Improving the Care of Patients with Gestational Diabetes Mellitus (GDM)

· INNOVATION ·

PARTNERS IN EXCELLENCE

OBGYN associates

PROVIDER

Obstetrics and Gynecology Associates, PA

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CHALLENGE

Identifying and treating gestational diabetes is very important in obstetrics. We expect gestational diabetic patients to come for clinic visits regularly, complete numerous self-directed blood sugar checks, and visit with outside providers for condition management. We previously assumed patients were compliant throughout diagnosis and treatment without checking on their progress. We challenged ourselves to implement a program to improve the care of patients with Gestational Diabetes Mellitus (GDM).

INNOVATION

We worked with diabetic educators, RN care coordinators, and outside endocrinologists to provide up-to-date, patient-centered materials to educate gestational diabetic patients on the disease and steps they should take both during and after pregnancy to improve their health. We developed a patient checklist and clinic system to track patients with GDM both during and after pregnancy. We also created an RN care coordinator call-back process to guarantee patient success during pregnancy and with postpartum testing.

IMPROVING HEALTH

- Standardization of criteria to diagnose GDM and to screen for resolution within the clinics.
- Our goal was to make significant improvements on processes to better educate, screen for, treat, and confirm resolution or persistence of GDM.

ENHANCING PATIENT EXPERIENCE

- Patients feel connected to and cared for by the clinics.

TAKING AIM AT AFFORDABILITY

- We measured patients that completed post-partum screening after declaring GDM status.
- The baseline measurement over the timeframe of 4/1/2015 to 9/30/2015 was 45 percent.
- Final measurement for the time period of 4/1/2016 to 9/30/2016 was 74 percent.

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caring *for* mom & baby

Park Nicollet®
HealthPartners®

PROVIDER

Park Nicollet Methodist Hospital

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CHALLENGE

We did not have a process in place for identification and outpatient follow-up of infants with in-utero drug exposure. Mothers are often at increased risk for postpartum depression and for relapse, especially in the year following delivery. Infants with in-utero drug exposure are at risk for delayed growth and development. It is important to follow mothers closely in pregnancy, and our system has a program in place to improve outcomes of the pregnancy and birth. It continues to be important to support and follow mother and infant after delivery and in the early years of life, where intervention can provide the most benefit. With over 3,100 deliveries a year and national rate of illicit drug use in pregnancy at 5 percent*, there are likely to be over 150 infants with intrauterine drug exposure delivered at our hospital annually.

INNOVATION

We created a process to identify infants with in-utero drug exposure and provide immediate and long-term support for mother and baby upon transition from hospitalization for delivery/postpartum care to the ambulatory setting. We also created mechanisms to alert care teams – both inpatient and ambulatory – regarding intrauterine exposure to substances so they can be matched with appropriate resources as part of their ongoing care.

IMPROVING HEALTH

- Provides social support to families after delivery.
- Aids in creating a healthy environment for optimal infant development.

ENHANCING PATIENT EXPERIENCE

- Provide nonjudgmental support of mother and baby.
- Create a trusting relationship in the primary care setting.
- Identify needs and provide resources in partnership with the family and our care coordinator.
- Ensure continuity of care is provided.

TAKING AIM AT AFFORDABILITY

- Low cost of implementation.
- Early childhood intervention has proven to reduce cost to society for infants affected by antenatal substance abuse.

*US Department of Health and Human Services. Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings. Substance Abuse and Mental Health Services Administration; Center for Behavioral Health Statistics and Quality, 2011.

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Intensive Review to Ensure High Quality-Low Cost Specialty Care

· INNOVATION ·

PARTNERS IN EXCELLENCE

Vibrant Health
FAMILY CLINICS

PROVIDER

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CHALLENGE

We needed to find a way to control the cost and utilization of specialty care for our patients. This would help ensure our patients receive high quality care at reasonable prices.

INNOVATION

We implemented a Total Cost of Care group to review controllable patient costs and quality on a quarterly basis. The group shares its findings with our referral staff. We also changed the way we refer patients for outside services. We now provide education so patients can make more informed health care decisions. This means taking into consideration cost, quality outcomes, and patient limitations like transportation. Finally, we work with our providers to ensure that low cost options are at the forefront of their minds when suggesting treatment for patients. We share our findings with providers and review referral practices with individual providers as necessary.

IMPROVING HEALTH

- Patients receive more appropriate and cost-effective testing and procedures.
- Patients have an increased willingness to complete specialty care.

ENHANCING PATIENT EXPERIENCE

- Helps patients make financially responsible health care decisions.
- Provides patients with cost/quality education.
- Allows patients to take a more active role in their health care decision making.

TAKING AIM AT AFFORDABILITY

- Reduced our overall Total Cost Index by 18 percent since 2015.
- Reduced our non-emergency High Tech Radiology Use Index 9 percent since 2015.
- Reduced our Resource Use Index 12 percent since 2015.

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Rural Minnesota Community Pharmacy Coordinated Program for Diabetes Management

· INNOVATION ·

PARTNERS IN EXCELLENCE

Employee Owned
Thrifty White PHARMACY
Est. 1884

PROVIDER

Thrifty White Pharmacy

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CHALLENGE

Diabetes is one of the largest and fastest growing health concerns in the U.S. Almost 30 million patients have diabetes and an estimated 86 million Americans have pre-diabetes. This amounts to direct and indirect costs totaling over $322 billion annually. Rural communities are disproportionately affected by this due to lack of access to care. Our challenge was to develop a program to support these patients with better care and increased access, while leveraging our pharmacy teams to deliver better outcomes.

INNOVATION

We created a diabetes program leveraging our local pharmacists and layering on diabetes-focused coaching and education, in-pharmacy lab testing, and motivational interviewing.

IMPROVING HEALTH

- Each patient received a comprehensive medication review to ensure they were on the most appropriate medications.
- Using goal setting and motivational interviewing, pharmacists held monthly coaching sessions as part of their medication pickup appointment.
- Pharmacist-driven interventions resulted in increased medication adherence and better controlled diabetes.

ENHANCING PATIENT EXPERIENCE

- Patients received focused coaching and counseling.
- Quarterly A1c checks monitored progress.
- Medication synchronization aligned their meds to one “pickup” appointment each month, as opposed to the patient only seeing their provider every three to six months.
- Our data has shown that a typical diabetes patient has medication for roughly 260 days a year. Through our program, we’ve been able to boost that to 354 days.

