



# The New and Improved, Improving Patient Care

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Chief Medical Officer



*The care Indian people choose when they  
have many choices.*

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**Dr. Roubideaux**

National Combined Councils Meeting



# IHS Priorities

- To renew and strengthen the partnership with Tribes and improve the tribal consultation process.
- To bring reform to the IHS in the context of national health insurance reform.
- To improve the quality of and access to care.
- To have everything we do be as transparent, accountable, fair and inclusive as possible.



# Outline

- Brief history of IHS collaborative
- Reasons for change
- Re-tooled model/ areas of emphasis
- Effective relationships
- Patient-centeredness
- Changing the healthcare organization



# History

- In 2004, then IHS Director, Dr. Grim announced three clinical initiatives
- One of these was the Chronic Care Initiative (CCI)



# History

- Rationale for CCI Implementation:
  - Recognition that most of the disease burden in the IHS has shifted to chronic diseases such as diabetes, cardiovascular disease, cancer, COPD, etc
  - IHS had made significant progress in diabetes care, a prototype for CCM
  - Build on strengths of existing population health approach, robust health IT system and metrics



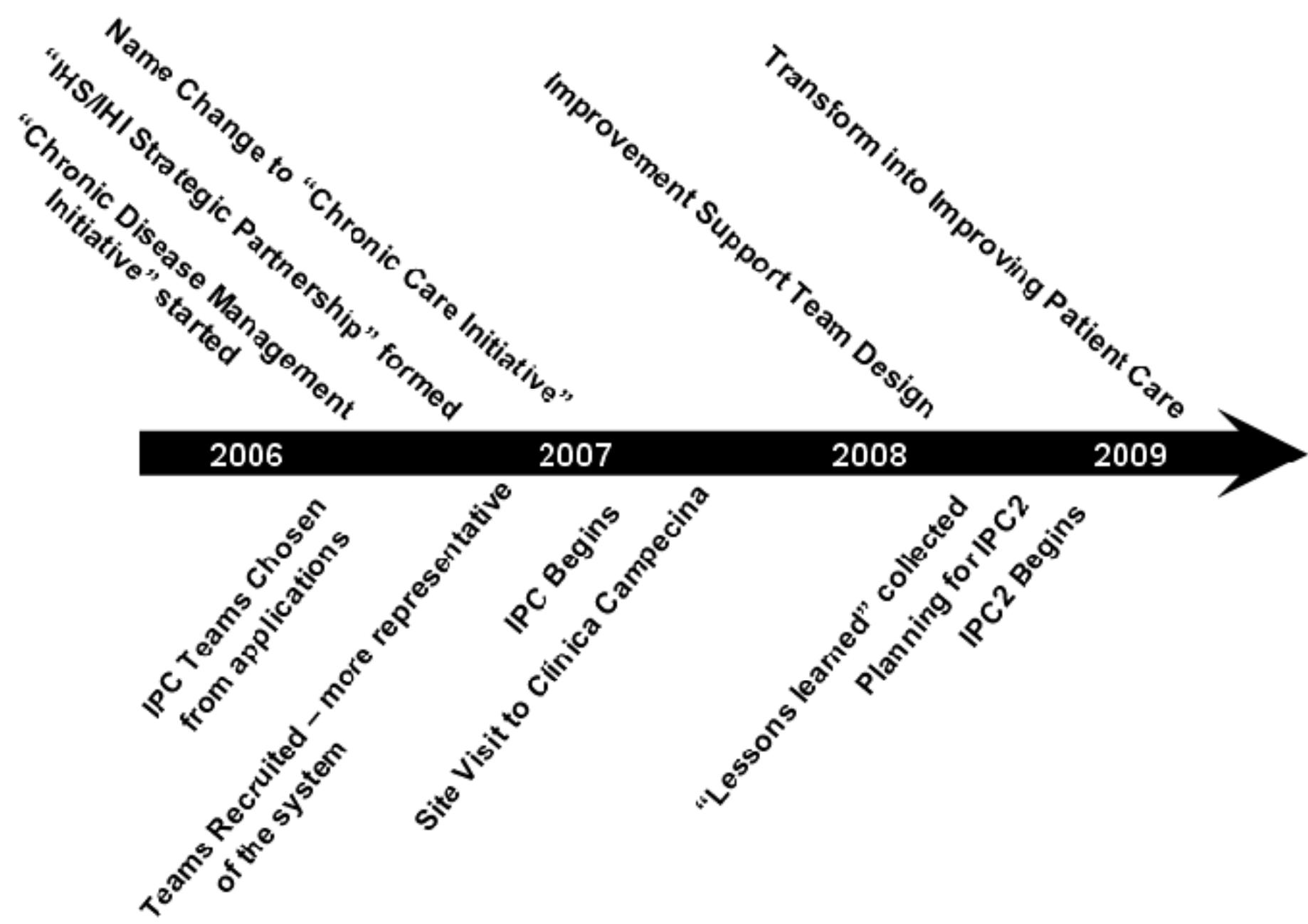
# History

- In 2006, the IHS entered into a business relationship with the Institute for Healthcare Improvement
- The aim of which was to guide the IHS through major, comprehensive healthcare improvement



# Purpose: The Triple Aim of IPC

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.





# Reasons for change

- Desire to build on existing strengths of IHS, and recognize other efforts

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- Vocabulary of previous collaborative difficult
- Need to make collaborative “our own” after expiration of contract with IHI



# Improving Patient Care

- Clarifying the purpose
- Simplifying the language
- Develop a plan to create internal I.H.S. capacity to lead and conduct (and institutionalize) this initiative
