



## Section 3: Additional Support for Trainers

This section of the guide includes a checklist to help you prepare for a training presentation, tips for facilitation, a training plan for Area IST members, a glossary of terms related to improving patient care and two blank pages for your notes.



## CHECKLIST FOR PREPARATION

The following checklist is not all inclusive and is provided to guide you and your team as you prepare to participate virtually in this exciting and informational three-day event.

- Leadership support** — are the leaders and/or sponsors at your organizations attending?  
Think about Tribal and Community leadership also.
- Contingency Plan** — Slide handouts are on the Listserv and the IPC Web portal [www.healthcarecommunities.org](http://www.healthcarecommunities.org) and in the case of disconnection from the National IPC office; forward them to all participants at your site.
- Rooms**
  - Schedule meeting room with adequate seating, computers, phones, screens, speakers, etc.
  - Designate and label rooms, have seating and tables.
  - Ensure rooms have internet access and conference call capabilities.
  - (In each room) Have a copy of: agenda, call-in info, phone number to call with technical problems.
  - Assign a greeter to stay in the room during the breakout session to troubleshoot problems.
- Equipment/Resources**
  - Need laptops or computers for five rooms.
  - Speaker phones/conference call equipment for five rooms.
  - LCDs/PowerPoint Presentation equipment for rooms that need projectors.
  - Extension cords/power strips.
  - Access Adobe Connect with each laptop (before start of first session); start this process no sooner than 30 minutes ahead of time.
    - If you've never logged into Adobe Connect, please test your connection to Adobe prior to the call at: [ih.s.adobeconnect.com/common/help/en/support/meeting\\_test.htm](https://ih.s.adobeconnect.com/common/help/en/support/meeting_test.htm).
    - If you need a quick Adobe Connect overview: [adobe.com/go/connectpro\\_overview](https://adobe.com/go/connectpro_overview).
    - Once you have entered the Adobe room, please select to have Adobe call you, if at all possible.
  - Some computers time out, "lock out" or go to "screen saver mode" after about 10 minutes — plan ahead how to manage the screen saver.
  - Have IT person(s) on standby and/or assisting with coordination efforts of IT equipment.
- Agenda/Room Schedule**
  - Prepare schedules with local time zones, room locations and Adobe session number (optional).
- Breaks**
  - There are breaks built into each day.
  - Provide drinks, snacks, order in food or have a potluck for your attendees as the sessions are continuous (optional).

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### Print Materials

- Print hard copy of each presentation's slides for each room.
- Copy all documents requested to have on hand (for reference).
- Signs to place on buildings or room doors to indicate the session scheduled.

### Invitations

- Will you invite non-team members?
- Will invited people need an IPC orientation ahead of time?

### Communications to participants

- Will not be time to go out for a meal: bring food/drinks.
- Email agenda: print it for yourself.
- Reminder: if hard copies of handouts will not be available, tell invitees, "Please print and bring your own copies before sessions begin."

### Important information regarding Adobe system and phone lines:

National conference lines are limited through the Adobe system. Use one call-in line for all attendees when calling in to Adobe connect, if possible.

For questions, please refer to: Susan Anderson, [susan.anderson@ihs.gov](mailto:susan.anderson@ihs.gov) (the rest of the team is involved with the learning session).

## TIPS FOR MEETING FACILITATION AND TRAINING

### *A Group Facilitator's Role — and Cultural Competency*

As a facilitator, you help a group discuss an issue, make a decision or solve a problem. You keep the group moving forward toward its stated goals. By listening, observing and using your intuition, you are also aware of individual needs and desires. While the group focuses on the task, you focus not only on the process but also on the people.

Cultural awareness is tremendously important. Culture affects how people communicate, understand and respond. The way a trainer communicates can show respect for Native people's beliefs, values and traditions. Personal introductions may include a handshake, for example, but a strong, firm grip may be taken as an aggressive gesture, whereas a gentler grip may show respect. When presenting information to Native audiences, listening is just as important as talking. Provide others a chance to share their feelings and concerns. Moderate the tone, speed and volume of your voice to match theirs. Remember that silence is often used to process and gather thoughts. Be respectful of this.

Ensure time for the audience to process the information and ponder questions. Do not speed through a presentation; provide ample time between sections or slides to allow the audience to identify with the information. One technique often used in conveying information among Tribes is storytelling. Consider weaving in time for examples, best practice information or share what has and hasn't worked in a particular scenario.

