CASE MANAGEMENT: PRACTICING POPULATION HEALTH TO ENGAGE PATIENTS AS PARTNERS IN CARE

Krista Haven RN, MSN, CCM, CDE
Diabetes Nurse Specialist
Chinle Comprehensive Health Care Facility, Chinle AZ

Chinle Service Unit

Canyon de Chelly, Chinle, AZ

Pinon Health Center

Chinle Comprehensive Healthcare Facility

Tsaile Health Center

WHO WE ARE

- Diabetes Program
  - 3 coordinators, 1 administrator, 1 lead health coach, 14 health coaches, 1 data manager, 1 nurse improvement specialist, 1 clinical consultant
  - Administratively housed in Public Health, Population Health
  - Accreditation (2018) by American Diabetes Care and Education Specialists (ADCES)
- Collaborations within the Chinle Service Unit (CSU) for diabetes clinical care and prevention
  - Primary care (adult, pediatrics, SCOB, case management), podiatry, optometry, dental, nutrition, integrated behavioral health, in-patient, Office of Native Medicine, mobile health unit, adolescent/school health, Wellness Center, HPDP, public health nursing
- Community partnerships
  - Schools, Chinle Navajo Nation Special Diabetes Program for Indians (SDPI), Navajo Nation Health Education, Community Health Representatives

OBJECTIVES

- Define case management and health coaching, and how case management programs may improve patient-centered clinical services, primary care infrastructure and population health.
- Describe how team members can be mentored to develop case management skills.
- Discuss how to identify high risk patients in a population, including those with a diagnosis of diabetes, utilizing tools such as RPMS: ICare, and Audit analytics.

WHAT IS HIGH-QUALITY PRIMARY CARE?

- High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care.

WHOLE PERSON CARE

More than addressing
"What is the matter with you?"

WHOLE PERSON CARE

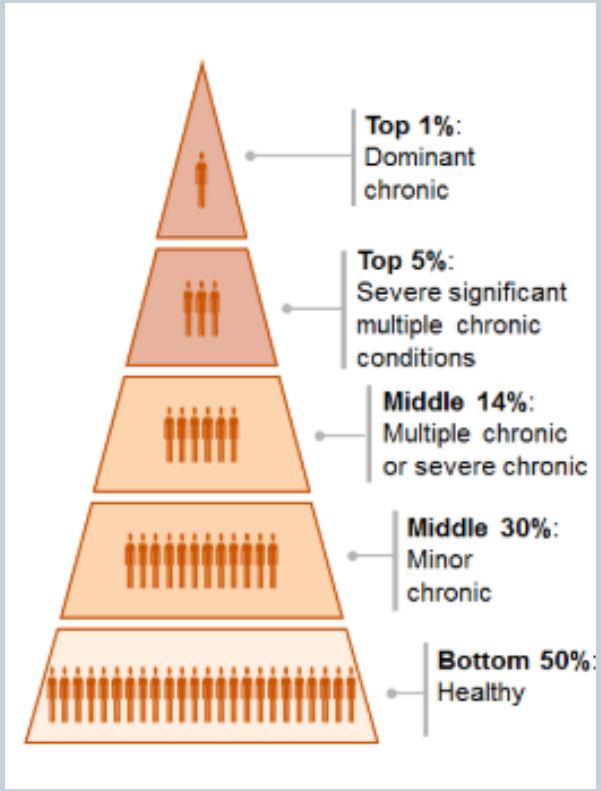
More than addressing
“What is the matter with you?”

Also, addresses
”What matters to you?”

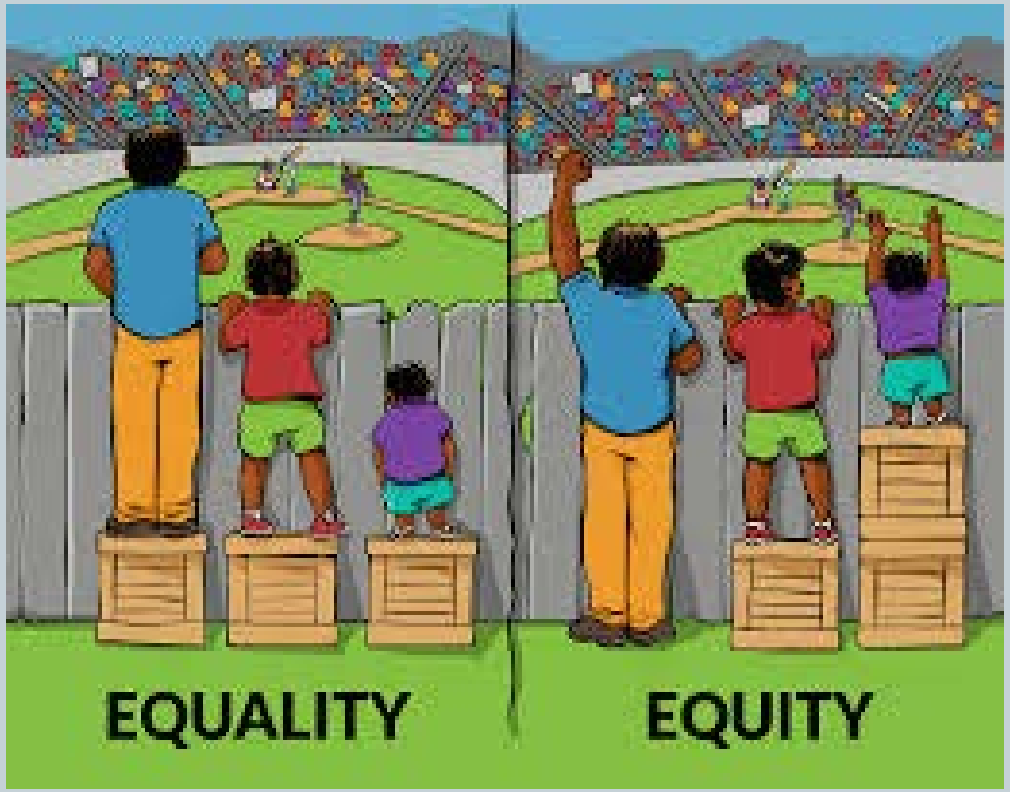
TEAM BASED CARE

Courtesy of the Medical Center Archives of New York Presbyterian/Weill Cornell Medicine

EQUITABLE CARE



http://radar.oreilly.com/2013/08/the-next-top-5-identifying-patients-for-additional-care-through-micro-segmentation-2.html



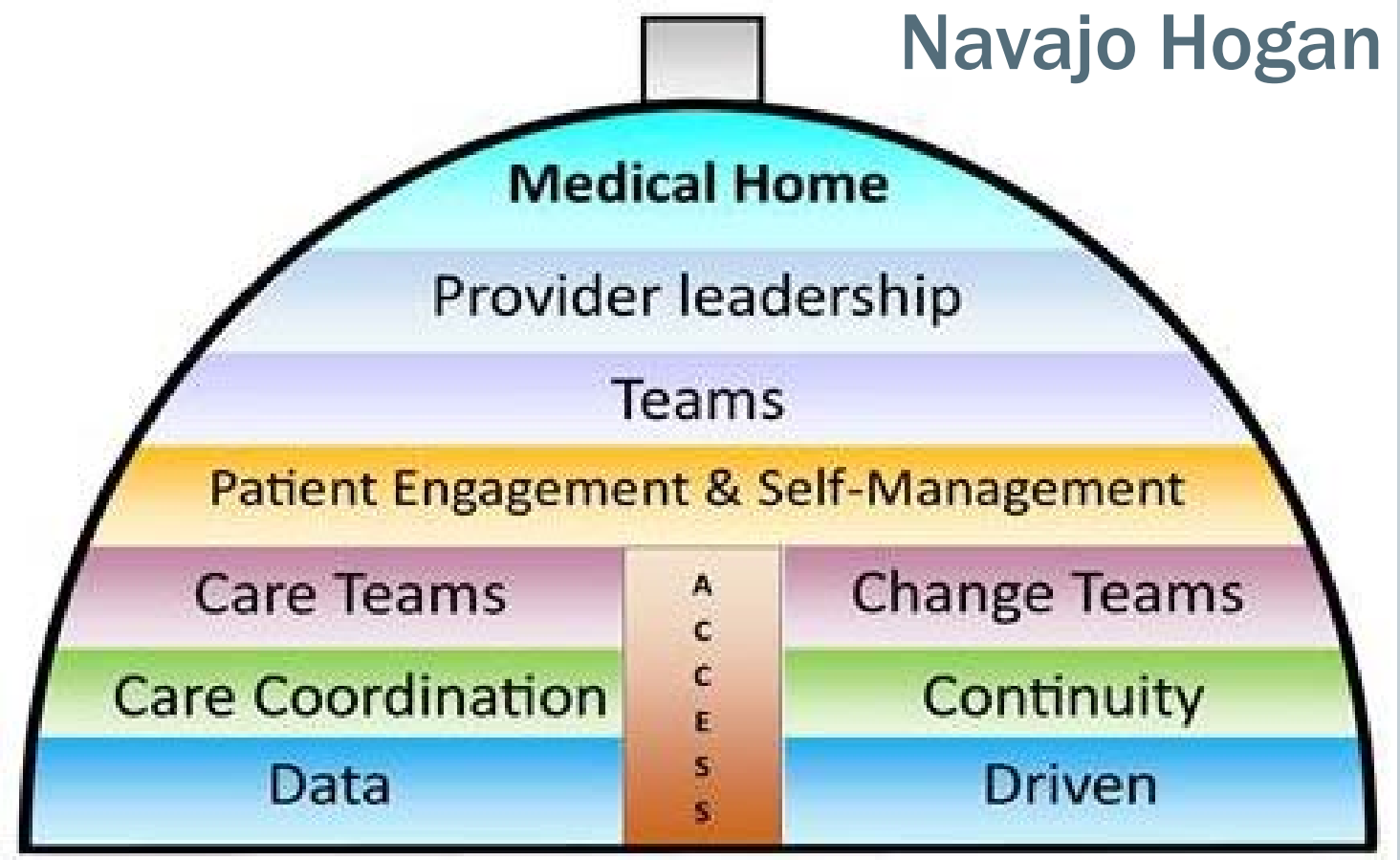
https://resistancetraining.wordpress.com/2016/06/28/the-equity-kids/

THE VISION OF RELATION-BASED CARE: "THIS CARE IS DIFFERENT."

