Improving Patient Care

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National Medical Providers Best Practices and
GPRA Measures Conference

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IHS Priorities

- To renew and strengthen our partnership with Tribes
- To reform the IHS
- To improve the quality of and access to care
- Ensure that our work is transparent, accountable, fair, and inclusive

The Aim of the IPC Program

- The aim of the Improving Patient Care Program is to change and improve the Indian health system. IPC will develop high performing and innovative health care teams to improve the quality of and access to care.

- The results will be a medical home that sets new standards for health care delivery and further advances the health and wellness of the American Indian and Alaska Native people.

Improving Patient Care

- IPC was launched in 2006.
- The IPC is our primary method to fulfill our priorities of improving quality and access to care and reforming the IHS.
- The IPC Program began with 14 IHS/tribal/urban sites whose aim was to use improvement principles to upgrade the manner in which they provided health care.
- We have now expanded to 90 IHS/tribal/urban sites and our goal is to include another 100 sites in the next two to three years, with ultimate inclusion of all sites as our long-term goal.


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IPC
PORTLAND
BILLINGS
ABERDEEN
BEMIDJI
PHOENIX
CALIFORNIA
NAVAJO
ALBUQUERQUE
TUCSON
OKLAHOMA CITY
NASHVILLE
ALASKA
IPC I
IPC II
IPC III
FEDERAL
TRIBAL
URBAN


IPC II
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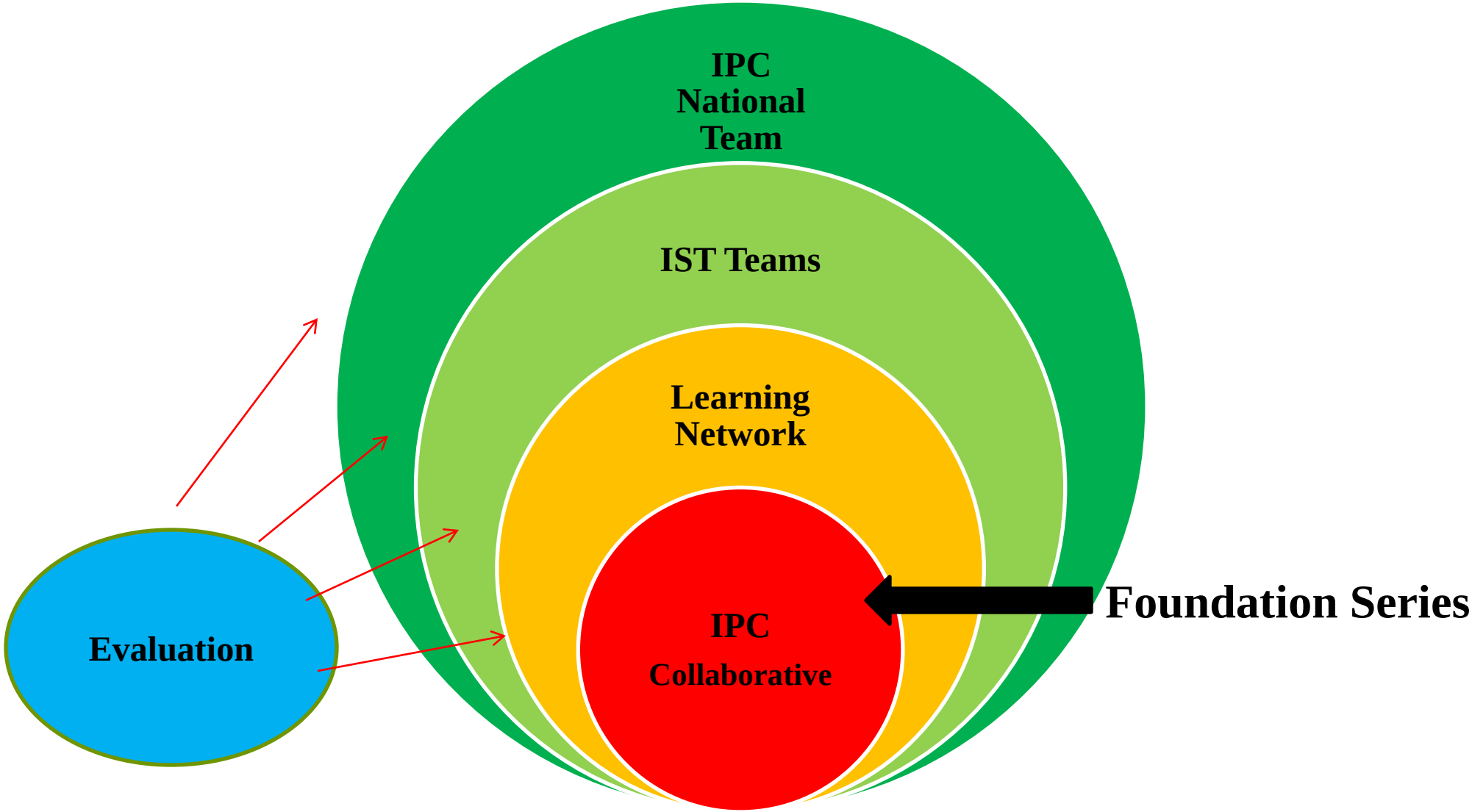
Arms of Improving Patient Care



