Yoga's Impact on Global Health in Breast Cancer Survivors

INNOVATION

PARTNERS IN EXCELLENCE

SPECIALISTS IN GENERAL SURGERY

PROVIDER

Specialists in General Surgery

CHALLENGE

For breast cancer survivors, practicing yoga can reduce inflammation and fatigue. It can also improve sleep quality and vitality. Besides improving quality of life, yoga can have an even greater impact on survivors. It can reduce the risk of recurrence and other chronic health conditions.

Yet current practice for breast cancer patients is to establish a surgical plan of care. Then, a patient is dismissed from surgery at the postop visit. Providers often encourage physicial activity. But it is challenging to offer a concrete care plan.

INNOVATION

Patients take free yoga classes as part of their postop and survivorship care plans. After each yoga class, patients completed a survey. The Patient Reported Outcome Measurement Information System (PROMIS) 10 Global Health survey looks at physical and mental perception of health.

IMPROVING HEALTH

- Regular yoga practice can decrease inflammation, fatigue and depression for breast cancer survivors.
- It can also increase vitality and sleep quality, and can alleviate symptoms associated with treatment.

ENHANCING PATIENT EXPERIENCE

- Yoga classes offer a way for patients to connect with others in the community in a non-threatening setting – avoiding the perceived stigma of formal support groups.

TAKING AIM AT AFFORDABILITY

- Our results show an increased physical health score on the PROMIS 10 Global Health survey among the cancer group when compared to the non-cancer group (guests) vs. no yoga (patients with breast cancer that did not do yoga).
- Average raw physical scores – 16.33-15.09-15.00.

HealthPartners®

Clinical Management to Self-Management: An Outpatient Chemical Dependency Model of Care

INNOVATION

PARTNERS IN EXCELLENCE

Hazelden Betty Ford Foundation

PROVIDER

Hazelden Betty Ford Foundation

CHALLENGE

Our previous outpatient substance use treatment program had low patient engagement and low patient satisfaction. The care model included a short-term 6-week treatment, with follow-up services available upon enrollment in a separate 8-week program. But transfer from the 6-week to 8-week program meant changing the patient's day and time of service, as well as the clinician. The average length of stay was also insufficient to allow patients the necessary time to learn skills for the self-management of their recovery from drugs and/or alcohol.

INNOVATION

We shifted from offering two separate short-term, highly prescriptive programs to one program that allows patients to move through the treatment program based on their individual treatment plan and recovery support needs.

We changed outpatient treatment services to create a program that begins with four sessions per week. As patients meet clinical milestones, they decrease in frequency to three sessions and then to two sessions and finally to one session per week. The goals focus on increased patient engagement, a longer length of stay, higher patient satisfaction, and a decrease in documentation time and cost to treat a patient.

IMPROVING HEALTH

- Patient engagement rose from 5.3 weeks to 12 weeks.

ENHANCING PATIENT EXPERIENCE

- Patient satisfaction scores increased from the 69th percentile to the 88th percentile ranking.

TAKING AIM AT AFFORDABILITY

- We reduced the number of per-patient hours while extending their engagement period.
- Patient treatment cost decreased with an increase in the number of patients served without increase in staff per group.

HealthPartners

Primary Care Payment Reform

INNOVATION

PARTNERS IN EXCELLENCE

Entira® FAMILY CLINICS
Where generations thrive®

PROVIDER

Entira Family Clinics

CHALLENGE

Our reimbursement is based on fee-for-service only. This form of reimbursement does not support care management and in-between health care services. We needed a way to provide these services with additional resources – while also maintaining our budget.

INNOVATION

We worked with HealthPartners to create a new payment model, called "Primary Care Case Rate Payment." The model pays us a monthly global payment for patients seen in the last 12 months.

We receive a larger amount when the patient has a visit, but smaller monthly payments for the remaining 11 months when the patient is not seen. This allows us to provide and receive reimbursement for in-between care.

Additionally, if a patient is seen by a provider, lab visit or telephone visit, this re-triggers the case rate payment.

IMPROVING HEALTH

- Ensured appropriate level of care management services by developing a systematic quarterly process using the HP Patient Management Application (PMA) tool.
- Used the PMA tool to make sure that patients are seen on a yearly basis (as appropriate).

ENHANCING PATIENT EXPERIENCE

- Patients have access to a care team to provide the right care, at the right time, with the right member of the team.
- Patient has quicker access to their care team.
- Patient care needs and gaps are captured in their care on a yearly basis.

TAKING AIM AT AFFORDABILITY

- Patients receive care management services with no additional out-of-pocket expenses.
- We achieved budget neutrality for our first year of experience.

HealthPartners®

Vibrant Health
FAMILY CLINICS

PROVIDER

Vibrant Health Family Clinics

CHALLENGE

Managing chronic disease is a constant struggle. Patients endure major symptoms while navigating appointments, financial needs and medication management. This is why our chronic disease patients need management and assistance from their health care team outside the clinic.

INNOVATION

We implemented our Chronic Care Management (CCM) program following CMS guidelines. Patients receive customized care and are empowered to actively manage their healtht.

IMPROVING HEALTH

- Personalized care
- Close care coordination follow-up to ensure health goals are met
- Resources to remove barriers to patient health
- Health coaching

ENHANCING PATIENT EXPERIENCE

- Fewer office visits
- Personal point of contact between patient and health care provider
- Support between office visits
- A care team with integrated care coordination that patients can use for help or answers when they are at home

TAKING AIM AT AFFORDABILITY

- We have a 75% enrollment rate for referred patients.
- Of our diabetic population, 47% are considered in control, 77% of our hypertension population are considered in control, and 70% of our ischemic vascular disease patient population are considered in control.
- Lowered cost per chronic patient to $39 per month on average.
- We created a patient brochure explaining how CCM program participation will help them stay healthier and save money in the long run.