- HOW WE HOPE PATIENTS TALK ABOUT THEIR EXPERIENCE

- There is a team helping me and they all seem to know what they're doing
- They care about me and what I want
- They are easy to get a hold of
- My appointments are better – things really get done
- They've taught me so that I can now really take care of myself
- They helped me get through one of the hardest periods of my life
- I am on more meds but I understand them better
- They listen
- I feel better

MEDICAL HOME MODEL: PRIMARY CARE BASED



http://www.foma.org/patient-centered-medical-home.html

WHAT IS HIGH-QUALITY PRIMARY CARE?

- The definition of high quality primary care was based on the following concepts:
  - integrated, whole-person health;
  - interprofessional care teams;
  - foundational, sustained relationships between the care team and patients and families;
  - the critical role of communities in providing primary care;
  - the importance of equitable access to primary care; and
  - the diversity of settings and modalities used to deliver primary care.

National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care.

HEALTH COACHING

- Health Coaching helps patients build the knowledge, skills, and confidence required to manage their chronic conditions and improve their health. Health coaches empower patients to play a central role in clinical encounters and to engage in self-management activities at home, work, and schools, where they spend most of their lives.
- Philosophy
  - Health coaching is built on a relationship
  - Health coaching frequently helps patients understand provider advice
  - Patients may or may not be ready for changes, and coaching meets them where they are
  - Health coaching can help patients be involved in the clinical decisions

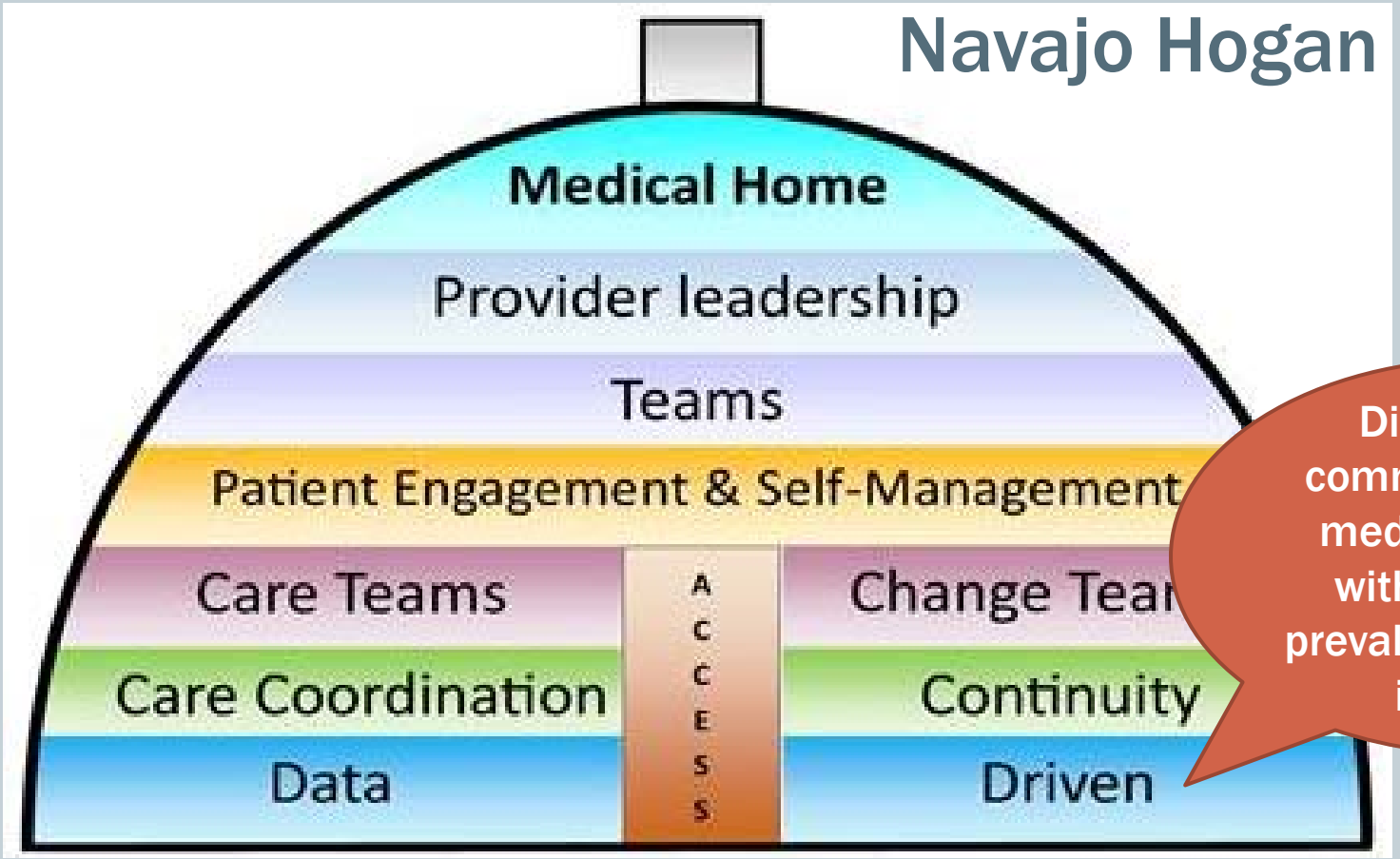
https://cepc.ucsf.edu/health-coaching

CASE MANAGEMENT

- "Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes."
- Philosophy
  - When an individual reaches the optimum level of wellness and function, everyone benefits
  - Case managers triangulate between patients/caregivers, providers, and the organization of health services to maximize benefits
    - Explicit advocacy (and equity) role for patients/caregivers within the health system
    - Knowledge of how the health system works and how it might best serve a patient and their needs
  - Bridge communication between patients and provider(s)

What Is A Case Manager | Case Management Society of America (cmsa.org)

MEDICAL HOME MODEL: PRIMARY CARE BASED



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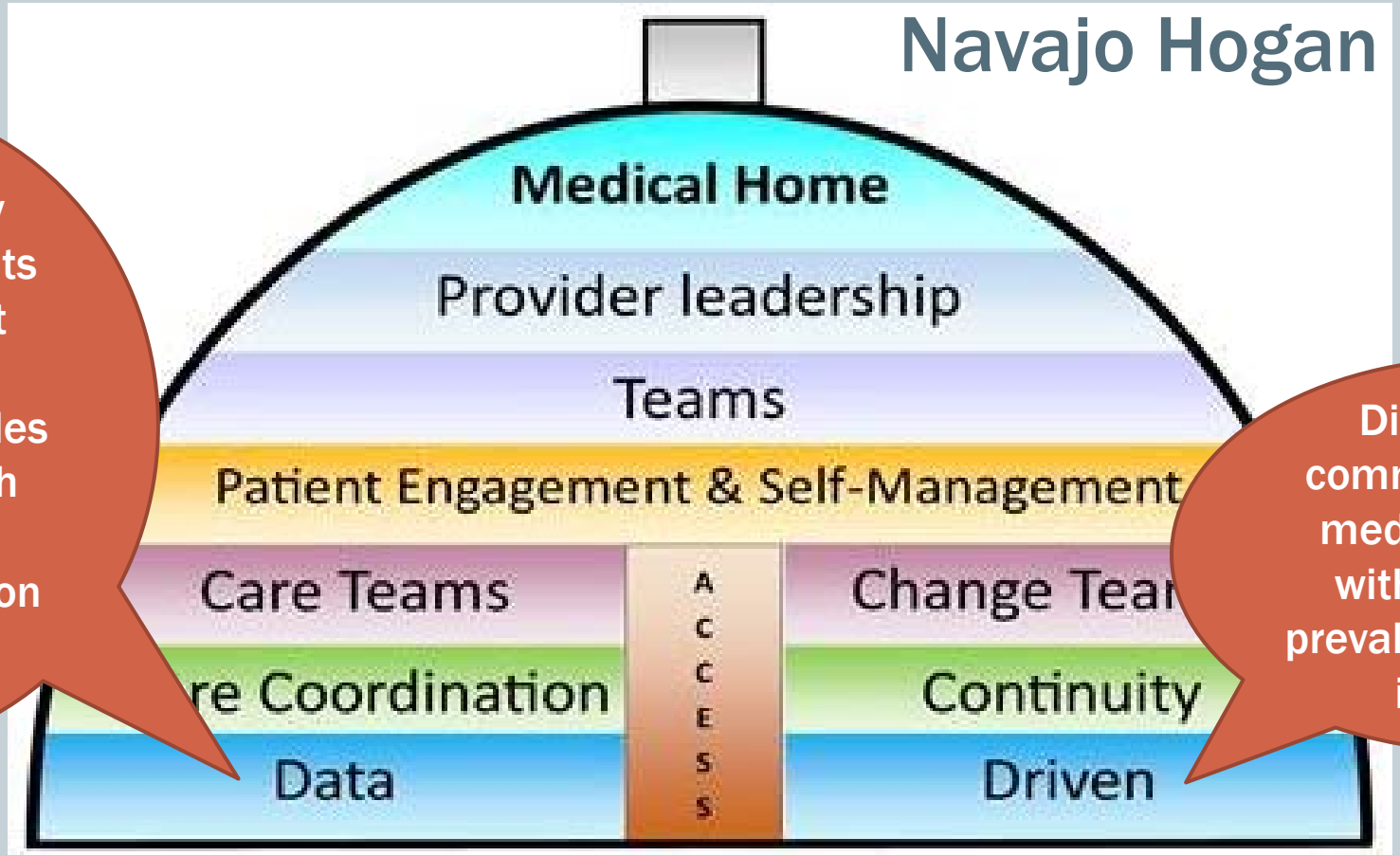
MEDICAL HOME MODEL: PRIMARY CARE BASED



