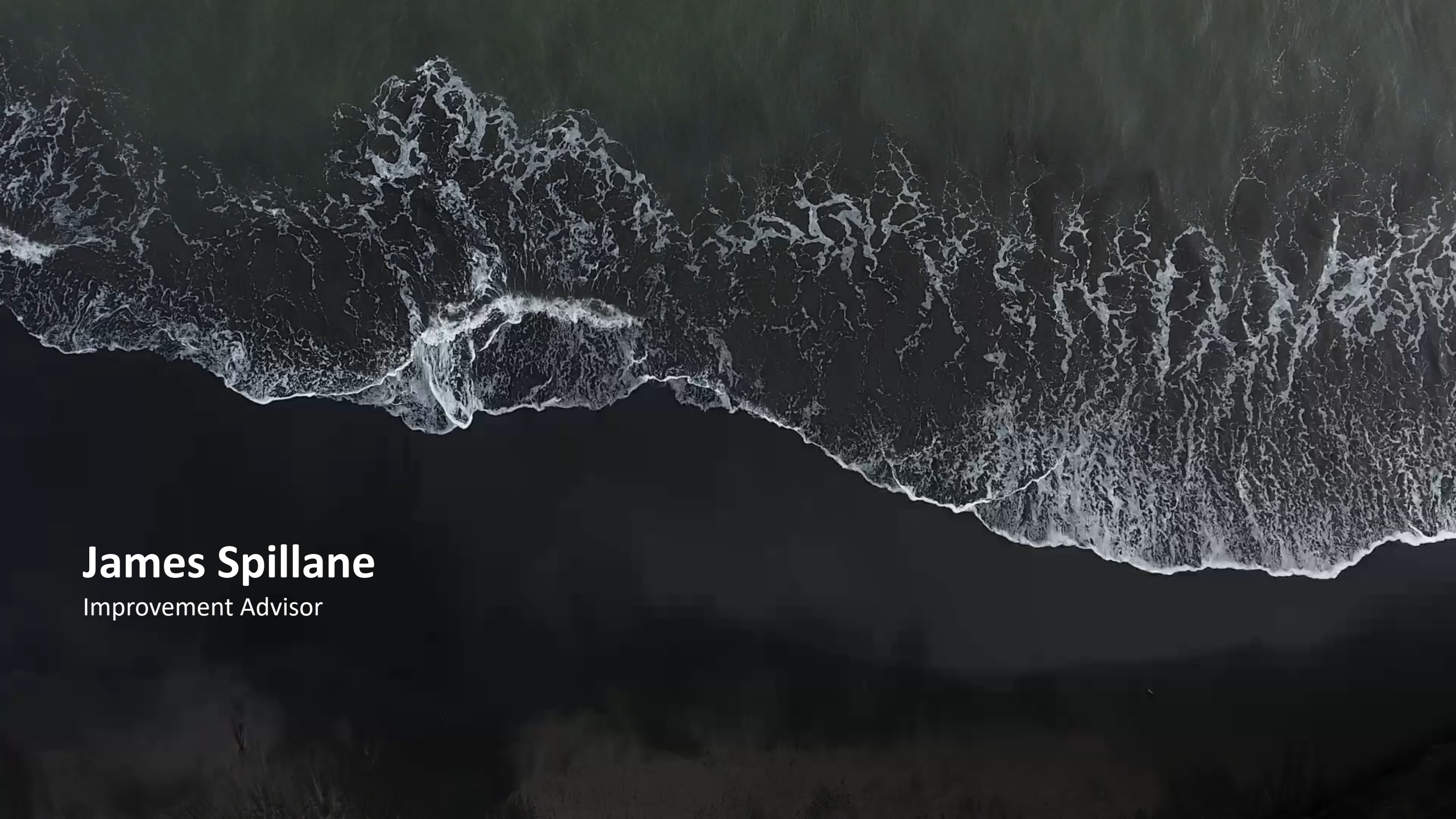
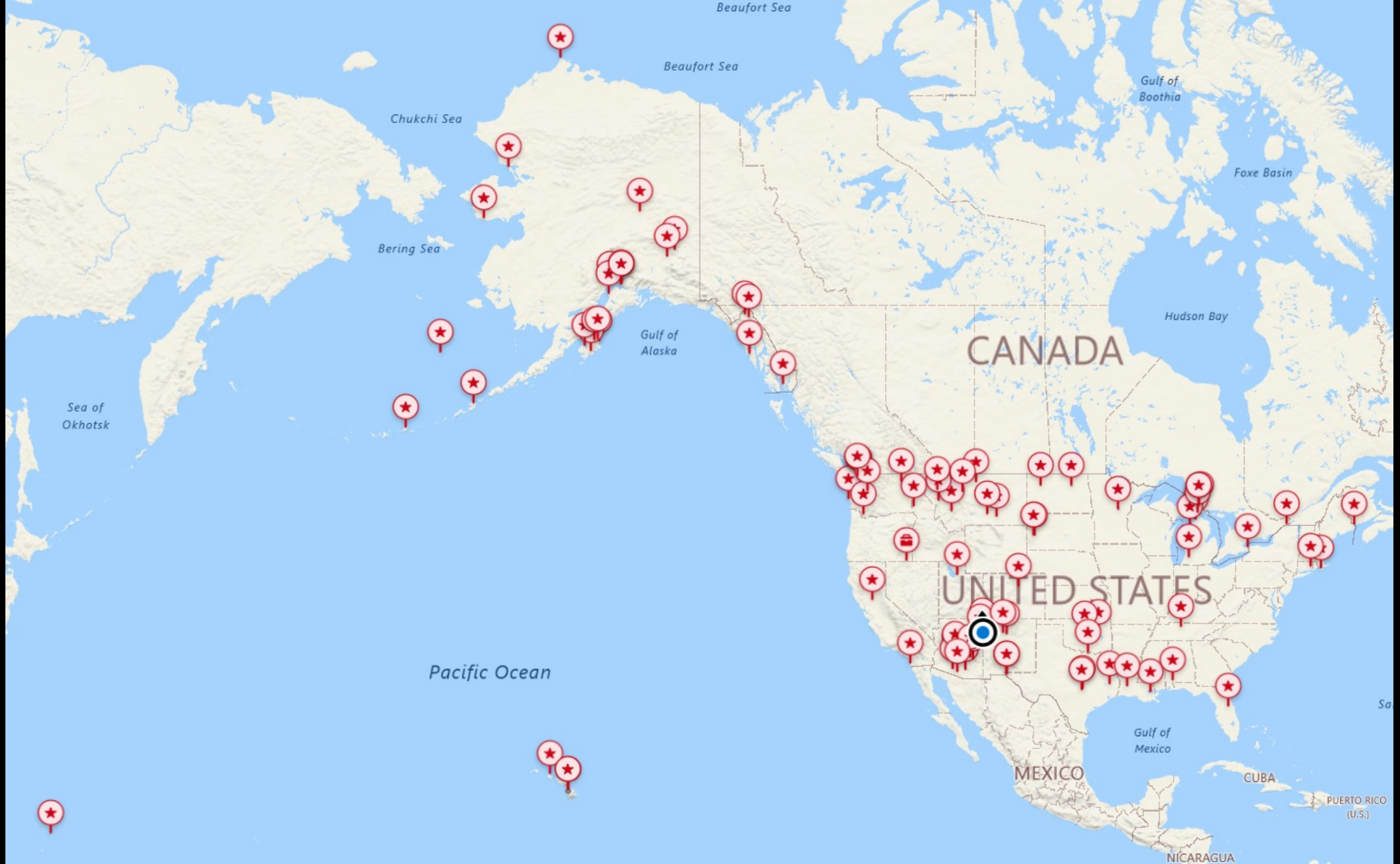


James Spillane

Improvement Advisor


Beaufort Sea
Beaufort Sea
Chukchi Sea
Bering Sea
Gulf of Alaska
Sea of Okhotsk
Pacific Ocean
Gulf of Boothia
Foxe Basin
Hudson Bay
CANADA
UNITED STATES
Gulf of Mexico
MEXICO
CUBA
PUERTO RICO (U.S.)
NICARAGUA



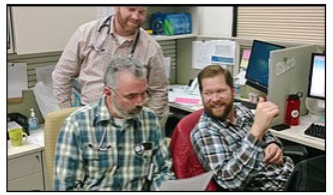


DRIVE


Mashantucket
Pequot

Ebowoods Memorial
Health Center

NE LA SHING
CLINIC






These are the innovation phases
Leadership needs to support:
INSPIRE
IDEATE
IMPACT

















BERING SEA





What is Your Mission Statement?

OUR VISION

To be the premier Native American healthcare delivery system empowered to serve the lifelong needs of our people.

OUR MISSION

To provide high-quality healthcare and improve the health of the Gila River and Ak-Chin Indian Communities.

OUR VALUES

- Accountability
- Commitment
- Patients & Families
- Culture
- Quality
- Self-Governance
- Trust

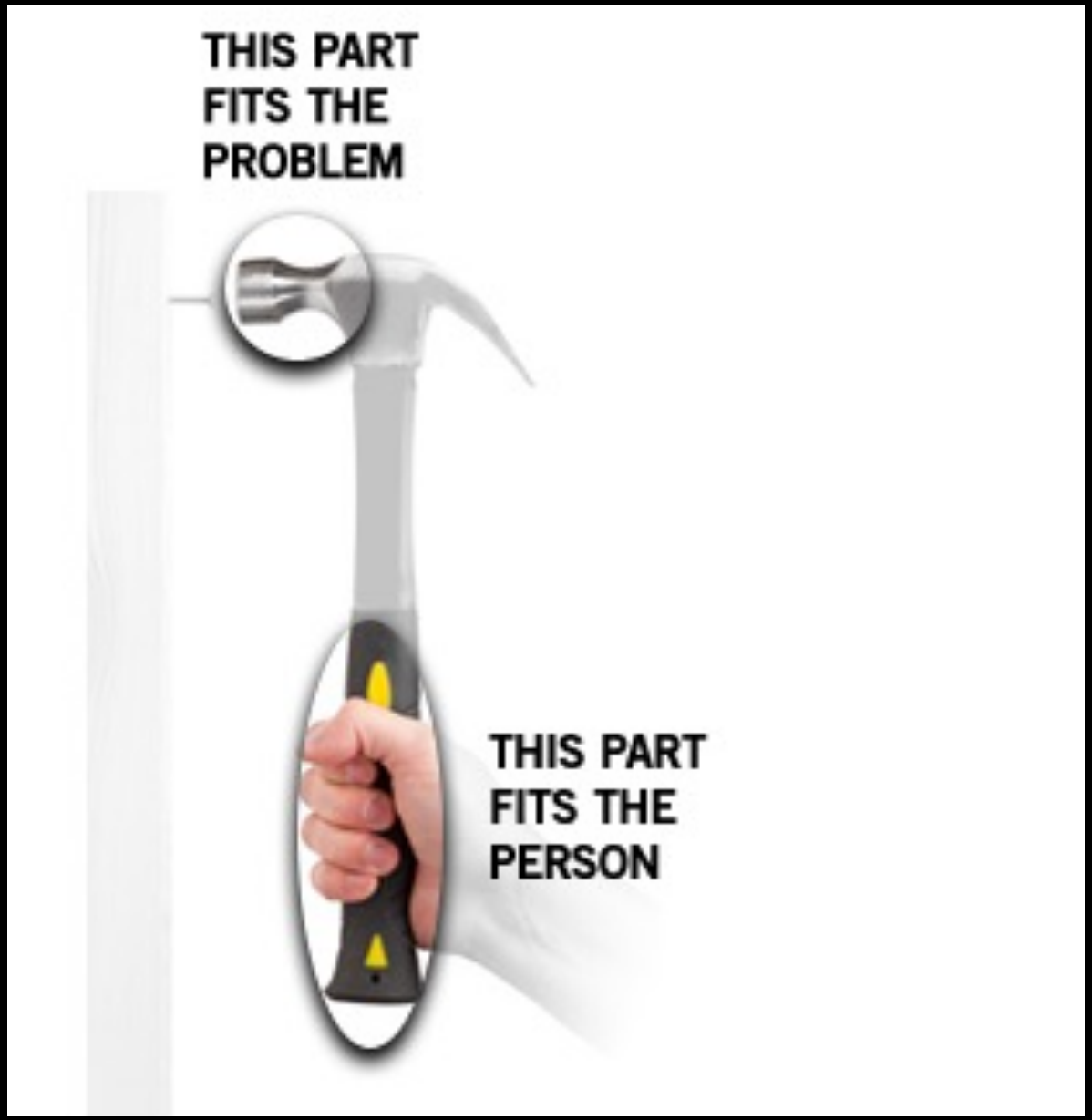
Read More about
Gila River Health Care

We are not in “Healthcare”
We are in “Health Caring”

Todays Focus PCMH

- Current state of Health Care
- Care Model for Indian Health
- GPRA
- PCMH
- Change Package: How to
- Training
- Care Team configuration
- Clinical Information Systems
- Putting it all together