- Examining the impact to date
- Strengthening the evaluation based on a clear logic model.

# Improving Patient Care Transitions



## Indian Health Home

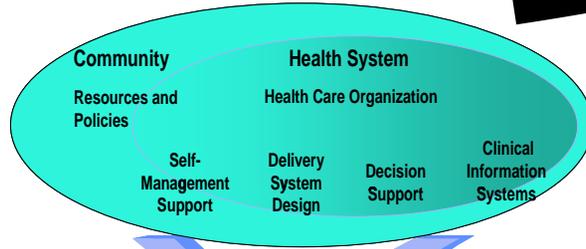
- Access and Continuity
- Care Centered on the Patient and Family
- Care Team
- Community Focus
- Quality and Transparency

Meaningful Use of the IHS Clinical Information System (or similar capabilities) is essential for making the changes of IPC.

IPC2

<b>LEADERSHIP ENGAGEMENT</b> Identify leadership; Identify sponsor who takes their role	<b>THE CARE TEAM</b> Identify and develop the care team, optimizing the roles of the care team, patients and families, and community programs	<b>SPREAD</b> Develop plan for spread
<b>VOICE OF THE COMMUNITY</b> Engage the community	<b>COMMUNICATION PLAN</b> Develop mechanisms to keep the community and staff informed	<b>EFFICIENCY</b> Increase value added time of all processes
<b>MICROSYSTEM</b> Population by the Microsystem /Target	<b>EMPANELMENT FOR IMPROVEMENT</b> Empanel patients to achieve continuity and improve outcomes	<b>CARE BETWEEN VISITS</b> Care management integrated into care team
<b>ASSESSMENT</b> Assess the microsystem, using the Green Book (revisit intermittently)	<b>CLINICAL INFORMATION SYSTEM</b> Optimize the CIS, using it for reminders, prompts, queries, etc	<b>SELF-MANAGEMENT</b> Empower the patient and family members by embedding self-management support processes in care
<b>THE AIM</b> Develop organizational Aim, including some initial plans relating to spread	<b>ACCESS AND CONTINUITY</b> Develop mechanism to ensure access to care and support continuity	
<b>STRATEGIC ALIGNMENT</b> Link IPC aim and goals to the organizational strategic plan	<b>TRANSPARENCY OF IMPROVEMENT</b> Make quality related data available to all (transparency)	<b>BEHAVIORAL HEALTH INTEGRATION</b> Integrate behavioral health
<b>THE IMPROVEMENT TEAM</b> ID Multidisciplinary Improvement team	<b>THE PRE-VISIT</b> Pre-visit planning and care delivery (huddles, previsit calls, etc.)	
	<b>CAPACITY FOR IMPROVEMENT</b> Build capacity in staff to support improvement	
	<b>RESOURCES FOR IMPROVEMENT</b> Identify inefficiencies and eliminate waste.	

