Managing Health Outcomes Through Integrated Care

Cree Board of Health & Social Services of James Bay

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Malcolm Baldrige National Quality Award
2011 & 2017 Award Recipient

65,000 voices

Southcentral Foundation

Malcolm Baldrige
National Quality Award

2011 & 2017 Award Recipient

Objectives

- Describe how SCF uses the integrated care teams to manage workflow and customer-owner panels
- Examine segmentation of high utilizers to optimize resources

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

Operational Principles

R **elationships** between customer-owner, family and provider must be fostered and supported

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

L **ocations** convenient for customer-owners with minimal stops to get all their needs addressed

A **ccess** optimized and waiting times limited

T **ogether** with the customer-owner as an active partner

I **ntentional** whole-system design to maximize coordination and minimize duplication

O **utcome** and process measures continuously evaluated and improved

N **ot** complicated but simple and easy to use

S **ervices** financially sustainable and viable

H **ub** of the system is the family

I **nterests** of customer-owners drive the system to determine what we do and how we do it

P **opulation-Based** systems and services

S **ervices** and systems build on the strengths of Alaska Native cultures

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.

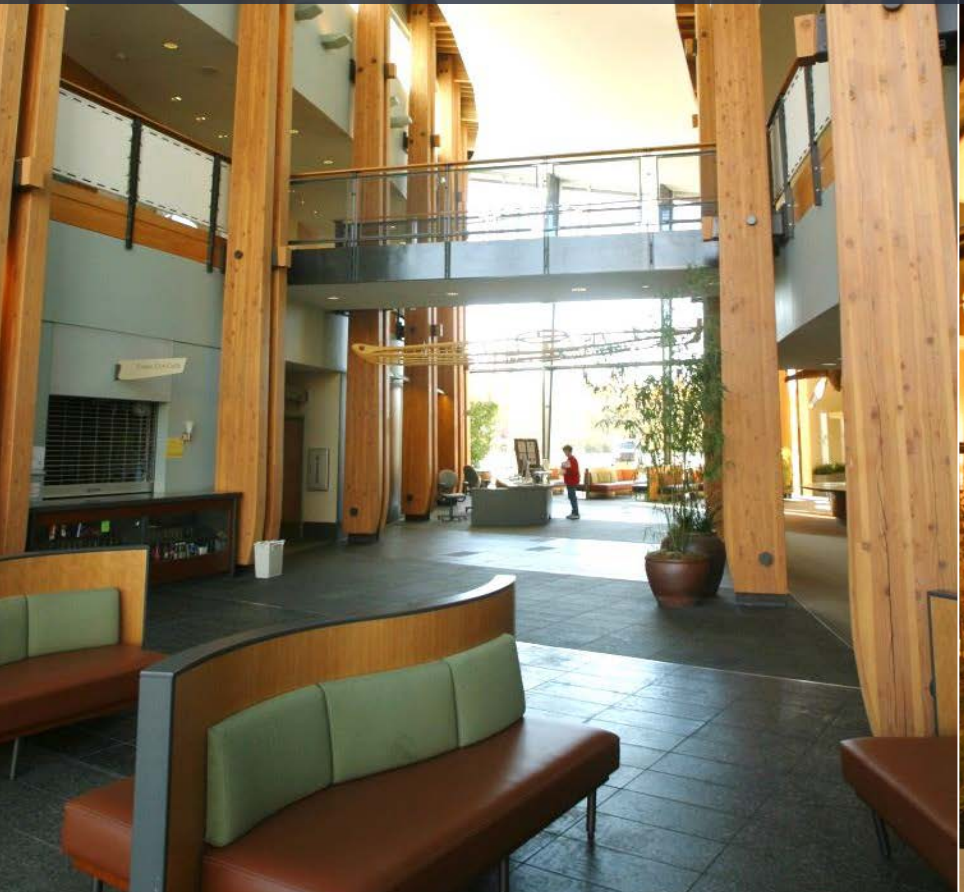
H **edge** people in by creating a safe environment where spiritual, ethical and personal beliefs are honored.