NEED
TOOL
CAPABILITY


THIS PART
FITS THE
PROBLEM
THIS PART
FITS THE
PERSON

Review of Systems/findings

Access

- Cycle times were well over 45mins
- 3rd next available was months out for PCP's in outpatients (now zero)
- Outpatient provider schedules were booked out for 40 days plus
- Emergency department utilization: lots of colds sniffles, ear aches etc.
- No shows were getting close to 45% in some areas

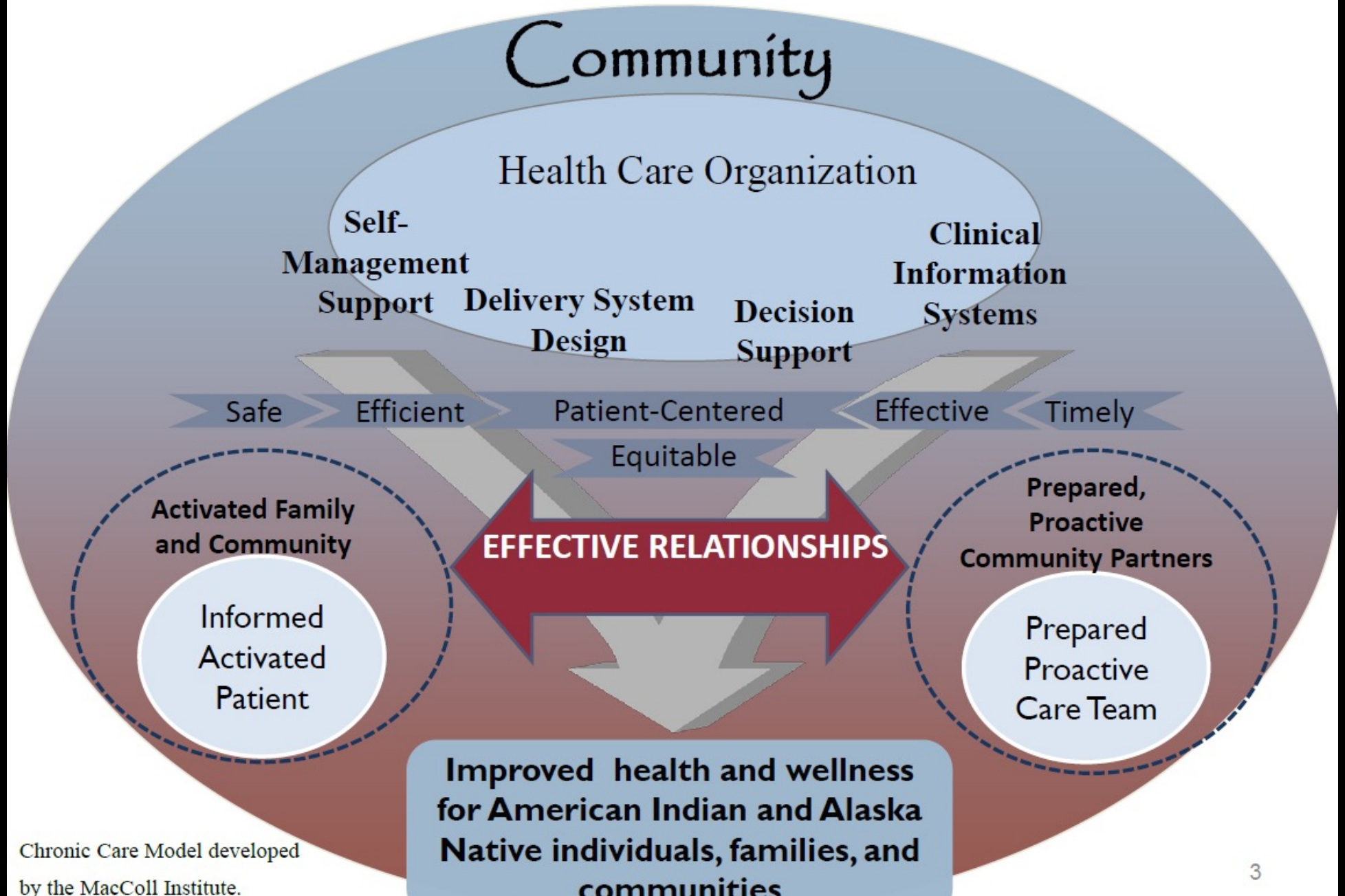
Care Teams

- Care teams weren't properly configured
- Job duties and responsibilities were not well understood and/or changing
- Patients were not properly empaneled to care teams
- Very little case management or care coordination outside the clinic

Clinical Information Systems (CIS)

- We were only using CIS at about 35% of its capacity
- EHR was moving forward, getting cleaned up and trained
- iCare patient population management was not in use by teams
- Care Management and Event Tracking was not in use
- Integrated Problem List (IPL) was not used fully
- Goals Tabs and patient self management was not in use

Care Model for the Indian Health System



Chronic Care Model developed by the MacColl Institute.

Care Model for Chronic Disease Management

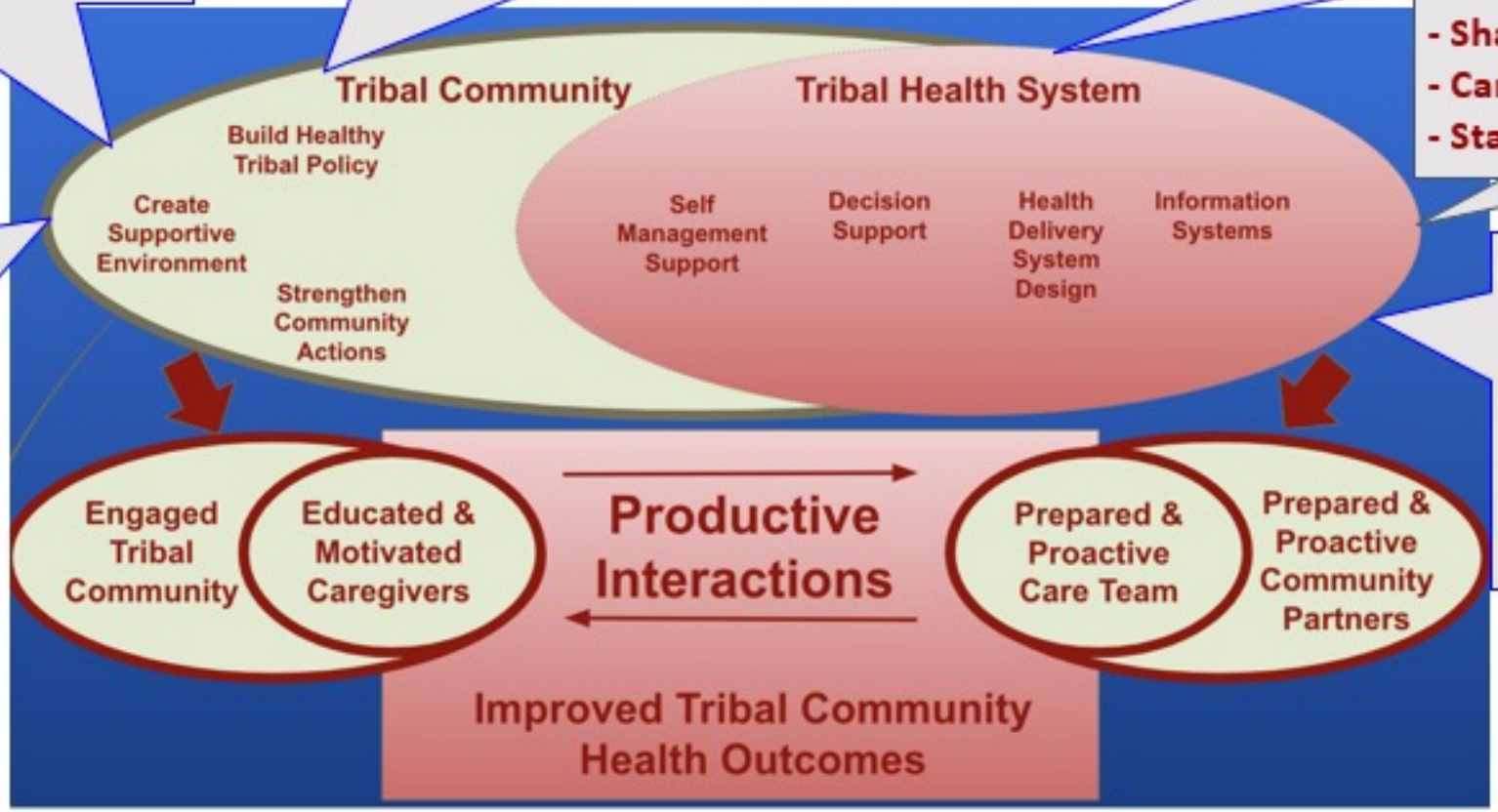
- Wellness Classes
- Cultural Programs
- Support Groups
- Transportation Systems

- Tribal Smoking Policy – Housing /Casinos
- Food Access, FDPIR, Home Grown Project
- Walking Paths, Accessible Fitness Ctr

- Screening Policies (Diabetes – HIV – Cancer)
- Standing Orders (Mamm – CRC – Pap)
- Vaccine Outreach (HPV - Hep A/B)

- Shared Decision Making
- Care Management
- Standardized EHR Practices

Tribal Clinic & Tribal Council implement strategies and policy that support the health of tribal community



Tribal clinic staff engaged with local health providers

McLaren - Munson Specialty Care Clinics

LTBB Health Center
September 2021

THREE FIRES
Comprehensive Cancer Consortium

GPRA

Indian Health Service
The Federal Health Program for American Indians and Alaska Natives

Search IHS

A to Z Index | Employee Resources | Feedback

The Indian Health Service continues to work closely with our tribal partners to coordinate a comprehensive public health response to COVID-19. Read the latest info.

GPRA and Other National Reporting

The Government Performance and Results Act (GPRA) requires Federal agencies to demonstrate that they are using their funds effectively toward meeting their missions. The law requires agencies to have both a 5-year Strategic Plan in place and to submit Annual Performance Plans describing specifically what the agency intends to accomplish toward those goals with their annual budget request. GPRA also requires agencies to have performance measures with specific annual targets. Every year, the Indian Health Service reports results for these GPRA performance measures.

GPRA measures for the IHS include clinical care performance measures, such as care for patients with diabetes, cancer screening, immunization, behavioral health screening, and other prevention measures. The agency also reports many non-clinical measures, including rates of hospital accreditation, injury prevention, and infrastructure improvements.

PCMH

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

A-Z Index

Search

Advanced Search

Division for Heart Disease and Stroke Prevention

Patient-Centered Medical Home (PCMH) Model

The patient-centered medical home (PCMH) model is an approach to delivering high-quality, cost-effective primary care. Using a patient-centered, culturally appropriate, and team-based approach, the PCMH model coordinates patient care across the health system.

The PCMH model has been associated with effective chronic disease management, increased patient and provider satisfaction, cost savings, improved quality of care, and increased preventive care.

Learn more about evidence related to PCMH model policies from CDC's Division for Heart Disease and Stroke Prevention's (DHDSP) Applied Research and Translation (ART) team.

