



COMPENDIUM



THE NCQA INNOVATION AWARDS 2019

Featuring Quality Accelerators in Health Care



ABOUT THE NCQA INNOVATION AWARD

NCQA encourages health plans to support delivery system redesign and patient engagement initiatives (including digital engagement strategies) that help drive integration and support person centered care.

The NCQA Innovation Awards recognize organizations that implement leading edge strategies to improve quality and value, and showcase these quality accelerators.

➔ **Categories:**

1. Integration of Care
2. Patient and Family Engagement
3. Delivery System Design
4. Use of Technology
5. Customer Experience

➔ **Selection Criteria:**

Winners were selected based on the following criteria.

- Innovation and creativity
- Sustainability
- Scalability
- Impact on intended audience
- Solution is distinct from existing approaches
- Quantitative data show results/impact
- Potential for cost impact
- Potential for quality impact
- Added value for payer/provider/patient

WINNER

PROJECT TITLE:

No Place Like Home: Surgical Home Recovery

Organization:

Kaiser Permanente Northern California (KPNC)

Award Category:

Delivery System Design

Project Contact:

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Project Scope:

The Total Joint Home Recovery (TJHR) and Surgical Home Recovery (SHR) programs are the paths of choice for surgical patients receiving a total joint replacement or other eligible surgeries. To ensure high-quality, patient-centered care, local teams are encouraged to consider overnight stays when warranted for clinical reasons and/or patient preferences.

Multidisciplinary local teams of clinical and operational partners drove program implementation. Teams were encouraged to have subject-matter experts play a role in the patient journey. Regional teams (composed of physician leads and business and analytic consultants from TPMG Consulting Services) enabled cross-pollination of best practices, developed a measurement strategy and partnered with local medical centers to facilitate a regionwide program rollout, to ensure a consistent and seamless patient experience.

The measurement strategy included Tableau dashboards that tracked home recovery progress and balance metrics at each medical center. Control charts allowed teams to identify significant changes, signaling best practices and opportunity areas that required further analyses.

Issue:

KPNC aims to deliver the highest-quality care and enable surgical patients to return to their usual activities as quickly as possible. Despite best efforts to reduce harm, a post-operative hospital stay may contribute to a hospital-acquired infection or delirium. A growing body of evidence suggests that in many cases, patients recover better at home. The hospital environment does not promote a good night's sleep or include familiar and favorite foods, contact with loved ones and control over activities of daily living. Advances in surgical technique, implant technology and improved anesthesia and pain protocols make recovery at home more practical. Eliminating an unnecessary overnight stay in the hospital also improves the affordability of care.

The goal of Home Recovery efforts is to give surgical patients the ability and choice to recover in the comfort of their own home, while ensuring a consistent, high-quality, and patient-centered care experience before, during and after procedures. This goal minimizes hospital-related harm and simultaneously improves access to acute care for patients with greater medical needs.

Solution:

The TJHR and SHR programs built on Kaiser Permanente's work with Early Recovery after Surgery (ERAS) to give eligible patients the opportunity to safely recover from surgery in the comfort of their own home without overnight admission to the hospital. Home recovery efforts began with the TJHR program in 2016 and expanded to additional surgical procedures in 2017 as a part of the SHR program. Both programs are patient centered; care teams work with patients to prepare for surgery and recovery.

Support services (preoperative classes, online tools, early discharge planning, home assessments, home health physical therapy, contact from the surgery team within 24 hours) are appropriate to the patient and the procedure. Medical centers formed specialized teams to standardize care, implemented new surgery protocols and developed proactive rapid-recovery protocols for the Post Anesthesia Care Unit. As TJHR progressed with no increase in adverse effects, home recovery efforts were expanded to selected surgeries through the SHR program.

Solution Description:

The TJHR and SHR programs work with patients throughout the surgical journey. Before surgery, care teams help patients prepare for surgery, ensure access to tobacco cessation and weight management programs and resources and optimize chronic conditions (diabetes, anemia). Patients attend a preoperative class, access online tools, receive early discharge planning and may receive a home assessment to prepare their home for recovery. After surgery, a home health physical therapist visits within 24 hours of discharge for total joints surgeries, and a representative of the surgical team contacts all patients within 24 hours. Patients continue to check in with the surgical team through office, video and phone visits.

Operationally, shifting to home recovery required establishing medical center steering committees, conducting current state assessments, identifying and implementing best practices and monitoring outcome and balance metrics. Medical centers formed multidisciplinary teams that standardized care, implemented new surgery protocols and developed proactive, rapid-recovery protocols for the Post-Anesthesia Care Unit (PACU).

SHR established criteria to identify patients for whom one-night admission was warranted. Home recovery efforts were expanded to surgeries where outcomes for home recovery were consistently as good as or better than hospital recovery. Variation between home recovery and a one-night hospital stay offered an opportunity to achieve greater consistency in care. Surgical specialties identified and shared best practices for home recovery. Surgeons with established procedures for home recovery engaged in peer-to-peer conversations, so colleagues felt confident discharging patients the same day. Home recovery progress rates were tracked and shared with relevant specialties.

Outcome:

The program saw significant success in a short time: 82% of joint patients recovered at home in June 2019, compared with 12% at the start of the program (August 2016). For the expanded group of surgeries, 87% recovered at home in June 2019, compared with 67% in September 2017. Adverse effects were closely monitored and no increase in returns to care (ED visit, readmission, return to OR) were seen at 7 and 30 days, nor were quality issues identified as practices shifted to home recovery across the KPNC region. The TJHR and SHR programs have improved acute care access, affordability and patient experience.

Outcome Details:

An intentional and actionable measurement strategy supported TJHR and SHR efforts as the programs flourished across the region. In 34 months, the average length-of-stay (LOS) for TJHR patients decreased from 1.46 days to 0.59 days. For SHR patients, home recovery increased to 87% in 21 months and LOS decreased from 9.88 hours to 5.71 hours. Most patients now spend 3 to 5 hours in PACU before discharge.

Balancing measures around quality, such as return to care (ED visit, readmission, return to OR) at 7 and 30 days were closely monitored. 30-day return to OR for total joint patients is at 1.3% in 2019—the same as in 2016. For the expanded group of surgeries, 30-day return to OR is at 1.7% in 2019, compared with 2.1% in 2017. The team noted a slight change in 7-day readmission rates for total patients, from 2.6% in 2016 to 1.7% in 2019, while rates for SHR patients were 0.86% in 2019 and 0.79% in 2017 (within normal statistical variation).

Home recovery efforts also led to an improvement in acute care access. In the two programs, 1,000 bed days are saved per month across the region (786 for TJHR, 237 for SHR). This has improved hospital access for patients with greater medical need. Affordability has also improved. A survey across Kaiser Permanente, conducted by the National Total Joint Replacement Initiative, revealed that physicians felt engaged and had a positive perception of the TJHR program. Patient experience and satisfaction remains at the core of home recovery efforts and the programs have high patient satisfaction scores. In a survey of a sample of TJHR patients in October 2018, 92% reported receiving “excellent or very good” care for their surgery. Notably, shorter length of stay (or same-day discharge) is associated with better care experience and patients reporting feeling ready to leave the facility, which is associated with lower 30-day ED readmission, better care experience and satisfaction with results of surgery.

Innovation/Creativity:

1. **Critical Moves Development.** The TJHR initiative brought together a diverse group of hospital, health plan and medical group stakeholders to map an ideal workflow for TJHR, which was later expanded to other procedures within SHR. Drawing on performance improvement principles, sites identified bright spots and opportunity areas, which in turn informed development of 12 critical moves to facilitate home recovery (e.g., pre-operative medical optimization, Patient and Family Engagement, Creating Specialized Surgical and Anesthesia Teams). Each critical move included a rationale, a list of stakeholders and success metrics. A Total Joint Home Recovery Playbook collected critical moves and ideal workflows and was distributed regionwide.
2. **Focus on Patient Experience.** Throughout the redesign process, stakeholders focused on five key questions driving patient experience:
 1. Can I manage my osteoarthritis?
 2. Is surgery right for me?
 3. How can I prepare for surgery?
 4. What can I expect on the day of surgery?
 5. What does recovery look like?

By emphasizing a seamless and consistent patient experience throughout the development and communication of home recovery programs, care teams and other stakeholders ensured that the goals of patient choice and patient safety remained central.

3. **Measurement Strategy.** Measurement strategy was a key component of both programs. They developed highly visible analytics and dashboards to track home recovery progress at each medical center, including same day discharge, next day discharge before 11am and return to care rates (OR, ED, Readmission). Medical centers were engaged in metrics development, are accountable for progress and are encouraged to share information and visit high-performing sites. All KPNC surgical sites have implemented a consistent home recovery workflow.
4. **Spread.** With executive leadership support, bright spots for TJHR spread to all sites and TJHR lessons were leveraged to support home recovery for other specialties and procedures. Surgeon champions who had an established home recovery practice shared their best practices, which were readily adopted by peers. Providing the time and space for surgeons to discuss successful strategies for home recovery and address concerns was key to the rapid spread across medical centers. Communication and alignment with all members of the care team was also critical for consistent messaging to patients and families.

Partners: Partnerships among Kaiser Permanente teams are integral to the success of SHR. Leaders at The Permanente Medical Group, Kaiser Foundation Hospitals and Kaiser Foundation Health Plan provided strategic direction and oversight. Leaders, providers and administrators (in OR, surgical specialties, anesthesia, hospital operations, hospital-based specialists, rehabilitation, adult and family medicine, perioperative medicine, nursing, scheduling, pharmacy and patient education) worked with patients and families to create a successful program. A special thank-you to Kaiser Permanente's National Total Joint Replacement Initiative, for guiding the spread of a patient-centered, national, total joints program that provides consistent care and maintains and improves value for patients, staff and Kaiser Permanente.

WINNER

PROJECT TITLE:

Leveraging Disparities Data to Impact Member Behavior and Provider Practice Patterns

Organization:

WellCare Health Plans, Inc.

Award Category:

Integration of Care

Project Contact:

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Project Scope:

This project is being implemented for all Medicare and Medicaid populations. Its objectives were to create meaningful reporting tools to identify disparities based on member-level data and to use that data to create tailored interventions. The budget was cost-effective because the program was led by a team of three associates: a senior manager of quality improvement, a statistician and a quality program development manager. The technical costs include Tableau licensing, SAS coding programs and server space to accommodate data processing.

Issue:

Health care disparities in Medicaid and Medicare Populations and the persistent vulnerability experienced by these populations.