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

We Asked the Community

We Changed Everything



Core Concepts

Work together in relationship to learn and grow
E ncourage understanding
L isten with an open mind
L augh and enjoy humor throughout the day
N otice the dignity and value of ourselves and others
E ngage others with compassion
S hare our stories and our hearts
S trive to honor and respect ourselves and others

The Philosophic Process of Redesign

- Outcome Not Income
- Person Not Disease
- Population Not Process
- Service Not Practice

Managing the Whole Population

Case Manager/Case Management Support/Support Clinic Data

Provider+ BHC/Pharm/Diet

40%
Of Customer-Owners Have Low Intensity Needs

VACCINES

CANCER SCREENINGS

EPISODIC COMPLAINTS

VISIT ACESS

40%
Of Customer-Owners Have Moderate Intensity Needs

LAB MONITORING

REFILL REQUESTS

HEALTH EVALUATIONS

CONDITION MONITORING

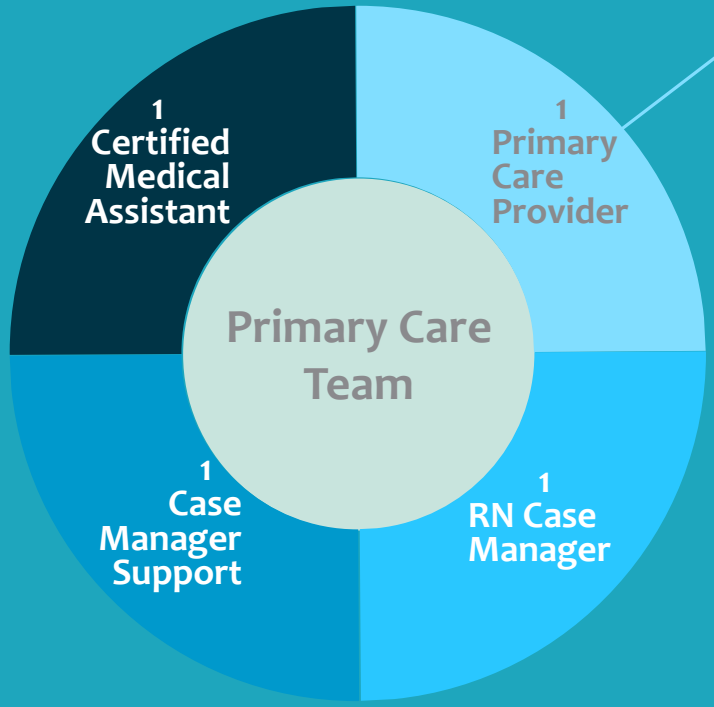
20%
Of Customer-Owners Have High Intensity Needs