HealthPartners®

Integrated Care Delivery Model in Primary Care Clinics

INNOVATION

PARTNERS IN EXCELLENCE

Ridgeview MEDICAL CENTER

PROVIDER

Ridgeview Clinics

CHALLENGE

Primary care has a history of being reactive rather than proactive in treating patients' chronic conditions. This pushes the responsibility back on the health care consumer. Often times, this results in patients ignoring their chronic conditions – until their problems are too severe to ignore. When patients aren't engaged in their own health, the ability to truly have an impact on the Triple Aim is lost.

INNOVATION

Ridgeview Clinics infused Health Navigators into the Primary Care setting – a role that has quickly become the hub of the clinic care team. Navigators work proactively with patients to improve their health, successfully manage their conditions and support them in sustaining positive behavior change. This role has also reshaped our clinic care teams to work more collegially and be more effective – which translates into better patient experience and better care.

IMPROVING HEALTH

- Provides individualized care within a multi-disciplinary, tightly-knit care team.
- Incorporates motivational interviewing and skilled coaching techniques to engage patients in their own health and care management.

ENHANCING PATIENT EXPERIENCE

- Provides patients with a better understanding of their health and what their role is in achieving wellness, through education and extra one-on-one health care provider time.
- Establishes a trusting relationship with patients, giving them one common person to connect them to any additional resources needed for their health.
- Provides a patient advocate through the integral and connective role of the Health Navigator – always with the patient's best interest at the forefront.

TAKING AIM AT AFFORDABILITY

- Achieves positive health outcomes, including decreased body weight, improvement in depression symptoms and improvement in diabetes control and overall decrease in tobacco use.
- Provide the invaluable Health Navigator service at no additional cost to our patients – which positively impacts health outcomes and patient satisfaction.

HealthPartners®

METROUROLOGY

PROVIDER

Metro Urology

CHALLENGE

Trans-rectal ultrasound-guided biopsy (TRUS) is the current biopsy standard used to detect prostate cancer. This procedure suffers from poor image resolution. And, the biopsy needle often passes through tumor-free areas of the prostate, potentially missing the tumor entirely. The TRUS procedure also makes it difficult to distinguish between lesions that necessitate only a “watchful waiting” period and more aggressive lesions that require therapy.

Consequently, we needed a more sensitive and effective tool for detecting significant prostate cancer in patients with rising PSA values and negative findings from traditional biopsy methods.

INNOVATION

We pioneered the use of the UroNav Fusion Biopsy System in the Midwest. The UroNav System is a technology that fuses pre-biopsy MR images of the prostate with ultrasound-guided biopsy images in real time. This provides excellent delineation of the prostate and suspicious lesions, as well as clear visualization of the biopsy needle.

IMPROVING HEALTH

- The UroNav Fusion Biopsy System allows us to detect significant and aggressive cancerous lesions in initial biopsies and in patients who have had previous negative biopsies.
- The technology also helps us determine the clinical significance of the cancers identified and provide earlier treatment.

ENHANCING PATIENT EXPERIENCE

- The UroNav Fusion Biopsy System causes patients minimal discomfort and saves them from the pain, cost and time spent having additional standard biopsies.
- By detecting the cancer earlier, it reduces the amount of treatment necessary.

TAKING AIM AT AFFORDABILITY

- In the two years that we have used the UroNav System, we have biopsied more than 750 patients and diagnosed more than 100 cancers that would have otherwise been missed. This represents a 13.3% positive detection rate.
- By detecting significant prostate cancer earlier, we are reducing the amount and overall cost of care.

HealthPartners®

Establishing Personalized Pain Goals in Oncology Patients to Improve Care and Decrease Costs

INNOVATION

PARTNERS IN EXCELLENCE

Park Nicollet®
HealthPartners®

PROVIDER

Park Nicollet Health Services

CHALLENGE

Cancer pain is one of the most problematic and pervasive aspects of cancer care and overall cancer management. Pain affects half of all patients diagnosed with cancer and more than 60% of those with metastatic cancer or advanced stage disease – impacting quality of life and survival rates.

Opioids remain a mainstay for managing oncology patients' pain. But long-term use of opioids poses significant challenges. Opioids carry the risk of abuse, are costly and have been associated with increases in cancer progression.

INNOVATION

We educated clinicians on opioid costs and the comparative effectiveness of long-acting opioids. We also implemented a new nursing protocol to document a personalized pain goal (PPG) in our medical record.

IMPROVING HEALTH

- Measuring and managing patients' pain can reduce unwanted outcomes.
- Pain at diagnosis has been reported to be associated with shorter survival in patients with lung cancer and other malignancies.
- Poorly controlled pain may also lead to increased emergency department and hospital encounters.

ENHANCING PATIENT EXPERIENCE

- We observed increases in the percentage of encounters with a documented PPG from approximately 20% to over 70%. On average, we achieved the PPG in nearly 90% of patients.
- By emphasizing achievement of PPGs rather than organizational pain score targets, we can improve patient satisfaction. In part, this is because use of PPGs signifies to patients that clinicians hear patient concerns and indeed focus on providing personalized, quality care rather than meeting arbitrarily generated pain measurement metrics.

