Providing Home-based Primary Care to Complex Seniors

Partners in Excellence – Innovation

Provider
Allina Health Senior Health

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Challenge
The traditional, clinic-based delivery model for primary care is not an ideal setting for the high risk senior population. Clinic-based primary care is challenged to meet the needs for the whole person which includes social, mental health and environmental concerns, all of which are critical for the high risk senior population.

Innovation
Our innovation involved developing and implementing a home-based primary care program that provides interdisciplinary care to high-risk seniors. The care team includes a nurse practitioner (NP), medical doctor (MD), registered nurse (RN), social worker (SW), pharmacist, care guide, as well as a program manager who also serves as a rehabilitation case manager.

Improving health
• The team develops a comprehensive care plan that addresses medical issues along with psychosocial and functional needs.
• Care team members coordinate care and facilitate access to community resources.
• The team pharmacist provides comprehensive medication review at time of program enrollment and is available longitudinally to provide medication consultation.
• The team SW, care guide and RN case managers monitor transitions of care to ensure timely follow-up from providers after a facility discharge. The team members also attend facility based care conferences and specialty provider appointments as needed to maximize care coordination.

Enhancing patient experience
• Patients have appropriate and timely care delivered in their home, which has optimized access to needed services.
• 90% of enrolled patients have discussed an advance care plan with members of the team.
• 85% of patients received a comprehensive medication review.
• 100% of patients who replied to a patient experience survey stated they were likely or extremely likely to recommend their provider to others.

Taking aim at affordability
• ED visit rates in the 6 months after enrollment were reduced by 62%.
• 30-day readmission rates in the 6 months after enrollment were reduced by 29%.
• Inpatient hospitalization rates in the 6 months after enrollment were reduced by 29%.
Challenge
It is exceptionally complex to coordinate follow-up care after inpatient rehabilitation for individuals who have experienced a spinal cord injury. In addition to extensive follow-up appointments with multiple specialty care providers, the follow-up for a spinal cord injury often includes home modifications, finding personal care assistants and adjustment to dramatic lifestyle changes. We recognized that more assistance was needed to help guide, advocate for, and sequence care over time. Caregivers were reporting overwhelming difficulty and providers were seeing a need for additional patient support. Gaps in care were also evident when reviewing re-hospitalizations, ED and outpatient utilization of therapy services.

Innovation
We implemented an outpatient spinal cord injury care coordination team consisting of an RN care coordinator, care guide, and social worker. The team receives a hand-off at discharge from the rehab unit and supports the individual and caregivers for the first two years after injury. Working in collaboration with the physical medicine and rehabilitation provider, the team connects with the patient at regular intervals. They advocate for services and problem-solve common issues like medical supply needs, home modifications, medication issues, insurance and funding barriers, adjustment to impaired functional ability, transportation, bowel and bladder management, emergency preparedness, and timely appointment access.

Improving health
• Actual follow-up with Primary Care Provider increased by 15% and follow-up with Physical Medicine and Rehabilitation Physician increased by 145%.
• Continued participation in outpatient therapies improved by 162% due to education and assistance with logistics like scheduling and transportation.

Enhancing patient experience
• Average QOL mental health score improved by 9% with involvement of the care coordination team.
• Caregivers benefited from the services of a team who advocates, problem-solves, and assists with removing barriers to needed care.

Taking aim at affordability
• 31% reduction in re-hospitalizations in the year following IPRU stay, with a total cost of care savings of $1,060,951.
• 34% reduction in emergency department utilization when followed by the care coordination team, demonstrating a total cost of care savings of $20,770.
Education and Dissemination of Appropriate Use Guidance for Advanced Imaging

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Challenge
In 2014, the federal government mandated that treating clinicians consult a Clinical Decision Support Mechanism (CDSM) when ordering advanced imaging procedures for Medicare Part B patients. This simple step promotes quality and preserves costs, helping to meet the Triple Aim. However, with evolving tools for clinical decision support (CDS) and evolving regulatory requirements, the mighty challenge is to inform and encourage ordering clinicians to utilize the mechanism effectively and have faith in the credibility of the criteria.

