The Indian Health Service Chronic Care Initiative: Innovations in Planned Care for the Indian Health System

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American Indian and Alaska Native people continue to face unacceptably high rates of illness, disability, and death from chronic and preventable conditions, injury, and suicide.[1] The IHS initiatives in Health Promotion and Disease Prevention, Behavioral Health, and Chronic Care provide a framework and strategy for addressing these health disparities and for improving the health status of all those cared for in the Indian health system (IHS, tribal, and urban Indian health programs).

In 2006 the IHS, through the Chronic Care Initiative, developed a partnership with the Institute for Healthcare Improvement (IHI) to use modern improvement methodologies to fundamentally transform our system of care for clinical prevention and for the management of chronic conditions. The ideas that guide this transformation come from the Chronic Care Model (Care Model), developed at the MacColl Institute for Healthcare Innovation, adopted by the World Health Organization and tested and implemented widely in the US and abroad.

The Care Model captures and defines the essential features of a system of care that focuses on the relationship between an informed and activated patient, family, and community and their prepared and proactive health care team. The Indian health system has extensive experience with the Care Model in diabetes care. In the Chronic Care Initiative, the Care Model is applied across conditions, including clinical prevention, for the entire population (see Table 1). The measurement plan is equally broad and comprehensive, and aims to guide improvement in four domains: clinical prevention, care of chronic conditions, patient experience of care, and the cost of care (see Table 2).

In 2007, 14 pilot sites representing a slice of the Indian health system began work on the Innovations in Planned Care[2] (IPC) for the Indian health system. This first prototype phase (IPC I) developed an adaptation of the Care Model and developed a set of changes designed to improve care across conditions. In fall 2009 an additional 25 sites joined the initial 14 sites in the second prototype phase (IPC II) to test and refine the changes derived from IPC I as well as the set of measures that will guide improvement. These sites have been building improvement capacity into their systems of care and using measurement to guide improvement efforts. In a process known as the "Breakthrough Collaborative,[3]" the IPC learning community engages every other week in 1 hour web-based seminars (action period calls), with more intensive two-day meetings (learning sessions) at 8-12 week intervals (some held in-person and others web-based). In these, IPC teams share learning with each other through reporting of common measures as well as changes, and exchanging ideas and questions on a website and listserv. Measurements are used to guide improvement, not to judge performance, with measures for monthly reporting introduced in phases. The intake screening bundle is comprised of six measures: Alcohol Misuse Screening, Depression Screening, Domestic Violence (DV)/Intimate Partner Violence (IPV) Screening, Tobacco Use and Assessment, BMI (Obesity) Assessed, and Blood Pressure Assessed. IPC I sites began reporting on these measures in

Table 1. The scope of IPC covers a large set of chronic conditions and clinical prevention activities

Chronic Disease Management	
Diabetes, type 1 and 2	Obesity
Cardiovascular disease	Diet and behavioral
Uncomplicated depression	counseling
	Asthma
Clinical prevention activities	
Screening	
Depression	Breast cancers
Obesity	Cervical cancer
Tobacco use	Colorectal cancer
Hypertension	Diabetes
Alcohol misuse	Dyslipidemia
Domestic violence/IPV	Fall risk
Preventive Services	
Tobacco cessation	Dental fluoride
Immunizations	Dental sealants

Table 2. IPC measurement plan outlining four domains and the areas of focus/coverage within each measurement domain.

IPC Measurement Plan	
Measurement Domains	**Areas of Focus/Coverage**
Clinical Prevention	Keeping Current on Preventive Screenings
	Keeping Current on Cancer-related Screenings
	Keeping Current on Immunizations
Management and Prevention of Chronic Conditions	Control of Blood Pressure
	Control of Lipids
	Tobacco Cessation Treatment
	Diabetes Care
	Obesity Assessment and Treatment
	Asthma on Appropriate Controller Medication
	Physical Activity Level
	Depression Outcome
	Functional Assessment
Costs	Revenue Generation
	Workforce Measures
	Cost Measure
Patient Experience	Experience and Efficiency
	Patient Activation
	Patient Satisfaction
	Building Relationships for Care
	Access

September 2007 and have seen a steady increase in the percentage of patients receiving all components of the intake screening bundle (see Figure 1). The teams are also making progress in screening patients for DV/IPV (see Figure 2).

Spotlight: Indian Health Council, Inc.

The Indian Health Council, Inc. (IHC) is located in San Diego County, California and provides services for nine tribes in 38 GPRA communities. One of the original pilot sites in the IPC collaborative, IHC has been testing and implementing changes within their health care system. The clinic has set very aggressive goals to improve efficiencies, close the gap between provider and patient, and streamline processes. Almost two years into their participation, IHC is seeing the rewards of their work with the collaborative in improved clinical measures and improved patient-provider relationships.