“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.
- Five group learning sessions-
  - Two face-to-face sessions
  - Two virtual web-ex based learning sessions
  - One nowledge gathering session
- Action-orientated initiative that provides the foundation for continued improvement.

Pre-work Assignments: Action orientated activities of IPC

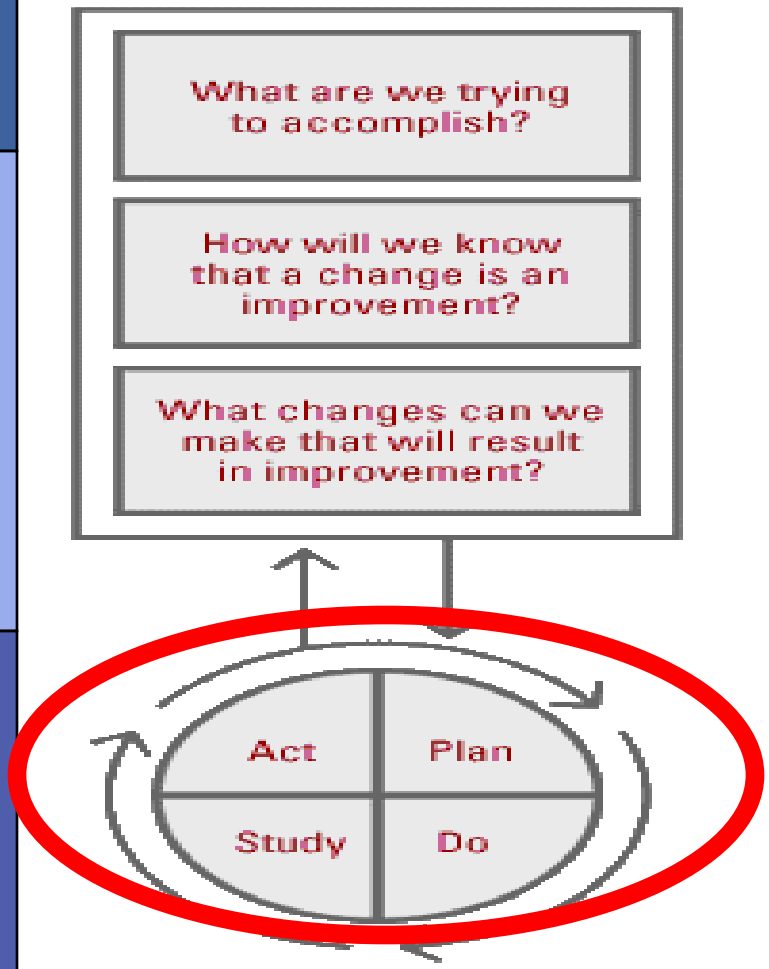
Empanelment Questions
Work Analysis Worksheet
Team Profile
The “Primary Care Profile”
“Through the Eyes of Your Patients”
"Personal Skills Assessment"
Primary Care Practice, Activity Survey
Primary Care Practice Patient Cycle time tool
Unplanned Activity Tracking Card
The Telephone Tracking Log
Assessing Your Practice Discoveries & Actions
IPC Patient Experience Survey Tool
IPC Staff Satisfaction Survey Tool
IPC CIS Assessment Tool
Creating your Charter
Patient and Family Centered Self Assessment

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.

