From Theory to Practice: Integrated Care Teams in Action

65,000 voices
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
Goals

Shared Responsibility
Commitment to Quality
Family Wellness
Customer-Ownership
Leadership Principles

O perate from the strength of Alaska Native cultures and traditions of leadership.
W ill stand in the gap to align and achieve the mission and vision.
N urture an environment of trust that encourages buy-in, systematic growth and change.
E ncourage ownership of responsible, calculated risk taking.
R espect and grow the skills of future generations to drive initiatives and improvements.
S hare and listen to personal life stories in order to be transparent and accountable.
H edge people in by creating a safe environment where spiritual, ethical and personal beliefs are honored.
I mprove for the future by learning from the past, giving away credit and celebrating achievements.
P ractice and encourage self improvement believing there is good in every person.
Operational Principles

Relationships between customer owner, family and provider must be fostered and supported

Emphasis on wellness of the whole person, family and community (physical, mental, emotional and spiritual wellness)

Locations convenient for customer-owners with minimal stops to get all their needs addressed

Access optimized and waiting times limited

Together with the customer-owner as an active partner

Intentional whole-system design to maximize coordination and minimize duplication

Outcome and process measures continuously evaluated and improved

Not complicated but simple and easy to use

Services financially sustainable and viable

Hub of the system is the family

Interests of customer-owners drive the system to determine what we do and how we do it

Population-Based systems and services

Services and systems build on the strengths of Alaska Native cultures
Core Concepts

Work together in relationship to learn and grow
Encourage understanding
Listen with an open mind
Laugh and enjoy humor throughout the day
Notice the dignity and value of ourselves and others
Engage others with compassion
Share our stories and our hearts
Strive to honor and respect ourselves and others
Objectives

- Describe how SCF uses integrated care team to manage workflow and customer-owner panels
- Examine segmentation of high utilizers to optimize resources
Where are you visiting from?

Go to www.menti.com and use the code 70 19 91
Reassessment of Work Flow
Business Demand Estimates

3500-4000 Physical Visits/Year/FTE:
Process Rate Limited Through Physical Visits

Nearly 50% of encounters had some
behavioral health component
Clinical Workload Prior to System Redesign

- New customers without a diagnosis or plan: 30%
- Rx refill of controlled diseases: 20%
- Ongoing monitoring of chronic disease: 20%
- Requesting outside referrals: 10%
- Needed known preventative medical interventions: 20%
- Total business volume already had known pathways or protocols: 50%
Empanelled Customer-Owners:
- Ensures Continuity of Care
- Builds Relationships
- Creates Trust Between Customer and Team
- Progress/Healthy Outcomes
- Open Access to Integrated Care Team
- Email, Phone, Talking Rooms
Traditional Work Flow

Preventive Med Intervention
Customer

Chronic Disease Monitoring
Customer

Medication Refill
Customer

New Acute Complaint
Customer

Test Results
Customer

Provider

Customer

Case Manager

Mental Health Provider

Referral to Specialist after Assessment

Certified Medical Assistant

Dietician

Clinical Pharmacist
Case Management Support
Primary Care Provider
Dietician
RN Case Manager
Certified Medical Assistant
Behavioral Health Consultant
Coverage NP/PA
Integrated Care Teams
The Primary Care Team: Provider

- Responsible for Initial Assessment and Diagnosis
- Responsible for In-Clinic Visits
- Adjusts Treatment Plans for Known Diagnosis Where Goals Are Not Being Met
- Helps Set Focus for Team on Priority Work Areas
- Sets Plan for Follow-up for Known Diagnosis Where Treatment Is Stable
RN Case Manager

- Population-Based Panel Management
- Chronic Disease Manager
- Preventive Disease Manager
- The RN’s Work Is Extraneous to the Physical Visit:
  - Customer-owner education
  - Labs/radiology reports
  - Medication refills
  - Huddles
  - Follow-up visit requests
Historically Assigned by Diagnosis:
- Diabetes Mellitus
- Cancer
- Cardiology
- Orthopedics
- Geriatrics
- Behavioral Health
Whole-Person Case Management

- Nuka System of Care for Customer-Owners Throughout Their Lifespan
- Whole-Person Care:
  - Physical
  - Mental
  - Emotional
  - Spiritual
Case Management Support (CMS)
Case Management Support (CMS)