Innovation
CDI has been active in finding efficient clinically-appropriate alternatives to prior authorization processes. An early adopter of CDS tools (in collaboration with local payers), CDI continues to help advise CMS on the implementation of the program. With the support of CDI, the CDI Quality Institute was qualified by CMS as a Provider Led Entity (PLE) in 2016. The PLE develops evidence-based Appropriate Use Criteria (AUC) that is embedded in a CDSM for the consultation of advanced imaging orders for Medicare patients.

To date, the CDI Quality Institute PLE has developed AUC for 14 clinical topics – providing a wealth of information to both CDI-affiliated radiologists and treating clinicians regarding what type of imaging procedure, if any, is most appropriate. There have been many technical innovations made to support these efforts, including the current initiative to provide a CDSM to referring physicians on CDI’s information platform.

Improving health
Evidence-based AUC for imaging assists clinicians in selecting the imaging study most likely to improve health outcomes for patients based on their individual context, while reducing inappropriate or harmful imaging.

Enhancing patient experience
• CDS assures patients that the most appropriate test has been given.
• Enhanced patient safety by avoiding unnecessary radiation, contrast, or other risks.

Taking aim at affordability
• Appropriate utilization results in cost savings.

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Challenge
Through public needs assessment and population health data, we identified a gap in treating incarcerated individuals with opioid addiction, mental health and other medical issues. Prior to release, these inmate patients did not have the means to build the relationships necessary to navigate the health care system. Accordingly, post-incarceration care plans did not promote patient accountability or coordination of care. These patients often relapsed with unresolved medical conditions.

To address these issues, we recognized an opportunity to partner with local correctional systems to reduce health care costs and improve health outcomes while also benefiting the community.

Innovation
• We established a correctional medicine program that coordinates care with the goal of reducing re-offense and making an impact on individuals with mental, clinical, and substance abuse concerns.
• This correctional-medical partnership includes CentraCare, correctional facilities, local law enforcement, social services, public health, probation, and community-based mental health.
• This population health initiative provides high quality, cost-effective, and comprehensive care for a population that is typically neglected in conventional systems.

Improving health
• In 2018, 164 inmates were connected with a mental health and clinical care resource.
• Since program inception, 497 prescriptions for buprenorphine were initiated from our local jail systems.
• Program resources include access to stable housing, health insurance, and employment.

Enhancing patient experience
• Patients experiencing heroin/opioid withdrawal at the jails are now treated with buprenorphine in an effort to reduce symptoms of withdrawal during their stay.
• After release from jail, patients now have a clinic for follow-up care – with the option to see the same providers in the clinic as they did in jail.

Taking aim at affordability
• Research supports an average health cost decrease of $17,477 per person by offering buprenorphine to this vulnerable population.
• Decreased emergency department utilization of these patients by 664 encounters, or 21%.
Embracing My Panel Metrics Dashboard to Improve Patient Outcomes

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Challenge
Accurately identifying and addressing care gaps at the time patients see their doctor is crucial in streamlining their access to preventive or chronic care management. Ideally, patients would leave with a follow-up plan/future appointment to close the care gap. Our challenges to closing gaps in care and staying connected to patients include:

• Patients seen for acute visits where health maintenance items not always addressed due to allotted visit.
• Patients fall on registry reports where the reports are run on a monthly basis.
• Registries were often outdated.
• Registry work was not part of nursing standard work and often not prioritized.

The question was – How do we continue to close patient care gaps while the patient is in the clinic, but also work a ‘real-time’ registry to help support those patients so they don’t slip through the cracks?

Innovation
We implemented EPIC’s Healthy Planet software module “My Panel Metrics,” a user-friendly, real-time patient registry dashboard within EPIC which nursing can access at any time.