TAKING AIM AT AFFORDABILITY

- Reduced unnecessary medication spending through MTM.
- Reduced A1c levels by an average of 0.8.
- Increased adherence resulted in cost avoidance from unnecessary hospitalizations and provider visits.

HealthPartners®

Don Stone, first LVAD patient at St. Cloud Hospital

Heart to Heart: A Collaborative Model to Improve Patient Experience

· INNOVATION ·

PARTNERS IN EXCELLENCE

CentraCare Clinic | M HEALTH SM

PROVIDER

CentraCare Health, University of Minnesota Health

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CHALLENGE

Some advanced heart failure patients require Ventricular Assist Device (VAD) placement. A VAD is a mechanical heart pump implanted in the body to help improve blood flow in patients with end stage heart failure. Patients often have to travel long distances for the evaluation, implant, post-operative education and frequent follow-up visits. Some CentraCare patients expressed interest in receiving this care in their local community. VAD programs are limited, in part, because developing one involves an enormous commitment to ongoing, multidisciplinary patient support and staff education.

INNOVATION

We implemented a Destination Therapy (DT) VAD program at CentraCare Health. (DT VAD implant means the patient is not eligible for transplant and will have the VAD for the remainder of his/her life.) This required massive coordination of resources and infrastructure to support ongoing care of patients with VADs, within the DT center itself and between hospitals.

IMPROVING HEALTH

- Provide holistic care to patients in their community through strong communication and collaboration with physicians and multidisciplinary team.
- Provide an opportunity for higher compliance for patients with limited resources, since required care is local.

ENHANCING PATIENT EXPERIENCE

- Allows patients to receive care and VAD workup in their community.
- Provides easy access for patients to receive care.

TAKING AIM AT AFFORDABILITY

- University of Minnesota Health and CentraCare Health accept testing and evaluations completed at the partnered center. This avoids duplication of services.
- Improved patient referral time by discussing cases at weekly teleconferences. Appropriate referral timing can result in improved morbidity and mortality.
- Receiving care locally decreases a patient's overall cost of care by avoiding hotels, transportation costs and decreasing time away from work.

HealthPartners

Evidenced-Base Spine Intake Tool Improves Access and Appropriateness of Care While Reducing Cost

· INNOVATION ·

PARTNERS IN EXCELLENCE

M HEALTH℠

PROVIDER

University of Minnesota Health

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CHALLENGE

A decrease in the number of spine surgeons left patients waiting up to five months for evaluation. Yet research reports providing appropriate care sooner improves positive outcomes and lowers cost. We also knew that many patients seeing the surgeons were not surgical candidates.

INNOVATION

Using best-practice guidelines, a team of surgeons, clinic nurses, call center employees, primary care nurse practitioners and physical therapists designed and implemented a seven-question intake tool for non-clinical, call center representatives. The tool appropriately directs spine patients to primary care, medical spine or surgical care. The team had participants from: The University of Minnesota Health Adult Call Center, University of Minnesota Physicians spine surgeons and nurses, University of Minnesota School of Nursing, and Institute for Athletic Medicine.

IMPROVING HEALTH

- Identified only 38 percent of 170 patients seeking a spine surgeon as potentially appropriate. Representatives scheduled evaluations for the remaining 62 percent with conservative care providers within two days.
- Call center representatives matched three times as many patients to the appropriate clinician for the patient's first visit.

ENHANCING PATIENT EXPERIENCE

- Reduced wait time for surgical visits from five months to three and a half months within a month.
- Immediately reduced wait times for non-surgical patients from five months to less than two days.
- Across 102 patients scheduling conservative care, an estimated 34 years of wait time was eliminated!
- Over 106 patients saved a co-pay and co-insurance for an avoidable visit.
- Removed guess-work for patients by escorting them to the most appropriate high-value entry point.

TAKING AIM AT AFFORDABILITY

- Eliminated unnecessary MRIs for 18 percent of patients calling for a surgical consult. Unnecessary spine imaging is linked to higher overall cost of care, excessive treatment, and increased risk to patients.
- Eliminated an unnecessary surgical consult for 62 percent of patients.
- Improved value of care without adding clinicians or software to triage patients
- Decreased overall cost of care for patients.

HealthPartners®

Cardiology Curbside: Meeting Provider Needs Across the Continuum

· INNOVATION ·

PARTNERS IN EXCELLENCE

Minneapolis Heart Institute®

Allina Health
ABBOTT NORTHWESTERN HOSPITAL

PROVIDER

Minneapolis Heart Institute

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CHALLENGE

Real-time access to specialty care is often unavailable to primary care, emergency department, and hospital medicine providers in the community. As a result, providers may feel challenged in specialty care diagnostic, treatment and triage decisions. This can lead to unnecessary testing, admissions and patient transfers that increase costs of care and decrease patient satisfaction. We sought to address this challenge in cardiovascular disease – a common, high-acuity and high-cost clinical setting.

INNOVATION

The Cardiology Curbside program is a direct phone line for real-time access to cardiology specialists. In the curbside role, a cardiologist interprets clinical data (e.g., EKGs), provides testing and treatment recommendations, and facilitates consultations and patient transfers in real-time with the calling provider. A range of providers take advantage of this service. From a sample of 40 hours of program data, 30 percent of calls were from providers in our hospital, 41 percent were from practitioners at other sites in our health system, and 29 percent were from providers outside of our health system.

IMPROVING HEALTH

- Enables real-time access to specialist cardiovascular expertise to inform care decisions and improve the quality and appropriate use of health care services.
- Examples from our sample data include guidance in the use of an outpatient diagnostic and treatment strategy to avoid hospital admission, providing answers that led to avoidance of formal inpatient consults, and recommending transfer of patients who required a higher acuity level of care.

ENHANCING PATIENT EXPERIENCE

Patients whose care is directed through an outpatient process are reassured by the knowledge that the care plan was devised in discussion with specialty care input. Patients admitted or transferred for higher-acuity care arrive with a better understanding of the rationale and plan of care.

