Physical activity and early stage breast cancer

**PROVIDER**
Specialists in General Surgery (Funding by Fairview Physician Associates)

**CHALLENGE**
Women with a recent breast cancer diagnosis often don’t engage in regular physical activity. Physical inactivity has direct effects on risk of chronic diseases, mental health, quality of life and early mortality. Women that engage in physical activity after a breast cancer diagnosis may reduce the risk of recurrence and death from this disease.

**INNOVATION**
Rather than dismissing patients after surgery for continued care under oncology staff, we employed a model in which postmenopausal women with clinical stage I or II breast cancer remained engaged with their surgical team for regular wellness coaching, Fitbit Flex monitoring and review of the Patient Reported Outcome Measurement Information System (PROMIS) 10 Global Health Survey.

**IMPROVING HEALTH**
- Wellness coaching encourages healthy behaviors, regular physical activity and nutritional eating.
- Regular physical activity during treatment and survivorship can improve mental health and physical well-being as well as blood pressure, body mass index, heart rate and quality of life.
- Regular physical activity during treatment and survivorship can reduce the risk of recurrence and death from breast cancer.

**ENHANCING PATIENT EXPERIENCE**
- Offering access to free weekly wellness coaching to reach health-related goals.
- Giving Fitbit Flex as a tracking device to monitor daily steps.
- Increasing patient interaction by offering six-month and one-year follow-up to obtain vitals and discuss coping strategies for survivorship.

**TAKING AIM AT AFFORDABILITY**
- 100 percent of patients in the study had their BMI stay the same or decrease from initial consult to post-op visit.
- 47 percent of patients met the daily goal of 7,000 steps.
- 80 percent showed significant increases in mental health scores and 60 percent increased physical health scores.
The benefits of BLAST:
Better Lifestyle, Attitude and Success Training

PROVIDER
Sanford USD Medical Center

CHALLENGE
Prior to BLAST, patients received bariatric surgery education through consultation, pre-operative appointment, or pre-operative class. In addition, patients completed other pre-operative tests and clearances, reducing information retention. This provided no time for patients to practice the lifestyle behaviors required for post-operative long-term success. Accordingly, patients required more post-operative education.

INNOVATION
BLAST consists of three one-hour classes over three months. Topics include mindful eating, menu planning, activity, barriers and feelings. By attending pre-operatively, patients learn about necessary behavior and lifestyle changes that are important for long-term success after bariatric surgery.

IMPROVING HEALTH
BLAST improves the chance of post-operative long-term success by pre-operatively providing education and tools that focus on psychological, emotional and lifestyle changes necessitated by bariatric procedures — areas identified by patients as critical to the success of their life after surgery.

ENHANCING PATIENT EXPERIENCE
• BLAST attendees are more likely to have surgery and attain wellness goals as they have continuous contact with the bariatric team.
• Patients have ample opportunity to network with others in a similar situation.
• Patients felt better prepared for bariatric surgery and the lifestyle changes that must occur afterward for success.
• Data show that BLAST patients have better long-term weight loss than those who didn’t attend.

TAKING AIM AT AFFORDABILITY
• The initial $60 per class fee was eliminated in 2014 as BLAST should be accessible regardless of financial means.
• As over 50 percent of our patients live in outlying areas, we offer online video versions of classes to reduce costs associated with travel.
• BLAST attendees are more likely to have surgery than those who don’t attend, increasing the opportunity for positive lifestyle and overall health changes that may eliminate future medical costs.
Centralized registry

**PROVIDER**
CentraCare Clinics

**CHALLENGE**
To meet quality measures and pay-for-performance goals, we needed to address chronic diseases and preventive services registries. This was done by nurses in each individual clinic. However, with busy nurse schedules, registry work received less priority and was normally addressed when staff members had time. As a result, patients were often overdue on their office visits and lab management, thus affecting quality measures.

**INNOVATION**
We trained centralized registry staff and developed workflows to allow them to reach out to all of our patients listed on the asthma and depression registries in a standardized manner that meets guideline recommended care. We changed staff perspective of “working the registries” from a task to a role with a primary function.

**IMPROVING HEALTH**
- Improvement in optimal chronic disease outcomes.
- Improvement in standardized use of guideline care.
- Ensures systematic follow-up visits when appropriate.

**ENHANCING PATIENT EXPERIENCE**
- Increased patient satisfaction knowing that the clinic is proactively reaching out to determine if treatment is effective.
  ‣ 100 percent of patients on the asthma and depression registries have received outreach from our analysts to help determine if additional treatment interventions are needed.
- Immediate follow-up appointment scheduled based on established guidelines.
- Patients may not recognize the name of our registry analyst, but proper scripting enables us to convey the message that we’re working together to reach patients.
- Timely care between visits.