Issue Description:

As a managed care organization, WellCare is responsible for advancing the health and well-being of vulnerable populations that are experiencing exacerbated health disparities in both access and outcomes. Disparity is a significant focus as we seek to reduce gaps across indicators such as race, gender and geographic location. Programs must consider disparities experienced beyond public health and community-surveillance data. The standard approach is to highlight a particular set of measures known for significant disparities (e.g., low birth weight, diabetes care, mental health care). This creates an intensified focus that allows unidentified disparities.

Solution:

Create an enterprisewide, actionable disparities dataset at the macro- and micro-levels, using nationally recognized quality improvement performance measures (HEDIS®), partnered with a comprehensive disparities program to continuously address opportunities.

Solution Description:

WellCare implemented a comprehensive program that includes an interdisciplinary disparities workgroup, a governance structure and a reporting suite. The program analyzes HEDIS data to identify actionable disparities. Disparities are presented at macro- and micro-levels for utilization by each local quality improvement team and to providers during quality discussions. The reporting suite includes year-over-year comparison dashboards, heat-mapping dashboards and data visualizations. The workgroup regularly convenes to review data at an enterprise level to identify opportunities, develop interventions and implement initiatives.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Outcome:

WellCare implemented a reporting suite that included multiple indicators of disparity for use of data to break down biases and cultural expectations about member behavior and provider practice patterns through tailored, culturally relevant interventions. The program included a governance workgroup and evaluation methodology to provide guidance in identifying opportunities and developing interventions.

Outcome Details:

The program enabled WellCare to achieve significant outcomes for targeted populations and to expand the perspective about which measures are indicators of disparity. There has been demonstrated success on a variety of measures. In one state, the disparity gap between compliance rates of men and women closed for the HEDIS measure Diabetes Monitoring for People With Diabetes and Schizophrenia: The rate for men showed more than an 11.9 point year-over-year improvement and an overall positive improvement of 8.22% year-over-year.

In a second state, WellCare reduced a racial disparity gap between White, Asian and African American communities for Imaging for Lower Back Pain compliance and exceeded the NCQA 75th Percentile on the overall rate.

In a third state, geographic disparities between rural and urban areas for Appropriate Testing for Children With Pharyngitis were reduced and the NCQA 50th Percentile for the overall rate was exceeded. Disparity-informed initiatives and targeting provided outreach to vulnerable populations to promote positive health outcomes and support providers in provision of equitable care.

Innovation/Creativity:

The project's core innovation was a model for analysis of disparities across all HEDIS performance metrics that included indicators such as race, ethnicity, gender and geographic location. Analytic capabilities were advanced because the program encompasses all membership and the full performance measure set as part of the standing programmatic approach. Additionally, methods for obtaining data to ensure relevant demographics and statistically significant conclusions involved innovative approaches to incorporating disparate data sources into one core system for processing.

HONORABLE MENTION

PROJECT TITLE:

Transition to Home

Organization:

Arnot Ogden Medical Center

Award Category:

Integration of Care

Project Contact:

Pallavi Kamjula, M.D., Chair, Department of Medicine, Arnot Ogden Medical Center

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Project Scope:

The objectives of the program are:

- Follow up with patients within one week after discharge to home. Ensure that patients have follow-up visits with primary and specialty care and transportation to get to appointments.
- Post-discharge medication management: Ensure that patients have access to medications and are familiar with medications and competent at taking them.
- Ensure that patients know signs and symptoms of decompensation, and know whom to call.
- Assess the home environment to address barriers to staying healthy and connect patients to community resources if needed.
- Treat any acute illness in the home, at no cost to the patient.

The program was implemented through a DSRIP grant with an initial budgetary proposal of \$165,550 that included the transitional case manager's salary, supplies and equipment, IT system, marketing, training and education, and travel and administrative costs. The pharmacist and the embedded case manager are provided through DSRIP grants and from Geroulds' pharmacy and Family Health Services. Home visits were restricted to NY state patients because resident physicians did not have licenses to practice in Pennsylvania.

Issue:

The hospital, located in Chemung County, NY, was ranked 57th (out of 62) for health care outcomes by Common Ground Health statistics. The patient population lacks health care literacy, is noncompliant with treatment, depends on food pantries as the main source of nutrition and uses the ED as primary care. These issues are compounded by an increased prevalence of mental health disorders and chronic medical conditions that result in a high percentage of readmissions, for which the hospital was penalized 3% (the maximum) by CMS. In addition, poor care coordination contributes to failures in transmitting critical patient information, adverse drug interactions, conflicting treatment plans and/or lapses in necessary treatment.

Issue Description:

Although community resources are available through DSRIP, there is a lack of interoperability and the hospital system and community do not communicate or collaborate on patient care. This “silo” mentality presents several major obstacles to health care reform. From encouraging episodic care, rather than holistic and well-care management, to preventing provider collaboration through inefficiencies in use of EHRs, silo-based barriers slow progress to achieving cost and quality goals of the Triple Aim.

Solution:

Arnot Ogden Medical Center trialed a one-year pilot—Transition to Home—that focused on patients with congestive heart failure, COPD, acute myocardial infarction, pneumonia, total hip and knee arthroplasty and CABG, with an intent to decrease cost and readmission rates while increasing patient satisfaction. The pilot team included a physician champion, a transitional care manager, internal/family medicine residents, CHF and COPD coordinators and a pharmacist.

The program’s objectives are to ensure that patients are comfortable transitioning from hospital to home; that patients can manage medication; that patients are connected with community resources if needed; and that acute illnesses are treated in the patient’s home, instead of hospitalization, at no cost to them. When a patient is identified with a listed diagnosis or has had four or more inpatient admissions within the last 12 months, the transitional care manager and the resident introduce the patient to Transition to Home before discharge and schedule a home visit within a week post-discharge.

Solution Description:

When a patient is identified with a listed diagnosis or has had four or more inpatient admissions within 12 months, the multidisciplinary team receives an automated alert email. Before the patient is discharged from the hospital, the transitional care manager and the resident introduce them to the Transition to Home program and schedule a home visit within the week.

If a patient in the program is readmitted to the hospital, the team discusses the patient in a morning huddle to identify and address barriers and process failures that contributed to the readmission. Patients who are readmitted despite multifaceted interventions are discussed with the provider to create possible ED care plans for preventing future readmissions.

The pharmacist identifies patients who qualify for the “Meds to Beds” program: medication reconciliation and a week of medications prescribed to the patient at discharge. This program also provides weekly outpatient follow-up to ensure patient compliance and comprehension of the effects of the medications provided. The Family Health Services case manager assesses patients’ needs in the community and connects them to mental health counseling, case management, housing, transportation, drug and alcohol rehabilitation and peer support.

Outcome:

Transition to Home has 218 participants within a 5-mile radius of the hospital; their average age is 73 years. The cost of health care before the program totaled approximately \$2.3 million. This decreased to around \$803,000 after the program was in place—a 66% decrease in cost of care. In May 2019, the program showed a decrease of 80% in cost. Readmission rates also decreased by 42% in 2018 and by 80% in 2019.

Outcome Details:

Outcomes were measured by calculating cost for health care 90 days pre-intervention, compared with costs 90 days post-intervention. 2018 charges for this population totaled \$2.3 million pre-intervention and \$803,000 post-intervention. This reflects a 66% decrease in cost of care. 30-day readmissions for this patient population decreased by 42%.

Innovation/Creativity:

The program helped achieve the quadruple aim of improving the health of populations, enhancing the experience of care for individuals, reducing the per capita cost of health care and attaining provider satisfaction. It helped the health care system focus on holistic approaches that required open exchange of information and shared accountability.

Shifting to a holistic health care system dissolved operational silos inherent to episodic care and supported higher-quality, collaborative care. The movement to higher-quality care standards and decreased cost depends on a shift to holistic care. This program prepares organizations to deliver health care in a model that is cost effective and holistic, rather than fragmented and episodic.

Partners:

Geroulds Pharmacy Family Health Services

OTHER 2019 SUBMISSIONS

Transformative changes are taking place in health care. Coordination and alignment across the continuum of care delivery is leading to innovative approaches and partnerships among health plans, providers, patients and families. Health care organizations are striving to provide high-quality, patient-centered care that is coordinated, effective, efficient and equitable.

The NCQA Innovation Award—Featuring Quality Accelerators in Health Care recognizes organizations that implement leading-edge strategies to improve quality and value.

In this, the award's inaugural year, 38 organizations shared their original and creative approaches to patient-centered health care. Two were chosen for top honors; one received honorable mention. But NCQA feels that it's important to recognize the work of all organizations that applied for the award. Their applications are a testament to the caliber and intensity of the competition.

Health plan professionals are encouraged to review this compendium, to identify best practices and lessons learned and to recognize peer organizations leading transformational quality improvement. Continued innovation among thought leaders is crucial in the rapidly changing health care environment.

The following content is developed from application submissions and has been edited.

PROJECT TITLE:

Increasing Medical Record Retrieval through Interoperability

Organization:

AIDS Healthcare Foundation

Category:

Use of Technology

Issue:

Retrieval of medical record documentation is time-consuming, costly and burdensome for both health plans and providers, particularly PCPs. More efficient and accurate processes are needed in order to pass measures, meet time frames and reduce complaints.

Solution:

Electronic medical record retrieval reduced costs by more than half, leveraging technology from HEDIS-Certified vendor, Advantmed, and its subcontracted vendor, HalfPenny.

Outcomes:

- Costs were reduced from \$15 to \$6 per record.
- No providers were contacted for medical records.
- No record-related complaints reported; 10 reported in the previous year.
- All EHR records were retrieved successfully.

Innovation/Creativity:

Greater interoperability, save money, remove PCP burden.

Partners:

Advantmed; HalfPenny; AHF IT—Vincent Chu

PROJECT TITLE:

Alabama Select Network Integrated Care Network

Organization:

Alabama Select Network

Category:

Integration of Care

Issue:

Fragmentation and cost inefficiency in Alabama’s Long-Term Services and Supports (LTSS) system affects quality of life for its 23,000 recipients, as well as the financial stability of a program that is expected to double in volume by 2040. Both beneficiaries and providers lacked knowledge about Home and Community Based Services options for care, which have a significantly lower annual cost (\$10,642 per recipient vs. \$60,000 for nursing home care).