• Dashboard allows multiple staff across the system to access reporting in "real time."
• Created a systematic review of all care gaps decreasing duplicative work and outreach.
• Increased work efficiencies as care gaps can be addressed in one visit.
• Staff education on understanding the quality metrics.
• Shared performance reporting for continual process improvement.

Improving health
• “Real-time” actionable preventive and chronic care management for our patients.
• Improved management of health measures across all patient populations.

Enhancing patient experience
• Increased patient satisfaction in getting care they need in a timelier manner.
• Decreased trips to the provider’s office to address individual care gaps.
• More engaged in planning care over time.

Taking aim at affordability
• Increased vaccine compliance rates that reduces the total cost of care for vaccine-preventable disease.
• Increased optimal diabetes rates resulting in reducing potentially preventable hospital, ED or provider visits.
• Improved hypertension management which decrease risk for further cardiovascular incidents.

Provider
CentraCare Health

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Challenge
As our community increased in diversity, we found that our immigrant and refugee communities struggled to meet colorectal cancer screening and vaccination targets while also frequenting the Emergency Room and Urgent Care Center. We believed this was a result of these communities not understanding the healthcare system, and the healthcare system not understanding the culture and beliefs of the communities.

Innovation
We implemented a variety of educational programming and resources to address social determinants of health, share information on health-related topics identified as important by the community, and increase awareness of the healthcare system. To do so, we spent time forming community relationships and seeking to understand cultural beliefs that might impede decreasing health disparities.

Improving health
- Community education that creates an awareness of the importance of preventive care – critical when patients are coming from an environment focused on surviving, not thriving.
- Community services offered at important access points.
- Follow-up and continued support.
- Leadership development and education for sustainability within the community.

Enhancing patient experience
- Enhancing the patient experience is easier when the people providing care understand the culture of those they serve.
- When patients understand the reason behind procedures, medications, diseases, and ways of prevention, they feel more in control and able to make informed decisions.

Taking aim at affordability
- We are working on prevention of diseases, social determinants, and discrimination within the healthcare system.
- By educating the immigrant and refugee population, we can create more informed patients, which reduces usage of urgent services and increases usage of preventive services.
- This decreases not only disparity and inequality, but clinical services are used more appropriately due to addressing the whole picture instead of snapshots. This will eliminate unnecessary visits, lessen chronic health issues, and lead to a thriving community.
Pharmacist Clinician Integration into Primary Care Team to Improve Outcomes in Patients with Diabetes

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Challenge
According to the Centers for Disease Control and Prevention, 30.3 million Americans have diabetes and 1 in 4 of them don't know they have it. Diabetes is the seventh leading cause of death in the U.S.

At Essentia Health, 22,535 adults ages 18-75 have diabetes. Essentia Health, in coordination with MN Community Measurement (MNCM), tracks the percentage of those patients who reach all five treatment goals, otherwise known as D5 compliance:

- A hemoglobin A1c of less than 8.
- Blood pressure reading of less than 140/90.
- Daily aspirin use for patients with ischemic vascular disease.
- Documented tobacco-free status.
- Use of a statin, drugs that lower cholesterol and triglycerides.

Currently only 11,027 (48.93%) of our diabetic patients are achieving these D5 goals.

Innovation
Our innovation involved pharmacist clinician integration into the clinic primary care team with a heightened focus on diabetes management through expanded Diabetes Collaborative Practice Agreement (CPA) utilization and full time access to pharmacist clinician services.

Improving health
- When reached together, the D5 goals represent the gold standard for managing diabetes. When a person achieves D5 success, they reduce their risk for complications such as heart attack, stroke and problems with their kidneys, eyes and nervous system.
- Pharmacists are highly accessible and well-trained health care professionals who can move patients closer toward achieving better medication therapy outcomes. Pharmacists utilize their clinical expertise in monitoring and managing diabetes medication plans to positively impact health outcomes and empower patients to actively manage their health. In addition, pharmacists serve as a resource to other health care providers to assure safe, appropriate, cost-effective diabetes medication use.