https://www.ahrq.gov/ncepcr/tools/pcmh/defining/index.html

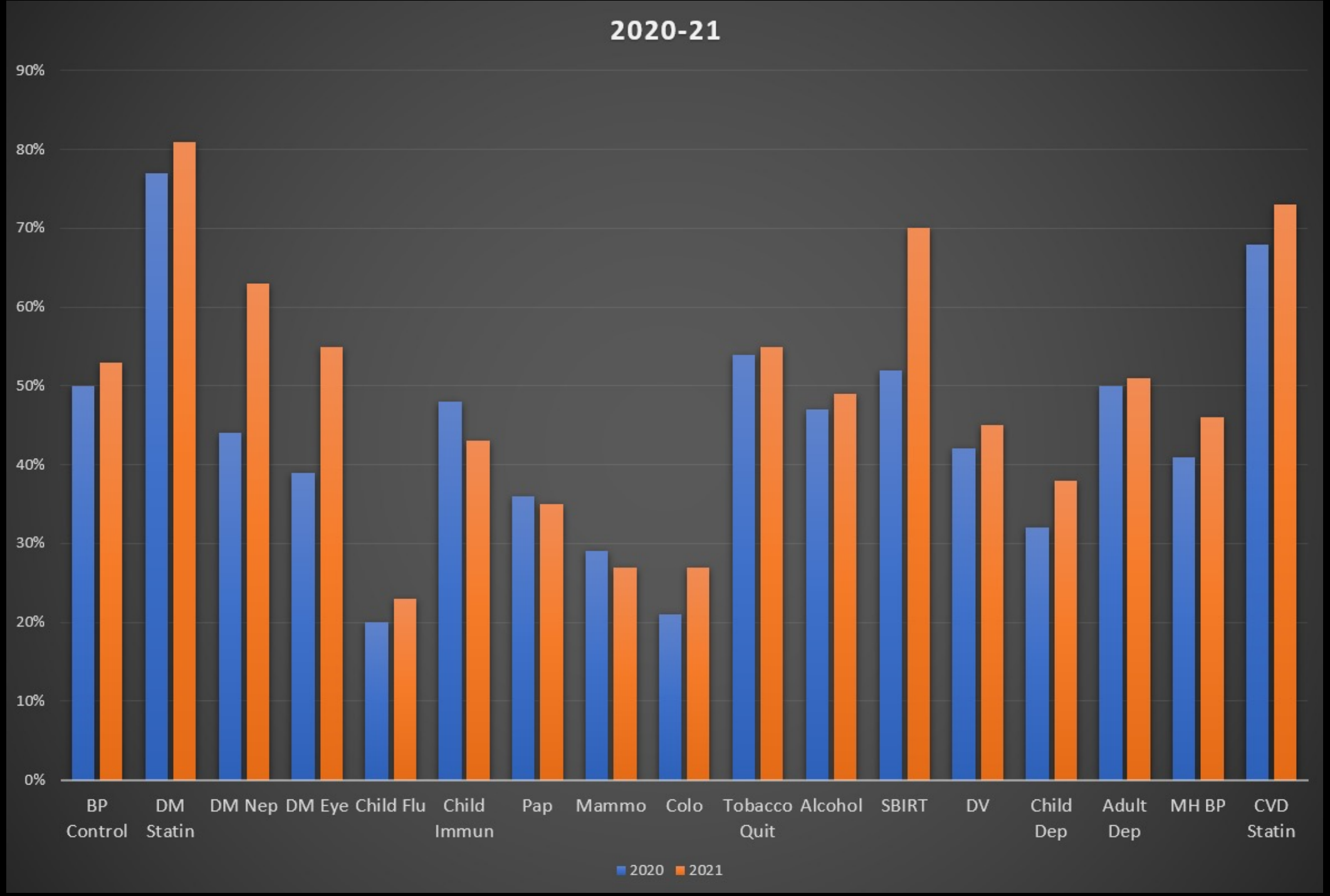
TEDGLOBAL2013

Think Again
June 10 – 14, 2013
Edinburgh, Scotland

MORE ON TED.COM

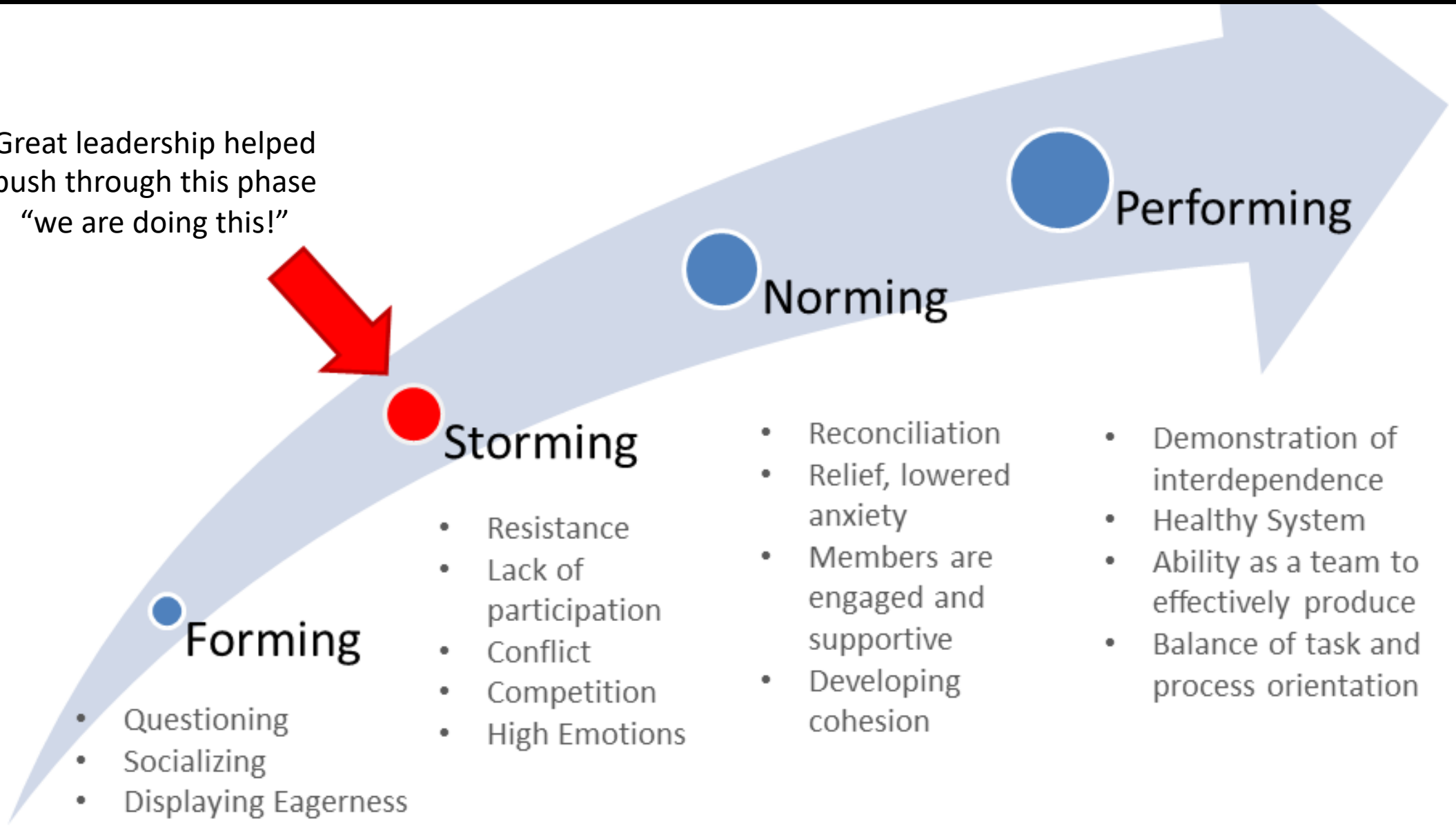
"You should measure things you care about. If you're not measuring, you don't care and you don't know."

– STEVE HOWARD


2020-21
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
BP Control
DM Statin
DM Nep
DM Eye
Child Flu
Child Immun
Pap
Mammo
Colo
Tobacco Quit
Alcohol
SBIRT
DV
Child Dep
Adult Dep
MH BP
CVD Statin
2020
2021

Phase 1	Phase 2	Phase 3
LEADERSHIP ENGAGEMENT Engage leadership; Identify sponsor who embraces their role	**THE CARE TEAM** Identify and develop the care team, optimizing the roles of the care team, patients and families, and community programs	**SPREAD** Develop plan for spread
THE VOICE OF THE COMMUNITY Involve and engage the community	**COMMUNICATION PLAN** Develop mechanisms to keep the community and staff informed	**EFFICIENCY** Increase value added time of all processes
THE MICROSYSTEM Identify the Microsystem /Target Population	**EMPANELMENT FOR IMPROVEMENT** Empanel patients to achieve continuity and improve outcomes	**CARE BETWEEN VISITS** Care management integrated into care team
ASSESSMENT Assess the microsystem, using the Green Book (revisit intermittently)	**CLINICAL INFORMATION SYSTEM** Optimize the CIS, using it for reminders, prompts, queries, etc	**SELF-MANAGEMENT** Empower the patient and family members by embedding self-management support processes in care
THE AIM Develop organizational Aim, including some initial plans relating to spread	**ACCESS AND CONTINUITY** Develop mechanism to ensure access to care and support continuity	
STRATEGIC ALIGNMENT Link IPC aim and goals to the organizational strategic plan	**TRANSPARENCY OF IMPROVEMENT** Make quality related data available to all (transparency)	
THE IMPROVEMENT TEAM ID Multidisciplinary Improvement team	**THE PRE-VISIT** Pre-visit planning and care delivery (huddles, previsit calls, etc.)	**BEHAVIORAL HEALTH INTEGRATION** Integrate behavioral health
	CAPACITY FOR IMPROVEMENT Build capacity in staff to support improvement	
	RESOURCES FOR IMPROVEMENT Identify inefficiencies and eliminate waste	

Great leadership helped push through this phase
"we are doing this!"



Forming

- Questioning
- Socializing
- Displaying Eagerness
- Focus on Group Identity and Purpose
- Sticking to safe topics

Storming

- Resistance
- Lack of participation
- Conflict
- Competition
- High Emotions

Norming

- Reconciliation
- Relief, lowered anxiety
- Members are engaged and supportive
- Developing cohesion

Performing

- Demonstration of interdependence
- Healthy System
- Ability as a team to effectively produce
- Balance of task and process orientation

Tuckman Model (1965)
"Developmental Sequence in small groups"

Alaska Native people experienced an average of **28.7** years of potential life lost from all-causes during the 2004-2008 time period.

The Alaska Native **cancer** mortality rate, both genders combined, was **24%** higher than the U.S. White rate.

Among Alaska Native people, **cancer was the leading cause of death** for all age groups 45 to 74 years.

http://www.anthctoday.org/epicenter/


Primary Care Provider
RN Case Manager
Certified Medical Assistant
Case Management Support
Coverage NP/PA
Behavioral Health Consultant
Dietician

Reminder Dialog Template: GPRA_SCREENING

☑ ----------CHIEF COMPLAINT --------

DEMO,KYLE is a 21 year old MALE who presents
today with No Chief Complaint.

BMI: 22.89

VITAL MEASUREMENTS:

☑ GPRA Screening

.

☐ Advance Directive: ○ Yes ○ No .

☐ 2 Patient Identifiers.

.

☐ -- Fever/RMSF---**Must complete regardless of chief complaint**
☐ -- Tobacco Use Screening
☐ -- Activity Level Assessment
☐ -- Alcohol Screening
☐ -- Depression Screening
☐ -- Intimate Partner Violence Screening
☐ -- Health Literacy Questions
☐ -- DM Nephropathy Screen

☑ GPRA Screening 2

☐ -- CVD Risk
☐ -- Diabetes Screening
☐ -- Fall Risk Screening
☐ -- Colon Cancer Screening
☐ -- Senior Height & Vision Screening
☐ -- Patient's Learning Preferences Described--
☐ -- Patient's Barriers to Learning Described Below--
☐ -- Record Historical Mammography
☐ -- Medication Reconciliation

Template: SOAP Brief

☐ ○ San Carlos AHC ○ Bylas HL CT - Ambulatory Care

Brief Visit Note
Indian Health Service

DEMO,PATIENT BABY GIRL, a 19 year old FEMALE
Presents to San Carlos Hospital Outpatient Clinics on 12/12/18 10:29
No Chief Complaint.

SUBJECTIVE:

☐ OBJECTIVE:

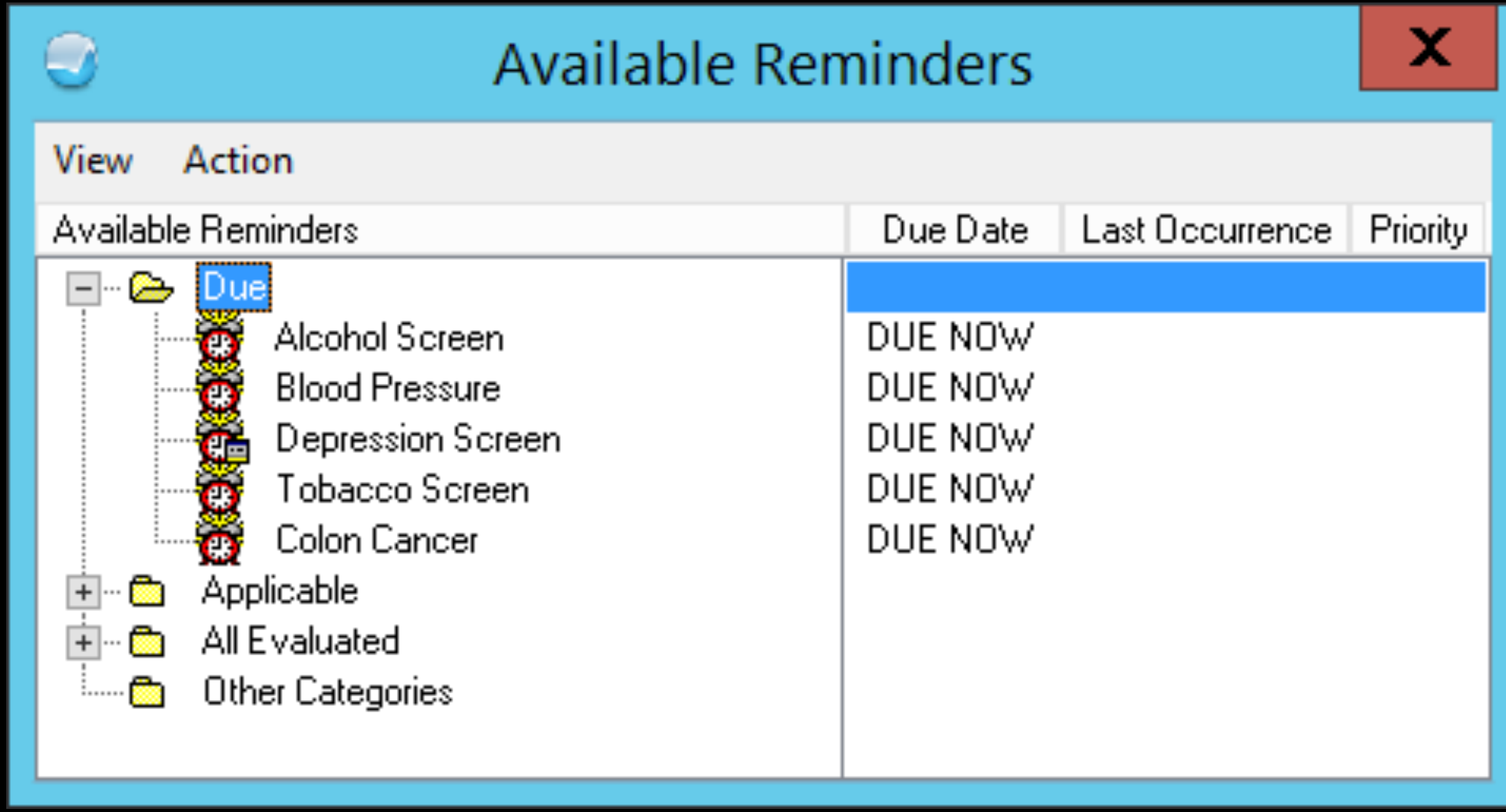
Last Height: 45.00 in [114.30 cm]
Last 2 WT: 271.17 lb [123.11 kg] (Oct 05, 2018@09:08)
120.00 lb [54.48 kg] (May 11, 2018@11:03) BMI: 94.15
Vitals:

