Nashville Area News

A publication of the Nashville Area Office of Public Health

Nashville Area IHS
Office of Public Health
615-467-1600

Volume II, Issue #2

May 15, 2008

Third Annual Nashville Area Health Summit Set For July 15-17 in Nashville

- The Nashville Area: is putting the "whole" back into Holistic Care

By Dr. Tim Ricks, OPH Director

You may have heard the terms integrated care and integrated medicine, but what can your clinic do to integrate the entire health team to provide quality care to your patients?

That is the question that the 3rd Annual Nashville Area Health Summit seeks to answer. This annual meeting, sponsored by the Nashville Office of Public Health, will be held this year at the Holiday Day Inn Express in downtown Nashville from Tuesday, July 15th to Thursday, July 17th. The theme of this year's meeting is "**Integrated Primary Care: Reunification in Practice of Mind, Body, and Spirit**."

The three-day event, which is open to all health care providers and support staff from the Nashville, Oklahoma City, and Albuquerque Areas, consists of a one-day plenary session for all participants, one and a half days of concurrent breakout sessions, and a half day of discipline-specific continuing education sessions.

132 people attended the 2007 Area Health Summit, with the theme of "Motivating Behavioral Changes in Patients."

The plenary session features Dr. Peter Stuart, a psychiatrist working in the Navajo Area, who will present on the meeting theme. This will be followed by a treatment demonstration by a multi-disciplinary team, which will be followed by one or two Nashville Area tribes who will share their best practices on integrated care. Finally, focus groups will be

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Office of Public Health Conducts Accreditation Program Reviews

- Micmac and Catawba are first to receive new OPH service

By Dr. Tim Ricks, OPH Director

In an effort to promote accreditation within the Nashville Area, the Office of Public Health (OPH) and Chief Medical Officer have teamed up to conduct program reviews based upon the standards of the Accreditation Association for Ambulatory Health Care (AAAHC).

A 6-person program review team that included Dr. Tim Ricks, Dr. Harry Brown, Dr. Palmeda Taylor, Michelle Ruslavage, Liz Neptune, and Neill Dial conducted 2-day program reviews at the Catawba Health Center (March 25-26) and the Micmac Health Clinic (April 8-9).

AAAHC has become one of the most prominent accreditation associations for ambulatory health care centers, and many IHS and tribal programs around the country are using the accreditation process as a springboard toward improving the quality of care at their clinics.

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An Introduction to the Chronic Care Initiative

- What is the Chronic Care Initiative?
- Rapid Cycle PDSA's—ever-changing improvements
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- A Clinician's and a Non-Clinician's View of the CCI

From the Nashville Area Director: Richie K. Grinnell, R.S., M.P.H.

Rear Admiral Richie Grinnell is an environmental health officer who has been the Area Director of the Nashville Area for the past the past three and half years.

I am excited to see this latest newsletter. The Nashville Area Indian Health Service remains committed to providing quality technical support to Nashville Area Tribes/ Nations.

The last few months have seen us create a new emphasis on chronic illness management, health promotion and disease prevention activities, and behavioral health issues. This renewed interest has been the result of the Director's Three Initiatives Campaign, the Model for HealthCare Improvement/Chronic Care Initiative Conference last December, and a dedicated Area Office staff.

We continue to work on special initiatives such as the Chronic Care Initiative. This process includes getting more Area programs to apply to be pilot sites, promoting the upcoming Institute for Healthcare Improvement conference that will be held in Nashville in December. The result of this attention on this initiative will hopefully be more integrated quality care aimed at patients with chronic diseases.

We also are continuing to work on other initiatives such as the electronic health record, telehealth program, childhood obesity, tobacco cessation, behavioral health, and the GPRA Challenge, and I believe all of these initiatives fit together to improve care in the patients we serve.

From the Office of Public Health Director: Timothy L. Ricks, D.M.D., M.P.H.

Dr. Tim Ricks is a dental public health specialist who has been the Director of the Office of Public Health and Area Dental Officer for the past year and a half.

The last year in the Office of Public Health has been an exciting time. Aside from this newsletter, our staff have been very busy planning program reviews, trainings, health awareness information, and many other activities to support the Nashville Area IHS, tribal, and urban health programs.

Since October, OPH staff have conducted over 50 site visits to assist Area health programs. We have listened to your needs, and have tried to tailor trainings and meetings to meet your needs.

Special projects have included the Health Focus brochures, the OPH GPRA Calendar, the unveiling of the Area Substance Abuse Plan, the tele-dentistry initiative, the $100,000 GPRA Challenge, the $50,000 Childhood Obesity Challenge, model HP/DP programs, online continuing education, and many others.

If your clinic has any needs where you think we could help, please don't hesitate to contact me or any of our staff (whose contact information is on the back page of the newsletter).

From the Chief Medical Officer: Harry J. Brown, M.D.

Dr. Harry Brown is a family practice physician who has been the Chief Medical Officer of the Nashville Area Indian Health Service for the past nine months.

Spring is coming out everywhere, and with the budding of new leaves and flowers, this is a good chance for us to get back to those New Year's resolutions we made a few months ago to live a more healthy life.

The Director of the Indian Health Service has three "Director's Initiatives": improving care in Chronic Disease, Mental Health, and Disease Prevention. A simple daily walk for 30 minutes can make life better in all 3 ways. Chronic diseases, such as diabetes, high blood pressure, and high cholesterol, can all be improved by daily exercise (a 30 minute walk is **excellent** exercise). It is also good for mental health, and of course helps prevent some diseases.

So let's all take a walk!

For assistance from the Chief Medical Officer, contact Dr. Brown at harry.brown@ihs.gov or 615-467-1531.

Third Annual Nashville Area Health Summit Set For July 15-17 in Nashville—continued from Page 1

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Focus groups will be conducted to help participants identify the best practices of their own health programs, barriers to fully integrating care at their facilities, and strategies on how they can integrate the entire health care team to provide optimal patient care.

The second day, and part of the third day, will consist of concurrent breakout sessions. Instead of dividing up participants based upon their respective health disciplines, such as was done last year, the Summit agenda will allow participants to freely move from one of the four conference rooms to another. Continuing education credits of up to 24 hours total will be offered to all health disciplines for all of the courses attended.

The table on the right shows the probable breakout presentations for this year's Health Summit. These presentations, chosen by a 14-member Planning Committee that included USET, the Area Office, and several health clinic staff, reflect the meeting's theme for the most part.

Each day, these concurrent sessions (4 during each time period) will be held from 8:00—9:15, 9:30—10:45, 11:00—12:15, 1:30—2:45, and 3:00—4:15. Some sessions will be repeated as well. On the final day of the meeting, there will be discipline-specific continuing education available in the afternoon.

This meeting will be open to the Oklahoma City, Albuquerque, and Nashville Area health programs and administrative offices. For Nashville Area programs, a travel reimbursement may be available and tuition is waived.

For more information about the 3rd Annual Nashville Area Health Summit, watch for upcoming e-mail and fax reminders. The registration deadline is July 1st.

PROBABLE PRESENTATIONS for the 2008 Health Summit
Innovations in Planned Care for the Indian Health System
Creating the Culture of Integrated Patient Care (repeated session)
Healing power of language
Implementing Tobacco Control into the Primary Healthcare Setting
Childhood Obesity and Type 2 Diabetes Clinical Recommendations for the Team
School Wellness Policy Implementation
School-based Pediatric Integrated Healthcare
How to Develop an Integrated Practice
Engaging new tool for teaching Nutrition and Diabetes: Conversation Maps from the American Diabetes Association
The Role of Traditional Healing in Primary Care
Spirituality and Healing in Medicine: The Importance of Forgiveness
Dealing Effectively with Organizational Change
Nutrition and Physical Activity in the Primary Care Patient
Stress Management for Healthcare Providers
Integrating Oral Health into Primary Care
Shared Decision Making: Patient Decision Aids in Practice in Primary Care
Interdisciplinary Approaches to improving Immunizations Rates
Herbs, botanicals and dietary supplements
Integrating Depression Screening into the Primary Care Setting
Immunizations – Childhood or Adult
Improving Patient-Provider Communication
Street Drugs and Dentistry
Asking Patients the Right Questions about Domestic Violence
Physical Activity
Group medical encounters for chronic disease care, including diabetes
Geriatric and Special Needs Populations
Thinking with the Heart
CMS Outreach Training (Medicaid 101 and Medicare 101) - repeated sessions
Quality Assurance/Quality Improvement 101
Practical Strategies for Managing Organizational Conflict
Identifying Elder Abuse and/or Child Abuse in the Primary Care Patient
Alcohol Screening in Primary Care: Implementation of the ASBI Program
Family Empowerment
System Changes and the Inter-Disciplinary Team
Identification of Gangs in Your 'Hood
Will you be ready and able to provide integrated primary care during and after a disaster?
Creating a secure environment for the provision of primary care

Office of Public Health Conducts Accreditation Program Reviews—continued from Page 1

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The first program review conducted by the Office of Public Health occurred at the Catawba Service Unit in late March, and the second review was conducted at the Micmac Service Unit in early April.

