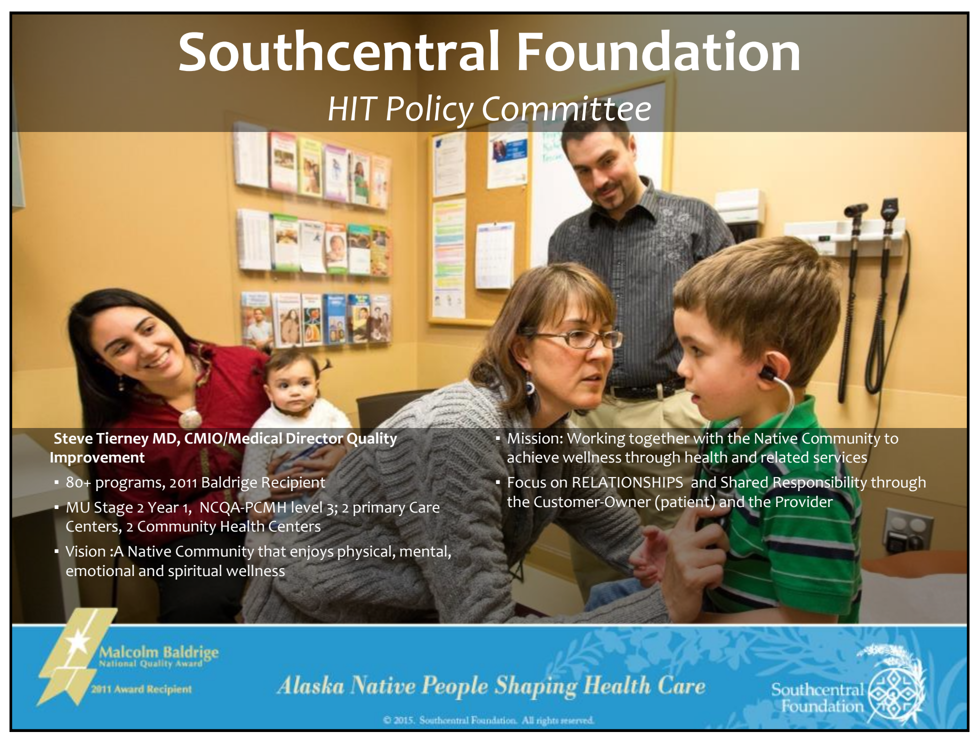
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HIT Policy Committee
Steve Tierney MD, CMIO/Medical Director Quality Improvement
▪ 80+ programs, 2011 Baldrige Recipient
▪ MU Stage 2 Year 1, NCQA-PCMH level 3; 2 primary Care Centers, 2 Community Health Centers
▪ Vision :A Native Community that enjoys physical, mental, emotional and spiritual wellness
▪ Mission: Working together with the Native Community to achieve wellness through health and related services
▪ Focus on RELATIONSHIPS and Shared Responsibility through the Customer-Owner (patient) and the Provider
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Healthcare is a Zero Sum Game
▪ Adding new work often requires the compromise of old
▪ Industry trend typically adds to workflow but rarely subtracts
▪ Does not often relatively rank each measure for value or system impact
▪ Details are added into the office visit at the expense of personal interactions
▪ Southcentral Foundation has taken a steps to mitigate these factors
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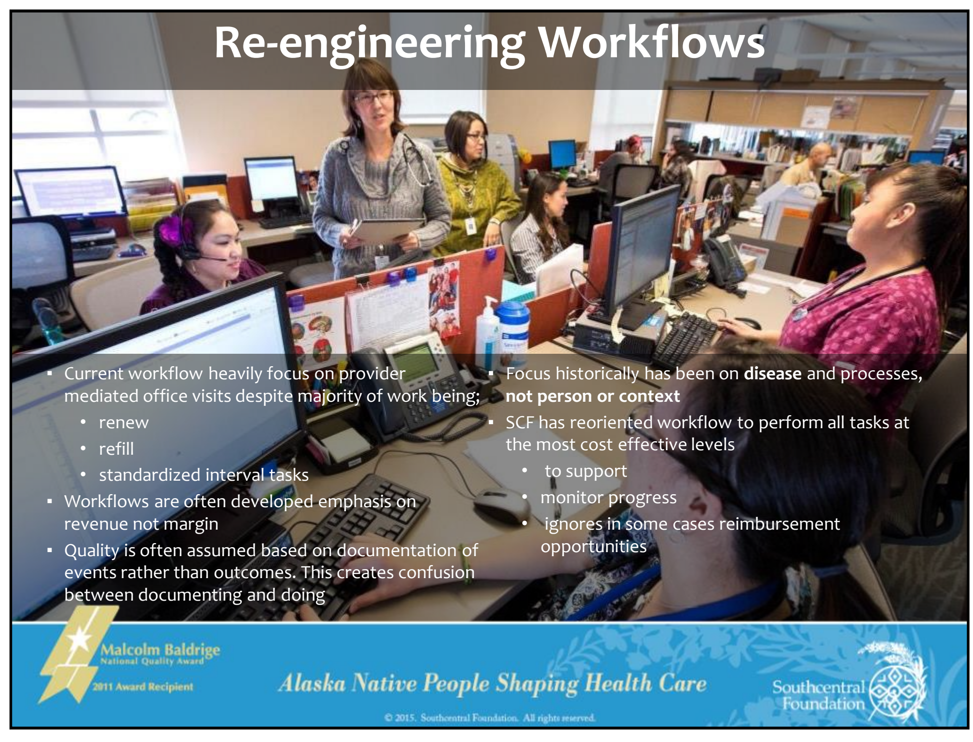
Re-engineering Workflows
Current workflow heavily focus on provider mediated office visits despite majority of work being;
