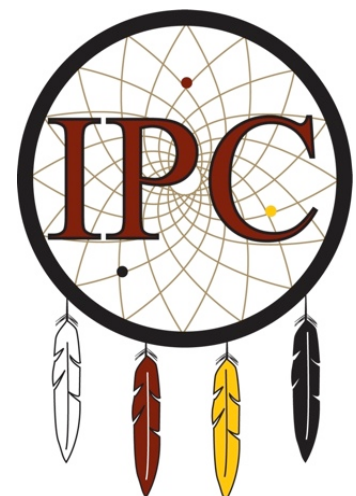




INDIAN HEALTH SERVICE IMPROVING PATIENT CARE RESOURCE GUIDE



JANUARY 2014



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OVERVIEW

Welcome to the Improving Patient Care (IPC) Program. This resource guide is intended to help orient your Improvement team to the IPC Collaborative 5.

BACKGROUND

The Indian Health Service (IHS) is responsible for the provision of healthcare to enrolled members of federally recognized Tribes either directly or through partnership with Tribal and Urban programs. It is a shared goal of all partners in the Indian health system to ensure universal access to high quality health care for American Indian/Alaska Native (AI/AN) people.

The IHS has four priorities aimed at system transformation; these priorities were established to meet current and future challenges of providing quality health care services for AI/ANs:

- (1) To renew and strengthen our partnership with Tribes;
- (2) To bring reform to the IHS;
- (3) To improve the quality of and access to care;
- (4) To make all our work accountable, transparent, fair and inclusive.

In keeping with these priorities, the Improving Patient Care (IPC) Program is an initiative to transform the Indian health system to a more integrated, well organized and higher performing system of care. A fundamental change from a provider-oriented approach to a patient/family/community-oriented system of care is needed in order to meet the future health care needs of the AI/AN people.

American Indian and Alaska Native people continue to be challenged by the disproportionately high prevalence of chronic conditions impacting AI/AN communities. While progress has been made on certain clinical measures, health disparities still remain.

As the number of AI/AN people with chronic illness increases, the Indian health system is increasingly challenged to provide evidenced-based optimal clinical outcomes, adequate delivery of preventive care services, and efficient access to care where and when needed. The Indian Health Service system must improve its performance in clinical and service quality in order to effectively prevent and address chronic disease, while also meeting the acute care needs of patients.

Therefore, the Indian health system must change and improve its delivery of care. This improvement can be achieved without costly resources, by predicting and managing patient demand, increasing efficiency in office and clinical practices, and streamlining the flow of patients.

IMPROVING PATIENT CARE PROGRAM

IPC PROGRAM MISSION

To partner with IHS, Tribal and Urban Indian health programs to improve health and promote wellness of American Indian and Alaska Native people through improved quality of and access to care.

IPC PROGRAM GOAL

The IPC program goal is to engage IHS, Tribal, and Urban (ITU) facilities in this transformation effort to improve the quality of and access to care by the end of 2015.

IPC 5

To transform the Indian health system to a more integrated, well organized, and higher performing system of care.

IPC COLLABORATIVE DESCRIPTION

Participants in IPC 5 will learn and implement an organizational approach to caring for AI/AN people in a primary care setting. The IPC 5 will focus on strengthening the positive relationships between the healthcare system/care team and the individual, family and community. Participating organizations will work together for 18 months to make improvements in preventive care, management of chronic conditions and patient's experience of care. Within 18 months all engaged sites will achieve a basic level of an Indian Health Medical Home (*see page 18 for more detail*) as evidenced by:

- Engaged leadership at all levels of the organization;
- Patient and family centered care;
- Healthcare that is vested in the culture and values of Tribes and communities;
- Effective and efficient access to the system of care when needed;
- Care Team optimization; and
- Health Information systems with improvement data to support effective communication, clinical decision-making, and patient self-management support.

The intent is to prepare teams to sustain improvements over time by implementing a system-wide model of care that focuses on assuring the delivery of evidence-based clinical care and strong support for self-management. Simultaneously, improvements in patient access will increase time available to meet Government Performance and Results Act GPRA prevention and chronic illness care goals.

Guidance:

- Engagement with Tribal leadership and community are essential features of IPC.
- The use and transparency of data to guide improvement is central to achieving an Aim.
- Alignment with organizational priorities and full support of clinical and administrative leadership at all levels within the Indian health system are critical to the success of IPC.
- Meaningful use of the Clinical Information System is important to the successful creation of the Indian Health Medical Home and quality improvement.

PARTICIPATION

The IPC 5 collaborative includes teams from IHS, Tribal, and Urban Indian health organizations. Working together with the IHS IPC National Team and faculty we will explore innovative models and approaches to guide the creation of an Indian Health Medical Home in your communities. Organizations will participate in a systematic approach to health care quality improvement in which they will test and measure practice innovations. IPC 5 sites will share their experiences in an effort to accelerate learning and widespread implementation of successful change concepts and ideas.

Although each participating team focuses on their own improvement designs and tests of change within their organization, continual communication with other IPC teams and faculty will remain intact through the use of conference calls, ADOBE CONNECT technology, the Internet, the IPC Listserv and e-mail. Internet access is required for any organization participating in the IPC program.