TAKING AIM AT AFFORDABILITY

- Rates of high-cost long-acting opioid prescriptions (oxycodone CR and fentanyl patches) as a total of all long-acting opioids declined 11 percentage points – from 46% pre-intervention to 35% post-intervention.

HealthPartners®

Comprehensive Opioid Response with the Twelve Steps (COR-12)

INNOVATION

PARTNERS IN EXCELLENCE

Hazelden Betty Ford Foundation

PROVIDER

Hazelden Betty Ford Foundation

CHALLENGE

People with opioid use disorders are much more likely to leave residential treatment prior to completion (atypical discharge). Lack of treatment completion is a predictor of negative outcomes, including relapse to opioid use – exposing patients to overdose and death. The atypical discharge rate for those with opioid use disorders prior to our project (2012) was 25%. In response, we sought a way to improve outcomes for individuals with opioid use disorders.

INNOVATION

We initiated a new and innovative treatment program within our residential and outpatient services. The program includes four basic changes of treatment for those with opioid use disorders:

- Group therapy for those with opioid use disorders separate from their peers with other drug and alcohol use disorders.
- Education about opioid use disorders and the risk they run of overdose and death upon relapse to use.
- Adding two medications approved for use in opioid use disorders. The real innovation was combining our longstanding 12 Step, abstinence based program with the use of these medications.
- A long-term approach using primarily outpatient services.

IMPROVING HEALTH

- We implemented an innovative, evidence-based treatment option to increase patient outcomes by increasing patient engagement.
- We created a curriculum for other health systems to follow.

ENHANCING PATIENT EXPERIENCE

- We increased patient engagement by building team atmosphere and specialized treatment options to maximize experience.
- We worked with a leading EMR company to incorporate our new program into its medical record offering.
- We developed patient tools for recovery support, including website portals and apps for their phone or tablet.

TAKING AIM AT AFFORDABILITY

- By focusing on treatment completion in the residential setting — the most costly level of care for substance use disorders — we have reduced recidivism and readmission.
- We reduced atypical discharges (the strongest correlated indicator of readmission) by nearly 80%.

HealthPartners

ICU Move It: Early Mobility in Critically Ill Patients

· INNOVATION ·

PARTNERS IN EXCELLENCE

Regions Hospital®
HealthPartners®

PROVIDER

Regions Hospital

CHALLENGE

We needed to engage critically ill patients in early mobility. This includes range of motion activities (passive or active), sitting on the side of the bed or chair, standing and walking. Studies show physical function improves from the early introduction of mobility. But, our existing resource allocation, protocols and workflows were not organized to support the successful implementation of an early mobility program.

INNOVATION

We developed an early mobility program with the approach to prescribe movement as medicine. The program has an interdisciplinary care team led by a physical therapist.

As part of the program, a physical therapist rounds on the medical intensive care unit every morning. The physical therapist connects with the nurses to identify and schedule critically ill patients for physical therapy sessions. This includes ambulation while on a ventilator. The program represents a cultural shift for many members of the care team. Physical therapists were not involved previously in the care of patients on ventilators.

This program impacts all patients in the medical intensive care unit. It recently expanded to include cardiac intensive care patients.

IMPROVING HEALTH

- Early movement decreases the risk of muscle loss and helps with balance.
- Early movement enhances cardiovascular function.
- Early movement decreases depression and improves cognition.

ENHANCING PATIENT EXPERIENCE

- We engaged patients and families in the program through education and participation.
- We helped build hope and confidence in the patient and family regarding recovery.
- Patients progress more quickly to less intense level of care.

TAKING AIM AT AFFORDABILITY

- We decreased overall hospital length of stay by 1 day – a 13.1% reduction.
- 19% more patients have physical therapy as part of their ICU care.

(Given we are not in a controlled setting please note other factors may have contributed to these results.)

HealthPartners®

Using Virtual Care to Prevent or Manage Diabetes

INNOVATION

PARTNERS IN EXCELLENCE

FAIRVIEW

PROVIDER

Fairview Health Services

CHALLENGE

To address the rising prevalence of diabetes in Minnesota, we needed to find a way to improve self-management. We needed to increase convenience, maximize the number of interactions, monitor progress, provide resources in-between visits and create long-term motivation for our patients.

INNOVATION

We facilitate patient access to daily online health education and social networking. This is combined with a weekly group phone call and continuous use of mobile technology and food logging.

The intervention involves a high-level of interaction in the first 4 months of participation (core phase), with much lighter interaction in the months that follow (maintenance phase).

IMPROVING HEALTH

- 18% higher patient activation (as measured by patient activation measure) p = 0.033
- Better self-perceived health status (as measured by CDC Core Healthy Days survey) p = 0.035
- 18% more physical activity (average km/day walked) p = 0.000
- Average weight loss of 12 lbs after 4 months (5.3% of body weight) p = 0.000

ENHANCING PATIENT EXPERIENCE

- Patient satisfaction with the online virtual care platforms was higher when combined with mobile technology and weekly telephonic group support.
- 95% of participants agreed or strongly agreed that the virtual care helped them better manage their health vs. 68% of participants who had self-directed access to the online education and networking alone.

TAKING AIM AT AFFORDABILITY

- Reduced risk-adjusted total cost of care when a diagnosis of diabetes is avoided ($7,500 per year/patient).
- One-third of the time commitment for care delivery as compared to traditional chronic condition education (e.g., diabetes), while generating 8x more points of contact for continuous monitoring and increased convenience to patient (zero office visits).

