Innovation

Successful Outpatient Management of Kidney Stone Disease

Provider
HealthEast Care System

Problem
Many patients with kidney stones return to the ED multiple times due to recurrent symptoms. Patients then tend to receive duplicative imaging studies and are frequently admitted to the hospital. Once admitted, most patients and physicians expect resolution prior to discharge through potentially unnecessary surgical care for simple stones.

Innovation
Our approach was to offer expert care in decision making regarding hospital admission and to facilitate outpatient management with same-day and next-day visits using a dedicated subspecialty stone management clinic. In this setting, with early expert review of clinical history, patients could be appropriately triaged based on prognostic criteria. Those patients with high chance of spontaneously passing their stone could be aggressively educated and supported in outpatient management. Those with minimal chances of spontaneous resolution (or significant comorbidities) could be expeditiously directed to definitive surgical care.

Improving Health
Safety
• 48% decrease in ED repeat visits
• 42% decrease in hospital admissions
• 92% of patients understood the purpose of medications
• 98% of patients understood how to access additional resources

Efficacy
• 134% increase in primary definitive surgery
• 88% of patients received adequate pain control

Equitable
• 96% of patients were able to get an appointment as soon as they wanted
• 89% of patients understood answers to their questions

Enhancing Patient Experience
Our program is associated with very high patient satisfaction ranking in the 91st percentile nationally.
• 93% of patients felt the provider listened to them
• 96% of patients able to get an appointment when they wanted

Taking Aim at Affordability
• We reduced unnecessary ED visits, hospital admissions/readmissions and non-definitive surgery
• The net effect of these improvements is a 21.2% reduction in cost of care (approximately $1,090 per stone patient presenting to the ED)
Provider
Allina Hospitals & Clinics

Problem
How do we provide access to mental health specialty care at points of critical decisions at Allina Regional sites that currently do not have the volume to support on-site staffing?

Innovation
Use the Tele-Health technology currently available at Regional Allina sites to provide the same high quality Mental Health assessment and treatment plan no matter where a patient presents for care.

Improving Health
• Allina has specialty care providers in emergency departments that previously had none
• Patients receive a thorough mental health evaluation and disposition planning by a licensed clinician (including admission or discharge with referrals) which is documented in a standard EMR for continuity of care

Enhancing Patient Experience
• The technology allows almost immediate face to face contact with the patient, their family and ED treatment team
• Patient wait times to access specialty mental health care and time spent in the ED is reduced
• Better assessments reduce the practice of ‘defensive decisions’ to admit patients when in doubt, thus reducing unnecessary admission
• Patients are provided with more comprehensive resources and referrals when discharged from the ED

Taking Aim at Affordability
• Reduced admissions (avoidable) means less transport, less Hospital cost
• Decreased ED length of stay
• Unintended finding, 50% greater utilization of crisis assessments

Innovation Reducing Disparities of Quality and Access in Emergency Room Assessment of Mental Health Conditions using Telemedicine
Problem
Little research existed about the needs of late pre-term infants, even though they are at higher risk of complications, including potentially life-threatening ones. Evidence-based protocols for this group remain rare. Our maternity care center physicians and nurses have long been concerned by the readmissions for these infants. Our gap analysis identified infants born in the 36th week are the most vulnerable.

Innovation
We created a NICU navigation system designed specifically to assess late pre-term infants, providing them an increased level of care. Nurses enter physician’s dates of gestational age on admission to quickly identify the infant as late pre-term. These babies are admitted directly to our NICU. Additional education and support for the parent are now part of navigation.

Improving Health
• Parents have their baby’s first primary care clinic appointment scheduled before discharge
• Two follow-up phone calls are made with all families

Enhancing Patient Experience
• Increased interaction - All care is provided for mother and infant in a couplet on the postpartum unit
• Parents report greater confidence in their ability to care for a late pre-term infant following discharge

Taking Aim at Affordability
• Marked decrease in re-admissions, with only two re-admissions out of 57 infants compared to 16 re-admissions the previous year
Innovation

Reducing Risk of Venous Thromboembolism Using a Team Approach

Provider
Lakeview Hospital

Problem
Inconsistent post-operative clinical practices with mechanical and pharmacological methods resulted in not meeting National Quality Standards for venous thromboembolism (VTE) prophylaxis.

Innovation
Through collaborative teamwork, practice and procedure changes led to rapid improvement and performance above national rates:
• Standardized VTE Prophylaxis order set for improved physician decision support
• VTE prophylaxis within 24 hours—Change in customized compression stockings and intermittent pneumatic device used to improve compliance and effectiveness

Improving Health
• 8% 30 day re-admission rate for VTE compared to 21% nationally
• 97% rate of compliance with national standards on VTE prevention after surgery

Enhancing Patient Experience
• In the 95th percentile on patient satisfaction consistently. Newer mechanical devices are quieter and easier to put on
• Provide every patient with safe, effective, and timely patient-centered care with standardized order sets

Taking Aim at Affordability
• Realized significant savings ($45,000) with the use of standardized devices
• Significantly less re-admissions
Provider
Allina Hospitals & Clinics

Problem
Given the well-known deterioration of primary care in the United States, there is a clear imperative to reinvent the system to ensure that care is provided to all patients effectively and systematically and address the inadequacies and consequences of the typical 15 minute patient-physician encounter.