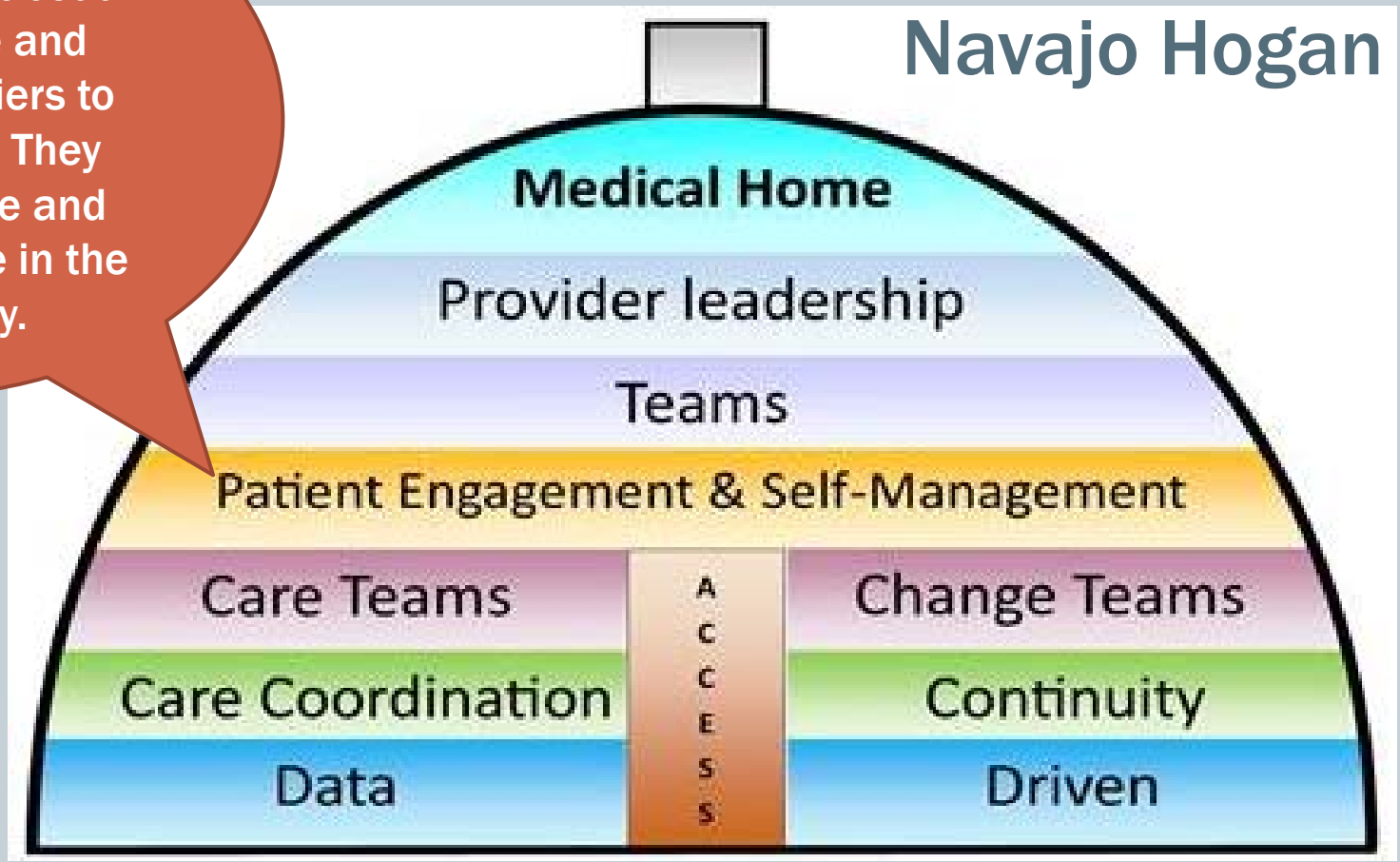
We can identify cohorts of patients who will benefit from special attention. Examples are patients with new onset DM, elevated A1c, or on insulin.

Diabetes is a common, complex medical problem with population prevalence of 21.6% in Chinle.

http://www.foma.org/patient-centered-medical-home.html

MEDICAL HOME MODEL: PRIMARY CARE BASED

Health coaches can help patients learn about diabetes care and overcome barriers to diabetes care. They share language and culture, and live in the community.



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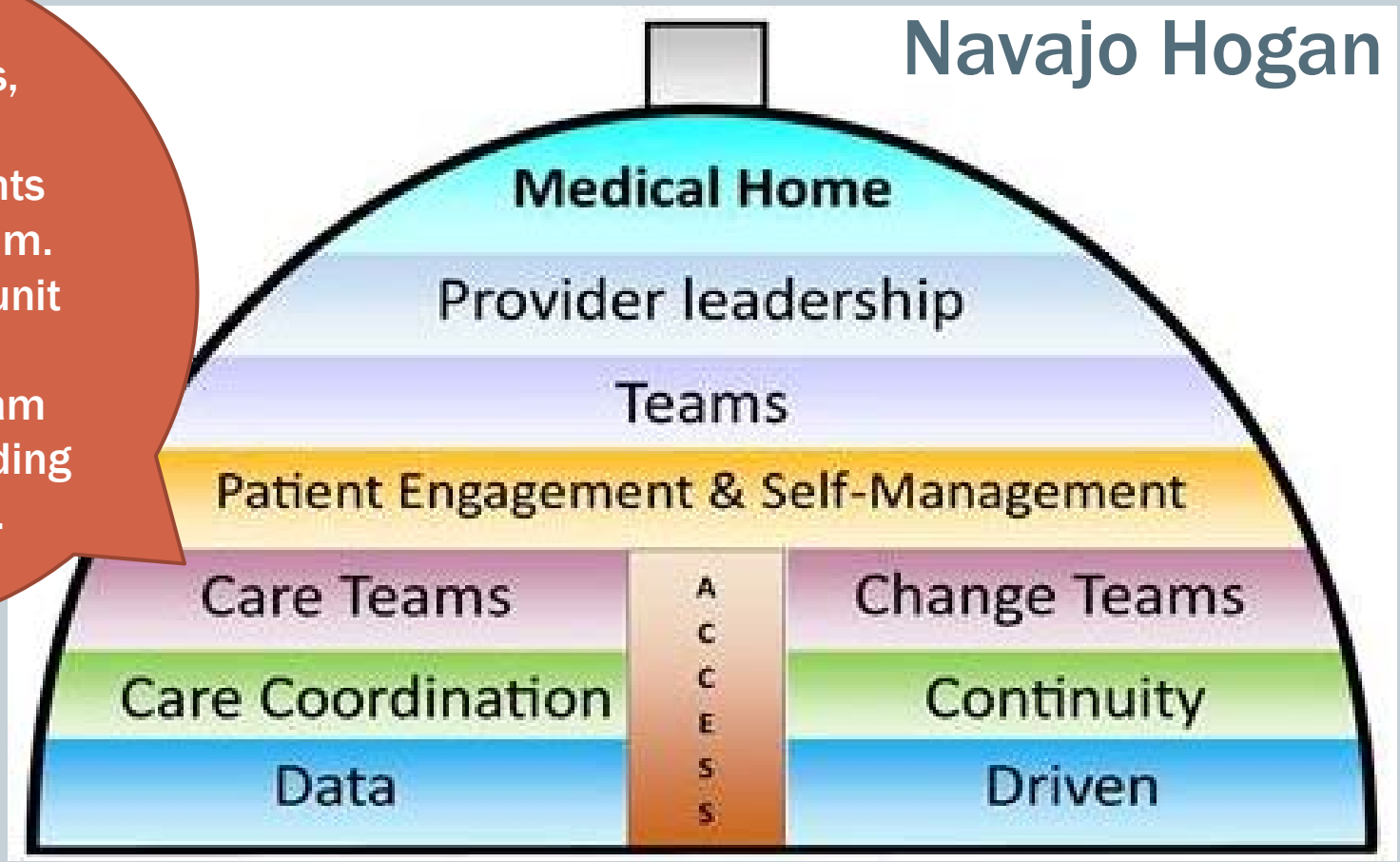
SOCIAL DETERMINANTS OF HEALTH FOR DIABETES

Socioeconomic Status	Neighborhood and Physical Environment	Food Environment	Health Care	Social Context
Education	Housing	Food Security	Access	Social Cohesion
Income	Built Environment	Food Access	Affordability/Quality	Social Capital
Occupation	Toxic Environmental Exposures	Food Availability		Social Support

F. Hill-Briggs, Diabetes Care, 2021

MEDICAL HOME MODEL: PRIMARY CARE BASED

Health coaches, providers, and medical assistants create a care team. This is the basic unit of support for patients. The team may grow, depending on the patient.



