Billings Area IHS
Integration Team

Integration Work Plan

Goal: Integration of Chronic Disease Management (CDM), Behavioral Health (BH), and Health Promotion (HP) Initiatives

Billings Area IHS Integration Team

1st Step
Development of multidisciplinary Team in Area Office

Comprised of; Nursing, Diabetes Consultant, Health Promotion Specialist, Behavioral Health

Billings Area IHS Integration Team

2nd Step

- Development of Work Plan with focus of promoting programmatic collaborations to maximize program effectiveness
- Began by describing current activities in an effort to maximize future opportunities for collaboration around the Director's 3 initiatives.

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Focus Areas of Work Plan

- Trainings/Conferences/Meetings
- Field Site Visits
- Community Activity Network
- Technology
- Resource Development

Monitoring

- Regular meetings of team to update each other regarding progress.

Billings Area IHS Integration Team

Billings Area Indian Health Service
Program Integration Training
March 20 & 21, 2007

Billings Area IHS Hosted a 2 day Area Wide Training for Program Integration on the Initiatives.

- Trainers: Dr. Chris Percy, Shelley Frazier & Janet Hayes
- 45 Individuals Participated (expected 20)

Billings Area IHS Integration Team

Participants:

- Representation from Our 8 Reservations and 2 Urban Sites
- Programs represented:
  - Diabetes Grant Coordinators, Outreach/ CHR's
  - Diabetes Clinic Nurses/Public Health Nurses
  - Health Educators
  - Behavior Health Professionals
  - Dental
  - Injury Prevention

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The Training was provided to introduce the 3 initiatives and how to best Utilize Services to meet the needs of our PATIENTS, with consideration of our limited resources and limited number of Providers.

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Objectives of the Training:

- To provide the participants with tools & ideas.
- Develop a home team to address serious health issues.
- Develop an Action Plan to address at least one health issue by integrating services, resources and efforts.

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As a Result of the Training the Home Teams bonded and left with a ***Plan to work Together*** and utilize resources in their community to address serious issues they felt were priority.

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The Blackfeet Action Plan is a great illustration of the linkages between the 3 disciplines and other resources:

1. Blackfeet Behavior Health Department is partnering with the health educator and the diabetes nurse to plan and train outreach workers, nurses (clinic and PHN) to work with a patient diagnosed with a chronic disease and treat the initial emotional trauma immediately.

Upon diagnosis patients will be briefed on the stages of grieving and final acceptance of their diagnosis - empowering them to take RESPONSIBILITY for their own health and take steps to healing and living a ***quality life***.

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Blackfeet Community Hospital

Project:
Debriefing for newly diagnosed diabetics.
Goal:
Provide debriefing training to 10 health care providers by June 1, 2007.

Key Steps

What	Who	By When
Identify providers who have 1st contact w/newly diagnosed pts & recruit.	Dawn-DM, Sharon-HE, Tom-BH	April 3, 2007
Set training date and apprise "students"	Sharon & Dawn	April 5, 2007
Provide training and evaluate	Tom	May 3, 2007

Team Members:
Dawn-DM, Tom-BH, Sharon-HE, Nutritionist, SPDP personnel, MDs, nurses, DON, other BH personnel, Healthy Heart Program

Billings Area IHS Integration Team

Other Action Plans:

- Educate Staff on the 3 Initiatives
- Improve Collaboration of Programs – Tribal, IHS & other community programs
- Behavioral Health Program will FIND Out what Health Education & Diabetes Program are doing regarding the initiatives.
- Meet & Maintain DM Benchmarks as a Team

Billings Area IHS Integration Team

- Participants were enthusiastic and engaged and requested a Follow up Training in the Fall of 2007.
- Other programs want to be involved and participate in the next training.

- We Successfully reached our target Professionals and raised a lot of curiosity from other health programs, who now want to be INVOLVED in Integration of Services!!!

Billings Area IHS Integration Team

As our Action Plans and Strategies evolved we Always kept the PATIENT in focus at all times.