ACUTE SERIOUS MEDICAL CONDITION

END OF LIFE

HIGH INTENSITY UTILIZERS

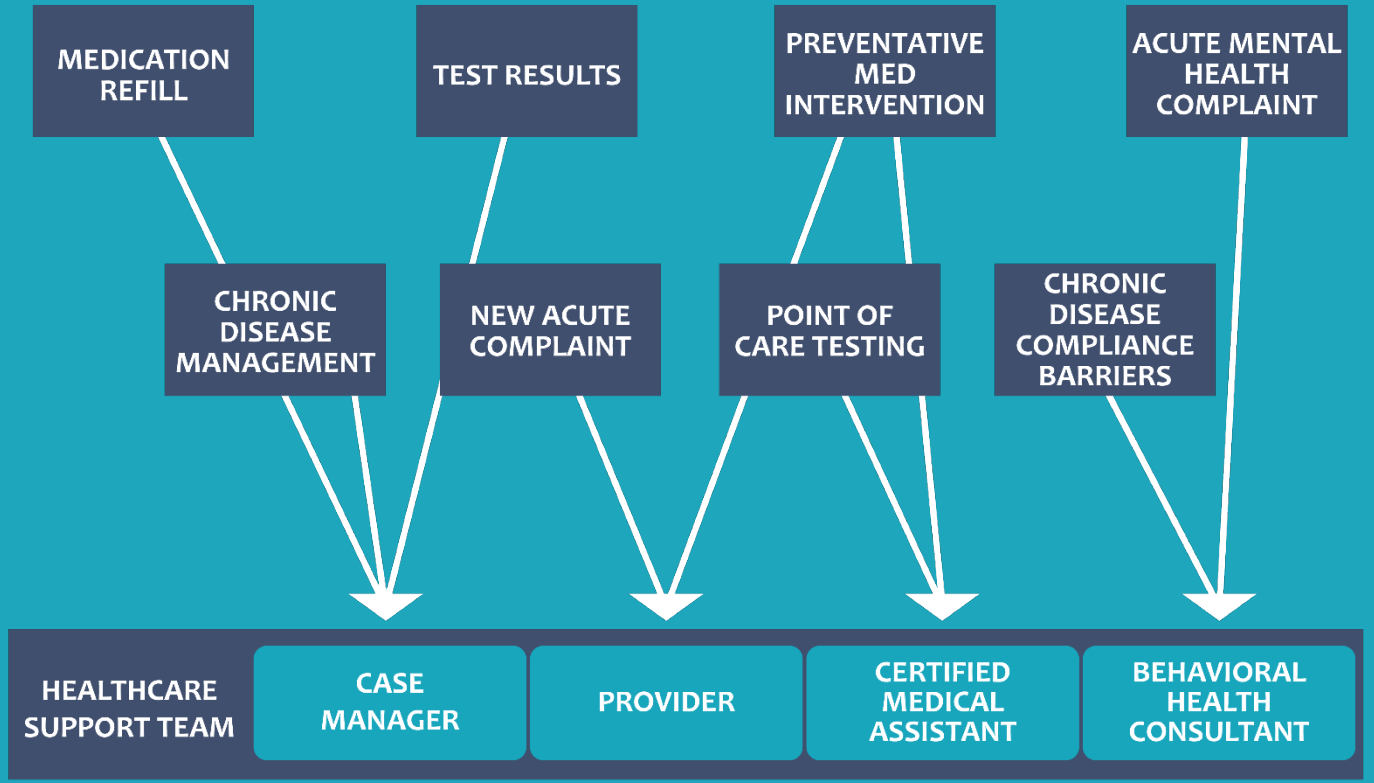
Care Team Ratios



1,100-1,400 Empaneled Customer-Owners

Integrated Care Clinic Team	
2 Behavioral Health Consultants	6 General Practice Physicians
1 Pharmacist	
1 Registered Dietitian	
1.5 Certified Nurse Midwife	
2 Coverage Physician Assistants/Nurse Practitioners	

Parallel Work Flow Redesign



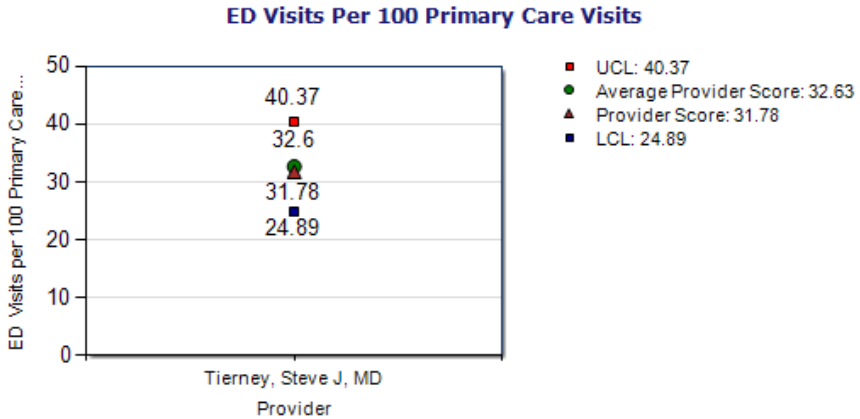
Integrated Care Teams

Data Management

Establish Benchmarks: Transparency

Clinical Metrics			Clinic Score Indicator
Red: Less than 50th HEDIS percentile or SCF Benchmark			
Green: Greater than or Equal to 50th HEDIS percentile or SCF Benchmark			
Clinical Measure *(Click measure title for methodology)*	**Measure Score**	**Measure Goal**	**Indicator**
Condition Management			
Cardiovascular Disease LDL Annual	100.0	81.45 - HEDIS 50th	
Diabetes Hba1c Annual	100.0	85.96 - HEDIS 50th	
Diabetes Hba1c Annual Poor Control	10.0	10.0 - HEDIS 50th	
Diabetes LDL Under 100	100.0	34.70 - HEDIS 50th	
Pediatric Diabetes Hba1c Annual	100.0	100.0 - HEDIS 50th	
Controlling Hypertension	60.9	54.8 - HEDIS 50th	
CVD Control Less Than 100mg/dL	80.0	41.36 - HEDIS 50th	
Prevention			
CDC Immunization Combo 2	100.0	100.0 - SCF Goal	
HEDIS Adolescent Immunization	100.0	100.0 - HEDIS 50th	
HEDIS Well Child Visits 12 To 21 Yr	43.8	48.41 - HEDIS 50th	
HEDIS Well Child Visits 3 To 6 Yr	100.0	71.42 - HEDIS 50th	
HEDIS Well Child Visits Less Than 15 Mo	100.0	59.57 - HEDIS 50th	
Screening			
ASQ less than 1 year	100.0	75 - SCF Goal	
ASQ less than 2 years	100.0	75 - SCF Goal	
ASQ less than 3 years	100.0	75 - SCF Goal	
Breast Cancer	60.6	58.15 - HEDIS 50th	
Cervical Cancer	70.6	55.9 - HEDIS 50th	
Colorectal Cancer	70.5	65.6 - HEDIS 50th	
Depression	85.7	75 - SCF Goal	
Peds BMI	81.8	67.54 - HEDIS 50th	
SBIRT	78.6	75 - SCF Goal	