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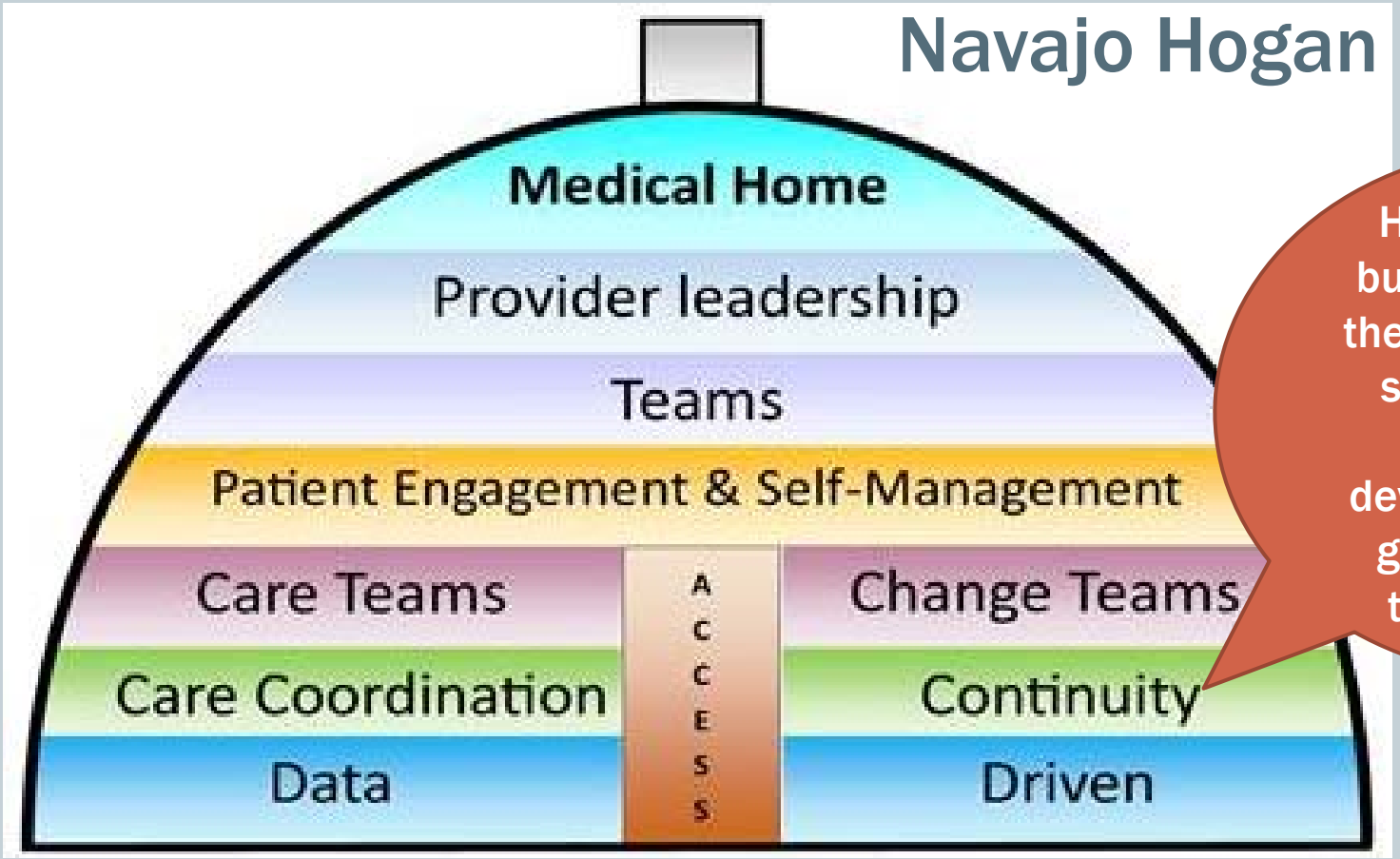

Health coaches build rapport with their patients. Over several visits, a relationship develops and trust grows. The care team benefits.

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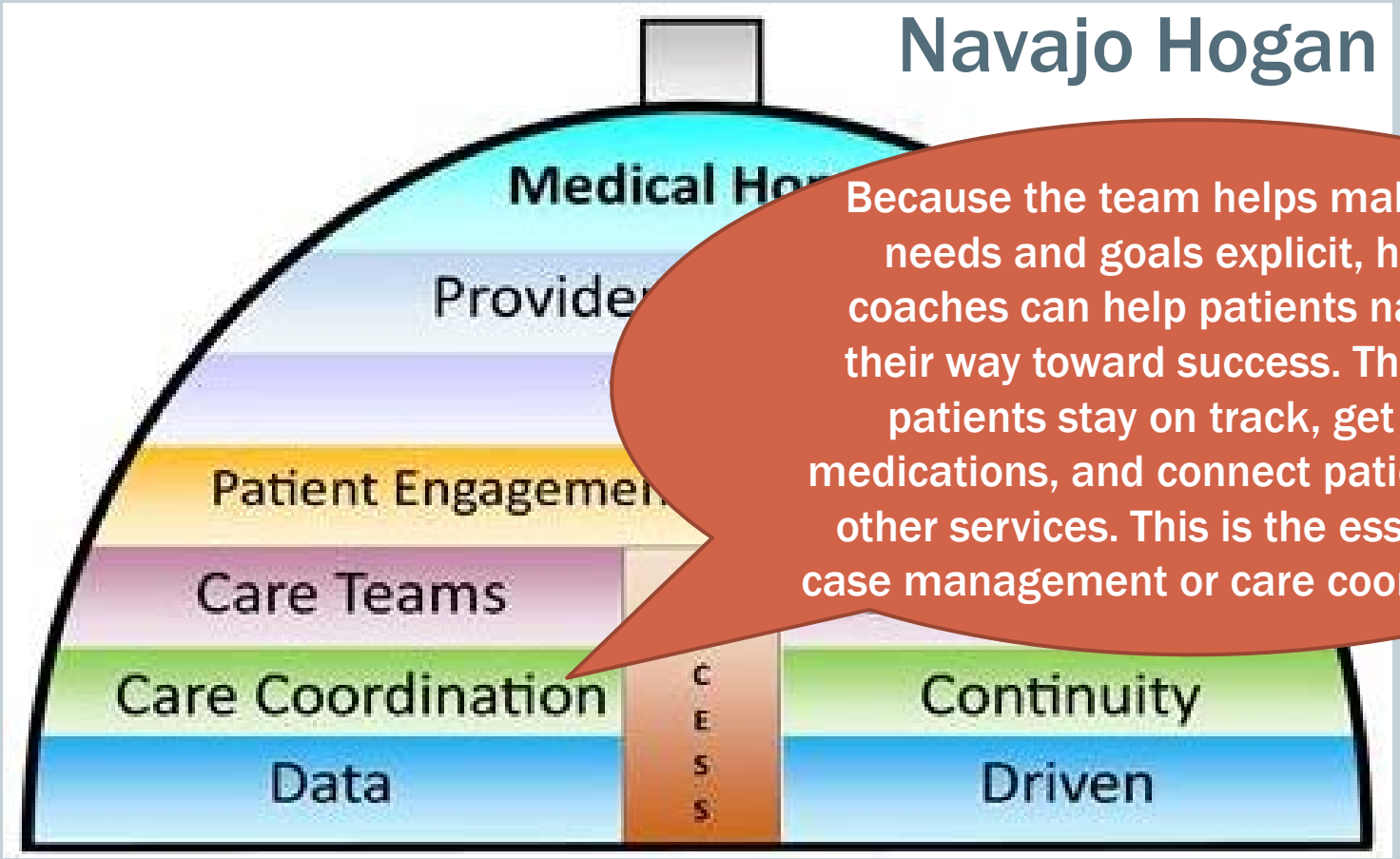

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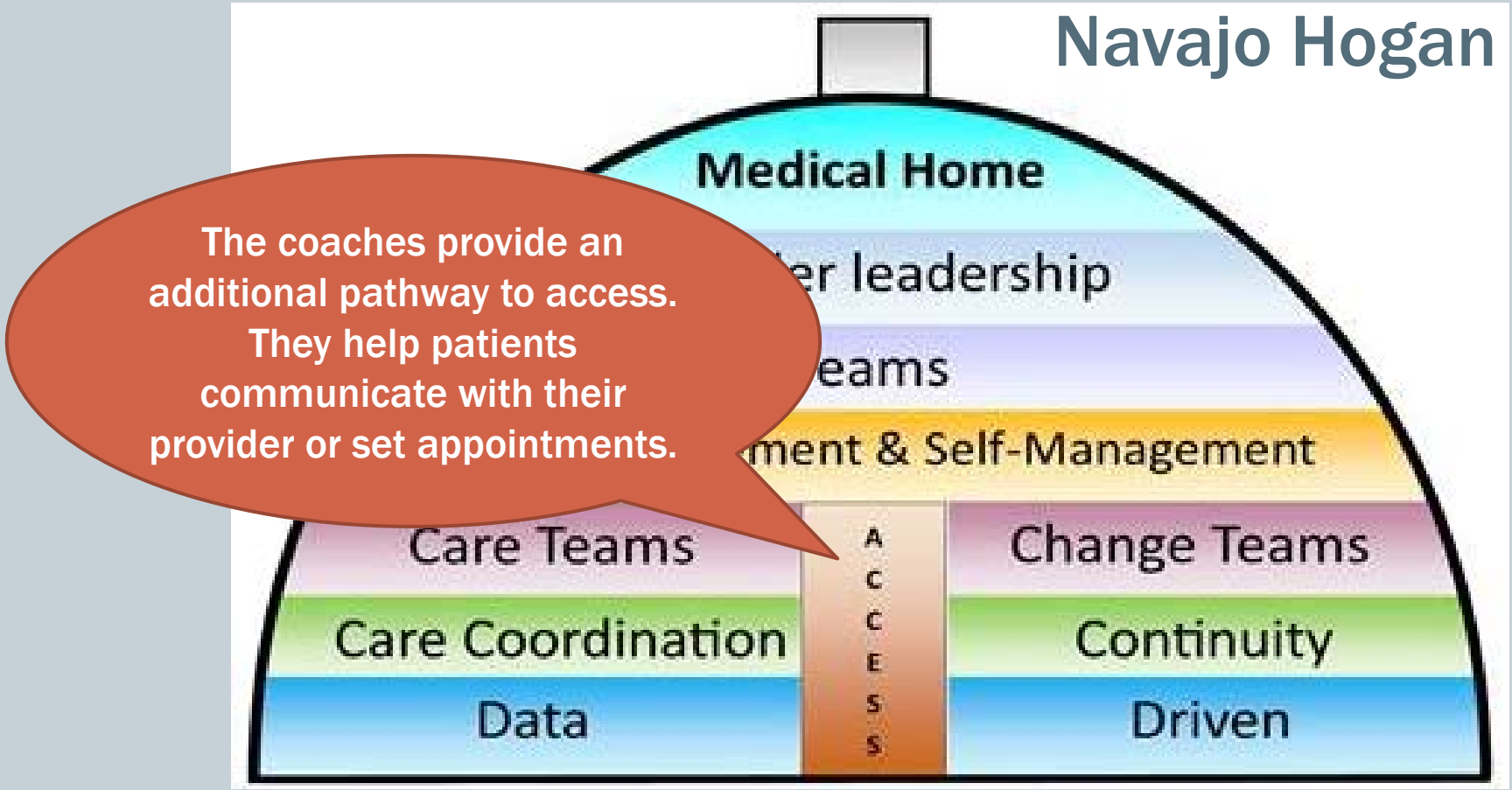