- Building Relationships
- CMS Is Main Point of Contact Between Customer-Owners & the ICT
- Schedules Customer-Owners
- Coordinate with RN Case Manager to Ensure Good Panel Management
- Message/Attach Documents in Electronic Health Record
- Various Other Duties
Certified Medical Assistant (CMA)

- Customer-Owner Check-In (V/S, Screenings, Procedure and Room Setup)
- Immunizations/ Venipuncture
- Medication Administration
- Manage Daily Schedule
- Preventive Screenings (Depression, Tobacco, etc.)
Dietitian
Dietitian

- Consults with Customer-Owners During or After Their Physical Visits to the Clinic (For Acute or Chronic Conditions)
- Phone Consultations for Those Customer-Owners Unable to Come in to the Clinic
- Consults with the Team for Ongoing Customer-Owner Conditions
- Support of Various Programs and Classes
Integrated Pharmacist

- Consultation and Education to Care Team on Evidenced Based Cost Effective Medication Use
- Pre/Post & Joint Visits with ICT Members and Those Customer-Owens Who Have Complex Medications Needs
- Population Based Panel Management with Goal to Improve Medication Use for Chronic Complex Conditions
  - Act as physician extenders to fully utilize unique skill set to manage medications for customer-owners with chronic stable conditions
  - Free up time for physicians to focus on those more critically ill in need of physician-based care
- Support of Various Programs and Classes
- Liaison: PCC Provider Mtg, P&T, NCM/PCP Orientation etc.
Midwifery
Integrated Midwife

- Went From Having 2 Midwives to 9 in Primary Care
- RN Case Manager Does a New Prenatal Intake with Customer Around 7 Weeks Gestation
- We Schedule Customer-Owners with the Midwives on Their Floor
- Six Week Post-Partum Exams Can Be Done by Midwives or PCP
- Midwives Can Help with Birth Control Options As Needed
Behavioral Health Consultant (BHC)

- Consultation/Education to Providers, Case Managers
- Joint Visits and Care Conferences with the Team
- Provides Educational Materials and Workbooks to Customer-Owners
- Screening, Assessment, Brief Intervention, Education and Follow-Up/Monitoring
- Consultation with Specialists, Referral for Longer Term Therapeutic Interventions
Manager/Supervisor
Manager/Supervisor

- Managers/Supervisors Are Operational and Not Clinically Trained
- All Staff in the Clinic Report to the Manager/Supervisors
- Partners with the Medical Director & RN CM Specialist to Address Any Clinical Questions That Arise
- Addresses Customer-owner Concerns
- Manages the Budget for Their Department
- Completes HR Functions
  - Performance improvement plans & corrective actions
  - Completes annual plans
  - Establishes initiatives & work plans
  - Delivers performance evaluations to staff & commission core staff
Is it working?
## HEDIS Diabetes HBA1C Annual Screening Scores

**HEDIS Diabetes HBA1C Annual Screening Scores as of: 5/30/2015**

2014 HEDIS Medicaid Benchmark 75th Percentile = 87.59%

<table>
<thead>
<tr>
<th>Organization</th>
<th>Clinic</th>
<th>Provider</th>
<th>Numerator</th>
<th>Denominator</th>
<th>% Screened</th>
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<td>SCF</td>
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<td>1637</td>
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*Click Here for Methodology!*
## SCF Balanced Scorecard - FY2015

### Customer-Owner

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Objectives</th>
<th>Measure</th>
<th>FY2015</th>
<th>Below Minimum</th>
<th>Annual</th>
<th>Stretch</th>
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</thead>
<tbody>
<tr>
<td>SR2</td>
<td>Overall Rating of Care (customer-owner satisfaction)</td>
<td>Q2</td>
<td>95%</td>
<td>&lt; 92%</td>
<td>92%</td>
<td>95%</td>
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<tr>
<td>SR1</td>
<td>Culturally Respectful (customer-owner satisfaction)</td>
<td>Q2</td>
<td>94%</td>
<td>&lt; 92%</td>
<td>92%</td>
<td>95%</td>
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<tr>
<td>SR2</td>
<td>Recommended Provider (customer-owner satisfaction)</td>
<td>Q2</td>
<td>95%</td>
<td>&lt; 94%</td>
<td>94%</td>
<td>96%</td>
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<tr>
<td>SR2</td>
<td>Input into my Care Decisions (customer-owner satisfaction)</td>
<td>Q2</td>
<td>96%</td>
<td>&lt; 94%</td>
<td>94%</td>
<td>97%</td>
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</table>