Meaningful Use Scores for Tierney, Steve J, MD	Goal	Avg Score	Indicator
CPOE for Medication	60	98.9	
CPOE for Laboratory	30	99.6	
CPOE for Radiology	30	100	
Transmit Prescriptions Electronically	50	100	
Patient Online Access 1	50	80.6	
Patient Online Access 2	0	47.2	
Patient Education	10	47.2	
Medication Reconciliation	50	93.1	
Transition of Care	10	0	



Centralized Data Warehouse Approach

Inputs

Electronic Record

Personal Health Record

Wellness Application

Socioeconomic Data

Outside Lab and Pharmacy

Vaccination Data Bases

Data Warehouse Repository

Outputs

Regulator Performance Reporting

Organizational Leadership Performance Scorecard

Workforce Scorecard

Pattern Recognition and Risk Adjustment Modeling

HEDIS Diabetes LDL Under 100 Scores

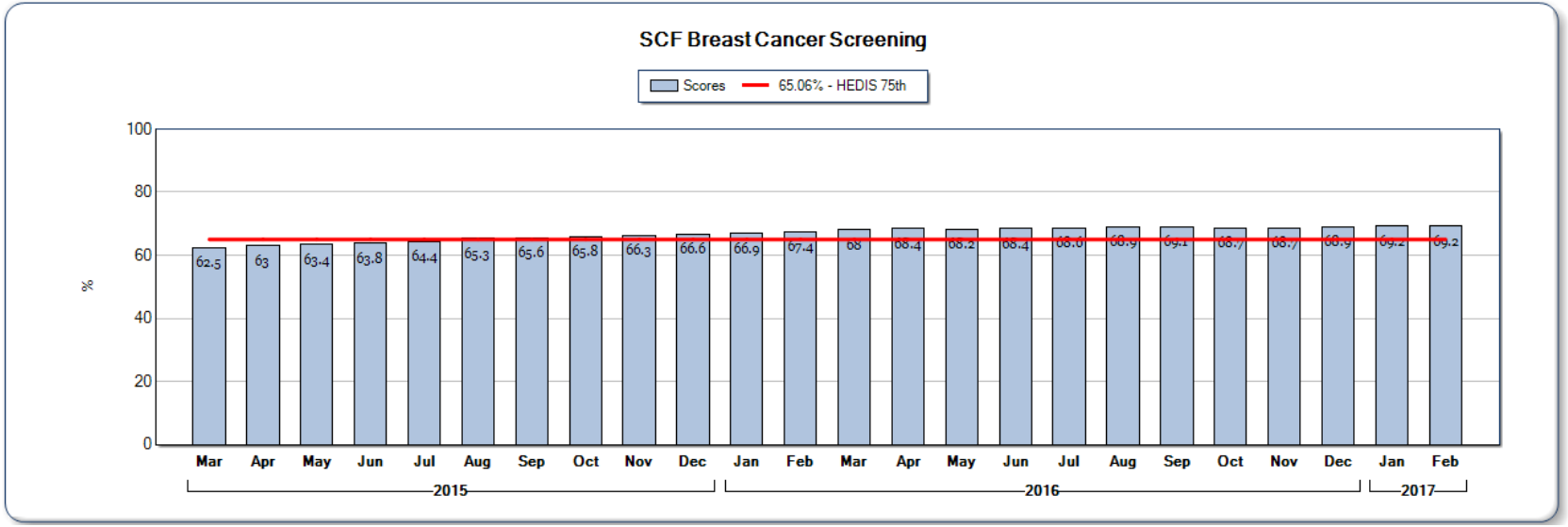
*Click Here for Methodology! Link to Action List