Each organization will submit monthly narrative and data reports. This allows transparent sharing of results and lessons learned with other participating teams and their internal senior leadership. Participation in IPC activities should not be limited to meeting attendees and we strongly encourage participating organizations to involve staff beyond the core care team members in LISTSERV discussions, conference calls, and site visits.

IPC MODELS AND CONCEPTS

Utilizing the Institute for Healthcare Improvement's (IHI) Breakthrough Series Learning Model to improve the care of participating sites' patients, IHS has worked with the IHI to complete four phases of this program (IPC 1, 2, 3 and 4). The IPC program utilizes the Chronic Care Model (CCM) (Wagner, 1998), which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. The CCM has been adapted to better reflect the unique features of the AI/AN healthcare system, emphasizing the role of families, communities, and Tribes.

Using the "patient-centered medical home" as a concept, the IPC program now refers to its change concepts as the Indian Health Medical Home (*see page 18 for more detail*) which represents a better way of organizing health care to meet the needs of AI/AN communities. The IPC program employs the Model for Improvement (Langley, 2009), a fundamental model which guides IPC sites through a process for testing and measuring their improvement efforts.

QUALITY AND INNOVATIVE LEARNING NETWORK (QILN)

After participating sites complete the collaborative and understand key improvement methodologies, they are eligible to join the IPC Quality and Innovation Learning Network (QILN). The QILN is geared to provide on-going collaboration and support for I/T/U programs that continually adapt and implement changes that lead to further improvement in quality and access to care.

FOUNDATIONS SERIES

The IPC Foundations Series is a series of training sessions designed to prepare non-participating sites for future participation in IPC. This series lays the foundation for committed engagement in the IPC Program. The Improvement Support Team members from each IHS Area will collaborate with the IPC National team in facilitating this series while encouraging the dissemination of the IPC Program throughout the Indian health system.

COLLABORATIVE EXPECTATIONS

PARTICIPATING TEAMS ARE EXPECTED TO:

- Align the Aim, Focus, and Goals of the care team with the organizational strategic plan;
- Complete pre-work activities and participate in all pre-work calls;
- Send consistent representatives from the Care Team to one (1) face-to-face Learning Session and four (4) virtual Learning Sessions;
- Participate in all Action Period calls between Learning Sessions and complete all assignments;
- Establish action plans;
- Commit to making specific, measurable changes within their organization to reach their goals;
- Perform tests of changes using PDSA rapid cycle methods;
- Complete monthly data and narrative reports for the duration of the Collaborative;
- Share information with the Collaborative, including details and measurements of changes made, both during and between Learning Sessions; and
- Present the teams' experiences and results when requested and prepare for dissemination of changes to other care teams within the organization.

Improving Patient Care (IPC) Program



SENIOR LEADERSHIP WILL:

- Participate in the IPC Leadership trainings;
- Serve as sponsors for the participating teams, serve as champions for dissemination of the changes within their site, and attend Learning Sessions;
- Provide the resources necessary to support their team, including staff time to invest in this effort (approximately 0.5 FTE or more is recommended for the duration of the collaborative);
- Provide expert staff from key support units in the organization (Quality Management, Clinical Information Systems, Finance, etc.) to support the team as needed and engage in the improvement processes taking place;
- Allow the care team time for testing and implementing changes;
- Attend rapid cycle PDSA training and understand concepts of comprehensive access, clinic efficiency, and planned care;
- Attend Care Team meetings;
- Review monthly reports and provide feedback to the teams; and
- Work with Area Improvement Support Team members to obtain ongoing consultation and support for problem solving and overcoming barriers.

NATIONAL IPC STAFF AND FACULTY WILL:

- Provide training and evidence-based information, application of subject matter content, training and methods for process improvement, both during and between Learning Sessions;
- Offer coaching and support to teams;
- Provide communication strategies to keep the teams connected to the National Team and to colleagues during the Collaborative;
- Host all Learning Sessions and conference calls;
- Be readily available to IPC teams, when needed;
- Assist teams to identify challenges and problem-solve solutions; and
- Review monthly reports and provide timely feedback.

COLLABORATIVE STRUCTURE

PRE-WORK

Pre-work is the timeframe prior to the first Learning Session. During this time, each team will participate in a series of 10 pre-work calls containing several important tasks to accomplish. Each call will last 60 minutes. During pre-work, teams will learn the terminology of the collaborative, the improvement models and methodologies, and begin to relate it to everyday work within the organization. Once the groundwork has been laid, teams will find their own methods of covering conference calls and accomplishing the work to meet their aims.

Including other organizational staff in pre-work is an effective mechanism to build the will for change, increase improvement capability, and to lay the foundation for expansion of improvements throughout the organization. The call-in number, conference information, and content of the calls will be announced and distributed prior to the calls.