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PATIENT SUCCESS STORY

DIABETES CASE MANAGEMENT COHORTS

Case-Management	Goal
Pre-Diabetes	Educate pre-DM patients with updated handouts and wellness center and nutrition referrals
Newly Diagnosed (Best Practice)	Engage new DM patients in care, support their personal journey with DM, educate them about DM and its management (ADCES self-care behaviors), and treat with lifestyle interventions and medications
Primary Care	Utilize motivational interviewing, self management, goal setting, and educate patients about DM with a focus on A1C < 8, Blood pressure < 140/90, Statin use for patients that have risk factors and/or >40 to decrease cardiovascular risk
Inpatient/Emergency/Urgent Care	Influence patients to use their care teams for follow-up and introduce Diabetes Health Coach model-of-care
Teen/Pediatric clinic	Healthy Habit and SMART goal setting
ADCES patients	Glycemic control and risk reduction

BEST PRACTICE PROJECT

GLYCEMIC CONTROL: EARLY AND SUSTAINED

- **Target Population:** Patients with new onset DM ages 30-60, residing in a CSU community, A1c ≥ 8% at the time of diagnosis
  - Primary goal is to achieve A1c <8%
  - Annual cohorts since 2015
- **Background:** Early glycemic control is associated with improved diabetes outcomes; providing an opportunity to alter the trajectory of DM morbidity.
  - In one study, the authors estimated a 7-fold mortality benefit for a 1% reduction of A1c in Y1-10 with diabetes compared to Y11-20 with diabetes (18.8% reduction vs. 2.7% reduction)[1].
- **Intervention:**
  - Assign a health coach to every patient in the target population
  - Early engagement, support, and case management in team-based primary care with emphasis on diabetes education, self-management support, and outreach
  - Additional options for education and support from Nutrition, the Wellness Center, Integrated Behavioral Health, Office of Native Medicine

1. M Lind, Diabetes Care, 2021

WHAT DO WE NEED TO DO TO BE SUCCESSFUL?

- Provide comprehensive primary care
  - Education about lifestyle
  - Prescribe and monitor medications
  - Self-management support with motivational interviewing and assessment for readiness to change
  - Track glycemic control
  - Screening and evaluation for prevention and early detection of complications
- Support individuals with new onset diabetes to accept this diagnosis
  - Recognize the emotional burden of the diagnosis
  - Build trust
- Help newly diagnosed become and remain our “partners in care”
  - Fragmented care to continuity
  - Understand the health system and engage with primary care
  - Case management to track visits and keep the primary care relationship going

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Coaching provides emotional support and helps build trust for primary care.

We added a case management role in support of continuity and navigation.

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THE FIRST SIX YEARS TAUGHT US….

….we could be successful

- **Evaluation:**
  - Comparison of glycemic control for the first three cohorts to similarly selected patients from the three years preceding the QI project
- **Results:**

  The Best Practice participants
  - Achieved an average A1c 1.0% lower ($p<0.001$)
  - More likely to achieve A1c <8% (58% vs. 42%, $p=0.013$)

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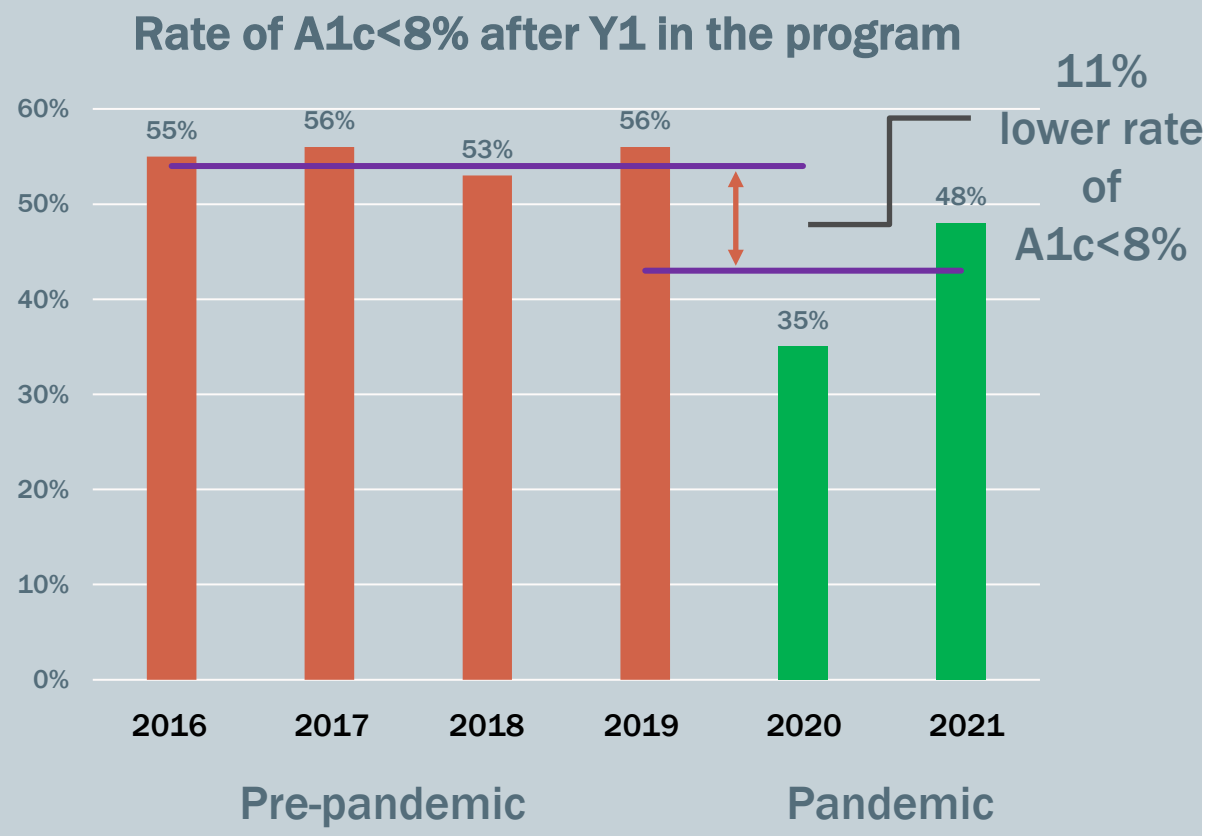
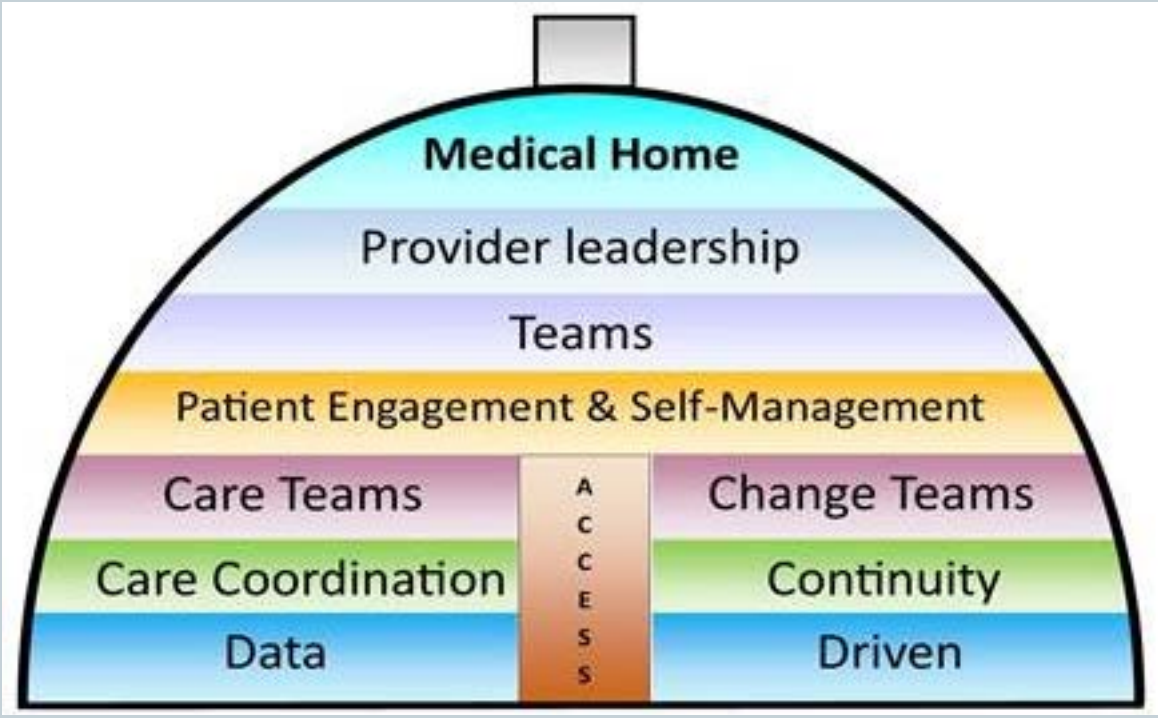
…..COVID affected this vulnerable population



LESSONS FROM THE BEST PRACTICE

- Data driven
- Patient engagement and self-management
- Care team
- Continuity
- Care coordination
- Access



MENTORSHIP: WHO ARE OUR COACHES ?