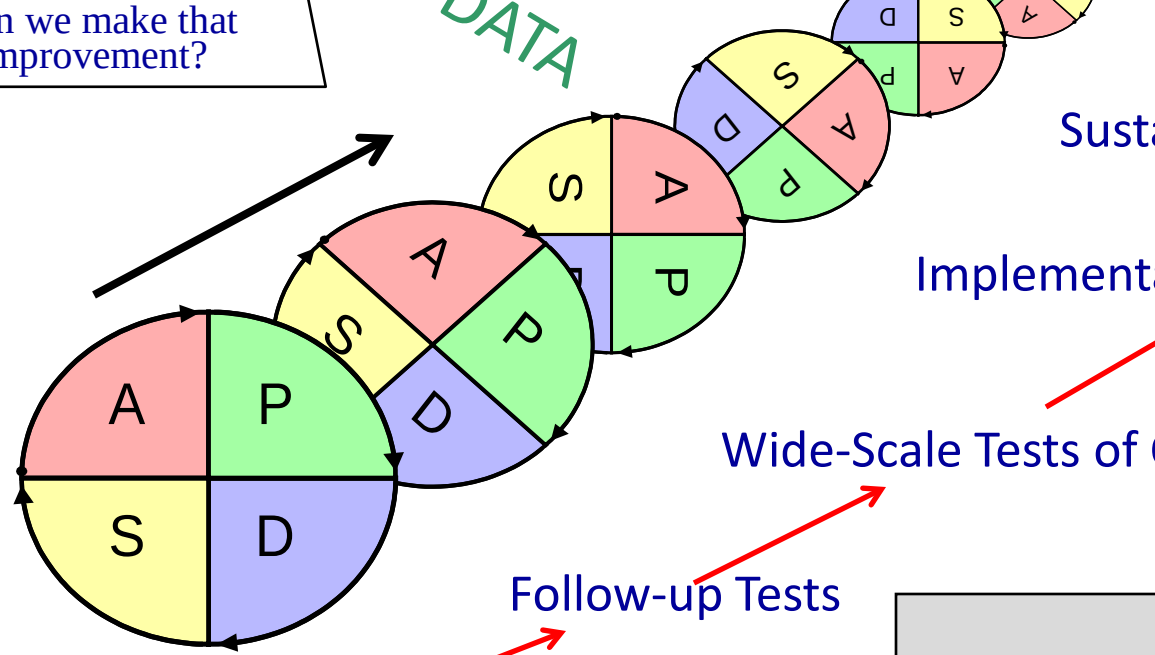
Repeated Use of the PDSA Cycle for Testing

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?



DATA

Changes That Result in Improvement

Spreading

Sustaining the gains

Implementation of Change

Wide-Scale Tests of Change

Follow-up Tests

Very Small Scale Test

Hunches
Theories Ideas

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 and 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
Clinical Prevention	Keeping current on preventive screenings	***Health Risk Assessment*:** **BMI, Tobacco Screening, DV/IPV Screening, Depression Screening, Alcohol misuse screening, Blood Pressure.**	80%	
	Keeping current on cancer screening	***Cancer Screening:*** **Colorectal Cancer Screening, Cervical Cancer Screening, Breast Cancer Screening.**	70%	
Management and Prevention of Chronic Conditions	Control of Blood Pressure Control of Lipids Control of Diabetes	***Outcomes:*** **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
Costs	Workforce	**Staff Satisfaction**		Survey Quarterly
Patient 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 and Innovation Learning Network

- Continue to spread the “change” improvements across sites.
- Participate in one or two of the following intensive programs:
  - Develop care coordination in blood pressure monitoring
  - Advanced access
  - Mobilize tribal and community based health programs
  - Behavioral health integration within the primary care setting
  - Integrate self-management support at the point of visit

Improvement Support Teams

- Expansion of the IPC Program to 100 sites in the next three years will require a national infrastructure of support for improvement in care.
- The 12 Area Improvement Support Teams were created to strengthen the capacity and infrastructure of the Areas to support spread and sustain improvement among the sites throughout the 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.

Foundation Series Seminars

The Foundations Series Seminars: Sites that are not in the IPC 3 can still participate in Improving Patient Care.