Enhancing patient experience
- Increased patient engagement in between provider visits.
- Improved patient access and more frequent patient interactions with consistent availability of service.
- Enhanced patient understanding of diabetes, their medications and health goals.

Taking aim at affordability
Improved D5 compliance resulting in decreased long term diabetic complications.
Wiping the slate clean: Improving opioid prescribing habits using refined EMR decision support

Partners in Excellence – Innovation

Challenge
In recent years it’s been widely established that opioid use is a national epidemic. The severity of this issue resulted in the U.S. Department of Health & Human Services declaring the opioid crisis as a public health emergency in October 2017. This is not only caused by high opioid prescribing rates (as a portion of patient visits and encounters), but by prescriptions with higher than necessary dosages. Much of this inappropriate prescribing occurs in Emergency Departments. With further exploration of the possible root causes of over-prescribing at Fairview, there appeared to be a lack of updated standards for appropriate pain management plan development, along with misaligned expectations from patients.

Innovation
We lowered the prescribing recommendations within the EMR medication order sets to <100 Morphine Milligram Equivalents (MME) based on ICSI guidelines, as well as deleted individual providers’ customization of these orders using preference lists.

Improving health
• Prescribing rate reduced from 10% (April 2017) to 7% (June 2019) over 26 months, amounting to 7,711 fewer opioid prescriptions written.
• Medication compliance with MME guidelines improved from 62% (April 2017) to 93% (June 2019) over 26 months, leading to 7,095 appropriate opioid prescriptions which previously were filled in excess.
• Fewer opioid orders prescribed to ED patients at lower dosage (MMEs) led to fewer instances of opioid abusers estimated in the range of 213 and 444 over 26 months.

Enhancing patient experience
• Enhancing common pain management expectations for patients resulting from standard prescribing practices.
• Savings from the lower cost of medications is passed along to patients due to 7,711 fewer prescriptions written.

Taking aim at affordability
Decreases in opioids prescribed and dosage levels have led to an estimated $3,251,112 to $6,239,976 in health care costs prevented over 26 months.
Building High-Reliability through the Daily Engagement System

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Challenge
Health care organizations lack clear measures and benchmarking to determine whether programs are influencing the daily experience of the patients’ health. Organizations need a measurement system that assesses both physical and mental health dimensions in an integrated fashion. This need is critical since we know that physical and mental health is inextricably linked in the lives of our patients.

Innovation
Our organization implemented a health risk quality of life assessment to evaluate the quality of our emerging primary care transformation model through evaluating its impact on the patient’s reported perception of physical and mental health. The assessment tool implemented is the Core Healthy Days Survey (CHDS).

Improving health
- CHDS will inform the development and performance of new effective care paths in ways that traditional quality, cost and patient experience measures have not always inspired.
- CHDS provides a way to measure and track perceived healthy days lived by a patient or a population.

Enhancing patient experience
- Patient reported quality of life encompasses a more holistic view of the lived experience of a patient while patient experience typically measures a person’s experience with the health care system (visit to the clinic, emergency room or inpatient stay).
- Asking patients about their perception of their health, rather than focusing solely on clinical data, engages them proactively in their health journey, improving the patient’s experience and their perception of care quality.

Taking aim at affordability
- Creation of a new value equation tying primary care program costs to the production of health within a population.
- Value assessment of programs and staffing models.
Improvement in Statin Therapy Prescribing in Persons with Diabetes

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Challenge
There are multiple measurement bodies that require our organization to report on Statin Use in Persons with Diabetes (SUPD), including Minnesota Community Measurement (MNCM) and Centers for Medicare & Medicaid Services (CMS). As a part of the CMS five-star quality rating system, our organization has multiple quality measures it is responsible for; one of them is SUPD. Opportunities in statin therapy prescribing and proper documentation of statin “intentionally not prescribed” prompted our work to improve statin therapy prescribing for persons with diabetes.