Billings Area IHS Integration Team

As a Result of Integrating Services we will Provide the MOST COMPREHENSIVE Care possible for our Patients by addressing the WHOLE person and not just the Symptom, which will enable Billings Area to meet the Mission of IHS:

…….**to Raise the Physical, Mental, Social and Spiritual HEALTH to the Highest Level.**

BEHAVIORAL HEALTH

Integration of Suicide Prevention and Depression Identification and Care

Suicide Prevention

- WHAT: Community based workshops for junior high and high school youth
- FOCUS: Provide culturally and spiritually relevant curriculum
- GOAL: Empower teens to break the "code of silence" (use skits and talking circles, short informational presentations on warning signs, active listening and how to get help for a friend who is at risk.

Involving Adults in Native Hope Workshops

- Networking within communities
  - Schools
  - Tribal Council
  - Tribal Health Departments
  - Substance Abuse Treatment
  - Law and Order
  - Boys & Girls Club
  - Traditional drumming & singing groups
  - Traditional Healers
  - Church pastors
  - Parents

Networking Within IHS

- Behavioral Health staff working with:
  - Health Promotion/Disease Prevention
  - Diabetes Care Providers
  - Primary Care Providers/ Implementing JCAHO Suicide Prevention Standards for ERDs and BH Programs
  - Child Abuse Prevention
  - Domestic Violence Prevention
  - Methamphetamine Prevention and Treatment

What We can Do Together

- H.O.P.E. stands for Help Our People Endure
- 2004 to 2007 248 adults have received training as group facilitators
- Trained facilitators from the communities are now planning, organizing, arranging and advertising the workshops.

Native HOPE for Youth

- June 2004 to March 2007 343 Youth have participated. Native HOPE effective in giving youth knowledge and skills
- Example: A modified HOPE curriculum used to help a group of Jr. High students following completed suicide of a peer.
- Students expressed hope and resilience in skits: “When there is no hope there is Help”. “Break the code of silence and save a friends life”

A Step Beyond Suicide Prevention to Primary Prevention

Native Youth Academy for 11-14 year olds

Theme: Identify warrior concept within and promote "Brother & Sister" relationships with their peers.

Five year Project: 2007 is the base year

Partners: BH and HP/DP, Area Diabetes Program and Billings Area Special Diabetes Programs for Indians, Native HOPE, BIA/Education and Law Enforcement, Artists, Dancers and many dynamic people from other agencies.

1st Year's Theme is "Native Youth Rising"

It is an honor to be selected

- Youth apply and are selected by Health Educators, Schools, others
- Youth are asked to describe their strength in either 1) Academic 2) Social 3) Spiritual areas
- Focus on: healthy relationships, self esteem, Native culture and leadership skills
- Each year the Academy will be held at a different university campus
- Meta-Message: "You are a unique, strong and gifted individual with many abilities"

Native Youth Academy
Warriors of the Future

Depression Identification and Care

- Advocated for BH Participation in Integration Workshop by Dr. Percy's group
- Effective format got all staff from all reservations communicating, brainstorming and planning
- Result of Brainstorming: Idea for Diabetes Support Group to deal with PTSD and grief issues. BH got involved with accident prevention; all group involved in suicide prevention ideas. All group got information re: HOPE workshops and invited to join. BH will involve HE's DM staff in helping youth gain a voice for their strategic plans.

Suicide Behavior Data

- BH 3.0 GUI with Suicide Register implemented in 2004
- Has resulted in data sharing with Tribal Health Departments, MT-WY Tribal Leaders Council, Seeds of Hope (SAMHSA funded suicide prevention program), EPI center suicide surveillance study
- Exchanging data with State of Montana; WY VS cooperating with Wind River

Networking with State Resources

- Data is Important in identifying trends and planning for future
- State Bureau of Vital Statistics has better data on completed suicides than BH 3.0 GUI
- BH 3.0 GUI has great epidemiological information for attempts and ideation