Solution:

Alabama Medicaid Agency, in conjunction with the Centers for Medicaid & Medicare Services, contracted with the Alabama Select Network to design and establish an integrated care network (ICN), and with the Area Agencies on Aging and Aging Disability Resource Centers, for case management and enrollment. Together, they are implementing a strategy to:

1. Improve education and outreach about LTSS options.
2. Provide comprehensive and integrative case management that drives person-centered planning, enhances quality of life and improves health outcomes.
3. Drive a change in the distribution of Medicaid beneficiaries who are nursing home residents (70%) vs. community-based waiver recipients (30%), with a five-year goal to shift the distribution to 67% vs. 33%.

Outcomes:

Metrics for enrollment for the Elderly & Disabled Waiver and the Alabama Community Transition Waiver programs are tracking progress with the ICN program’s community-based population goals. Between October 2018 and June 2019, the program filled 8,019 of the 9,035 waiver spots. To improve its progress on goals for education and outcomes, the program created an ICN brochure and website, established and streamlined case management processes, hired additional personnel and established a level-2 support center.

Innovation/Creativity:

Alabama Select Network is composed of three entities that would typically compete against each other: Shared Health (a wholly owned subsidiary of BlueCross BlueShield of Tennessee), AlaHealth (a wholly owned subsidiary of BlueCross BlueShield of Alabama) and SeniorSelect Partners (a provider group that operates 52% of nursing facility beds in Alabama). Giving nursing facilities part ownership in the ICN program incentivizes them to support its strategy to shift the distribution of beneficiaries in nursing facilities to home and community-based settings. Each partner brings a unique asset to the relationship, which all partners can leverage for their shared goal.

Partners:

Alabama Select Network (Shared Health, AlaHealth, SeniorSelect Partners; Area Agencies on Aging; Aging and Disability Resource Centers; Alabama Department of Senior Services; Alabama Medicaid Agency).

PROJECT TITLE:

Increase Health Care Interpreters in the Region

Organization:

AllCare Health

Category:

Integration of Care

Issue:

Lack of opportunities for training and certification is the main barrier to satisfying the Latino community's need for more certified medical interpreters.

Solution:

AllCare licensed a biannual 64-hour interpreter training; improved access to certification by offering scholarships and holding oral exams in additional locations; and created opportunities for interpreters by adding a measure for Health Equity to provider contracts, which can be satisfied by having a certified or qualified medical interpreter on staff.

Outcomes:

Increased the number of interpreters in the region from 2 to 112 between 2014 and July 2019. Reduced per-member per-month (PMPM) claims for AllCare's Spanish-speaking population by 28%.

Innovation/Creativity:

AllCare's Health Equity initiatives resulted in the creation of internal committees that represent 51% of the affected communities and incorporation of external accountability into internal operations to increase community involvement.

Partners:

Southern Oregon Health Equity Coalition, Rogue Community Health, Oregon Healthcare Interpreter Council, AllCare Members

PROJECT TITLE:

Integrated Appointment Scheduling Platform

Organization:

Blue Care Tennessee

Category:

Patient and Family Engagement

Issue:

BlueCare Tennessee’s comprehensive member outreach program was challenged by the complex needs and requirements of individual providers, members, and vendors. This resulted in a lengthy appointment scheduling process involving multiple coordination calls.

Solution:

BlueCare introduced a single streamlined appointment scheduling platform where BlueCare Health Navigators can quickly view available appointments while speaking with members during first outreach. This decreased call times and the volume of calls between the health navigator, member and provider office; eliminated the need for follow-up calls and provider office involvement in scheduling appointments; enhanced the scheduling process by generating automated reminders to patients and reporting accurate appointment attendance to BlueCare in real time.

Outcomes:

Under this platform, participation expanded from 20 primary care sites to more than 100 primary care, women’s health and behavioral health sites. It is expected that BlueCross BlueShield of Tennessee will expand participation across lines of business in the next 12 months.

The benefits of this platform were:

- An average 10-minute reduction in call times between members and BlueCare Health Navigators.
- An 18% improvement in closing gaps, compared with traditional outreach calls.
- A 132% increase in scheduled appointments.
- A 6% improvement in EPSDT rates.
- A 20% increase in well child visits for assigned members, compared with the previous year.
- Overall decreased PMPM claims costs, in spite of the increase in well-child visits.
- Increased utilization of transportation services.

Innovation/Creativity:

The platform’s real-time notifications about appointment scheduling and attendance made it possible for BlueCare to discover trends and understand the unique needs of individual practice sites, make site-specific recommendations to adjust appointment inventory and improve member access at the local level.

Partners:

BlueCare, TennCare, provider groups, vendors, members

Contact Information:

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PROJECT TITLE:

High Complexity Case Unit (HCCU)

Organization:

Blue Cross and Blue Shield of Minnesota and Blue Plus

Category:

Integration of Care

Issue:

Traditional complex case management cannot effectively and efficiently address the needs of high-cost health care utilizers who have multiple diagnoses and complications.

Solution:

Develop a new care management team, the “High Complexity Case Unit (HCCU),” a dedicated cross-functional team of clinicians, to provide a deeper level of care management for the highest risk, highest cost and most medically complex members. Members are identified through data and referrals, stratified and engaged directly. The most complex HCCU cases are reviewed weekly by an interdisciplinary group, to identify possible clinical and social determinant drivers and make recommendations to address their needs.

Outcomes:

In 2018, two years into the program, the HCCU produced \$3.5 million in savings.

Innovation/Creativity:

The program is designed to reduce the case load of HCCU case managers, giving them time to delve into a case and determine cost-driver impact, explore member needs and resolve complex and intensive problems.

Partners:

The HCCU team partners include all departments represented at Interdisciplinary Care Team rounds: physical medicine medical directors, behavioral health medical directors, pharmacists, complex case management, quality improvement, medical policy, network management, provider relations.

PROJECT TITLE:

Multi-disciplinary Approach for Opioid Use Disorder: Data, Member, Provider and the Community

Organization:

BlueCare Clinical Improvement

Category:

Patient and Family Engagement

Issue:

In 2017, Tennessee ranked 16th for opioid deaths and 3rd for highest prescriber of opioids. Despite efforts to combat opioid abuse and its negative outcomes, the epidemic persists and continues to evolve.

Solution:

TennCare and the Tennessee Department of Health implemented a multidisciplinary approach to:

- Study data surrounding interventions for Medicaid members, providers and the community.
- Create and distribute opioid educational materials to Medicaid members.
- Develop the Opioid Dashboard, an interactive tool for subpopulation assessment.
- Create an Opioid Task Force, a multidisciplinary team that provides oversight/direction of the strategic plan.

Outcomes:

In 2018, Tennessee saw its first decline in the rate of neonatal abstinence syndrome, a 13.2% decrease in dispensing opioids, a 43% reduction in morphine milligram equivalent dispensing and a 62% reduction in pain clinics. The Opioid Task force engaged over 5,000 Medicaid members with educational materials and referred over 50 members for opioid use disorder in the first quarter of 2019.

Innovation/Creativity:

Developed the Opioid Dashboard to assess the data and population demographics. Incorporated data from the Controlled Substance Monitoring Database data into electronic medical records that will contribute to an opioid-use disorder risk score and drive future interventions. Developed multiple approaches to member outreach, including social media, posts, mailers, interactive calls and a new text platform.

Partner:

Division of TennCare

Contact Information:

Angie Finch

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PROJECT TITLE:

Quality Care Partnership Initiative—Commercial

Organization:

BlueCross BlueShield of Tennessee

Category:

Delivery System Design

Issue:

Organization's lack of value-based programs designed for the commercial population.

Solution:

The Quality Care Partnership Initiative (QCPI), launched in 2015, was designed to improve the clinical quality, patient experience and value of commercial health care by using primary care provider performance on evidence-based quality measures to determine reimbursement for the coming year.

Outcomes:

Twenty-one of 29 incentive measures in the QCPI program had a statistically significant rate higher than the control group rate. Three increased benchmark scores due to the Program. One average, QCPI program scores were 80 out of 100 (4 Stars), compared with 54 out of 100 (2 Stars) for traditional fee for service. The program has grown from 5 PCMH practices in 2015 to 50 individual contracts with over 1,500 providers across all PCMH practices.

Innovation/Creativity:

- Developed the QCPI scorecard and interface with the provider Quality Rewards Portal.
- Mined historical claims data to establish a baseline for member attribution methodology.
- Created a clinical team to support providers and deliver monthly scorecards that identify potential areas of impact.
- Collaborated with QCPI practices to secure exchange of data through points of entry including direct flat files, HL7, CCDA and outside vendors.
- Developed a HEDIS performance-based fee schedule.

PROJECT TITLE:

Critical Incident Management Reporting Timeliness Study

Organization:

BlueCross BlueShield of TN

Category:

Use of Technology

Issue:

BlueCross BlueShield of TN is contractually required to report all critical incidents (abuse, neglect, exploitation, severe injury, unexpected death, medication error and theft) in home and community-based services settings within 24 hours of discovery. In 2016, compliance was 49% due to late submissions by providers and internal staff. Noncompliance negatively affects members' quality of life and exposes the organization to fines and sanctions.

Solution:

Develop and implement processes to improve timeliness and accuracy of reporting critical incidents. Create a Quality of Care Oversight (QOC) department to centralize handling and oversight of concerns, which ultimately resulted in:

- An automated QOC system and streamlined initial notification process. Templates embedded in the intake process eliminate the need for manual entry by feeding critical information directly into the QOC system.
- Implementation of an escalation huddle process to discuss and solve high-profile, high-risk cases.
- Establishment of a weekly interdisciplinary team meeting to discuss current cases.
- An on-call process that provides 24-hour staff availability to respond to time-sensitive reports.
- Analysis of key factors affecting critical incidents.
- Contractual clarification from the State Regulator, updating the initial notification time frame from 24 hours to 24 business hours.
- Creation of provider/staff educational pocket cards containing key information about critical incident types, reporting timelines, contact information and reporting tools.
- A website, ReportItNow, to increase ease and convenience of reporting, provide information about the process and provide access to forms, templates and instructions for submission.
- Training sessions designed to educate providers and internal staff about the new reporting requirements.
- Oversight committees that evaluate and provider feedback to address barriers and opportunities for the future.

Outcomes:

Compliance rates for critical incident reporting increased from 49% to 94.85%.

Innovation/Creativity:

- Identified a key barrier to meeting reporting timelines: Providers did not always have designated staff to process critical incidents.
- Directed solutions toward improving ease of access to reporting tools—providers and internal staff can now report while in the field or in the member's home and have access to information about the critical incident process via the website and informational pocket cards.
- Eliminated manual reporting methods by establishing a single point of contact for reporting incidents verbally, which required network server connections that can exchange data between the customer service system and the QOC system.
- Engaged the provider community by holding numerous webinars, Q&A sessions and town halls and forming member advisory councils.