### Operational Effectiveness

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Objectives</th>
<th>Measure</th>
<th>FY2015</th>
<th>Below Minimum</th>
<th>Annual</th>
<th>Stretch</th>
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<tbody>
<tr>
<td>FMW2</td>
<td>Cervical Cancer Screening Rate (with new HPV screen considered)</td>
<td>Q2</td>
<td>72%</td>
<td>&gt; 72%</td>
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<td>77%</td>
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<td>FMW2</td>
<td>Colorectal Cancer Screening Rate</td>
<td>Q2</td>
<td>63%</td>
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<td>FMW3</td>
<td>PrimeMD Depression Screening Rate</td>
<td>Q2</td>
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<td>FMW5</td>
<td>SBIRT Screening Rate</td>
<td>Q2</td>
<td>77%</td>
<td>&lt; 75%</td>
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<td>FMW6</td>
<td>Diabetics with A1C in Poor Control (Lower is Better)</td>
<td>Q2</td>
<td>24%</td>
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<td>30%</td>
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<td>FMW6</td>
<td>Diabetics with LDL in Control</td>
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<td>44%</td>
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<td>46%</td>
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<td>FMW6</td>
<td>Diabetics Annual HBA1C Screening Rate</td>
<td>Q2</td>
<td>93%</td>
<td>&lt; 88%</td>
<td>88%</td>
<td>92%</td>
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### Workforce Development

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Objectives</th>
<th>Measure</th>
<th>FY2015</th>
<th>Below Minimum</th>
<th>Annual</th>
<th>Stretch</th>
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<tbody>
<tr>
<td>CQ3</td>
<td>Percent of Alaska Native/American Indian Employees</td>
<td>Q2</td>
<td>56%</td>
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<td>60%</td>
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<td>CQ3</td>
<td>Percent of Alaska Native/American Indian Hire</td>
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<td>62%</td>
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<td>CQ1</td>
<td>Total Turnover Rate (Lower is Better)</td>
<td>Q2</td>
<td>14%</td>
<td>&gt; 14%</td>
<td>14%</td>
<td>10%</td>
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# Action Lists

(Fictitious Customer-Owners)

## Diabetes Action List

**Diabetes Actionlist as of: 2/21/2015**

<table>
<thead>
<tr>
<th>HRCN</th>
<th>Patient</th>
<th>Sex</th>
<th>Age</th>
<th>HBA1C Result</th>
<th>HBA1C Date</th>
<th>LDL Date</th>
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<td>72048</td>
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**Total Diabetic Patients: 47**

Links to Documentation:
- Report Methodology
- Data Resolution/Error Correction Process
Provider Performance Over Time

HEDIS Diabetes HBA1C Annual Screening Scores

*Click Here for Methodology!  
Link to Action List

SCF Diabetes HBA1C Annual Screening Scores

Scores  Goal - 89.43% - HEDIS 75th
Comparison Charts to Identify Best Practices

HEDIS Diabetes LDL Under 100 Scores

As of 03/11/2017
Training and Support

Ensure Successful Relationships:
- 5 Dynamics
- Mentor Training
- Core Concepts
- Motivational Interviewing
- Crucial Conversations
- Team Dynamics
Sustained Improvements

- Employee Satisfaction: 95%
- Customer Satisfaction: 97%
- Reduction in ER Visits: 36% (2000-2015)
- Reduction in Hospital Admissions: 36% (2000-2015)
Questions?
Thank You!

Qaɡaasakung
Aleut

Mahsi'
Gwich’in Athabascan

Quyanaa
Alutiiq

Igamsiqanaghalek
Siberian Yupik

Quyanaq
Inupiaq

Awa'ahdah
Eyak

Háw'aa
Haida

Quyana
Yup’ik

T’oyaxsm
Tsimshian

Gunalchéesh
Tlingít

Tsin'aen
Ahtna Athabascan

Chin’an
Dena’ina Athabascan