- Local Navajo tribal members – bicultural and bilingual
- Variable educational backgrounds:
  - High school grads
  - College graduates: health promotion, nutrition
  - Medical assistant
- Non-licensed professionals
- Selected for experience, ability and potential
- Trained on the job with a competency-based curriculum

TRAINING DIABETES HEALTH COACHES

- Extensive orientation with curriculum
  - Shadowing
- Ongoing support
- Competencies
  - Competency based career advancement

TRAINING DIABETES HEALTH COACHES

- Motivational Interviewing
- Brief action planning
- Ask-tell-ask
- Teach back strategies
- Shared decision making
- Empathic listening
- Culturally sensitive communication
- Case management skills
- Electronic Health data tools

ADCES: LEVEL ONE/TWO CAREER PATH FOR DIABETES EDUCATORS

Level One Characteristic: Level 1 includes community healthcare workers and other non-professional healthcare providers who have little expertise in diabetes education and/or management, but provide and/or support healthcare services to individuals with diabetes. This level includes, but is not limited to: health promoters, health educators, and community health workers. **Level One Definition:** This level comprises healthcare workers who do not have a clinical background, but who nonetheless work with persons with diabetes in supportive or clinical environments.	**Basic** Need to develop skills & confidence in this area		**Developing** Making some progress and have begun to acquire skills & confidence		**Proficient** Skills and confidence have developed significantly (Can perform "teach-back")		**Advanced** Highly proficient level of skills and fully confident. Can teach/mentor other employees (Consistent positive patient change in outcome)	
	Self Assessment: Initial/Date	**Mentor Assessment** Initial/Date	**Self Assessment** Initial/Date	**Mentor Assessment** Initial/Date	**Self Assessment** Initial/Date	**Mentor Assessment** Initial/Date	**Self Assessment** Initial/Date	**Mentor Assessment** Initial/Date
Domain One: Pathophysiology Epidemiology, and Clinical guidelines of diabetes. **Competency: Demonstrates familiarity with pathophysiology, epidemiology, and clinical guidelines consistent with diabetes care for a provider level one.**								
Lifespan 1. Identifies and refers high risk and/or patients with unstable diabetes to diabetes care providers 2. Encourages use of family and community support systems 3. Identifies support systems								

PEER EVALUATION CHECKLIST: CHRONIC DISEASE/DIABETES HEALTH COACH PEER EVALUATION

EMPLOYEE NAME : _____ Title:_____ Clinic:_____

Average Score: _____ (Supervisor to determine) Evaluator's Name:_____

Instruction Key:	**Evaluation Key:**	**Validation of Competency**			
Includes: R= Role play education F= Clinic observation/participation D= Demonstration in case study discussion	O= Observation RD= Return Demonstration V= Verbal **Education Level Key:** N= Novice PR= Practitioner P= Preceptor	Date	Initials	Evaluation Key	Education Level
Peer evaluation					
Pre-plans and meets with care team for action plan for each patient					
Introduces self to patient in a culturally competent manner					
Attempts to build trust/rapport with respectful communication					
Uses motivational interviewing skills to determine patient barriers					
Directs patients to the 7 self-care behaviors for setting goals: Healthy eating, being active, monitoring, taking medication, problem solving, risk reduction, and healthy coping					
Articulates correct diabetes language and examples to describe diabetes pathophysiology and management					
Set a goal with the patient and set a time for follow-up					
Communicates patient information in a clear manner with other members of the diabetes					
After visit follow-up done with the patient in a timely manner					
Navajo language and interpretation					
Peer evaluation for Duties					
Insulin start					
Newly diagnosed diabetes					
Glucometer use					
Low blood sugar prevention and treatment					
General nutrition					
Pre-DM education					
Medication review					

Name:	**Initials:**	**Signature:**

Suggestions/Comments:_____

_____

LIST OF COMMUNITY RESOURCES

List of Resources

For Children	
Aquatic Center-Chinle Unified School District	June & July Summer Pool Hours: Mon. & Wed. 6:00pm-8:00pm, Fri. 11:00am-1:00pm** Hours of operation are seasonal POC: Aquatic Center Supervisor (928) 674-9487
Early Steps to School Success-Chinle Elementary School	Program serves children 0-3 years of age to promote early literature skills. POC: Program Coordinator, Karen Spencer (928) 674-9355
Office of Youth Development	Seasonal Sports- T-Ball, Baseball, Football, Basketball Registration and fees for each sport POC: Receptionist, (928) 674-2064/2066
Wings of America Summer Camp	Program services children 6-18yrs old to promote fitness POC: Wings Coordinator, Emily Jackson, (505) 982-6761
Girls on the Run Northern Arizona	Program offered to Many Farms Public School to promote fitness and making healthy nutrition choices. POC: Admin. Assistant, Alberta Gorman(928)674-7602
Shiprock Kid's Marathon	

For Recreational	
Wellness Center, Indian Health Services	Monday-Friday 6am-9pm, Saturdays 6am-4pm Closed- Thursdays, 8am-12am, Sundays, Holidays (Government Observed) POC: Administrative Assistant, (928) 674-7529
Bicycle Rides-Chinle Health Promotion	April/May, Spring Seasonal Bike Rides POC: Recreation Specialist, Eula Billie (928) 674-7487
Diabetes Awareness Walk/Run-Diabetes Program	Community event scheduled in February & November POC: Administrative Assistant, Estinda Jibie (928) 674-7788
Tsaile Dine College Museum Tours	Hours of operation are seasonal POC: Office Assistant, Alex Mitchell (928) 724-6654
National Park Service Canyon de Chelly Visitors Center	Hikes into the canyon https://www.nps.gov/cach/planyourvisit/calendar.htm https://www.nps.gov/cach/planyourvisit/loader.cfm?csModule=security/getfile&PageID=555692 Phone contact: 928-674-5500 Abbie Jumbo
Annual Walking for Healthier Nations- Health Promotion	Community walk and bike ride, event scheduled in April/May POC: Recreation Specialist, Eula Billie, (928) 674-7487
Community Clean-up - National Park Service	Annual event scheduled in the months of March/April POC: Devon Gorman, (928) 674-5500
The New Dawn Program	Program provides education on horticulture, food preservation, nutrition, and the distribution of vegetable and follower seeds, trees, and gardening supplies. POC: Program Educator, Wanda Clark, (928) 674-2281 or (928) 871-6874

For Food	
Program services for children 0-5 years of age. Home visits are targeted to promote healthy food choices,	Program services for children 0-5 years of age. Home visits are targeted to promote healthy food choices, gardening, and obesity prevention.

Updated 6.27.2017

List of Resources

gardening, and obesity prevention.	
Fruits and Vegetable Program	Program increases knowledge of healthy food and beverage options. POC: Administrative Assistant, Alberta Gorman(928)674-7602
Commodity Supplemental Food Program	Providing commodity food to eligible low-income households POC: Technician, Fort Defiance Office (928) 729-4022
Food Bank Distribution-Lady of Fatima Church	
Department for Self-Reliance /Temporary Assistance for Needy Families (TANF)	Assisting eligible families in need. Program target is to educate parents and provide necessary resources to become self-reliant POC: Receptionist, (928) 674-8194 or (866) 700-5175

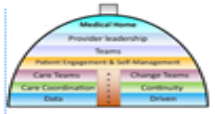
For Assistance	
Division of Social Services (DSS)	Family Services-Foster Care, Guardianship, Adoption, Counseling, etc. Adult Services-Elderly Protective Services, Institutional Care, Long Term Care Services, In-Home Care Financial/Cash Assistance-Temporary assistance for short term education/training needs, burial assistance, emergency assistance. POC: Administrative Assistant, (928) 674-2050/2051
Navajo Nation Department of Child Support Enforcement	Assisting families that seek Child Support services, including: establishing paternity, child support, and medical support POC: Receptionist, (928) 674-2300 or (866) 732-2223
Social Security Administration	Family services-Social Security Benefits, SSI, Disability, Name Change, Manage or Change Social Security Benefits, etc. POC: Administrative Staff, (928) 674-5295 or (800) 722-1213
Women, Infants, and Children (WIC)	Provides assistance to mothers and children 0-5 years old with supplemental foods, health care referrals, and nutrition education. POC: Receptionist, (928) 674-2184
Car seat clinics- HIS Injury Prevention Program	Car seat clinic is conducted monthly at one of the following sites Rock Point, Chinle, Pinon, Tsaile Health Center. POC: Chinle Clinic, Charlotte Hadley (928) 674-7486, Pinon Office, Tina Yazzie (928) 725-9704, Tsaile Office, Sheridan Nodestine (928) 724-3725
Alcoholic Anonymous Narcotic Anonymous Meetings- Chinle Area	Chinle Monday 7pm-8pm (AA/NA) Seventh-Day Adventist Church Tuesday 12p-1pm (AA) Treatment Center (DBHS) Wednesday 7:30pm-8:30pm (NA) Seventh-Day Adventist Church Thursday 12p-1pm (AA) Treatment Center (DBHS) Thursday 6:30pm (Addiction Recovery) Church of Jesus Christ of LDS Thursday 7:30pm (Spouse and Family Support) Church of Jesus Christ of LDS Thursday 7:30pm-8:30pm (AA) Seventh-Day Adventist Church ⟶ Canyon DeChelly Groups – Freddie Brown (928) 349-1749, Lisa H. (928) 349-7826 ⟶ LDS church call (662)312-8000 ⟶ Chinle Jesus Anonymous - Don K. (830) 733-0554