Contact Information:

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PROJECT TITLE:

Development of an Integrated Wound Care Center Within a Regional Mixed Model HMO

Organization:

Capital Health Plan

Category:

Integration of Care

Issue:

In 2010, analysis of claims data identified an increasing trend of outpatient hyperbaric oxygen treatments costing \$1.43 PMPM for the Medicare population. Retrospective review of patient medical records revealed many patients in the same population had received long-term treatment for chronic wounds without complete healing, often resulting in amputation.

Solution:

Develop and implement an integrated, nurse-managed Wound Care Center that is embedded in the Physician Group of Capital Health Plan (CHP), a regional, mixed model HMO located in the panhandle of Florida. An embedded Wound Care Center was started as a pilot project during 2011. The Center was originally staffed with an enterostomal therapist and a physician assistant with experience in treating wounds. CHP patients were initially accepted on a referral basis. In 2013 two additional experienced wound care nurses were hired and the center was opened to the entire physician network.

Outcomes:

Significantly reduced overutilization of hospital-based outpatient hyperbaric oxygen treatments, decreasing the cost from \$1.43 to \$0.33 PMPM over an 8-year period. There were 8,000 visits during 2018, where patients were successfully managed utilizing a patient-centered approach to providing care. Treatment is specific to individual patients.

Innovation/Creativity:

Created a Wound Care Center within a health plan, staffed by experienced nurses with support from a plastic surgeon, who regularly evaluates patients. Nurses design specific dressing techniques to unload the patient's weight from the wound. Patients are seen several times a week initially; visits are spaced further apart as the wound heals. Patient-centered, outcome-driven processes are behind the center's success.

Partner:

A local plastic surgeon with an interest in treating nonhealing wounds.

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PROJECT TITLE:

Implementing Bidirectional Data Exchange to Improve Adolescent Depression Screening and Follow-Up Rates

Organization:

CenCal Health

Category:

Use of Technology

Issue:

Because many mental health diagnoses are stigmatized, depression data may be underreported by PCPs within CenCal Health's provider network. Even when PCPs identify and diagnose youths with depression, the rate of referral to a mental health provider is significantly low. Identifying barriers to detection and treatment of depression in youth in a primary health care setting requires that health plans obtain data related to youth screenings and their outcomes, whether timely follow-up care was provided and whether that care was appropriate.

Solution:

Partnered with two large provider practices to establish a two-way data feed through the plan's secure file transfer portal, which is loaded to CenCal Health's data warehouse monthly through a secure file transfer portal. CenCal Health's Quality Measurement and IT staff consolidated data files and mapped all data elements to a single table in the data warehouse to ease the interface with CenCal Health's HEDIS vendor software. Collaborated with providers to refine office workflow to more reliably conduct periodic depression screenings and ensure appropriate and timely follow-up to positive screenings; data that was reliably captured in the EMR extracts. Information that was not possible without EMR data provided clinical insight that PCPs otherwise did not have.

Outcomes:

On a plan level, for ages 12–17, CenCal Health's screening rate was 10.02% for HEDIS 2019, an almost 6 percentage point increase over HEDIS 2018. By the end of HEDIS 2019 (MY 2018), the depression screening rate for one participating practice had climbed to 67.45% for adolescents 12–17, a 44 percentage point increase from HEDIS 2018 (MY 2017). For HEDIS 2019, the practice achieved a depression follow-up submeasure rate of 30.00%, an almost 7 percentage point increase from the HEDIS 2018 rate of 23.53%. The practice is considered a model provider that has achieved an extraordinary rate of routine depression screening.

Innovation/Creativity:

Defined a new framework to measure, report and improve patient-centered care that relied on data from EMR systems and CenCal Health's use of technology to establish bidirectional data feeds and share information with PCPs. EMR data feeds enabled new and innovative collection, integration and reporting of reliable and consistent information to PCPs. As providers were given more information from CenCal Health on their progress, and insight to understand their depression screening and follow-up practices, they were better able to reliably refer patients to appropriate resources.

Partner:

PMG, the provider office that was the main steward to promote depression screening and follow-up; a multispecialty clinic that provided data extracts; a community-based organization that helped improve collaborative care; internal employees at CenCal Health who were involved to improve data governance, reliability and accuracy of the EMR data through regular validation and clean-up.

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PROJECT TITLE:

“Know More: HPV” —Addressing vaccination rate disparity with a digital, in-office patient intervention

Organization:

CenCal Health

Category:

Use of Technology

Issue:

Healthy People 2020 and the American Cancer Society set a goal to achieve 80% HPV vaccination for males and females by 2020 and 2026. CenCal Health, the Medicaid health plan serving Santa Barbara and San Luis Obispo Counties in California, achieved only a 38.36% HPV vaccination rate in Santa Barbara County in 2016. CenCal Health identified a significant geographic health disparity: north Santa Barbara County had an HPV vaccination rate of 48.72%; the south Santa Barbara County rate was 31.03%.

Solution:

CenCal Health approached a high-volume, low-performing provider in south Santa Barbara County—Santa Barbara Neighborhood Clinics (SBNC)—for an HPV vaccination improvement pilot. They determined that an innovative approach to HPV patient education, including a call to action, would be the best way to improve HPV vaccination rates. CenCal Health developed a digital, interactive, tablet-based educational program, “Know More: HPV,” to educate parents/guardians on the importance of vaccination when a child is already at the provider’s office.

Outcomes:

The program’s SMART (Specific, Measurable, Attainable, Relevant, Timely) goal was to increase the rate of CenCal Health members assigned to SBNC who have completed HPV vaccination by their 13th birthday, from a baseline of 19.05% to 48.72% by December 31, 2019. As of July, the HPV vaccination rate at SBNC is 40.9% and is projected to reach 55.53% by December.

Innovation/Creativity:

A digital educational program given directly to parents via tablet, in the clinic setting where the child is already present, is not a widely used strategy to improve HPV vaccination. CenCal determined that there was very little available that was appropriate for their target audience (Spanish-speaking), and created its own program. Implementation of the “Know More: HPV” program also gives health care providers a creative starting point for having a conversation with vaccine-hesitant parents. The program additionally increases clinic workflow efficiency regarding HPV education for parents who are unaware of the HPV vaccine.

Partners:

SBNC and The American Cancer Society.

PROJECT TITLE:

Improving Adolescent Depression Screening and Follow-Up Rates within the Primary Care Setting

Organization:

CenCal Health

Category:

Delivery System Design

Issue:

The rate of completed referrals from primary health care practices to mental health providers for adolescents is significantly lower than to other specialists. Encouraging physicians, particularly pediatricians, to regularly screen adolescents for depression allows timely and effective management of depression and prevents development of negative outcomes. In 2018, CenCal Health began monitoring the NCQA Depression Screening and Follow-Up measure as a requirement of all Medi-Cal plans by the California Department of Health Care Services. CenCal HEDIS 2018 Depression Screening and Follow-Up rates for adolescents were 4.18% for screening and 36% for follow-up. Analysis indicated that rates were artificially low due to insufficient service reporting.

Solution:

CenCal partnered with a high-volume pediatric office, Pediatric Medical Group of Santa Maria (PMG), to implement a pilot project to increase adolescent depression screening and management that implemented interventions to improve rates: provider education on CenCal Health-recommended depression screening tools, EMR data extracts from providers, coordination of the referral process with CenCal Health's Managed Behavioral Health Organization.

Outcomes:

PMG's HEDIS 2018 adolescent depression screening rate was 23.49%. For patients that screened positive and completed follow-up within 30 days, the rate was 23.53%. Through CenCal Health's partnership, provider engagement and process improvements, PMG's HEDIS 2019 adolescent depression screening rates increased to 67.45% and follow-up rates increased to 30%.

Innovation/Creativity:

CenCal Health partnered with its largest pediatric office to use screening tools to increase depression screening rates and ensure that follow-up is completed for patients who screened positive.

Partners:

National Collaborative for Innovation in Quality, AHRQ/CMS, Family Service Agency (FSA)

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PROJECT TITLE:

Integration of Medi-Cal Managed Care Quality Workforce in the local healthcare system: Kinetic Quality Improvement (QI) External Program

Organization:

Central California Alliance for Health

Category:

Delivery System Design

Issue:

The primary care clinics in Central California Alliance for Health’s provider network experienced a 53% increase in Medi-Cal members with the Affordable Care Act. Along with provider staff shortage/burnout and new Medicaid regulations, it was difficult to scale/improve processes to meet demand. This resulted in flat/worsening quality measure trends for preventive screenings and access for Medi-Cal members. Providers indicated that their top challenges included staff recruitment/ retention, patient engagement/education and IT/IS systems and operational processes.

Solution:

To build quality improvement capacity in its primary care clinics, a Kinetic QI external program was developed. Health plan QI staff integrated into the clinic workforce by providing Practice Coaching and Learning Collaboratives, and by developing a Practice Transformation Academy to improve outcomes in preventive measures. Practice coaching was piloted at one clinic site in April 2018 by having health plan QI staff onsite for 1–2 days/week. Learning collaboratives were hosted by the health plan to share best practices through interactive face-to-face meetings with other change agents from the health care system (e.g., clinics, hospitals, pharmacists). A Practice Transformation Academy trained clinic staff on clinical process improvement.

Outcomes:

The Kinetic QI External Program includes nine clinics engaged in practice coaching and six completed learning collaboratives. The Practice Transformation Academy is in development. At the pilot site, a Quality Dashboard was developed to track quality measures. Childhood immunization rates improved from 50.33% (September 2018) to 64.8% (May 2019).

Innovation/Creativity:

The health plan and the clinic partnered to make improvements. Health plan QI staff were onsite 1–2 days a week to work on improvement activities. They were considered part of the clinic workforce and as an immediate, helpful resource that could align the goals of the health plan and the clinic.

PROJECT TITLE:

Increasing the Diabetic Retinal Examination Rate for Medicaid Enrollees in Six Target Cities

Organization:

Community Care Plan

Category:

Use of Technology

Issue:

Six cities in Community Care Plan’s Medicaid contract area were under-performing for annual eye examination in diabetics. The overall eye examination rate was 43.12%; the six cities were performing at 37.9%. Issues were incomplete referrals to vision providers; visits completed for glasses/contacts, but no retinal exam completed; enrollees did not feel they needed to see another doctor; enrollees did not know about/use free transportation; and referrals were not issued or followed up on.