HealthPartners®

PrimaCare Direct: A Cure for the Common Coverage

INNOVATION

PARTNERS IN EXCELLENCE

PRIMACARE+ DIRECT

PROVIDER

PrimaCare Direct – a healthcare cooperative that markets direct primary care to employers and patients

CHALLENGE

High deductible health plans prompt patients to question the need to visit their physicians, especially for wellness checks or management of chronic conditions. Instead, they wait for a medical emergency. The current health care system also rewards physicians for procedures that might have been avoided with earlier clinic visits. Both challenges raise health care costs.

INNOVATION

Direct primary care lowers health care costs, provides better patient care and reduces administrative burdens for physicians. For a flat monthly fee of $75, patients have access to all the primary care they need, including physician visits, lab, x-ray and medications prescribed by their physician.

IMPROVING HEALTH

- Patients who address their illnesses – especially chronic conditions – early and often have better clinical outcomes.
- Wellness visits, for example, help curtail smoking, encourage weight loss and provide better management of chronic diseases. This includes diabetes, hypertension and asthma.

ENHANCING PATIENT EXPERIENCE

- Direct primary care patients choose to see their physicians more frequently and spend more time when they are there.
- Physicians are now freer to talk to their patients on the phone or via e-mail. And, they can be more creative with delivering patient care.

TAKING AIM AT AFFORDABILITY

- There is one low monthly fee – no additional copays, deductibles or surprise bills.
- The cost of membership is often less than a monthly cell phone bill.
- Direct primary care reduces out-of-pocket costs for patients.
- Our statistics show a reduction of $128 per member per month in health care claims cost.

HealthPartners®

Coaching for Patient Activation Improves Treatment Adherence

INNOVATION

PARTNERS IN EXCELLENCE

PDR Physicians' Diagnostics & REHABILITATION CLINICS

PROVIDER

Physicians' Diagnostics & Rehabilitation Clinics

CHALLENGE

Physical rehabilitation using an active biopsychosocial model is quickly becoming the gold standard of care for the treatment of nonspecific chronic back pain. The treatment includes active exercise, lifestyle modification and cognitive-behavioral health coaching.

Roughly 50% of our patients do not adhere to the treatment program and do not receive an official "discharge." This leaves them less likely to self-manage their back pain going forward. Poor patient adherence is our biggest hurdle in providing the best care for our patients – and ensuring these patients can adequately self-manage their chronic condition.

The Patient Activation Measure (PAM) 13 inventory measures a patient's skills, knowledge and confidence in managing their health care. Research supports that patients that are more activated (higher PAM score) will be more likely to adhere to treatment regimens, get preventive care and engage in healthier behaviors.

We needed to develop and apply coaching techniques to improve patient activation and achieve better patient adherence for our therapy program.

INNOVATION

We implemented an improved therapy evaluation tool (Care Card) to engage patients at the initial evaluation. We also included provider training in motivational interviewing and patient activation coaching for integration into patient care.

IMPROVING HEALTH

- Patient adherence improved from 34% to 50% in the Low Activation (Level 1) patient group.

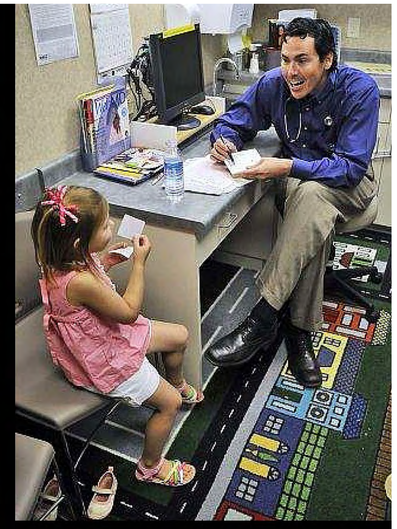
ENHANCING PATIENT EXPERIENCE

- Patient activation greatly improved – 78% of the Low Activation (Level 1) patient group improved their activation scores. Thus, they improved skills and confidence in managing their health care.
- Favorable patient reported recovery in all patient activation levels.

TAKING AIM AT AFFORDABILITY

- We suspect a reduction of downstream spine related treatment cost as patient activation increases.
- Research suggests that higher activation also reduces ongoing use of health care in not only back pain conditions, but with other health issues.

HealthPartners®



Health-Focused School Fundraising Model

· INNOVATION ·

PARTNERS IN EXCELLENCE

BLEND
A PARTNERSHIP FOR HEALTHY LIVING
BETTER LIVING: EXERCISE & NUTRITION DAILY

PROVIDER

BLEND (Better Living: Exercise & Nutrition Daily) & CentraCare Health

CHALLENGE

School fundraising techniques often involve sales of unhealthy junk food and candy. This provides patients with easy access to unhealthy foods resulting in increased consumption when outside clinic walls. The health consequences of these options include increased weight gain and perpetuation of childhood obesity. To positively impact health, we looked for a positive way to influence how children receive healthy food and physical activity in schools.

INNOVATION

We implemented a highly effective fundraising model ("BLEND Walk-a-Thon") built on physical activity and school spirit. As a childhood obesity prevention program, BLEND collaboratively works to implement sustainable, healthy transformations in policies, systems and environments to improve access to physical activity and healthy eating. Walk-a-Thons became a catalyst for Parent Teacher Organizations and school administrators to begin discussions around healthy fundraising and nutrition policies within schools.