Catawba, which had received AAAHC Accreditation in 2007, used the OPH Program Review as an opportunity to refine their policies, procedures, and practices in preparation for a re-accreditation survey in 2009. Staff at the facility were impressed by the thoroughness of the Program Reviews. Tonya Cornwell, a nurse at Catawba, said that "AAAHC doesn't go as in depth as you do, but we can and should always go above and beyond what the requirements are. Your team asked questions that we haven't even thought of before."

While the AAAHC Standards are designed to improve the quality of care provided to patients, the Standards don't only apply to a clinical setting. The Program Review Team examined policies, procedures, and practices and interviewed both the health care team and all of the support staff at each clinic as well as some patients. Adding the patient interview component was particularly helpful to the clinics. "It was a good plus that you included patients in the process," said Ms. Cornwell.

The AAAHC Standards that were reviewed included:

- Rights of Patients
- Governance
- Administration
- Quality of Care
- Quality Management and Improvement
- Clinical Records and Health Information
- Facilities and Environment
- Anesthesia Services
- Surgical Care
- Overnight Care
- Dental Services
- Emergency Services
- Urgent Care Services
- Pharmaceutical Services
- Pathology and Medical Laboratory Services
- Diagnostic and Imaging Services
- Radiation
- Employee and Occupational Health
- Other Professional Services
- Teaching and Publication Activities
- Research Activities
- Managed Care
- Health Education and Health Promotion

The program reviews at Catawba and Micmac went very well. Catawba, which has already undergone accreditation, performed well, especially in the area of policies and procedures. Micmac, on the other hand, is seeking accreditation for the first time, yet still performed very well in the areas of clinical practice, administration, and a commitment to quality assurance.

Accreditation Review, Catawba Service Unit, Rock Hill, South Carolina, March 2008.

Review Team: Dr. Tim Ricks, Dr. Harry Brown, Dr. Palmeda Taylor, Neill Dial, Michelle Ruslavage, and Liz Neptune.

Staff at both facilities were very appreciative of the program reviews. Lynn Maillett, who serves as a Medical Support Assistant and Clinical Applications Coordinator, commented: "I thought it was a very good process. Everyone was friendly and helpful in the direction we need to go. We are looking forward to having the 'crew' back again." Karen Beck, Patient Registration Coordinator at Catawba, said that there was "always room for improvement, and we welcomed the chance to improve to better serve our community and patients."

"I would encourage all Nashville Area Clinics to undergo this type of program review. It is very helpful to compare what you already have in place to what the needs are."
- Bob Lemoine, FNP

Feedback from administrators from the two clinics was equally positive. Diane Carnes, CEO at Catawba, stated that the program review "reinforced what we have been doing right while also helping steer us on what we need to do" for reaccreditation. John Ouellette, CEO at Micmac, said that "AAAHC stands for the highest standards and becoming accredited will tell my community that our program is committed to quality care. The program review was very beneficial, especially the on-the-spot technical assistance provided by the program review team." Bob Lemoine, the clinical director at Micmac, said that "the process was an excellent review in a non-threatening manner. "

If your health program is interested in receiving a pre-accreditation program review from the Office of Public Health and Chief Medical Officer, please contact Dr. Tim Ricks at 615-467-1508 or tim.ricks@ihs.gov.

What is Medical Reconciliation?

By Neill Dial, B.S., RPH, Area Clinical Applications Coordinator, Pharmacy Contact

The first tenet of health care is to do no harm. However, approximately 1.3 million Americans become ill or have adverse side effects from medical therapy each year. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the Accreditation Association for Ambulatory Health Care (AAAHC) are focusing on reducing these drug misadventures by improving communication about prescribed medications between health care providers.

Medication reconciliation improves care by comparing medication lists of expected medications with what the patient is actually taking (Ex: Hospitals, Health Centers, and Pharmacies). It is the process of comparing what medication the patient is taking at the time of admission or entry to a new setting or level of care, with what the health system is prescribing (admission or new medication orders) to avoid errors such as conflicts or unintentional omissions.

The failure to communicate at critical transition points (changes in setting, service, practitioner or level of care) is responsible for 50% of all medication errors and 20% of adverse drug events in hospitals. The JCAHO and AAAHC standards on medication reconciliation are:

JCAHO - Accurately and completely reconciles medications across the continuum of care (Sections 8a and 8b).

AAAHC - The provision of high-quality care services is demonstrated by at least the following: "Review and reconciliation of all medications, including over-the-counter products and dietary supplements."

Medication reconciliation should be done at every transition of care (handoff) in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner or level of care. This process comprises five steps:

1) develop a list of current medications;
2) develop a list of medications to be prescribed;
3) compare the medications on the two lists;
4) make clinical decisions based on the comparison; and
5) communicate the new list to appropriate caregivers and to the patient.

Upon discharge the patient will have a complete list of prescription medications, OTC's, Herbals and supplements. It is recommended be instructed to maintain this list and share it with any providers.

Health Center providers should know what medications, OTC's, and Herbals patient's use prior to their outpatient visit. This reduces the incidence of medication duplication, drug interactions or other adverse events. This medication history should be obtained for all patients, regardless of the home environment (home, long-term care, assisted living, etc). The medication list should include all medications (prescriptions, OTC's, herbals, supplements, etc.) with dose, frequency and route. The provider should determine whether the patient is actually taking the medication as prescribed or instructed.

The provider should ask these two questions at the end of the encounter:

1. As a result of the visit, should any medication that the patient was taking or receiving prior to the visit be discontinued, altered, or held pending consultation with the prescriber?

2. Were any new medication(s) prescribed today?

These questions should be reviewed by the provider who evaluated and treated the patient. If the answer to both questions is "no"' the process is complete If the answer to either question is "yes," the patient needs to receive clear instructions about what to do – all changes, holds, and discontinuations of medications should be specifically noted.

Approximately 1.3 million Americans become ill or have adverse side effects from medical therapy each year. Medication Reconciliation is one way to lessen medication errors.

Include any follow-up required, such as calling or making appointments with other practitioners and a timeframe for doing so. A medication list can be kept on file rather than be re-created on every visit for frequent chronic care patients. However, at each visit the list should be re-verified for any additions, deletions or changes to medications, doses, frequencies, routes and alterations from original prescription or instructions.

Implementing medication reconciliation will ensure that patients and their caregivers possess the most accurate and up to date medication list possible to reduce the risk of medication misadventures. Medication reconciliation involves every member of the health care team (prescribers, nurses, pharmacists etc.,) with the goal of improving patient care and outcomes.

The Institute for Healthcare Improvement (www.ihi.org), AAAHC (www.aaahc.org) and Joint Commission (www.jointcommission.org) can provide more information on medication reconciliation.

Onondaga: Working Together To Bring Health Education To Our Patients

By Wanda Lyons, CHS Administrator, Manlius Service Unit

The Onondaga Nation Health Center and Manlius Service Unit are working to improve the health of the Onondaga citizens through a series of health education seminars developed through a survey of the Onondaga citizens to find out what they were the most interested in. The series of seminars are designed for the elderly group, but anyone who attends will benefit from the useful information.

The first one, "We Are What We Eat," was held on April 15 at Tsha hon nonyen dakhwa, the Nation's Arena.

Deb McCasland, R.D. the Nutritionist for the Onondaga Nation Health Center, spoke about how to make affordable changes to their diet. She provided educational packets, and recipes; a light healthy breakfast was served demonstrating healthy alternatives to the standard American breakfast.

Although the first session had less than 10 people, they were very inquisitive and ask many good questions about healthy eating. A smaller number of attendees was a plus because each person was able to ask questions and receive special attention from the Nutritionist.

In the evaluation, everyone found the information presented useful; 83% said they would used the information presented to improve or change their daily meals; and everyone said they would attend future seminars. They were asked what they would like covered in future seminars, many of the topics have sessions planned such as "Elder Exercise," "Controlling Diabetes," and "Preventing Diabetes Complications."

The next session, "Elder Exercise," is scheduled for May 20 and is to be held at Tsha hon nonyen dakhwa prior to the Elders luncheon. The speaker, Karen Kemmis, MS, PT, CDE, will be coming from the Joslin Diabetes Center in Syracuse, NY.

Increasing Internet Access to Native Americans: A New Avenue for Health Education

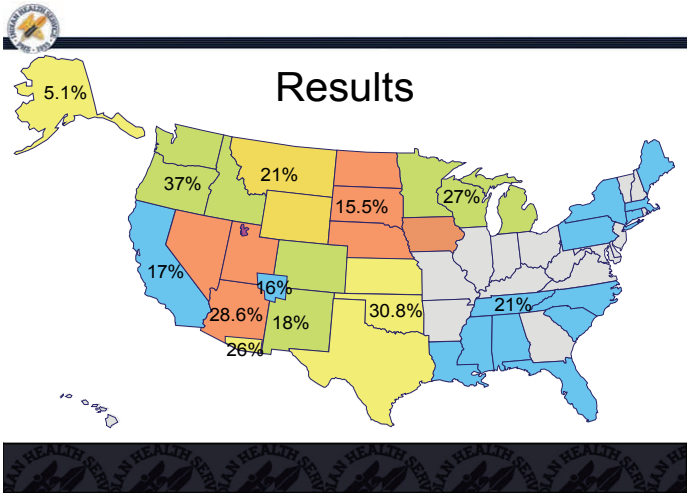
By Mary Wachacha, IHS/Area Health Education Consultant

The Indian Health Service is attempting to increase Internet access for AI/ANs. The first step is to determine how many AI/ANs have access to a computer. The intent is to increase health information via the Internet to AI/ANs.