**TAKING AIM AT AFFORDABILITY**
- Centralizing resources versus individual site registries.
- Decreased variability between clinics.
- Increased LPN availability on the floor.
- Better outcomes resulting in potential savings of health care dollars due to uncontrolled disease.
Point-of-care testing for strep throat and influenza in the community pharmacy setting

PROVIDER
Target Pharmacy

CHALLENGE
Patients often visit pharmacies with symptoms of strep throat or influenza. Pharmacists operating under the present practice model recommend over-the-counter remedies for symptomatic relief or refer the patient to a higher level of care for treatment. In this environment, patients lacking a primary care provider either fail to receive care or visit an emergency room or urgent care for treatment, leading to increased risk for disease spread, potential complications and increased medical spend. We challenged ourselves to improve access to low cost, convenient care for common infections, such as strep throat and influenza, in the community setting.

INNOVATION
In October 2014, we launched point-of-care testing (POCT) for strep throat and influenza in five Minnesota pharmacies. In this model, the patient presenting with symptoms is evaluated by a pharmacist for medical stability and administered a rapid diagnostic test (RDT) in an exam room adjacent to the pharmacy. If the RDT is positive, the pharmacist can treat under an evidence-based protocol within a collaborative physician practice agreement.

IMPROVING HEALTH
• Provides access to appropriate level of care for patients who don’t have a primary care physician (PCP).
• Reduces antibiotic overuse by requiring positive test for antimicrobial treatment.
• Supports continuity of care through pharmacist follow-up with documented PCP.
• Reduces spread of infectious disease by providing convenient, timely access to care.

ENHANCING PATIENT EXPERIENCE
• Patients receive appropriate level of care at their convenience during the weekday, at night and on weekends.
• Access to professional care is available in the community without an appointment or prior relationship.

TAKING AIM AT AFFORDABILITY
• Reduction in cost for treatment of strep throat or influenza.
• Fewer emergency room and urgent care visits for patients lacking a PCP.
PROVIDER
Target Pharmacy

CHALLENGE
In 2014, several Medicare payors asked Target to perform interventions on individual patients to improve their Star Ratings, but these interventions focused on a small number of Target Medicare guests. A Medication Therapy Management solution that could be applied to the Target total population was needed to improve medication adherence, close gaps in care and provide the most appropriate, effective medications.

INNOVATION
Target implemented an internal analytic process and service strategy that utilized claims data to proactively identify guests meeting criteria for pharmacist intervention regardless of payor or Medicare status. The pharmacy teams reached out to guests to identify, resolve and prevent medication-related problems using motivational interviewing techniques. This interaction identified clinical issues, guest health goals, barriers in achieving health goals and action plans.

IMPROVING HEALTH
- Improved medication adherence in patients with chronic illnesses.
- Reduction in care gaps for patients with diabetes and hypertension.
- Reduction in adverse events for elderly patients on high-risk medications.
- Communication with prescribing provider.

ENHANCING PATIENT EXPERIENCE
- Decreased prescription transfers by 65.2 percent.
- On-going access to trusted health care advisor (pharmacist).
- Increased guest loyalty.

TAKING AIM AT AFFORDABILITY
0.6 percent estimated decrease in total cost of care for guests with diabetes receiving an intervention (CBO, 2012) based upon three percent PDC improvement.
Project BrainSafe (Funded by CentraCare Health Foundation)
Participants include CentraCare Health, HealthPartners Central Minnesota Clinics, St. Cloud Medical Group, Williams Integracare, Veteran’s Administration, Sartell Pediatrics and St. Cloud Orthopedics

CHALLENGE
Community-wide, there’s limited awareness about concussions, symptoms and possible long-term consequences. In addition, our medical community lacks consistent standards for evaluating, diagnosing and managing concussions. As a result, many patients struggle for months before receiving the proper diagnosis and treatment to help them successfully resume prior roles at school, work or in the community.

INNOVATION
Implemented a community-wide collaborative to improve the recognition, diagnosis and management of concussions/mild traumatic brain injuries for people of all ages, with an initial focus on schools. This unique network includes medical providers, educational facilities, athletics, community partners and patient advocates.

IMPROVING HEALTH
• Standard screening for concussions, mild trauma and at-risk population.
• Consistent care standards for evaluation and management.
• Prevention of repeat concussions and/or prolonged recovery.
• Increased community and provider education to minimize missed/delayed diagnoses and adverse patient consequences.

ENHANCING PATIENT EXPERIENCE
Standard education for consistent care and messaging across settings.

TAking AIM AT AFFORDABILITY
• Free baseline ImPACT testing for high school athletes.
• Community test scores and guidelines improve efficiency in care and transitions.
• More efficient and effective treatment, decreased recovery time, as well as reduced secondary sequelae requiring additional testing and treatment.
CHALLENGE
Traditionally, once patients are referred to behavioral health for medication management, they often remain on the behavioral health prescriber’s case load even after condition stabilization. This leads to poor access for new patients in behavioral health because the prescribers’ schedules fill up with returning patients. We challenged ourselves to increase access to mental health services by improving the process for referral of stable patients with anxiety/depression back to primary care.

INNOVATION
We created a shared care protocol to send “stable” patients back to primary care, opening up access in psychiatry.

IMPROVING HEALTH
- Patients have more of their needs met by their primary care provider.
- Improved access to psychiatry for patients with complicated behavioral health conditions requiring specialized care.