Solution:

A retinal camera was placed in the clinics on a rotating basis, so a retinal photograph could be captured during the routine diabetic follow-up visit with the primary care physician. The offices scheduled enrollees to come in for “diabetic days” if they did not have a scheduled follow-up date for the time the camera was in that clinic. The health plan also scheduled two diabetic days at its offices, which included education, eye examinations and diabetic labs. Free transportation was provided, as well.

Outcomes:

A standard PDSA (Plan-Do-Study-Act) format was utilized to monitor three interventions: outreach calls to enrollees, eye provider education regarding the annual need for a retinal examination and placing a retinal camera in the primary care clinics. Measurement rates increased from 37.9% to 58.0%.

Innovation/Creativity:

Placing a retinal camera in the primary care clinic for an eye examination became a routine part of enrollees’ diabetic monitoring.

Partner:

20/20 Vision and Medicaid primary care clinics in South Broward county.

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PROJECT TITLE:

Interactive NCQA Risk Dashboard

Organization:

Excellus BCBS

Category:

Use of Technology

Issue:

Excellus BCBS's Accreditation department had no comprehensive method for displaying and accessing high-level accreditation status and granular progress notes. The Accreditation Team relied largely on providing static risk reports in an Excel file. Although reports contained information on specific standards, barriers, actions and risk status, they were difficult to manage cohesively. The Accreditation department realized that the organization needed an accessible, one-page tool for assessing and monitoring accreditation standard risk. The tool would be used for presentations, understanding individual standards and strategic planning.

Solution:

The Accreditation team created an interactive Tableau dashboard that contained high-level and granular information on the current accreditation cycle, is accessible to anyone in the company and provides a "self-service" tool for NCQA standard stakeholders. The tool emphasized standards at risk, highlighting the level of risk, barriers, resource needs, plan of correction and progress notes. The primary visual of the dashboard is a dynamic scatter plot displaying all standards at high, medium and low risk. Users can hover over each mark to see detailed information that includes the plan of correction, progress notes and expected completion date.

Outcomes:

The NCQA risk dashboard is used to report status during monthly NCQA stakeholder meetings, Quality Oversight Committees and Accreditation readiness meetings. NCQA stakeholders can easily access updates related to requirements. The dashboard has proven useful in highlighting the standards that require the most focus, funding and attention from senior leaders. Excellus BCBS is currently transitioning from Tableau to Microsoft PowerBI.

Innovation/Creativity:

The dashboard was created to be visually appealing and to use consistent color schemes and size coding. The scatter chart required innovative use of numerous variables correlating with the size, shape, color and position of the mark. The final variable included in the "barrier grade" calculation was deemed the "Accreditation Director Variable": a wild-card value that the Accreditation Director could manually enter. Sometimes barriers are driven by intangible factors!

PROJECT TITLE:

Predictive Analytics to Drive an Improved Customer Experience: Predicting Negative CAHPS® Responders

Organization:

Excellus Health Plan, Inc.

Category:

Customer Experience

Issue:

The CAHPS Health Plan Survey 5.0 is the national standard for measuring and reporting on nearly every aspect of the health-care consumers' experience and is conducted in almost every State in the U.S. However, due to its lack of member-level data, health plans are faced with two significant challenges: plans do not know why a member responded positively or negatively and therefore cannot use the feedback to improve plan/provider perception; plans do not know who will be surveyed next year and whether these members have similar issues. CAHPS performance factors into nearly every quality rating program—some that have significant incentive dollars tied to performance—so it was critical that Excellus Health Plan, Inc. resolve this issue.

Solution:

Excellus fielded a CAHPS-like survey to enable the use of predictive analytic techniques to profile and predict members at the highest risk of reporting a negative experience with the health plan, its network of providers and while accessing care. The survey's additional drill-down questions identified key pain points/opportunities to improve member experience. Excellus could then profile a negative responder across four domains of experience (satisfaction with plan, satisfaction with provider, accessing care, ability to schedule specialist appointment) to identify significant variables that were "predictors" of a negative responder, develop four predictive models (one for each domain) and develop a member engagement strategy targeting members predicted to be at the highest risk of negative responses.

Outcomes:

Excellus aimed for 5,000 responses, to provide 1,000 negative responses necessary to conduct predictive modeling and create four negative responder profiles and predictive models. Excellus also targeted the top 10% of high-risk responders and promoted telemedicine to those members, driving increased registration and utilization of telemedicine. It is currently assessing the impact on CAHPS scores.

Innovation/Creativity:

Developed and deployed a CAHPS-like survey to overcome the limitations (lack of member-level data) of the official CAHPS survey; leveraged a data-driven approach to profile and predict negative CAHPS responders using predictive analytic techniques (predictive modeling); assigned likelihood of negative response risk scores to the entire membership, to identify members at the highest risk of negatively responding. This resulted in a proactive approach to improve member experience and achieve higher CAHPS scores.

Partners:

Analytics & Data Team, Market Research & Insights Team, Document Services Team, Health Care Improvement Leadership (all internal).

PROJECT TITLE:

Healthy Heart, Healthy You

Organization:

Harris Health System

Category:

Integration of Care

Issue:

Harris Health System 2016 data showed that, of empaneled patients with two or more visits in the last 18 months, nearly half have a diagnosis of hypertension. Nearly one-third of these patients are considered to have poor BP control (>140/90). Data highlighted the need for comprehensive, patient-centered care and support of patients living with hypertension, in order to prevent development of long-term medical complications associated with higher health care costs.

Solution:

To address the growing volume of hypertensive patients and associated costs of caring for these patients, Harris implemented the “Healthy Heart, Healthy You” remote BP monitoring program. The program gives patients a Bluetooth-enabled BP monitor, home visits, coaching calls, education, referrals to other service lines, links to community resources and incentives to improve BP control. Through collaboration with physicians and mid-level providers, as well as with an indirect care nursing team, patients with uncontrolled hypertension can be managed between office visits, allowing adjustment of the medication regimen. Patients are also educated on hypertension; the potential consequences of poor control; medication adherence; lifestyle modification; and a low-sodium, balanced diet. Social determinants of health that affect the patient’s ability to be compliant with a plan of care were assessed and addressed.

Outcomes:

The program began in February 2019 and has enrolled 232 patients. The first cohort (February–June) of 50 patients had an average starting BP of 148/86; after four months it was 126/75. Scores for the HEDIS measure Controlling High Blood Pressure improved from 53.29% to 56.59%. Multiple surveys will evaluate the program’s effectiveness, including pre- and post-knowledge surveys, self-efficacy surveys and patient and provider satisfaction scores. Patients will be reassessed at set intervals via telephone for sustainability of BP goals.

Innovation/Creativity:

The program utilized BP self-monitoring, remote BP monitoring and online tracking. Harris partnered with the American Heart Association to provide evidenced based educational materials and resources for patients and to provide education to staff and providers. Incentives were provided to the patients, which encouraged timely tracking of BP readings and reaching BP goals. Harris also partnered with Interfaith Ministries to provide expedited nutritional care for patients, to improve health outcomes and reduce costs for the most vulnerable members of the community.

Partners:

Internal Harris Health System departments, including nutrition department, behavioral health, pharmacy, social services, health educators and diabetes educators. External stakeholders include YMCA and recreational centers; the American Heart Association Check, Change, Control Program; and Interfaith Ministries’ Hospital to Home Program.

PROJECT TITLE:

Pregnancy Concierge Program by Health Plan of Nevada

Organization:

Health Plan of Nevada—UnitedHealthcare

Category:

Customer Experience

Issue:

Health Plan of Nevada (HPN) and Nevada state data indicated that measures regarding pregnancy and childhood vaccines had opportunities for improvement. Some employer groups also noted adverse costs associated with maternity and subsequent NICU admissions related to poorly engaged members. HPN HEDIS data indicated opportunities to increase prenatal/postpartum engagement for women and infant vaccines during the first two years of life. Other areas of interest included breastfeeding rates, Tdap vaccination during pregnancy and education about vaginal vs. cesarean deliveries.

Solution:

The HPN quality improvement department launched a Pregnancy Concierge Program whose intent was to engage key decision makers (women) through a direct connection to offer customized support and trusted, credible medical information when it was needed. HPN also wanted to counter myths about vaccines and pregnancy propagated by social media and bloggers. The concierge team was not expected to be a case management team or generic telephone support service; its mission was to create a genuine bond with members and provide support.

Outcomes:

Members in the program received customized support and education in their preferred method: in person, telephone, text or through the HPN pregnancy app. The Pregnancy Concierge Program gave HPN an opportunity to improve quality measures and engage members in personal, meaningful way. The program also added value to employers who were looking for specific maternity solutions for employees. HPN was able to forge an authentic bond with members and create some longevity in servicing members. Program participant satisfaction ranges from 97%–100%.

Innovation/Creativity:

The team found ways to use the data to push the quality of health care in the Nevada region; for example, tracking Tdap vaccinations during pregnancy. The team noted that overall Tdap vaccine rates for one group was just under 70%. OB offices contracted with HPN were given education on optimal timing of Tdap and where members could get the vaccines if the OB office did not stock it. An intervention based on real-time data can protect these families in the event of a pertussis outbreak.

PROJECT TITLE:

Colorectal Cancer Screening Project—FIT Outreach to Unattributed Members

Organization:

HealthPartners

Category:

Patient and Family Engagement

Issue:

HealthPartners colorectal cancer screening rates had dropped significantly and remained flat. The organization conducted data analysis of members' colorectal screening rates and learned that unattributed members had a much lower rate of colorectal cancer screening than those who have a relationship with a primary care provider.

Solution:

Many clinicians agree that the best screening test is the one the patient will actually complete. However, unattributed members may not hear that message, so we decided to take that information directly to our members and conduct a FIT outreach campaign. HealthPartners identified home testing as a viable option for improving colorectal cancer screenings by offering FIT tests to members in their homes. The target audience for this project is unattributed commercial members and Medicare members with gaps in care for colorectal cancer screening, as defined by HEDIS specifications. The organization defined unattributed members as having no primary care clinic identifiable in claims.

Outcomes:

In 2018, HealthPartners expanded the project to send FIT kits to 30,529 members, which included unattributed commercial and all Medicare members with gaps in care. The overall response rate was 24.1%. Of the 7,365 kits that were completed by members, 841 were positive or inconclusive and required follow-up by the RN team. Of those, there were 4 confirmed cases of colon cancer and many instances of preventing future cancer by removing polyps at a subsequent colonoscopy. The overall screening rate for commercial HEDIS 2019 increased to 78% from 69.2%, which reflects the impact of the expanded FIT outreach project.