TAKING AIM AT AFFORDABILITY

- The program delivers significant benefits to health care affordability and does not adversely affect the Health System.
- Estimated annualized payer savings: $3,242,136
- Estimated annualized patient savings: $662,246

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Allina Health Cognition and Memory Program (CAMP)

· INNOVATION ·

PARTNERS IN EXCELLENCE

Allina Health

PROVIDER

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CHALLENGE

Over 5 million people live with Alzheimer's disease and related dementias (ADRD). Only 50 percent of people who have ADRD are diagnosed. Historically, dementia evaluation has been reactive. It is triggered by a cognitive concern, and formal assessment is limited to establishing a diagnosis. Ideal quality care would include a system for screening and evaluation of ADRD impact on daily function, as well as a community-based system for ongoing support after diagnosis.

INNOVATION

Our Cognition and Memory Program (CAMP) developed a primary care based "best-practice" model for screening, diagnosis and management of people with ADRD. This included a formal connections and feedback-loop with dementia-friendly community partners. We incorporated diagnostic assistance and referral options in our EMR tools. We also developed ADRD care guides, and launched a community resources referral pilot via the MN Board on Aging Isanti County Dementia Grant, among other tactics.

IMPROVING HEALTH

- Enhanced screening processes: Mini-Cog administered during Medicare Wellness Visits with 52,000+ Mini-Cogs completed system-wide.
- Improved diagnostic accuracy; diagnosis now correlates more closely with disease prevalence.
- Increased diagnosis and treatment of common issues related to ADRD.
- Reduced patient and caregiver stress.
- Provided longitudinal support for patients and caregivers via dementia-trained support staff.

ENHANCING PATIENT EXPERIENCE

- Patients and their care circle feel connected to medical, psychosocial and community resources.
- Educational resources at time of diagnosis enhances planning and manages expectations.
- Staff interact more effectively with cognitively impaired patients.

TAKING AIM AT AFFORDABILITY

- Measures in place to understand program implementation costs and impact of total cost of care for persons with ADRD and their caregivers.

HealthPartners

Preparing for an episodic low back pain payment model: Using predictive indicators to improve outcomes

· INNOVATION ·

PARTNERS IN EXCELLENCE

PDR Physicians' Diagnostics & REHABILITATION CLINICS

PROVIDER

Physicians' Diagnostics & Rehabilitation Clinics

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CHALLENGE

In contrast to a biomedical model that emphasizes treatments based on physiologic structure of the spine (i.e., joint, disc, or muscle injury), the biopsychosocial model addresses a broader spectrum. Cognitive Functional Therapy (CFT) is a behaviorally targeted intervention that combines normalization of movement while discouraging pain behaviors by reconstructing maladaptive thoughts about pain.

We took a first step by looking at predictive indicators to outcomes to help us understand if there was a relationship between the patient's initial presentation and their potential outcomes or completion rate – knowing this would allow best allocation of resources to obtain the best patient outcomes.

INNOVATION

We studied patient activation and its relationship to neck and low back pain therapy outcomes and program adherence and its relationship to other routine inventories performed in our office. We also wanted to determine if there is any opportunity to better triage patients for improved completion rate and outcomes.

IMPROVING HEALTH

- Using predictive indicators for poor outcome may allow providers to triage care earlier in the process, offering a more targeted approach to obtain higher outcomes.
- The PAM-13 measure for patient activation and Keele STart Back measure for psychosocial risks factors allow providers to understand patient psychology and employ coaching for activation and motivational interviewing skills appropriately within the care.

ENHANCING PATIENT EXPERIENCE

The results demonstrate that regardless of the level of activation or severity of disability, patients get similar outcomes. This validates that patients completing a CFT-based rehabilitation program achieve outstanding results in function, pain, and psychosocial outcomes.

TAKING AIM AT AFFORDABILITY

Understanding the relationship of patient activation and psychosocial barriers to recovery and adherence helps provide some preliminary knowledge moving forward into health care payment reform.

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Cardiovascular Emergencies Mobile App

· INNOVATION ·

PARTNERS IN EXCELLENCE

Minneapolis Heart Institute®

Allina Health

Abbott Northwestern Hospital

PROVIDER

Minneapolis Heart Institute at Abbott Northwestern Hospital

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CHALLENGE

Paper copies and posters of Minneapolis Heart Institute's Cardiovascular Emergency protocols were impossible to keep current at over 40 referring hospitals. Eventually, these protocols were available on our website. While this system worked well, any type of change or improvement was difficult to communicate to referring partners. The challenge was to find the best opportunity to positively impact patient care utilizing technology.

INNOVATION

We developed a mobile app to assist referring hospitals in having the most current CV Emergency protocols at their fingertips.

IMPROVING HEALTH

- Latest CV Emergency Protocols decreases variation in care and improves outcomes.
- Improves timeliness to intervention, eliminating delays in care (from using outdated protocols).

ENHANCING PATIENT EXPERIENCE

- Greater speed at reaching tertiary hospitals for required care by eliminating unnecessary delays.
- Patient is able to follow up with Cardiology group back in home town after MI.

TAKING AIM AT AFFORDABILITY

- Improves efficiency of local ED by giving template of care prior to transfer.
- App use has now expanded to primary care providers as it improves efficiency of their care.