Since there is little data available on the number of AI/AN who have Internet access, a new RPMS field was added to the Patient Registration application (version 7.1, patch 2). Currently Patient Registration clerks are prompted to ask 3 questions of patients:

1. **Do you have access to the Internet?** If the patient confirms that they can access the Internet, the Registration clerk then asks a 2nd question:
2. **Where does the patient access the Internet from?** (home, work, school, health care facility, library, or tribal/community center?). Soon a 3rd question will be asked:
3. **What is your email address?** This information can be used by the Tribal or IHS Health program to send health information to our patients. This information might include: reminders of appointments, test results and health education information.

This information is documented in the patient's medical record. Voluntary reports from over 75 IHS and Tribal programs were submitted for evaluation in January 2008. 356,748 patients, representing 23.8% of the IHS user-pop responded.



Results show that 20.9% of AI/ANs report having access to the internet and 21% of Nashville Area Tribal members have access to the Internet. Is your Patient Registration clerk asking these 3 questions?

For more information about this subject, contact Mary Wachacha at 828-292-1175 or Mary.Wachacha@ihs.gov.

Hope, Help, and Healing: A Guide to Helping Someone With a Substance Abuse Problem

Submitted by Liz Neptune, Area Substance Abuse Consultant

Editor's note: This information was originally printed in a brochure from the Partnership for a Drug Free America. For more information, go to http://www.drugfree.org

Are you worried that someone you care about has a drug or alcohol problem? Or do you feel your own use is out of control? You or your loved one can get better, and there are many ways to get help. This article will provide important facts about addiction and ways to get started on a path to recovery.

First steps are often the most difficult, but when it comes to addiction, you cannot wait. Addiction is a disease—a serious health problem like heart disease, cancer or diabetes—that can happen to anyone who uses drugs or alcohol. If left untreated, it can progress and may even be fatal.

Addiction can affect anyone. It afflicts 22 million Americans: men and women, teens and adults, poor, middle class and affluent, in rural towns, suburbs and cities. Because it has a strong genetic component, addiction tends to run in families. However, families just like yours have successfully intervened when loved ones are in trouble with drugs or alcohol and helped them get well.

The most obvious sign of addiction is using drugs or alcohol uncontrollably, despite the fact that use is causing problems. Addicted people's behavior can change dramatically, and they can act out of character, which is confusing and upsetting to friends and family members. If you've noticed any of the warning signs listed in the boxes to the right, investigate as soon as possible.

PHYSICAL SIGNS TO LOOK FOR

- Bloodshot eyes
- Slurred or agitated speech
- Sudden or dramatic weight loss
- Skin abrasions/bruises
- Neglected appearance/poor hygiene
- Frequently sick
- Accidents or injuries
- Unusual odors on breath; stains and odors on clothing

BEHAVIORAL

- Hyperactivity or unusual aggression
- Secretive behavior, including lying and locked doors
- Hidden stashes of alcohol, drugs or drug paraphernalia
- Missing alcohol or prescription medicine
- Not fulfilling responsibilities or missing school or work
- Avoiding eye contact

EMOTIONAL

- Sudden shifts or changes in mood and personality
- Emotional instability
- Depression
- No interest in previously enjoyed hobbies or activities

Learn the facts. Educating yourself about drug or alcohol addiction is the first step. For more information about addiction and types of treatment, visit www.drugfree.org.

Friends and family members can influence and motivate addicted people to get well. However, people sometimes feel powerless to help, because they accept "myths" like the ones below:

"Family members and friends need to educate themselves about addiction and change their own behavior if their loved one's recovery is to succeed."

Myth:
"She can stop using drugs if she really wants to."

Reality:
A person can control his or her alcohol or drug use at first. But long-term use actually changes some people's brain and body functions so they crave alcohol or the drug, and feel bad and sick without it. They find it difficult to stop on their own using willpower.

Myth:
"Treatment won't work for him."

Reality:
No matter how compulsive the addiction, treatment can work, especially when a person is committed to working on recovery and has a strong support system. In fact, the success rate for such treatment is similar to other chronic illnesses like diabetes, asthma and hypertension.

EFFECTIVE INTERVENTIONS

To be effective, an intervention needs to include an addicted person's loved ones. Often, they reach "rock bottom" before the person who needs help does, and can team up to push him or her to seek professional help. Family members and friends need to educate themselves about addiction and change their own behavior if their loved one's recovery is to succeed.

Locate resources—near and far. People get well through a variety—and sometimes a combination—of approaches, so it's essential to find out what help is available before you intervene. Call 1-800-662-HELP, or go to www.drugfree.org, click on Get Help for Drug Problems, then Find Treatment to identify appropriate alcohol or drug treatment programs.

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Treatment has many forms, but effective treatment will address physical, psychological, emotional and social problems and will involve family members. Make an appointment at a treatment center and attend meetings of local self-help groups to better understand what your loved one is going through. Recovery is much more effective with support from family members and friends.

HOW TO INTERVENE

Intervene as soon as possible. Whether you are a friend, family member, concerned employer or co-worker, you can encourage an addicted person to get the help he or she needs. Interventions do not have to be angry or dramatic, and effective ones can be loving, but firm, expressions of concern. But do intervene, either immediately or as soon as possible. It's never too late, although the earlier you act, the greater the likelihood of successful treatment and recovery.

DURING THE INTERVENTION

- ♦ Talk when the person has not been using drugs or alcohol.
- ♦ Stay calm.
- ♦ Express your comments with non judgmental caring and concern.
- ♦ Avoid labeling the person an "alcoholic" or "addict."
- ♦ List specific incidents resulting from the person's drug or alcohol problem (for example, "You were recently arrested for DWI.").
- ♦ Stick to what you know firsthand, not hearsay.
- ♦ Talk in "I" statements, explaining how the person's behavior has affected you ("I felt scared when you came home high last night…").
- ♦ Be prepared for denial, resentment and rejection.
- ♦ Be supportive and hopeful about change.

RECOVERY

Recovery is much more effective when family members are involved and have realistic, yet optimistic, expectations about the process.

People with drug and alcohol problems can get well; they can regain their physical health and well-being and improve their relationships with others. This happens when the person has stopped using drugs or alcohol and is "in recovery." Recovery is not instantaneous. It's a process that requires work to maintain, but it can lead to a profound life transformation with enormous personal growth. Some people experience it as a spiritual awakening, but recovery is also possible through therapy and non-spiritual self-help groups. If you are worried that you or someone you care about may have a drug or alcohol problem, it's important to intervene now.

Find links to the best resources on the Web and to find a treatment program, go to www.drugfree.org

The Chronic Care Initiative—Resources (from pages 16-21)

For more information on the IHS Chronic Care Initiative (CCI), please contact:

Kristina Rogers, Statistician/GPRA Coordinator Phone: 615-467-2926 Fax: 615-423-4925 Email: kristina.rogers@ihs.gov

For more information on the Chronic Care Initiative, please visit:

http://www.ihs.gov/NonMedicalPrograms/DirInitiatives/index.cfm?module=fact_chronic

For information on the iCare application, please visit:

http://www.ihs.gov/CIO/ca/icare/index.asp

References used on the CCI Section (16-21) and Resources for your clinic:

Institute for Healthcare Improvement. "How to Improve". http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/

Institute for Healthcare Improvement. "Plan-Do-Study-Act (PDSA) Worksheet". http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Tools/Plan-Do-Study-Act%20(PDSA)%20Worksheet

Institute for Healthcare Improvement. "Leaderships Role in Execution". http://www.ihi.org/NR/rdonlyres/163519D3-BB7A-496B-9C10-C345B81462FB/0/BisognanoLeadershipsRoleinExecutionACHEMar08.pdf

Institute for Healthcare Improvement. "Clinical Microsystems". http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Resources/Clinical+Microsystem+org.htm

Institute for Healthcare Improvement. "Forming the Team". http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/HowToImprove/ChronicFormingtheTeam.htm

Institute for Healthcare Improvement. "Self-management Support Measures". http://www.ihi.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport/EmergingContent/SelfManagementSupportMeasures.htm

Institute for Healthcare Improvement. "Use Planned Visits in Individual and Group Visits". http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Changes/IndividualChanges/Use+PlannedVisitsinIndividualandGroupSettings.htm

Institute for Healthcare Improvement. "Measures". http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Measures/

Thoughts Can Heal Your Body

By Robert Moss
Published: March 9, 2008

Editor's note: This information was originally printed in the Washington Post's Parade Magazine on March 9, 2008. It is being reprinted with permission.

Our thoughts can make us sick, and they can help us get well. That may seem like New Age thinking, but medical research increasingly supports the role played by the mind in physical health.