IMPROVING HEALTH

- Participation of 26 schools, with 17 participating in 2015-2016.
- Over 78,750 miles have been walked by students – that is more than 3 times around the world!
- 64,337 packages of cookie dough or 128,675 frozen pizzas were not sold.
- CentraCare EMR records show a 24% relative decline in obesity rates of 12-year olds since 2008 in the St. Cloud area.

ENHANCING PATIENT EXPERIENCE

- BLEND Walk-a-Thons have impacted 15,083 students, 21,126 family members and 1,523 teachers = 37,686 people!
- BLEND Walk-a-Thons are FUN!

TAKING AIM AT AFFORDABILITY

- As of 2016, we have raised over $1 million cumulatively ($1,093,742).
- 100% increase of the funds stay at the school. There is no "middle man" company that receives a 40-60% fee from the school.
- The 24% decline in child obesity extrapolates out to a $3 million savings for prevented costs in obesity-related care over the next 8 years.

HealthPartners®

Creating a Positive, Patient-Centered Environment by Evaluating Patients' Experiences

INNOVATION

PARTNERS IN EXCELLENCE

FULCRUM HEALTH

PROVIDER

Fulcrum Health, Inc.

CHALLENGE

To adopt a certified and standardized patient satisfaction tool that evaluates patients' experiences, perceptions and safety, and allows us to compare ChiroCare network clinics' results to others across the industry.

INNOVATION

In 2013, we incorporated the Group Practice Consumer Assessment of Healthcare Providers and Systems (GP-CAHPS) survey into our quarterly patient satisfaction initiative. This survey was selected because it allows us to effectively evaluate patient experiences, perceptions and safety by using questions customized for a chiropractic environment. Through the use of this tool, we are able to identify where our network excels, as well as areas where the patient experience can be improved. Fulcrum Health, Inc., is the first entity to submit statistically significant chiropractic data to a validated third-party vendor.

IMPROVING HEALTH

- We use patient feedback in an innovative way by identifying and executing quality improvements within our network. We do this through the development of toolkits, in-person and recorded seminars, educational packets and online resources, etc.
- By creating resources that educate providers and their clinic staff about best practices in the industry (i.e., reviewing patients' medical histories, hand hygiene recommendations), we not only help keep patients safe but also promote a patient-centered environment.

ENHANCING PATIENT EXPERIENCE

- Our CAHPS survey goes beyond rating a particular doctor – it asks patients to report on their experiences with health care services. Gathering this type of feedback gets at the heart of patients' perceptions and provides insight into the topics most important to them.
- In 2015, Fulcrum Health Inc.'s ChiroCare network was named a Press Ganey Guardian of Excellence award winner for achieving 95th percentile in Patient Experience.

TAKING AIM AT AFFORDABILITY

- Beyond using patient feedback for quality improvement initiatives, we used our CAHPS survey to help identify and recover health care dollars spend on fraud, waste and abuse.

HealthPartners®

New Ulm Medical Center Drug Courts

INNOVATION

PARTNERS IN EXCELLENCE

Allina Health

NEW ULM MEDICAL CENTER

PROVIDER

New Ulm Medical Center – Allina Health

CHALLENGE

An increase in crimes commited by people with extensive addiction issues and incarceration not solving the problem.

INNOVATION

Our health care facility teamed up with criminal justice personnel, social workers and mental health providers to create a program where patients receive intense monitoring and long-term treatment. At the start, they have home checks twice weekly, drug screens three times weekly, treatment three times weekly and court once weekly. This team approach promotes high accountability for the patient. Having a team also allows patients to access numerous outside supports.

IMPROVING HEALTH

- Our program reduces hospital/ER admissions due to overdose, infection from needle sharing and malnutrition.

