Chinle Service Unit Improvement Work

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Outline

• Background on CSU
• Improvement milestones
• Triple Aim overview
• Improvement governance
• Improvement leadership
• Improvement learning system
• Improvement examples
• Challenges and meeting them
Navajo Nation
Chinle Service Unit

• Comprehensive health care and public health services
• Serves over 30,000 people, mostly Navajo
• One hospital, 2 health centers
• Almost 1000 employees
• Operating budget of >$90 million
Improvement Milestones

- Chinle Hospital Outpatient Project (CHOP) – 1996-2001
- Tapestry of Wellness – 2000
- Culturally based improvement model – 2003
- Improving Patient Care (IPC) – 2007
- Bluebirds formed – 2009 (IPC2)
- Balanced Scorecard – 2010
- Joined Triple Aim in 2012
The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. Accomplished by pursuing the three dimensions:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

The Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts (www.ihi.org)
Concept Design

IHI’s innovation team developed a concept design and described an initial set of components of a system that would fulfill the IHI Triple Aim.

• Focus on individuals and families
• Redesign of primary care services and structures
• Population health management
• Cost control platform
• System integration and execution

The Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts (www.ihi.org)
The Triple Aim Collaborative

• IPC-like collaborative process with learning sessions, online meetings, change packages and measures
• Other sites from across the country and the world
• Work done through improvement teams using the model for improvement with tests of change and measures

The Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts (www.ihi.org)
CSU Improvement Governance

- Incorporated Triple Aim concepts into strategic plan
- Aligned strategic measures and Triple Aim measures
- Approved participation in Triple Aim collaborative as strategic initiative
- Progress reported quarterly to executive committee
Chinle Service Unit Tapestry of Wellness 2014-2016

Chinle Service Unit Vision
Sá’ah Naaghél Bik’eh Hózhóón bee ii’ná dóó bee oodááл.
A prosperous journey of beauty and healthy living

Mission
As’ah na’adá dóó asáh oodááł biniiyé ahi
nidelnishgo binahji’ nihi Diné’ bits’íls
hadáa’té náádleé.
To provide accessible, safe, high quality,
community guided public health services.

Walking in Beauty:
Customer Perspective
- Achieving wellness through self-reliance
- Ensuring exceptional customer experience

Learning: Workforce Perspective
- Growing our own
- Promoting effective communication
- Ensuring quality work-life
- Assuring competent, culturally appropriate staff

Healing: Internal Process Perspective
- Building stewardship
- Supporting services improvement
- Building partnerships
- Building relationships with patients and families
- Assuring interdepartmental collaboration
- Supporting Iná (healthy living)
- Improving health outcomes
- Optimizing health services

Harvesting: Financial Perspective
- Assuring Financial Accountability
- Optimizing Revenue Generation

Certified by the Diné Medicine Man Association, Inc. 05.2014
CSU Improvement Leadership

Bluebirds

• Team of senior and mid-level leaders
• Supported by Quality Management
• Meets weekly
• Online meetings so all locations can easily participate
• Hosts monthly internal improvement collaborative
The Bluebird Aim:

The Bluebirds aim to effectively guide, promote, support and communicate improvement work throughout Chinle Service Unit using the Tapestry of Wellness.
How Do The Bluebirds Guide?

Modeling and Coaching Improvement Practices

Developing Partnerships

Building the Capacity of Improvement Teams

Communicating Improvement Accomplishments
CSU Improvement Teams

- Across all divisions in organization
- Multidisciplinary
- Meet at least monthly
- Defined leaders, members and meeting times
- Use the model for improvement with change ideas, action plans, tests of changes and measures of success
Sa'ah naagháí Bik'eh Hózhóó bee ii'Nov bee oodáát.
A prosperous journey of beauty and healthy living.
CSU Tapestry of Wellness Vision
Doorway
Ahiłna’anish doo Alhaa’ácohwiiinidzin
Commitment and Accountability

North
Sihasin
Reflecting

West
Iiná
Implementing

South
Nahat’á
Planning

CSU Performance Improvement Cycle
# CSU Population Level Measures

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Proposed Measure</th>
<th>Data Source</th>
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</table>
| Population Health   | Self reported health status  
Injury related ER visits  
Childhood healthy weight  
Diabetes incidence  
Diabetes prevalence | Customer survey  
RPMS  
CRS  
RPMS  
CRS |
| Experience of Care  | Amb care patient satisfaction  
Patient confidence  
Outcome bundle  
30 day readmission rate | Customer Survey  
Customer Survey  
RPMS  
NDW |
| Per Capita Cost     | Emergency room utilization  
Urgent care utilization  
Hospital bed days    | RPMS  
RPMS  
RPMS |
Our Triple Aim Population

CSU User Pop (35,000)

Empanelled Pts (25,000)

Diabetic Patients (3500)