"People have been seeking healing through prayer and intention since Paleolithic times," notes Dr. Herbert Benson, founder of the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital. "What's new is our detailed scientific knowledge of how the mind-body connection operates."

Scientists first proved a link between stress and disease in the early half of the last century. Since then, researchers have examined old and new practices—including biofeedback, meditation, guided imagery, spiritual healing and deep breathing. The fast-expanding field of psychoneuroimmunology, which examines how the neurological and immune systems interact, is providing new clinical evidence of the connection between thoughts and health.

"We now can measure changes in immune cells and the brain in ways that give us objective scientific proof of the connection between them," says Mary Jo Kreitzer, director of the Center for Spirituality & Healing at the University of Minnesota.

Some people still are surprised to discover that thoughts can control physical sensation. "The body responds to mental input as if it were physically real," explains Larry Dossey, a physician and an advocate for mind-body study since the 1980s. "Images create bodily changes—just as if the experience were really happening. For example, if you imagine yourself lying on a beach in the sun, you become relaxed, your peripheral blood vessels dilate, and your hands become warm, as in the real thing."

Similarly, under clinical hypnosis, someone who is told he is being touched by a red-hot object often will produce a burn blister, even though the object touching him was at room temperature.

Brain scans show that when we imagine an event, our thoughts "light up" the areas of the brain that are triggered during the actual event. Sports psychologists have done pioneering work in this area. In one study, skiers were wired to EMG monitors (which record electrical impulses sent to the muscles) while they mentally rehearsed their downhill runs. The skiers' brains sent the same instructions to their bodies whether they were doing a jump or just thinking about it.

The "placebo effect" is an example of how the connection between brain and body works in healing. It has been demonstrated that when a patient believes something will relieve pain, the body actually releases endorphins that do so. In a recent study, Parkinson's patients who were given fake surgery or fake drug treatments produced dopamine (a chemical their bodies lack) in quantities similar to those they might have received in a genuine intervention. Medical research has suggested that 30% to 70% of successful treatments may be the result of the patient's belief that the treatment will work.

'There is ample evidence that negative thoughts and feelings can be harmful to the body," says Lorenzo Cohen, director of the Integrative Medicine Program at the M.D. Anderson Cancer Center in Houston. Stress is known to be a factor in heart disease, headaches, asthma and many other illnesses.

Studies by Janice Kiecolt-Glaser and Ronald Glaser at Ohio State University demonstrate how even minor psychological stress—that of newlyweds having their first fight or of students facing an exam—can compromise the immune system. The researchers found that a marital spat delays wound-healing and that the stress of caring for an Alzheimer's patient leaves the caregiver more vulnerable to illness even years later.

When the body fights a virus or heals a wound, it releases cyto-kines (literally, "moving cells")—chemical messengers that call in immune agents. The Glasers' research showed that stress distracts these cytokines from doing their proper work, instead sending them ranging wildly through the bloodstream. "When the cyto-kines are misdirected," says Kiecolt-Glaser, "they produce something you don't want—a prolonged inflammatory response that far exceeds what is needed with infection."

Just as our thoughts can make us ill, they also can help us heal, say those who practice mind-body therapies. There is growing clinical evidence that imagery is beneficial in treating skin disease, diabetes, breast cancer, arthritis, headaches and severe burns, among other conditions. Imagery also has been helpful in managing pain. "The mind is our most potent weapon in the battle for health," says Lyn Freeman, a researcher of mind-body therapies for chronic diseases. "It can be both slayer and healer."

What To Do

Adjust your mind-set to promote good health:

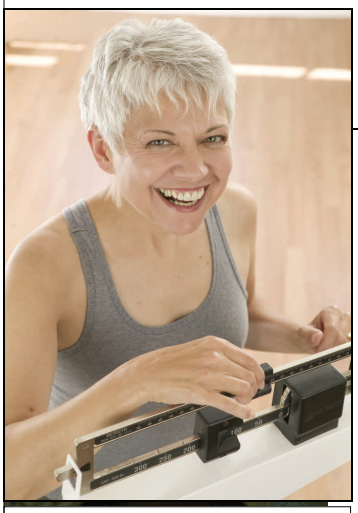
•**Take a deep breath.** Hold it, exhale, then repeat for 10 minutes. Take a walk, preferably in nature. Breathe in the fresh air.

•**Laugh!** When you do, you pump more oxygen into your lungs, improve blood flow and boost your immune system.

•**Keep a journal.** Writing about emotionally charged events helps us deal with them mentally and physically.

Robert Moss is the author of "The Three 'Only' Things: Tapping the Power of Dreams, Coincidence & Imagination."

Promoting a Healthy Lifestyle: Winning at Losing



Stepping up to the scale doesn't have to be a recipe for failure if you follow the practices of those who have successfully lost weight and kept it off.

To keep the pounds off, people did a variety of things, but many similar things are done by most of them...such as eating breakfast, weighing themselves regularly, watching less TV, and exercising regularly.

By Lisa Martin, MA, RD, CDE, Area Nutritionist Contact

Have you ever tried to lose weight? How about the patients you may see who either are trying or being encouraged to try? If so, you know there's a range of diets, techniques, medications, and programs that are available. From Weight Watchers, Jenny Craig, Atkins diet, Xenical, surgery and the cabbage soup diet, you can pick from the tried and true to the newest wacky fad.

How about once some weight is lost-what next? The often quoted statistics on maintaining weight loss are downright depressing-the one cited most often is that 95% of dieters gain back the weight they lost. According to some weight experts this number can be traced back to a single survey done in a hospital nutrition clinic in 1959! More recent numbers are mostly from university based studies which tend to enroll people with tougher weight problems than most, so the outcomes may not be as good.

If you think about it, you can probably come up with quite a few people who have been successful at keeping off their loss. I look around at just my co-workers and can count at least 7 who have taken weight off over the past few years and kept it off. Since we don't have a big facility-this is about 40% of our staff! They have lost it through a variety of ways - lifestyle change, medications, breastfeeding (burns a LOT of calories!), but they all do some things in common to keep it off.

The good news is that weight loss CAN be maintained. The National Weight Control Registry, started in 1994, is the largest prospective investigation of long-term successful weight loss maintenance. It was developed to find and track the commonalities of people who have succeeded at long-term weight loss. Detailed questionnaires and annual follow-up surveys are used to examine the behavioral and psychological characteristics of weight maintainers, as well as what they do to maintain their weight loss. Anyone can join the Registry if there has been a weight loss of at least 30 pounds, kept off for a year or more. Most people lost weight by changing their intake somehow, either on their own or through a program. Most also increased their activity level while they were losing. Many did not succeed the first time they tried, but were able to keep weight off after losing and gaining a few times. Those attempts were not wasted, as people learn what works or doesn't for them.

To keep the pounds off, people did a variety of things, but many similar things are done by most of them. Most report eating a low(er) calorie, low fat diet and doing high levels of activity.

Also:

- 78% eat breakfast every day
- 75% weigh themselves at least once a week
- 62% watch less than 10 hours of TV per week
- 90% exercise, on average, about 1 hour a day

Other things mentioned by the majority are: they allow themselves treats, but know when to stop or get back on track, they don't let weight start creeping back up, and most eat several servings of fruits and vegetables daily as a way of keeping calories low and feeling full.

Coincidentally, these are all good strategies for losing weight in the first place.

To read more good news:

⇒ www.nwcr.ws
National Weight Control Registry. Success stories and research studies.

⇒ www.annemfletcher.com
Author of 'Thin for Life', 'Weight Loss Confidential'(about teens) and several other books about successful losers. All are highly recommended.

Got Milk?
The Facts About the Benefits of Breastfeeding

By Michelle Ruslavage, BSN, RN, CDE, Area HP/DP Coordinator

Two of the most important contributors to infant health are immunizations and breastfeeding. Breastfeeding provides a range of benefits for infant's growth, immunity, and development. In addition, breastfeeding improves maternal health and contributes economic benefits to the family and healthcare system.

Child Health Benefits

Breast milk contains an abundance of factors that are active against infection. The infant's immune system is not fully mature until about 2 years of age. Breast milk specifically contains immunologic agents such as antibodies, leukocytes and carbohydrates that act against bacterial meningitis, bacteremia, diarrhea, respiratory infection, otitis media, urinary tract infection and necrotizing enterocolitis.

Other health outcomes include decreased rates of Type 1 & 2 diabetes, overweight and obesity, hypercholesterolemia, lymphoma, leukemia and Hodgkin disease, and asthma.

Maternal Health Benefits

Important health benefits of breastfeeding for mothers include decreased postpartum bleeding which can lead to decreased anemia, earlier return to pre-pregnancy rate, decreased risk of breast and ovarian cancer. Also, the possibility of increased self-confidence, facilitated bonding with the infant, decreased risk of hip fractures and osteoporosis in the postmenopausal period may occur.

Community Benefits

Breastfeeding provides economic and social benefits to the family, and healthcare system. These benefits include a potential for decreased annual health care costs of **$3.6 billion** in the United States (*Pediatrics.1999:103*). Breastfed infants typically require fewer sick care visits, prescriptions, and hospitalizations (*Pediatrics.1999:103*).