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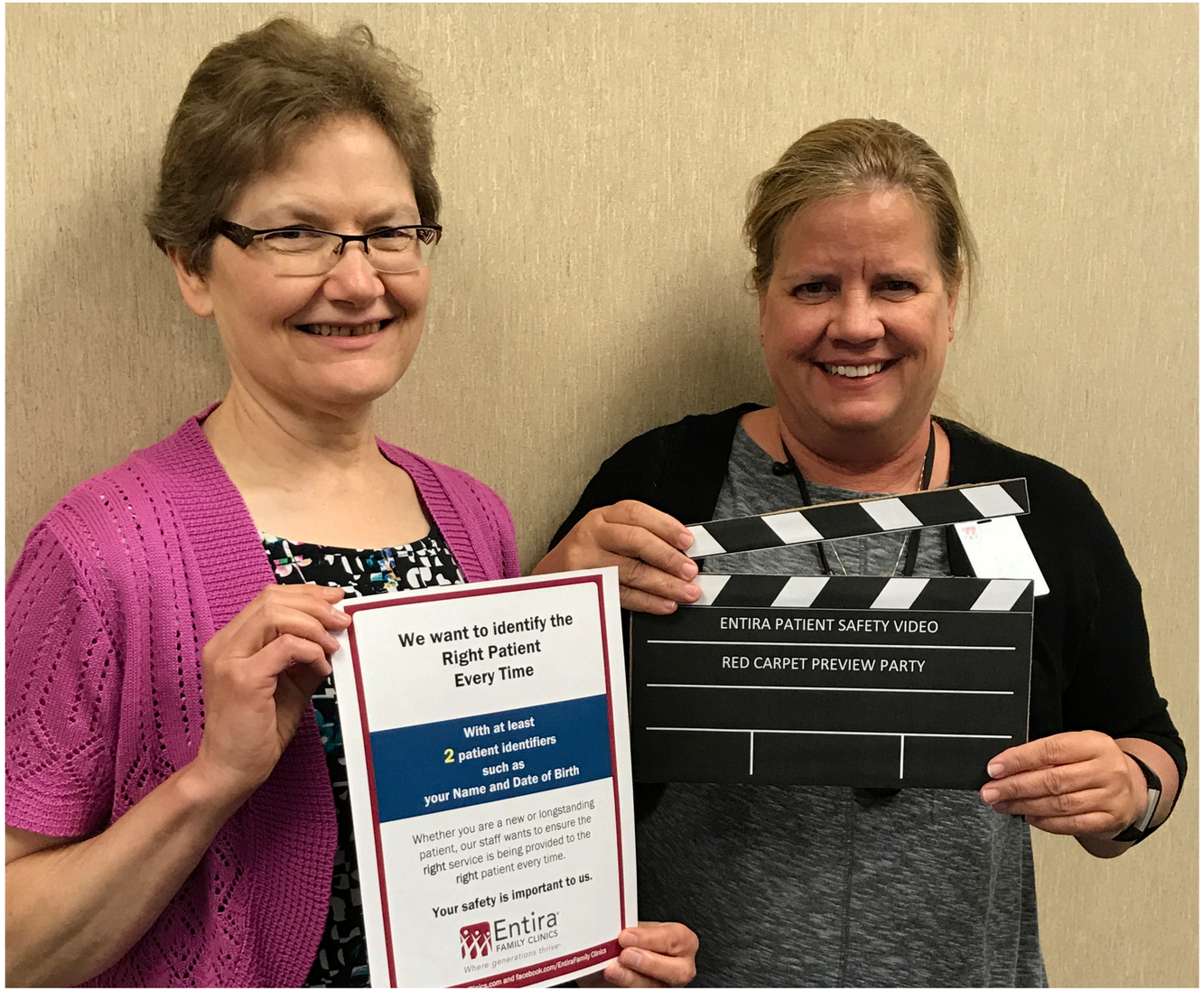

Multifaceted Approach to Organizational Engagement in a Safe Culture

· INNOVATION ·

PARTNERS IN EXCELLENCE

Entira® FAMILY CLINICS
Where generations thrive®

PROVIDER

Entira Family Clinics

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CHALLENGE

Accountability to make safe behavioral choices and to design and improve safe systems foster a "Just Culture" environment. But a Just Culture journey takes time to create, implement and build awareness where the team trusts a system of shared accountability for learning and improving patient safety to prevent avoidable events from happening in the future.

INNOVATION

We increased patient member representation on our advisory board and quality and safety committees. The patient safety committee was empowered to create its own patient safety video to raise awareness and reinforce the Just Culture principles. Committee members designed, scripted and recruited co-workers as actors to produce the video. Staff from the safety committee arranged a fun red carpet recognition party to celebrate their achievement and debut the safety video.

IMPROVING HEALTH

- Preventing potential harm and reducing risk through safe learning from errors.
- Improved problem solving across settings to prevent and minimize future events.
- Improved patient engagement.

ENHANCING PATIENT EXPERIENCE

- Patients are able to share their perspectives and experience.
- Improved organizational focus on patient experience.

TAKING AIM AT AFFORDABILITY

- Strengthens the decision-making process; enhances provider patient collaboration for better outcomes.
- Improved follow-up action to a reported safety event and response to policy changes.
- Reduces and minimizes future liability.

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Occupational Therapy in the NICU

· INNOVATION ·

PARTNERS IN EXCELLENCE

FAIRVIEW

PROVIDER

Fairview Health Services, Occupational Therapy System
NICU Team

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CHALLENGE

Premature births cost our nation over $26 billion per year. Beyond financial hardships, parents leaving the hospital with a premature infant are often fearful and feel unprepared for fulfilling the primary caretaker role after weeks of medical intervention and care. Successful outcomes for these infants depend on the pre-habilitative care in the NICU and parent education for life outside of the NICU. This requires consistent collaboration with medical staff, rehabilitation staff and parents. Standardization across the system and family-centered care must become a focus.

INNOVATION

We implemented a standardized approach to rehab throughout three NICU sites. The approach utilizes various levels of clinical skill sets of Occupational Therapists (OTs) only based on each patients' need. OT interventions consist of developmental and feeding related services, thus limiting the number of professionals interacting with the infant and the family and providing consistency.

IMPROVING HEALTH

- Improved outcomes and decrease in length of stay.
- Consistency of care for infants and families.
- Pre-habilitative intervention focus to assist with infant development.
- Collaboration with all disciplines and unified communication with the families.
- Reduction in missed therapy visits due to staffing.

ENHANCING PATIENT EXPERIENCE

- Decreased length of stay.
- Increased readiness to leave the NICU.
- Increased consistency of services provided and therapist working with that infant/family.
- Increased parent education and collaboration prior to discharge.

TAKING AIM AT AFFORDABILITY

- Decreasing overall costs while in the NICU.
- Fewer infants are returning to emergency department following discharge.
- Decreasing need for long term outpatient services.

HealthPartners®

Enhancing Patient Safety through Clinical Hygiene Best Practices

· INNOVATION ·

PARTNERS IN EXCELLENCE

FULCRUM HEALTH

PROVIDER

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CHALLENGE

With the increased prevalence of multidrug-resistant bacterial infections, health care professionals should be informed on how to prevent the transmission of pathogens through health care encounters.

INNOVATION

To better understand what infection prevention steps our network clinics were taking or not taking, we launched a Patient Safety and Infection Prevention project within our ChiroCare network. In collaboration with providers and third-party vendor CLIPS Consulting, LLC, we completed an in-person infection prevention evaluation of 30 network clinics. These site visits focused on identifying potential infection prevention concerns, including hand and respiratory hygiene, surface cleanliness, sharps safety, and blood-borne pathogen exposure.