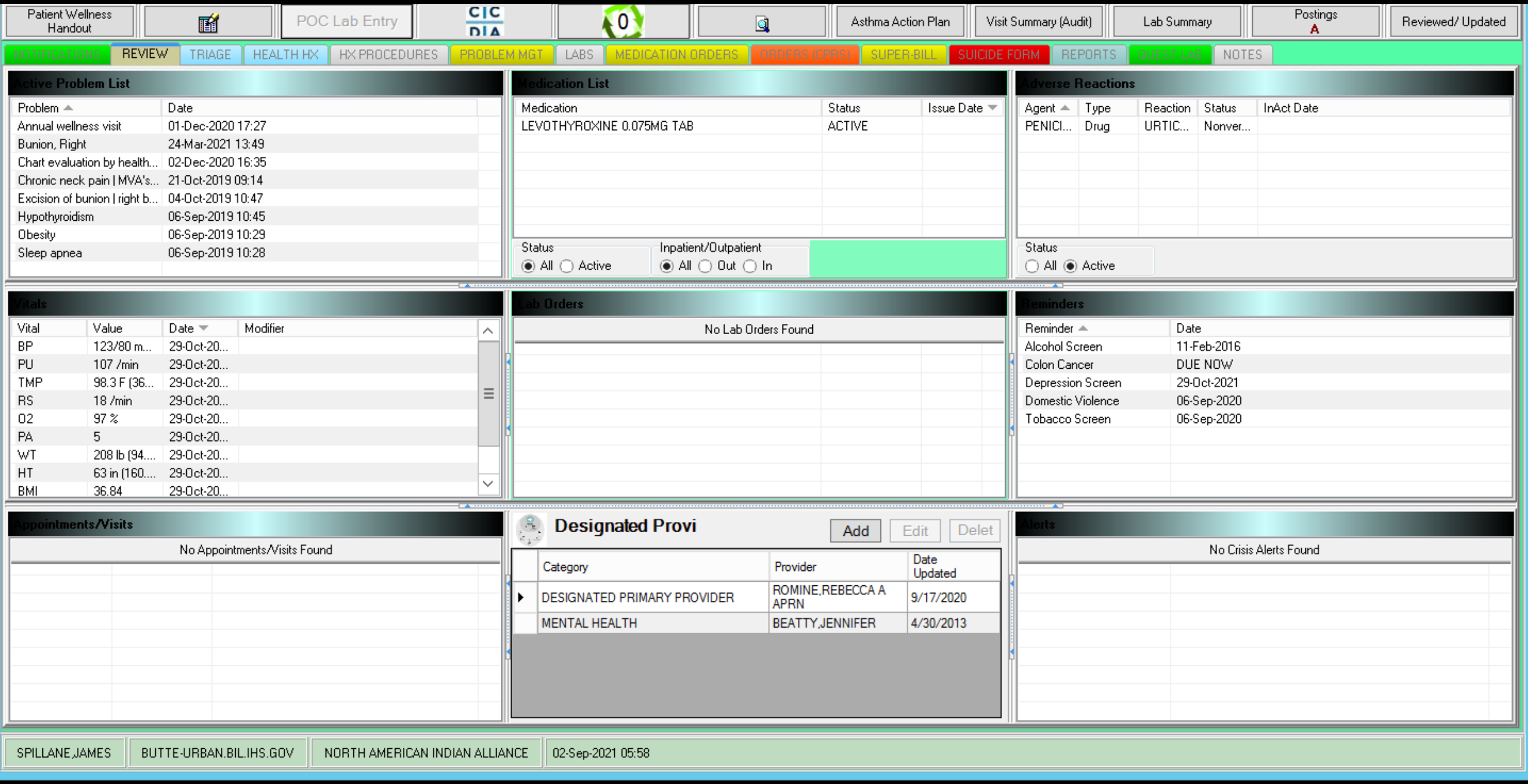
☐ ASSESSMENT:
---
1)Depressive disorder | (P)
-GOALS:
WORK ON WRITING DOWN TIMES FEELING DEPRESSED (12/12/2018 by VERDUGO,CHRISTINA)
-CARE PLANS:
SEE PATIENT IN ONE MONTH (12/12/2018 by VERDUGO,CHRISTINA)
-INSTRUCTIONS:
MAKE APPT WITH bh (by)
-EDUCATION:
Depressive disorder-COMPLICATIONS
Depressive disorder-DISEASE PROCESS

Depression Screen:Date: Sep 01, 2015 Results: POSITIVE
PHQ 2 =3 (Sep 01, 2015@13:43:05)
PHQ 9 =None found

☐ MEDICATION RECONCILIATION:
Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	ACETAMINOPHEN 325MG TAB TAKE TWO (2) TABLETS BY MOUTH NOW (DISPENSED FROM ED CLINIC) IF NEEDED FOR PAIN OR FEVER	ACTIVE


Available Reminders
View
Action
Available Reminders
Due Date
Last Occurrence
Priority
Due
Alcohol Screen
Blood Pressure
Depression Screen
Tobacco Screen
Colon Cancer
DUE NOW
DUE NOW
DUE NOW
DUE NOW
DUE NOW
Applicable
All Evaluated
Other Categories


Patient Wellness Handout
POC Lab Entry
CIC DIA
0
Asthma Action Plan
Visit Summary (Audit)
Lab Summary
Postings A
Reviewed/ Updated
NOTIFICATIONS
REVIEW
TRIAGE
HEALTH HX
HX PROCEDURES
PROBLEM MGT
LABS
MEDICATION ORDERS
ORDERS (CPRS)
SUPER-BILL
SUICIDE FORM
REPORTS
QUEST LAB
NOTES
Active Problem List
Problem
Date
Annual wellness visit
01-Dec-2020 17:27
Bunion, Right
24-Mar-2021 13:49
Chart evaluation by health...
02-Dec-2020 16:35
Chronic neck pain | MVA's...
21-Oct-2019 09:14
Excision of bunion | right b...
04-Oct-2019 10:47
Hypothyroidism
06-Sep-2019 10:45
Obesity
06-Sep-2019 10:29
Sleep apnea
06-Sep-2019 10:28
Medication List
Medication
Status
Issue Date
LEVOTHYROXINE 0.075MG TAB
ACTIVE
Status
All
Active
Inpatient/Outpatient
All
Out
In
Adverse Reactions
Agent
Type
Reaction
Status
InAct Date
PENICI...
Drug
URTIC...
Nonver...
Status
All
Active
Vitals
Vital
Value
Date
Modifier
BP
123/80 m...
29-Oct-20...
PU
107 /min
29-Oct-20...
TMP
98.3 F (36...
29-Oct-20...
RS
18 /min
29-Oct-20...
O2
97 %
29-Oct-20...
PA
5
29-Oct-20...
WT
208 lb (94....
29-Oct-20...
HT
63 in (160....
29-Oct-20...
BMI
36.84
29-Oct-20...
Lab Orders
No Lab Orders Found
Reminders
Reminder
Date
Alcohol Screen
11-Feb-2016
Colon Cancer
DUE NOW
Depression Screen
29-Oct-2021
Domestic Violence
06-Sep-2020
Tobacco Screen
06-Sep-2020
Appointments/Visits
No Appointments/Visits Found
Designated Provi
Add
Edit
Delet
Category
Provider
Date Updated
DESIGNATED PRIMARY PROVIDER
ROMINE,REBECCA A APRN
9/17/2020
MENTAL HEALTH
BEATTY,JENNIFER
4/30/2013
Alerts
No Crisis Alerts Found
SPILLANE,JAMES
BUTTE-URBAN.BIL.IHS.GOV
NORTH AMERICAN INDIAN ALLIANCE
02-Sep-2021 05:58

RPMS iCare - active patient pop - Panel View

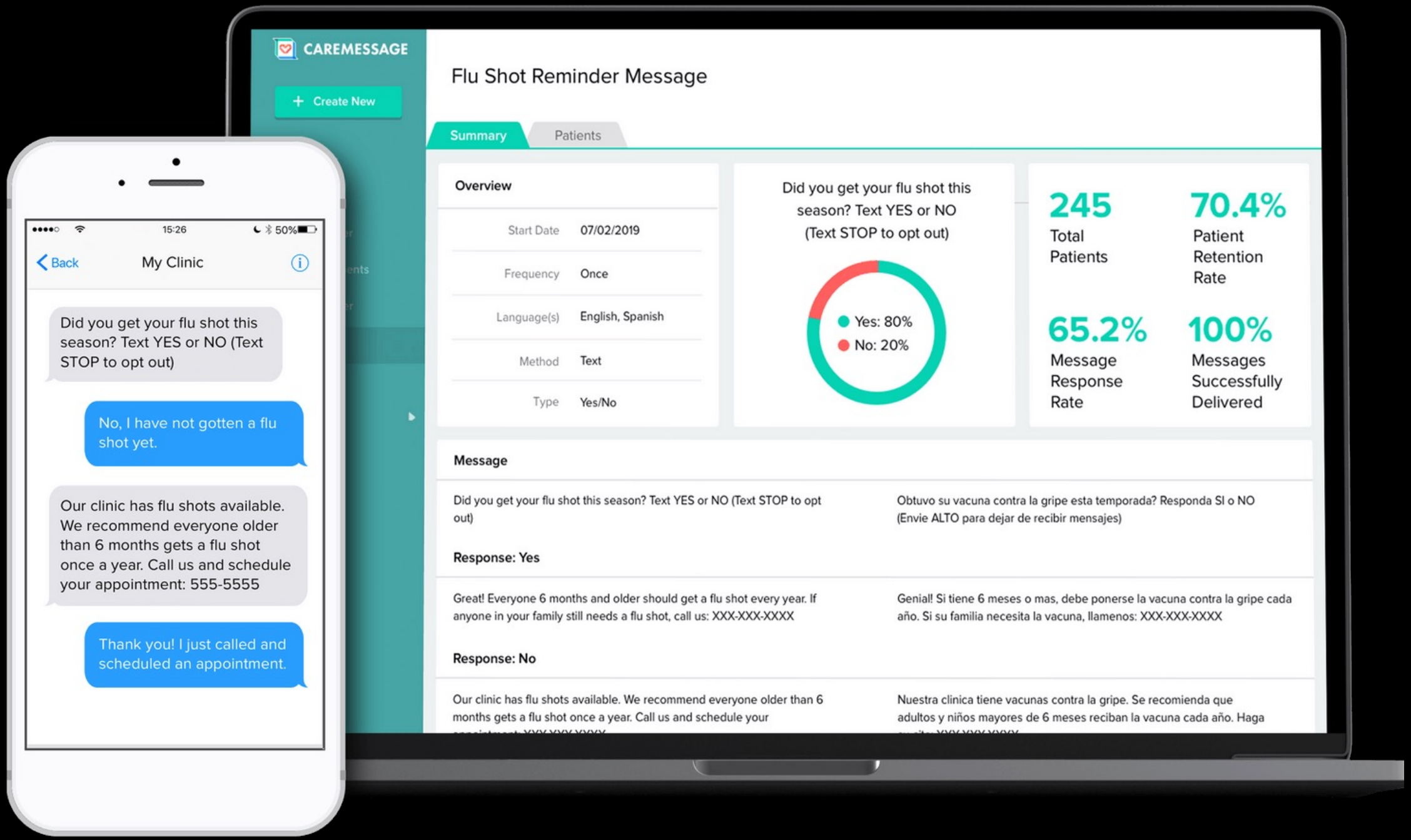
asures | Natl Aggregated | CMET | Care Mgmt | Diagnostic Tags | Flags | Referrals | Consults