Families can save several hundred dollars over the cost of feeding breast milk substitutes, even after accounting for the costs of breast pump equipment and additional food required by the nursing mother (*J Am Diet Assoc 1997; 97).*

Employers benefit from less maternal absenteeism lower medical costs and higher productivity.

RPMS

Did you know that the Resource Patient Management System (RPMS) has the capacity to track Infant Feeding Choices through the EHR, PCC or PCC+?

The definitions are as follows:

- Exclusive Breastfeeding: Formula supplementing less than 3 times per week (<3x per week)
- Mostly Breastfeeding: Formula supplementing 3 or more times per week (≥3x per week) but otherwise mostly breastfeeding
- ½ Breastfeeding, ½ Formula Feeding: Half the time breastfeeding, half the time formula feeding
- Mostly Formula: The baby is mostly formula fed, but breastfeeds at least once a week
- Formula Only: Baby receives only formula

You can get more information about RPMS data entry at: http://www.ihs.gov/MedicalPrograms/MCH/M/documents/FAQs-Infant%20Feeding%20Choice_110207.doc

You can also visit the IHS Breastfeeding website at: http://www.ihs.gov/MedicalPrograms/MCH/M/bf.cfm

"Breastfeeding provides a range of benefits for infant's growth, immunity, and development."

Dental Sealants: Common Myths and Facts

By Tim Ricks, DMD, MPH, Area Dental Officer

MYTH #1: If there is an incipient lesion, it is best to restore the tooth rather than place sealants.

FACTS: As dentists, we are often worried that we may be sealing over caries. In a study published in the Journal of the American Dental Association in March 2008 (Oong EM et al, JADA, **J Am Dent Assoc.** 2008 Mar;139(3):271-8.), authors examined six studies that looked at the effect of dental sealants on bacterial levels in caries lesions. They found that "there were no findings of significant increases in bacteria under sealants… Sealing caries was associated with a 100-fold reduction in mean total VBC (viable bacteria counts)." The authors concluded "that sealants reduced bacteria in carious lesions, but that in some studies, low levels of bacteria persisted. These findings do not support reported concerns about poorer outcomes associated with inadvertently sealing caries.

MYTH #2: Sealants should be placed only in certain teeth and only at certain ages.

FACTS: Sealants are best applied to all non-cavitated teeth in children and adolescents. In an article published in the Journal of the Canadian Dental Association in March 2008 (Azarpazhooh A et all, J Can Dent Assoc. 2008 Mar;74(2):171-7), the authors made the following recommendations:

1. Sealants should be placed on all permanent teeth without cavitation (i.e., teeth that are free of caries, teeth that have deep pit and fissure morphology, teeth with "sticky" fissures or teeth with stained grooves) as soon after eruption as isolation can be achieved.
2. Sealants should not be placed on partially erupted teeth or teeth with cavitation or caries of the dentin.
3. Sealants should be placed on the primary molars of children who are susceptible to caries (i.e., those with a history of caries).
4. Sealants should be placed on first and second molars within 4 years after eruption.
5. Resin-based sealants should be preferred, until such time as glass ionomer cements with better retention capacity are developed.
6. Sealants should be placed as part of an overall prevention strategy based on assessment of caries risk.

MYTH #3: You don't really save money with sealants; eventually you have to restore the teeth anyway.

FACTS: Every $1 spent on prevention activities saves $38 down the road, so say public health experts. One study done on Alabama Medicaid children showed a $16 cost savings on patients receiving sealants (Restorative cost savings related to dental sealants in Alabama Medicaid children, Dasanyake AP et al, Pediatr Dent. 2003 Nov-Dec; 25(6):572-6). Another study in Quebec in the late '90s showed that dental sealants reduce costs by up to 31% (Treatment cost savings with universal dental pit and fissure sealants in Quebec, Brodeur JM et al, J Can Dent Assoc. 1997 Sep;63(8):625-32.). The cost savings may even be higher, though; based on the ADA fee analysis in 1999, the cost of sealing a tooth may be almost $50 less than a restoration (American Dental Association. 2000. *1999 Survey ofDental Fees.* Chicago, IL: American Dental Association Survey Center).

MYTH #5: "I've already sealed all the teeth on my patients."

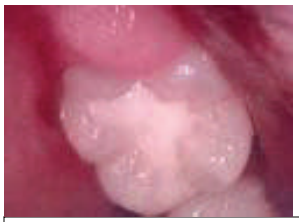
FACTS: During my site visits in the Area, many records examined did not have sealants treatment planned or applied on many of the patients. I would encourage dental clinics to assess caries risk on all patients and treatment plan dental sealants accordingly.

Area Dental Program Releases "Dental GPRA Measures—How to Track Locally"

By Tim Ricks, DMD, MPH, Area Dental Officer

On March 10th, the Nashville Area Dental Program released "Dental GPRA Measures—How to Track Locally."

This document, with contributions from Dr. Bonnie Bruerd, a consultant with the Portland Area Dental Support Center, Cathy Hollister, the director of the Nashville Area Dental Support Center, and Dr. Tim Ricks, the Nashville Area Dental Officer, was designed to encourage local dental programs to track progress on meeting the three dental GPRA measures of access to care, patients receiving topical fluorides, and dental sealants.



Dental sealants (in both adults and children) are one of three dental GPRA measures in the Indian Health Service.

The document contains:

- The GPRA Logic for each dental GPRA measure
- Screen-by-screen tracking in RPMS
- Special notes and limitations to tracking
- How to make changes clinically to improve GPRA performance

Dental Program Reviews: Assisting Tribes in Productivity, Efficiency, and Quality

By Tim Ricks, DMD, MPH, Area Dental Officer

Ever wonder how your dental program compares with other public health programs or recommendations from the Indian Health Service?

The Nashville Area Dental Program provides a detailed analysis of dental programs using tools created by the Indian Health Service, and has conducted over 20 reviews using these tools in the past year.

Productivity.

Clinical productivity is measured through the number of patients treated, total number of patient visits, total services provided, levels of those services (based on CHS), and service minutes or relative value units.

Efficiency.

Dental clinic efficiency is measured by over 20 measures including dentist to population ratio, staff to patient visit ratio, and so on. These efficiency measures can show where things can be changed to maximize available staff.

Dr. Ricks conducted a program review using the new assessment tool in May at the Hollywood Clinic of the Seminole Tribe

Quality.

Quality improvement is measured through patient satisfaction surveys, administrative feedback, and different quality improvement data studies, such as periodontal recalls. Clinics develop their own quality improvement priorities.

For more information on how to set up a dental program review at your facility, contact Dr. Tim Ricks at 615-467-1508.

Area Dental Program Becomes First to Release Free Online Continuing Education Courses

By Tim Ricks, DMD, MPH, Area Dental Officer

February 21st marked a milestone for the Nashville Area and Indian Health Service. "Fluoride Varnishes" became the first online continuing education course offered by an IHS Area, good for one hour of free continuing education credit for participants who pass the online test.

Housed on the IHS dental portal, this presentation, along with a second one entitled "Dental Public Health," were created by the Area Dental Officer and Dr. Mary Beth Kinney and Tal-ee Roberts, contractors with the IHS Division of Oral Health who manage the IHS Dental portal.

At least five additional courses are in the final stages of development, and it is hoped that a total of 10 online courses will be offered—at no charge—to Nashville Area Dental Staff before the end of the year.

"I think that especially for the clinics that are isolated, that this is a great idea for continuing education without the expense of travel to a meeting," said Dr. Brian Berg, Chief Dentist at the Choctaw Dental Program in Mississippi.

For more information on the online courses available in this Area, go to: www.doh.ihs.gov.

Dental Support Center Review Set For June 10-12

By Tim Ricks, DMD, MPH, Area Dental Officer

The Nashville Area Dental Support Center, under the direction of Cathy Hollister, RDH, MSPH, PhD, and housed with the United South and Eastern Tribes, Inc. (USET) will undergo its first external review June 10-12, 2008.

Dr. Cathy Hollister serves as the Nashville Area Dental Support Center Director

The review will be conducted by Delores M. Malvitz, Dr.P.H. Dr. Malvitz has an extensive public health background, serving in the Oklahoma Area IHS, as a leader in the Centers for Disease Control and Prevention, and as a consultant with the American Dental Association Council on Dental Accreditation (CODA).

As part of the review process, Dr. Malvitz will be reviewing documents, interviewing USET and NAO leaders, and interviewing stakeholders throughout the Nashville Area. The purpose of the review will be to assess how well the Dental Support Center is meeting its mission to provide support to Nashville Area tribes/nations.

Landmark Study on the Treatment of Hypertension in the Very Old

By Bruce Finke, M.D., IHS/Nashville Area Elder Care Consultant

An international study published in the New England Journal of Medicine this past March shows that we can prolong life and prevent disability in people 80 years and older by paying close attention to their blood pressure.

We have known for a long time that treatment of high blood pressure helps prevent stroke and heart disease, but this had not been shown in the oldest old, those 80 years and older. Because older people are often more sensitive to medications many have worried that treating high blood pressure in those 80 years and older could cause more harm than good.