Innovation/Creativity:

HealthPartners feels that the focus on unattributed members made this campaign uniquely successful. The organization worked hard to bring care to members at home, with no time off work required or dietary restrictions. Because members are not connected with a primary care provider, the team provided RN outreach to those with a positive result, to help with next steps. The team also created a secure phone line that connected members with an RN. The team tracked these calls to identify the number and the types of questions.

Partners:

Health information vendor, biometric screening vendor, member services, claims, marketing communications, network contracting, privacy and legal experts, care delivery partners (internal).

PROJECT TITLE:

Implementing a Virtual Quality Care Team to Mitigate Patient Risk

Organization:

Kaiser Foundation Hospital and Health Plan Northern California

Category:

Use of Technology

Issue:

40%–50% of hospitals use some form of telehealth.¹ Kaiser Permanente Northern California developed an Advance Alert Monitor predictive model for patients at risk of deterioration in the hospital. Care gaps in patient care were identified during times of varied staffing. To provide 24/7 surveillance, a Virtual Quality Care team prototype was implemented for real-time nursing surveillance. This solution has been implemented in all 21 hospitals in Northern California.

Solution:

The Advance Alert Monitor identifies patients with considerable risk of mortality. The use of the EMR and a predictive analytic model gives a 12-hour lead of a patient's potential for clinical deterioration. This lets the Virtual Quality Care Team provide 24/7 oversight to 2,700 Medical-Surgical and Tele beds. The Virtual Quality RN reviews the EMR of patients with Advance Alert Monitor alerts and communicates with the Rapid Response Team RN.

Outcomes:

Advance Alert Monitor deployment is associated with decreased mortality and total hospital length of stay. Combined with review by the Virtual Quality Care Team and standardized hospital workflows, it represents a systematic approach to reducing mortality for an at-risk population. Proactive reporting of at-risk patients has resulted in absolute reduction in inpatient mortality ~20% for Advance Alert Monitor cases vs. Advance Alert Monitor controls and Absolute reduction in 30-day mortality ~14% for Advance Alert Monitor cases vs. Advance Alert Monitor controls. Identification of care gaps by the Virtual Quality Care Team has enabled real-time performance improvement and mitigated risk.

Innovation/Creativity:

Support from senior leadership and staff funding was essential, as was appointing a medical director and nursing director to facilitate discussions with key stakeholders. The EMR enabled a predictive analytic model to be integrated into the dashboard for remote staff, to determine which patients were at the highest risk of deterioration. Establishing a communication reporting structure for each hospital requires ongoing dialogue and regular touchpoints. Regular reporting on outcomes and opportunities for improvement ensures that all stakeholders are informed and aware of potential increases in RN staffing or areas of risk that need attention. A process for interrater reliability and ongoing competency evaluation of the RN staff is essential to the success of the entire virtual team.

Reference:

Tuckons RV, Edmunds M, Hodgkins ML. Special Report: Telehealth. *New England Journal of Medicine*, 2017: 377(16) 1585-1592

PROJECT TITLE:

Kaiser Permanente National Quality Conference: Activating Patient Partners to Accelerate Learning and Spread

Organization:

Kaiser Permanente

Category:

Patient and Family Engagement

Issue:

Kaiser Permanente activated an inter-regional network of “patient partners” to accelerate learning and spread evidence-based practices, empower diverse stakeholders to become “Quality Advocates” and change the dialogue from “what’s the matter with you” to “what matters to you,” to improve the health of 12.3+ million members and uplift communities served. KP must readily translate “knowing” into “doing.” A leading strategy to bridge this gap and shepherd progress is to create inclusive and psychologically safe collaboration forums. Opportunities must engage patient partners end-to-end and keep in the forefront, the patient advocacy adage: “Nothing about me, without me.”

Solution:

KP executive leadership commissioned the National Quality Conference (NQC). The 2019 NQC encouraged multidisciplinary contributions across interdependent content tracks: Quality; Affordability; Joy in the Workplace; and Tools. In Patient and Family Engagement, patient partners were collaborators and contributors from early engagement on the planning committee, to submitting and prioritizing program elements, to delivering onsite content. To harness the distributed expertise and experience of those who provide care and those who receive it, content and objective prioritization was sourced from a distributed network of contributors.

Outcomes:

KP facilitated focus groups (e.g., patient partners, key stakeholders) to collect input and translate it into meaningful insight. Key outcomes included:

- Crowdsourcing for Efficacy, Sustainability, and Scalability.
- Enabling Multidisciplinary Collaboration.
- Closing “Knowing-Doing” Gap.
- Empowering Participants as “Quality Advocates.”
- Encouraging Bidirectional Learning.
- Engaging Patient Partners End-to-End.

Innovation/Creativity:

Patient partners served on the planning committee; submitted abstracts for consideration; prioritized sessions using criteria-based methodology; delivered plenary, breakout and working session content; were positioned as “equals” alongside senior executives, board members and clinicians; served in post-conference focus groups and agreed to contribute to 2020 planning and cascade information to other patient partners.

Interdisciplinary contributors and patient partners submitted abstracts across interdependent content tracks of Quality, Affordability, Joy in Workplace and Tools. This approach yielded 195 scientific abstract submissions for consideration, including direct submission from a distributed network of patient partners. To create a sustainable and scalable approach to prioritization: a criteria-based scoring methodology and tool was developed and implemented, and a diverse network of 120 abstract reviewers was recruited, including patient partners and other interdisciplinary subject matter experts. Breakout and working sessions represented the highest-rated abstracts on the grounds of impact, transferability, inclusion, measurability and audience engagement.

PROJECT TITLE:

MAPSS—Mentoring And Peer Support System

Organization:

Kaiser Permanente

Category:

Patient and Family Engagement

Issue:

Facing a life-threatening illness, chronic condition or health care journey such as cancer can be scary and emotionally isolating. Peer support can decrease stress and anxiety and improve understanding of next steps and confidence in shared decision making. Three Kaiser Permanente members—breast cancer survivors—established a peer support and mentoring program for newly diagnosed patients at their local KP medical center in Oakland, CA. They envisioned expanding it to offer peer support and mentoring for variety of conditions throughout the entire KP health care system.

Solution:

In 2012 the members teamed with the director of the Breast Care Center Director to write a business plan to establish a peer support and mentoring program for breast cancer patients. After this program was launched, Dexter Borrowman, Kaiser Permanente director of National Service Quality, created a comprehensive, adaptable framework to support and launch peer support and mentoring programs for any medical condition or health journey throughout the entire KP health care system.

Outcomes:

KP now has over a dozen peer support and mentor programs across the U.S. in half of its regions, and other KP medical centers are starting programs for cancer (various forms), transgender care, rehabilitation, chronic kidney disease and so on. Dexter Borrowman developed online resources and on-demand consultation sessions for medical centers interested in starting such a program. She also facilitates a virtual community of practice that provides seasoned peer support and mentor programs to interact and engage with newly launched sites.

Innovation/Creativity:

No other health care system has such an interdisciplinary interregional network of grassroots support for peer support programs. To meet the growing demands for consultation and program launching support, KP held the first-ever regionwide training program in October 2018 with multiple centers and participants representing clinical and administrative staff and patient advisors. The creativity, perseverance and dedication of a core group of individuals, coupled with KP's commitment to person-centered care, will ensure the spread of peer support and mentoring programs.

Partners:

Janet Borrowman, Dr Veronica Shim, Judey Miller, Marlene Zuehlsdorff & Dr Claudia DeYoung.

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PROJECT TITLE:

The Kaiser Permanente Emerging Therapeutics Strategy Program

Organization:

Kaiser Permanente

Category:

Integration of Care

Issue:

New and emerging high-cost drugs often have limited clinical evidence, involve specialty target populations, possess unique challenges regarding cost or resource utilization and have unusual safety considerations and supply restrictions.

Solution:

In response to the trend in specialty drug approvals, the KP Emerging Therapeutics Strategy Program was launched in 2017 with the mission “to proactively evaluate, strategize, and plan for optimal use of selected emerging therapeutics and to assess their value through the monitoring of outcomes.” This program was formed as a collaborative effort between KP’s National Pharmacy, Permanente Medical Group physician partners, National Permanente Quality Leaders and The Permanente Federation. This partnership works collectively to map out practice recommendations and usage strategies for selected emerging therapies to incorporate evidence-based medicine into practice. This review process helps ensure that patients receive high quality and value in their care, while maintaining safety.

Outcomes:

Emerging drugs, particularly orphan drugs that demonstrate promise for the treatment of rare diseases with small patient populations, are being approved more quickly than ever before by the FDA—often with limited clinical trial data. The ETSP was developed as a centralized, evidence-based approach to provision and management of emerging drugs, to ensure the best patient outcomes. Pharmacy and physician specialists partner to follow the best available evidence and provide the highest quality and safe care to patients. The program promotes affordable, quality care for KP members.

Innovation/Creativity:

The risks, benefits and best available evidence are discussed and a nonbinding recommendation for treatment is provided. ETSP has an internal SharePoint site with available resources for frontline practitioners across all KP regions. Tools for clinical decision support and documentation are also available to help practitioners manage these innovative therapies. The partnership is instrumental in creating a national solution for KP’s interregional physician panel, which supports an evidence-based approach to improve decision support for care. Developing a common set of templates that leverage clinical patient history data from different regional versions of KP HealthConnect, KP can access more real-world insights. The team also stays aligned with physician feedback via retrospectives, to hear firsthand how frontline physicians use these tools in their workflows, which provides insights for future tool enhancements.

Partners:

As part of the overall drug strategy development, ETSP may engage various stakeholders such as pharmacy, information technology/systems, legal/compliance, benefits, finance, provider contracting, nursing, laboratory, hospital and health plan operations in preparation of onboarding a drug.

PROJECT TITLE:

HCD and CoDesign at Kaiser Permanente

Organization:

Kaiser Permanente Design Consultancy

Category:

Patient and Family Engagement

Issue:

The landscape of health care is shifting; consumers expect care to align with their preferences and to meet their needs. Partnering with members and families is essential to providing truly member-centered care. Kaiser Permanente has a rich legacy of continuously improving care, but must also design care and services that have not been invented yet—develop creative solutions to challenges it has not faced before, in the context of a large health care delivery system, and get solutions right the first time.