With the proper facilitation skills and knowledge, you can help any group achieve its goals efficiently and enjoyably.

### *Knowledge and Skills of a Good Facilitator*

An effective facilitator:

- » Listens and observes.
- » Uses visual aids effectively (overheads, flipcharts, etc.)
- » Records ideas legibly.
- » Asks probing questions.
- » Thinks quickly.
- » Acknowledges and responds to emotions.
- » Paraphrases and summarizes.
- » Resolves conflict.
- » Uses gentle humor.
- » Knows a variety of techniques for group discussions, including problem solving and decision making.
- » Designs or chooses appropriate group discussion techniques.
- » Understands people and groups.
- » Energizes the group.

### *Values and Attitudes of a Good Facilitator*

An effective facilitator must also hold certain values and attitudes. Demonstrate the following values and attitudes yourself and you will help foster them in those with whom you work:

- » **Respect and Empathy.** All ideas are important. Listen and speak with respect.
- » **Cooperation.** You can create an environment that fosters respect and teamwork.
- » **Honesty.** You and the group need to be honest and open about feelings, values and priorities.
- » **Responsibility.** The facilitator's actions affect the group's content, participation and actions.
- » **Flexibility.** Be sensitive to group needs and adjust process and schedule as necessary.

### MEETING FACILITATION TIPS

**1. Maintain an informal, relaxed style; pay attention to your body language.**

*"Thanks for your thoughts."... "That's a good point. Do you have anything else to add?"*

Smile. Open your hands and arms often; do not fold your arms across your chest.

**2. Respond to nonverbal behavior.**

*"You look like you have a question." ... "Something seems to be on your mind. What is it?"*

**3. Attempt to involve all participants.**

*"Would someone else care to comment on this?" ... "What other points of view are there?"*

**4. Keep the discussion on track.**

*"It looks like we have drifted off our agenda. Shall we continue or get back to our topic?"*

**5. Deal effectively with objections and disagreements.**

*"You have some concerns about this recommendation."... "Who can give us the advantages?"*

**6. Move the discussion along to a conclusion or decision.**

*"Is everyone clear on the proposal?" "We've talked a lot about it; the consensus seems to be ..."*

**7. Help the group identify clear action items and commitments.**

*"Let's brainstorm a list of tasks that must be completed to reach this objective."*

**8. Close the meeting on a positive, forward-looking note.**

*"How do you feel about what we accomplished today?" ... "Let's take a few minutes to reflect on our meeting process. Anything we might want to consider doing differently next time?"*

*Sources: Indian Health Service; Ontario Ministry of Agriculture, Food and Rural Affairs; Strategic Training Solutions.*

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## IMPROVING PATIENT CARE (IPC) AREA IST TRAINING PLAN

The document below is available for download from the HealthCare Communities Portal [[www.healthcarecommunities.org](http://www.healthcarecommunities.org)] in the IPC Community Area IST folder. It is reproduced here for information only. Area IST members should download the document, complete the requested information and send it to Susan Anderson at [susan.anderson@ihs.gov](mailto:susan.anderson@ihs.gov).

IMPROVING PATIENT CARE (IPC) — AREA IST TRAINING PLAN IPC – MS CURRICULUM IMPLEMENTATION	
Purpose: IPC – MS Implementation Planning	Area:
Effective Start Date: 10/01/15	Area IST Lead:

### Purpose:

Improving Patient Care – Made Simple (IPC – MS) will support the IPC 2.0 aim by teaching the foundational principles of Quality Improvement (QI) to participating I/T/U care teams within each of the 12 IHS Areas. This form enables each Area office to record information needed for the successful implementation of an IPC – MS offering.

### 1. Dates of IPC – MS Training Events

SESSION	DATE	LOCATION (MAY BE A VIRTUAL MEETING)
Two-Day Training		
One-Day Training: Month 3		
One-Day Training: Month 6		
One-Day Training: Month 9		

### 2. Participating Teams

ORGANIZATION NAME	SERVICE UNIT	EMAIL OF DAY-TO-DAY CONTACT	PHONE # OF DAY-TO-DAY CONTACT
Add rows as needed			

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### 3. Faculty

TOPIC	FACULTY 1	FACULTY 2*
IPC – MS Introduction and Overview		
IPC – MS History		
Building a QI Team		
The Model for Improvement		
Practice Self-Assessment		
Empanelment		
Data Management for QI**		
Optimizing the care team		
Access to Care		

\* Assigning a second faculty member to each session serves as a contingency/backup plan in case the primary faculty person is unavailable. It may not be necessary to have two faculty members cover a given topic.