SCHEDULE OF PRE-WORK CALLS (ALL ON TUESDAYS AT 3 PM ET)

<i>Date</i>	<i>Topic</i>	<i>Assignment</i>
<i>Jan 7</i>	<i>Introduction to IPC</i>	<i>Knowledge and Data Portal Scavenger hunt</i>
<i>Jan 14</i>	<i>Foundational Team Development and Communication</i>	<i>Identify and post Improvement team names onto Knowledge portal</i>
<i>Jan 21</i>	<i>CIS Training and Optimization</i>	<i>Test, run and assess CIS capabilities</i>
<i>Jan 28</i>	<i>Executing and Accelerating Change</i>	<i>Develop and Post AIM Statement</i>
<i>Feb 4</i>	<i>Empanelment and Identification of the microsystem</i>	<i>Empanelment related</i>

<i>Date</i>	<i>Topic</i>	<i>Assignment</i>
<i>Feb 18</i>	<i>Team Based Care and optimization of the Care Team</i>	<i>Test optimization of the Care Team</i>
<i>Feb 25</i>	<i>Patient and Family Centered Care</i>	<i>Test of change to Brief Action Planning</i>
<i>Mar 4</i>	<i>Tribe and Community</i>	<i>Upload a Tribal engagement experience to knowledge portal</i>
<i>Mar 11</i>	<i>Preparation for LS 1</i>	<i>Create a storyboard</i>

LEARNING SESSIONS

Learning Sessions are the major training events of the Collaborative. Through plenary sessions, group discussions, and team meetings, attendees have the opportunity to:

- learn from faculty and colleagues;
- receive individual coaching from faculty members and colleagues;
- gather new knowledge on the subject matter and process improvement;
- share experiences and collaborate on improvement plans; and
- develop strategies to overcome challenges to improvement.

ACTION PERIODS

The time between each Learning Session is called an Action Period. During Action Periods, team members work within their organizations to test and implement changes that will transform the system of care for their patients. Teams try out multiple changes in their organizations and collect data to measure the impact of the changes. Although participants focus on their own organizations, they remain in continual contact with other participating teams, IPC staff and faculty. This communication takes the form of conference calls, e-mail, a LISTSERV, and a virtual site visit to a high-performing health care organization. In addition, organizations share the results of their improvement efforts in monthly reports.

PREPARE A STORYBOARD

Each Learning Session is designed to create an environment conducive to shared learning.

Accordingly, each team is asked to create a storyboard for the first face-to-face learning session. You will receive additional information about the structure and process for this effort on the pre-work calls.

PREPARING YOUR ORGANIZATION

Pre-work is designed to help organizations accomplish the groundwork required before the initial Learning Session 1 (LS 1).

Checklist of Activities

- Develop Your Aim Statement.
- Define Your Clinical Microsystem.
- Create Your Care Team and Improvement Team.
- Complete Assessment of Your Clinical Systems (aka Green Book).

DEVELOP YOUR AIM STATEMENT

Improvement requires setting aims. An organization will not improve without a clear and firm intention to do so. The aim should be time specific and measurable. It should also define the specific population of patients that will be affected. Agreeing on the aim is crucial, as is allocating the people and resources necessary to accomplish the aim.

DEFINE THE MICROSYSTEM

The microsystem is a small, distinct, inter-dependent group of individuals who work together on a regular basis to provide care to a focus population of patients at the community's clinical facility level.

The emphasis of initial changes in practice during the collaborative is geared towards the focus population. This is the preliminary panel of patients of the microsystem. The panel should not be based on risk levels or conditions (i.e., patients with an A1C over 10 or all Diabetic patients), but based on a demographic type; such as patients seeing a primary care provider (PCP) for x amount of visits, an age group such as 18+ yr. olds, per PCPs, or a clinic type, based upon the active clinical user population.

During the initial period of the IPC 5 collaborative, Care Teams will have the ability to redesign the facility's clinical systems and to improve care for all patients. The expectation is that the defined microsystem is likely to be anywhere between 900 – 2,000 patients. Ideally, there should be >1000 patients in the microsystem, or if the focus population is < 1000, the microsystem should reflect the number of the total active user population. Too small of a focus population may mean that the Care Team can use short-term fixes that are not systemic changes but only accommodate a few patients.

Establishing a balanced microsystem and plans to disseminate the changes throughout your entire organization and all patients is paramount. With the appropriate selection of patients, the clinical site(s), the selected provider(s), and Care Team members along with effective changes attained with

the initial focus population, the Care Team can make a convincing case to senior leadership and other providers to include the dissemination of change within the entire organization.

CREATE YOUR CARE TEAM

The care team is an identified group of primary care providers and nurses, medical assistants, and other ancillary staff that provide care and support to patients in the microsystem. The care team is a part of the improvement team. Once the microsystem is selected, Care Teams will choose provider(s) and clinic(s) where appropriate primary care change concepts are most effective and are eagerly welcomed by community and staff. The Care Team is to concentrate their improvement efforts by assigning patients from the focus population to chosen primary care provider(s) for empanelment, and assess the identifiable changes in the microsystem.

CREATE YOUR IMPROVEMENT TEAM

You will be expected to identify a team that will be adapting and implementing the high leverage changes to improve access and efficiency in your clinical practice. This team will be actively involved for the duration of Collaborative.

Having an appropriate and effective improvement team is a key component of successful improvement efforts. Effective teams include members representing three different kinds of expertise within the organization: system leadership, technical expertise, and day-to-day leadership. There may be one or more individuals on the team with each kind of expertise. Or, one individual may have expertise in more than one area. In the end, all three areas should be represented to drive improvement successfully.