IMPROVING HEALTH

Our Patient Safety and Infection Prevention project physically protects patients and providers from multidrug-resistant bacterial infections and health care-associated infections through best practice education and application of hygiene products.

ENHANCING PATIENT EXPERIENCE

- In the short term, we have already seen an initial uptick in our CG-CAHPS data, bringing us from a 34 regional percentile ranking in the third quarter of 2016 to a 60 regional percentile ranking in the first quarter of 2017.
- Patients feel protected when they observe providers washing their hands and using hygiene products during an appointment.
- Patients also feel at ease and comfortable knowing they are in a clean office environment.

TAKING AIM AT AFFORDABILITY

- Participating providers were able to sample and evaluate the effectiveness of various recommended clinical hygiene products at no cost to them.
- Fulcrum also negotiated reduced rates for future provider purchases, making clinical hygiene protocols more cost effective.
- Fostering a clean environment reduces the likelihood patients or providers will contract a costly infection. By taking these steps, we hope to further enhance the patient experience, safety and affordability of care.

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Utilization of a Work Conditioning Program to Return to Work Post-Concussion

· INNOVATION ·

PARTNERS IN EXCELLENCE

NovaCare® REHABILITATION
SPORTS MEDICINE

PROVIDER

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CHALLENGE

Workplace concussions or mild Traumatic Brain Injuries (mTBI) are associated with a high economic burden. Sixty-three percent of mTBIs occur in adults of working age (Theadom 2017). Among patients employed at the time of injury, those in manual labor jobs have the lowest rate of return to work following concussion (Yasuda 2001). Limited access to appropriate healthcare following mTBIs has been well documented (Langlois 2006). Especially in Minnesota, many individuals demonstrate longer-than-typical recovery due to long wait times for specialists, misdiagnosis and decreased resources.

INNOVATION

Our organization implemented a Work Conditioning program for post-concussion individuals. The program is specific to the long-term impairments that limit an individual's ability to return to the workforce at the same job demand level.

IMPROVING HEALTH

- Typically, concussion/mTBI care does not include a step-wise progression for return to work. The Work Conditioning approach includes monitoring of self-limiting symptoms during completion of essential tasks of the individual's job. The task is modified to allow success, then each individual activity within a work task is reintroduced incrementally for successful completion within symptom parameters.
- Treatment emphasis is placed on physical conditioning, including functional activities and job simulation. Training sessions focus on minimizing symptom provocation during task simulation with focus on factors that may impact vestibular and oculomotor impairments if needed.

ENHANCING PATIENT EXPERIENCE

The program allows return to activities that restore confidence and create skills needed to identify causative factors and how to mitigate them.

TAKING AIM AT AFFORDABILITY

This focused approach will save employers, employees, and health systems valuable resources in unfocused activity.

Sources:

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HealthPartners®

Closing the Disparity Gap through Personal Outreach

· INNOVATION ·

PARTNERS IN EXCELLENCE

Allina Health™

PROVIDER

Allina Health

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CHALLENGE

Typically, a colonoscopy is the main or only option presented to patients for colorectal cancer screening. Additionally, there are unique barriers to completing a colonoscopy for some patient populations. These include the fear of pain based on cultural practices as well as misconceptions regarding the idea of preventive screenings. Often, patients are not aware of other colorectal cancer screening options.

INNOVATION

We implemented a program where we would make personal phone calls to specific patient groups experiencing disparity for colorectal cancer screening. Interpreters and a nurse made calls in the patient's preferred language. Patients were invited to complete colorectal cancer screenings in their own home. The caller was equipped to answer basic questions about screenings and available screening methods. We made these calls during both the day and evening hours. We made three attempts to connect with the patient. Once they agreed to participate, we mailed a screening kit to them.

IMPROVING HEALTH

- Number of patients called: 1,616
- Kits sent: 1,031
- Returned kits: 188
- Overall return rate: 18 percent
- The callers were able to speak in person to 85 percent of those who were sent a kit

ENHANCING PATIENT EXPERIENCE

- Patients received personal outreach in their preferred language.
- We offered a screening option that could be completed in the comfort and privacy of their own home.

TAKING AIM AT AFFORDABILITY

- Our initial program year resulted in 188 additional screenings in the target population.
- We reduced the overall cost by centralizing the program and optimizing the EMR.

HealthPartners®

HealthCare Integration Collaboration: Reverse Integrated Behavioral Health

· INNOVATION ·

PARTNERS IN EXCELLENCE

CentraCare Clinic

PROVIDER

CentraCare Health

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CHALLENGE

Patients with serious mental illness do not access primary care. Sixty-eight percent of adults with a serious mental illness have one or more chronic physical conditions. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), patients with mental health conditions die up to 25 years earlier than those who do not.

INNOVATION

We embed primary care services into the mental health center. Patients with serious mental illness receive care by a collaborative treatment team of medical and mental health professionals in the same clinic location. Health promotion activities encourage tobacco cessation, exercise, and nutrition through evidence based practices.

IMPROVING HEALTH

- Patients with serious mental illness are more likely to access primary care when the care is delivered in coordination with their mental health treatment.
- Health promotion activities like walking groups, healthy living classes, and cooking classes encourage healthy lifestyles. Peer wellness support specialists attend and coach patients on setting healthy lifestyle goals.

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 “re-telling” of a patient’s mental health background to multiple providers.
- Patients feel more comfortable in the embedded primary care clinic because they have built trusting relationships with their mental health providers that are more easily extended to a primary care provider in the same location.
- The coordination of appointments and availability of same day appointments satisfied many patients, especially those with mobility and transportation challenges.

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®

Reducing the Incidence of Unmanaged Diabetes in the Latino and East African Patient Population

· INNOVATION ·

PARTNERS IN EXCELLENCE

CentraCare Clinic

PROVIDER

CentraCare Health

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CHALLENGE

CentraCare Health believes that community-based education and community health workers can play an integral role in raising the level of healthcare obtained by the East African and Hispanic population. The project is centered on providing the Somali and Latino populations with a community health worker who represents the cultural background of the population. Recently, our population expanded to include other high-risk minority individuals.