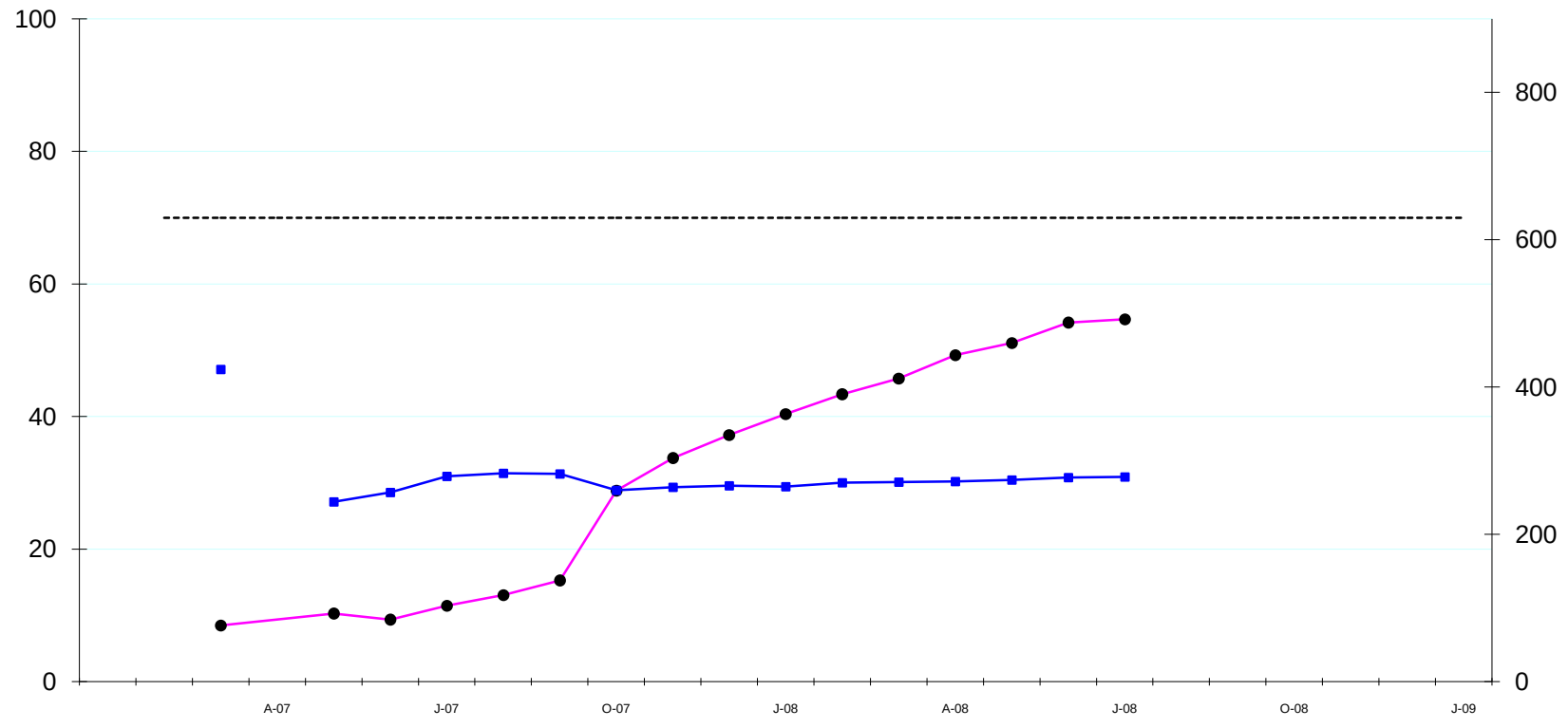
- Monthly web-based sessions will provide individuals with hands-on learning and prepare participants with tools, strategies, and best practices to use in their outpatient settings.

- Help organizations prepare for participation in the next IPC collaborative.