ENHANCING PATIENT EXPERIENCE
- By having stable patients follow up with primary care for their ongoing mental health management, the patients will be able to reduce the number of visits they need to address all of their health concerns.
- Patients are assured that ongoing mental health medication management recommendations are communicated to the primary care provider by the behavioral health prescriber in the plan of care in the EMR.
- With patient partner input, we developed stick cards to help educate patients when transitioning from primary care to psychiatry and back.
- MTM pharmacists aid in the transition as a main point of contact for patients regarding medications.

TAKING AIM AT AFFORDABILITY
- Psychiatry sees more new patients because stable patients return to primary care.
- Primary care’s ability to provide holistic care is strengthened, leading to an increase in health outcomes.
- Along with other health care needs, primary care incorporates mental health maintenance treatment into routine visits.
Integrating palliative care into comprehensive heart failure care

PROVIDER
North Memorial Medical Center

CHALLENGE
Despite the many advanced heart failure therapies available today, individuals often experience uncontrolled symptoms. Heart failure carries a high risk of mortality and disability and many patients don’t perceive the life-limiting nature of their illness. Palliative care is a way of helping patients understand and cope with the chronic and progressive nature of their illness. Literature supports the integration of palliative care as part of the comprehensive care of patients with chronic illnesses such as heart failure. Standard practice at our organization hasn’t historically involved the support of the palliative care team in routine heart failure care, and a consistent process for palliative care referral for heart failure patients was needed.

INNOVATION
We implemented a process for palliative care referrals for patients hospitalized with acute decompensated heart failure (ADHF). Palliative care support would ultimately provide more patient-centered care while aiding in the reduction of hospital readmission rates for the heart failure population.

IMPROVING HEALTH
• Improved documentation of patients’ care goals.
• Better patient and family understanding of chronic, progressive nature of illness.
• Assistance to patients and families in medical decision making.
• Increased attention to management of distressing symptoms.

ENHANCING PATIENT EXPERIENCE
• Palliative care support promotes patient-centered care.
• Extra layer of support to patients and families as they cope with serious illness.
• Improved communication of patients’ goals of care results in care that’s more aligned with patients’ wishes.

TAKING AIM AT AFFORDABILITY
• Reduced readmission rates.
• Reduced incidence of unwanted invasive procedures and testing.
• Increased rates of health care directive or Provider Orders for Life-Sustaining Treatment (POLST) form completion.
Clinical curriculum enhances patient outcomes and provider satisfaction

PROVIDER
Physicians’ Diagnostics and Rehabilitation

CHALLENGE
Continuing education for physical and occupational therapy providers in the treatment of chronic neck and low back pain is vast and expensive. Patient treatment plans often depend on which provider they see and what latest and greatest continuing education course the therapist attended. Approaches vary immensely between providers and clinic groups. This makes it difficult to provide measurable care outcomes as treatment at one clinic may vary based upon the treating therapist.

INNOVATION
Our clinic realized an opportunity to provide guidance and standardization of continuing education in an effort to ensure our clinic methods were based on clinical evidence, and to train all providers to a consistent level of skill and expertise. This permits patient outcome data collection and care delivery optimization across multiple providers.

IMPROVING HEALTH
Patient care delivery is optimal due to:
- Treatments based on current best evidence.
- Skill-tested providers that are also monitored for outcomes.

ENHANCING PATIENT EXPERIENCE
- Patients receive improved access to appointment times and flexible schedules because they’re free to see any provider at their clinic.
- Patients report nearly a 75 percent total recovery, with pain reduction, improvement in strength, function and emotional stress, and overall activation in their health.

TAKING AIM AT AFFORDABILITY
- The overall cost of our rehabilitative program is a good value compared to more invasive procedures. In fact, it’s considerably less expensive than an MRI and/or back injection(s).
- Patients that improve activation levels and reduce their emotional barriers to chronicity, as evidenced by our outcomes, stand a greater chance of maintaining self management and decreasing long-term health care utilization.
  
  » In fact, research on the PAM-13 (patient activation measure) suggests improvement in activation scores not only reduces health care utilization and cost, it transfers to managing other medical problems and comorbidities.
BLEND was created to accomplish an ambitious goal of reducing childhood obesity by 10 percent in Central Minnesota by 2016.

BLEND is a community collaborative that leads community-wide efforts to increase physical activity and promote healthy eating through transformations in policies, systems and our environment. BLEND is governed by synergistic and passionate people representing health care, business, community policy makers, schools and parents. BLEND’s initiatives include 5-2-1-0 (a prescription for healthy living), healthy fundraisers, Safe Routes to School (SRTS), family fitness events and NuVal (an easy food scoring system).

Rates of overweight and obesity among 12-year-olds have dropped 14 percent in the St. Cloud area since BLEND began in 2008, including a 28 percent drop among boys. More children are now walking or biking to school, with 23 percent to 40 percent more in participating SRTS schools. More than 8,550 kids participate in the Fit Kids Club events, many of which are available for free or at reduced prices for families.

BLEND’s focus on childhood health allows for positive health-building discussions with families rather than on sick care.