SENIOR LEADERSHIP

Sponsor: Teams need an individual with authority in the organization to institute and to overcome challenges that arise. The team's system leader understands both the immediate implications of the proposed change for various parts of the system and the more remote impact such a change might trigger. It is important that this person have authority in all of the areas that are affected by the change. This person must have the authority to allocate the time and resources the team needs to achieve its aim.

The work of the improvement team must be connected to the strategies of the organization, making it essential that the sponsor is accountable to his or her organization for the performance and results of the improvement team. This person is a formal member of the improvement team, and is responsible for communicating its progress to other leaders in the organization, tribe, and community. Most often in the Improving Patient Care team, the sponsor has been the CEO or COO of the organization. It *must* be someone who can bridge the gap between the clinical and operational chasm that often exists in health care organizations. The sponsor must have a basic knowledge of improvement, the authority to muster resources and address challenges in the organization, and a direct connection to senior leadership. The sponsor understands that his or her responsibilities include the success of the improvement team.

Other Leadership: Other senior members should be those that are responsible for assuring quality standards of care are provided. These individuals should also have a level of authority to assign roles, duties, and processes within the care system. These should include:

- Chief Nurse Officer/ Director of Nursing,
- Clinical Director/ Chief Medical Officer,
- Chief Financial Officer/Administrative Officer.

DAY-TO-DAY LEADER

The day-to-day leader will be the critical driving component of the team, ensuring that tests of change are implemented and overseeing data collection. It is important that this person understand not only the details of the system, but also the various effects of making changes in the system. This individual also needs to be able to work effectively with the provider champion, sponsor, and other department leads and staff members in the organization. The day-to-day leader will be the key contact at your organization. This individual is responsible for coordinating communications between the team, system leadership, and staff. This individual may be a provider, nurse manager, or clinic manager.

PROVIDER CHAMPION

It is critical to have at least one provider champion (physician, nurse practitioner, or physician assistant) on the team. This champion should be interested in driving change in the system and have a good working relationship with colleagues, the day-to-day leaders, and support staff. Look for providers who are positive opinion leaders in the organization (individuals sought out for advice who are not afraid to test change).

CLINICAL TECHNICAL EXPERT

A technical expert is someone who knows the subject in depth and who understands the processes of care. An expert on improvement methods can provide additional technical support by helping the team determine what to measure, by assisting in the design of simple, effective measurement tools, and by providing guidance on collection, interpretation, and display of data. This individual may be a provider, nurse, lab technician, pharmacist, quality improvement manager, a member from the front-office and medical records, information systems specialist, etc.

OTHER MEMBERS OF THE IMPROVEMENT TEAM

Improving care for all patients will require changes that cut across traditional department boundaries. To develop an overall system of changes within your organization, team members should be system thinkers with the ability to work across departments to test and effect change. The specific makeup of teams will vary, but some key roles to consider include:

- Primary care providers—physicians, nurse practitioners and physician assistants;
- Nurses, public health nurses, and community health representatives;
- Health technicians, medical assistants, and other direct care providers;
- Ancillary care providers, such as pharmacists, behavioral health providers, dietitians, therapists, and others;
- Quality improvement staff;
- Information system staff, such as Clinical Applications Coordinators, IT, and coders;
- Administrative and office staff; and
- Finance staff.

COMPLETE DIAGNOSTIC ASSESSMENT

DIAGNOSTIC ASSESSMENT

Each participating organization will complete a diagnostic assessment for its organization during the pre-work phase. Teams will be asked to complete the following sections of the *Assessing, Diagnosing, and Treating Your Outpatient Primary Care Practice* (also known as the *Green Book*, which is accessible at <http://www.clinicalmicrosystem.org/materials/workbooks/>). At a minimum, they should complete “Know Your Patients” and “Know Your Professionals” on page six, and “Walk Through” on page nine.

Collecting this information and discussing results with your team and colleagues will allow you to identify key areas where new designs are needed. It will also allow you to build a strategy for instituting effective, efficient planned care tailored to your organization’s strengths and existing capacity. The materials you need for the diagnostic assessments will be distributed and discussed on a pre-work call. We may offer additional diagnostic tools and activities based on the needs and issues you bring to the discussion.

LEADERSHIP FOR IMPROVEMENT

Leadership that drives improvement across all conditions, departments, and offices in a health care system requires a profound transformation of the system. The task of the leader is to create a vision that tells people where the team is going and how it will get there, to convey the big picture, and to create excitement about working together to achieve an objective.

Senior leaders are the ones who best understand that picture of the organization. Their primary responsibility is to lead the organization toward high-performance goals. With senior leadership support, a well-chosen improvement team can significantly improve the quality of care that an organization delivers. The senior leader of an improvement team must embrace the roles and responsibilities that will help the team achieve success.

SENIOR LEADERSHIP ROLES

SERVE AS A SPONSOR FOR THE IMPROVEMENT TEAM

The word sponsorship is synonymous with the words backing, support, resources, and protection. When the care team is confronted with obstacles that impede their progress, the care team will need your guidance to assist in overcoming challenges.

SELECT A TEAM

Using the team selection information in this resource guide will allow organizations to quickly identify individuals who will comprise your high-performing team.

