Objectives

• Identify ways to use resources effectively and efficiently to serve high-cost or high-utilization populations

• Understand how HealthPartners has worked across its system and community to meet the mission of achieving better health, better experience, and lower cost for patients
Feet in 2 Canoes (sort of...)

Outline

• Background
  – Minnesota Market
  – HealthPartners
• Transforming care
  – Culture
  – Care design
    • Population focus
    • Focus on Total Cost of Care
Minnesota Market

• Collaboration & transparency
  – Agreeing on best evidence through the Institute for Clinical Systems Improvement (www.icsi.org)
  – Public reporting of results through MN Community Measurement (www.mncm.org)

• Health plan product design
  – Value-based contracting

• Consumer cost sharing
  – 25% of plan members have coinsurance or high deductible products

• Low premiums on insurance exchange for ACA (Affordable Care Act)

• 3rd Healthiest State

HealthPartners – Our Organization

<table>
<thead>
<tr>
<th>Care Group Locations</th>
<th>Facts &amp; Figures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-specialty Group Practice –</td>
<td>• 22,000 employees</td>
</tr>
<tr>
<td>• 1,700 physicians/clinicians</td>
<td>• 1 million patients care for annually</td>
</tr>
<tr>
<td>• 50 + locations in MN &amp; WI</td>
<td>• 1st NCQA Level 3 ACO</td>
</tr>
<tr>
<td>• Multi payer</td>
<td>• Top performing medical group on Minnesota Community</td>
</tr>
<tr>
<td>Main Referral Hospitals –</td>
<td>Measurement</td>
</tr>
<tr>
<td>• Regions – St. Paul, MN</td>
<td>• 2012 American Medical Group Association Acclaim Award Winner</td>
</tr>
<tr>
<td>• Methodist – Minneapolis, MN</td>
<td>• Environmental Excellence recognitions for sustainability</td>
</tr>
<tr>
<td>Community Hospitals –</td>
<td></td>
</tr>
<tr>
<td>• Hudson, WI</td>
<td></td>
</tr>
<tr>
<td>• Amery, WI</td>
<td></td>
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<tr>
<td>• New Richmond, WI</td>
<td></td>
</tr>
<tr>
<td>• Stillwater, MN</td>
<td></td>
</tr>
</tbody>
</table>
HealthPartners:
Aspiring for our Best with Triple Aim

Mission
To improve health and well-being in partnership with our members, patients and community.

Vision
Health as it could be, affordability as it must be, through relationships built on trust.

Values
Excellence, Compassion, Partnership, Integrity

TRIPLE AIM: Health-Experience-Affordability
HealthPartners Clinics

- Total Cost Index (compared to statewide average)
  - < 1 is better than network average

- % patients with Optimal Diabetes Control*
  - * controlled blood sugar, BP and cholesterol per ICSI guideline A1c changed from < 7 to < 8 in 1Q09 and BP control changed from <130/80 to <140/90

- % patients “Would Recommend” HealthPartners Clinics

47%
Minnesota Community Measures High Performing Medical Groups in 2013 (Primary Care)

<table>
<thead>
<tr>
<th>Measure</th>
<th>HealthPartners Clinics</th>
<th>Entra Family Clinics</th>
<th>Fairview Health Services</th>
<th>Park Nicollet Health Services</th>
<th>Quello Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent Immunizations</td>
<td>12 out of 18</td>
<td>10 out of 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Bronchitis</td>
<td></td>
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<tr>
<td>Cervical Cancer Screening</td>
<td></td>
<td></td>
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<tr>
<td>Childhood Immunization Status (Combo 3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chlamydia Screening</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td></td>
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<tr>
<td>COPD</td>
<td></td>
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</tr>
<tr>
<td>Depression Remission at 6 months</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Depression Remission at 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharyngitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimal Asthma Care - Children</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Optimal Asthma Care - Adults</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Optimal Diabetes Care</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Optimal Vascular Care</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- Medical Group rate and CI fully above average
- Blank = measure reported but rate was average or below average

AMGA Physician Satisfaction Survey 2005

2005

AMGA Correlation with Overall Satisfaction

Low - High
AMGA Physician Satisfaction Survey 2013

Transforming Care:
- Culture
- Care Design
MINNESOTA: COME FOR THE CULTURE
STAY BECAUSE YOUR CAR WON'T START
Culture
Involving Patients