s of: Aug 28, 2021 02:00 AM

HRN	DOB	Colorectal Cancer Screening (50-75) (UP)	Mammogram Rates 52-74	Pap Smear (30-64) (AC)	Pap Smear w/HPV (24-64) (AC)	Pap Smear w/HPV (30-64) (AC)	Home Phone
1975-NAIA	Jan 14, 1952	NO	NO	N/A	N/A	N/A	(406)-459-2795
T00004-NAIA	Jul 31, 1958	NO	NO	NO	NO	NO	
3132-NAIA	Oct 16, 1962	NO	NO	NO	NO	NO	
3026-NAIA	Mar 06, 1956	NO	NO	N/A	N/A	N/A	
3085-NAIA	Sep 22, 1961	NO	NO	NO	NO	NO	
3051-NAIA	Aug 26, 1947	NO	NO	N/A	N/A	N/A	
3265-NAIA	Mar 09, 1958	NO	NO	NO	NO	NO	(208)-541-1354
1684-NAIA	Sep 26, 1954	NO	NO	N/A	N/A	N/A	479-4930
3073-NAIA	Oct 15, 1955	NO	NO	N/A	N/A	N/A	
1842-NAIA	Jul 15, 1967	NO	NO	NO	YES	YES	(406)-450-3680
1038-NAIA 75	May 07, 1958	NO	NO	NO	NO	NO	490-6573
1085-NAIA 153	Mar 25, 1961	NO	NO	NO	NO	NO	491-0264
1192-NAIA 562	Apr 10, 1965	NO	NO	NO	NO	NO	4067825776
1811-NAIA	Sep 09, 1953	NO	NO	N/A	N/A	N/A	498-2295
1076-NAIA 142	Jul 17, 1967	NO	NO	NO	NO	NO	4067235133
1157-NAIA 357	Jun 25, 1958	NO	NO	NO	NO	NO	(406)-490-5089
1693-NAIA	Dec 07, 1966	NO	NO	NO	NO	NO	565-3449
3234-NAIA	Oct 26, 1963	NO	NO	NO	NO	NO	
3152-NAIA	Sep 18, 1967	NO	NO	NO	NO	NO	
1241-NAIA 612	Feb 20, 1950	NO	NO	N/A	N/A	N/A	417-1452
3050-NAIA	Jan 09, 1964	NO	NO	NO	NO	NO	
3045-NAIA	Aug 10, 1965	NO	NO	NO	NO	NO	
3159-NAIA	May 29, 1959	NO	NO	NO	NO	NO	
2892-NAIA	Dec 07, 1963	NO	NO	NO	YES	YES	503-329-2860
2219-NAIA	Apr 19, 1957	NO	NO	NO	NO	NO	498-7967

National Performance Measures detail for panel: Willow team

Flag Ind.	Tickler Ind.	HRN	DOB	Cancer Screening: Mammogram Rates (52-64) (UP)	Cancer Screening: Pap Smear Rates (24-64) (UP)	Colorectal Cancer Screening (50-75) (UP)	Tobacco Cessation: Counseling, RX or Quit	Home Phone
Y		4898 96115-PIMC 4898-SC	Mar 25, 1950	N/A	N/A	NO	N/A	DISCONNECTED
	Y	5464 146600-PIMC 5464-SC	Oct 30, 1953	N/A	N/A	NO	N/A	(928)475-5026
		28506 28506-SC 7890-By 28506-SCT 7890	Apr 10, 1956	YES	NO	NO	N/A	(928)475-4407
Y		31299 31299-SC	Oct 07, 1957	NO	NO	NO	N/A	(928)475-2259
		7646 7646-SC	Jan 25, 1945	N/A	N/A	NO	N/A	(928)200-6280 CELL
		7401 7401-SC	Dec 11, 1957	NO	NO	NO	N/A	(928)475-4631
Y		18962 18962-SC	Jun 25, 1962	N/A	N/A	NO	YES	(928)812-3919
		13237 13237-SC *5367-By 27493-WRH	Nov 16, 1965	NO	NO	NO	YES	
Y		4768 4768-SC	Apr 13, 1955	N/A	N/A	NO	N/A	(928)475-4851
Y		12589 12589-SC 6951-By 12589-SCT 6951	Sep 24, 1966	N/A	N/A	NO	N/A	(928)475-5266
		9550 9550-SC	Aug 17, 1960	N/A	N/A	NO	N/A	(928)228-8058/MSG.
		8613	Jun 15, 1953	N/A	N/A	NO	N/A	(928)475-9976


CAREMESSAGE
+ Create New
Flu Shot Reminder Message
Summary
Patients
Overview
Start Date 07/02/2019
Frequency Once
Language(s) English, Spanish
Method Text
Type Yes/No
Did you get your flu shot this season? Text YES or NO (Text STOP to opt out)
Yes: 80%
No: 20%
245
Total Patients
70.4%
Patient Retention Rate
65.2%
Message Response Rate
100%
Messages Successfully Delivered
Message
Did you get your flu shot this season? Text YES or NO (Text STOP to opt out)
Obtuvo su vacuna contra la gripe esta temporada? Responda SI o NO (Envie ALTO para dejar de recibir mensajes)
Response: Yes
Great! Everyone 6 months and older should get a flu shot every year. If anyone in your family still needs a flu shot, call us: XXX-XXX-XXXX
Genial! Si tiene 6 meses o mas, debe ponerse la vacuna contra la gripe cada año. Si su familia necesita la vacuna, llamenos: XXX-XXX-XXXX
Response: No
Our clinic has flu shots available. We recommend everyone older than 6 months gets a flu shot once a year. Call us and schedule your
Nuestra clinica tiene vacunas contra la gripe. Se recomienda que adultos y niños mayores de 6 meses reciban la vacuna cada año. Haga
15:26
50%
Back
My Clinic
Did you get your flu shot this season? Text YES or NO (Text STOP to opt out)
No, I have not gotten a flu shot yet.
Our clinic has flu shots available. We recommend everyone older than 6 months gets a flu shot once a year. Call us and schedule your appointment: 555-5555
Thank you! I just called and scheduled an appointment.

Outreach

Patient Segmentation

Women

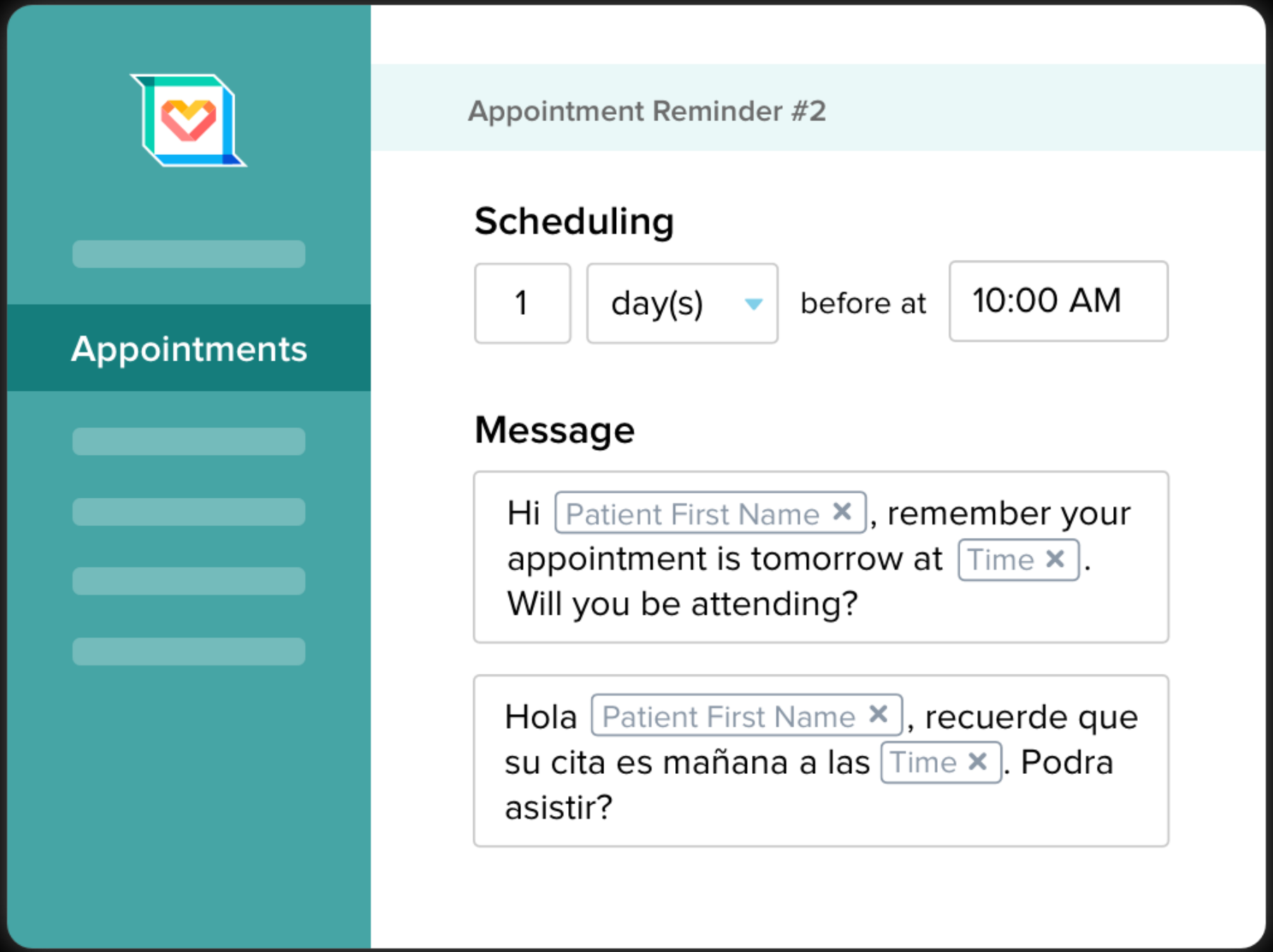
Age: 50+

Message

- [x] English
- [x] Spanish

Doctors recommend that women over the age of 50 get a mammogram every 2 years. To schedule this important breast exam please, call XXX-XXX-XXXX.

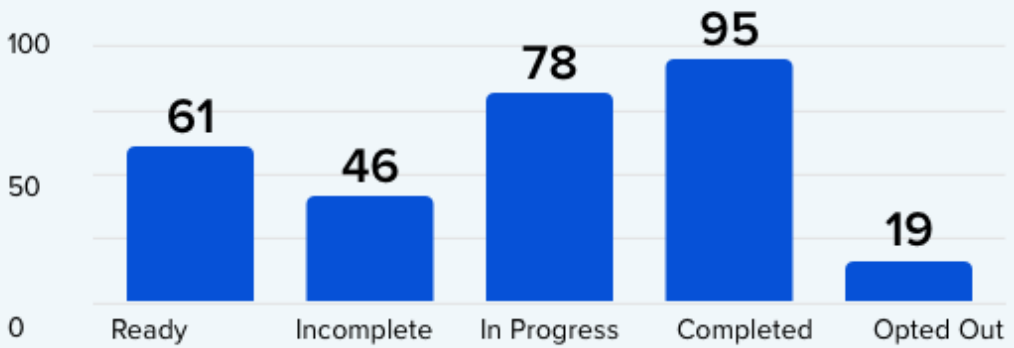
Los medicos recomiendan que las mujeres mayores de 50 se hagan una mamografia cada 2 años. Para hacer esta cita importante, llame al XXX-XXX-XXXX.


Appointments
Appointment Reminder #2
Scheduling
1
day(s)
before at
10:00 AM
Message
Hi Patient First Name , remember your appointment is tomorrow at Time . Will you be attending?
Hola Patient First Name , recuerde que su cita es mañana a las Time . Podra asistir?