HEDIS Diabetes LDL Under 100 Scores as of: 4/15/2017

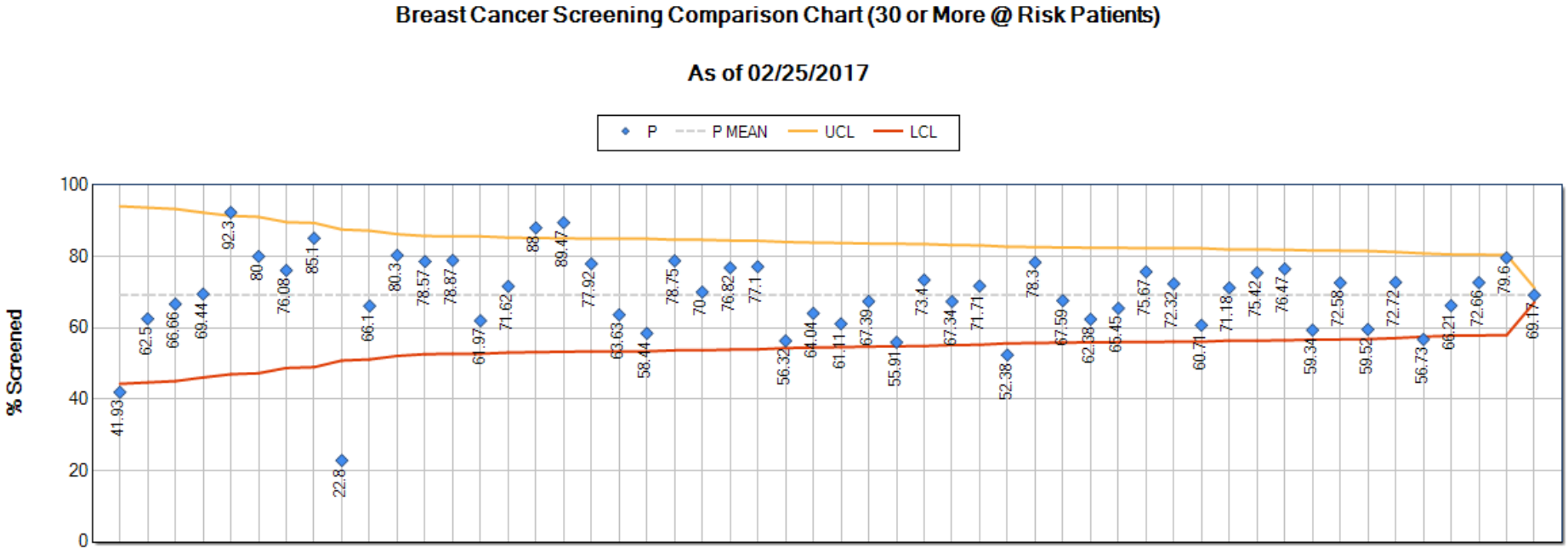
HEDIS Medicaid Benchmark 75th Percentile = 40.39%

Organization	Clinic	Provider	Numerator	Denominator	% Screened
SCF			**829**	**1843**	**45.0**
	⊞ **1 East**	*Integrated Pharmacist:*	**109**	**231**	**47.2**
	⊞ **1 West**	*Integrated Pharmacist:*	**96**	**226**	**42.5**
	⊞ **2 East**	*Integrated Pharmacist:*	**122**	**274**	**44.5**
	⊟ **2 West**	*Integrated Pharmacist.*	**96**	**236**	**40.7**
			13	36	36.1
			13	35	37.1
			13	36	36.1
			16	34	47.1
			0	0	
			18	43	41.9
			18	42	42.9
		Tierney, Steve J, MD	5	10	50.0
	⊞ **3 East**	*Integrated Pharmacist: Beiergrohslein, Mike*	**107**	**217**	**49.3**
	⊞ **3 West**	*Integrated Pharmacist: Castellanos, Theresa H*	**87**	**213**	**40.8**

SCF Data Mall



SCF Data Mall Learning from our Approach



Using Data: Discover & Manage Process

- High performance is often already occurring, as are patterns of events that indicate risk
- Initiative-based improvement assumes even performance for all participants and process change is applied to all with the same expectations
- Instead of using process enforcement to drive change, identify current high performance and study approaches that already work

Creating a Learning System

- Compare high performance with high outcome avoidance etc.
- Look for segmentation and effect

Step 1

Choose a condition with a process item and interval

Step 2

Pick a performance expectation

Step 3

Choose an avoidable outcome this may prevent

Step 4

Compare when the process is done or not done against the rate for avoidable outcomes (test impact)