INNOVATION

CentraCare designed a home visit model for this project and identified patients for community care coordination by accessing data in the diabetes registry at two CentraCare Health Care Home-certified clinics: Melrose and Family Health Center. Two community health workers, one representing the Latino population and the other from the East African population, visit patients in their homes and help navigate the health care system.

The community health workers also coordinate care between the primary care provider, diabetic educator, pharmacist, and the health care home coordinator. The team functions through warm handoffs, and by utilizing the electronic medical record to stratify patients and document patient encounters for consistent and coordinated care. We collect client feedback via intake forms, phone calls, focus group discussion, and word of mouth.

IMPROVING HEALTH

- We collaborate with community resources to provide patient education outside of the office.
- We coordinate care between office visits.

ENHANCING PATIENT EXPERIENCE

- Due to the home visit format, patients' lives were less disrupted.
- Patients experience fewer barriers to care as a result of care coordination.
- Patients were assisted in understanding care plans and instructions.

TAKING AIM AT AFFORDABILITY

- We met patients where they are at, using the appropriate level of service.
- Providing information outside of clinical care ensures patients are aware of socioeconomic resources (e.g. transportation, food assistance, etc.) that help avoid unfavorable health outcomes.

HealthPartners®

Endovascular Thrombectomy for Stroke Patient

· INNOVATION ·

PARTNERS IN EXCELLENCE

St. Luke's

PROVIDER

St. Luke's

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CHALLENGE

There are 795,000 strokes per year in the United States. Stroke treatment is time-critical: 1.9 million neurons die for every minute the brain is deprived of oxygen-rich blood. This can result in adverse effects to a person's speech, movement, or memory. There were no endovascular treatment options in our region.

INNOVATION

There are currently two treatment options available for stroke: intravenous alteplase and endovascular thrombectomy. Intravenous alteplase alone has limited efficacy on large vessel occlusions, which can lead to a devastating stroke. Endovascular thrombectomy is much more effective at removing the clot that is causing the stroke and improving functional outcomes of patients.

Endovascular thrombectomy requires specific training and skills for the medical providers and support staff. To improve stroke outcomes, we developed a new clot-removal program for stroke patients called endovascular thrombectomy. We are the only facility in the region offering this treatment option.

IMPROVING HEALTH

- Our endovascular thrombectomy program trend has demonstrated significant reductions in deficits caused by acute strokes.
- Patient functional independence rates are improving if treated with thrombectomy.

ENHANCING PATIENT EXPERIENCE

- We are optimizing and improving the time it takes for this treatment, which allows more efficient decision making by physicians, patients and family members. This enhanced patient experience allows us to treat the patient in a timely manner, which improves outcomes.
- Family members are able to stay in their community and close to their loved ones during this stressful time.

TAKING AIM AT AFFORDABILITY

- Strokes are a common event that requires hospital and long term care admissions. Endovascular thrombectomy will reduce the risk of disability. It also reduces the cost of initial hospitalization, rehabilitation and longer term nursing homes, which account for the majority of stroke-related costs.
- Reduces emergency medical transport costs by providing the treatment locally.

HealthPartners®

St. Luke's Community Care Team

· INNOVATION ·

PARTNERS IN EXCELLENCE

St. Luke's

PROVIDER

St. Luke's

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CHALLENGE

There was a lack of resources and access to primary care for our most medically complex patients living in our SNFs, group homes, and assisted living facilities in the Duluth/Superior area. In this patient population, we saw higher ED utilization and admission rates paired due to non-compliance. We also observed a lack of primary care access due to socioeconomic factors and resource shortages. This population was primarily being served by basic round compliance or by ED/UC.

INNOVATION

Implemented a community care team providing primary care to our patients in their homes or living facility, supported and staffed by our internal medicine program at St. Luke's.

IMPROVING HEALTH

- Provides primary care access without barriers for our patients with high disease burden and offers their support to their facilities and care teams.
- Increases patient compliance with frequent "eyes on patient" exams.

ENHANCING PATIENT EXPERIENCE

Increased patient access and convenience by bringing primary care to them on regularly scheduled intervals and as requested in their homes.

TAKING AIM AT AFFORDABILITY

There is no measure to date, but we have a goal of reducing ED utilization by 10 percent for the target population.

HealthPartners®

Medicare Wellness – Preparing for a Healthy Retirement

· INNOVATION ·

PARTNERS IN EXCELLENCE

Allina Health™

PROVIDER

Allina Health

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CHALLENGE

The intent of the Medicare Wellness Visit (MWV) is to keep beneficiaries healthy, rather than paying for treatment when they become ill. There is generally a better outcome and lower expense when we detect a problem earlier rather than later. We needed a new process to improve the MWV participation rate of our eligible patients.

INNOVATION

We developed a plan for calling MWV beneficiaries who had not participated and invited them for an appointment. We also designed a streamlined electronic flowsheet with all Medicare and quality of life questions, some of which could be completed in advance by phone and the rest during the visit. Lastly, we created a brochure to explain billing processes when patients request exams beyond Medicare coverage.

IMPROVING HEALTH

- Educated RNs to connect with beneficiaries who have not participated in the MWV.
- Standardized the questions and tracking for MWVs to increase efficiency.
- Developed a workflow to establish a Pre-Visit call to gather information from the beneficiary and set the stage for a productive face-to-face visit by including what the beneficiary wanted to discuss and gaps in education that the nurse felt should be discussed.

ENHANCING PATIENT EXPERIENCE

- Home phone calls mean patients spend less time in the office.
- Home phone calls provide an opportunity for improved medication reconciliation because patients have the bottles more readily at hand than they would in the office.
- Fifty-seven percent of the population with a previous MWV returned for a follow-up MWV.

TAKING AIM AT AFFORDABILITY

MWV-participating patients have higher rates of preventive screens and immunizations (e.g., mammogram, colorectal screen, pneumonia vaccine, influenza vaccine, and Zostavax vaccine) than those who do not participate in the MWV.

HealthPartners®

Combating Opioid Abuse with Data-Driven Prescription Reduction

· INNOVATION ·

PARTNERS IN EXCELLENCE

Allina Health™

PROVIDER

Allina Health

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CHALLENGE

Each day 91 Americans die from an opioid overdose. To prevent opioid misuse within the community, we sought to evaluate how acute non-cancer pain in the outpatient setting among opioid-naïve patients could be better managed.