BLEND is the first coalition in the country to demonstrate a significant sustained drop in obesity rates highly attributable to policy and environmental changes at schools and in the community. Prevention of being overweight and obese is far less expensive than hospital and clinic treatment of the associated chronic conditions.
A pharmacy-based care management program for epilepsy

PROVIDER
Thrifty White Pharmacy

CHALLENGE
For patients prescribed medication for epilepsy, it has been found that seizures persist in 20 percent to 30 percent of cases.* Thrifty White Pharmacy partnered with MOBĒ™ to address modifiable factors which could lead to improved seizure control in patients on anti-epileptic drug therapy.

INNOVATION
We developed a process to ensure patients with epilepsy receive a consistent generic product (same size, shape, color and ingredients) month after month. In addition, we created a care management program in partnership with MOBĒ that’s provided by care partners and pharmacists located at the Thrifty White Pharmacy Patient Care Center in Fargo, North Dakota.

IMPROVING HEALTH
The epilepsy care management program included a motion monitor tool which allowed care partners to monitor patients’ activity levels. This enabled care partners to help identify opportunities for monthly coaching around the importance of medication adherence and meeting physical activity goals. The program aims to improve patient self-management, improve medication management, reduce the cost of care (e.g., reduce hospital admissions and ER visits) and improve clinical outcomes.

ENHANCING PATIENT EXPERIENCE
• “At-home” pharmacy experience.
• Frequent outreach at least four times each year.
• Enhanced support, coaching for medication adherence and activity goals.
• Greater accessibility with extended hours Monday through Saturday,
• Timely delivery with next day delivery of all new prescriptions.

TAKING AIM AT AFFORDABILITY
By providing patient self-care and medication management support, we were able to keep patients adherent (PDC more than 80 percent). Studies have associated medication adherence to a decrease in total cost of care due to a reduction in inpatient and emergency room utilization.

Aris Clinic offers intensive outpatient programming for kids age five to 18 with behavioral health issues such as depression, anxiety, anger, post traumatic stress disorder and autism. Often, these issues lead to struggles with and avoidance of school. In some cases, these patients may require mental health services at IOP, PHP and sometimes inpatient levels of care. Our goal is to prepare kids with behavioral health challenges to start the school year successfully.

We designed and implemented a school readiness curriculum delivered through our Intensive Outpatient Program. It’s administered the last four weeks of the summer leading up to the start of the K-12 school year in the fall, and focuses on issues that typically prevent kids with behavioral health issues from starting the school year. Patients discharging in May and June without the opportunity to complete a transition back to school were informed of the school readiness curriculum and recommended to return to Aris to prepare to start the school year.

- Proactively prepares patients to cope with behavioral health challenges when returning to school.
- Increases self-image and confidence upon a successful return to school.
- All August 2014 participants started their school year successfully without seeking Aris services in the fall, contrary to the experience of non-participants.

- Supports patients through the transition to school and addresses acute issues as they arise.
- Tailored approach to meet the needs of the patients participating in the program.

- The school readiness curriculum participants’ average length of stay was two to four weeks. This is compared to a six to eight week typical IOP length of stay for patients who struggle at school and seek out services.
- Our program proactively addresses challenges and prevents longer and more expensive future stays.
Enhancing the delivery of transitions care:
Using a patient reported activation assessment to guide discharge processes

PROVIDER
Fairview Health Services

CHALLENGE
Too often patients with high-risk conditions are discharged from an inpatient setting and readmitted shortly thereafter. This may be due to condition complexity, inadequate coordination of care, and/or low patient compliance with discharge instructions. Addressing the root causes of these readmissions is a high priority for all health care providers.

INNOVATION
To improve the rate of post-hospital follow-up visits in a primary care setting, our innovation included an initial assessment of a patient’s engagement level using the Patient Activation Measure (PAM). This determined the version of condition-specific education provided and reviewed by a care transition specialist (CTS) prior to discharge. In addition, streamlined scheduling methods assisted in setting up a follow-up clinic appointment before patients left the hospital. Text (SMS) or email reminders were sent 24 hours prior to the scheduled appointment in the next seven days.

IMPROVING HEALTH
• A systematic process for real-time assessment and engagement of patients in post-hospital care.
• Higher rates of seven day follow-up clinic visits in the intervention group when compared to standard of care (65 percent vs. 47.1 percent).
• Lower readmission rates in the intervention group when compared to standard of care, 26.5 percent versus 10 percent, about 2.5 times lower.

ENHANCING PATIENT EXPERIENCE
• Increased opportunity for patient-led discussion of key barriers to health and short-term goals.
• Significant improvement in patient perception as to “why my follow-up appointment is important to my health.”

TAKING AIM AT AFFORDABILITY
• During pilot phase (six months), we estimate four readmissions were avoided for a group of 22 participants, amounting to more than $160,000 in averted charges.
• Potential cost savings in 30-day readmissions if the program was provided to all CMS COPD and pneumonia inpatients is estimated at $3.7 million in a given year.
PROVIDER
Summit Orthopedics

CHALLENGE
Patients having total knee arthroplasty (TKA) or total hip arthroplasty (THA) typically spend two or more nights in a hospital, have inconsistent experiences including a lot of pain, varying amounts of rehabilitation and often are transferred to an extended care facility before going home.

