

WPHCA

2026 Performance Excellence Award Nominee
Scenic Bluffs Community Health Centers

INTEGRATED POPULATION HEALTH & CHRONIC CARE MANAGEMENT INITIATIVE

Scenic Bluffs Community Health Centers (Scenic Bluffs) developed an Integrated Population Health and Chronic Care Management initiative to improve outcomes for patients with complex chronic conditions while advancing value-based care. The model uses a proactive, team-based approach to identify patients who may benefit from additional support, including those with uncontrolled diabetes, chronic care needs, recent hospital or emergency department use, Medicare quality gaps, or other risk factors.

Once Scenic Bluffs identifies the eligible patient, the integrated team connects them with individualized care plans, remote patient monitoring, medication support, nutrition counseling, health education, regular nurse outreach, referral coordination, and/or follow-up with primary care providers. These touchpoints help patients better understand their health conditions, address barriers to care, manage medications and lifestyle changes, and stay connected to the care team between scheduled visits.

The initiative strengthens core workflows that support population health management, including Medicare Annual Wellness Visits, transitions-of-care follow-up, documentation improvement, chronic care management processes, monthly quality audits, and care gap closure. Scenic Bluffs works with Medical Home Network, a nationally recognized non-profit transforming care in safety net communities; Inlusa, a Wisconsin-based ACO with a community focused approach to long-term care services; local hospitals; and internal interdisciplinary teams. Together, these partners support timely outreach after hospital or emergency department visits and connect patients to community-based resources for identified social or access needs.

Key Outcomes

- Reduced the number of patients with uncontrolled diabetes by more than 3%



Scenic Bluffs Integrated Medical Team

- Expanded earlier intervention through remote patient monitoring and regular nurse outreach
- Strengthened patient and care team relationships through individualized care plans, education, and consistent follow-up
- Improved documentation of patient complexity and supported stronger quality performance
- Reduced care gaps and supported readiness for value-based care arrangements

Challenges Faced

- Identifying and prioritizing patients with complex needs across multiple data sources, including Azara (a population health management tool), provider panels, chart audits, payer platforms, and quality measures
- Coordinating follow-up for patients with multiple chronic conditions, care gaps, recent hospital or emergency department use, and social or access-related barriers
- Standardizing workflows for Medicare Annual Wellness Visits, chronic care management, transitions of care, documentation, and monthly quality audits across interdisciplinary team members
- Maintaining consistent patient engagement between visits through outreach, remote monitoring, education, referral coordination, and care plan follow-up
- Balancing day-to-day clinical demands with the additional work needed to close care gaps, improve documentation, and support value-based care performance

Early results show meaningful progress. The initiative improved earlier intervention through remote monitoring, strengthened relationships between patients and care teams, supported more complete documentation of patient complexity, improved quality performance, and reduced avoidable gaps in care. Together, these changes demonstrate how coordinated, data-informed care management can improve patient experience, support clinical outcomes, and position Scenic Bluffs for success in

The Scenic Bluffs Integrated Medical Team includes:

- Primary Care Providers
- Registered Nurses
- Registered Dietitian
- Quality Improvement and Population Health Staff
- Health Educators
- Referral Coordinators
- Medical Assistants
- Patient Access Staff
- Support Personnel