Innovation
This innovation introduced a new primary care paradigm—a team-based, patient-centered approach focused intensely on chronic disease management for patients with diabetes, heart failure and hypertension using non-clinically trained lay persons called care guides.

Improving Health
- Adherence to 13 nationally recommended care guidelines improved by 28% (P < .001)
- Improvement (p < .05) in key individual care goals including: tobacco use; blood pressure; pneumonia vaccination; LDL level; aspirin use
- Patients meeting the fewest care goals at baseline improved the most

Enhancing Patient Experience
- Patient One worked with a care guide for less than three months on exercising and diet to lose weight. She lost 26 pounds and reported “never feeling happier or healthier.” Her physician remarked, “I can’t believe it. I’ve been trying to get her to lose weight for 3 years.”
- Patient Two smoked for 20 years. He had made several quit attempts and was ready to try again because now “Someone is watching over my health, so I better start taking care of it.”

Taking Aim at Affordability
Care guides provide effective chronic disease care management at a relatively low cost:
- Cost per patient - $392 per year
- Average care guide salary $34,000 (compare average RN salary $79,000)
Innovation

Ventilator Liberation: An Innovative, Interdisciplinary Model for Patient Care

Provider
Bethesda Hospital, Member, HealthEast Care System

Problem
Previously strong ventilator weaning rates plateaued in the winter 2008. Short-term acute care hospitals had come to rely on us—a long-term acute care hospital (LTACH)—for our specialty in successfully weaning patients who had failed past ventilator weaning attempts. It was important for us to achieve sustainable clinical improvement in ventilator weaning rates for these chronically ill patients with multiple medical challenges.

Innovation
Instead of solely focusing on nursing and pulmonary disciplines, we created a five-phase, integrated, interdisciplinary pathway to ventilator liberation involving multiple hospital departments, many of whom are not typically included in ventilator weaning programs. We offered extensive staff training as well as created both an in-house educational DVD and early progress meet and greet sessions for patients and families.

Improving Health
- Above the national benchmark standard for ventilator weaning for the last 17 months consistently
- Ventilator Associated Pneumonia (VAP) rates and Central Line Blood Stream Infection (CL-BSI) rates below the national benchmarks

Enhancing Patient Experience
- Patients are weaned more quickly—freedom from heavy, restrictive medical equipment and procedures, including tube feeding
- Retain their mobility to travel outside of the hospital room or to physical therapy
- Regain their voice, to once again speak with family members and caregivers to clearly indicate their needs

Taking Aim at Affordability
- 2% drop in the number days over the Medicare geometric mean length of stay, this equates to a yearly cost savings of $120,000
- Reducing Total Cost of Care—$814/day LTACH nursing care cost compared to $1500/day for hospital ICU

HealthPartners
Provider
North Memorial

Problem
System Wide Approach to Advance Care Planning

Innovation
Interdisciplinary Team applied Honoring Choices model of advance care planning across the enterprise:
- Employee Health Services
- Primary Care Clinics
- Palliative Care Inpatient Unit
- Home Care

Improving Health
Both employees and patients had opportunity to work with trained facilitators to create advance care plans thus improving the communication with families and health care providers regarding wishes for end-of-life care.

Enhancing Patient Experience
- Employees had assistance from coworkers whom they trusted
- Patients and their family had timely answers to questions and help in completing the form
Provider
Therapy Partners, Inc

Problem
Health care providers are challenged by present insurers’ reimbursement models to provide services that achieve the “Triple Aim” – measurable quality, exceptional service, lower total cost.

Innovation
Therapy Partners (TPI) and Focus on Therapeutic Outcomes, Inc (FOTO) developed a value based measurement of patient outcomes that considered risk-adjusted utilization and functional improvement measures in collaboration with HealthPartners health plan (HP). HP and TPI implemented a reimbursement pilot in which HP paid TPI a per diem rate with a percent of that payment withheld until the “value” of the therapy care was analyzed. Withhold payment was based on the level of “value” achieved for the patient population.

Improving Health
FOTO’s proven reliable, valid, sensitive to change, and responsive data allowed for:
• Quantifiable functional status improvement across the patient population
• Therapists and patients to effectively adjust care plans and expected outcomes

Enhancing Patient Experience
• Faster recovery with more effective care plans
• Better understanding of their care and outcomes by comparing their progress to patients with similar conditions

Taking Aim at Affordability
Through FOTO outcome results:
• Physical therapists at TPI achieved “Higher than Expected” or “Expected” value for majority of cases
• 33% less utilization compared to FOTO national average (over 2,000 practices using)
• 50% less utilization compared to other national data base