renew
refill
standardized interval tasks
Workflows are often developed emphasis on revenue not margin
Quality is often assumed based on documentation of events rather than outcomes. This creates confusion between documenting and doing
Focus historically has been on disease and processes, not person or context
SCF has reoriented workflow to perform all tasks at the most cost effective levels
to support
monitor progress
ignores in some cases reimbursement opportunities
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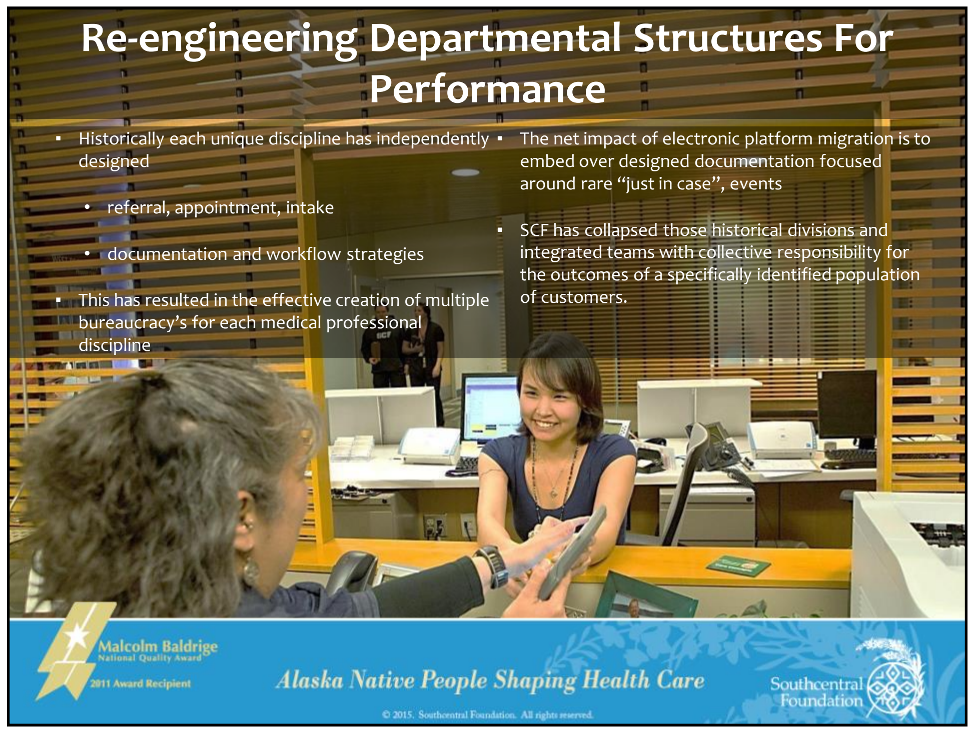
Re-engineering Departmental Structures For Performance
Historically each unique discipline has independently designed
referral, appointment, intake
documentation and workflow strategies
This has resulted in the effective creation of multiple bureaucracy's for each medical professional discipline
The net impact of electronic platform migration is to embed over designed documentation focused around rare "just in case", events
SCF has collapsed those historical divisions and integrated teams with collective responsibility for the outcomes of a specifically identified population of customers.