Innovation
We initiated a collaborative practice agreement with our Medical Director which allows pharmacists in our community pharmacies to initiate statin therapy in individuals with diabetes. In addition, the agreement allows pharmacists to prescribe the medication and order laboratory tests in the electronic health record (EHR).

Improving health
• Identified patients who may benefit most from initiation of statin medication.
• Improved documentation of statin therapy in the Electronic Health Record.
• Achieved 2.1% increase in statin use in persons with diabetes.

Enhancing patient experience
• Allowed collaboration of community pharmacists and healthcare providers to achieve positive health outcomes for patients.
• Addressed the need for initiation of statin therapy immediately at a community pharmacy versus requiring patients to make an appointment at the clinic.
• Improved patient satisfaction and convenience of health care.

Taking aim at affordability
• Reduced inadvertent prescribing of statin therapy by appropriately documenting in the Electronic Health Record reason for “intentionally not prescribed”.
• Utilized appropriate resources to ensure workload was manageable at community pharmacies.
Reducing the Availability of Prescription Opioids through Deterra Bags

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Challenge
Despite garnering local, state and national attention, efforts to address the opioid crisis in Minnesota have not brought down prescription opioid use, misuse or addiction. Opioid overdose deaths have actually increased in recent years per the Minnesota Department of Health. Data has also consistently shown that rural Minnesotans and minority individuals are disproportionately impacted by the opioid crisis in our state. A call for evidence-based interventions to remove excess prescription opioids from homes and encourage proper usage is a timely and necessary endeavor.

Innovation
We piloted the use of Deterra Drug Deactivation bags in the orthopedic patient population to assess if this provided patients with a safe, easy-to-use, at-home disposal option for excess prescription opioids. This pilot was launched in 2019 at three Fairview Health System Orthopedic departments. The goal was to be able to quantify the number of prescription opioids disposed of in the provided Deterra bags.

Improving health
• Providing patients with a disposal option for excess prescription opioids that will protect communities and the environment.
• Ensuring effective patient education and discharge discussions about disposal options can influence proper medication usage and deter prescription opioid misuse while effectively treating acute pain.

Enhancing patient experience
• Facilitating prescription opioid disposal by providing safe, easy to use at-home disposal options.
• Providing comprehensive patient education regarding safe prescription medication disposal options.

Taking aim at affordability
• 37.4% of prescribed opioids were disposed of by eligible patients with excess opioids using the Deterra bags.
• Eligible patients rated the usefulness of the bag at a 4.5 of 5, and 10 out of 10 said that they would use the bag again to dispose of excess opioids.
In today’s patient-centric and outcome-focused health care environment, we continue to be challenged by the lack of standardized outcome assessments and the lack of wide adoption of those assessments. Identifying a standardized outcome assessment and creating a method to capture data that would allow for analysis and comparison was our primary goal, along with improving our chiropractic network focus on patient-centered care.

Our utilization management program for chiropractic care has been dramatically enhanced to become a patient-centered platform that incorporates the concepts used in the CMS (Centers for Medicare & Medicaid Services) value-based model. These program enhancements strengthen our chiropractic provider networks through validated outcome assessment tools, treatment decision support tools, and ongoing provider education with a simplified and systematic program.

Improving health
- Support our chiropractic providers by demonstrating and measuring outcomes that focus on improving patient care.
- Support ongoing patient care by systematically assessing progress against treatment protocol through regular and required collection and data analysis across our chiropractic network.
- The outcomes focus on the delivery of patient-centered care and the data we are collecting on these assessments will show patient functional improvement.

Enhancing patient experience
- Patient educational and outcome assessment tools and resources are readily available to providers.
- The innovation supports providers by recognizing that every patient is different. The outcome tools provide a measure for improvement of the patient’s activities of daily living.
- Focus on the patient enables the patient to see progress and engage in their recovery process.