Programs

Type II Diabetes Texting Program

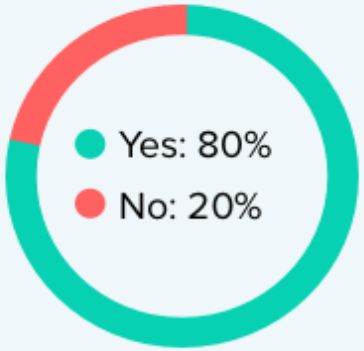
Patient Overview

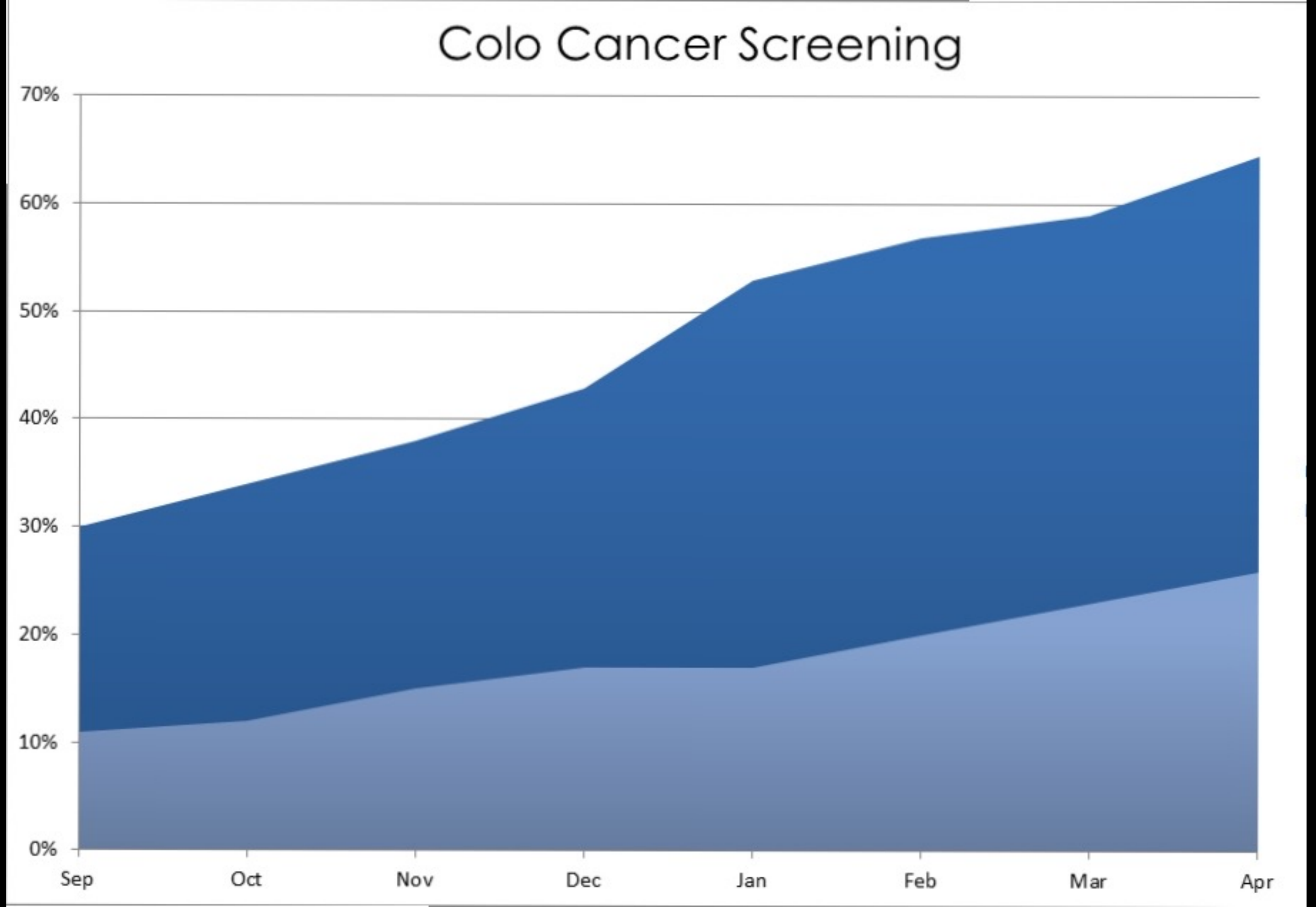


Do you know what can make you have low blood sugar? Text YES or NO

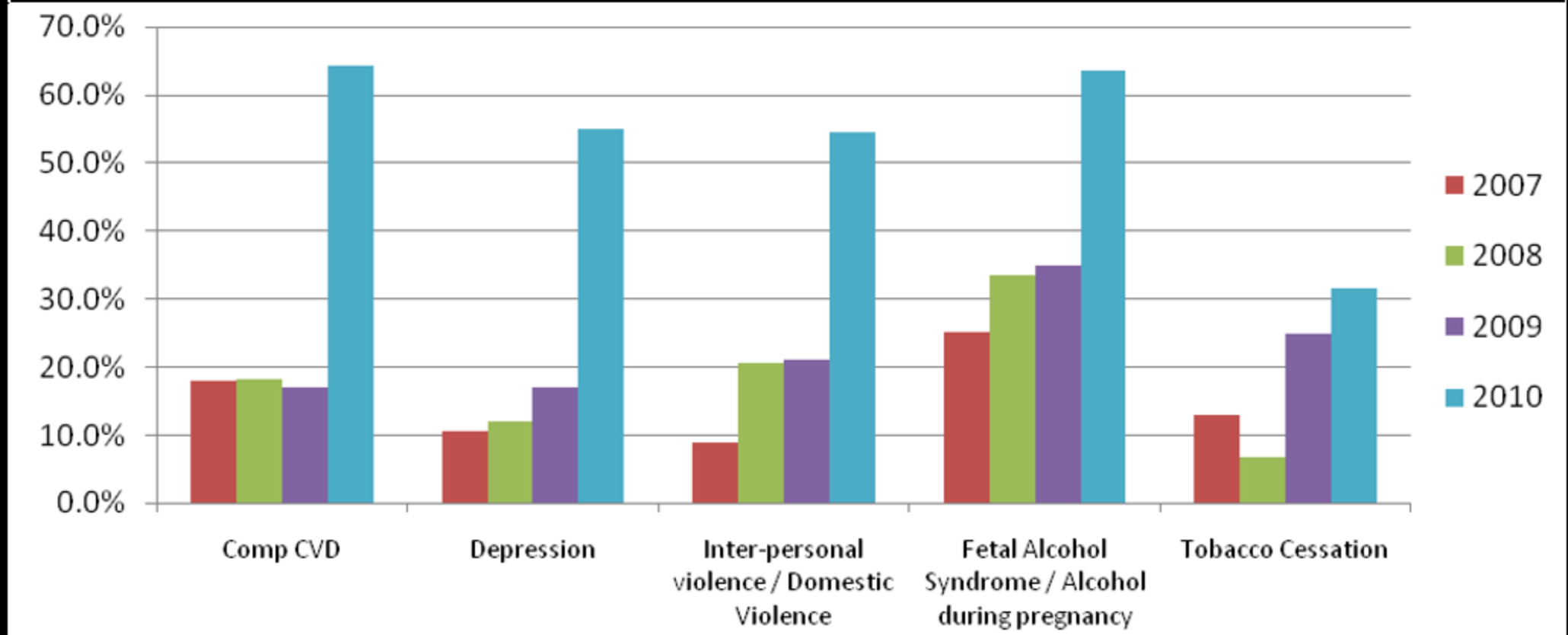
82.5%

Response Rate




Colo Cancer Screening
70%
60%
50%
40%
30%
20%
10%
0%
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr

Reminders have been identified as a leverage point in clinical information systems (CIS) and can help your providers increase screening rates.



Case Study

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Use of Electronic Clinical Reminders to Increase Preventive Screenings in a Primary Care Setting: Blueprint From a Successful Process in Kodiak, Alaska

Robert Onders[1], James Spillane[2], Brigg Reilley[3] and Jessica Leston[4]

Abstract

Purpose: The Kodiak Area Native Association (KANA) provides primary health care in Kodiak, Alaska and 6 outlying villages. KANA sought to actively improve key preventive screening rates for its patients. **Methods:** KANA adopted an electronic health record in 2008 and deployed national clinical reminders from the Indian Health Service for 5 key preventive screenings: tobacco use, alcohol use, depression, intimate partner violence, and a comprehensive cardiovascular exam. Clinical reminders were deployed in a 5-step process: (*a*) establish clinical demand, (*b*) pilot test reminder, (*c*) expand reminder to all providers, (*d*) measure outcomes and share results, and (*e*) delegate clinical reminder follow-up (primarily to nurses). **Results:** Data from 2007-2011 show screening rates for all 5 measures improved considerably, to levels significantly above the national average for Indian Health Service facilities. **Conclusions:** Clinical reminders have been a key part of a multistep process to

Health IT for Proactive Colorectal Screening

Mr. James Spillane: Maniilaq Health Center

The Issue:

The Maniilaq Health Center operates in a small village in Northwest Alaska and services a group of eleven surrounding villages. The health center provides multiple specialty clinics, including cancer screening clinics. State and regional surveillance data have shown that this center's patients have higher rates of cancer and cancer mortality, especially colorectal cancer, compared to other states. The extent of the problem was realized approximately five years ago, when they were able to get data from the Alaska Native Health Consortium's epidemiology center. These data showed that their rates for several diseases and health risk behaviors were much worse than the rest of the United States.

Although the Maniilaq Health Center has offered two screening clinics each year for several years, they were mostly diagnosing invasive colorectal and gastrointestinal cancer. Patients who came to the clinic when they had acute symptoms, such as a stomachache, were often found to have late-stage cancer. The center was also aware that many patients were at increased risk of colorectal cancer because of their family history and dietary behaviors. Previously, the organization relied upon an inefficient system of paper, notebooks, and handwritten notes to try to schedule and follow up with patients who needed screening and follow-up care. They also relied on staff members who knew community members to identify those who should be approached to come to the screening clinic.

Kodiak Area Native Association: Many Tools for Change

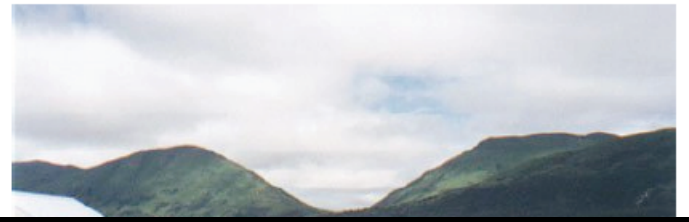
Nobody likes to get a colonoscopy. But, what if getting a colonoscopy required a several-day journey from your remote village by boat, air, and car to a large city? There, in a hotel room or the home of a friend of a friend, you do the colon prep. Afterwards, you reverse the journey and arrive home a few days later.

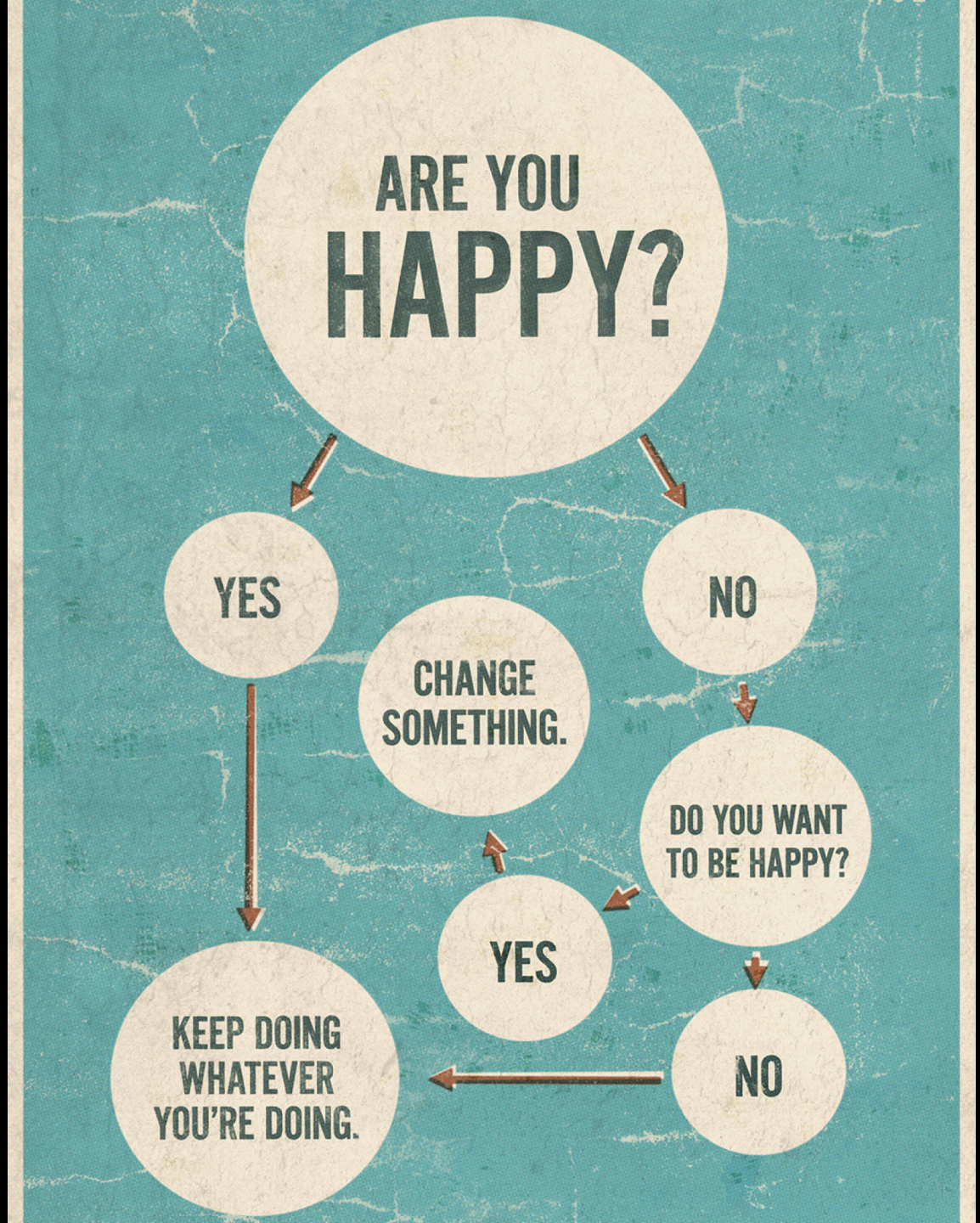
It's easy to imagine putting that off.