High Risk Dispensing Patterns

Drug Category	Order Date	Date Dispensed	Total Qty Prescribed	Qty Dispensed	Days Supply	Date Supply Ends	Dispense Overlap Day
Total Prescriptions: 23				Total Qty: 1,664	MAX Consecutive Days: 166		
Benzodiazepine Prescriptions: 5		Last Dispensed: 4/13/2016		Benzodiazepine Qty: 180			
	9/1/2015	11/24/2015	120	30	30	12/23/2015	2
	12/22/2015	12/22/2015	120	30	30	1/20/2016	2
	12/22/2015	1/19/2016	120	30	30	2/17/2016	2
	2/16/2016	2/17/2016	120	30	30	3/17/2016	1
	3/8/2016	3/16/2016	30	30	30	4/14/2016	0
	4/12/2016	4/13/2016	30	30	30	5/12/2016	2
Opiate Prescriptions: 18		Last Dispensed: 4/13/2016		Opiate Qty: 1,484	Total Days > 120 mg: 165	Last Date > 120 mg: 5/7/2016	
	11/24/2015	11/24/2015	56	56	28	12/21/2015	0
	11/24/2015	11/24/2015	56	56	28	12/21/2015	0
	11/24/2015	11/27/2015	140	140	24	12/20/2015	0
	12/22/2015	12/22/2015	56	56	28	1/18/2016	0
	12/22/2015	12/22/2015	56	56	28	1/18/2016	0
	12/22/2015	12/22/2015	126	126	21	1/11/2016	0
	1/19/2016	1/19/2016	56	56	28	2/15/2016	0
	1/19/2016	1/19/2016	126	126	28	2/15/2016	0
	1/19/2016	1/19/2016	56	56	28	2/15/2016	0
	2/16/2016	2/17/2016	126	126	28	3/15/2016	0
	2/16/2016	2/17/2016	56	56	28	3/15/2016	0
	2/16/2016	2/17/2016	56	56	28	3/15/2016	0
	3/8/2016	3/16/2016	126	126	28	4/12/2016	0
	3/8/2016	3/16/2016	56	56	28	4/12/2016	0
	3/8/2016	3/16/2016	56	56	28	4/12/2016	0
	4/12/2016	4/13/2016	168	168	28	5/10/2016	0
	4/12/2016	4/13/2016	56	56	28	5/10/2016	0
	4/12/2016	4/13/2016	56	56	28	5/10/2016	0
Total Prescriptions: 4				Total Qty: 378	MAX Consecutive Days: 152		
Benzodiazepine Prescriptions: 4		Last Dispensed: 5/3/2016		Benzodiazepine Qty: 378			
	9/29/2015	11/10/2015	84	14	7	11/16/2015	0

High Risk Visit Patterns Indicating Distress

Medication Agreement	Inpatient Visits Last 1 Year	ED Visits Last 1 Year	UCC Visits Last 1 Year	Ambulatory Visits Last 1 Year	Specialty Visits Last 1 Year	Addiction Medications
			1	138		
		4		107	38	Hydrocodone, Oxycodone
	1	2	6	83	7	
			1	66		
	1	1		53		
				51	41	Tramadol, Methadone
7/15/2015		3	8	50	1	Diazepam
	6	12	1	46	10	
		7	6	40	2	
	2	1		38	12	
	1	2		38	12	
	1	2		37	15	
		14	8	36	1	
6/5/2015			3	35	9	
		3	9	35		

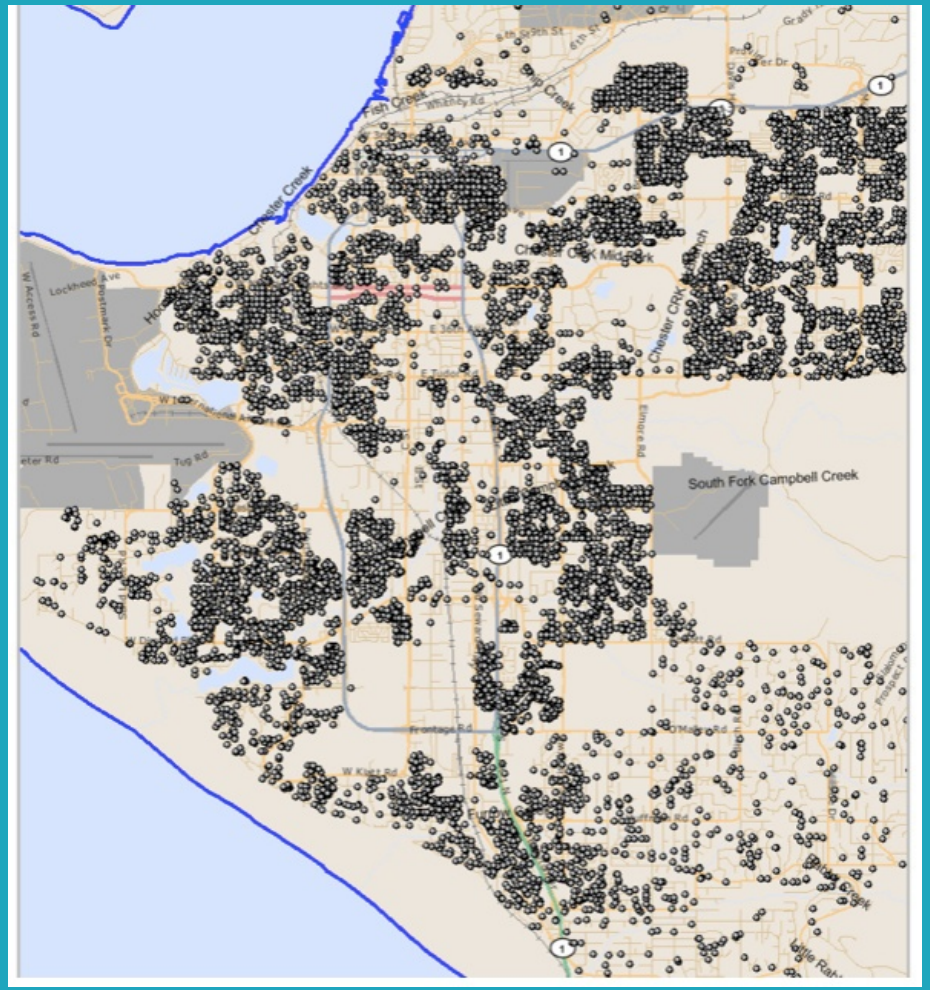
Intervention Where it Makes a Difference