1. Patient Councils
2. Focus Groups
3. Patient survey comments
4. “ASK 5”
5. Online Community

Transforming Care:
- Culture
- Care Design
HealthPartners Health Driver Diagram

Key Outcome: Improved Health

Health Determinant:
- Health Care (20%)
- Health Behaviors (40%)
- Socio-economic factors (40%)
- Environmental Factors (10%)

Primary Drivers:
- Preventive Services
- Acute Care
- Chronic Disease
- End of Life
- Patient Engagement
- Cross Cutting Issues

- Tobacco Non-use
- Activity
- Diet/Nutrition
- Alcohol Use
- Education (ex. Early childhood)
- Economic Development
- Other Community identified
- Safe, walkable streets
- Access to grocery stores and fresh foods

Modified from David Kindig, MD, PHD, University of Wisconsin

Population & Cost Distribution

% of Population: 70%, 20%, 9%, 1%
% of Total Healthcare Expense: 11%, 21%, 39%, 29%

Data Source: Thomson Reuters Market Scan Database
National Sample of 21 million insured Americans, 2003-2007
Population View – Primary Care

Diabetes - 14,467 eligible patients
25% of State Program patients have mental health diagnosis
18% of State Program patients have Opioid script
2000 Frail & Elderly that have an avg of 16 scripts

Challenge: Applying the 80/20 rule while Customizing Care for Individuals

Population Health:
- Patient Care Coordination (Chronic Care & Special Needs Children)
- Opioid Management
- Behavioral Health Access & Integration
- Care Plan Documentation
- Frail & Elderly
- Reducing Use of ED
- Post ED & Hospital Notifications & Follow-Up
- Co-Management w/Disease & Care Management
- Advance Directives
- Health Care Home Re-certification
- Risk Stratification

- Disease Registries
- In-hospital Management
- Advance Directives
- Call, Click, Come In
- Disparities
- Care Model Process Care Modules
- Care Model Process Resource Modules
- Medicare Annual Wellness
Four Care Design Principles

We use the following design principles to ensure our care achieves Triple Aim results:

- **Reliability**: Reliable processes to systematically deliver the best care
- **Customization**: Care is customized to individual needs and values
- **Access**: Easy, convenient and affordable access to care and information
- **Coordination**: Coordinated care across sites, specialties, conditions and time

Why Standardize?
Why Standardize?

27* Clinics x 60 Measures
(PEOPLE, HEALTH EXPERIENCE & STEWARDSHIP) =
1,560 Processes

300 Primary Care Teams x 60 Measures =
18,000 Processes

*HealthPartners Medical Group Clinics

Cycle and Care Team Roles
(Care Model Process)
Efficiencies are Reflected in Professional Price

Care Design Principles

1. Standardize to the science
2. Customize care to individual patient preferences and values and unique personal characteristics
Reducing the Gap: Breast Cancer Screening

- Pre-visit planning/decision aid
- Same Day mammogram
- Registry
- Culturally-specific mammogram days

![Graph showing reduction in GAP from 80.3% to 83.3% over 2008-2013]

Care Design Principles

We design ways to make care and information

- More convenient
- Easy to access; and
- Affordable
• 9,700 scheduled phone visits
• Examples: depression, anxiety, osteoporosis, ADHD

• 3,600 e.visits
• 10,000 patient emails
• Test Results
  90% within 4 hours
• 10% Online Scheduling

• 30% same day access
• 64% of patients saw their primary care physician
**virtuwell™ at a Glance**

- Available around the clock – 24/7/365
- Custom treatment plan with prevention advice
- A simple $45 price, insurance accepted
- Money-back guarantee
- Free and easy triage if higher level of care needed
- Free 24/7/365 follow-up care
- Ability to connect with a nurse practitioner anytime
- 99% would highly recommend

**Care Design Principles**

We coordinate care across sites, specialties, conditions and time
Predictive Modeling as an input to identify and stratify patients

<table>
<thead>
<tr>
<th>Configured a predictive model leveraging our integrated capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Electronic Health Record (EHR) data is the sole input into the model</td>
</tr>
<tr>
<td>2. Electronic Health Record (EHR) data is supplemented with the claims data</td>
</tr>
</tbody>
</table>

- EHR predicts risk and supplemented for more complete picture by claims data when available
  - Severity of condition (labs, assessments, etc.)
  - Social history
  - Problem List Diagnoses
  - Prescriptions
  - Surgical and procedure history
  - Tier 0-4