That was the case of an older patient in Larsen Bay, Alaska, on Kodiak Island. The Island is part of a long archipelago in the Gulf of Alaska. The main settlement on the island is the City of Kodiak, located 250 miles south of Anchorage. The city has a population of about 13,000, of whom about 2,000 are members of federally recognized American Indian or Alaska Native tribes. Another 1,500 people live in remote villages that can only be accessed by boat or small plane. Larsen Bay, for example, is 64

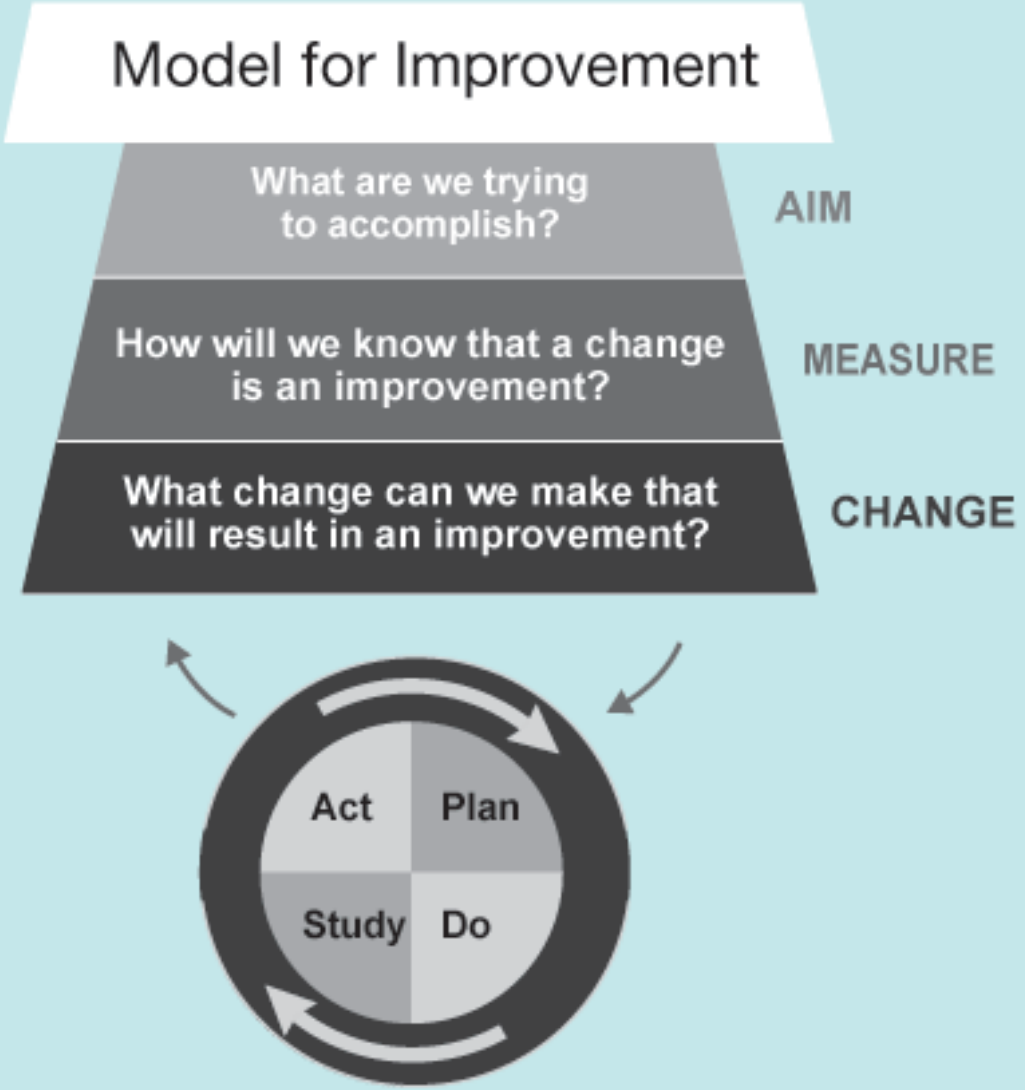
"Only through access and continuity were we able to build a relationship with him where he felt trusting enough to get a colonoscopy," says Robert Onders, MD, primary care physician with the Kodiak Area Native Association, which provides care to about 3,500 beneficiaries in the City of Kodiak and five villages, including Larsen Bay. "It was only through effective case management helping him negotiate the health care system that he was able to get it done."

Providing that kind of consistent, accessible, and coordinated care is not easy in this part of the country.




ARE YOU HAPPY?
YES
NO
CHANGE SOMETHING.
DO YOU WANT TO BE HAPPY?
YES
NO
KEEP DOING WHATEVER YOU'RE DOING.

The Quality Improvement Framework



Focus

One measure at a time

Use your nurse huddles

Alcohol Screening (9-75) (UP)	Alcohol-Related Education	
YES	NO	Y
YES	NO	N
YES	NO	N
YES	NO	N
YES	NO	N
YES	NO	N
YES	NO	N
YES	NO	N
YES	NO	N
YES	NO	N
YES	NO	N
YES	NO	N
YES	NO	N
YES	NO	N
YES	NO	Y
YES	NO	Y

GY2013/ GY2014 Quarter	Measure of the Quarter (GPRAMA)	GY2013/GY2014 Month	Measure(s) of the Month	Health Awareness Correlation
1	Childhood Immunizations	July	Dental (3 measures)	
		August	Immunizations (3 measures)	National Immunization Awareness Month
		September	Depression Screening	National Suicide Prevention Week
2	Coronary Heart Disease	October	Breast Cancer Screening / Mammograms	National Breast Cancer Awareness Month; National Mammography Day
		November	Diabetes (5 measures)	American Diabetes Month; Diabetic Eye Disease Month
		December	STD Screening	World AIDS Day
3	Depression Screening	January	Tobacco Screening/Cessation	
		February	CHD Measures	American Heart Month
		March	Colorectal Cancer Screening	National Colorectal Cancer Awareness Month
4	DM: Ideal Glycemic Control	April	Alcohol Screening	National Alcohol Awareness Month; National Alcohol Screening Day
		May	Blood Pressure Control – DM and CHD	American Stroke Month
		June	DV/IPV Screening	

Education Topic Selection

3746 items

Select By
- Category List
- Disease & Topic Entry
- Pick List
- Name Lookup
- Procedure & Topic Entry

Pick Lists: Gpra

OK

Cancel

Show All

- [x] Alcohol Sbirt
- [x] Tobacco Quit

Type of Training: Individual / Group

Comprehension Level: GOOD

Length: 20 (min)

Readiness to Learn:

PRIVACY | PATIENT CHART | RESOURCES | COMMUNICATION

Demo,Patient A
101 23-Jan-1945 (76) F

CHART REVIEW 23-Aug-2021 11:04
SPILLANE,JAMES Chart Review

Primary Care Team Unassigned

* Problem L R | Advs Rea Needs R | Medicatio Needs R

Patient Wellness Handout | POC Lab Entry | CIC DIA | 0 | Asthma Action Plan | Visit Summary (Audit) | Lab Summary | Postings A | Reviewed/ Updated

NOTIFICATIONS | REVIEW | TRIAGE | HEALTH HX | HX PROCEDURES | PROBLEM MGT | LABS | MEDICATION ORDERS | ORDERS (CPRS) | SUPER-BILL | SUICIDE FORM | REPORTS | QUEST LAB | NOTES

Ed/Exams/HF
Imms/Skin Test

Education

Show Standard | Add | Edit | Delete

Visit Date	Education Topic	Comprehension	Status	Objectives	Comment	Provider	Length	Type	Location
08/23/2021	Tobacco Use-Quit	GOOD				SPILLANE,JAMES	10	Individual	NORTH AMERICAN INDIAN AL
08/23/2021	Alcohol And Other Drugs-Behavioral And Emotional Health	GOOD				SPILLANE,JAMES	10	Individual	NORTH AMERICAN INDIAN AL
07/14/2021	Immunizations-Schedule	GOOD				SPILLANE,JAMES		Individual	NORTH AMERICAN INDIAN AL
07/14/2021	Immunizations-Literature	GOOD				SPILLANE,JAMES		Individual	NORTH AMERICAN INDIAN AL
07/14/2021	Immunizations-Information	GOOD				SPILLANE,JAMES		Individual	NORTH AMERICAN INDIAN AL
04/29/2021	Type 2 Diabetes Mellitus-Nutrition	GOOD				ROMINE,REBECCA A APRN	2	Individual	NORTH AMERICAN INDIAN AL
04/29/2021	Type 2 Diabetes Mellitus-Lifestyle Adaptation	GOOD				ROMINE,REBECCA A APRN	2	Individual	NORTH AMERICAN INDIAN AL
04/29/2021	Type 2 Diabetes Mellitus-Prevention	GOOD				ROMINE,REBECCA A APRN	2	Individual	NORTH AMERICAN INDIAN AL

Exams

Add | Edit | Delete

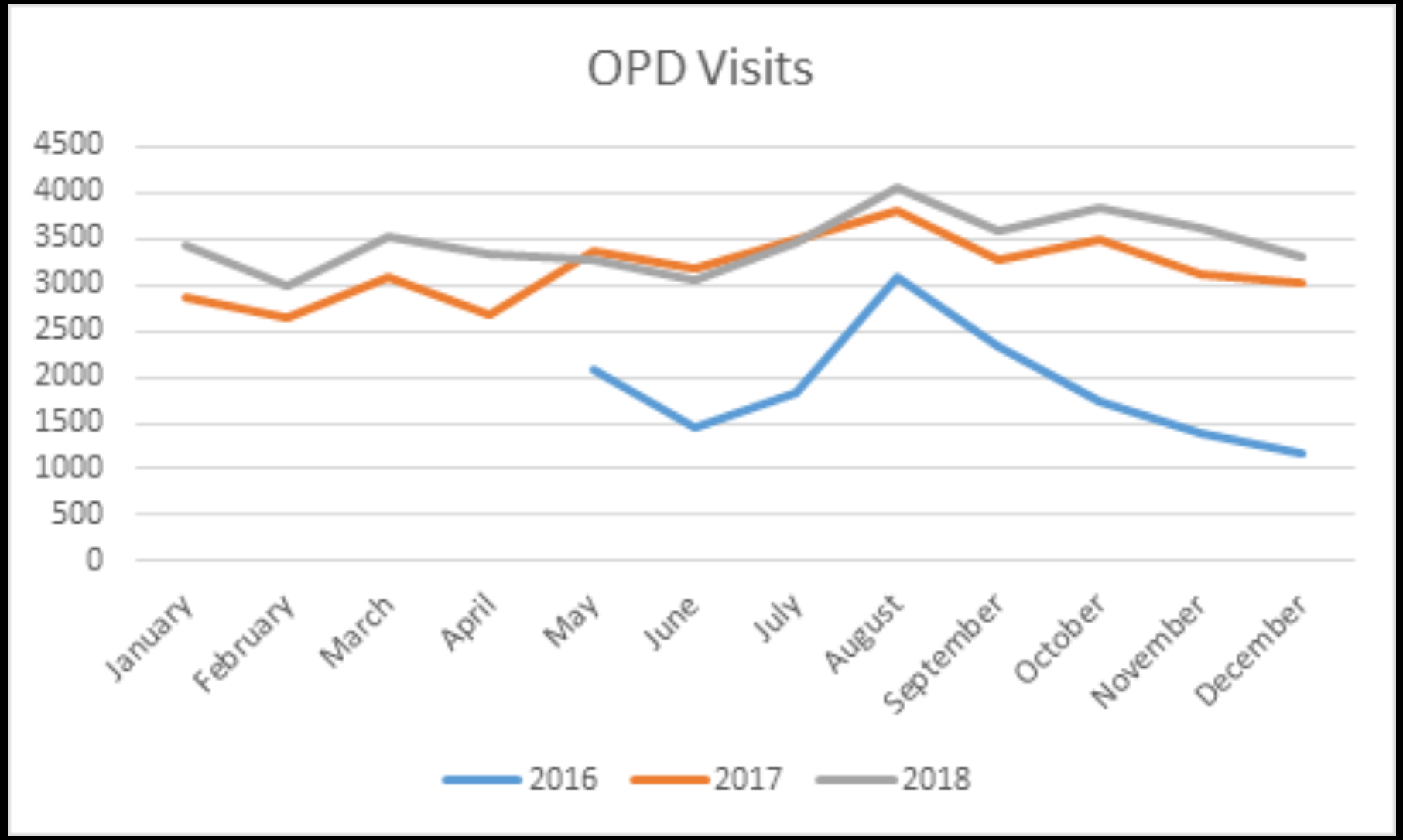
Visit Date	Exams	Result	Comments	Provider	Location
08/09/2021	DIABETIC EYE EXAM	NORMAL/NEGATIVE		SPILLANE,JAMES	pt rpts normal neg
04/23/2021	INTIMATE PARTNER VIOLENCE	NON-ACUTE POSITIVE		SULLIVAN CRADDOCK,TINA	NORTH AMERICAN INDIAN ALLIANCE
04/23/2021	DEPRESSION SCREENING	NORMAL/NEGATIVE		SULLIVAN CRADDOCK,TINA	NORTH AMERICAN INDIAN ALLIANCE
04/06/2021	INTIMATE PARTNER VIOLENCE	PRESENT	verbal abuse/violence	SULLIVAN CRADDOCK,TINA	NORTH AMERICAN INDIAN ALLIANCE
04/06/2021	ALCOHOL SCREENING	NORMAL/NEGATIVE		SULLIVAN CRADDOCK,TINA	NORTH AMERICAN INDIAN ALLIANCE
04/06/2021	DEPRESSION SCREENING	NORMAL/NEGATIVE	phq9-0	SULLIVAN CRADDOCK,TINA	NORTH AMERICAN INDIAN ALLIANCE
03/17/2020	DIABETIC EYE EXAM	NORMAL/NEGATIVE		SPILLANE,JAMES	Pt reports neg exam
10/14/2019	DEPRESSION SCREENING	NORMAL/NEGATIVE		HANSEL ALLEN,PAULA J	NORTH AMERICAN INDIAN ALLIANCE
04/10/2019	INTIMATE PARTNER VIOLENCE	NORMAL/NEGATIVE		SANDOVAL,KEVIN D	NORTH AMERICAN INDIAN ALLIANCE