INNOVATION
A surgery center and home health care program were built under one roof for patients meeting specific criteria to have TKA and THA in an outpatient setting, yet allow for home health services as necessary. A detailed clinical pathway was established for these patients to improve experience, speed up recovery and improve outcomes.

IMPROVING HEALTH
• Clinical pathways (including anesthesia regimen) results in less pain, sooner post-operative ambulation, decreased LOS and quicker return to work or daily routine.
• Lower risk of infection and complications.
• Staff are 100 percent orthopedic trained.

ENHANCING PATIENT EXPERIENCE
• Experience is seamless from the time they’re a candidate for TKA/THA to three months after surgery, patients work with a single organization.
• THA/TKA candidates meet with an orthopedic CNS who thoroughly educates patient and significant others about what to expect.
• On average, patients walk three hours post-operatively. After discharge, rehabilitation continues using Secure Track; only one in Midwest.
• More than 70 percent of patients rate pain at zero when first asked post-operatively.
• Care team is always present with limited interruptions and quiet environment.
• Concierge and valet services for patients and families.

TAKING AIM AT AFFORDABILITY
• Reduced out-of-pocket cost and time away from work.
• Reduced cost of care to employers and payers for TKA/THA episode.
Implementing best practices:
Integrating active care and spinal manipulation for adult low back pain

**PROVIDER**
Chiropractic Care of Minnesota, Inc. (CCMI)

**CHALLENGE**
Active care remained an underutilized activity across the chiropractic community. With the support of documented clinical benefits and a growing demand by key stakeholders, CCMI sought to develop a program that educates and trains its network providers on the advantages and application of active care.

**INNOVATION**
Our Active Care Certification program is built on a foundation integrating active care and spinal manipulation to improve and advance patient outcomes. During our four-part program, providers are offered a value-based education, hands-on training and the take-home tools needed to instruct and inspire their patients to play an active role in their body’s recovery. Our Active Care Certification program includes both online and in-person training, is tailored to the specific needs of the chiropractor and can be completed in five to six weeks.

**IMPROVING HEALTH**
- Current research validates spinal manipulation with active care exercise to provide the best long-term patient recovery outcomes.
- Active care activities result in:
  - Faster recovery with increased functional activities
  - Improved muscle strength and joint stability
  - Fewer psychological issues and reduced likelihood of developing chronic pain

**ENHANCING PATIENT EXPERIENCE**
- Reduces the amount of visits and time to recovery for patients, and provides a greater sense of control and empowerment by taking a more active role in their treatment, and experience reduced anxiety and “fear of pain.”
- Individualized care plans offer a value-added benefit for patients.

**TAKING AIM AT AFFORDABILITY**
- Decrease number of episodes of care (chiropractic and other).
- Fewer recurrences of injury.
A team approach to delivering efficient, innovative, and patient- and family-centered care to orthopedic surgery patients

**INNOVATION**

- Home medications reviewed preoperatively for potential drug interactions with postoperative anticoagulant.
- Preoperative antibiotics adjusted due to allergies.
- Tranexamic acid held due to contraindications or increased risks.
- Ketorolac doses reduced or held due to impaired renal function.

**ENHANCING PATIENT EXPERIENCE**

- Patients more actively involved in their care and recovery.
- Fewer questions the day of surgery; more prepared for surgery and recovery.
- 100 percent of patients had medication reconciliation completed prior to day of surgery (n=121).

**TAKING AIM AT AFFORDABILITY**

- Pre-authorization of anticoagulant medication resulted in 4 percent of patients changing postoperative anticoagulation plan due to cost.
- Patients informed ahead of time to bring in non-formulary home medications, preventing a non-formulary charge for medications.
- Reduced surgery delays due to medication preparation.
- Reduced staff’s time by 15 minutes on average.
PROVIDER
Fairview Rehabilitation Services

CHALLENGE
Not all patients have a qualifying rehab diagnosis for supervised exercise (e.g., peripheral artery disease). In addition, cardiac rehab/pulmonary therapy patients often are uncomfortable transitioning to a regular gym without supervision. There was a need to offer a transition environment from outpatient rehab therapy and outpatient therapy to a wellness activity in the community that supports lifestyle changes which optimize health and prevent readmission.

INNOVATION
Developed an affordable, safe, supervised exercise and education program that enables patients to continue healthy lifestyle changes to live longer, healthier lives. Actively seek individual patient feedback through rounding to modify and improve their program to ensure it’s consistently meeting the needs of patients.

IMPROVING HEALTH
• Low cost physical activity option where patients can work with a skilled therapist to support health promotion and disease prevention in a safe, monitored setting.
• Increased touch-points between patients and medical professionals to decrease risk of readmissions.
• Encourage participants to join community fitness centers and health clubs in their community when they’re ready.

ENHANCING PATIENT EXPERIENCE
• Offers a safe, supportive, comfortable environment to continue with physical activity program.
• Education and expertise in risk reduction for comorbidities.
• Enhanced relationships and support network through participation.
• 84 percent of patients would recommend to others.