Nearly 4000 elders aged 80 and older with high blood pressure (systolic blood pressures of 160mm Hg or higher or diastolic blood pressure of 90 or higher) agreed to participate in the study and were randomly selected to receive either a blood pressure medicines (a diuretic similar to HCTZ) or a placebo (no active ingredients – only given in research settings with the informed consent of the study participants). Those elders in the treatment arm were given a second blood pressure medicine if they needed it to reach the target blood pressure of 150/80.

Treatment of hypertension in people 80 years and older is as important as treatment of the disease in younger people, with significant reductions in strokes and heart failure.

Researchers followed these elders for over 2 years and found that those elders who had active treatment for high blood pressure had nearly 1/3 (30%) fewer stroke and nearly 2/3 (64%) fewer cases of heart failure. Those actively treated had reduced death rates from stroke (reduced by 39%), cardiovascular disease (reduced by 21%), and all causes (reduced by 23%). Those elders whose blood pressure was actively treated had fewer total adverse events than those not treated (given placebo).

This is an important study that clearly shows the benefit of treatment of high blood pressure in the in the very old. I was especially interested in the marked reduction in stroke and heart failure, two conditions with huge implications for the function and quality of life of older people. Treatment of high blood pressure is not just about preventing death, but also about preserving quality of life.

Reference:

Treatment of Hypertension in Patients 80 Years of Age or Older. Beckett N et al. N Engl J Med. 2008 Mar 31

Nashville Area Senior Leadership Participates in National Emergency Drill - "Eagle Horizon 2008"

By CAPT Kevin Molloy, Nashville Area Emergency Management Director

The Nashville Area Office of the Indian Health Service and all Executive Branch departments and agencies, recently participated in a national COOP exercise called Eagle Horizon 2008. COOP, or Continuity Of Operations are plans and procedures to enable government programs to preserve, maintain and/or reconstitute their capability to perform essential functions in the event that a threat or actual occurrence of any disaster or emergency disrupts normal operations and services. Eagle Horizon was a full-scale national level exercise in continuity of operations that was initiated by the White House under the National Continuity Policy.

Government programs are required to be capable of continuing to provide their essential functions even when an emergency occurs. Planning and testing of those plans and procedures are crucial to ensuring that government services are still available when needed. COOP plans and procedures include having redundant communications and data systems in place, having the ability to relocate if necessary, and having the ability to "hand off" functions to working units to ensure continuation of services until normal operations are reconstituted. Tests of these systems are critical in finding gaps in the planning process and filling in those gaps. Lessons learned from Eagle Horizon 2008 will be used to make the existing COOP programs more effective.

Management of the COOP program is one of the functions of the Division of Emergency Management in the Nashville Area Office. Assistance for COOP planning and exercises can be requested from Captain Kevin Molloy at 615-467-1504 or Captain Mickey Rathsam at 615-467-1509.

Planning Prevention Programs Using The "POARE" Model

By Tim Ricks, DMD, MPH, Office of Public Health Director

Editor's Note: The Nashville Area Office of Public Health has been using the POARE Model, developed at the University of Michigan, for all program planning for the past year. While there are many models to assist tribes in planning prevention or health promotion programs, the POARE model may be preferred because it closely aligns to the logical approach used in quality improvement activities.

The Nashville Area advocates the use of the POARE model in planning, implementing and evaluating health promotion/disease prevention activities. "By following this model, staff will able to clearly identify a problem of importance to the community they serve, make plans for the best use of resources, and plan a thorough evaluation of the program. Below are the components of the POARE model." (From the IHS Oral Health Program Guide)

Many programs plan health promotion and disease prevention activities without a written plan. However, many programs fall apart when a leader leaves, when there seems to be staff resistance to the program, or whenever contingencies have not been planned. A comprehensive written program plan utilizing the POARE format will help programs:

- Get buy-in from key stakeholders such as administrators, community members, patients, and staff who will participate in the project
- Organize programs and projects to meet the clinic's overall objectives.
- Relate project activities to specific problems and objectives.
- End programs once objectives have been met (equivalent to "closing the loop on quality assurance").

Problem:
Decide which health problems are of the greatest concern in your community. This can be done in many ways:

⇒ Surveys of community members

⇒ Survey of other key stakeholders such as staff or administration.

⇒ RPMS data searches

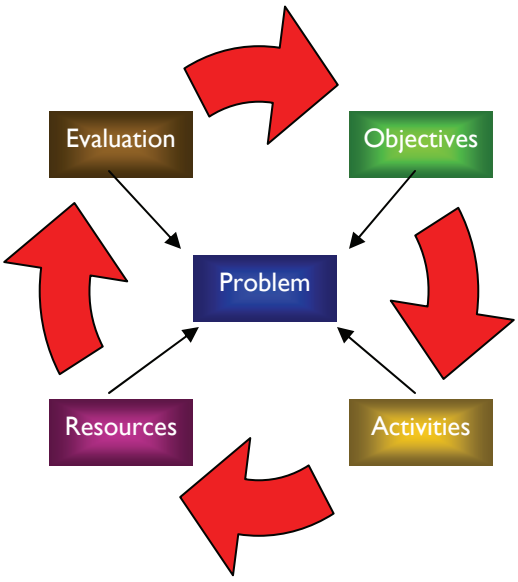
⇒ Focus groups

"For instance, if diabetes is a major health problem in you community, then you might want to focus on limiting pop and other sweetened beverages" (from the OHPG). **Identifying the problem, and writing that problem as detailed as possible, is the most important step in program planning.**

POARE Model

P—Problem
O– Objectives
A—Activities
R—Resources
E—Evaluation

Objectives:
Write one or more objectives that address what you can realistically achieve. Objectives should be "SMART" - significant, measurable, attainable, relevant, and have a timeline.



Activities:
What are the activities that you will implement to meet your objectives? All of the activities should directly relate to the objectives.

Resources:
Decide what resources your program will need. Resources do not only include funds, but also supplies, equipment, printing, and most importantly, personnel. Who will be doing the activities? Are people outside the clinic going to assist with the project, and if so, how? Start out by thinking big. You can make reductions later as needed.

Evaluation:
Evaluating a health promotion/disease prevention program is important in that a thorough evaluation will:

⇒ Help justify resources for the next program planned

⇒ Communicate with community members, patients, administrators, and participating staff the successes of your program

⇒ Result in "lessons learned," so the next time a project is planned, the same mistakes aren't repeated.

By following this approach at program planning, clinics may be able to better communicate all aspects of the program. More information on this topic will be presented at this year's Health Summit. In addition, the Office of Public Health (OPH) and the USET Tribal Health Program Support (THPS) are working together on a "Program Planning Guidebook" for the Nashville Area, which may be completed and distributed by the end of this year.

GPRA and CCI

The Government Performance and Results Act (GPRA) is a federal requirement that can be used to improve patient health, which in turn can decrease the cost of caring for patients to allow for better quality and quantity of care. Using GPRA measures to improve chronic conditions and test changes in practice is a good way to begin implementing portions of the CCI processes. Learning to measure improvement based on GPRA data can help sites identify gaps in service and the need to redesign clinical processes to provide quality health care to patients.

What is the Chronic Care Initiative (CCI)?

By Kristina Rogers, Area CCI Contact

Chronic health conditions are becoming increasingly prevalent in American Indian and Alaska Native communities. These conditions are placing a growing strain on the healthcare system where resources and services are dwindling.

Chronic conditions such as diabetes, cardiovascular disease, asthma, renal disease, depression and cancer have begun to overwhelm available health care resources. There is an urgent need for a strategic plan to address both the treatment and the prevention of chronic conditions within the Indian Health Service (IHS) health care systems.

The goal of the Chronic Care Initiative is to improve the available care for patients and populations by reducing both the prevalence and the impact of chronic conditions. The CCI claims to implement strategies within the Indian health systems to support community and individual wellness and strength. The CCI claims to create a process that can be adapted and applied for care across multiple chronic conditions. It will utilize the Model for Improvement to develop, test and package a system so that it can be spread throughout Indian Health Service and all Indian health systems.

This system should be more effective and efficient at addressing chronic conditions. It will help eliminate wasted time and energy. It will also encourage patient self-management, which will help decrease frequent visits by patients with chronic health conditions. This will leave more resources for prevention services.

The Indian Health Service has partnered with Tribes/ Nations and the Institute for Healthcare Improvement to develop an organized improvement system to use, test and implement innovative changes in the delivery of chronic illness care. The expectation is that these pilot sites will share lessons learned with other sites within Indian health systems. Success hinges on the active engagement of community and tribal leadership in this effort to support innovative concepts that address

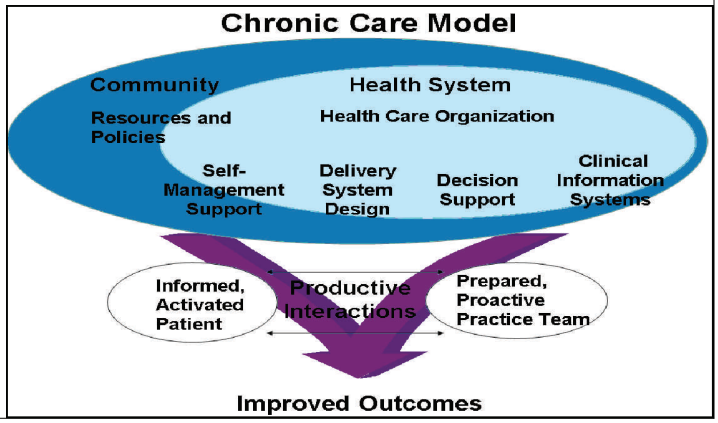
Vision of the Top

By Kristina Rogers, Area CCI Contact

A vision of a better tomorrow can help motivate improvement beginning today. Creating an environment where care teams are active, multidisciplinary and committed to improving patient care, are ways the Chronic Care Initiative can impact life at your facility.