Solution:

Relying on team-based collaboration and creativity, HCD helps reveal customer needs, reframe opportunities, imagine new possibilities, rapidly prototype and test new ways to provide care and services to members and families and energize and engage providers and employees. Kaiser Permanente partners with members and families throughout the journey of designing or improving care in CoDesign—radically different than gathering information by observation or soliciting feedback. Members and families are full partners in reimagining care. The CoDesign recipe fuses methods from HCD (e.g., journey mapping) and performance improvement (e.g., metrics that matter.) In 2016, CoDesign training became part of the core curriculum for improvement advisor programs at Kaiser Permanente’s internal Improvement Institute. Thousands of employees now have HCD and CoDesign knowledge and skills across all eight regions.

Outcomes:

Nursing and transport staff partnered with patients to reduce waiting times for transport to nuclear stress testing. Using HCD methods uncovered patients’ anxiety about the test; reducing patient anxiety became as important as transport efficiency. The CoDesign solution reduced transport time by 83% (from 80 to 13.5 minutes) and alleviated patient anxiety. KP’s Center for Health Living used HCD to redesign the bariatric surgery experience in one region. The solution CoDesigned with patients includes a pre-surgery education and skill-building program, a post-surgery long-term engagement group, a member-friendly website and a bariatric-specific wellness coach by phone.

Behavioral health leaders and providers in another region annually sought to understand patient experiences with care delivery and opportunities for improvement and to merge innovation with operational excellence. Participants in the CoDesign session designed an app empowering patients with tactics and FAQs related to behavioral health diagnoses. Patients can articulate their symptoms at initial visits, allowing providers to create better treatment plans.

Innovation/Creativity:

Although many health care organizations and systems have well-developed performance improvement systems and expertise and some have design capabilities, KP’s fusion of the two in CoDesign is unique. Putting the experiences and stories of patients and families at the center of CoDesign sessions is profoundly different from a traditional problem-solving approach and grounds all solutions generated by patients, families and staff in real needs. Solutions generated by HCD and CoDesign efforts are entirely new. HCD and CoDesign have spread to all corners of Kaiser Permanente.

PROJECT TITLE:

The Hepatitis C Care Cascade: A Regional Program to Increase Comprehensive Screening and Care for an At-Risk, Vulnerable Population

Organization:

Kaiser Permanente Mid-Atlantic States / Mid-Atlantic Permanente Medical Group

Category:

Patient and Family Engagement

Issue:

Chronic hepatitis C virus (HCV) is the most common US blood borne infectious disease. HCV kills more Americans than any other infectious disease. Significant gaps persist for screening, diagnosis, triage to care and curative treatment. The Hepatitis C Care Cascade program addresses these challenges and comprehensively redesigns HCV screening and care. Kaiser Permanente's HCV Pathway offers a direct path for providers to improve HCV screening and care with one program. Improvements in HCV screening and care can offset cirrhosis, liver failure and liver transplant.

Solution:

The Kaiser Permanente Mid-Atlantic States (KPMAS) hepatitis C virus testing care cascade (HCV Pathway) is a technology driven, coordinator-supported process to screen at-risk patients for HCV chronic infection (initial testing with HCV Antibody, confirmed by HCV RNA), co-infection testing (hepatitis B and HIV), liver assessment (including staging) and physician referral. The multistep pathway closes patient care gaps, improves quality and eliminates unnecessary physician work.

Outcomes:

Since its implementation in 2014, total regional HCV Antibody testing has doubled and the percentage of Baby Boomers screened is 72% (May 2019). Known gaps in care have been closed. The HCV Pathway has saved physician time, eliminating unnecessary primary care and gastroenterology Encounters. PCP encounters were replaced with coordinator telephone visits and extra GI encounters were eliminated. Patient-facing HCV educational resources have been translated into five languages to meet the needs of the diverse patient population.

Innovation/Creativity:

The KPMAS comprehensive approach closes gaps in care for HCV screening, while innovatively using IT/EMR solutions and coordinators to optimize staffing. The program offers a direct path for providers to improve HCV screening with one program. The streamlined laboratory HCV testing pathway ensures a comprehensive chronic HCV diagnosis with one blood draw—usually this takes multiple lab trips for the patient. The coordinator-based program gives patients a central point of contact during their testing process. Using telephone-based care saves patients trips to the clinic while offering comprehensive clinical information. Our EMR based alerts make it easier for physicians to know which of their patients need HCV screening, in real time.

Partners:

The Kaiser Foundation Health Plan provided senior level executive support, purchased the Fibroscan machines and provided an LPN-level care coordinator. The Mid-Atlantic Permanente Medical Group, clinical teams and the Mid-Atlantic Permanente Research Institute research team contributed.

PROJECT TITLE:

Design4Patients: Person-Centered Care via Integrated Medical-Dental System Design

Organization:

Kaiser Permanente Northwest

Category:

Integration of Care

Issue:

Kaiser Permanente Northwest (KPNW) identified an opportunity to reinforce preventive services to provide high-quality health care to members. 40% of KP members with both medical and dental coverage seen in a medical-dental integration (MDI) clinic had not had a primary care visit in 2 years. Patients may be missing opportunities to stay current on their preventive care and be screened for medical conditions. The KP Dental Care Program, via the MDI program, supports convenient, high-quality, holistic patient care by working with patients to close gaps in care during a visit to the dentist. Diabetic care, cancer screening and immunizations can be closed while the patient is at the office or via a follow-up telephone outreach call.

Solution:

KPNW is the only Kaiser Permanente region with dental services as part of the health plan. Despite having several locations where medical and dental services were co-located, these services remained siloed due to incompatible health record systems. Implementation of an EHR that interfaced with the medical services EHR presented the opportunity to utilize dental visits as an additional coordinated touchpoint with patients: Dental teams could see patients' medical histories and medical teams could see patients' dental histories. Staffing models for full MDI focused on addressing care gaps such as preventive screenings, immunizations and minor examinations.

Outcomes:

Short-term outcomes have shown an increased proportion of selected care gaps addressed at MDI sites. KPNW also identified a significant patient population that had not seen a medical provider in over a year but were regularly seen for dental services. For these patients, the dental visit is the only opportunity to actively engage in their total health.

Innovation/Creativity:

Dental and medical services are often co-located in the same building or on the same campuses. Addition of the Epic-based EHR for dental care has made coordination of medical and dental services tenable. The KPNW Dental Program set a goal to provide an MDI experience that is a new standard for high-quality, convenient and affordable health care. The approach taken to evaluate the program has embedded research into clinical operations to create an evidence-based learning health system for the Dental Care Program at KPNW. Integration of research and practice was welcomed by leadership. The culture of inquiry and determination to support evidence-based decision making made the work possible, together with an organizational infrastructure and data architecture.

Partners:

Kaiser Permanente Northwest, Permanente Dental Associates, Northwest Permanente, Kaiser Permanente Center for Health Research, EPIC.

PROJECT TITLE:

Connect to Care: Mental Health Triage Remodel

Organization:

Kaiser Permanente Northwest

Category:

Delivery System Design

Issue:

In 2018, the volume of phone calls demanding mental health services increased more than 20% from the previous year. Staff could not keep up with the call volume of members needing services. Calls went to voicemail and members could wait up to 2 weeks for a callback. At one point there were more than 600 people in the call-back queue. Delay in accessing this care posed a significant risk for suicidal patients and patients in crisis. For many people, their first encounter with KP mental health care was a negative experience.

Solution:

The KP Northwest Mental Health department revamped its care delivery system at portals of entry for mental health services. Patient access specialists (PAS), nonclinical staff, took over initial suicide screenings to determine acuity. Patients were scheduled for routine appointments or urgent call backs, or were routed to a clinician in real time. This remodel allowed the department to identify and understand the needs of members, particularly in responding to those with high risk. It fostered a strong partnership with the PAS team, increased efficiency in the workflow and improved the member experience. It also supported training all of PAS in mental health first aid, destigmatizing the needs of mental health patients when they call for care.

Outcomes:

The new workflow resulted in improved access, elimination of delay, improved pathways for urgent needs and an increase in clinician engagement and care of members. Services were enhanced through digital wellness apps and virtual therapy services, which improved the ability to initiate a plan of care with members from the first phone call. The work with PAS and changes in workflows also gave a deeper breadth of best practices and trauma-informed care.

Innovation/Creativity:

This was a staff-initiated change, with support of senior leadership. Creativity and innovation came from collaboration between the triage and PAS team willingness to own the problem, trial new workflows and have difficult conversations about care was provided. Patient feedback improved the process, helped the PAS team meet patient needs more effectively and developed a pathway to identify and respond quickly to urgent needs. Adding the digital wellness apps and options for virtual therapy was the next phase in providing creative and innovative care. The team worked with the billing department to ensure that patients were not charged for the service.

Partners:

PAS, patient partners, coding and billing, detail, KP senior leadership team.

PROJECT TITLE:

Early Chronic Kidney Disease Management

Organization:

Kaiser Permanente—The Permanente Federation

Category:

Customer Experience

Issue:

CKD patients progress to ESRD at an unpredictable rate. Interventions to control the decline of renal functions are inconsistent. Kaiser Permanente led a program-wide effort to identify and assign CKD stages to patients using its EHR, the creation of two national metrics and risk prediction modeling.

Solution:

The goal was to prevent CKD patient progression to ESRD through early proteinuria screening, risk stratification based on risk prediction modeling and prescribing ACEI/ARB to control hypertension in CKD patients. Two metrics were tracked at the program level: CKD 1–4 members monitored for albuminuria/proteinuria and CKD 1–4 members with hypertension and elevated albuminuria/proteinuria on ACEI or ARB treatment. Successful identification and treatment improve patient quality of life by delaying or avoiding the need for dialysis or kidney transplantation, and conserves medical care resources. Electronic risk prediction modeling has also been implemented to support risk stratification and the ability to identify and manage high-risk patients.

Outcomes:

Increase proteinuria screening and risk prediction modeling, and ensure prescriptions of ACEI/ARB, slowing progression to late-stages of CKD.

Innovation/Creativity:

This program systematically and proactively identifies patients at risk of progression to ESRD. The presence of KP Health Connect EHR data makes it relatively simple and inexpensive to identify patients monitored for albuminuria/proteinuria and determine if CKD patients with albuminuria/proteinuria who meet proper criteria are being treated. The same applies for identification of CKD patients who are hypertensive and need ACEI/ARB.