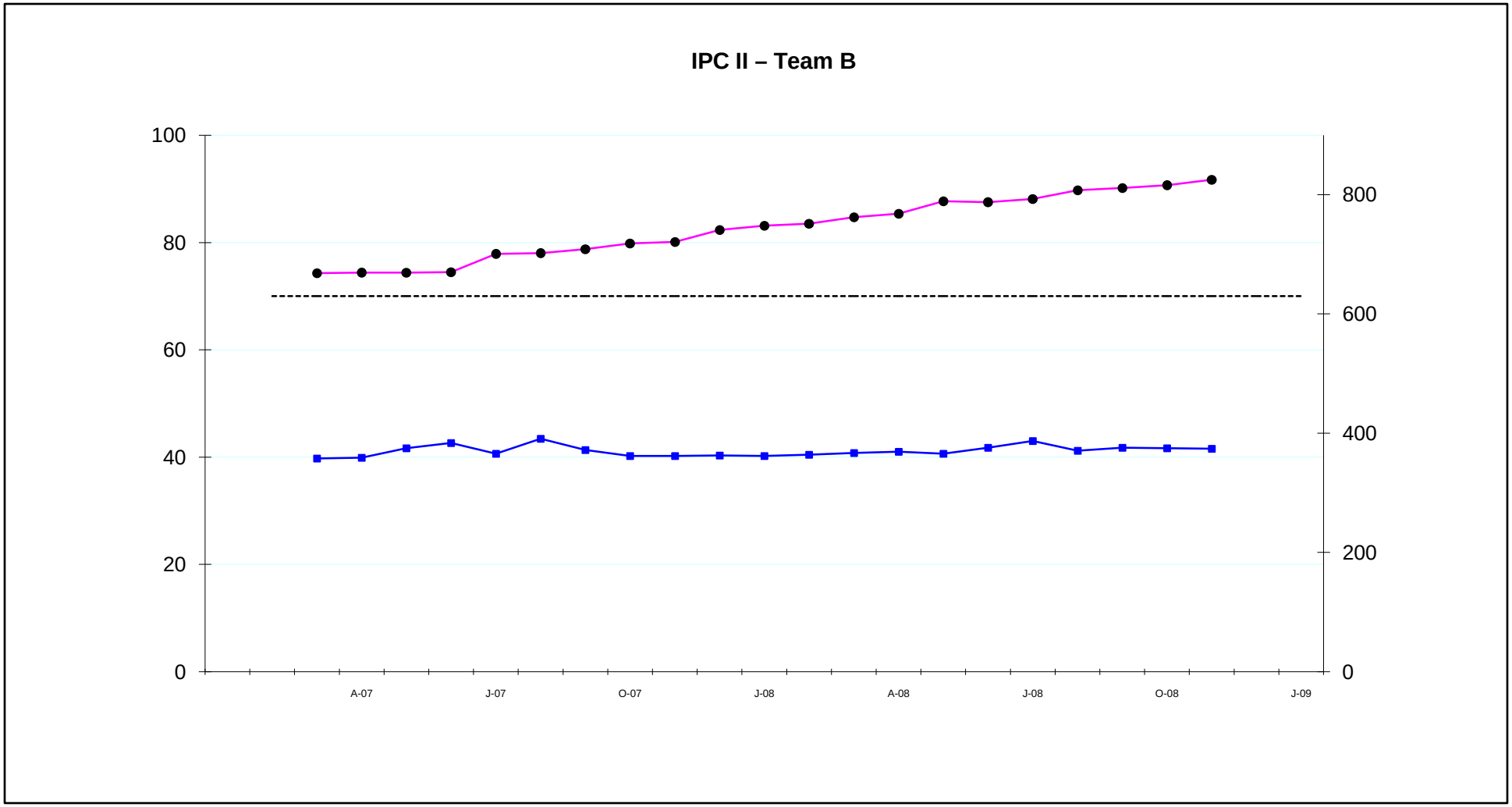
IHS Colorectal Cancer Screening GPRA Results

- 2010 GPRA result: 37 percent (target is 36 percent)
- 2009 GPRA result: 33 percent