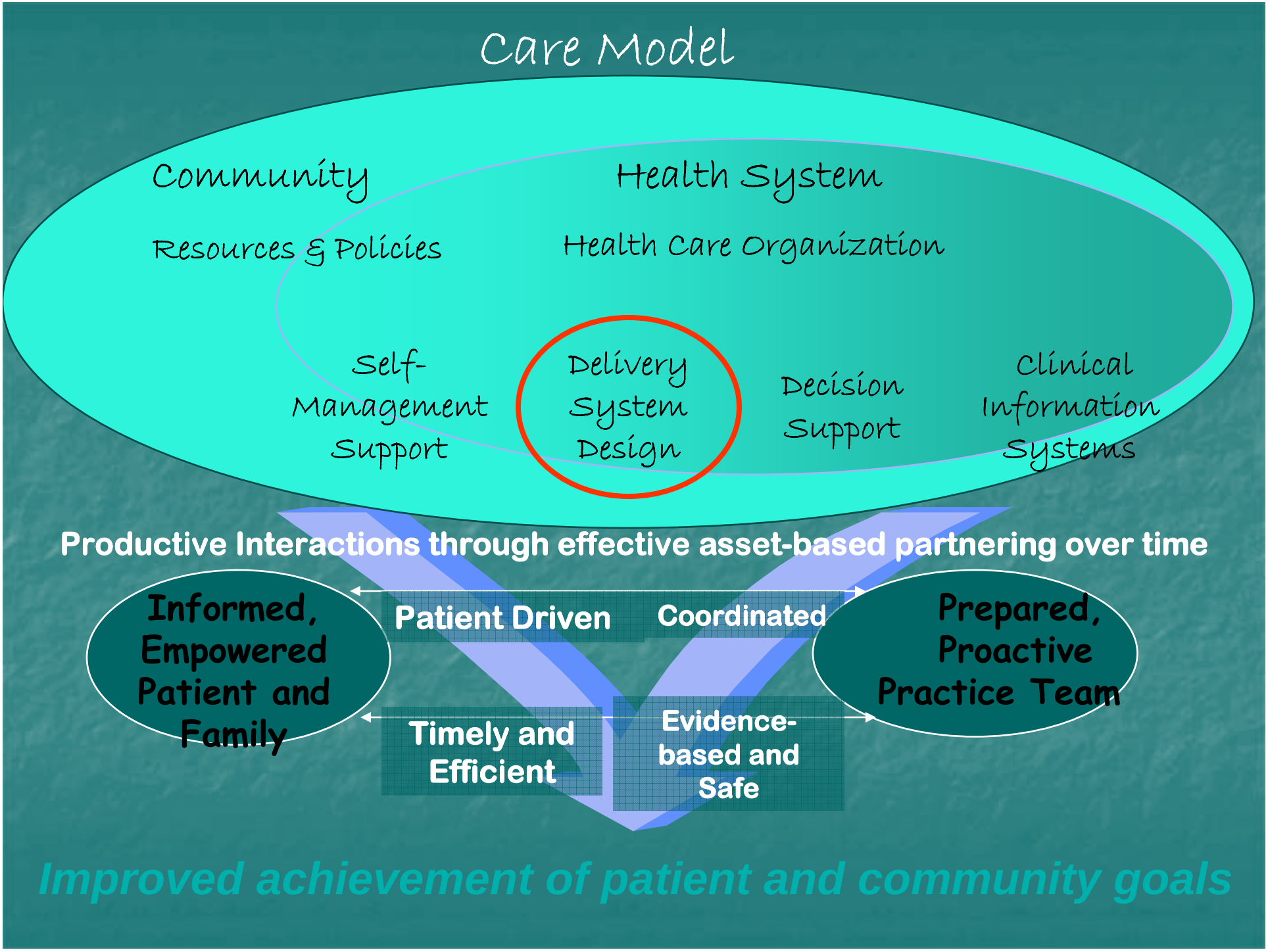
The Future of Suicide Surveillance

Columbia Suicide Surveillance Risk Scale

- NIH/NIMH/CDC rating scales of suicidal behavior, intensity of behavior, potential lethality of attempts and ideation
- Objective: Develop discriminatory measures of suicidal behavior leading to more effective intervention and treatment.
- Coordinators at NIH/NIMH looking for collaborative relationships to enhance this project

WIND RIVER HEALTHCARE IMPROVEMENT COLLABORATIVE

- Fort Washakie Health Center · Arapahoe Health Center
- The community we serve on the Wind River Reservation in Central Wyoming is predominantly Eastern Shoshone and Northern Arapaho. Diabetes and chronic upper respiratory infections are common (many smokers).
- We hope to better address their HP/DP and immunization needs by starting our improvements in the area of Delivery System Design.


