guaiac (exam)		
Eyes? (exam, dental, ophthalmology, both done)		
Teeth? (exam)		
Feet? (exam)		
Neurology screen (exam)		
Labs		
Accu✓ (exam, see notes) / HgbA1c (exam)		
TSH / LFTs		
Serum Creatinine (exam)		
UA (if positive, do micro) (exam)		
Microalbuminuria (exam)		
Lipid profile (exam)		
Pregnancy test / Depo		
Immunizations		
Flu (only Hep B (immunize) PCV (if 5 yrs) PPD (once per 5y) Td (if 10 yrs)		
Special Aspects of DM Care		
SBGM?		
Depression?		
Anti-platelet therapy? (exam, exam)		
Tobacco use ETOH use Drug use DV		
Classifying DM		
Self care education/Referral		
Nutrition Diabetes Exercise Glycemic Control / Ed.		
Ophthalmology Foot Inspection Ed. SBGM		
Dental Podiatry Community Health Human Svcs		
Outside Referral		
Name: _____ DOB: _____		

Huddle Table Top Exercise

10-15 Minutes

- Scenario – 58 year old diabetic female presents for a 15 minute appt for a rash x 2 days.
- How many deficits are there and what will you accomplish in today's visit.
- Have each group review the chart –
 - Anticipate needs
 - What standards of care are needed for this indiv
 - Acute/Chronic conditions

Answers

- **At least 15 deficiencies**
 - Physical due, Mammo due, Pap due, A1C due, EKG due, PPD due, Eye exam due, complete foot exam due, flu shot, depression screenings, dental exam, Med Ed, Diet and Exercise Ed, Colonoscopy
 - Ck med sheet for ACE, ASA, Lipid Lowering meds, and all DM meds.
- **What can we do Today in a 15 min visit**
 - Update vaccines (flu and PPD), Depression Screen, A1C and EKG (protocol), review meds
 - Set up appts for CPE, Mammo, Dental, Colonoscopy, Ophthalmology, Podiatry, DM Clinic to include Nutrition and Exercise Ed, PAD/Cardiology clinic. (All clinics housed in PCP setting except Dental)

Those that Complete Our Team

“THE Big Team”



QUESTIONS????

- Contact Information:
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cnyquist@indianhealth.com