\*\* Includes coaching participating teams in submitting data during IPC – MS

### 4. Preparation Prior to First Session

TASK	SUPPORTING MATERIAL	STATUS
Recruit teams	IPC National Team to complete this info	
Orient teams	IPC National Team to complete this info	
Orient faculty	IPC National Team to complete this info	
Meeting logistics confirmed*	IPC National Team to complete this info	
Meeting materials prepared	IPC National Team to complete this info	
Add additional rows if needed		

\* Meeting logistics may include confirming a venue and meeting room set up for a face-to-face meeting or, for a virtual meeting, establishing a link to a virtual session and testing its functionality prior to the meeting date.

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### 5. Activity Between Sessions

TASK	SUPPORTING MATERIAL	STATUS
Host monthly support calls		
Provide one-on-one support where needed or requested		
Share lessons learned/stories		
Support teams in submitting monthly data		
Add additional rows if needed		

### 6. Assessment

TASK	SUPPORTING MATERIAL
Add additional rows if needed	

## IMPROVING PATIENT CARE GLOSSARY

**Advanced Access:** A system in which patients have the opportunity to see their own providers when they choose and by various means not limited to face-to-face encounters. Examples may include: group visits, open access (same day appointments), telephone contact, secure messaging and a patient portal.

**Aim or Aim Statement:** A written, measurable and time-sensitive statement of the desired results of an improvement process.

**Annotated Run Chart or Time Series:** A line chart showing the results of improvement efforts plotted over time. The changes made are also noted on the line chart at the time they occur, allowing the viewer to connect changes made with specific results.

**Area Improvement Support Team (IST):** An IST is a three- to six-member interdisciplinary team whose function is to serve as lead faculty for instruction of IPC – Made Simple within their IHS Area and to support improvements in care in the field. Variably consisting of Area, Tribal and field staff, the IST serves as the infrastructure team for the sustainability of improvement in the Indian health system (IHS, Tribal and Urban Indian Health programs).

**Backlog:** Backlog consists of appointments that have been scheduled in the future due to lack of openings on the current schedule. These appointments represent delayed or deferred work.

**Best Practices:** Best practices can be defined as the most efficient (least amount of effort) and effective (best results) way of accomplishing a task, based on reproducible procedures that have proven themselves over time for large numbers of people.

**Carve-Out Model:** Also called the “carve-out” model of advanced access, whereby a number of appointment times each day are saved for same-day appointments. This can also be described as a partial open-access model in which some appointments are booked into the future and others are reserved for same-day only.

**Change Idea:** Change ideas are the list from which actual changes are generated. By using benchmarking and brainstorming, teams can formulate an actual change (intervention) for a Plan, Do, Study, Act (PDSA) cycle. By formulating change ideas, teams can identify what tests are needed for PDSA cycles.

**Change Package:** A collection of change concepts, key changes and specific examples of change ideas that serves as a resource for embarking on change within an organization.

**Clinical Information System (CIS):** A Clinical Information System (CIS) incorporates the development of a comprehensive, integrated information system that is “patient centered” and includes patient registries, a practice management system including a billing system, an electronic health record and personal health records.

**Collaborative Director:** Role is to develop and conduct evidence-based, structured curriculum courses that educate participants on IPC concepts, principles and application of the Model for Improvement in the health care setting.

**Cycle Time or Office Visit Cycle Time:** The amount of time in minutes that a patient spends at an office or clinic visit from the time of checking in for an appointment to the time of checking out. Additional information about cycle time is available at: [[www.ihl.org/knowledge/Pages/Measures/OfficeVisitCycleTime.aspx](http://www.ihl.org/knowledge/Pages/Measures/OfficeVisitCycleTime.aspx)].

**Data Collection Plan:** A specific description of the data to be collected, the interval of data collection and the subjects from whom the data will be collected. The IPC Data Collection Plan can be located on the IPC Knowledge Portal.

**Electronic Health Record (EHR):** The Resource and Patient Management System (RPMS) is intended to help providers manage all aspects of patient care electronically by providing a full range of functions for data retrieval and capture to support patient review upon encounter and follow up. Tribal and Urban Indian facilities may use other EHRs with similar features but without connectivity to IPC population health/management tools (see iCare below).