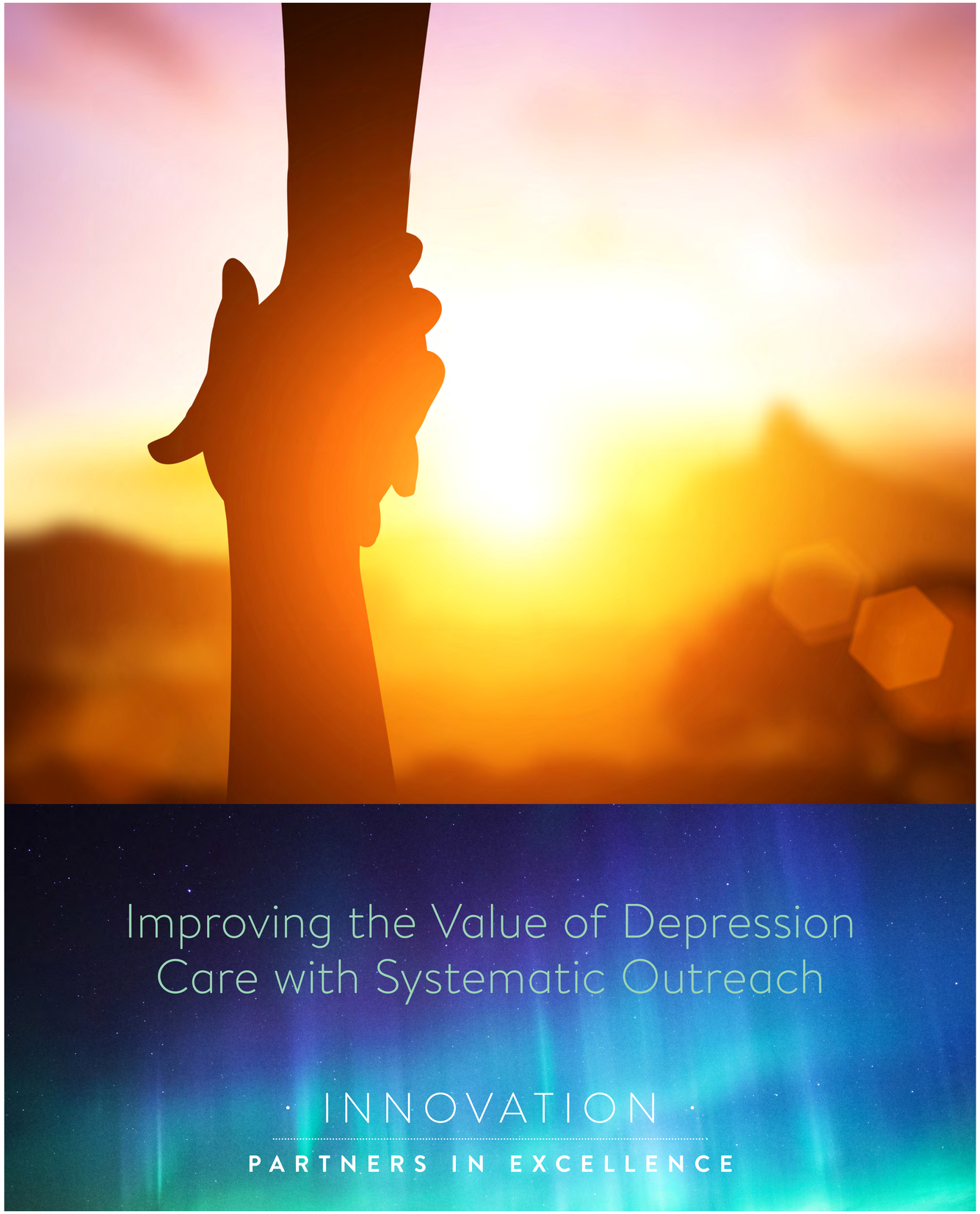
ENHANCING PATIENT EXPERIENCE

- Our program gives patients the opportunity to work therapeutically on their addiction instead of sitting in prison.
- We also improve patient experience by surrounding them with professionals that can secure valuable resources, like housing and employment.

TAKING AIM AT AFFORDABILITY

- Drug courts reduce crime and save money.
- The program also ensures participant compliance and restores families in a collaborative model that meets the unique needs of each individual.
- We currently have 99 individuals in the program. Since 2005, we have had 258 participants graduate with just an 8.5% recidivism rate.

HealthPartners



Park Nicollet®
HealthPartners®

PROVIDER

Park Nicollet Health Services

CHALLENGE

Depression is a serious condition. If left untreated, it can lead to major depressive episodes. This high-risk population requires a comprehensive approach to detect and effectively treat this major debilitating disease. In Minnesota, the remission rate for depression at 6 months is only 8%, as measured by Minnesota Community Measurement.

INNOVATION

We developed and implemented tools and processes that:

- Correctly identify high risk patients and their remission window.
- Provide a personalized care team outreach.
- Add 3- and 12-month outreach contacts to the standard 6-month outreach.
- Increase care and treatment plan updates.
- Link Primary Care and Behavioral Health to enhance care coordination.

IMPROVING HEALTH

- Increased symptom assessment.
- Provided patients with timely care and treatment.
- Increased likelihood for full remission.

ENHANCING PATIENT EXPERIENCE

- Embeds empathy and understanding in our program.
- Meets patients where they are at by using their preferred mode of communication.
- Lessens stigma and fosters sense of holistic care.
- Consistent care team guide to “quarterback” across medical and behavioral health needs.

TAKING AIM AT AFFORDABILITY

- 11% increase in our major depression remission rate, resulting in a 15% remission at 6 months overall – nearly twice that of the state average.
- Anticipate 9-16% savings achieved through effective integration.
- Reduced ER visits and hospital admissions.

HealthPartners®

System-wide Integration of Tobacco Dependence Treatment

INNOVATION

PARTNERS IN EXCELLENCE

Essentia Health

Here with you

PROVIDER

Essentia Health

CHALLENGE

Tobacco use is the single most preventable cause of disease, disability and death in the United States – adding more than $193 billion in medical costs annually (according to Healthy People 2020). At Essentia Health, 18.9% (32,762) of patients use tobacco, significantly exceeding the 2014 Minnesota state rate of 14.4% and the 2014 national rate of 16.8%. The tobacco use rate among our patients with diabetes or vascular disease is even higher, at 19.5% and 21.5% respectively. We identified limited or no tobacco cessation resource availability as a barrier to lowering the tobacco use rate across Essentia's mainly rural population.

INNOVATION

Using a systems approach, we offered an accredited 5 day Certified Tobacco Treatment Specialist (CTTS) course. We had 20 staff members complete the training, increasing the internal resources from 13 to 33 CTTS counselors and increasing the number of clinics with a local tobacco cessation resource from 13 to 35 clinics. We also expanded the RN role in Primary Care to include tobacco treatment counseling. Lastly, we provided scholarships to six additional community partner staff that serve a population disproportionately affected by tobacco use.

IMPROVING HEALTH

- In-house tobacco counseling referrals increased 57% following integration of clinic-based CTTS resource.
- Counseling/referral and/or medication at time of visit increased from a baseline of 53% to 81%.
- Provider education program on clinical guidelines that support ongoing, face-to-face counseling plus medication as the most effective treatment.

ENHANCING PATIENT EXPERIENCE

- CTTS staff in rural clinic settings offers convenient on-site counseling.
- Shared decision-making with CTTS counselors and individualized treatment plans.