### Care Model



Productive Interactions through effective asset based partnering over time

Informed, Empowered Patient and Family

← Patient Driven | Coordinated | Prepared, Proactive Practice Team

← Timely and Efficient | Evidence-based and Safe

IPC1



### Care Model for the Indian Health System



Adapted from the Chronic Care Model developed by the McCall Institute.

Improving Chronic Disease Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's MacCall Institute for Healthcare Innovation



# Indian Health Home

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- Care Team
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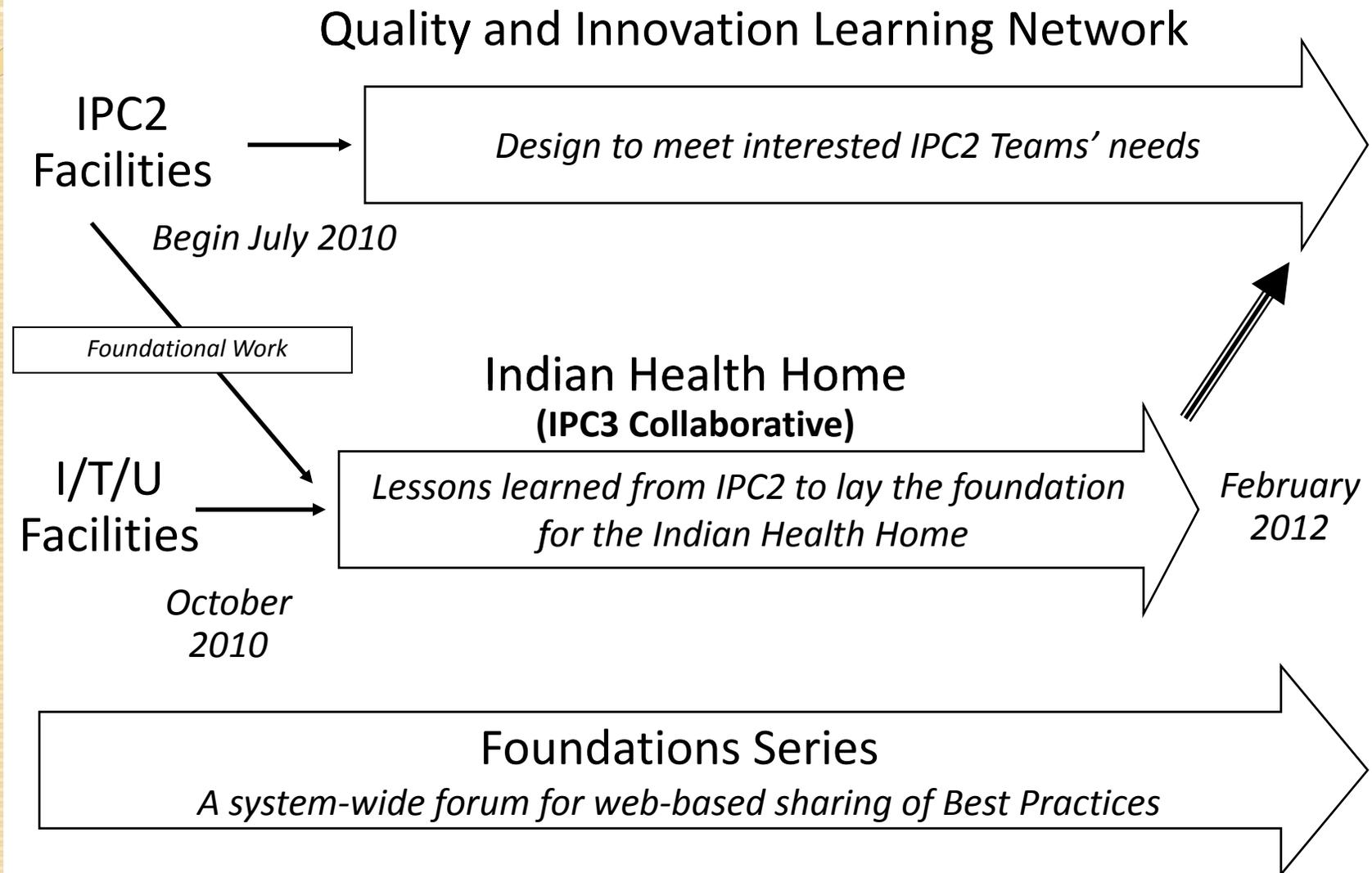
# Indian Health Home

- **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.
- **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.
- **Community Focus**
  - Renew and strengthen partnerships with Tribes and community-based services, and the culture or cultures of the Tribe(s) are integrated into the organization & delivery of care.
- **Quality and Transparency**
  - Everyone in the system has the skills and tools for making improvement, and uses measurement and data to build better care.