INNOVATION

We studied prescribing patterns by specialty and reviewed the top 10 procedures by specialty when opioids are prescribed. We identified opportunities to reduce the number of opioids prescribed. We had a multidisciplinary panel of experts create a system-wide guideline based on a systematic review of the latest literature. This guideline specifically outlines conditions for which opioids are not prescribed such as fibromyalgia, migraines, neck pain or dental pain. This includes a plan for monitoring adherence with modifications incorporating new research. We also developed a patient education tool to use before surgery in order to share the plan of treatment for pain ahead of time.

IMPROVING HEALTH

- Creation of evidence-based guidelines for pain management and opioid prescribing for use across our organization.
- The Institute for Clinical Systems (ICSI) set the goal for opioid reduction based on our results over the past year.
- These results include:
  - 980,527 fewer opioid pills prescribed in the outpatient setting in 2016 (12 percent reduction)
  - 2,079 fewer patients receiving eight or more opioid pill prescriptions over 12 months (18 percent reduction)
  - 13,391 patients receiving opioid prescriptions for more than 20 pills (13 percent reduction)

ENHANCING PATIENT EXPERIENCE

- No reduction in patient satisfaction given reduction in opioids.
- We are developing more alternative therapies (holistic care) for pain modification and a patient tool for shared decision making (opioids vs. alternatives) with patient panel input.

TAKING AIM AT AFFORDABILITY

As noted above, our results demonstrate that we are prescribing fewer pills. This reduces the chance of addiction and lowers costs due to prescription refills.

HealthPartners®

A partnership of women's healthcare specialists

Improving Care for Patients Experiencing First Trimester Loss

· INNOVATION ·

PARTNERS IN EXCELLENCE

Premier ObGyn *of* Minnesota

PROVIDER

Premier OBGYN of Minnesota

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CHALLENGE

At least 15 percent of all pregnancies end in miscarriage, making it one of the most common health issues for women. Most of these losses occur in the first 12 weeks of gestation and many require medical intervention. Our organization recognized that women experiencing first trimester loss were not receiving consistent information about their treatment options. Some providers were not well-versed in the use of misoprostol.

INNOVATION

Our Quality Committee developed protocols to educate physicians and patients on misoprostol, a safe, non-surgical treatment option for the management of first trimester loss. This included: dosage and timing of misoprostol use, medications for pain and nausea, follow-up with ultrasound, and a patient instruction sheet. We implemented this treatment with the goal of reducing surgical intervention and improving patient satisfaction across the 14 clinics that are part of the Premier OBGYN network.

IMPROVING HEALTH

- Developed educational materials to ensure patients diagnosed with a first trimester loss were offered comprehensive counseling and appropriate treatment options.
- Ensured that consistent care was provided with a single treatment protocol utilized by all 60+ providers.
- Through increased use of misoprostol we achieved a significant decrease in surgical interventions.

ENHANCING PATIENT EXPERIENCE

- Patient survey conducted three months after new protocol implemented.
- Patients reported feeling emotionally supported and well-informed.
- Patients reported their pain was adequately managed with all treatment options.
- More than 95 percent of patients would choose the same treatment again.

TAKING AIM AT AFFORDABILITY

- Our goal was to reduce the number of surgeries (there are over 500,000 first trimester losses a year in the U.S.), which results in significant savings.
- Surgery to treat first trimester loss can cost up to $5,000 vs. $20 for the medication.

HealthPartners®

Safe Disposal of Unused Opioid Prescriptions

· INNOVATION ·

PARTNERS IN EXCELLENCE

Lakeview Hospital

HealthPartners®

PROVIDER

Lakeview Hospital

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CHALLENGE

As drug abuse problems rise in our communities, it is more important than ever to safely and responsibly dispose of unused prescription medications. Recent studies suggest a greater than 50 percent disposal rate for all prescribed medications. Environmentally, it is no longer safe to dispose drugs down the drain. Our goal was to find a solution that provides our patients a convenient means to dispose leftover opioid prescriptions, protect our environment, and prevent drug abuse.

INNOVATION

Our innovation is to provide a drug deactivation system package with each opioid prescription dispensed at our pharmacy. A disposal bag is provided to our hospital patients discharged on opioids. We also educate our pharmacy, nursing, and prescribers on the science of these bags.

IMPROVING HEALTH

- By providing patients a convenient way of safe disposal and education, we encourage prompt and proper handling of leftover opioids, reducing the number of unused opioids.
- Since implementation in February 2017, we are currently distributing 250 disposal bags/month for all inpatients discharged with an opioid prescription filled in our pharmacy.
- Of the 120 patients surveyed, 49 percent reported they used the disposal bag. Almost half the 2,345 pills that were not needed by patients were prevented from getting into the wrong hands.

ENHANCING PATIENT EXPERIENCE

- Provided education and a disposal bag at no cost to patients.
- Easier access for patients to dispose of unused medications, preventing drug abuse.
- Reducing patient cost (fewer opioids prescribed) and potential for unused opioids, minimizes the chance of diversion or accidental exposure to children or pets.

TAKING AIM AT AFFORDABILITY

- We aim at being good stewards of our environment by providing environmentally friendly disposal bags.
- The cost of the disposal bags are not reimbursable. Instead, internal grant program supports the generosity and innovative thinking that allow us to go above and beyond for our patients.

HealthPartners®

Patient-friendly Medication Cards

· INNOVATION ·

PARTNERS IN EXCELLENCE

Lakeview Hospital

HealthPartners®

PROVIDER

Lakeview Hospital

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CHALLENGE

Our performance scores on the outpatient survey for "Before giving you any new medicine, did the staff describe possible side effects in a way you could understand?" identified an opportunity for improvement. Improvement emphasis was on patients understanding their new medications.

INNOVATION

In our high-paced Endoscopy environment, patients are anxious to receive their medication information and be discharged. The standard practice was to print drug monograph patient education, which can be lengthy and overwhelming. The Manager identified a need for simplifying new medication information and the Director of Pharmacy engaged PharmD students to create a simple resource for most commonly used new medications.

To help alleviate apprehensiveness and provide education at an appropriate reading level, we developed a simplified medication card that describes the purpose and side effects of the new medication. Patients receive this card when they obtain their medication.