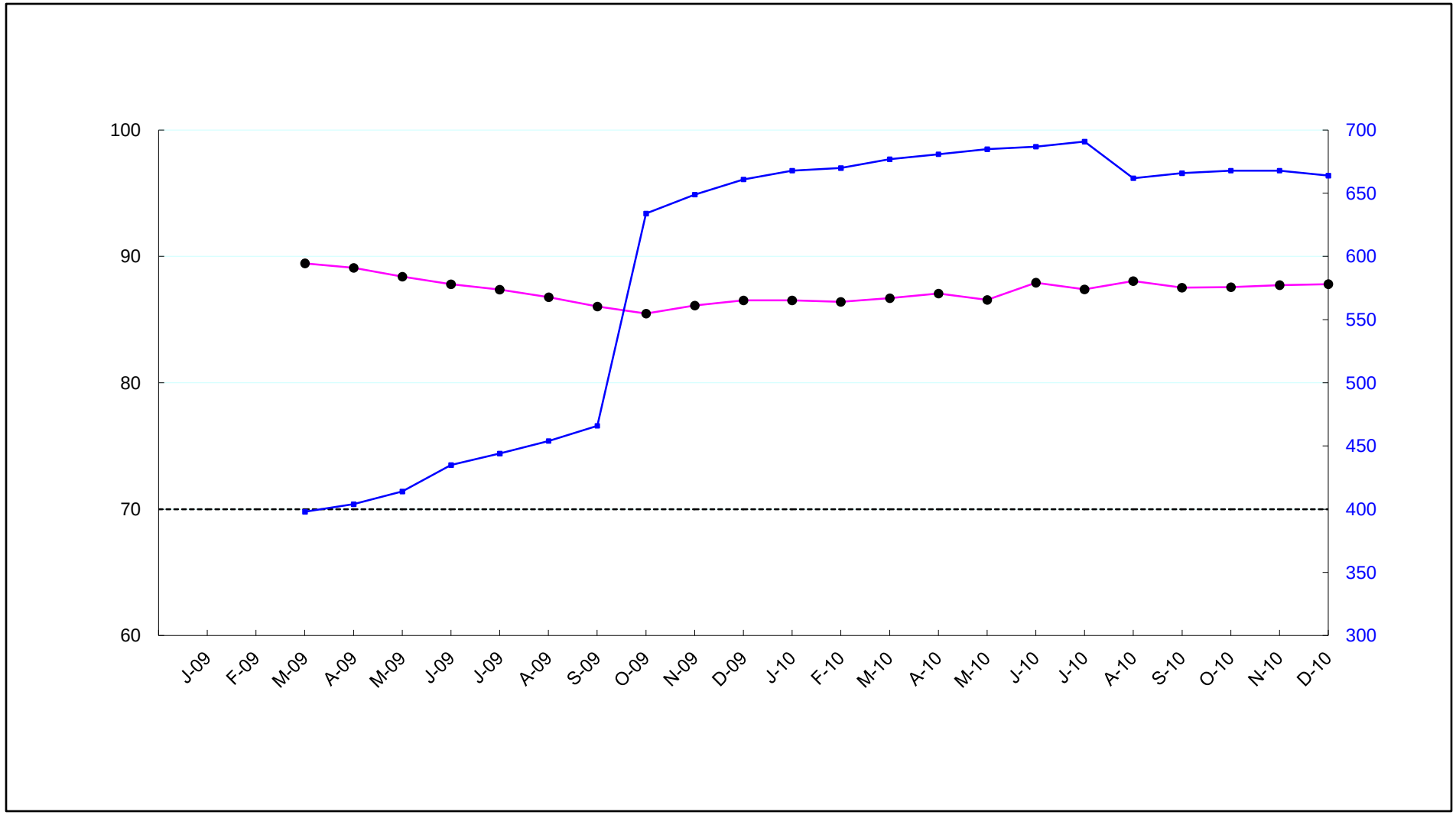
IPC Colorectal Cancer Screening Rates: Team A