Imagine a place where continuity of care is standard, where clinicians are utilized to the best of their ability and patients visit the clinic as much for preventive measures as for treatment of chronic conditions. **The Chronic Care Initiative is the model to this future.** By reorganizing existing systems, patient outcomes can change and better patient health can be achieved. Open your mind to a place where demand equals supply; a place where patients get what they need and want, and a place where patients see their own provider and staff are happy and go home on time.

Implementing concepts from the Chronic Care Initiative is the answer. All it takes is the WILL to change a system that isn't working, new IDEAS and proper EXECUTION of a plan to implement the new ideas.



Patient, Family and Community - The Center of Care

By Kristina Rogers, Area CCI Contact

Patients visit clinics to get a sense of reassurance and receive explanations as to possible health issues and how they can obtain better overall health. They expect information, recommendations, medication, education and relief. There is currently a professional shortage and continuity of care is limited. Patients often do not feel they are getting required individual care. There is poor employee retention and high turnover in facilities. Employees become unresponsive to patient needs because there is no sense of partnership or pride and "status quo" is the mantra of the facility.

Why not create an environment where patient needs come first to clinic production, supply and demand are balanced, variation is acceptable and organizational members are willing to try new things and work toward improvement?

By redesigning health systems, there can be a decrease in wait time, an increase in patient and staff satisfaction, and the overall health of the patient

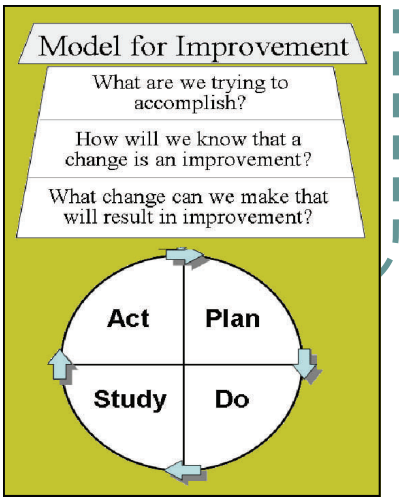
The Model for Improvement

By Kristina Rogers, Area CCI Contact

The Model for Improvement is based on the idea that system outputs are a product of system designs. In order to get different results, the system must be redesigned. The Model for Improvement offers tools that can help organizations redesign their systems.

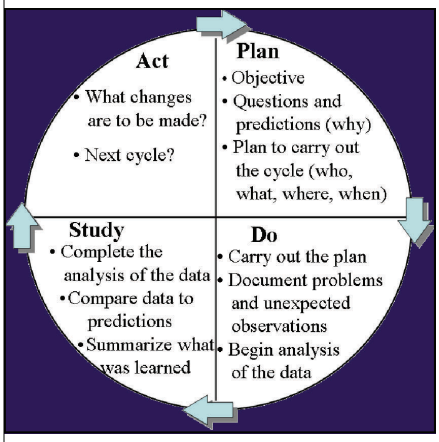
PDSA cycles and the 3 questions associated with the Model for Improvement will help create system changes. Start off by identifying what you want to accomplish. Think about what you can do to accomplish that goal and determine what will be measured to conclude that a change was an improvement. This will aid the team in measuring where they are and what PDSA cycles would benefit the organization.

These changes and ideas can allow care teams to establish a belief that change is possible. Gathering, analyzing and displaying data allow the team to determine the expected outcome of a test and whether the changes tested are sufficient to achieve the organizational aims. Linking series of tests together can help identify positive changes. The model for improvement is meant to implement change across all health conditions. Making sure tests are done over a wide range of conditions and integrating the results system wide will ensure the change will be successful. Using iterative learning to create improvement allows the team to test an idea until the outcome helps the organization achieve their goals. Involving team members throughout the testing process will help decrease resistance to change and allow staff to contribute to organizational changes.



Rapid Cycle PDSAs

By Kristina Rogers, Area CCI Contact



PDSA cycles mirror the way humans learn and think. Learning by trial and error allows people to test and implement changes in aspects of work, home and life.

In a health care system, using small scale tests and multiple cycles of testing, can build knowledge about needed changes within an organization. Each PDSA cycle creates information that can be used to determine how close a team is to meeting their objectives.

Rapid cycle PDSAs allow for quick feedback and the opportunity to change testing components along the way. Team members interested in learning about change and improvement will enable the team to move rapidly from test to test. This team approach will help lay the ground work for involving other organizational members in the process and contributing to the spread of change throughout.

Keys to Success

By Kristina Rogers, Area CCI Contact

One of the ways to measure success is by collecting data. Knowing what you are measuring and why it is important to measure helps the team track positive or negative progress. Sharing outcomes with all staff within the clinic will help cut down on resistance to change and encourage other staff members to get involved in the improvement process.

Using a team approach allows patients and staff experiences to positively increase. Patients feel like they are valued by the care team and the members of the care team feel less overwhelmed. Working on eliminating inefficiencies through process mapping can cut down on wasted time and patient dissatisfaction. If patients are having to walk the length of the clinic 3 or 4 times to sign in, see the doctor, get prescriptions and finally, leave the clinic, they are wasting their time and energy. Redesigning the layout and the process for which they flow through the clinic can benefit the clinic and the patients it serves. Program evaluation throughout the year also helps facilities make changes when necessary. Identifying weaknesses within a clinic process can help prompt a need for PDSAs or improvement evaluation.

Ways to achieve great health care:

- *Have a prepared and active care team*
- *Use "Huddles" to evaluate each patient coming in for a visit*
- *Max pack visits*
- *Maintain continuity of care*
- *Utilize group visits for patient education, immunizations, GPRA screenings, etc.*
- *Test improvements in a small scale to find weaknesses and strengths*

The Role of Leadership

By Kristina Rogers, Area CCI Contact

Organizational leaders need to invest in the process for improvement in order for it to be successful. They need to show an authentic interest and knowledge of all aspects of the project and it's subsequent transitions. They must be involved in the design of the new system by allowing people to step out of their comfort zones and solicit input from all staff. Leadership can show its support for improvement projects by aligning system measures, strategies and projects. Encouraging project managers to set deadlines and keep

them helps keep the team on track. Leadership must help identify aspects of the system that need improvement and make sure that everyone in the organization knows their role and is willing to change their practices at work. Leadership needs to show staff that they are paying attention in a positive way by building trust with patients and staff - attention is the currency of leadership. All supervisors need to be on board and supportive of improvement projects. Leadership needs to make sure the right team is assembled for the project. It needs to make sure team members understand the importance of the project and that they have the skills to carry out the project. Team members with the right attitude and right heart will make the project a success.

The Community Factor

A patient's community has a large influence on their activities and practices. In order for the Chronic Care Initiative to be successful at your facility, you will need to look at building a system of care based on community values, and existing individual, family and community strengths. Begin by developing strong and trusting relationships with consumers, family, and respecting the community's traditional beliefs and values. Imagine how you can integrate traditional medicine with clinical medicine and make sure all staff members (full and part-time) are culturally competent. It is important to involve the community in health improvement by linking community activities with clinical practices. Mobilizing community resources to meet needs of patients and encourage patients to participate in effective community programs can create a support network for patients with chronic illnesses. By promoting community involvement in both strategic planning and improvement activities, you can understand and fix access barriers to relationships over time. This will inevitably improve patient health and, in turn, improve the population of the people you serve.

The Clinical Factor

By Kristina Rogers, Area CCI Contact

Success depends upon having the right team in place. They must be able to adapt to situations and work to their full ability. The care team should be prepared, active and should be able to communicate and resolve relational issues between staff to ensure the project moves forward successfully.

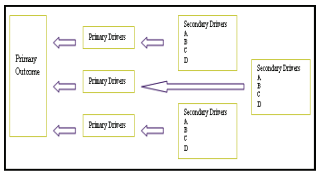
In every organization there are members who are motivated, willing to learn and are champions for improvement. These people can help jumpstart the project, help communicate the importance of the project and help sway other staff participation with the project. Optimizing care is one of the ways a system can improve. By redesigning staff functions and making sure staff is capable of performing duties they are assigned as well as improve staff satisfaction and system processes. It will help drive work away from the provider so that they can concentrate on treating patients.

Adopting aspects of motivational interviewing techniques and promoting self-management support will also make your health system a success. Frontline staff work with leadership to create an environment where improvement is possible.