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**Empanelment:** A deliberate attempt to identify the group of patients for whom a physician or team is responsible. The number of actual unduplicated patients assigned to each PCP and/or Care Team.

**Greenbook:** Officially titled *Assessing, Diagnosing, and Treating Your Outpatient Primary Care Practice*, this is one of a series of workbooks developed by The Microsystem Academy at The Dartmouth Institute for Health Policy and Clinical Practice. It provides tools and methods that clinical teams can use to improve the quality and value of patient care. For more information and to download visit: [[clinicalmicrosystem.org/workbooks](http://clinicalmicrosystem.org/workbooks)].

**Huddle:** A brief clinic meeting among the microsystem to discuss the day's patient schedule. The huddle is held to ensure the team is prepared to meet the needs of each patient to be seen. Intended not to exceed 15-minute duration, huddles may be convened while standing or sitting, and should be in a HIPAA-secure space but need not be confined to a conference room. Every huddle should have an assigned leader and a specific agenda to prevent delay or distraction.

**iCare:** iCare is a population management software tool that helps organizations manage the care of their patients. The ability to create multiple panels of patients with common characteristics (age, diagnosis, community) allows personalization of the way patient data can be viewed. iCare is a Windows-based, client-server Graphical User Interface (GUI) to the IHS Resource and Patient Management System (RPMS). It retrieves patient information from various components of the RPMS database in a single, user-friendly interface.

**IHS Care Model:** IHS clinical leadership recognizes that fundamental changes in our system of care are required in order to achieve new standards of care. The IHS Care Model incorporates the following key elements: Anytime Access to the Care Team, Well Care and Sick Care (Preventive and Chronic care), High-quality, Reliable Care and Coordinated Team-based Care. The supporting foundations of the Care Model are Cultural and Spiritual Respect, Engaged Leadership, Integrated Clinical Information Systems and Community Involvement and Engagement. (See Care Model above.)

**IHS Change Package:** A step-by-step guide to transforming primary care delivery in the IHS to achieve the milestones of a patient-centered medical home. The sequenced approach of the change package ensures the development of initial capabilities laying the groundwork for later steps of implementation. (See Change Package above.)

**Improvement Advisor:** The improvement advisor is devoted to helping identify, plan and execute improvement projects throughout the organization, delivering successful results and disseminating changes throughout the entire system.

**Improving Patient Care (IPC) Program:** The IPC Program is the IHS initiative for establishing Patient Centered Medical Homes (PCMHs) throughout the Indian health system. Since 2008, this patient-care model has improved the quality of health care, provided greater access to care and strengthened the positive relationships between the care team, patients, their families, the community and the Tribe. Through health education, IPC engages patients more fully in decision making, emphasizing prevention and wellness. As the IPC program implements clinical quality enhancements, incorporating new models for health care delivery (including behavioral health integration), it will require the efforts of the entire care team and facility management to be successful.

**Improving Patient Care (IPC) 2.0:** After seven years of IPC Collaboratives using the Break Through Series model of learning, the IPC Program underwent a review and upgrade. The aim of the IPC 2.0 initiative is to transform the Indian health system at I/T/U sites through the three cornerstones of discovering, learning and applying quality-improvement processes and the Patient Centered Medical Home (PCMH) model of care to continuously improve the health and wellness of American Indians and Alaska Natives.

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### **Improving Patient Care – Made Simple (IPC – MS):**

IPC – MS teaches the foundational principles of Quality Improvement (QI) to participating I/T/U care teams, led by the Area ISTs, with a standardized curriculum maintained by the IPC program national staff. It allows for smaller group trainings at a regional level with more opportunities for face-to-face engagement and facilitation.

### **Improving Patient Care Medical Home (IPCMH):**

Replacing the Quality and Innovation Learning Network, IPCMH develops capability in IHS primary care practices to achieve Patient Centered Medical Home (PCMH) milestones and ultimately PCMH recognition. A 16-month recurring curriculum of webinars educates participants on the National Committee for Quality Assurance (NCQA) standards for PCMH recognition and illustrates the path for PCMH-related changes driven by the IPC 2.0 Change Package.

**Intensives:** Intensives are an intense immersion in focused topics lasting from six to 20 weeks for health care quality improvement topics not related to PCMH development, but of high priority to IHS. Teams will participate in frequent calls, collect data and collaborate with peers and subject matter experts to dramatically and rapidly accelerate improvement.