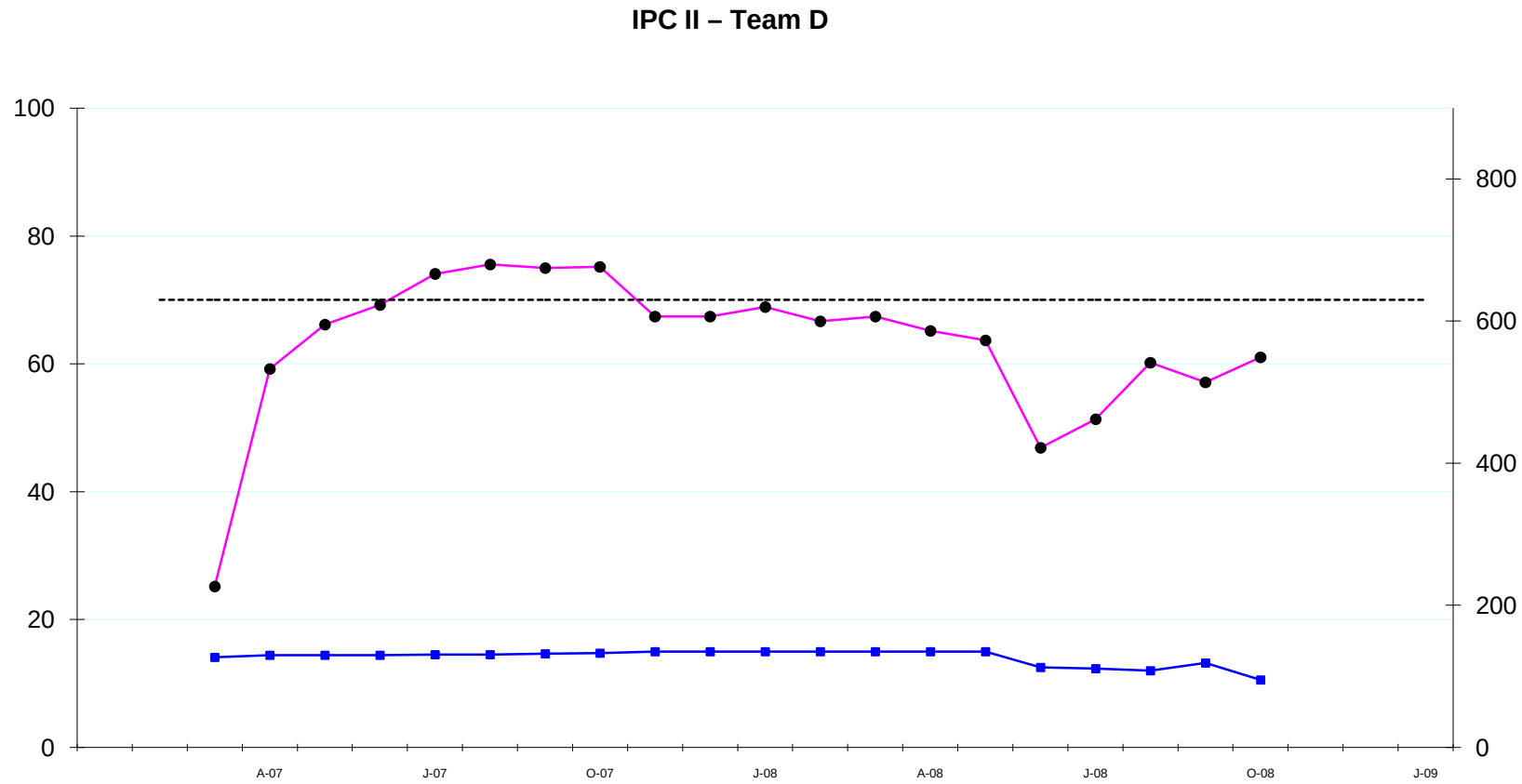
IPC Colorectal Cancer Screening Rates: Team B