SERVE AS A CHAMPION FOR EXPANSION OF POSITIVE CHANGES

Your team will generate positive results on a defined population of patients. A major role of senior leadership is to guide the dissemination of these changes throughout the whole organization. This effort includes engaging the health board or governing body to gain support in planning for expansion and in removing obstacles to change in the organization.

MAKE IMPROVEMENT A PRIORITY

Set the tone for the team and the organization that improvement is important. Align quality improvement to the strategic plan of the organization. Provide the team with time to meet. Convey the message that improvement is part of everyone's job—not an “add on.”

MONITOR THE PROGRESS OF THE TEAM

A key role of leadership is to monitor team progress, check in with the team leader regularly, and regularly attend Improvement Team meetings each month. The improvement team should provide a senior leader report with graphs that will be submitted to the IPC Portal and IPC leadership. IPC work should be integrated into the organization's quality improvement program and must be shared with the board as part of the quality improvement program.

Executive reviews of projects can be a powerful method for channeling leadership attention to quality initiatives. The following link will take you to a primer (Executive Review of Improvement Projects) that helps organizational leaders do effective project reviews focusing on results, diagnosing problems with projects, helping projects to succeed, and facilitating the dissemination of good ideas across the organization:

<http://www.ihl.org/knowledge/Pages/Tools/ExecutiveReviewofProjectsIHL.aspx>.

FUNDAMENTAL MODELS

CHRONIC CARE MODEL

The Chronic Care Model (Wagner, 1998) identifies the essential elements of a health care system that encourage high-quality chronic disease care. The evidence-based change concepts under each component foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, preventive services, health care settings, and target populations.

FIGURE 2: CHRONIC CARE MODEL

Developed by The MacColl Institute
©ACP-ASIM Journal and Books



SIX COMPONENTS OF THE CHRONIC CARE MODEL: CHANGE CONCEPTS

The following information is courtesy of Improving Chronic Illness Care (ICIC), a national program supported by the Robert Wood Johnson Foundation, with direction and technical assistance provided by the Group Health Cooperative's MacColl Institute for Health Care Innovation.

1. HEALTH CARE ORGANIZATION

- Create a culture, organization, and mechanisms that promote safe, high-quality care.
 - Visibly support improvement at all levels of the organization, beginning with the senior leader.
 - Promote effective improvement strategies aimed at comprehensive system change.
 - Encourage open, systematic handling of errors and quality problems to improve care.
 - Provide incentives based on quality of care.
 - Develop agreements that facilitate care coordination within, and across organizations.

2. COMMUNITY RESOURCES AND POLICIES

- Mobilize community resources to meet needs of patients.
 - Encourage patients to participate in effective community programs.
 - Form partnerships with community organizations to support and develop interventions that fill gaps in needed services.
 - Advocate for policies to improve patient care.

3. SELF-MANAGEMENT SUPPORT

- Empower and prepare patients to manage their health and health care.
 - Emphasize the patient's central role in managing his or her health.
 - Use effective self-management support strategies that include assessment, goal setting, action planning, problem solving, and follow-up.
 - Organize internal and community resources to provide ongoing self-management support to patients.

4. DECISION SUPPORT

- Promote clinical care that is consistent with scientific evidence and patient preferences.
 - Embed evidence-based guidelines into daily clinical practice.
 - Share evidence-based guidelines and information with patients to encourage their participation.
 - Use proven provider education methods.
 - Integrate specialist expertise and primary care.

5. DELIVERY SYSTEM DESIGN

- Assure the delivery of effective, efficient clinical care and self-management support.
 - Define roles and distribute tasks among team members.
 - Use planned interactions to support evidence-based care.
 - Provide clinical case management services for complex patients.
 - Ensure regular follow-up by the care team.
 - Give care that patients understand and that fits with their cultural background.

6. CLINICAL INFORMATION SYSTEMS

- Organize patient and population data to facilitate efficient, effective care.
 - Provide timely reminders for providers and patients.
 - Identify relevant subpopulations for proactive care.
 - Facilitate individual patient care planning.
 - Share information with patients and providers to coordinate care.
 - Monitor performance of practice team and care system.

IPC CARE MODEL

The original Chronic Care Model has been updated to reflect advances in the field of chronic and preventive care both from the research literature and from the scores of health care systems that implemented the Chronic Care Model in their improvement efforts. The IPC Care Model reflects those changes as well as the features of high-quality care outlined in the Quality Chasm report. The IPC Care Model differs from the Chronic Care Model in two important ways: (1) the inclusion of the six aims from the Quality Chasm report as criteria for high-quality services and (2) the addition of change concepts addressing staff development, cultural competence, care coordination, and patient safety.