Taking aim at affordability
- Our enhanced patient-specific program contains costs by reducing over, under, and mis-utilization.
- Ensures that the appropriate care is given to each individual patient based on real data and outcomes.
Oblique Lateral Lumbar Interbody Fusion (OLLIF)

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Challenge
The current standard of care for the Transforaminal Lumbar Interbody Fusion (TLIF) surgery has been in place since the 1980s. It includes a large incision in the patient’s back, notable blood loss, and a 2-3 month recovery period. Spine surgery is behind the technological advances of other orthopedic procedures, including those performed on the knee, shoulder, hip, etc.

Innovation
Mastered a minimally invasive spine procedure, Oblique Lateral Lumbar Interbody Fusion (OLLIF), that provides the patient with shorter OR time, considerably less blood loss, shorter hospital stay, and much quicker recovery time than the current standard of care (TLIF).

Improving health
- Patients experience a much shorter OR time (every additional 30 minutes of OR time increases the risk of complications by 17%).
- We have now done over 1,000 OLLIF procedures and have seen 0.2% of cases (2 out of 1,000) that experienced an infection. Both were treated by antibiotics and did not require a re-surgery.
- In a study of over 100 patients a year post-surgery, our patients experienced a 98% fusion rate.
- This procedure can be performed on patients who would normally get turned away from other providers because of high BMI, age, morbidities, etc.

Enhancing patient experience
This procedure is giving patients their quality of life back in a much quicker timeframe and without repeat surgeries.

Taking aim at affordability
The cost of the procedure is relatively the same as the current standard of care. However, with the decreased OR time and decreased hospital stay, the savings would be over $3 billion if all lumbar fusions were done this way.
Challenge
Diabetes is prevalent and leads to long-term health consequences and higher cost of care. Our project sought to identify and reduce medication related barriers in achieving target glycemic control among patients with diabetes in the MHealth Primary Care Clinic.

Innovation
We implemented a post-visit phone call conducted by an MTM pharmacist for patients with a hemoglobin A1c ≥8%. The pharmacist conducted medication management to identify barriers to diabetes control.

Improving health
Post-visit phone calls conducted by a pharmacist allow for identification of drug-related problems soon after an office visit, allow real-time changes, and allow for outreach between visits to facilitate timely, patient-centered care, thereby improving access across the system.

Enhancing patient experience
• Post-visit calls improve patient satisfaction as they do not require an office visit.
• Standard of care requires multiple professionals to review a problem before a solution can be identified. Frequent pharmacist touchpoints help address problems that arise outside of a visit quickly and provide patient education that providers may not have time to address in a brief office visit.

Taking aim at affordability
The pilot cohort identified 25 patients who met initial criteria. Of these 25 patients, 21 required pharmacist intervention. Of these 21 patients, 14 have returned to clinic for a follow-up A1c. Of these 14 patients, 13 had a lower A1c upon return to clinic. Seven of these patients had an A1c of 9% or greater during the initial post-visit call. Six of these patients achieved an A1c of less than 9% after pharmacist intervention. Based on NCQ/PQRS estimates, this results in an estimated, one-time cost savings to the health care system of $8,598. If extrapolated to the 107 patients in the MHealth Primary Care Clinic who have A1c measurements of ≥9%, an estimated savings of $130,000 is achieved.
Challenge
- High volume of triage nurse calls for care questions and prescription refills after the visit.
- Provider dissatisfaction with a decrease in face-to-face time with the patient.
- Increased concern for provider burnout.
- One-on-one staffing for providers with different panel sizes, causing frustration due to workload and lack of teamwork.