## IPC changes compared with other models of care referred to as a “Medical Home”

Improving Patient Care	NCQA Patient Centered Medical Home	AHRQ Transforming Primary Care
Access and Continuity	Access and Communication (1)	Continuous Access
Care Team	Patient Tracking and Registry Functions (2) Care Management (3) Test Tracking (6) Referral Tracking (7)	Care Coordination Team-Based Care
Centered on the Patient and Family	Patient Self-Management Support (4)	Whole Person Orientation
Empowerment for Improvement	Performance Reporting and Improvement (8)	System-Based Commitment to Quality and Safety
Community Focused	<i>Not addressed</i>	<i>Not addressed</i>
<i>Meaningful use of the IHS Clinical Information System or similar capabilities is essential for making the changes of IPC.</i>	Electronic Prescribing (5) Advanced Electronic Communications (9)	<i>Collection/exchange of information is critical, with health IT an essential tool for achieving these principles</i>

# Improving Patient Care



# Care Model for the Indian Health System



# Goal

- Improved health and wellness for American Indian and Alaska Native individuals, families, and communities

**Activated  
Family and  
Community**

Informed  
Activated  
Patient

**EFFECTIVE  
RELATIONSHIPS**

**Prepared,  
Proactive  
Community Partners**

Prepared  
Proactive  
Care Team



# Effective Relationships

- Overlap with the other elements of the Care Model
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- What are the elements of effective relationships?



# Respect for patient

- Ways to show respect
  - Listen
  - Reflection
  - Validation of feelings
  - Elicitation of wellness goals- it's their life
  - Willingness to correct misperceptions (respectfully)



# Respect for coworkers

- Recognition of common goal of patient wellness, everyone has a part
- Patients pick up on tension, mistrust between staff



# Communication with patient

- Limitation of verbal instruction (% retained)

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- Non-verbal communication
- Barriers: anxiety, anger
- Relevance



# Communication with coworkers

- Forming a healthcare team helps to keep the mission of healthcare delivery front and center

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- It communicates to the team that each team member is important
- Fosters openness and timely problem solving
- A brief meeting on a frequent basis (daily preferably) can help to anticipate and pre-empt service delivery problems



# Medical Home/ Empanelment

- Way to optimize the effective relationship
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# Chronic Care Management