Hospitalized Patients (2000)
# Portfolio of Projects

<table>
<thead>
<tr>
<th>Projects</th>
<th>Improvement Teams</th>
<th>Project Measures</th>
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</thead>
<tbody>
<tr>
<td>Improving Patient Care Medical Home</td>
<td>All 5 Primary Care Improvement Teams</td>
<td><strong>Outcome</strong>: ED/UC visits; Child Immunizations; Outcome Bundle; Primary care access</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Process</strong>: Continuity Rates; Supply/Demand Ratio</td>
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<tr>
<td>Diabetes Healthy Heart Initiative</td>
<td>Diabetes Team with IM and FP Teams</td>
<td><strong>Outcome</strong>: A1c, LDL, BP under control; rate of hospitalization</td>
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<tr>
<td></td>
<td></td>
<td><strong>Process</strong>: Active diabetics current on comprehensive care measure; Percent of patients with a health coach visit</td>
</tr>
<tr>
<td>Chinle Hospital Engagement Network</td>
<td>5 Inpatient Improvement Teams</td>
<td><strong>Outcome</strong>: Inpatient satisfaction; Inpatient Safety Index</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Process</strong>: Measures of team function</td>
</tr>
<tr>
<td>Community Health Improvement Councils</td>
<td>3 teams of PHN, Health Promotion, NN CHR and NN Health Ed</td>
<td><strong>Outcome</strong>: Coalition Development Score</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Process</strong>: Attendance at Council Meetings by Sector</td>
</tr>
</tbody>
</table>
Our Triple Aim Portfolio

- **Improving Patient Care Medical Home** – focuses on establishing a medical home with primary care access and continuity
- **Diabetes/Healthy Heart Initiative** – focuses on improving diabetic care using health coaches to provide intensive care coordination and self management support
- **HEN (PfP Hospital Engagement Network)** – focuses on improving quality and safety of inpatient care and reducing readmissions
- **Community Health Councils** – supports formation of community health improvement councils in the three regions of the Chinle Service Unit to improve the health of the population using the Community Health Improvement Process (CHIP) Model.
Joogii (Oriole) Pediatric Clinic Improvement Team

• Formed in 2008 as part of IPC2
• Meets twice monthly
• Nurses, providers, MSA, CNA, medical assistants, PHN, Community Nutrition, CAC, and others
• Triple Aim connection – One of 5 teams in IPC Medical Home
Joogii Aim Statement

- Orioles (Joogii) bring happiness and harmony to Chinle Service Unit by providing excellent care to our community children. Specifically, we will test changes in our clinic and public health efforts to improve healthcare experience of all children and families.
Change Ideas Tested and Spread

- Formed multidisciplinary care teams with team rooms and coordinated scheduling
- Advanced access
- Care coordination
- Clinic flow and efficiency
- Parent involvement in improvement team
- Communication with families: Newsletters, brochures
- Clinical improvement projects: immunizations, asthma care, developmental screening, nutrition education
Team work is the name,
Your health is the gain!

Our pediatric providers supply important knowledge and skills that can help you and your family make healthy choices.

In creating care teams, we encourage our patients and their families to be active members of the team.

You and your family play the most important role on the team by choosing healthy activities, eating healthy foods, having safe behaviors, and getting the most from your healthcare visits.

Join a Team!
Choose a pediatric provider and be a part of your team.

"T'aa hwi ajit'eeego
It's Up To You!"

Contact your Health Team Coordinator:
LeShelly Crank, RN
Sunbeam Team: 674-7066

Please arrive 30 minutes before your appointment, Bring any medications your child is taking.
Primary Care Patient Survey - Percent agree to statement, "I would recommend this hospital to my family and friends."
Primary Care Patient Survey – Percent agree to question, “I am able to get the care I need and want-when I need and want it.”
Adult Care Unit Chi’íshiibeezhii (Chickadee) Improvement Team

- Formed in 2013
- IHS Hospital Consortium
- Meets monthly
- Includes nursing, providers, pharmacy, diabetes, PHN, and more
- Triple Aim connection – One of 5 teams in Chinle Hospital Engagement Network
ACU Chi’íshiibeezhii Team
Aim Statement

The purpose of the Adult Care Unit Chickadee Team is to develop strategies to assure the safety and improvement of the culturally sensitive quality care we provide to our Native American population, while increasing third party revenue/CMS reimbursement.

We will achieve this by: 1) Decreasing/preventing readmissions ≤ 30 days, 2) Improving patient safety by decreasing/omitting all patient falls, 3) Improving urinary catheter care/documentation, thus preventing CAUTIs, and 4) Improving our customer service.
Change Ideas and Tests

• Reducing readmissions
  – Investigating drivers
• Reducing falls
  – 7P’s hourly rounds, personal alarms, yellow slippers
• Decreasing incomplete/delinquent charts
• Improving patient satisfaction
  – Starting by improving response rate and data quality
Chinle Hospital Readmissions

Percent of Discharges Readmitted Back to CCHCF or Transferred from Chinle ED within 30 Days by Month

Percent Readmitted


Percent Readmitted (Median)

Moving Average
Understanding Readmissions

• Chart review of 105 readmissions from Feb 2013-April 2014

• Causes of readmissions:
  – Need for palliative care – 38%
  – Polypharmacy – 33%
  – Psychological issues – 20%

• Problem diagnoses:
  – Skin and soft tissue infection – 25
  – Diabetes - 12
  – Congestive heart failure – 11
  – Known terminal illness - 35
Chickadee Next Steps

• Implement care process models for diabetes, CHF, cellulitis
• Polypharmacy- test medication reconciliation at discharge
• Palliative Care – strategic initiative approved for feasibility study of local hospice and palliative care services
Challenges

- Competing priorities
- “Extra work”
- Proliferation of measures
- Limited capacity, skills and experience
- Leadership turnover
Meeting the challenges

- Senior leader involvement
- Long term view
- Aligning measures
- Aligning projects
- Sponsoring teams
- Building capacity
  - Data extraction staff
  - Internal collaborative
  - IHI Open School
- Communication
  - Internal collaborative
  - Newsletter for staff and community
  - CEO emails
THANKS!