**Learning Community:** This is a network of organizations whose members work to achieve rapid, continual improvement. The community serves as a source of innovative, breakthrough improvement ideas inspired by others. The community provides the opportunity for peer exchange of ideas and is designed to drive and support the hard work of leading improvement and implementing sustainable change at the front line.

**Listserv:** A Listserv is an automatic electronic mailing list. Listservs are moderated to ensure appropriate content and applicable topics for the target audience. Registration for Listservs is required. For more information on the IHS Listserv, visit [[www.ihs.gov/listserv/index.cfm/topics](http://www.ihs.gov/listserv/index.cfm/topics)].

**Measure:** A measure is a measurement or indicator of change used to track the delivery of proven interventions to patients and to monitor progress over time. They are the way in which change implementation is measured or evaluated.

**Microsystem:** Clinical microsystems are the front-line units that provide most health care to most people. They are the places where patients, families and care teams meet. Microsystems also include support staff, processes, technology and recurring patterns of information, behavior and results.

**Model for Improvement:** An approach to process improvement developed by Associates in Process Improvement. It involves asking three questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What change can we make that will result in improvement? The Model for Improvement helps teams accelerate the adoption of proven, effective changes using the Plan, Do, Study, Act (PDSA) cycle.

**Office Hours:** Scheduled conference calls or webinars with multiple participating organizations that address specific or varied topics and or interest areas.

**Optimized Care Team:** The optimized care team has each member of the team working most effectively together to maximize the supply of the clinic's services and to improve the flow of work and patients. Working at the height of licensure or credentials is a crucial principle of optimizing care team functioning.

**Patient-centered Care:** Care that is truly patient centered considers patients' cultural traditions, their personal preferences and values, their family situations and their lifestyles.

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### **Patient Centered Medical Home (PCMH):**

A Patient Centered Medical Home is a team-based model of care led by a personal provider who, as part of the care team, provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.

**Plan, Do, Study, Act (PDSA) Cycle:** PDSA is a major component of the model for improvement. The focus of the PDSA is experimentation. This model has four steps to test changes, provide a way for testing ideas, enable one to learn from the testing and move ahead with better-informed actions to make improvements. The four steps are:

- » **Plan.** Specific planning phase.
- » **Do.** Attempt the change and observe what happens.
- » **Study.** Analyze the results of the trial.
- » **Act.** Devise next steps based on the analysis.

**Practice Assessment:** Practice assessment tools from the *Greenbook* that support teams in their quality improvement work. Assessing the "5Ps," — Purpose, Patients, Professionals, Processes, Patterns — and reflecting on their connections and interdependence often reveals new improvement and redesign opportunities. The aim is to get the big-picture view of your system, which allows teams to see beyond one patient at a time.

**Process Change:** A specific change in a process of the organization; a process change describes what specific changes should occur.

**Process Mapping:** An activity that diagrams the steps, decision points and influencing factors in a workflow process to bring forth a clearer understanding of that process or series of parallel processes.

**The Resource and Patient Management System (RPMS):** An integrated solution for the management of clinical, business practice and administrative information in health care facilities of various sizes. For more information, visit [[www.ihs.gov/rpms](http://www.ihs.gov/rpms)].

**Run Chart:** This is a graphic representation of data over time; it is also known as a time series graph or line graph. This type of data display is particularly effective for process improvement activities.

**Sampling Plan:** The sampling plan is a specific description of the data to be collected, the interval of data collection and the subjects from whom the data will be collected.

**Self-Management Support (SMS):** SMS is the care and encouragement provided to people with chronic conditions to help them understand their central role in managing their illness, making informed decisions about care and engaging in healthy behaviors.

**Service Population:** A broad operational definition of those who might reasonably be expected to use the services of a given organization. For IPC purposes, service population is defined as all persons who have had one visit within the past three years to anywhere within the organization.

**Sponsor:** The executive in the organization who supports the team(s) and manages the resources employed in the processes to be changed.

**Virtual Training/Learning:** A process to create and provide access to learning when the source of information and the learners are separated by time, distance or both. Virtual training or learning is also the process of creating an educational experience of equal qualitative value for the learner to best suit his or her needs when a face-to-face meeting is not possible. Web conferencing and webinars are typically used to conduct live meetings or presentations via the internet. In a web conference, each participant or team sits at a computer and is connected to other participants via the internet.