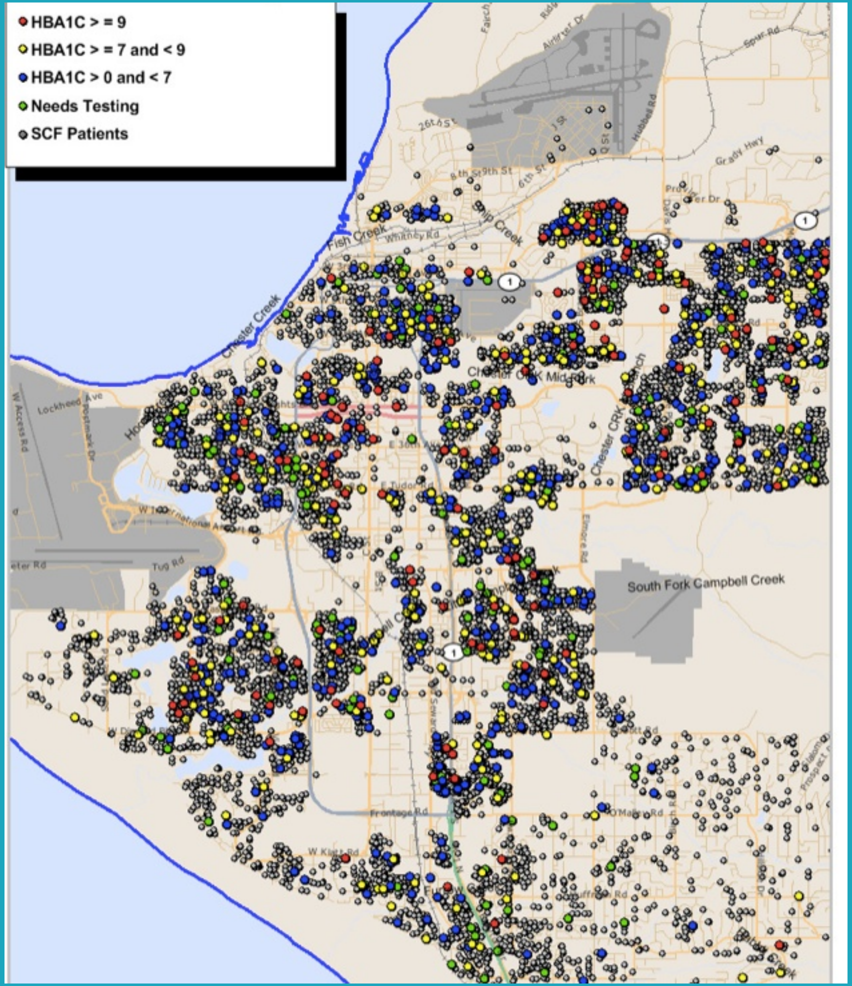
Once you identify an indicator for increased risk or decompensation, create focused efforts around modifying the trajectory.