Innovation
- Patient population management occurs in small groups within the clinic through use of a new Team Care Coordinator nurse role for every team of two MDs, one midlevel provider, and support staff.
- Team Care Coordinators work directly with these teams to maximize the patient visit by:
  - Focusing on closing care gaps for their panel of patients
  - Lowering overall costs with improved professional satisfaction

Improving health
- Team Care Coordinator is responsible for pre-visit planning and documentation, including:
  - Noting all preventive services due and date of last service
  - Recording chronic disease order protocols and medication refills
  - Reviewing all controlled substance contracts and PMP registry to ensure compliance
  - Verification that any post hospital discharges are available to provider, along with updating medication and problem list in chart

Enhancing patient experience
- All of the patient’s needs are addressed at the visit by the whole team. Specifically, the Team Care Coordinator:
  - Answers all patient calls for the team of providers (70% answered live) and addresses the majority of issues with the help of the provider at the time of the initial call.
  - Acts as scribe for all patient message responses from the provider.
- Our approach ensures a warm hand-off from provider to Team Care Coordinator for enrollment in CCM.

Taking aim at affordability
- Improved risk scores with pre-visit planning by having the Team Care Coordinators pre-populate the high HCC diagnosis to be addressed.
- CCM enrollment done at visit.
- 2018 Total Cost of Care for HealthPartners-insured patient population: -3%.
Early Post-Surgical Spine Program

Partners in Excellence – Innovation

Challenge
Typical post-surgical care for spine surgery is aimed more at monitoring healing of the surgical structure (wound, hardware fixation, bone graft) versus the biopsychosocial healing (physical, psychological, and social well-being) of the patient. And, unlike orthopedic surgeries such as total hip or knee replacements in which therapy begins two weeks after surgery, spine surgeons are not likely to refer to rehabilitative therapy until much later or not at all.

We hypothesized that monitoring and providing therapy in the early weeks following surgery would be helpful in reducing fear of movement, provide support and expectations around pain and the recovery process, and prevent post-surgical complications. Thus, it would lead to improved patient outcomes and ultimately decrease health care costs.

Innovation
Our vision is to create a new standard of care for post-surgical spine patients through a model that combines the post-surgical clinic care visits with an early rehabilitative therapy referral to ultimately reduce post-surgical complications, revision surgeries, and longer-term failed surgery syndrome.

By partnering with local spine surgeons we created an early post-surgical spine rehabilitation program. Patients were seen as early as two weeks after surgery and monitored in the early recovery phase. Therapy focused on graded return to safe functional activities, pain neuroscience education, and progressive exercise.

We concluded that 80% responded favorably in Total Perceived Recovery (TPR), 80% discharged at a low risk of psychosocial barriers to recovery (Keele), and 74% had a meaningful improvement in function (PSFS).

Improving health
- Reduced disability.
- Improved return to work.
- Reduced pain medication / narcotics.
- Improved self-efficacy.

Enhancing patient experience
- Continuity of care.
- Improved self-care and recovery process.
- Reduced uncertainty, fear, anxiety.

Taking aim at affordability
- Reduced surgical complication costs and/or revision surgery.
- Reduced cost of later post-surgical rehabilitation (chronic disuse, fear of movement).
Nicotine Cessation: Become a Quitter

Partners in Excellence – Innovation

Challenge
We had a lack of patients as the MN Quit Line was the only option we had to help patients with nicotine cessation.

Innovation
• We implemented a nicotine cessation program including education for one-on-one and group sessions.
• Generally health care facilities provide education and support in a single person approach. With the group class, participants are able to talk to others who are struggling with the same issues but attempting to reach the same goal.
• One of our group classes started with 12 participants with five of them being nicotine free at completion of the classes. Whereas in 2017 when we solely used the MN Quit, the facility only made ten referrals to that program and none of the patients were successful in nicotine cessation.

Improving health
• Systematic approach in providing patients with education materials and referrals for nicotine cessation.
• Our facility created workflows to run reports, send letters, and call patients needing to address their nicotine use.

Enhancing patient experience
• High patient satisfaction in having a designated person who helps with nicotine cessation.
• We heard success stories of patients and shared those with staff members and soon the community. It was evident and expressed by the patient they would not have been able to quit smoking without the group class and leader.