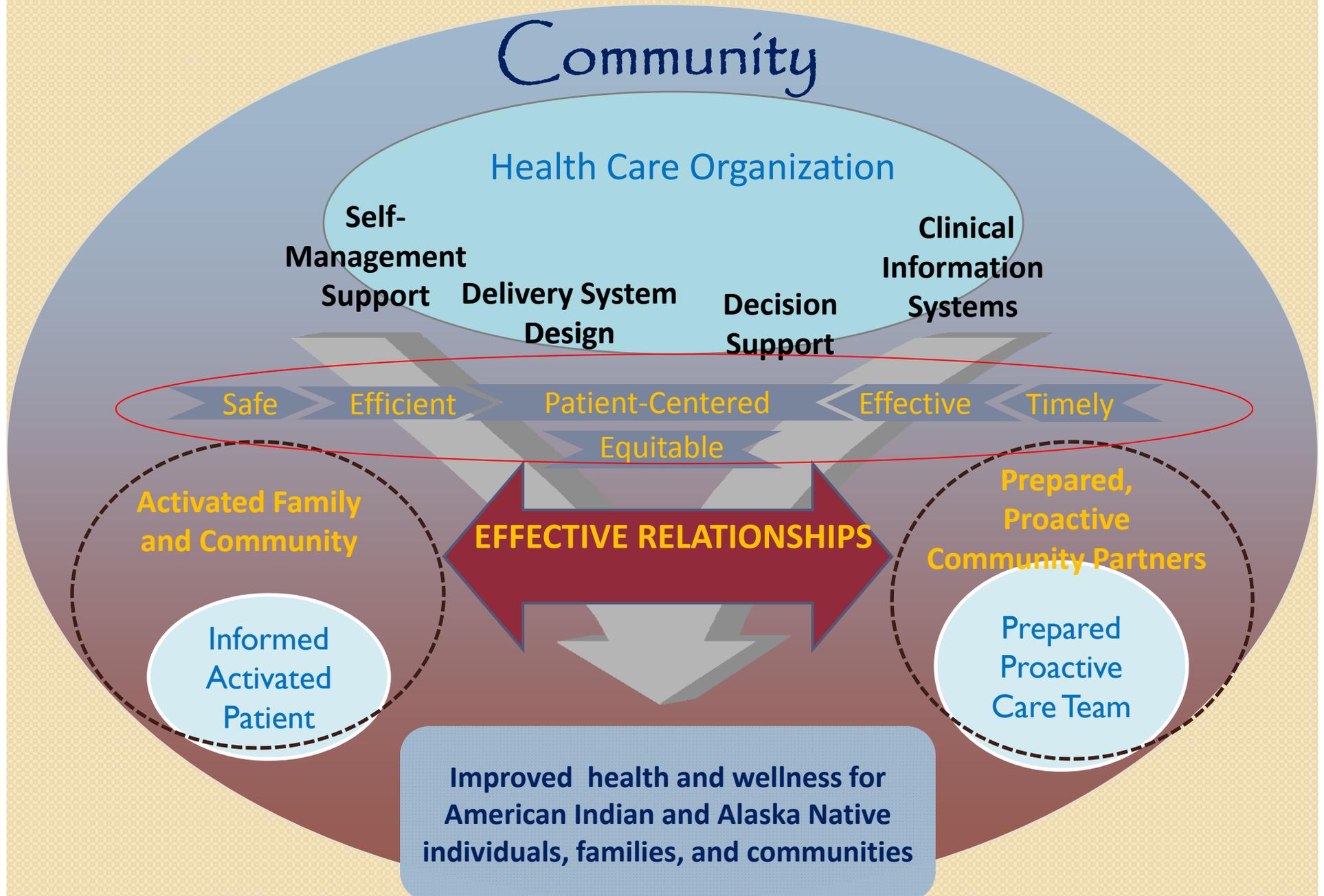
## **The Patient's Perspective**

Helen Maldonado, PA-C, CDE

June 8, 2010

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# Care Model for the Indian Health System



**Safe    Efficient    Patient-Centered    Effective    Timely**  
**Equitable**



# American Health Care

- Inconsistency in delivery of high-quality care
- Two studies by RAND Health: “Americans with common health problems receive only about 50 percent of recommended care

Nolan, T., et.al. *Improving the Reliability of Health Care*, Institute of Healthcare Improvement, Cambridge, Mass. 2004



# Institute Of Medicine (IOM)

- 2001 published the report: *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*
- Calls for fundamental change
- Organized around six aims for improvement

Nolan, T., et al. *Improving the Reliability of Health Care*, Institute of Healthcare Improvement, Cambridge, Mass. 2004



# All Health Care Should Be....

- Safe
  - Efficient
  - Patient Centered
  - Effective
  - Timely
  - Equitable
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# Safe

- Patients should not be harmed by the care that is intended to help them



# Efficient

- Care should be given without wasting equipment, supplies, ideas, and energy



# Patient Centered

- Care should be respectful of and responsive to individual patient preferences, needs, and values

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- Self-management support, Health Literacy, and Cultural humility



# Effective

- Care should be based on scientific knowledge and offered to all who could benefit, and not to those not likely to benefit



# Timely

- Waits and sometimes-harmful delays in care should be reduced both for those who receive care and those who give care



# Equitable

- Care should not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status



# Patient-Centered Care Model

- As providers, we are with a patient 20 minutes every 3 months on average for chronic illness care
- The patient is the major care giver for themselves
- The patient will do what they think is right for themselves based on their relationship with their provider/team and understanding the need for lifestyle changes



# Health Literacy

- The responsibility is ours to help patients understand instructions on how to take medications or follow a treatment plan
- We must be sure we have communicated in a way they understand what we are saying
- 80% of patients leaving your exam room don't understand what was just said



# Challenge

- Go back to your clinical site and create a survey for your patients to fill out as they leave

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- Ask basic questions about their understanding of what was discussed, “Did your provider explain how to take your medicines in a way you can understand?”