## Tier 4 patients example view

<table>
<thead>
<tr>
<th>Name/Age/Gender</th>
<th>Hospitalization Risk</th>
<th>Last Hospitalization</th>
<th>Case Manager?</th>
<th>Next Primary Care Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td></td>
<td>12/30/2013</td>
<td>Yes</td>
<td>4/8/2014</td>
</tr>
<tr>
<td>Paula Brown</td>
<td></td>
<td>1/15/2014</td>
<td>No</td>
<td>3/15/2014</td>
</tr>
<tr>
<td>Sally Adams</td>
<td></td>
<td>2/23/2014</td>
<td>Yes</td>
<td>5/2/2014</td>
</tr>
</tbody>
</table>
Population Health Framework
(with thanks to Everett & Virginia Mason)

Populations
- Behavioral Health
  - Patients with Opioid Use
  - Special Needs Children
  - Chronic Care Patients
  - ED Discharges
  - Hospital Discharges
- Pre-Visit Work Flow
- Initial & Ongoing Assessment Visits
- Care Plan Development & Follow-up
- Pharmacist
- Care Coordinator
- Case/Disease Management
- Specialty Consults
- Community Resource

Shared Visits for Complex Patients

- 20 minutes
  - Patient and Nurse: Pre-Assessment
  - Initial history

- 20 minutes
  - Patient and Physician: Diagnosis
  - Care Plan

- 20 minutes
  - Patient and Nurse: Close the loop
  - Action Plan
What does this mean to the patient?

- A complicated patient with progressive muscular dystrophy who was wheelchair bound and had multiple other chronic, uncontrolled conditions came to clinic for a SHARED RN VISIT
- Clinic staff:
  - Facilitated a phone conversation between the patient and his case manager that wasn’t happening outside of clinic
  - Arranged Home Health services
  - Helped the patient complete an Advanced Care Directive
  - Made appointments for multiple specialists

Care Plans & Action Plans

<table>
<thead>
<tr>
<th>Plan of care</th>
<th>Includes the full scope of patient management including the action plan and care plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Plan</td>
<td>Patient specific strategies designed to guide health care professionals involved with the patient’s care. Includes brief pertinent history and recommendations/goals for care</td>
</tr>
<tr>
<td>Action Plan</td>
<td>A written plan that contains patient centered/driven goals, specific tasks or actions to be completed, timelines, identifies resources and builds on successes</td>
</tr>
</tbody>
</table>
Plan of Care example

Date: 4/14/13—Signed: J.Smith, MD

- **Care Coordination**

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Phone Number</th>
<th>Role in Care</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthPartners Brooklyn Center Clinic</td>
<td>763-111-4444</td>
<td>Assessing symptoms and concerns</td>
<td>Monday-Friday 8am-5pm</td>
</tr>
<tr>
<td>HealthPartners Careline RN-Triage Nurse</td>
<td>612-333-3333</td>
<td>Assessing symptoms and concerns</td>
<td>After hours and on weekends</td>
</tr>
<tr>
<td>Complex Case Management</td>
<td>952-222-2222</td>
<td>Supporting patient in their home</td>
<td>Benefit &amp; self management</td>
</tr>
</tbody>
</table>

- **Care Plan:** He will weigh himself daily and if weight is up by over 5 lbs should take an added 40 mg of Lasix
- **Action Plan**
  Raymond will work on a low salt diet and weigh himself daily and call if weight is up over 5 pounds
- **Patient Instructions**
  Raymond will follow the low salt, low fat and cholesterol diet
  Raymond will take his medication as prescribed
- **Follow-up**
  Sherry will follow-up with Raymond by phone by June 2013

---

**Care Coordination**

- **Primary Care to Specialty Care**
  - Standardized referral template
  - Specialty assumes accountability for appointments and access
  - Hotline
- **Urgent Care and ED to Primary Care**
  - Scheduled orders for follow-up
  - Pro-active outreach to patients
- **Home to Hospital**
  - Physician notified of admission
- **Hospital or TCU to Home**
Current State: Regions

Regions Readmission Rates

- RH Readmissions - Excl OB, Newborn, Neonatal
- PEPPER (same and other)

Inpatient Admissions

Average cost of admission per day: $2,000
Maintain Health for the 80%

Healthy Lifestyle Reduces Incidence of Chronic Disease

Difference in 2 year incidence of new disease between people who adhere to 0 or 1 and 3 or 4 healthy behaviors (%).