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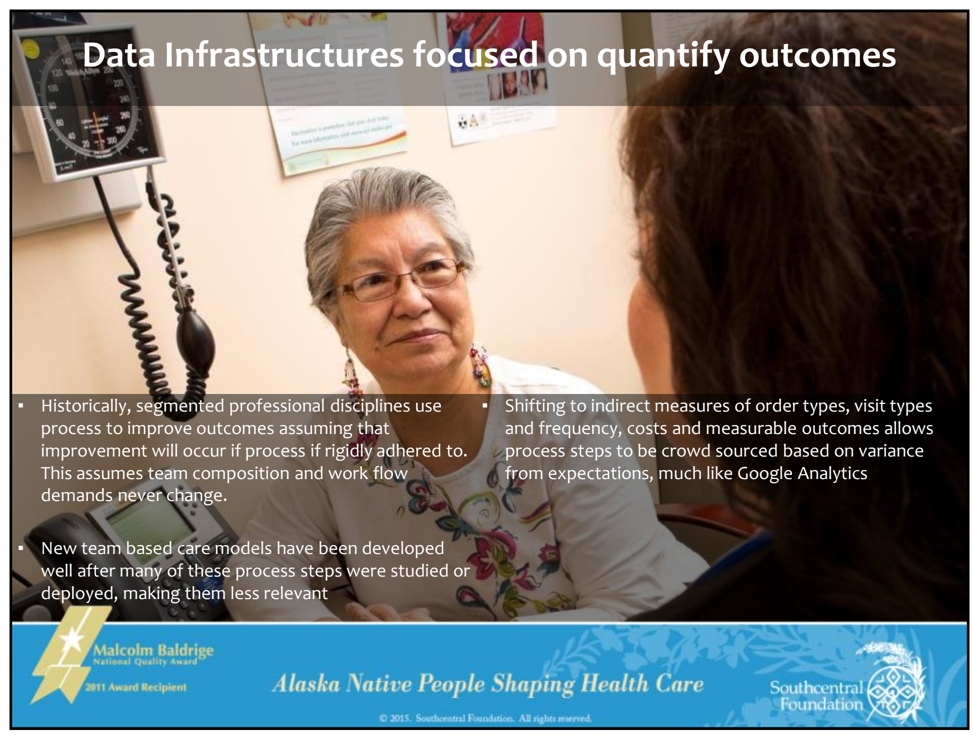
Data Infrastructures focused on quantify outcomes
Historically, segmented professional disciplines use process to improve outcomes assuming that improvement will occur if process if rigidly adhered to. This assumes team composition and work flow demands never change.
New team based care models have been developed well after many of these process steps were studied or deployed, making them less relevant
Shifting to indirect measures of order types, visit types and frequency, costs and measurable outcomes allows process steps to be crowd sourced based on variance from expectations, much like Google Analytics
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Re-engineering The Workforce for remote or underserved communities
Healthcare professional recruiting is already a challenge. Significant healthcare workforce shortages are anticipated in may segments over the next decade.
Southcentral Foundation has created new professional workforce classifications and tied them into a network of consulting and referral providers to support them.
Medical, Behavioral Health, and Dental Healthaides serve many remote rural sites with direct support via integrated electronic networks from urban based medical, mental health, dental and pharmacy professionals. All on the same electronic platform.