Prior to the collaborative, IHC had begun an effort to ensure that improved care was woven into the fabric of their organization. The aim of IHC is to redesign and standardize the delivery of care to decrease morbidity and mortality in the community they serve. Efforts will be made to advance both preventive strategies and the treatment of chronic conditions across the population. The clinic plans to partner with their community to support education and empower patients to become active partners in their health care planning.

Teams at IHC start their day differently than two years ago. In the past, staff would come to work not knowing who they would be working with that day. In the new system, an identified care team, called a pod, cares for their own set of impanelled patients. Each of the three pods hosts a care team comprised of providers, nurses, and medical assistants. As a result, staff now come to work knowing with whom they are working, the kind of team they have, what the team has to do, and what patients they will be seeing that day. Continuity of care is enhanced by ensuring that patients are seeing providers from the same pod each time they come to the clinic.

The first task of the day for the care team is to do pre-visit planning, which they accomplish during a 30-minute "huddle" prior to the clinic opening. During this huddle time, the care team reviews reports generated by the iCare application in RPMS to see who is and who is not up to date with screenings and what care is needed. IHC has also been able to improve care for their patients by integrating their community health program, housing, public health nursing, and Community Health Representatives (CHRs). The field nurses join the morning huddle, are actively engaged in the pre-planning process, and are able to reach beyond the clinic to meet patient needs.

Getting started in the collaborative can be intimidating. The iCare reports can be lengthy due to needed screenings and assessments, but as the teams work together the reports get smaller, and it doesn't feel like a game of catch-up. Another benefit is that patients are updated on health screens and GPRA requirements. Slowly, patients are becoming more interested in their own care and have been asking to see their charts. Providers are able to open up charts and say, "Here is where you were, here is where you are, and this is how we can work together to help you reach your goals."

Other departments at IHC are also noticing that patients are starting to be more active with their self care. Physical activity and exercise referrals have increased, and staff have noted that patients are taking control of their own personal

health and well being. In the past, patients would come to their appointment because their doctor told them to do so, without being able to verbalize why they were there. As the collaborative has progressed, patients now know not only that their cholesterol is high, but what their level is and the level they want to reach, and that exercise and diet will help them reach their goal. A next step for the collaborative is to create individual scorecards outlining standards of care based on diagnosis, in hopes that patients will demand more of the care team. Patients will expect certain kinds of treatment and tests and will be able to ask questions about their treatment plan.

The result of this work has been consistent improvement in alcohol misuse screening, colorectal cancer screening, and childhood immunizations; decreasing office visit cycle time; and improved continuity of care. More importantly, the staff members can see the changes and know that they are able to improve the care they provide to their community.

References

1. *Trends in Indian Health*. Rockville, MD: Indian Health Service; 2000-2001. (Available at *http://www.ihs.gov/NonMedicalPrograms/IHS_Stats/*).
2. Kabcenell AI, Langley J, Hupke C. Innovations in Planned Care. Innovation Series. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2006. (Available on www.IHI.org).
3. *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org).

Figure 1. IPC I weighted average of the Intake Screening Bundle

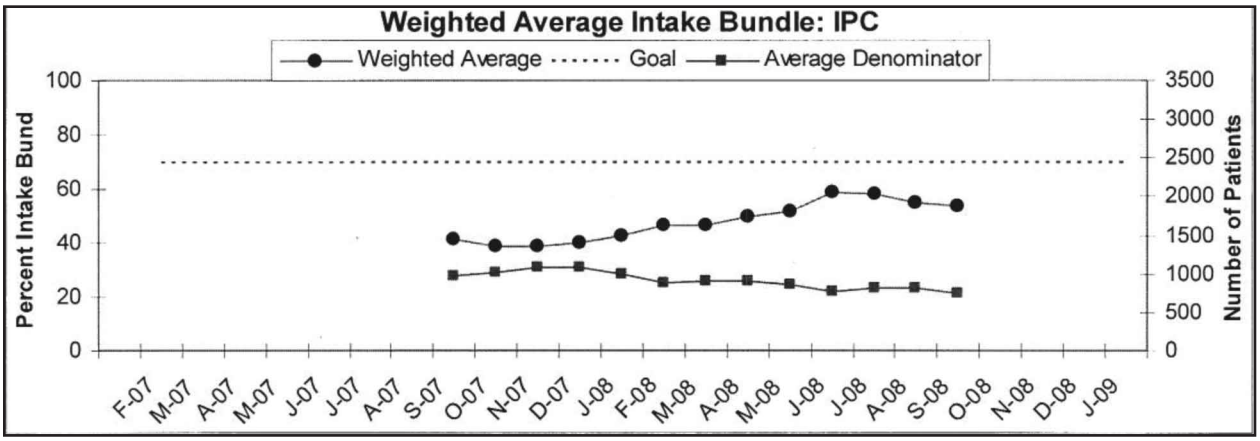

Figure 2. IPC I weighted average of Domestic Violence/Intimate Partner Violence screening