TAKING AIM AT AFFORDABILITY

- Knowledgeable CTTS staff ensures patients are aware of resources available at minimal cost and Affordable Care Act benefits that include counseling and medication.
- Locally deployed resources make participation in tobacco cessation more convenient and affordable.
- Decreasing the tobacco use rate makes health care more affordable for all.

HealthPartners

Healthcare Integration Collaboration: Reverse Integrated Behavioral Health

INNOVATION

PARTNERS IN EXCELLENCE

CentraCare Clinic

PROVIDER

CentraCare Health and Central Minnesota Mental Health Center

CHALLENGE

Adults with serious mental illness live 10 years less than those without serious mental illness. Many factors lead to this outcome, including higher rates of tobacco use and poor management of chronic health conditions. Unfortunately, patients with serious mental illness do not access primary care.

INNOVATION

We developed the Healthcare Integration Collaboration (HI-C) program. HI-C embeds primary care services into a mental health center. Patients with serious mental illness receive care by a collaborative treatment team consisting of medical and mental health professionals at the same clinic location. We offer health promotion activities to encourage tobacco cessation, exercise and nutrition through evidence based practices.

IMPROVING HEALTH

- 130 patients have enrolled in the program to receive integrated primary care. Prior to enrollment, over 60% of the patients did not have a designated primary care provider.
- Health promotion activities like walking groups, healthy living classes and cooking classes encourage healthy lifestyles.
- Patients with serious mental illness are more likely to access primary care when the care is delivered in coordination with their mental health treatment.

ENHANCING PATIENT EXPERIENCE

- Patients report improved experience with primary care providers that are already familiar with their mental health background. This can prevent the frustrating and sometimes difficult experience of “re-telling” a patient’s mental health background to multiple providers.
- Many patients with serious mental illness have difficulty with public transportation and so reducing the number of visits to the medical or mental health provider helps the patient be more engaged and compliant.

TAKING AIM AT AFFORDABILITY

- Patients who do not have an established primary care provider are more likely to see services from costly emergency treatment centers when medical issues go untreated.
- Preventive services lower the costs of potential future services.

HealthPartners®

Responsible Opioid Prescribing: Reduction in Patients on Chronic Opioid Analgesic Therapy (COAT)

INNOVATION

PARTNERS IN EXCELLENCE

Essentia Health

Here with you

PROVIDER

Essentia Health

CHALLENGE

Opioids are highly addictive medicines. They have been incorrectly marketed as a safe, effective method for treating chronic, non-cancer pain. Opioids have been liberally prescribed, contributing to what the CDC has termed an epidemic of opioid addiction and deaths due to overdoses. Essentia Health clinics serve counties with the highest rates of death from opioid overdose, and an alarming increase of babies born suffering from opioid withdrawal. Baseline data demonstrated over 10,000 patients across Essentia were on long-term opioids. Yet, no consistent process existed to monitor opioid management or evaluate prescription practices.

INNOVATION

Essentia Health provided education and training for providers on the opioid crisis and responsible opioid prescribing. We also developed and implemented a Chronic Opioid Analgesic Therapy (COAT) Standard of Care, with a goal to improve assessment and monitoring of this patient population. And, we developed robust data reports that provide feedback on opioid management and prescription practices.

IMPROVING HEALTH

- 28% decrease of primary care patients on COAT in the last 2 years.
- 40% reduction of new COAT patients started on therapy per month between July 2014 and July 2016.
- Reduces flow of opioids into community.
- Educates patients about risks and lack of efficacy of long-term opioid therapy.
- Helps patients find safer ways to manage chronic pain that are as or more effective.
- Promotes collaboration to collectively address this community health crisis.

ENHANCING PATIENT EXPERIENCE

- Consistent standard of care – no matter where the patient is seen within the health system.
- Offers patients support in tapering and/or discontinuing opioids when appropriate.

TAKING AIM AT AFFORDABILITY

- Leverage electronic medical record (EMR) tools and centralized support services to minimize time physicians/advanced practitioners spend in collecting/calculating critical information for assessment and monitoring of this patient population.
- Utilize EMR tools and centralized support services to increase efficiency of collecting/calculating critical information.

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Entira® FAMILY CLINICS

PROVIDER

Entira Family Clinics

CHALLENGE

Reduce facility cost for sleep studies while increasing patient experience.

INNOVATION

We worked with a pulmonologist and durable medical equipment (DME) vendor to review options for in home sleep studies and supplies (CPAP, dental appliance, etc.). Our goal was to reduce total cost of care and increase patient compliance for sleep disturbance screening. We brought the pulmonologist and DME vendor into our clinics to offer access and convenience for our patients.

IMPROVING HEALTH

- Better patient compliance for in home sleep studies vs. sleep labs.
- Screening more patients for sleep disturbances and providing the patient with the appropriate treatment options.
- Treating patients prior to onset of more chronic medical conditions.
- Pulmonary consultant available 3 days a week.

ENHANCING PATIENT EXPERIENCE

- Patients are more comfortable sleeping at home than in a sleep lab or with a technician in their home.
- Convenience of service within the clinics.
- More accurate result outcomes due to patient comfort.
- DME availability within our clinics for convenience.

TAKING AIM AT AFFORDABILITY

- More cost effective to have home sleep study than in a facility based lab.
- By screening, we are treating patients prior to future medical complications.
- Our family practice providers have immediate access to a pulmonologist at time of service eliminating additional visits.