Updated 6.27.2017

List of Resources

	⟶ Chinle Treatment Center (928) 674-2589 ⟶ Alcohol Addiction Hotline (877) 750-9526 ⟶ National Substance Abuse & Disorder (800)622-4357 Outpatient Treatment Centers Behavioral health services Chinle (928)674-2190 Crownpoint (505) 786-2283 Fort Defiance (928) 729-4012 Shiprock BHS (505) 368-1050/1051 Tuba City BHS (928) 283-3032 Dilkon BHS (928) 657-8000 Page Treatment Center (928)645-6840
School/Community Flu Clinics-Public Health Nursing Dept.	Scheduled throughout Chinle, Many Farms, Rough Rock, Nazlini Seasonal Dates run through October and November yearly POC: Program Assistant, (928) 674-7179

Updated 6.27.2017



Medical Home Teams

Chinle Service Unit

Department	Team	Care Coordinator	Providers
Internal Medicine Fax (928) 674-7906	Sage	**Kristin St. Germaine, RN** **Case Manager** (Detailed) **Savanah Begay,** **Care Coordinator** P(928) 674-7061 Cell (928) 221-9466 **Vacant, Care Coordinator** P (928) 674-7896 Cell (928) 380-8896	David Goldberg, MD Christina Knight, MD Jennifer McRae ANP Joshua Wadlin, MD Elizabeth Stranges, MD Xavier Orcutt, MD
	Yucca	**Regina Fuller RN Case Manager** P (928) 674-7062 Cell (928) 380-8157 **Samanthaleen Honyumptewa,** **Care Coordinator** P (928) 674-7894 Cell (928) 380-3904 **Tammy Roane,** **Care Coordinator** P (928) 674-7895	Sayumi De Silva, MD May Tanay, ANP Jacqueline Selig, ANP Leslie Stewart, MD Puthiery Va, MD Donald Miles, MD
Family Practice Fax (928) 674-7702	Cedar	**Vacant RN Case Manager** P (928) 674-7928 **Lena Lewis HT,** **Care Coordinator** P (928) 674-7919 Cell (928) 380-8124 **Colleen Begay HT, Care C**	John Tisdale, MD Joseph Salay, MD Jonathan Powell, MD Clair Ojima, MD Samantha Austin, ANP Elizabeth Winfield ANP Rona Suen NP
	Juniper	**Heidi Eikom, RN** P (928) 674-7898 F (928) 674-7702 **Joncita Todechine,** **Care Coordinator** P (928) 674-7749 Cell (928) 380-8126 **Candelaria Jim,** **Care Coordinator** P (928) 674 7893	Andrew Baker, MD Evan Taylor, MD Jessica Weeks, MD Stephen Neal, PA Elizabeth Ziatyk, MD Esther Shin, MD Alean Frawley MD Charlene Brush NP

In the event that a Care Coordinator cannot be contacted, please call Shavonna White, RN (Assistant Chief Nurse Executive) Outpatient Department (928) 674-7459
Updated 10/20/2022

Chinle Service Unit

Department	Team	Care Coordinator	Providers
Pediatrics	Morning Mist	**Cephia Jim, RN** **Case Manager** P (928) 674-7405 F (928) 674-7458 **Rose Yellowhair, MSA**	Joseph Salay, MD John Tisdale, MD Elizabeth Ziatyk, MD Kelly Menachof, MD Evan Taylor, MD
	Sunbeam	RN Case Manager — Vacant P (928) 674-7066 F (928) 674-7458 **LaTonya Jones MSA**	Annie Moon, CPNP Benjamin Simms, MD Jillian Mador, MD Carrie Warner PNP
	Rainbow	**Lenora Mark, RN Case Manager** P (928) 674-7840 F (928) 674-7458 **Zhaun Harvey, MSA**	Sayumi De Silva, MD Robert Solomon, MD Esther Shin MD Molly Alexander Jessica Miller

In the event that a Care Coordinator cannot be contacted, in Chinle please call Shavonna White at (928) 674-7459

Case Managers

Department	Case Manager	Phone & Fax
Adult/Specialty	**Steffanie McCloud RN CWCA CMS** **Aggie Davis, HT**	P: (928) 674-7271 P: (928) 674-7750 F: (928) 674-7706
OB/GYN F: (928) 674-7706 F: (928) 674-7729	**Pam Guy HT,** **Shawna Yoe HT** **Vacant, RN**	P: (928) 674-7055 P: (928) 674-7057
Specialty F:(928) 674-7627	**Jane Littrel RN (Surgery)** **Kim Begay RN (Breast)** **Kaye Wartz RN (Nephrology)**	P: (928) 674-7470 P: (928) 674-7589 P: (928) 674-7709

Department	Practitioner	Phone
Native Medicine	**Woody Tsosie** (outpatient) **Sherman Woody** **Vacant**	P: (928) 674-7042 P: (928) 674-7586 P: (928) 674-7586
	Leroy Nelson (Pinon Health Center) **Roland Begay** (Public Health)	(928) 725-9534 (928) 674-7588

Monday-Friday 8-5 (no coverage Thursday AM from 8-12, Lunch 12-1)
In the event that a practitioner cannot be contacted, call Cassandra Tah at (928) 674-7181.

Your Care Team

Matthew Werito, Health Coach
Phone: 928-674-7896
Email: matthew.werito@ihs.gov

Wilma Hunter-Pine, RN, Nurse care coordinator
Phone: 928-674-7754
Email: wilma.hunterpine@ihs.gov

Internal Medicine
Primary Care Provider
Appointment desk
928-674-7069

Chinle Comprehensive
Healthcare Facility
Drawer PH
Chinle, AZ 86503

IMPROVING PATIENT CARE
IMPROVING THE QUALITY OF AND ACCESS TO CARE

PERSONAL HEALTH RECORD

Personal Health Record

What is the Personal Health Record?
The Indian Health Service Personal Health Record (PHR) can help you access your health information. You can track medications and lab results, contact your health care provider, and much more - all from the privacy of your personal computer and mobile device.

When should I use the Personal Health Record?

The PHR is a tool that provides you with timely access to your health information. It is not a substitute for meeting with your health provider. If you are experiencing a medical emergency, call 911 or go immediately to the closest emergency room.

https://phr.ihs.gov

Baa Hózhǫ́ Care

Engaging Patients as Partners in care

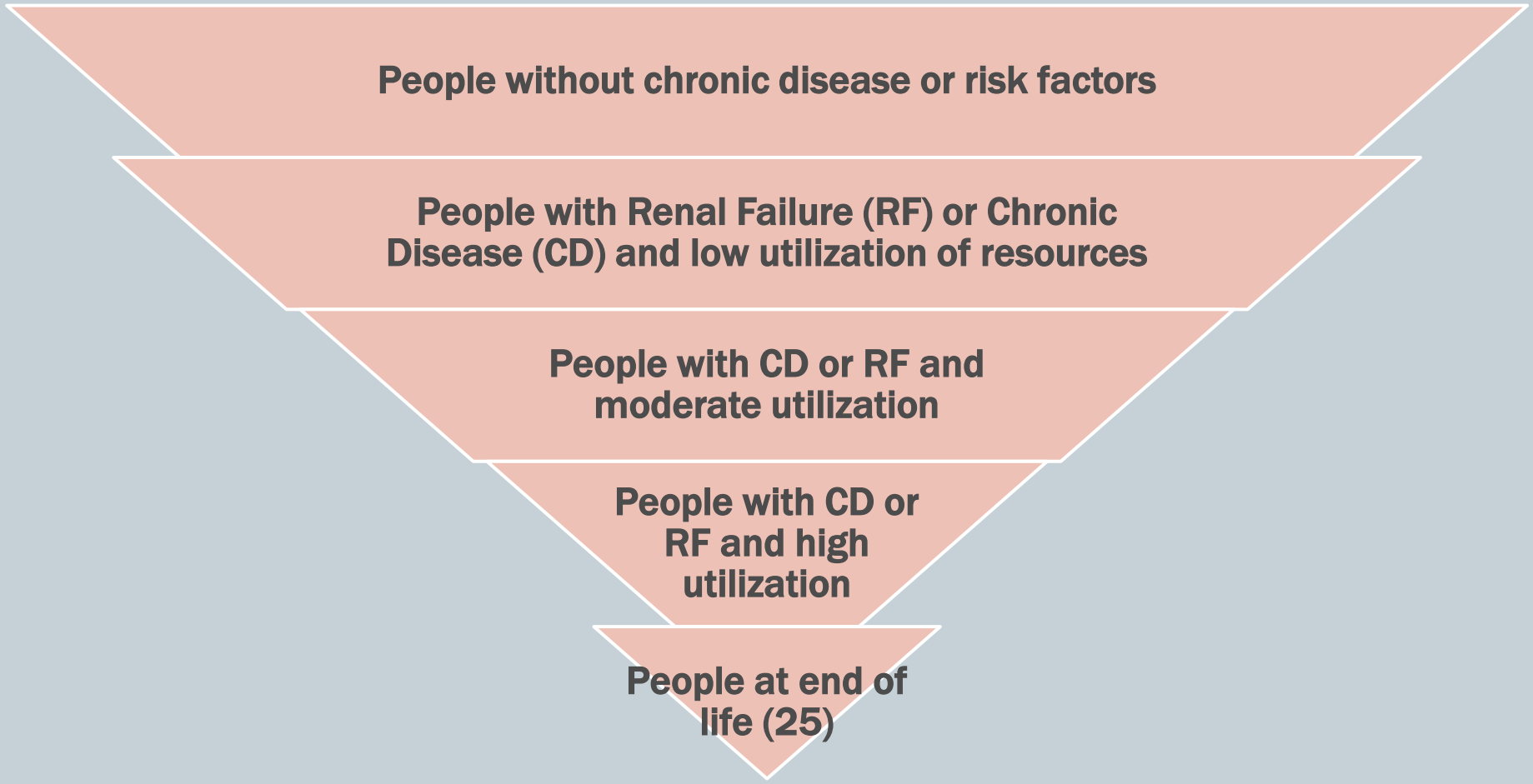
Chinle Comprehensive
Health Care Facility