Partners:

Inter-regional Clinical Practice Group for Nephrology, Renal Business Group, local KPIT, The Permanente Federation

PROJECT TITLE:

Perioperative Pain Management Utilizing Scheduled Gabapentin, Acetaminophen, and Ketorolac in Bariatric Surgery in a Community Hospital in Southern New Mexico

Organization:

Memorial Medical Center

Category:

Integration of Care

Issue:

Opioids have long been the most common analgesics for post-operative pain control. Even though about 80% of patients use an opioid medication, a study reported that 75% of post-op patients experience moderate to extreme post-op pain. Opioids are often associated with adverse side effects such as drowsiness, constipation, nausea, vomiting, CNS and respiratory depression. Overuse is associated with increased risk for dependency. Although studies show that multimodal pain medications with unique mechanisms are effective in controlling post-op pain, this approach has not been commonly accepted.

Solution:

A bariatric surgeon at Memorial Weight Loss Center recognized that changing the post-op pain medication regimen could provide better pain control, limit the number of opioid-related adverse effects, enhance recovery after surgery and help alleviate the national opioid crisis. The surgeon worked with the hospital's pharmacy team and with the pharmacy team to develop a multimodal pain protocol. Additional analgesics, either tramadol or an opioid, are ordered in case patients need additional pain control. This regimen was implemented for all patients under bariatric surgery at Memorial Medical Center; and the surgeon worked with departments throughout the hospital to ensure proper implementation.

Outcomes:

Challenges surfaced during implementation. Because the pain regimen was built on a set schedule, scheduling medications properly was extremely important. Scheduling of post-op medications was based on time of administration of pre-op acetaminophen dose, which was often difficult to find in patient's record. The pharmacy and pre-op teams worked together to have the pre-op document medication administration consistently so post-op pain medications could be scheduled properly. Another challenge was timely medication administration per regimen. An around-the-clock non-opioid pain regimen has not been common practice; thus, nurses were not aware of the importance of giving medications promptly. Ongoing monitoring of the timing of medication administration, in addition to education, ensured that patients were given medications on schedule.

Innovation/Creativity:

This study shows that scheduled multimodal non-opioid pain medications are effective in post-bariatric surgery patients and are associated with a low incidence of severe post-operative pain and low adverse event profile. This approach decreases the need for post-operative narcotic prescriptions, which results in potentially decreased access to unused prescription opioids for diversion or inappropriate use. Program improvements are ongoing: In March 2019, solid-dose acetaminophen and gabapentin replaced original liquid formulation, to improve palatability and patient acceptance of this pain regimen. The success of this project and results will be shared with other surgeons to reduce post-op opioid use, enhance recovery after surgery and improve patient outcomes.

Partners:

Memorial Weight Loss Center, Memorial Medical Pharmacy, Somnia Anesthesia, Memorial Medical Center OR staff.

Contact Information:

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PROJECT TITLE:

MMM Mobile App

Organization:

MMM Healthcare, LLC

Category:

Use of Technology

Issue:

As a company primarily focused on the Medicare eligible population, MMM Healthcare, LLC noticed there was no solution available for integrating this population into the technological era. Pressure was on providers to comply with quality of care measures and there was a lack of alternatives to promote beneficiary accountability. MMM conducted analysis on technology adoption by beneficiaries, identifying that mobile tools had greatest adoption among Medicare-eligible beneficiaries. Analysis determined that there was no available application that targeted the needs of the Medicare population.

Solution:

MMM Healthcare developed a mobile app to provide members with information about their health condition and required preventive care and coverage, including incentives for closing their gaps in care, facilitating access to services through messaging and a functionality to order OTC medications, among other features. The mobile app is available to members and their authorized caregivers. The application's objective was 10,000 members by end of 2018—there were close to 14,000 members by the end of 2018.

Outcomes:

On a weekly basis, MMM Healthcare monitored registrations, the percentage of app adoption and members' profile utilization. The mobile app improved member self-service, experience and accountability. As of July 2019, over 32,000 members access the mobile app, including 1,000 registered caregivers. Since the functionality was put in place, more than 4,600 orders of OTC medications have been managed. 45% of registered members have accessed their clinical profile, which includes clinical information about test results, lists of medications, pending preventive/screening tests and providers/specialists visited, including contact information.

Innovation/Creativity:

This project included the elderly as the main focus for development of technological tools: understanding their needs and embracing their capability to adopt technology. The app is designed to provide beneficiaries and their authorized caregivers with information and solutions 24/7, improving access to services and catering to a more sophisticated generation of beneficiaries. This platform serves as the baseline for future development, enhancing the care provided to members and improving their experience with care.

Partners:

MISO of Puerto Rico, InnovaMD

PROJECT TITLE:

The Kaiser Permanente Emerging Therapeutics Strategy Program

Organization:

Kaiser Permanente

Category:

Integration of Care

Issue:

New and emerging high-cost drugs often have limited clinical evidence, involve specialty target populations, possess unique challenges regarding cost or resource utilization and have unusual safety considerations and supply restrictions.

Solution:

In response to the trend in specialty drug approvals, the KP Emerging Therapeutics Strategy Program was launched in 2017 with the mission “to proactively evaluate, strategize, and plan for optimal use of selected emerging therapeutics and to assess their value through the monitoring of outcomes.” This program was formed as a collaborative effort between KP’s National Pharmacy, Permanente Medical Group physician partners, National Permanente Quality Leaders and The Permanente Federation. This partnership works collectively to map out practice recommendations and usage strategies for selected emerging therapies to incorporate evidence-based medicine into practice. This review process helps ensure that patients receive high quality and value in their care, while maintaining safety.

Outcomes:

Emerging drugs, particularly orphan drugs that demonstrate promise for the treatment of rare diseases with small patient populations, are being approved more quickly than ever before by the FDA—often with limited clinical trial data. The ETSP was developed as a centralized, evidence-based approach to provision and management of emerging drugs, to ensure the best patient outcomes. Pharmacy and physician specialists partner to follow the best available evidence and provide the highest quality and safe care to patients. The program promotes affordable, quality care for KP members.

Innovation/Creativity:

The risks, benefits and best available evidence are discussed and a nonbinding recommendation for treatment is provided. ETSP has an internal SharePoint site with available resources for frontline practitioners across all KP regions. Tools for clinical decision support and documentation are also available to help practitioners manage these innovative therapies. The partnership is instrumental in creating a national solution for KP’s interregional physician panel, which supports an evidence-based approach to improve decision support for care. Developing a common set of templates that leverage clinical patient history data from different regional versions of KP HealthConnect, KP can access more real-world insights. The team also stays aligned with physician feedback via retrospectives, to hear firsthand how frontline physicians use these tools in their workflows, which provides insights for future tool enhancements.

Partners:

As part of the overall drug strategy development, ETSP may engage various stakeholders such as pharmacy, information technology/systems, legal/compliance, benefits, finance, provider contracting, nursing, laboratory, hospital and health plan operations in preparation of onboarding a drug.

PROJECT TITLE:

Vita Care—Integrated Care for the Chronically Ill

Organization:

MMM Holdings, LLC/Vita Care

Category:

Integration of Care

Issue:

Adults living in Puerto Rico have multiple lifestyle risk factors and a high prevalence of chronic diseases, namely cardio-metabolic and psychological conditions. 66% of residents have a self-reported BMI consistent with overweight or obesity. The elderly population has an increasing need for high-touch personalized services and social determinants of health are becoming more relevant in the patient care model. Puerto Rico has also experienced a reduction in primary care specialists, which has resulted in patient churning and reduced quality of health care visits.

Solution:

Vita Care’s providers work hand-in-hand with members’ PCPs to build holistic plans focused on physical and mental well-being. Vita Care providers, supported by proprietary InnovaCare technology, help engage members to create an individualized care plan that involves a custom medication adherence plan, specific clinical steps and clear benchmarks to track progress toward specific health goals. PCPs are incentivized to collaborate to ensure patients receive coordinated care, personalized treatment and better outcomes.

InnovaCare’s network of Vita Care clinics represents the latest innovation with an advanced strategy to deliver value-based care to complex patient populations. The key to the care model is to direct members to Integrated Care Management Practice Units, where they are holistically managed within the same site, in constant and active communication with their PCP. Transportation services are provided and coordination of services not available in the clinic, such as radiography, labs, pharmacy and authorizations, are coordinated to remove barriers to care.

Outcomes:

Program goals are to deliver a high-quality, affordable, patient-centered care experience; improve communication with provider; and create a partnership to improve outcomes with medical management. Vita Care followed 3,000 patients over 12 months and compared their utilization data before and after enrollment in the program.

Innovation/Creativity:

This is the first project of its kind in Puerto Rico. No other interdisciplinary chronic care management program has aligned the individual and the group educational components to empower patients. To support connectivity and communication, providers are 100% reachable electronically through EHRs. Telemedicine provides patients with timely access to specialists—previously, the wait was an average of 4 months for evaluation.

PROJECT TITLE:

Readmission Reduction in a Georgia Integrated Health System

Organization:

The Southeast Permanente Group

Category:

Integration of Care

Issue:

In 2016, monthly 30-day readmission rate fluctuations remained cyclical and 6-month trending data showed signs of sustained increase. Transitional care management interventions were not adequately staffed and were only partially implemented. Post-discharge medication reconciliation processing and documentation was not consistently performed and resourced, increasing the number of potential uncaught adverse drug events as demand increased with higher inpatient census.

Solution:

To develop a comprehensive solution, the Southeast Permanente Group leveraged evidence-based solutions and research to create a high-risk patient identification system and a Transitions Case Management (TCM) program specific to the KP Georgia Region, which had limited access to real-time patient-level hospital data.

Outcomes:

Patients participating in the TCM program, which included phone call follow-ups, post-discharge medication reconciliation, physician follow-up and coaching home visits, experienced significant reduction in the likelihood of readmission. After adjusting for variables, participating members have a 68% reduction in the likelihood of readmission, compared with nonparticipants. The high-risk patient readmission reduction bundle (medication reconciliation, outreach, follow-up appointment) was shown to reduce the likelihood of readmissions by 74%. The low/moderate risk bundle (follow-up call, appointment) reduced the likelihood of readmission by 63%.

Since the program start in January 2017, there has been a 28.9% reduction in the raw rate of readmissions for high-risk patients (in the target population) and an 18.8% reduction in the raw rate of readmissions for low-to-moderate-risk patients.

Innovation/Creativity:

The current method for identifying high-risk patients utilizes ACE and LACE scores. Although this is effective in capturing potential high-risk patients more than half the time, [organization] is working on implementing a new 30-Day Readmission Predictive Model that uses 353 variables to identify high-risk patients. This new model accurately captures potential high-risk patients 69%–71% of the time.



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