IMPROVING HEALTH

- The card improves appropriate use and understanding of new medications for patients.
- Patient and Family Council feedback provided an opportunity to improve the design, content, and effectiveness of the medication cards.

ENHANCING PATIENT EXPERIENCE

- We improved our Endoscopy performance for "Before giving you any new medicine, did the staff describe possible side effects in a way you could understand?"
  - o 2015: 78th percentile rank
  - o 2016: 99th percentile rank
- We improved our inpatient HCAHPS performance for "Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?"
  - o 2015: 66th percentile rank
  - o 2017 (partial): 90th percentile rank
- Patient feedback on the medication cards' concise information indicates a high level of satisfaction.

TAKING AIM AT AFFORDABILITY

- We utilize paper with low environmental impact for our medication cards.
- Utilized our PharmD students to help develop the medication cards.

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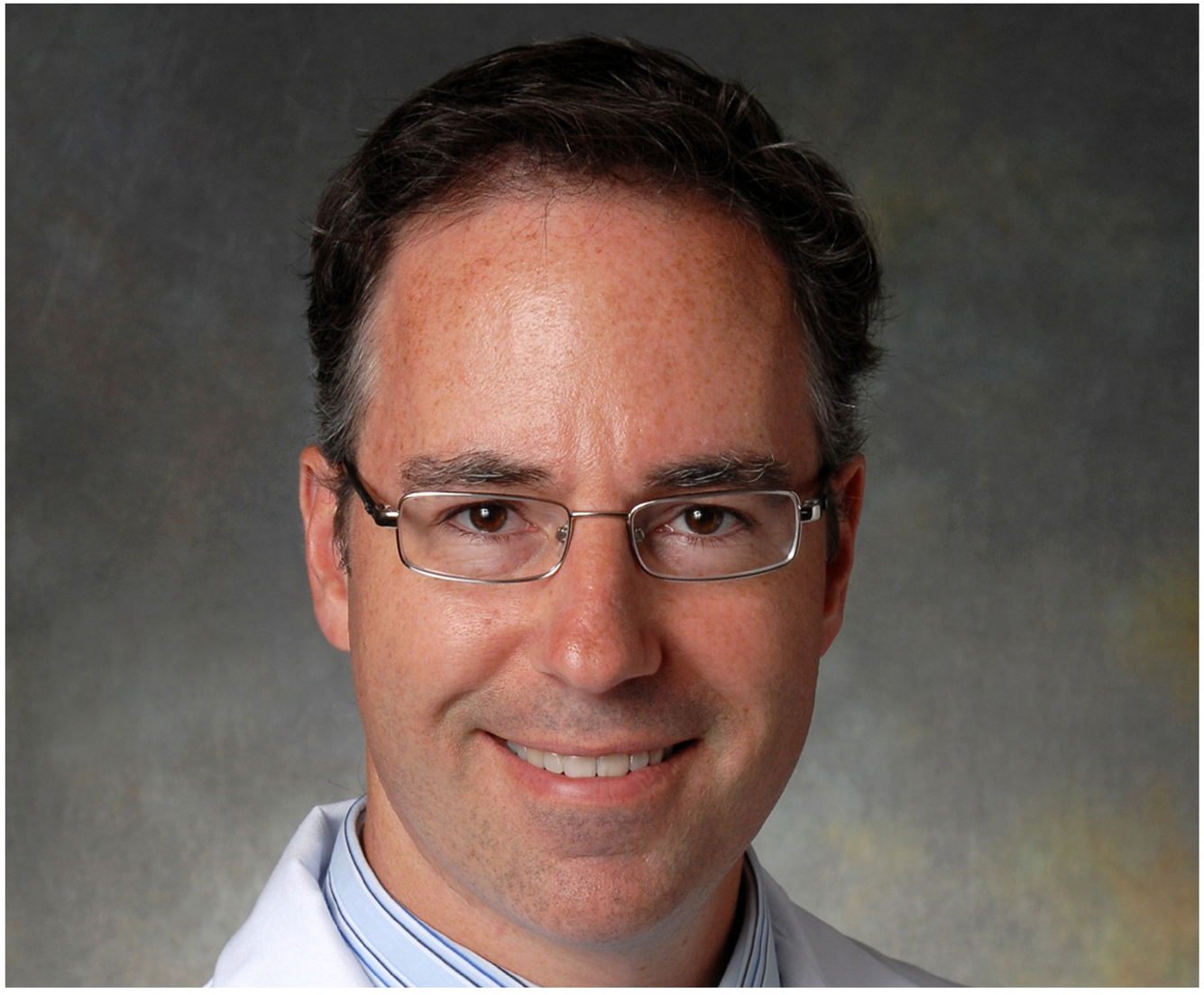

A Clinical Tool to Risk Stratify Potential Kidney Transplant Recipients and Predict Major Adverse Events

· INNOVATION ·

PARTNERS IN EXCELLENCE

Hennepin County **Medical Center**

PROVIDER

Hennepin County Medical Center

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CHALLENGE

Preoperative risk assessment of potential kidney transplant recipients often fails to adequately balance underlying health risk with the beneficial impact of kidney transplantation. Commonly used tools to evaluate surgical risk are incomplete in this complex group of patients. One example includes the revised cardiac risk index, which is used to estimate risk of operative cardiac events in patients undergoing non-cardiac surgery. Other tools have focused primarily on the specific outcome of kidney loss in transplant. Thus, the need arose for a specific kidney transplant predictive scoring tool that was based on key variables known at the time of being placed on the transplant list, predicting the likelihood of severe adverse events following kidney transplantation.

INNOVATION

We developed a tool to objectively score an individual patient's risk during the candidate selection period based on the literature and scientific study. This system was created with four components: age, cardiopulmonary factors, performance status and metabolic factors.

IMPROVING HEALTH

- Helps objectively evaluate each patient's risk prior to transplantation.
- Helps determine follow-up intervals while patients are on the deceased donor waiting list.

ENHANCING PATIENT EXPERIENCE

Assists in counseling patients regarding their risk prior to their transplant by providing an objective tool to help them understand their individual risk.

TAKING AIM AT AFFORDABILITY

- Assists transplant teams and patients in objective transplant selection. This assists in appropriate patient selection and utilization of organs, thus using resources more wisely.
- Allows the Transplant Center to appropriately use resources for wait list follow-up.

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