The Indian Health Service Improving Patient Care Collaborative: Lessons Learned and Focus for the Future

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Capstone Project Focus

- Program analysis of the Indian Health Service (IHS) quality improvement collaborative entitled Improving Patient Care (IPC)
- Analysis, conclusions, and recommendations reflect those of the author alone, not the IHS or IPC

Background

- IHS established in 1955; federal agency in DHHS
- 5.2 million self-identify as American Indian/Alaska Native (AI/AN), 2.9 million as exclusive AI/AN[1]
- 566 federally recognized tribes
- IHS budget $4.4 billion; 2.2 million users in 35 states[2]
- PL-93-638: tribes can manage their own programs; $1.5 billion of IHS budget for self-governance programs[2]

[1]US Census Bureau (2012). *The American Indian and Alaska Native Population: 2010, Issued January 2012*. Retrieved from US Census Bureau web site: http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf

[2]Indian Health Service (2014). *About IHS*. Retrieved from Indian Health Service website: http://www.ihs.gov/aboutihs/

Background

- Annual per capita personal health expenditures:
  - US all races: $7713
  - IHS beneficiaries: $2849
- AI/AN vs. all-race US age-adjusted mortality:
  - 4.7 times greater from chronic liver disease and cirrhosis
  - 2.8 times greater from diabetes mellitus
  - 2.4 times greater from unintentional injuries
  - 1.8 times greater from homicide
  - 1.6 times greater from suicide
  - 1.6 times greater from chronic lower respiratory diseases

Source: Indian Health Service (2014). *About IHS*. Retrieved from Indian Health Service website: http://www.ihs.gov/aboutihs/

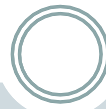
Improving Patient Care Collaborative

- 2006: IHS and Institute for Healthcare Improvement (IHI) partnership initiated
- IPC collaborative developed using IHI Breakthrough Series as framework
- 2007: 14 IHS sites enrolled in pilot IPC collaborative (IPC-1)
- 2009: 25 IHS sites enrolled in IPC-2
- 2011-2013: 90 IHS sites enrolled in IPC-3 and IPC-4
- January 2014: IPC-5 initiated with 45 IHS sites

IPC Sites by Collaborative

Area	IPC-1	IPC-2	IPC-3	IPC-4	IPC-5
Alaska	1	3	10	4	1
Albuquerque	1	1	2	2	4
Bemidji	2	2	4	2	7
Billings	1	2	3	6	2
California	1	0	5	1	12
Great Plains	1	2	6	6	4
Nashville	1	2	5	2	3
Navajo	2	3	6	3	0
Oklahoma	1	4	8	4	5
Phoenix	1	3	5	1	5
Portland	1	3	3	2	2
Tucson	1	n/a	n/a	n/a	n/a
TOTAL	**14**	**25**	**57**	**33**	**45**

IPC Collaborative Learning Model



Select Topic
Expert Meeting
Planning Group

Participants
"Prework"

Develop Framework & Changes

Action Oriented!

P
D
S
A

LS 1
Site Visit
Virtual LS 3
Virtual LS 4
LS 5

Spread to many

Supports

E-mail
Phone
Extranet

Visits
Assessments
Senior Leader Reports

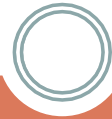
Source: Indian Health Service Improving Patient Care Web Site http://www.ihs.gov/ipc

- IPC is data-rich at participating sites
- IPC has been deployed to 174 IHS sites
- There are no publicly available aggregated data to demonstrate sustained changes in clinical processes or population-level clinical outcomes attributable to participation in IPC
- IHS budget can no longer support the travel of IPC care teams and subject matter experts
- Project aimed at obtaining qualitative data to guide future efforts

Methods

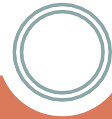
- Autumn 2014: In-depth interviews conducted with 13 IPC subject matter experts
- Interview focus:
  - Short-term and long-term impact of IPC participation
  - Unexpected outcomes or aspects of IPC participation
  - Ways in which IPC could have better fit sites' needs
  - Features of ideal patient-centered care and clinical quality
- Shared concepts and terminology grouped into common themes

Results: Impact of IPC



Good/Positive	Bad/Negative
• Data-driven clinical decisions • Staff energized and invigorated • Patient empanelment organized clinical duties • Team-based care clarified staff roles and responsibilities • Common quality improvement language • Increased patient satisfaction • Increased staff satisfaction	• Inordinate demands on time and resources • Polarization of staff • Staff resistance to change • Patient/community resistance to change • Exhaustion of limited resources • Lack of measureable improvements in clinical outcomes

Results: Unexpected Outcomes of IPC



Good/Positive	Bad/Negative
• Evidence-based decisions throughout organization • Unsolicited praise from patients and community leaders • Expanded scope of work for all care team members • More interdepartmental collaboration and long-term planning • Early naysayers eventually became vocal supporters	• Difficulty incorporating community members • Empanelment and team-based care have increased, not decreased demands • Resources not forthcoming to support IPC efforts • Staff turnover devastating for team-based care • Some staff refuse to participate in quality improvement efforts

Results: How Could IPC Have Been A Better Fit For Organization

- IPC can feel rigid and inflexible – would have been better to recognize facilities' unique needs
- "One size does not fit all:" some sites may need major overhaul, others simply focused refinement
- Resources must be procured to hire all support staff needed to carry out team-based care

Recommendations

- Shift IPC focus from training and deployment to analysis of systematic impacts of collaboratives
- Conduct pre-intervention/post-intervention or retrospective cohort studies of IPC sites
- Conduct in-depth interviews and focus groups with past and present IHS leaders, clinicians, beneficiaries, and tribal leadership
- Aggregate data, disseminate publicly, and use results to guide future IPC efforts

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