Complex Care Management: The Nuts and Bolts

Beth Waterman
Chief Improvement Officer, HealthPartners
Cory Sevin, Director, Institute for Healthcare Improvement
Karen Tomes, VP Care Management & Coordination, Allina Health System
Roxanna Gapstur, Sr. VP, COO, & CNO, HealthPartners
Steve Bergeson, Medical Director Care Improvement, Allina Health System

These presenters have nothing to disclose

Workshop Objectives

- Describe how Allina Health and HealthPartners identify and provide complex care management to their patients with complex needs.
- Describe strategies to measure the impact on costs and outcomes of complex care management programs.
- Identify two to five care management ideas to apply to their own program.
Session Faculty

- **Steve Bergeson, MD**
  - Medical Director – Care Improvement, Allina Health
- **Roxanna Gapstur**
  - Sr. VP, Chief Operating Officer, HealthPartners – Park Nicollet
- **Karen Tomes**
  - VP Care Management & Coordination, Allina Health
- **Beth Waterman**
  - Chief Improvement Officer, HealthPartners

Before we start…

- Who is in the room?
- What size are your organizations?
- What are you hoping to get out of today?
TRIPLE AIM LEARNING: CORE CONCEPTS

A System design that is one aim with three dimensions:
- Improving the health of the populations;
- Improving the patient experience of care;
- Reducing the per capita cost of health care.
Triple Aim Populations

- **Defined Populations**: Triple Aim for a defined population that makes business sense (e.g. who pays, who provides)
- **Community-Wide Populations**: Solving a health problem within the community and creating a sustainable funding source

Foundation for Population Management

1. **Choose a relevant Population** for improved health, care and lowered cost.

2. **Identify and develop the Leadership and Governance** for your effort.

3. **Articulate a Purpose** that will hold your stakeholders together.
“Better Health Lower Cost” Roadmap

- Choose your macro population and learn its segments
- Identify individuals who are good candidates for your enhanced care design
- Develop a care model to fit the needs and strengths of the target population
- Recruit people into care
- Engage people into care
- Partner within and outside your organization

Learn to operate sustainably at full scale: 5 to 25 then 5X

ALLINA HEALTH & HEALTHPARTNERS: OVERVIEW
About Allina Health

Allina Health is a not-for-profit health system consisting of clinics, hospitals, and other health services, providing care throughout Minnesota and western Wisconsin.

Serving the community

- 61 primary care clinics
- 49 rehabilitation locations
- 23 hospital-based clinics
- 13 hospitals
- 15 retail pharmacies
- 2 ambulatory care centers
- Home care, hospice, palliative care offerings
- Emergency medical services
- Home medical equipment
Vision:
The AIM Network aligns independent physicians and Allina Health to deliver market-leading quality and efficiency in patient care.

AIM Network Profile

Current Membership:
>2,900 Physicians (1,300 Allina; 1,600 Independent)
>60 Physician Groups
26 Hospitals
- 12 Allina
- 14 Independent Regional Health Systems

AIM Network Goals:
- Achieve clinical integration that enables AIMN participants to partner with each other to improve quality and reduce cost
- Build an infrastructure that supports effective care coordination
- Deliver consistent, evidence-based, best practice health care to the patients and communities we serve
- Position AIMN to jointly contract with payers for value-based payment

About Minnesota

- In 2012, 35.4 percent of insured Minnesota residents had at least one diagnosed chronic condition;
- More than half of Minnesota residents with a chronic condition (57.8 percent) had multiple chronic conditions;
- Minnesotans with diagnosed chronic conditions accounted for 83.1 percent of all medical and pharmacy spending in the state;
- Annual per-person medical and pharmacy spending for Minnesotans with one or more chronic condition was, on average, 8 times higher than that of residents with no chronic condition;
Allina Health’s ACOs

• CMS – Pioneer ACO - 35,000
• BCBS Blueprint - 20,000
• UCare for Seniors (Medicare Advantage) - 22,000
• Allina Health Employee Plan - 48,000

Allina Health has Shared Savings arrangements with others, HP NW Alliance

Care Management

• Advanced Care Team
• Hospital Care Management
• Specialty Care Management
• Personal Primary Care Team – provides the opportunity and staff to provide in clinic care management
Complex Care Management Advanced Care Team

Quick Facts:

Advanced Care Team is divided into 3 geographic interdisciplinary teams

The team travels to meet the member

Populations Served are Pioneer, BluePrint, U-Care Medicare Advantage, Employees

Engagement of eligible members is 65%

Average enrollment period is 90 days

Technology:

- Excellian (Epic) promoting My Chart
- Qlik View Dashboards
- Telehealth
Care Guide

Improving Chronic Disease Care by Adding Laypersons to the Primary Care Team
A Parallel Randomized Trial

Richard A. Zaslav, MD, Douglas A. Whitley, MD, Jon Chalmers, PhD, Karen H. White, EDD, Heather Britt, PhD, and Sarah L. Lax, MPH

Background: Improving the quality and efficiency of chronic disease care is an important goal.