SCF has sites only accessible by several hours of bush plane flight that are certified by NCQA as PCMH Level 3 and staffed by Healthaides. Even pharmaceuticals prescribed by their urban based providers are "dispensed" by remote electronic preloaded kiosks by urban based pharmacists after health aide assessment and collaborative coordination with their linked urban provider
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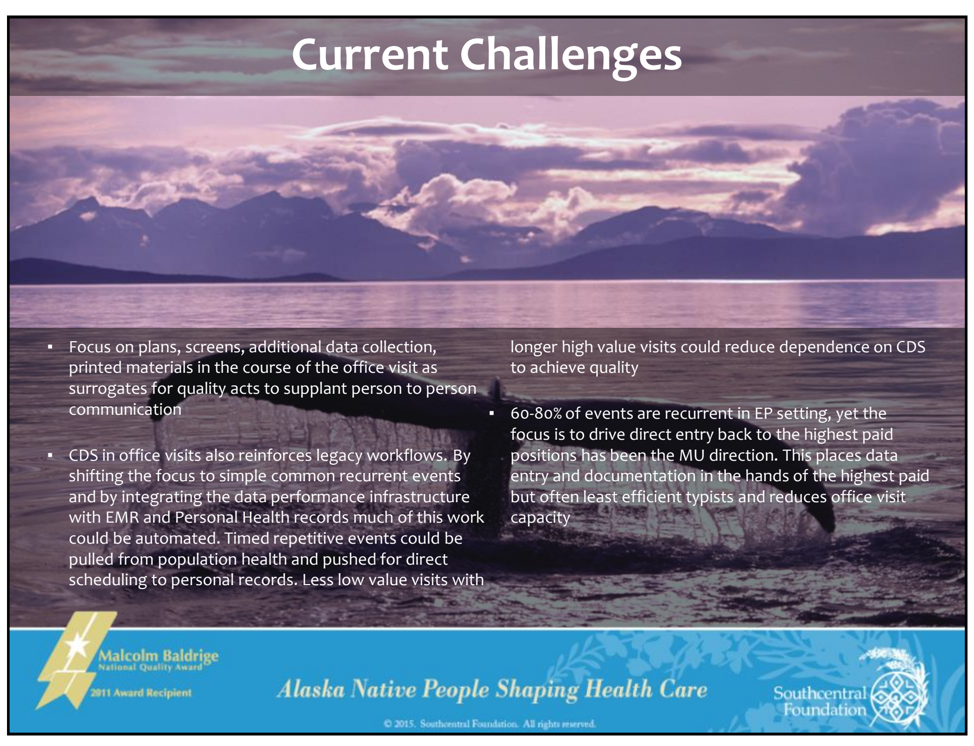
Current Challenges
Focus on plans, screens, additional data collection, printed materials in the course of the office visit as surrogates for quality acts to supplant person to person communication
CDS in office visits also reinforces legacy workflows. By shifting the focus to simple common recurrent events and by integrating the data performance infrastructure with EMR and Personal Health records much of this work could be automated. Timed repetitive events could be pulled from population health and pushed for direct scheduling to personal records. Less low value visits with longer high value visits could reduce dependence on CDS to achieve quality
60-80% of events are recurrent in EP setting, yet the focus is to drive direct entry back to the highest paid positions has been the MU direction. This places data entry and documentation in the hands of the highest paid but often least efficient typists and reduces office visit capacity
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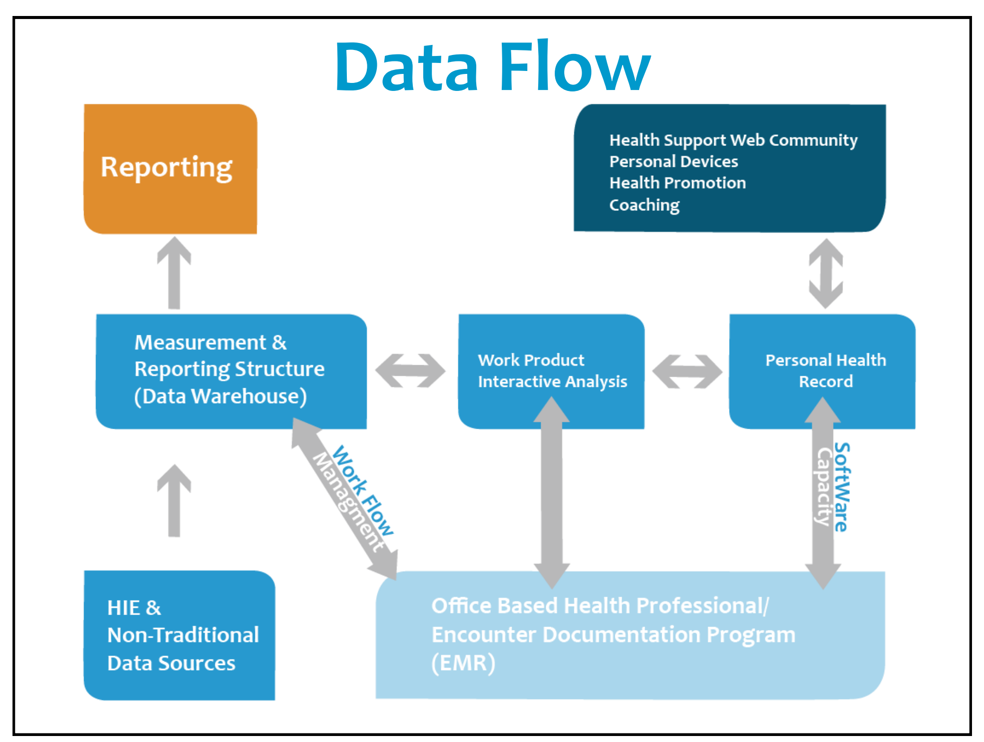
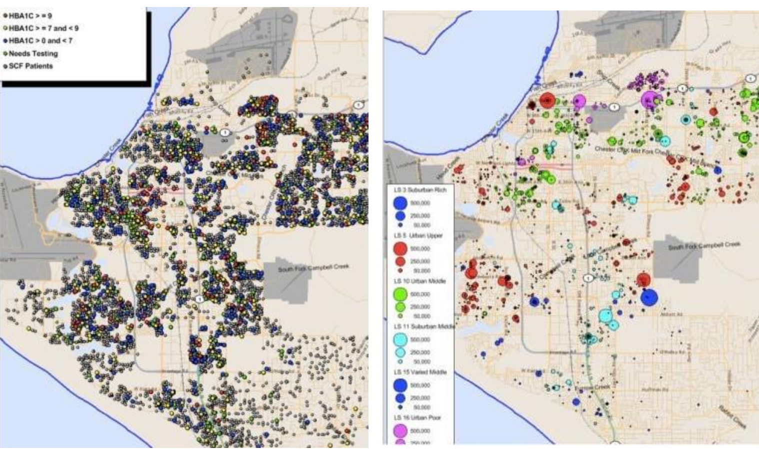

Data Flow
Reporting
Health Support Web Community
Personal Devices
Health Promotion
Coaching
Measurement & Reporting Structure (Data Warehouse)
Work Product Interactive Analysis
Personal Health Record
Work Flow Managment
SoftWare Capacity
HIE & Non-Traditional Data Sources