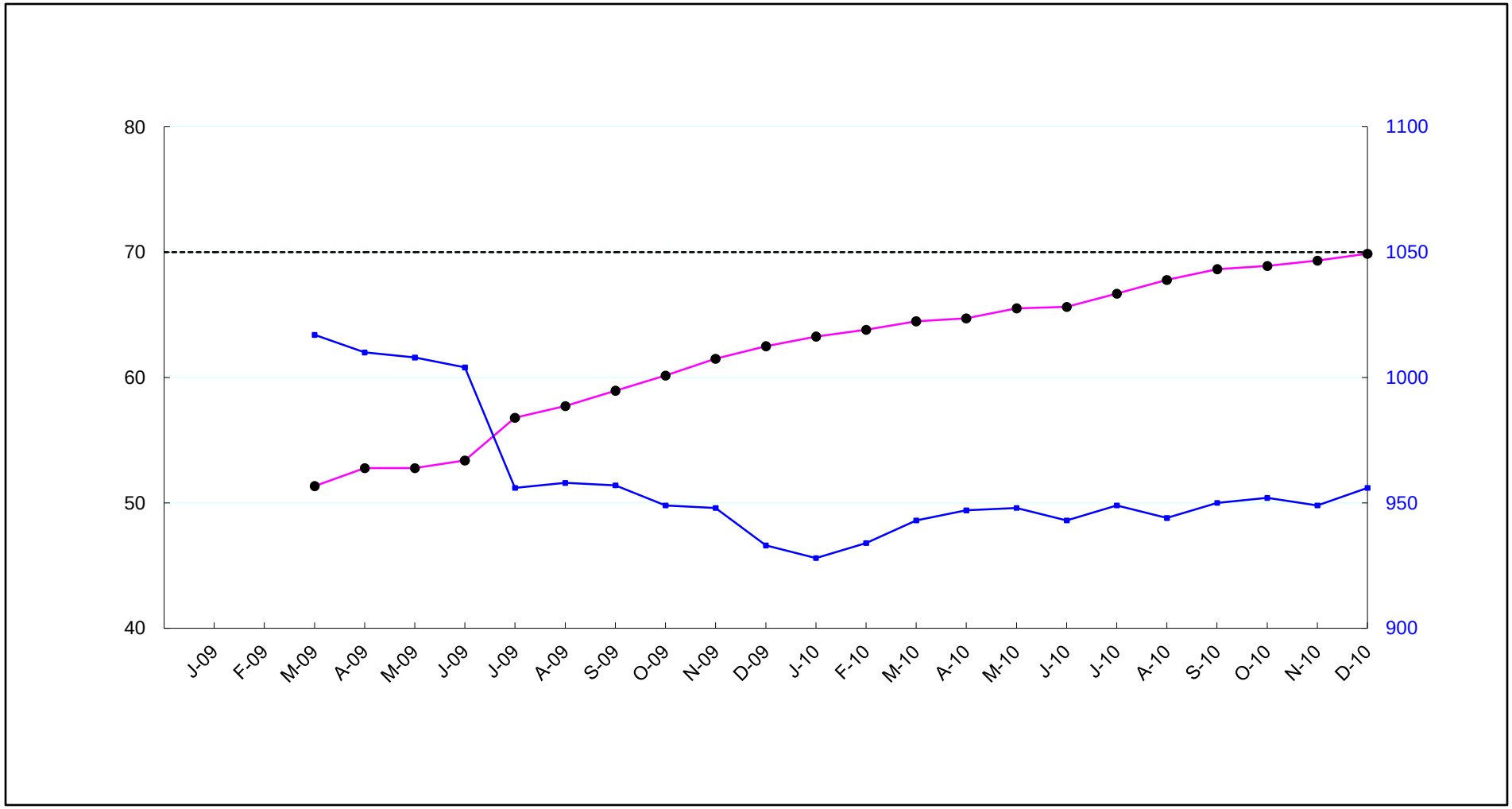
Sustained Improvement in Screening Rates



IPC Colorectal Cancer Screening Rates: Team D



Colorectal Cancer Screening
IPC



New Data and Knowledge Management Portal

- Key features of the new IPC knowledge management and IPC data portals include:
  - An active learning community among all IPC sites.
  - Open access to team documents and best practices.
  - Up-to-date aggregation of measurement data.
  - At-a-glance team progress based on patient health outcomes.

IPC Communication

- IPC Listserv – 723 Subscribers
- IPC 3 Listserv – 600 Subscribers
- Learning Network – 332 Subscribers
- Improvement Support Teams – 123 Subscribers
- IHS Listserv Subscription Link: *http://www.ihs.gov/listserver/index.cfm?module=list&firstRecord=51*

- Leadership distribution
- Partnership shared distribution
  - Office of Tribal Self Governance
  - Office of Direct Service Tribes
  - Urban Indian Health Programs

IHS National IPC Team

- Susan Karol M.D., Chief Medical Officer
- Charlene Avery M.D., Director, Office of Clinical and Preventive Services
- Lyle Ignace M.D., M.P.H., Director, Improving Patient Care
- Lisa Palucci R.N., IPC Collaborative Director
- Sandra Haldane, Chief Nurse, Director of Nursing, IPC Collaborative Director
- Candace Jones, R.D.H., M.P.H., Administrative Officer
- Candice Donald, Program Management Specialist
- Stephanie Smith, Program Assistant
- Misty Nuttle, Staff Assistant

Contact information:

- Visit IPC website at www.ihs.gov/ipc under Announcements and News.

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