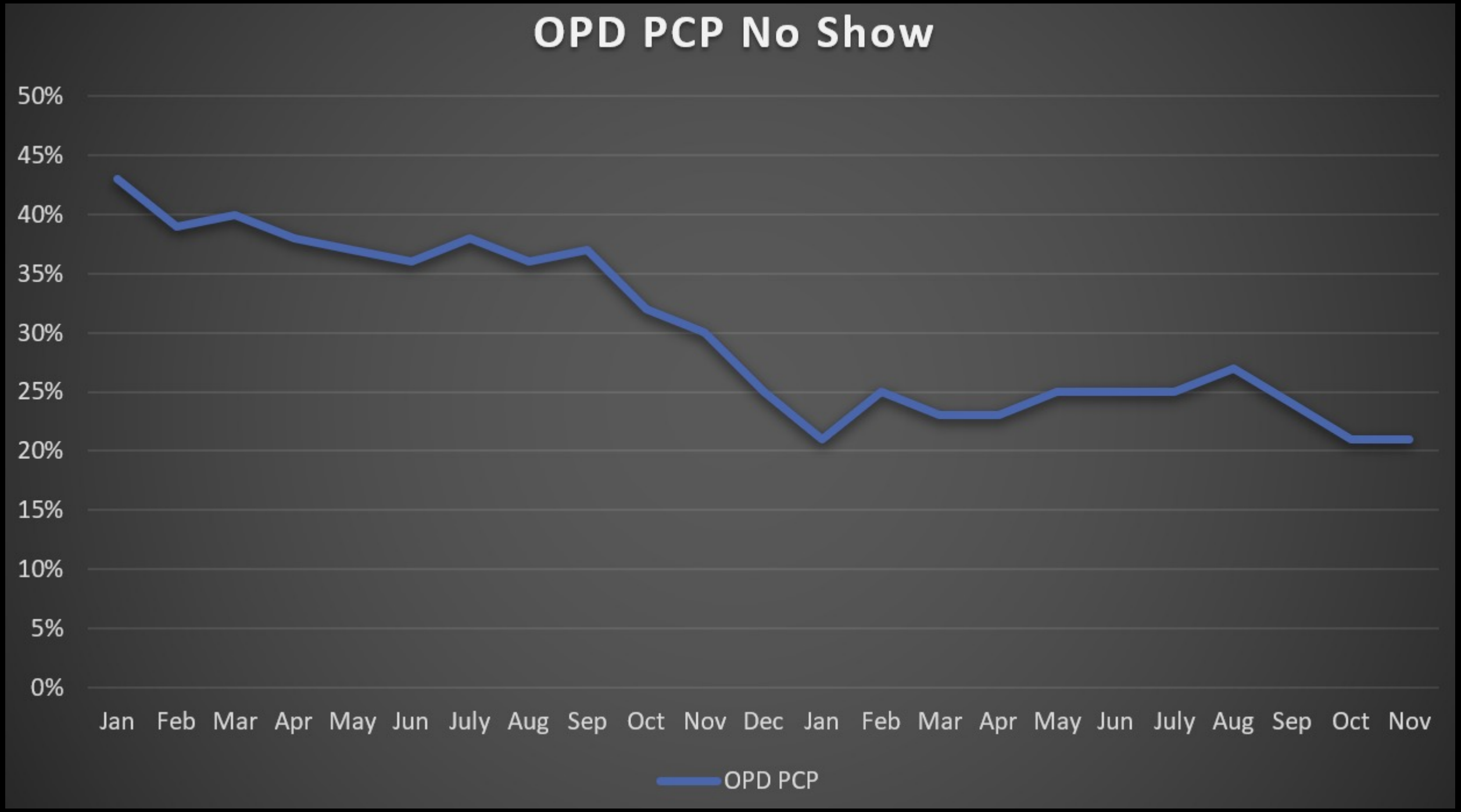
Health Factors

Add | Edit | Delete

Visit Date	Health Factor	Category	Comment
04/23/2021	Some Activity	Activity	2 times a week
04/23/2021	Cage 2/4	Alcohol/drug	
04/23/2021	Smoke Free Home	Tobacco	
04/23/2021	Never Used Smokeless Tobacco	Tobacco	
04/23/2021	Never Smoked	Tobacco	
04/06/2021	Current Smoker, Every Day	Tobacco	
10/14/2019	Never Smoked	Tobacco	
04/10/2019	Smoke Free Home	Tobacco	
04/04/2017	Current Smoker, Every Day	Tobacco	

SPILLANE,JAMES | BUTTE-URBAN.BIL.IHS.GOV | NORTH AMERICAN INDIAN ALLIANCE


OPD Visits
4500
4000
3500
3000
2500
2000
1500
1000
500
0
January
February
March
April
May
June
July
August
September
October
November
December
2016
2017
2018


OPD PCP No Show
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Jan
Feb
Mar
Apr
May
Jun
July
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
July
Aug
Sep
Oct
Nov
OPD PCP

San Carlos Apache Healthcare Corp.

SEPT, 2018

GPRA	2018 SEPT	National Goal	11/6/2018 Goal Met? Yes	No	# Pts needed to meet goal
DM: Good Glycemic Control	39.2%	36.2%	X		
DM: Blood Pressure Control	53.7%	52.3%	X		
DM: Statin Therapy to Reduce CVD Risk	56.2%	37.5%	X		
DM: Nephropathy Assessment	60.1%	34.0%	X		
DM: Retinopathy Assessment	62.4%	49.7%	X		
General Dental Access	37.1%	27.2%	X		
Dental Sealants (Ages 2-15)	20.5%	16.0%	X		
Topical Fluoride (Ages 1-15)	35.8%	30.0%	X		
Influenza - Children 6mo - 17yrs	24.2%	20.6%	X		
Influenza - Adults 18+	23.6%	18.8%	X		
Adults 19+ Combo	67.7%	baseline			N/A
Childhood Immunizations - Active IMM pkg Pts.	53.4%	45.6%	X		
Cervical Cancer Screening / Pap Smears	36.2%	35.9%	X		
Breast Cancer Screening / Mammography	34.3%	42.0%		X	56
Colorectal Cancer Screening	15.2%	32.6%		X	406
Tobacco Cessation	40.9%	27.5%	X		
Universal Alcohol Screening 9-75	50.0%	37.0%	X		
IPV/DV Screening	49.0%	41.6%	X		
Depression Screening	49.5%	42.2%	X		
Depression Screening Ages 12-17	27.3%	27.6%		X	4
CVD Statin Therapy	31.4%	26.6%	X		
Controlling High BP - Million Hearts	49.1%	42.3%	X		
HIV Screening Ever	44.5%	17.3%	X		
Breastfeeding Rates	11.6%	39.0%		X	12
SBIRT	33.8%	8.9%	X		
Childhood Weight Control	23.6%	22.6%	X		
Total			**21**	**4**	

Patient Satisfaction

95%

“I’m so very thankful for my provider, Since this new building, I’ve never in my 40+ years have received the care that I do now!” –patient of Dr. Cruzado

“You’re all doing an awesome job, well done! And thank my MA Evie Logan for explaining the process of my visit today”
–patient of Dr. Rauscher

“I like my team with my Doctor Rauscher. MA Evie is helpful with providing good care and checking my sugar every time I’m seen. RN Trent schedules me when I need my appointments!” –patient of Dr. Rauscher

“I’m happy to know the 2 outpatient desk folks speak Apache and understand. It makes it easier to let them know our needs –Outpatient

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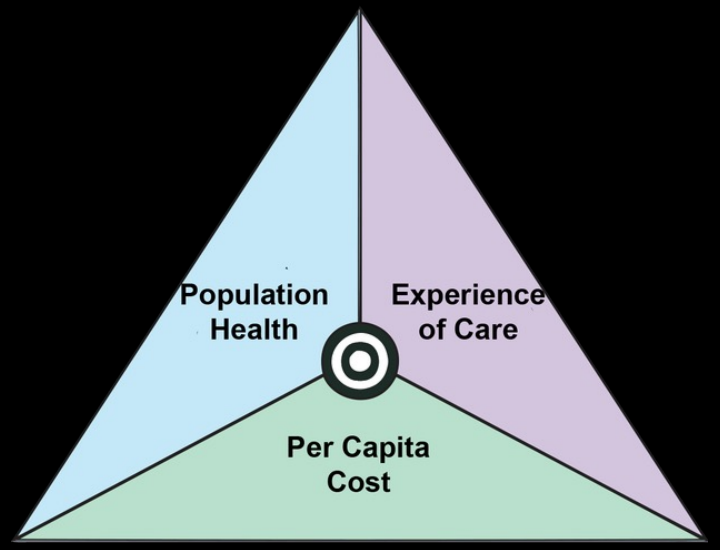

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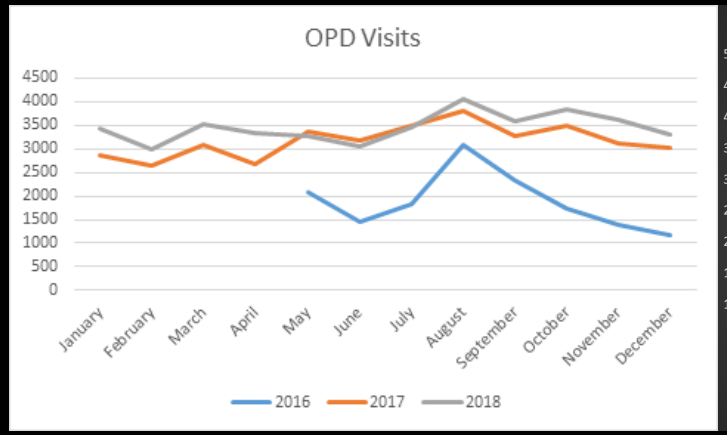
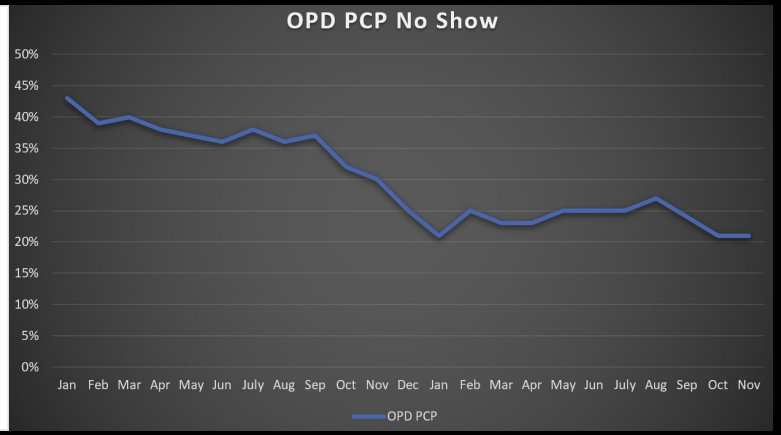
95%






Thank you