INDIAN HEALTH MEDICAL HOME

Many health care organizations, including those within the Indian health system, are working on changes to their systems using the concept of the “patient-centered medical home (PCMH).” In IHS the Improving Patient Care (IPC) Program builds on this PCMH concept and refers to the changes made by IPC sites as the Indian health “medical home”, a patient-centered system of care where the Patient and Health Care Team work in partnership to achieve positive health outcomes while emphasizing the role of family, community, and Tribe in the approach to health care. The IPC program has established the foundation for Indian Health Medical Home transformation that includes six Change Concepts:

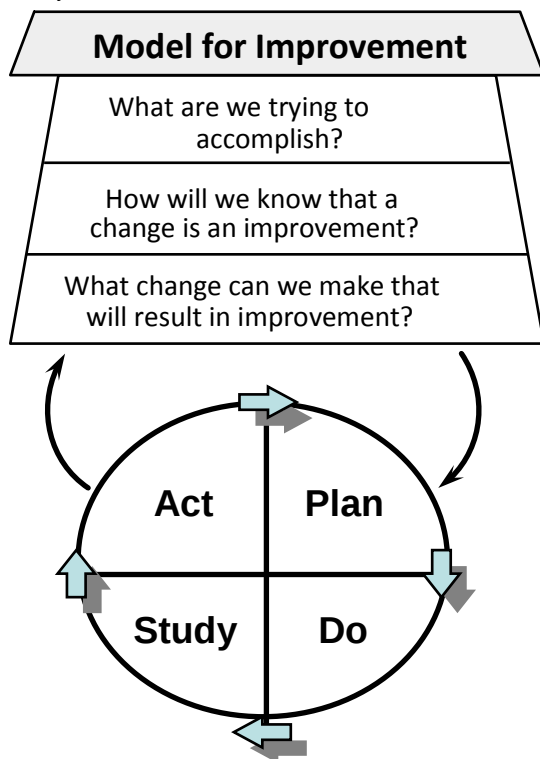
- **Engaged Leadership:** Leadership is highly engaged and visibly supports improvement efforts to include removing barriers to ensure success. Leaders allocate resources and build structure to sustain the improvements.
- **Patient and Family Centered Care:** Health programs design their services to put the patient and family at the center of care, to provide great customer service and to support them as they strive toward wellness.
- **Tribe and Community:** The culture and values of the Tribes and communities become part of the way care is organized and delivered. Health programs actively renew and strengthen partnerships with Tribal and community-based services to reach beyond the walls of the clinic to meet the needs of patients and families.
- **Optimized Care Team:** The doctors, nurses, pharmacists, physician assistants, therapists, clerks, lab technicians, and others involved in care are organized as teams that work in a coordinated and highly functioning manner to meet the needs of the patient. Care Teams improve efficiency and access to care.
- **Access and Relationship Continuity:** Every patient has a relationship with a consistent provider and Care Team and can count on reliable access to see that provider and Care Team for their ongoing care. This continuity helps patients achieve their health goals.
- **Culture of Quality and Transparency:** All staff members in the system have the skills, tools and resources for making improvement. Teams use measurements, clinical information systems and data to deliver better care.

MODEL FOR IMPROVEMENT

The Model for Improvement, developed by Associates in Process Improvement (Langley, 2009), is a simple, yet powerful tool, for accelerating improvement. The model is not meant to replace change models that organizations may already be using, but rather to accelerate improvement. This model has been used very successfully by hundreds of organizations in many countries to improve health care processes and outcomes.

FIGURE 4: MODEL FOR IMPROVEMENT

Langley et. al. (2009). The Improvement Guide.
Jossey-Bass: San Francisco



The Model has two parts. The top half of the diagram asks three questions and the bottom half portrays a cycle of actions.

THREE FUNDAMENTAL QUESTIONS

The Model asks three fundamental questions that can be addressed in any order.

WHAT ARE WE TRYING TO ACCOMPLISH?

Improvement requires setting aims. The aim should be time specific and measurable. It should also define the specific population of patients that will be affected.

HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?

Teams need both quantitative and qualitative feedback to determine if a specific change actually leads to an improvement. This feedback is often in the form of specific measures, plotted over time.

WHAT CHANGE CAN WE MAKE THAT WILL RESULT IN IMPROVEMENT?

All improvement requires making changes, but not all changes result in improvement. Organizations, therefore, must identify the changes that will result in improvement. The PDSA cycle is used to both identify changes and to test these changes.

PLAN-DO-STUDY-ACT CYCLE

The Plan-Do-Study-Act (PDSA) cycle (Deming, 1993) is used to identify, test, and implement changes in real work settings. To test a change, the PDSA cycle involves planning the test including predictions (on a small scale at first), running the test, observing the results, comparing the results to the predictions (learning), and acting on what is learned. This is the scientific method used for action-oriented learning. The PDSA cycle guides the test of a change to determine if the change will result in improvement for the system.

After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale, for example, for an entire population or for an entire unit.

Improving Patient Care Program

IPC Mission Statement

To partner with IHS, Tribal and Urban Indian health programs to improve health and promote wellness of American Indian and Alaska Native people through improved quality.

IPC AIM

To transform the Indian health system to a more integrated, well organized, and higher performing system of care.

IPC 5 Collaborative Focus

All engaged sites will work to achieve a basic level of development of an Indian Health Medical Home Evidenced by:

- Highly engaged leadership
- Patient and Family Centered Care
- Care that is delivered through continuity with Care Teams
- Health Information systems with improvement data to support effective communication, clinical decision-making, and patient self-management support.
- Health Care that is vested in the culture and values of Tribes and communities
- Systems of care that is provide effective and efficient access when needed.

QILN Focus

As participating sites complete the IPC Collaborative and understand key improvements, they are invited to join the IPC Quality and Innovation Learning Network (QILN). The QILN is geared to provide on-going collaboration and support for I/T/U programs continually adapting and implementing changes that lead to improved quality of and access to care.