Creating Quality Care Teams

By Kristina Rogers, CCI Contact

Successful care teams should consist of a multidisciplinary team where each member of the team shares the same vision. Good quality teams include members who are creative and think "outside" the box. They are people who respect the other team members, utilize patient feedback and are good leaders. Care teams with these kinds of individuals are successful because they have a clear goal, and are motivated about the relevant project. They also understand the effectiveness of rapid cycle testing and the clear link they have to improvement in clinical quality. They must also utilize driver diagrams. These diagrams help clarify concepts, set clear aims and identify primary system components. The driver diagram helps keep the team on track and moving toward a goal. They aid in the development of measures and they help the team articulate their contribution to the overall mission of the organization.



Encouraging Self-Management

By Kristina Rogers, CCI Contact

Self-management is defined as an individual's ability to manage symptoms, treatment, physical and social consequences and lifestyle changes inherent in living with a chronic condition. The Chronic Care Initiative emphasizes the patient's central role in managing his/her own health. It supports strategies for goal setting, action planning, problem solving and follow-ups for patients with chronic conditions. By organizing internal and community resources to provide ongoing self-management, patient health will improve. Models of community care such as community treatment and group interventions based on principles of motivational interviewing ,encourage patients to manage their own healthcare. Principles of motivational interviewing include expressing empathy, supporting self-efficacy, rolling with resistance and developing discrepancies. These concepts allow the patient to make decisions with the guidance of a clinician to improve their health and manage their own healthcare.

Organize internal and community resources to provide ongoing self-management support:

- *Provide behavior change interventions and ongoing support with peers and professionals*
- *Emphasize group support opportunities*
- *Provide case management for patients who need to ask for additional support with self management skills and confidence*
- *Develop resources and tools to aid patients in dealing with emotional barriers to change*

"The 5 As" of Self-Management:

1. ***ASSESS*** *patient's & family's motivation, beliefs, behavior, and knowledge*
2. ***ADVISE*** *patients/families by providing specific information about health risks and benefits of change*
3. ***AGREE*** *on collaboratively set goals based on patient's/family's conviction and their confidence in their ability to change the behavior*
4. ***ASSIST*** *patients/families by identifying personal barriers, strategies, and social/environmental support*
5. ***ARRANGE*** *a specific follow-up plan*

Utilizing Group Visits

By Kristina Rogers, Area CCI Contact

Group visits are a great way to enhance education, access and efficiency. They can be used to improve prevention and chronic disease management and allow the patient to spend more time with a provider or care team.

Using a multidisciplinary team to address the "mind" as well as the "body" allows teams to increase quality care and decrease costs. Group visits help facilities leverage existing resources, increase patient-physician interaction and create an environment of learning and fun.

Patients enjoy group visits because they feel more important and valued. Even in the group setting, they visit with the physician on a one-to-one basis and discuss personal health issues. Providers are able to give necessary services by "max packing" visits and offering other services to patients as needed.

Using Data for Improvement

By Kristina Rogers, Area CCI Contact

Data helps determine whether or not a change has occurred. Using run charts to plot data on a weekly and monthly basis can help identify whether current changes made a positive, negative or neutral impact. Plotting and reporting data will help clarify the team's aim and make it tangible.

Integration of measurement into everyday routines increases the team's ability to verify whether change has occurred quickly. Effective use of data consists of developing a balanced set of measures that can be plotted over time. It can be qualitative or quantitative data that is gathered from a sample of patients. Using clinical bundles such as cancer (pap smears, mammograms, and colorectal cancer), or behavioral health (FAS, depression or DV/IPV) can help determine if a particular population of people received the care that they needed. The use of run charts and line graphs are the most effective way of determining change. Eight or more data points in one direction designates a tread which can be evaluated. Large changes (or blips) up or down in the data mean that a change occurred. Depending on the layout of the subsequent data points, it is easy to tell if the change was sustained. The best way to track improvement is to do PDSA cycles and plot the results on a run chart. Documenting PDSA cycles and using action plans will help determine what changes resulted in improvement and which did not. GPRA measures and CRS reports can also be used to determine if patient health is improving.

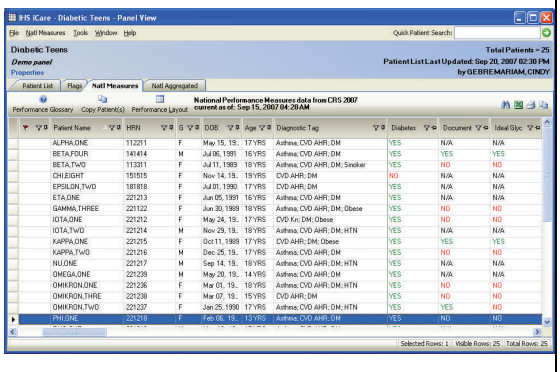
iCare

By Kristina Rogers, Area CCI Contact

iCare is a population management tool that can be used by a wide variety of providers to manage the care of their patients. This free software displays Clinical Reporting System (CRS) National Performance Measures.

The Government Performance and Results Act (GPRA) logic is utilized by iCare to determine patients' compliance status for each measure on a routine basis.

By creating a panel of patients based on a common characteristic (same provider, active clinical diabetic patients, etc.) patient health can be evaluated quickly and more often. iCare allows the user to filter and/or sort on columns displaying individual measures to display patients' compliance status with each displayed measure.



Clinician View of the CCI

By Dr. Harry Brown, Nashville Area Chief Medical Officer

The Chronic Care Initiative is an exciting new program in the Indian Health Service. The project began about 2 years ago, and involved 14 initial pilot sites. Soon an additional 26 sites will be added.

The exciting thing about the program from my perspective as a clinician is that, although its focus is on improving the care of chronic diseases, it is actually a program that will improve the overall health care delivery system of any facility. It works for large hospitals as well as small clinics. It doesn't require a huge outlay of money for special equipment or personnel. It does require a desire to change for the better and commitment to improving the system. It does take time and effort.

The Chronic Care Initiative can make the whole system work better for everyone. It makes the experience of health care better for the patient. It allows the nursing staff to do more interesting and fulfilling patient care. It allows the medical staff to spend more of their time in doing medical care as opposed to clerical work. When the Chronic Care Initiative works the way it is designed to work, everyone has a better and more fulfilling experience.

Area CCI Support

Area Staff that can assist tribes on the Chronic Care Initiative include (L to R): Neill Dial, Dr. Palmeda Taylor, Kristina Rogers, Dr. Harry Brown, Liz Neptune, Michelle Ruslavage, Dr. Tim Ricks, Wanda Lyons, and Lisa Martin.

Non-Clinician View of the CCI

For those of you that don't know me, my name is Kristina Rogers. I am the Statistician/GPRA Coordinator and the Chronic Care Initiative contact for the Nashville Area. I am not a clinician and I do not have a clinical background. I have a Bachelor's degree in Mathematics with emphasis in Computer Science. When I first got involved in the Chronic Care Initiative, I was a little weary. I didn't know much about it or what it entailed. I was put at ease when I met with the CCI pilot sites where I learned they were also unfamiliar with the process they were about to undertake. We all knew what the ultimate goal was, but we didn't know how to get there. The initial meetings included an introduction to the enhanced care model, realizing the impact of community on individual's health, working as a team, self-management support, how to see healthcare and delivery system design in a different way, how to use PDSA cycles effectively and, finally, how to measure improvement. Subsequent meetings have delved deeper into these topics to help push teams to continue improvements. Like me, some of you may be weary of the benefits of utilizing concepts from the Chronic Care Initiative. Something you have to consider is that you may already be using these concepts. The model for improvement and the use of PDSA cycles are done on a regular basis in life. Humans are natural problem solvers. We learn by trial and error and we keep track of the outcomes associated with those trials. As children, we test our boundaries. We learn what actions are acceptable and what actions result in a punishment. Even at that early age we are using PDSA cycles unconsciously to determine how people are supposed to act. Taking a toy from another child, lying or inflicting pain are negative actions that, as children, we learn are not good. People are not supposed to be mean to each other or lie to one another and children learn appropriate behaviors. We all push boundaries and test ideas to determine what actions will get us to our desired outcome. All through life we learn, we run tests and we analyze what happens. Learning to drive a manual car, searching for a soul-mate or even something as simple as learning to tie our shoe laces helps us learn how to improve on the things we do. People test ideas and come to conclusions about whether or not the actions are beneficial. The CCI aims to create an environment where people can learn and test ideas to determine what is beneficial to specific clinics. While its overall aim is to create a process for improvement that can be used at all facilities under any condition, the consolation prize is the knowledge on how to improve and change aspects about life, relationships and ourselves. In my eyes, this is the greatest aspect about the Chronic Care Initiative, the concepts associated with it can also be applied to everyday life. Improvement can be made in any environment or organization. All it takes is the WILL to change, an IDEA about what change can occur, and the EXECUTION of the idea to reach a desired outcome. The Chronic Care Initiative is an important part of patient health, clinic function and employee satisfaction.

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Nashville Area Indian Health Service Office of Public Health

- Assisting Tribes in Promoting Health

The goal of the Office of Public Health is to provide consultative and technical support to tribes and nations in the Nashville Area

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