Office Based Health Professional/ Encounter Documentation Program (EMR)

Diabetes Distribution by Incidence and Control & Diabetes Distribution by Cost and Social Grouping



Total Population with Diabetes and level of control are Highlighted. We wanted to know who is Diabetic, but also how they are able to control their condition by Neighborhood. When you change your philosophy from treating disease to relationships with people you begin to see context.

What Could Help?

- Significantly limit whole population or disease based care plans, education documentation, and reminders. They are based on old organizational structures and workflows and increasingly less relevant in redesigned structures
- Shift to measurable outcomes, interaction types and patterns. Add location based socioeconomic data sources to traditional biomedical health factors. Analyze patterns and look for cost and quality opportunities with focus on variance
- Incentivize low overhead methods of task completion. Direct population based milestone measurement, pushed to smartphones, using direct consumer scheduling and customer driven ordering with ordering provider approval. Now this is done at a perceived loss in visit based incomes
- Encourage non office visit interactions on secure platforms augmented by web linked information sources. Observe shifts of system resources use and outcomes linked to patterns of interactions. Look for opportunities by incentivizing pattern analysis.
- The lesson SCF has learned is neighbors with basic medical training in remote communities helping each other with urban professional linked supports can achieve top tier clinical outcomes and NCQA PCMH Level 3 certification in the most challenging of environments, all on fully integrated electronic platforms, with minimal direct provider office visits.

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