Source: HealthPartners Health Assessment Database, 2007
Focus on Total Cost of Care

- Population based model
- Attributable to medical groups for accountability
- Includes all care, treatment costs, places of service, and provider types
- Measures overall performance relative to other groups
- Illness-burden adjusted
- Drillable to condition, procedure and service level
- Identifies price differences and utilization drivers

www.healthpartners.com/tcoc
Total Cost of Care Data

Actionable Data: Overview

<table>
<thead>
<tr>
<th>Provider Group XYZ</th>
<th>TCI</th>
<th>Price Index</th>
<th>Resource Use Index</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.01</td>
<td>1.00</td>
<td><strong>1.02</strong></td>
</tr>
<tr>
<td>Metro Total</td>
<td>1.00</td>
<td>1.00</td>
<td><strong>1.00</strong></td>
</tr>
</tbody>
</table>
Actionable Data: Drill Down

<table>
<thead>
<tr>
<th>High Cost Utilization Measures</th>
<th>Admit Count Index</th>
<th>ER Count Index</th>
<th>High Tech Radiology Services Count Index (non-ER)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider XYZ</td>
<td>1.00</td>
<td>0.92</td>
<td>1.07</td>
</tr>
<tr>
<td>State Average</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Total Cost of Care by Condition

- Population-based Total Cost of Care can be drilled down to a condition level, splitting out price and resource use.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Members</th>
<th>TCI</th>
<th>Price Index</th>
<th>RUI</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARTHRITIS</td>
<td>6000</td>
<td>1.02</td>
<td>1.02</td>
<td>1.03</td>
</tr>
<tr>
<td>ASTHMA</td>
<td>1,600</td>
<td>1.06</td>
<td>1.02</td>
<td>1.03</td>
</tr>
<tr>
<td>BACK PAIN</td>
<td>6,500</td>
<td>1.06</td>
<td>1.02</td>
<td>1.04</td>
</tr>
<tr>
<td>CHF</td>
<td>50</td>
<td>1.03</td>
<td>1.00</td>
<td>1.03</td>
</tr>
<tr>
<td>CHRONIC RENAL FAILURE</td>
<td>105</td>
<td>0.91</td>
<td>1.03</td>
<td>0.89</td>
</tr>
<tr>
<td>COPD</td>
<td>175</td>
<td>0.91</td>
<td>1.06</td>
<td>0.89</td>
</tr>
<tr>
<td>DEPRESSION</td>
<td>2,300</td>
<td>1.04</td>
<td>0.99</td>
<td>1.05</td>
</tr>
<tr>
<td>DIABETES</td>
<td>1,300</td>
<td>1.05</td>
<td>1.00</td>
<td>1.03</td>
</tr>
<tr>
<td>HYPERLIPIDEMIA</td>
<td>3,700</td>
<td>1.03</td>
<td>1.02</td>
<td>1.03</td>
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<tr>
<td>HYPERTENSION</td>
<td>3,500</td>
<td>1.06</td>
<td>1.02</td>
<td>1.04</td>
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<tr>
<td>ISCHEMIC HEART DISEASE</td>
<td>350</td>
<td>1.00</td>
<td>0.99</td>
<td>1.00</td>
</tr>
<tr>
<td>ALL OTHER CONDITIONS</td>
<td>12,500</td>
<td>1.07</td>
<td>1.02</td>
<td>1.05</td>
</tr>
<tr>
<td>Provider XYZ</td>
<td>26,000</td>
<td>1.03</td>
<td>1.00</td>
<td>1.03</td>
</tr>
</tbody>
</table>
Description: Key stakeholders across primary care, specialty care, ancillary services, a health plan

- Admission rate dropped -- $1,027,960 savings
- Prescriptions written dropped -- $390,066 savings
- High Tech imaging use dropped -- $138,654 savings
- Use of the ER dropped -- $76,628 savings

39% reduction in lumbar fusions
15% decrease in lumbar surgeries

TCOC: Medical Spine Metrics
TCOC: Generic Drug Prescribing Rate

TCOC: Hi-Tech Diagnostic Imaging
Where we are going next

- Team effectiveness
- Patient engagement
- Specific population support examples
  - ADHD
  - Frail and Elderly
  - Pre-op and Peri-operative care
- Specialists as population consultants

What our patients are saying

“Dr. S gave me exceptional care. She thoughtfully assessed my concerns and delivered professional, empathetic responses. I am new to HPMG and feel I now have a medical home in her.”

“I absolutely trust Dr. W in everything he does. He is very thorough and helpful. He is truly a good, competent doctor who cares about me and my health.”

“Dr. R is caring, knowledgeable, thorough, trustworthy and supremely approachable. And funny - her sense of humor is most definitely appreciated!”