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Chronic Disease Management (CDM)

· INNOVATION ·

PARTNERS IN EXCELLENCE

CentraCare Clinic

PROVIDER

CentraCare Health

CHALLENGE

Patients with complex chronic health conditions often require more attentive care than the general population. The challenge was to approach chronic disease management while balancing cost of care and health outcomes.

INNOVATION

By modifying the AIMS Center's TEAMcare model, we created a care team consisting of a registered nurse (RN) care manager, doctor of pharmacy, care coordinator, consulting physician and consulting psychiatrist. We delivered targeted care management through use of disease specific treatment algorithms. The RN care manager used behavioral activation and motivational interviewing skills, acted as primary patient contact, and held weekly case reviews of complex patients.

IMPROVING HEALTH

- 87 Diabetes patients enrolled, average baseline A1c of 9.3
  - › 32 patients met goals and the average final A1c is 6.8 (27% improvement)
- 34 Uncontrolled hypertension patients enrolled, average baseline SBP of 153
  - › 33 patients met their goals, average final SBP 123 (20% improvement)
- 21 Hyperlipidemia patients received statin therapy
  - › Per the 2013 ACC/AHA Blood Cholesterol Guideline
- 14 Depression patients enrolled, average baseline PHQ9 of 13.5
  - › Latest average PHQ9: 4.1 (70% improvement)

ENHANCING PATIENT EXPERIENCE

- Surveys show patients appreciate the team based care approach.
- Patients like the support and accountability of regularly checking in with their RN care manager (often more frequent than primary care communication).

TAKING AIM AT AFFORDABILITY

- Utilizing an RN reduced the cost by 60-70%.
- Assisted 50% of patients in selecting medications that were clinically appropriate and lower in cost.
- Average estimated savings per patient in the 12 months post intervention was $9,700. For the 36 patients that had lowered costs, there was a savings of $349,200.

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Collaborating with Patients to Establish Care with a Primary Care Provider

INNOVATION

PARTNERS IN EXCELLENCE

Park Nicollet®
HealthPartners®

PROVIDER

Park Nicollet Health System

CHALLENGE

Research shows that patients with an established Primary Care provider have better overall health outcomes and are more likely to receive preventive services. In 2012, internal measures showed that 24% of patients seen at Park Nicollet had either no one listed in the Primary Care provider field of the electronic medical record or had a generic non-provider identifier within the Primary Care provider field.

INNOVATION

We created the Clinician Finder Team in 2013. This is a patient service-oriented department that assists patients in finding a Primary Care provider. The Clinician Finder team's main focus is to contact patients without an identified Primary Care provider, share the importance of having a Primary Care provider, and assist patients with scheduling with the right provider for them. We created an identifier in the electronic medical record to help flag patients for outreach.

IMPROVING HEALTH

- Patients identified as needing a Primary Care provider are contacted to help them receive appropriate care.
- Building relationships with a Primary Care provider promotes management of chronic conditions, increased access to preventive services, coordination of care and collaboration with other healthcare resources.

ENHANCING PATIENT EXPERIENCE

- Created pamphlet to increase patient awareness of the importance of having a primary care provider.
- Attributed 55,000+ patients to a Primary Care provider in less than 3 years.
- Developed process with the Hospital Unit Coordinators to contact the Clinician Finder Department at hospital discharge for patients without a Primary Care provider.
- Created partnership with OB/GYN department to assist mothers that expect to establish care with a pediatrician.
- Improved patient satisfaction.

TAKING AIM AT AFFORDABILITY

- Standardized process and consolidated resources to a specific group, removing work from others and enabling them to focus on their true tasks.
- Helped to close gaps in care and improve quality metrics.

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Accredited Chest Pain Center with PCI: care for the low-risk ACS patients

INNOVATION

PARTNERS IN EXCELLENCE

North Memorial Health Care

PROVIDER

North Memorial Medical Center

CHALLENGE

For Acute Coronary Syndrome (ACS) patients, the majority of United States hospitals have a practice standard of inpatient admission. To minimize a misdiagnosis, all patients are admitted for lengthy observation and testing. Appropriateness tossed aside, diagnostic stress tests are ordered for all without consideration for pre-test probability. Many of those defined as low-risk ACS patients do not end up with a diagnosis of Coronary Artery Disease (CAD) or unstable angina; thus, the admission and subsequent cost of care is unnecessary.

Current practice is not cost-effective or efficient and does not result in improved customer satisfaction. Our challenge was to develop a process to provide these patients with a thorough work-up in an outpatient setting – thereby minimizing unnecessary costs and improving customer satisfaction and reimbursement dollars.

INNOVATION

A multidisciplinary team of providers implemented a Chest Pain Clinic to streamline diagnosis, treatment, and symptom management across the care continuum in an expedited manner ensuring best practice, evidence-based care.

IMPROVING HEALTH

- Standardized risk stratification to ensure timely and appropriateness of care.
- Active community outreach efforts, within primary service area, to heighten awareness to ACS signs/symptoms and life-saving skills, e.g., hands-only CPR.

ENHANCING PATIENT EXPERIENCE

- Shift in care from inpatient to outpatient after ruling out Acute Myocardial Infarction (AMI), positively impacting length of stay.
- Improved efficiency in procedure/lab completion.

TAKING AIM AT AFFORDABILITY

- Decrease in average length of stay and non-AMI patient admission.
- Improved capture of Emergency Department (ED) ordered diagnostic stress testing, YTD 91% (YOY improvement = 40%).
- Reimbursement revenue positively impacted by 37.5%.

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