# Cultural Humility

- Very important to understand and embrace the differences between your own culture and the culture of those you serve
- Respect the differences
- Be humble in your approach
- Be aware of your own culture



# Self Management Support

- **Ask** the patient what their goal for wellness is first
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- **Quality** educational time
  - **Effective** communication
  - **Support** by staff



# Chronic Care Management

Wendy Blocker MSN

National GPRA Support Team

June 8, 2010

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# Importance of Chronic Care Management

- Certain problems related to chronic illness are not specifically medical
  - Families
  - Workplaces
  - Lifestyle Changes
  - Education
  - Motivation
- No 'cure' for chronic illness



# Chronic Care Management Premise

- Right thing

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- Right patient
- Right time



## Fundamentals of change:

- **Will-** To do what it takes to change
- **Ideas-** New ways to make improvements
- **Execution-** Getting started with change ideas

# Care Model for the Indian Health System



# Health Care Organization



**Health Care Organization**

**Self-  
Management  
Support**

**Delivery  
System  
Design**

**Decision  
Support**

**Clinical  
Information  
Systems**



# Health Care Organization

- Self Management Support
- Delivery System Design

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- Decision Support
- Clinical Information Systems



# Delivery System Design

- Define roles and distribute task
- Planned interactions for evidence-based care

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- Clinical case management services for complex patients
- Regular care team initiated follow-up
- Cultural sensitive care



# Decision Support

- Daily practice of evidence-based care
- Share clinical guidelines and information with patients
- Provide professional education
- Integrate specialty and primary care



# Clinical Information Systems

- Timely reminders for providers and patients
- Identify subpopulations for proactive care
- Facilitate individual patient care planning
- Share information
- Monitor outcomes



# Self Management Support

- Patient has a central role in managing health
- Self-management support strategies
  - Assessment, goal-setting, action planning, problem solving, and follow-up
- Community resources to support self-management



## Resources:

- <http://www.ihs.gov/ipc>
- [www.guidelines.gov](http://www.guidelines.gov)
- <http://www.endabuse.org/>
- <http://www.lungusa.org/>
- <http://www.cancer.org/docroot/home/index.asp>
- <http://www.aa.org/?Media=PlayFlash>
- <http://www.ihs.gov/MedicalPrograms/Diabetes/>

# Assessment of your Health Care Organization

## Assessment of Chronic Illness Care, Version 3.5

**Part 1: Organization of the Healthcare Delivery System.** Chronic illness management programs can be more effective if the overall system (organization) in which care is provided is oriented and led in a manner that allows for a focus on chronic illness care.

Components	Level D	Level C	Level B	Level A
<b>Overall Organizational Leadership in Chronic Illness Care</b>	...does not exist or there is a little interest.	...is reflected in vision statements and business plans, but no resources are specifically earmarked to execute the work.	...is reflected by senior leadership and specific dedicated resources (dollars and personnel).	...is part of the system's long term planning strategy, receive necessary resources, and specific people are held accountable.
Score	0 1 2	3 4 5	6 7 8	9 10 11
<b>Organizational Goals for Chronic Care</b>	...do not exist or are limited to one condition.	...exist but are not actively reviewed.	...are measurable and reviewed.	...are measurable, reviewed routinely, and are incorporated into plans for improvement.
Score	0 1 2	3 4 5	6 7 8	9 10 11
<b>Improvement Strategy for Chronic Illness Care</b>	...is ad hoc and not organized or supported consistently.	...utilizes ad hoc approaches for targeted problems as they emerge.	...utilizes a proven improvement strategy for targeted problems.	... includes a proven improvement strategy and uses it proactively in meeting organizational goals.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total Health Care Organization Score \_\_\_\_\_ Average Score (Health Care Org. Score / 3) \_\_\_\_\_

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