TAKING AIM AT AFFORDABILITY
• Stable, affordable pricing and pre-pay discounts comparable to health club and fitness center pricing ($49/month).
• More than 80 patient scholarships awarded through Fairview Foundation to provide financial assistance based on income.
• Overall growth of 263 percent since start of program with 16,082 projected patient visits.
Care model design to improve value of physical therapy for patients at low risk of long-term disability from low back pain

PROVIDER
Fairview Health Services, Orthopedic Service Line and Institute for Athletic Medicine

CHALLENGE
Low back pain is costly and ever increasing in incidence. Despite many technological innovations and advances in medical knowledge, the U.S. isn't producing better patient-reported outcomes for this large population. Identifying patients at low risk for long-term disability based on psychosocial health provides the opportunity for new care models of physical therapy.

INNOVATION
Piloted a care model design to deliver an intentional, value-driven intervention, focused on education, reassurance and decreased utilization for patients who are at low risk for long-term disability due to their back pain.

IMPROVING HEALTH
• Demonstrated improvement of back condition as evidenced by the patient-reported global rating of change (4.1/5).
• Reduced low back pain medication use by 77 percent.
• Reported return of usual activities of daily living, zero work days missed and confidence in patient ability to self-manage current and future episodes of low back pain.

ENHANCING PATIENT EXPERIENCE
• 100 percent of pilot patients reported the care met their expectations, and they got what they needed from physical therapy.
• 94 percent of pilot patients reported they didn’t seek additional health care during the six-week follow up.

TAKING AIM AT AFFORDABILITY
• Piloted care demonstrated a 36 percent reduction in utilization of physical therapy, patient copays and indirect costs such as time away from work and family to attend physical therapy visits.
• Potential annual savings of physical therapy charges of approximately $1 million.
Primary care provider teams: Developing a collaborative MD and NP-PA Model

PROVIDER
Essentia Health

CHALLENGE
To achieve the Triple Aim in an ACO environment, the future of health care depends on the utilization of team based care and better stewardship of resources. The match of physicians and NPs-PAs in primary care was inconsistent and staff wasn’t fully utilized efficiently and at the appropriate skill level within the clinic’s panel assignments. High quality, effective care would improve through a consistent care team that has supportive professional role guidelines and shared compensation alignment.

INNOVATION
We developed a Physician/NP-PA collaborative model with guidelines for sharing patients and providing care to the appropriate type of patients based on provider type. Action plans and strategies were developed to close the gap between actual and available capacity. We also designed and utilized a tool to determine ideal staffing ratio for MDs to NPs/PAs to support the team model and ensure the clinic has enough capacity to meet patient demand. The proposed staffing is entered into a financial modeling tool to see impact on direct operating margin.

IMPROVING HEALTH
• Improved the quality and continuity of care for patients by developing a relationship with their primary care provider team.
• Prescriptive guidelines for the collaborative MD/NP-PA team ensured that patients were being seen by the right type of provider.

ENHANCING PATIENT EXPERIENCE
• Increased the ability for patient’s to access their primary care team within the clinic.
• “Voice of consumer” surveys found improved satisfaction with the teams providing care.

TAKING AIM AT AFFORDABILITY
• MD/NP-PA ratios have improved from 2.69 to 1.83, resulting in savings in MD/NP-PA salary expenditure of $2.24 million annually.
• Action plans improved clinic productivity by closing the gap between actual and available capacity, which equaled 26,000 annual encounters.
PROVIDER
Essentia Health Virginia Clinic/Hospital

CHALLENGE
The previous laboratory at the Virginia hospital was compartmentalized. This contributed to many forms of waste, including the inefficient transport of specimens and movement of staff. The nearby Virginia Clinic laboratory offered redundant services, requiring duplicative laboratory instrumentation and supplies. There was variation in work flows between both labs. In addition, the fractured nature of the hospital lab space was prone to safety concerns and provided a less than optimal patient experience.

INNOVATION
The decision was made to consolidate the hospital and clinic labs into a new hospital space. The innovation involved the design of a new laboratory utilizing Lean principles and involving participants from both labs, maintaining focus on how work flows would serve to decrease the time patients waited for results. Lean design principles, such as waste reduction in motion and transportation, adjacencies and process workflow were employed. Initial lab designs were “mocked-up” using cardboard, 1x2’s and other materials in a dimensionally equivalent space to the future-state lab. The team used this “test lab” environment to conduct lab processes. These simulations helped identify additional design changes, supporting patient centricity in the lab’s processing of test results. Coupled with testing and workflow efficiencies, a Kanban inventory system was also designed and implemented.

IMPROVING HEALTH
• Improved lab result turnaround time.
• State-of-the-art environment provides for optimal laboratory testing and high quality results.

ENHANCING PATIENT EXPERIENCE
• Layout of facility friendlier and aesthetically pleasing for our patients.