Objective: To test whether patients with chronic disease working with lay “care guides” would achieve more evidence-based goals than those receiving usual care.

Design: Parallel-group randomized trial, stratified by clinic and controlled from July 2010 to April 2013. Patients were assigned in a 2:1 ratio to a care guide or usual care. Patients, providers, and participants receiving education were not blinded to treatment assignment. ClinicalTrials.gov NCT01535735.

Setting: It is primary care clinics in Tennessee.

Patients: Adults with hypertension, diabetes, or heart failure.

Interventions: 270 patients were given disease-specific information about standard care goals and asked to work toward those goals for 12 months. The care guide group also had a 15-minute monthly behavioral counseling call.

Measurements: The primary end point for each patient was change in percentage of goals not met 1 year after enrollment.

Results: The percentage of goals not met increased in both the care guide and usual care groups (change from baseline, 10.0% and 10.9%, respectively). Patients with care guides achieved more goals than usual-care patients for 12 of 14 goals, with improvements ranging from 1.1% to 58.1%. Among patients with hypertension, 64.2% of patients with care guides met the goal of less than 130/80 mm Hg compared with 32.7% in the usual-care group (adjusted P = .014). Compared with usual care, care guided goals was associated with 14.2% fewer medical visits, 15.3% fewer hospitalizations, and 11.9% lower total medical costs per patient per year.

Conclusions: Care guides may be effective in improving care for patients with chronic disease at low cost.

Primary Funding Source: The Robert Wood Johnson Foundation.

Comprehensive Scorecard

<table>
<thead>
<tr>
<th>Measures of Caring Scorecard</th>
<th>Measures of Caring Scorecard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal Health and Well-Being for Individuals</td>
<td>Optimal Health and Well-Being for the Community</td>
</tr>
<tr>
<td>Access to Care</td>
<td>Access to Care</td>
</tr>
<tr>
<td>Patient-Centeredness</td>
<td>Patient-Centeredness</td>
</tr>
<tr>
<td>Provider Communication</td>
<td>Provider Communication</td>
</tr>
<tr>
<td>Patient Education</td>
<td>Patient Education</td>
</tr>
<tr>
<td>Self-Management</td>
<td>Self-Management</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>Emotional Support</td>
</tr>
<tr>
<td>Physical Function</td>
<td>Physical Function</td>
</tr>
<tr>
<td>Social Integration</td>
<td>Social Integration</td>
</tr>
<tr>
<td>Community Engagement</td>
<td>Community Engagement</td>
</tr>
<tr>
<td>Environmental Support</td>
<td>Environmental Support</td>
</tr>
<tr>
<td>Organizational Indicators</td>
<td>Organizational Indicators</td>
</tr>
<tr>
<td>Revenue</td>
<td>Revenue</td>
</tr>
<tr>
<td>Cost</td>
<td>Cost</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>Patient Satisfaction</td>
</tr>
<tr>
<td>Referral</td>
<td>Referral</td>
</tr>
<tr>
<td>Access</td>
<td>Access</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Financial Performance</td>
<td>Financial Performance</td>
</tr>
<tr>
<td>Clinical Quality</td>
<td>Clinical Quality</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>Access</td>
<td>Access</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Financial Performance</td>
<td>Financial Performance</td>
</tr>
<tr>
<td>Clinical Quality</td>
<td>Clinical Quality</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>Access</td>
<td>Access</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Financial Performance</td>
<td>Financial Performance</td>
</tr>
<tr>
<td>Clinical Quality</td>
<td>Clinical Quality</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>Access</td>
<td>Access</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Financial Performance</td>
<td>Financial Performance</td>
</tr>
<tr>
<td>Clinical Quality</td>
<td>Clinical Quality</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Patient Experience</td>
</tr>
</tbody>
</table>
# Allina Health Clinics Scorecard