Foundations Series Focus

Foundations Series is the pathway of the IPC program designed to provide education and training to non-participating sites of the Indian health system in order to lay the foundation for committed engagement in the IPC program.

IMPROVING PATIENT CARE GLOSSARY

This glossary is current as of May 2012.

Action Period: The period of time between learning sessions when teams work on improvement in their home organizations is the action period. These are regularly scheduled conference calls during the action period that connect all participating teams with each other, faculty, and collaborative leaders. Content is provided, teams share stories, ideas and tools, and results are discussed.

Action Plans: These are work plans prepared by participating organizations, to develop and guide tests for change, implementation, and dissemination. Action plans subsequently define the timeline for the actions. Brief Action Plans (BAP) may be utilized as a tool to accomplish a smaller test of change, implementation, or dissemination.

Advanced Access: The goal of advanced access is to build a system in which patients have the opportunity to see their own providers when they choose. For additional information about advanced access, see http://www.ihl.org/offerings/VirtualPrograms/Webinars/Web_Action/ImprovingAccess/Pages/default.aspx.

Aim or Aim statement: This is a written, measurable, and time-sensitive statement of the expected results of an improvement process. Tips for setting aims can be found at <http://www.ihl.org/knowledge/Pages/HowtoImprove/ScienceofImprovementTipsforSettingAims.aspx>

Annotated Run Chart or Time Series: A line chart showing results of improvement efforts plotted over time is an annotated run chart or time series. 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.

Backlog: Backlog consists of appointments on the future schedule that have been scheduled in the future due to lack of openings on the current schedule. For additional information, go to <http://www.ihl.org/knowledge/Pages/Changes/RecalibratetheSystembyWorkingDowntheBacklog.aspx>.

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 repeatable procedures that have proven themselves over time for large numbers of people.

IPC Care Model: The IPC Care Model is a refinement of the Chronic Care Model. The IPC Care Model differs from the Chronic Care Model in two important ways: (1) the inclusion of the six aims from the Quality Chasm report as criteria for high-quality services and (2) the addition of change concepts addressing staff development, cultural competence, care coordination, and patient safety. See the [figure](#) on page 17.

Champion: This is an individual in the organization who believes strongly in quality improvement and is willing to work with others to test, implement, and dissemination changes.

Change Concept: A general idea for changing a process is a change concept.

Change Idea: An actionable, specific idea for changing a process is a change idea.

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

Chronic Care Model: This model represents the ideal system of health care for people with chronic disease and an approach to redesigning health care to mirror that ideal system. For additional information, see <http://www.improvingchroniccare.org>.

Clinical Information System (CIS): This is a comprehensive, integrated information system that is “patient centered.”

Collaborative: This is a systematic approach to health care quality improvement in which organizations and providers test and measure practice innovations, then share their experiences in an effort to accelerate learning and widespread implementation of best practices.

Cycle Time or Office Visit Cycle Time: The amount of time in minutes that a patient spends at an office or clinic visit is the cycle time. For additional content, tools, and related changes, see <http://www.ihl.org/knowledge/Pages/Measures/OfficeVisitCycleTime.aspx>.

Data Collection Plan: This 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. The IPC Data Collection Plan can be located on the IPC Knowledge Portal.

Day-to-Day Leader: This person manages the team and arranges meetings; he or she ensures tests are completed and data is collected.

Decision Support (DS): Methods to enable patients and providers to make informed choices about optimal care is decision support.

Delivery System Design (DSD): DSD is how care is provided to patients, including the types and roles of the health care team and the types of appointments and follow-up techniques used by the practice to ensure high-quality care.

Electronic Health Record (EHR): The Resource and Patient Management System EHR 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 for follow-up. For more information, visit <http://www.ihl.gov/cio/ehr/index.cfm?module=clinicaloverview>.

Gantt Chart: A type of bar chart that illustrates a project schedule is a Gantt chart. Gantt charts illustrate the start and finish dates of the terminal elements and summary elements of a project.

Government Performance and Results Act (GPRA): The Indian Health Service (IHS) has developed a set of GPRA performance indicators with annual and long-term goals to measure the progress of the agency in improving the health status of American Indians and Alaska Natives (AI/AN). **Green Book:** Officially known as *Assessing, Diagnosing, and Treating Your Outpatient Primary Care Practice* and found at <http://www.clinicalmicrosystem.org>, this workbook provides tools and methods that clinical teams can use to improve the quality and value of patient care.

Harvesting Meeting (Knowledge Gathering Session): National leads and subject matter faculty members review results, approaches, challenges, etc., with successful teams to identify the most useful changes and the measures that were most productive.

iCare: iCare is a population management software tool that helps organizations manage the care of their patients. For more information, visit <http://www.ihs.gov/CIO/ca/icare/>.

Implementation: Taking a change and making it a permanent part of the system is implementation.

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.

Improvement Support Team (IST): An IST is a 3-6 member interdisciplinary team whose function is to support improvements in care in the field.

Indian Health Medical Home: Patient-centered system of care where the Patient and Health Care Team work in partnership to achieve positive health outcomes while emphasizing the role of family, community, and Tribe in the approach to health care.