Care Model
Community
Resources & Policies
Health System
Health Care Organization
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Productive Interactions through effective asset-based partnering over time
Informed, Empowered Patient and Family
Patient Driven
Coordinated
Prepared, Proactive Practice Team
Timely and Efficient
Evidence-based and Safe
Improved achievement of patient and community goals

Wind River Aim Statement

- We aim to (1) improve continuity of care while balancing health maintenance activities with treatment for acute care needs in our chronically ill patients. We also aim to (2) improve access to care by changing the organization of service delivery first at Fort Washakie and, later, at Arapahoe Health Center. By achieving the above, we aim to (3) improve patient involvement and satisfaction with their health care.

- We will accomplish our aims by clarifying patient panels according to primary care provider (PCP) over the next quarter (120 days). Although panels will be dynamic, it is necessary to establish panels for tracking purposes. A service delivery system that is well organized by panel will allow the clinic to focus more time and resources on HP/DP and health maintenance goals as stated in the strategic plan, make efficient use of human resources, and optimize communication between departments.

Wind River Aim Statement

- **The microsystem of focus will be the panel of patients assigned to Dr. Bill Calder (approximately 1,375). Over a 90-day period, we will put into place a Care Team for his panel of patients. The team will include a nurse, pharmacy technician, nutritionist, receptionist, diabetes educator, and psychologist. Each patient will be given a card with contact information for all the team members. Team members will be assigned clear roles and will meet regularly to case-manage complex patients.**

- **Patients will register with the receptionist at the front desk and their E.H.R. information will be updated to reflect their choice of Dr. Calder or other PCP. Each patient will complete a WE CARE card (and another objective measure) before and after the care team approach begins, allowing us to determine if patients perceive an improvement in waiting time and access to care. Our measures, then, will be patient-centered, focusing on their perception of improvement in these areas. We will also begin tracking availability of appointments by industry standard measures to assess actual appointment availability.**

CALDER'S CARE TEAM CARD

DR. CALDER'S CARE TEAM

Erin Watson (appointments) 332-7300
Nurse (referrals, health questions) 335-5988 or 5989
Cynthia Blanton, RD (nutrition) 335-5940
Marion Ute, RN (diabetes education) 335-5941
Sandra Delehanty, PhD (stress, coping) 335-5949
Charlene Gambler (mental health) 335-5949
Roxanne Hines (medication info) 335-5982
Bill Calder, MD: 335-5966

Name
In emergency, call:
_____

_____

Medication *Dose* *Take at this Time*

_____
_____
_____
_____
_____
_____

- Wallet-size for convenience
- Font = Century Gothic for ease of reading
- Physician intentionally is last on the list
- Flip-side has space for an emergency contact
- Physician can write in new medications
- Native American graphics and border on card
- Indian Health Service logo

PDSA on Cycle Time

Clinic Patient Cycle Time

Day: _____ Date: _____

Appointment Time _____ Provider you are Seeing Today _____

Time	
	1. Time you checked in at front desk.
	2. How long you sat in the waiting room.
	3. Time staff came to get you.
	4. Time you were put in an exam room.
	5. Time provider came to exam room.
	6. Time you and provider left exam room.
	7. Time you returned to waiting room.
	8. Time you were called to pharmacy (or N/A).
	9. Time you left the clinic.

Comments: (*for example, were you pleased with how smooth your visit went?*)

- Plan= ask patients to complete form provided in "Greenbook"
- Do= 4 patients did
- Study= reviewed patient responses and found all were confused by wording, none gave comments
- Act= modified language of form, put example of comment

Team Wind River

Sandra Delehanty, Ph.D.,
Diabetes Coordinator & Behavioral Medicine; Key Contact

Cynthia Blanton, Ph.D., R.D.,
Public Health Nutritionist; Data

Members Not Pictured:

Cathy Keene, CEO
Bernadette Oberly, Patient
Margaret Cooper, IT Manager
Marsha Taggart, R.N., MPH, Community Health Educator
Trina Nation, Utilization
Aleta Whiteman, IT
Micki Schuffert, RN

Erin Watson,
Fort Washakie Medical Receptionist, Team Member

Charlene Gambler,
Behavioral Health Secretary, Team Member & Resource Extraordinaire

Bill Calder, M.D., **Family Practice, Medical Champion & Team Member**


Sunset over the Wind River Range