TAKING AIM AT AFFORDABILITY
• Reduced redundant equipment and reagent costs.
• Ability to see efficiency gains in staffing by consolidating laboratory services.
• Estimated one time savings of $350,000 with a $375,000 equipment savings over three years.
Telehealth medical weight loss management

**PROVIDER**
Essentia Health

**CHALLENGE**
More than two-thirds (69 percent) of adults and one-third (32 percent) of children are considered overweight or obese. As an ACO, Essentia Health is committed to improving overall population health. A key component of assisting patients with a weight loss program is to increase the ease and availability of access to their health care teams so feedback on the patient’s efforts can be discussed to ensure healthy habits are reinforced or established. Patients in rural areas would have to spend three to six hours driving to and from each appointment to receive that care, so they were unlikely to commit to it, especially since winter driving can be treacherous.

**INNOVATION**
We provided additional support to primary care practitioners by using telehealth outreach. Services are provided by Dr. Stephen Park, the bariatrician from our Ely Clinic location.

**IMPROVING HEALTH**
- With more than 1,400 new encounters, total patient weight loss per year has doubled to more than 9,000 lbs.
- Provides a referral source to address obesity, overweight, insulin resistance and metabolic syndrome in adults and children.
- Improving the general health of the public to assist them with maintaining a healthy body weight and reduce the probability of some chronic diseases, as well as reduce the severity of the effects of those diseases.

**ENHANCING PATIENT EXPERIENCE**
- Reduced barriers to patient care by decreasing travel time for the patient.
- Provided a means to improve patient access.

**TAKING AIM AT AFFORDABILITY**
- Reduced physician outreach travel time.
- Provided an alternative to surgical bariatric intervention.
- Reduced cost when compared to a traditional visit.
TRIA Orthopaedic Center

CHALLENGE
Sport concussion program services can vary widely. There's a distinct difference between simply treating a concussion and having a concussion program. In our market analysis, we found that not all disciplines of medicine that are specifically trained in concussion management were included in existing programs. In addition, other programs may not include athletic trainers, who are the front line providers of concussion care. TRIA’s challenge was to develop an evidence-based sport concussion care model to meet our community’s needs.

INNOVATION
Same-day access to a multi-disciplinary team that develops a formalized management plan based on an athlete’s symptom cluster, evaluates when an athlete is ready to return to full sports and a concussion care coordinator for follow-up care. Our program will include an athlete concussion support group for those struggling to return to their desired activity.

IMPROVING HEALTH
• Guideline and screening standards for concussion injury that include:
  › Sideline concussion evaluations
  › Return to play guidelines
  › Return to learn guidelines
• Ensure timely but safe return to sport through specialized sport-specific return to play protocols and exertion therapy.

ENHANCING PATIENT EXPERIENCE
• One location for timely access and resources.
• Reassure athletes and parents about recovery through education, objective screening and “return to learn” programs.
• Guided communication between parents, coaches, athletic trainers, primary care physicians and school educators by a designated concussion coordinator.

TAKING AIM AT AFFORDABILITY
• Reduce cost associated with emergency department use, advanced imaging and multiple provider visits.
• Early identification and reduction in duration or burden of symptoms.
Improving efficiency in living organ donation

PROVIDER
University of Minnesota Health Living Donor Kidney Program

CHALLENGE
The time from inquiry to evaluation for potential kidney donors was too long due to inefficiency in living donor workflow and matching processes. Donors, recipients and physicians had expressed dissatisfaction about the delay and process.

INNOVATION
Designed and implemented an innovative living organ donation workflow which improved health outcomes, satisfaction and cost, and expanded the Paired Exchange Program (PEP).

IMPROVING HEALTH
• Designed one standard workflow process based on donor intent, an innovation we believe to be the first in the nation, which used value-stream mapping to ensure donation occurs in a timely manner.
• Reduces wait time for organ recipients, therefore decreasing adverse outcomes of a recipient continuing to suffer from kidney failure.

ENHANCING PATIENT EXPERIENCE
• Decreased wait time in the evaluation period by 11 business days (nearly two weeks of unnecessary waiting).
• 100 percent of patient care team surveyed say the changes made in this innovation were safe for our patients and resulted in improved patient satisfaction.
• 100 percent of the patient care team would participate in an additional quality improvement innovation project in the future, demonstrating the innovation improved likelihood of caregivers to continue improving patient satisfaction by our new design model.

TAKING AIM AT AFFORDABILITY
• Reduced unnecessary testing for cross-matches by 15 percent.
• Decreased costs by $1,400 for each patient.
Medical weight loss: A truly integrated approach

---

**PROVIDER**
Allina Health

**CHALLENGE**
Primary care providers caring for patients with a diagnosis of overweight or obesity didn’t have an evidence-based quality program to refer patients to.

**INNOVATION**
Created a comprehensive, integrated, multi-disciplinary medical weight loss program for patients with a BMI more than or equal to 30. This is the only truly physician-led, comprehensive adult medical weight loss program in the area.

**IMPROVING HEALTH**
- Provides an alternative to community-based retail weight loss programs.
- Created team approach to weight loss; medical, nutrition, lifestyle and wellness components.
- Patients see a physician, dietitian, exercise staff and health coaches.
- Physician supervised program.