Taking aim at affordability
• Increased efficiency by having a small group handle all referrals for nicotine cessation.
• Increase in value of education for nicotine cessation by using evidence-based group classes
  - Patients are saving money upon completion of the classes, seeing reduction in abnormal lab values, and need for medications associated with use of nicotine.
  - The facility is using fewer staff resources to perform repeat lab orders because they are abnormal, and to complete medication refills for patients.
Retrospective Record Review of Patient-Reported Adverse Events Following Surgical Intervention

Partners in Excellence – Innovation

Provider
Twin Cities Orthopedics

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Challenge
There is potential for an adverse event (AE) while caring for patient’s orthopedic conditions in the operative environment. Common AEs among orthopedic patients include falls, surgical site infections (SSIs), deep venous thromboembolism (DVTs), or injuries to nerves and/or blood vessels. These AEs greatly contribute to negative patient outcomes, increased readmissions and prolonged treatment. Furthermore, such complications translate to increased healthcare costs and reduction in quality of life.

Innovation
TCO developed a three-phase process to track and monitor patient reported AEs. This process, known as Retrospective Record Review (RRR), involved identifying the frequency, nature, preventability, and consequences of AEs in the organization patient population. The RRR process intended to utilize an evidence-based process to improve healthcare from a patient-centered approach.

Phase 1: Data collection. Ensure surgical patients have the opportunity to self-report on their procedure through an AE patient-reported outcome questionnaire (PRO).

Phase 2: Establish an extensive AE reporting protocol. Align protocol with nationally accepted requirements guiding the reviewing process. The concerning PROs are presented to TCO’s Chief Medical Officer (CMO) and review board members to categorize and confirm.

Phase 3: Utilize data to build transparent reports. Leverage reports to affirm variability of internal complications, focus direction toward minimizing frequency of AEs, and optimizing standard of care.

Improving health
• Routine tracking/analysis of PROs ensures proper follow-up and care is provided by partnering hospitals and Ambulatory Surgery Centers.
• Optimizing standard of care and surgical outcomes.
• Provider engagement and patient education.

Enhancing patient experience
• Identify trends to personalize patient safety and treatment plans.
• Reduce time away from family and work.

Taking aim at affordability
• Identification of preventable AEs with transparent communication reduces readmissions, enhances communication between healthcare organizations and improves overall healthcare costs.
• Concludes the quality value equation (adds risk stratification to claims & outcomes).
Self-Monitoring Blood Pressure Kits

Partners in Excellence – Innovation

Challenge
Blood pressure management in a clinic can be difficult due to multiple variables that can affect a patient’s blood pressure. We wanted our communities to have access to self-monitoring blood pressure machines, which would give them the ability to monitor their blood pressure between clinic visits.

Innovation
Our clinics began a project to expand patients’ and county residents’ access and ability to self-monitor their blood pressure outside of the clinic. To address the incidence of high blood pressure, we collaborated with three of our local libraries and a county agency to create a blood pressure kit containing a blood pressure monitor, blood pressure cuff, directions to properly check blood pressure, educational material about blood pressure, and a blood pressure tracking card. Patients and residents are able to check out a blood pressure kit for two weeks at a time, which allows them to capture a picture of what their blood pressure looks like during their routine day-to-day activities. They are also allowed to keep the resources that are supplied in the kits at no cost.

Improving health
• Allows for tracking of blood pressures outside of a clinic visit, providing opportunities for more proactive treatment.
• Provides a clear picture of a patient’s blood pressure during their normal routine.
• Gives direction on whether a patient needs medication management and/or therapeutic lifestyle changes to obtain optimal blood pressure control.

Enhancing patient experience
Patients or residents can access the self-monitoring blood pressure kits from the public library. There is potential to impact thousands of patients and residents, as anyone in the community can check out the kits – not just patients from our clinics.

Taking aim at affordability
• Eliminates unnecessary and costly office visits.
• Free blood pressure monitoring.
• Decreases out-of-pocket costs for prescriptions.