Institute for Healthcare Improvement (IHI): IHI is an independent, not-for-profit organization helping lead the improvement of health care throughout the world. For more information, visit <http://www.ihl.org>.

IPC 1: Improving Patient Care 1. Originally called Innovations in Planned Care, this was the first phase of IPC. It included 14 pilot sites (8 IHS, 5 Tribal, and 1 Urban Indian health program) in 2007.

IPC 2: The second phase of IPC began in the Fall of 2008; 25 new sites joined the original 14 to total 39 participating sites (24 IHS, 12 Tribal, and 3 Urban Indian health program).

IPC 3: The third phase of IPC began in January 2011 with 56 new sites.

IPC 4: The fourth phase of IPC began in May 2012 with 30 new sites.

IPC 5: The fifth phase of IPC began in January 2014 with 46 new sites.

Key Changes: A list of essential process changes that will help lead to breakthrough improvement, key changes for IPC are located in a high-leverage, sequenced, change grid in the change package.

Knowledge Management: In IPC, knowledge management is the process of gathering information about the dissemination process as it unfolds in the organization.

Learning Community: This is a network of organizations whose members work to achieve rapid, continual improvement.

Learning Session: A learning session is a meeting during which participating organization teams meet with faculty and peers to collaborate and to learn key changes in a topic area (including how to implement them).

LISTSERV: A LISTSERV is an automatic mailing list.

Measure: An indicator of change is a measure. A measure is used to track the delivery of proven interventions to patients and to monitor progress over time.

Micro System: It is a small, distinct, inter-dependent group of individuals who work together on a regular basis to provide care to a focus population of patients at the community's clinical facility level. Many resources and tools can be found at <http://www.clinicalmicrosystem.org>.

Model for Improvement: An approach to process improvement developed by Associates in Process Improvement, the Model for Improvement helps teams accelerate the adoption of proven, effective changes. See figure in the [previous section](#). For additional information on the Model for Improvement, go to <http://www.ihl.org/knowledge/Pages/HowtoImprove/>.

Motivational Interviewing: Motivational interviewing is a direct, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Narrative Report: This is a monthly report submitted to summarize changes that have been tested or implemented within participating organizations.

Office Hours: These are scheduled conference calls or WebEx conferences with multiple participating organizations that are used to address specific 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. For more information, visit <http://www.ihl.org/knowledge/Pages/Changes/OptimizetheCareTeam.aspx>.

Patient-Centered Care: Care that is truly patient centered considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles. For additional information and ideas, visit <http://www.ihl.org/explore/PFCC/Pages/default.aspx>.

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

PDSA or PDSA Cycle: This cycle is a structured trial of a process change. Drawn from the Shewhart cycle, this effort includes:

- **plan**—a specific planning phase;
- **do**—a time to try the change and observe what happens;
- **study**—an analysis of the results of the trial; and
- **act**—devising next steps based on the analysis.

. For additional information, see the [Model for Improvement section](#) above.

Pre-work Period: Pre-work is the period between the beginning of pre-work conference calls and Learning Session 1.

Process Change: A specific change in a process in the organization, a process change is more focused and detailed than a change concept.

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.

Project Manager: This is an individual who tracks the progress, interaction, and tasks of various parties in such a way that reduces the risk of failure, maximizes benefits, and restricts costs of an improvement initiative.

QILN: The Quality and Innovation Learning Network, or QILN, is open to all programs that have participated in the IPC Collaborative.

RPMS: The Resource and Patient Management System (RPMS) is an integrated solution for the management of clinical, business practice, and administrative information in health care facilities of various sizes. For more information, visit <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.

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.

Special Diabetes Program for Indians (SDPI): SDPI is a congressionally established grant program that provides funding for diabetes treatment and prevention services at 399 IHS, Tribal, and Urban

Indian health programs. Find more information at <http://www.ihs.gov/MedicalPrograms/Diabetes/?module=programsSDPI>.

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, make informed decisions about care, and engage in healthy behaviors. For more information, go to <http://www.ihl.org/knowledge/Pages/Changes/SetandDocumentSelfManagementGoalsCollaborativelywithPatients.aspx>.

Service Population: A broad operational definition of population is meant to capture all 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 one visit within the past three years anywhere in the organization.

Site: An organization may have one or more sites of care, i.e., satellite clinics. As part of IPC, organizations develop plans for dissemination to each of their sites.

Sponsor: The executive in the organization who supports the team and controls all the resources employed in the processes to be changed is the sponsor.

Storyboard: The storyboard displays information about a team and its progress.

Technical Expert: The technical expert is the team member in the organization who has a strong understanding of the process to be improved and changes to be made. A technical expert may also provide expertise in process improvement, data collection and analysis, and team function.

Test: A small-scale trial of a new approach or a new process, a test is designed to learn if the change results in improvement and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

Transparency: Sharing performance data in an effort to make organizations more accountable and promote improvement is transparency.

Virtual Training/Learning: This is a process to create and provide access to learning when the source of information and the learners are separated by time or 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 is usually 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.

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Additional URL Links on Clinical Microsystems:

<http://forces4quality.org/clinical-microsystems-practice-assessment-dartmouth>

<http://www.ncbi.nlm.nih.gov/pubmed/12216343>

<http://www.ashpfoundation.org/lean/CMS7.html>