**ENHANCING PATIENT EXPERIENCE**
- All services are provided in one clinic setting and are coordinated.
- Personalized treatment plans; no one-size-fits-all approach.
- Flexible scheduling.
- Flexibility to enhance program through additional physician and dietitian visits.
- Additional fee-for-service exercise and wellness components available.

**TAKING AIM AT AFFORDABILITY**
- Enrollment fee is significantly lower than community-based programs.
- Measuring metrics for reduction of medications for hypertension, dyslipidemia, diabetes and need for CPAP use for patients with obstructive sleep apnea.
- Weight loss contributes to significant decreases in total cost of medical care.
- We were successful in getting our program covered as a “Be Fit” benefit for employees, which means they’ll be able to get the majority of their retail fee portion of the program refunded to them upon completion.
Know thyself: A diagnostic tool for assessing your care team’s health

INNOVATION

PROVIDER
HealthPartners Orthopedic and Sports Medicine

CHALLENGE
Our department functions as a team of teams, with each care team consisting of a physician, nurse or medical assistant, athletic trainer and a physician assistant or nurse practitioner. Our challenge was creating a way to easily visualize how the team felt it was functioning. Specifically, we focused upon how the physician felt he or she was leading the team compared to how the team felt they were being led.

INNOVATION
We used a modified version of Google’s Upward Feedback Survey, a tool that Google uses to allow teams to evaluate their managers. We tailored the survey to better address our health care environment and to incorporate the triple aim. Taking Google’s evaluation further, not only would the team members evaluate the physician, but the physician also evaluated how they felt they were leading the team. Our assessment is bidirectional (versus Google’s unidirectional orientation) and it uses radar plots (versus bar graphs) to display areas of disconnection within a department and individual teams.

IMPROVING HEALTH
It’s easier to prescribe a treatment once the diagnosis is known. Our assessment evaluates the health of a team and quickly identifies areas of disconnection.

ENHANCING PATIENT EXPERIENCE
• Quite simply, when a team is functioning well, they provide better care and a better patient experience.
• Engaged team members take greater ownership in patient care.

TAKING AIM AT AFFORDABILITY
• Employee turnover is incredibly costly. Not only does it take time and money to orient a new team member, but the departing employee takes with them invaluable institutional memory.
• Better communication leads to a wiser use of resources and health care dollars.
PROVIDER
CentraCare Clinic

CHALLENGE
It was identified that substance use in the primary clinic setting could be addressed more efficiently and effectively through the use of evidence-based tools in a structured model. Referrals to chemical dependency programs don’t always result in actual visits when patients no-show for an appointment or fail to schedule.

INNOVATION
The Screening, Brief Intervention, Referral to Treatment (SBIRT) model was used in conjunction with the Alcohol Use Disorder Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST) to screen patients for risky substance use. A social worker was also utilized in the clinic to see patients for brief interventions on the day the screening was completed.

IMPROVING HEALTH
• Improvement in goal setting and follow through for reduction in substance use.
• Improved follow-through with chemical dependency visit.
• Reduction in risky alcohol and drug use.

ENHANCING PATIENT EXPERIENCE
• Patients can speak with someone the same day a substance use issue is raised.
• Patient interactions included elements of motivational interviewing.

TAKING AIM AT AFFORDABILITY
• Same day handoff between the provider and the social worker are more efficient than rescheduling a visit.
• Allows provider to continue to see other patients, thereby increasing productivity.
• Less risky substance use leads to less alcohol and drug related emergency department visits, and costly health complications.
Reducing catheter associated urinary tract infections through implementation of a comprehensive education bundle

PROVIDER
United Hospital, a part of Allina Health

CHALLENGE
Urinary tract infections (UTI) are the most common type of hospital acquired infections and most are associated with the placement of a urinary catheter. Catheter associated UTIs (CAUTIs) can lead to prolonged length of stays, increased costs, morbidity and mortality. CAUTIs are also included measures in federal pay-for-performance programs and can adversely impact reimbursement. Minnesota hospitals, including United Hospital, had a higher incidence of CAUTI infections than desired. An analysis was conducted to assess insertion and maintenance practices and to identify possible interventions which could be implemented to help reduce the risk of CAUTI.

INNOVATION
Implemented a comprehensive bundle composed of CAUTI prevention education and urinary catheter insertion competency assessment by trained Super Users for all of our inpatient nurses. Change in practice protocol requires a two person insertion technique designed to ensure asepsis is maintained for every insertion.

IMPROVING HEALTH
• Increased staff awareness of CAUTI prevention recommendations.
• Ensured asepsis during urinary catheter insertions.
• Decreased risk of CAUTI minimizes a patient’s risk of further complications following a hospital associated UTI, including secondary bloodstream infections, Clostridium Difficile and surgical site infections.

ENHANCING PATIENT EXPERIENCE
Infection risk has been greatly reduced, furthering the decreased risk of lengthened hospital stays, morbidity and mortality.

TAKING AIM AT AFFORDABILITY
• 95 percent of inpatient nurses completed the Cutting CAUTI education and competency by Dec. 31, 2014.
• 100 percent of new nurses complete the Cutting CAUTI education and competency upon hire.
• CAUTI infections decreased by 77 percent hospital wide, with only five infections since education launch.