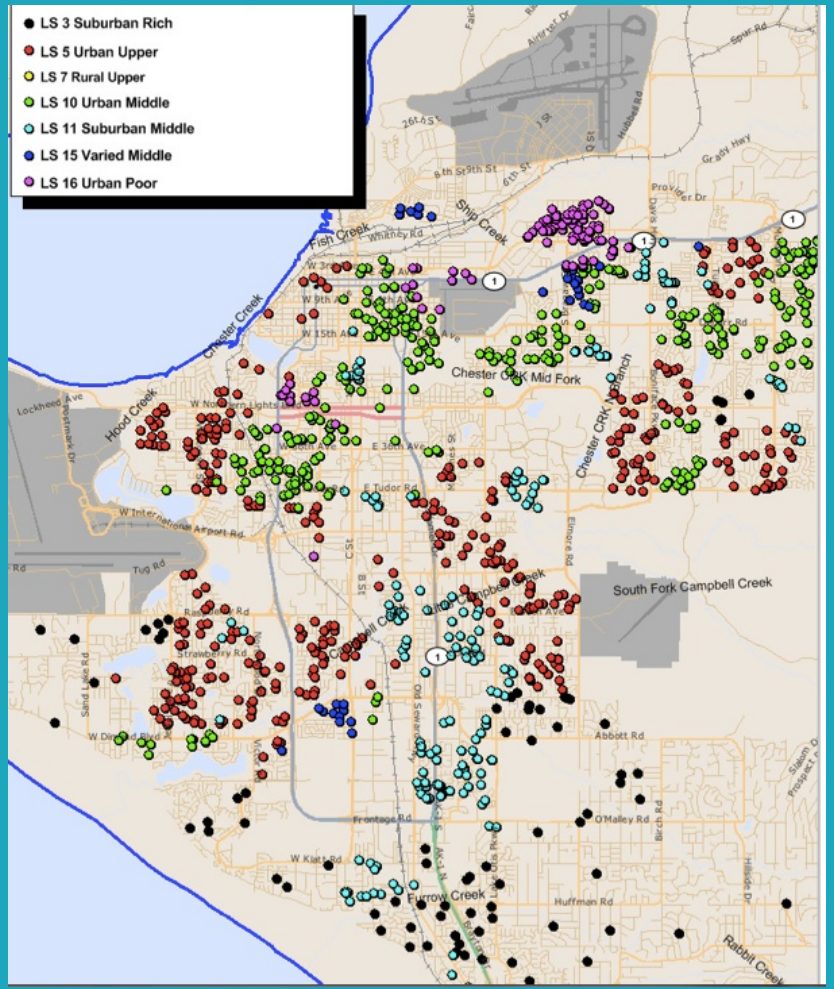
This refines and targets who and why you add a process, with a clear means of tracking impact of that process over time.

Using Targeted Segmentation

- Geographic location, age, gender, condition, visit numbers can offer opportunities for segmentation
- Using labs, medications, procedures or visits that are potential indicators of distress, you can target resources and interventions
- Examples: Nebulizer treatments, blood gas, BNP lab, cardiac enzymes, D-Dimer, admission event, A&E visits, medications like benzodiazepines or narcotics over a certain threshold indicate decompensation


Fish Creek
Chandler Creek
Lockheed Ave
W Access Rd
Tug Rd
Chester Creek Mid-Fork
Chester CRK Branch
Elmore Rd
South Fork Campbell Creek
Frontage Rd
W Klatt Rd
Prospect Rd


HBA1C > = 9
HBA1C > = 7 and < 9
HBA1C > 0 and < 7
Needs Testing
SCF Patients
South Fork Campbell Creek
Chester Creek
Fish Creek
Lockheed Ave
W Access Rd
Tug Rd
Frontage Rd
O'Malley Rd
W Klatt Rd
E Tudor Rd
Grady Hwy
Spur Rd


LS 3 Suburban Rich
LS 5 Urban Upper
LS 7 Rural Upper
LS 10 Urban Middle
LS 11 Suburban Middle
LS 15 Varied Middle
LS 16 Urban Poor
Fish Creek
Ship Creek
Chester Creek
Hood Creek
Chester Creek Mid Fork
Chester CRK West Branch
South Fork Campbell Creek
Furrow Creek
Rabbit Creek
Whitney Rd
Tudor Rd
Abbott Rd
Huffman Rd
O'Malley Rd
Frontage Rd
Tug Rd
Lockheed Ave
Elmore Rd
Birch Rd
Minnesota Dr
Spenard Rd
Glenn Hwy

Questions?

Thank You!

Qaĝaasakung
Aleut

Quyanaa
Alutiiq

Quyanaq
Inupiaq

Awa'ahdah
Eyak

Mahsi'
Gwich’in Athabascan

Igamsiqanaghalek
Siberian Yupik

Háw'aa
Haida

Quyana
Yup’ik

T’oyaxsm
Tsimshian

Gunalchéesh
Tlingit

Tsin'aen
Ahtna Athabascan

Chin’an
Dena’ina Athabascan