POPULATION HEALTH AND THE QUADRUPLE AIM

- Population Health: "the health outcomes of a group of individuals, including the distribution of such outcomes within the group."[1]
  - Traditionally the domain of public health
  - Impacted by the local social determinants of health
  - Important for health equity
  - **More recently, primary care is embracing population health for their empaneled patients**
- Quadruple aim[2]
  - Enhancing patient experience
  - **Improving population health**
  - Reducing cost
  - Improving the work life of health care providers

1. D Kindig, Health Affairs, 2015
2. T Bodenheimer, Annals of Family Medicine, 2014

POPULATION SEGMENTATION MODEL
(RPMS DATA)



RPMS UTILIZATION

- Active users, living, CSU communities
- Histogram (frequency distribution) of ER visits in past year
- Histogram of hospital or transfers in past year, exclude birth and delivery
- Crosstab by number of ER and hospital/transfers

CHRONIC CONDITIONS

- DM
- HTN
- Heart disease or MI
- COPD
- Arthritis
- Depression
- Kidney disease
- Stroke
- Cancer
- Asthma
- Developmental delay
- Disability
- SA/Etoh abuse
  - Etoh lab value, withdrawal dx, abuse dx
- Prior trauma
- IPV positive
- Depression/anxiety
- Morbid obesity (BMI>35)

CASE MANAGEMENT: ICARE REGISTRY

Currently:

- Asthma
- COPD
- HIV/AIDS
- Diabetes
- Hypertension
- CVD Known
- CVD At Risk
- Obese
- Pre-DM Metabolic Syndrome
- Tobacco Users (Smokers)
- Pregnant
- Glaucoma
- End Stage Renal Disease
- Chronic Kidney Dis NOS
- Chronic Kidney Dis Stg 1
- Chronic Kidney Dis Stg 2
- Chronic Kidney Dis Stg 3
- Chronic Kidney Dis Stg 4
- Chronic Kidney Dis Stg 5

Future possibly to add:

- Acquired Hypothyroidism
- Acute Myocardial Infarction
- Depression
- Alzheimer's Disease, Related Disorders, or Senile Dementia
- Anemia
- Heart Failure
- Atrial Fibrillation
- Hip / Pelvic Fracture
- Benign Prostatic Hyperplasia
- Hyperlipidemia
- Cancer, Colorectal
- Cancer, Endometrial
- Cancer, Breast
- Osteoporosis
- Cancer, Lung

Future possibly to add:

- Rheumatoid Arthritis / Osteoarthritis
- Cancer, Prostate
- Stroke
- Cataract
- Schizophrenia and Other Psychotic Disorders
- Autism Spectrum Disorders
- Hepatitis C (already have a Change Request)

DM AUDIT TOOL

- RPMS for criteria
- Make a registry
- iCare panel
- Pull into excel
- Chart review new diagnosis
- Assign to the health coaches
- Case management

Approximately 60 pts on average fit the criteria

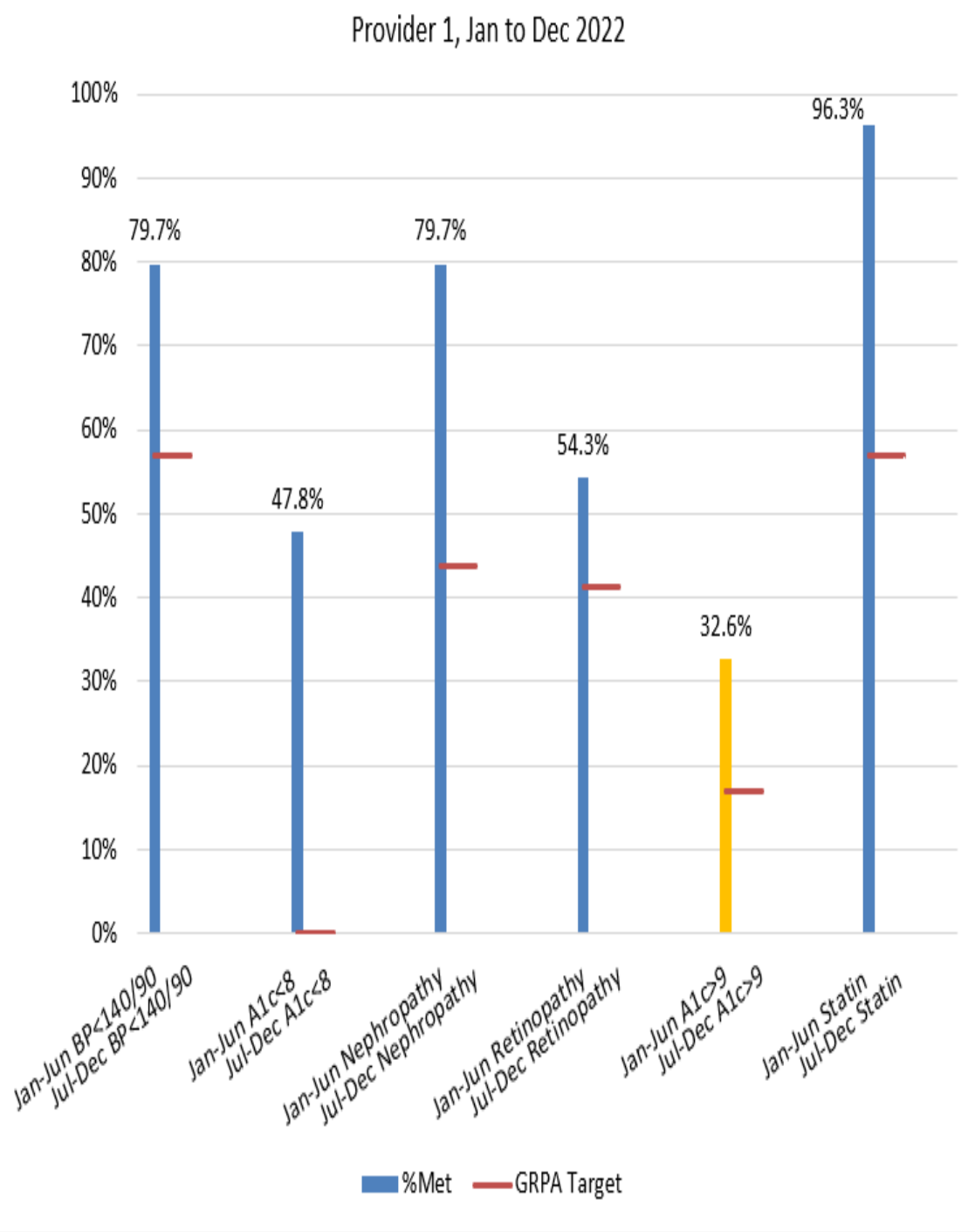
Provider 1	% Met	# Patients in Denominator	# Patients in Numerator	2022 Goal
DM: BP <140/90	79.7%	138	110	57.0%
DM: A1c<8	47.8%	138	66	
DM: Nephropathy	79.7%	138	110	43.7%
DM: Retinopathy	54.3%	138	75	41.2%
DM: A1c>9	32.6%	138	45	16.8%
DM: Statin Therapy	96.3%	109	105	56.8%

Jul-Dec

Provider 1	% Met	# Patients in Denominator	# Patients in Numerator	2022 Goal
DM: BP <140/90				57.0%
DM: A1c<8				
DM: Nephropathy Assessed				43.7%
DM: Retinopathy				41.2%
DM: A1c>9				16.8%
DM: Statin Therapy				56.8%

Should be less than 16.8%

	%Met	GRPA Target
Jan-Jun BP<140/90	79.7%	57.0%
Jul-Dec BP<140/90		57.0%
Jan-Jun A1c<8	47.8%	0.0%
Jul-Dec A1c<8		0.0%
Jan-Jun Nephropathy	79.7%	43.7%
Jul-Dec Nephropathy		43.7%
Jan-Jun Retinopathy	54.3%	41.2%
Jul-Dec Retinopathy		41.2%
Jan-Jun A1c>9	32.6%	16.8%
Jul-Dec A1c>9		16.8%
Jan-Jun Statin	96.3%	56.8%
Jul-Dec Statin		56.8%



Audit Years: 2017 to 2021

Chinle Service Unit (Chinle, Pinon, Tsaile) 5 year comparison	2017	2018	2019	2020	2021
BLOOD SUGAR CONTROL					
A1c <7.0					
A1c 7.0-7.9					
A1c 8.0-8.9					
A1c 9.0-9.9					
A1c 10.0-10.9					
A1c > =11.0					
Not Tested or No Valid Result					
A1c <8.0					
A1c >9.0					
BLOOD PRESSURE CONTROL-Based on l value or mean of 2 or 3 values					
<140/<90					
140/90 - <160/<100					
160/100 or higher					
BP category undetermined					
If age >=60, <150/90					
HYPERTENSION					
Diagnosed ever					
Diagnosed hypertension & mean BP <140/90					

ENHANCING PATIENT EXPERIENCE

1. In the last 6 months, did you contact this provider's office to get an appointment for an illness, injury, or condition that needed care right away?
    - Yes
    - No
2. In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away. How often did you get an appointment as soon as you needed?
        - Never
        - Sometimes
        - Usually
        - Always

(Insert 2a: During your appointments within the last 6 months, how often did you feel that your concerns were adequately addressed? Never/Sometimes/Usually/Always).

(Insert 2b): Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you see a specialist for a particular health problem? (CAHPS 20):

(Insert 2c): In the last 6 months, did the provider seem informed and up-to-date about the care you get from specialists? (CAHPS 21)

IN SUMMARY, WE TALKED ABOUT….

- The principles and attributes of high quality primary care
  - We described the multi-faceted Medical Home Model
  - The importance of teams and relationships
- The role of health coaching and their integration into the primary care team
  - The contribution of health coaches to care in a Medical Home
  - The importance of competencies for a para-professional workforce
  - Extending the coaching role (and competencies) to include focused case management
  - Having tools for health coaches to use when they apply case management functions
- Principles of population health in primary care
  - Using the Electronic Health Record to support the design and/or tracking of population health efforts

AHÉHEE’