Driven by MNCM

## Scorecard Dec 2015

<table>
<thead>
<tr>
<th>Clinic Group</th>
<th>Region</th>
<th>Levels</th>
<th>Classroom (8%)</th>
<th>Literacy (8%)</th>
<th>Dog (8%)</th>
<th>Cat (8%)</th>
<th>Can (8%)</th>
<th>Prof (8%)</th>
<th>GLO (8%)</th>
<th>Prest (8%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 2015 Total</td>
<td></td>
<td></td>
<td>88.5%</td>
<td>78.5%</td>
<td>82.0%</td>
<td>79.8%</td>
<td>72.4%</td>
<td>87.8%</td>
<td>81.8%</td>
<td>55.1%</td>
</tr>
<tr>
<td>Allina Health Clinic</td>
<td>Subtotal</td>
<td></td>
<td>88.5%</td>
<td>78.5%</td>
<td>82.0%</td>
<td>79.8%</td>
<td>72.4%</td>
<td>87.8%</td>
<td>81.8%</td>
<td>55.1%</td>
</tr>
<tr>
<td></td>
<td>East Metro Region</td>
<td></td>
<td>88.5%</td>
<td>78.5%</td>
<td>82.0%</td>
<td>79.8%</td>
<td>72.4%</td>
<td>87.8%</td>
<td>81.8%</td>
<td>55.1%</td>
</tr>
<tr>
<td></td>
<td>East Region</td>
<td></td>
<td>88.5%</td>
<td>78.5%</td>
<td>82.0%</td>
<td>79.8%</td>
<td>72.4%</td>
<td>87.8%</td>
<td>81.8%</td>
<td>55.1%</td>
</tr>
<tr>
<td></td>
<td>North Metro Region</td>
<td></td>
<td>100.0%</td>
<td>80.0%</td>
<td>82.4%</td>
<td>79.8%</td>
<td>76.0%</td>
<td>87.8%</td>
<td>81.8%</td>
<td>60.1%</td>
</tr>
<tr>
<td></td>
<td>North Region</td>
<td></td>
<td>98.4%</td>
<td>78.5%</td>
<td>80.0%</td>
<td>79.8%</td>
<td>77.8%</td>
<td>83.8%</td>
<td>81.8%</td>
<td>53.2%</td>
</tr>
<tr>
<td></td>
<td>Northwest Region</td>
<td></td>
<td>98.4%</td>
<td>78.5%</td>
<td>80.0%</td>
<td>79.8%</td>
<td>77.8%</td>
<td>83.8%</td>
<td>81.8%</td>
<td>53.2%</td>
</tr>
<tr>
<td></td>
<td>Southwest Region</td>
<td></td>
<td>97.5%</td>
<td>77.4%</td>
<td>80.0%</td>
<td>79.8%</td>
<td>76.8%</td>
<td>83.8%</td>
<td>81.8%</td>
<td>44.5%</td>
</tr>
<tr>
<td></td>
<td>West Metro Region</td>
<td></td>
<td>96.7%</td>
<td>78.5%</td>
<td>80.0%</td>
<td>79.8%</td>
<td>73.8%</td>
<td>83.8%</td>
<td>81.8%</td>
<td>42.1%</td>
</tr>
</tbody>
</table>

## Health Partners

- **Health Plan**
  - 1.5 million members
- **Medical Clinics**
  - 1,700 physicians
  - 50 primary care locations
  - 55+ medical specialties
- **Dental Clinics**
  - 60 dentists across 22 clinics
  - 6 dental specialties
- **Hospitals**
  - 6 hospitals
  - Level 1 trauma and tertiary center
  - Acute care hospitals
  - Critical access hospitals

- **Consumer-governed, non-profit**
- **Integrated health and financing**
- **22,500 team members**
Care Coordination Structure

- Clinic RN role
- Centralized case and disease management
- Care coordinators

Scorecard: Ambulatory

Categories:
- Preventive Care
- Pediatric Measures
- Depression and Mental Health
- Care for Chronic Disease
- Best Care
- Patient Experience
- Cost of Care
Scorecard: Hospital

Categories:
- Core Health Measures
- Patient Experience
- Adverse Health Events
- Readmissions
- Patient Safety
- Value Based Purchasing
- Advanced Care Planning

---

HPMG Primary Care -- Care Team Scorecard

Diabetes-Optimal Diabetes Care

Preventive-Optimal Preventive Care

Preventive-Breast Cancer Screening Rate

Preventive-Breast Cancer Screening Rate By Race

Preventive-Breast Cancer Screening Rate By Payor

Preventive-Colorectal Cancer Screening Rate

Created by Create Innovate & Measure

Data as of 4/1/2014
Care Team Scorecard Meetings

**Structure**
- Meet every 90 days with site leadership
- Physician/Provider, LPN/CMA, RN

**Process**
- Celebrate & share
- Identify opportunities and learn
- Test improvements: care teams and leaders partner

**Site Leaders send plans to division leaders**
- Identify best practices
- Reward and recognize
- Share with others
Choose your macro population and learn its segments.

Learn to operate sustainably at full scale: 5 to 25 then 5X

CHOOSE YOUR MACRO POPULATION AND IDENTIFY CANDIDATES FOR ENHANCED CARE DESIGN

Quiz

In which Minnesota city is the Spam Museum located?

- A. Bloomington
- B. Austin
- C. Chanhassen
- D. St. Paul
Identifying Members by Risk

Medical Record & Claims Data
- Allina Health Risk Tools
- Epic/Healthy Planet General Risk Score
- Payer ID/Strat Engine

Targeted Members

High Rising Risk
Healthy

Additional Stratification Considerations
- Quality of Life (PROMIS)
- Primary diagnosis (e.g., Cancer, Heart Failure)
- No Primary Care Provider (PCP) or recent PCP visit
- Social Risks (e.g., Lives Alone)
- # and type of medications
- # of Problems on the Problem List

Allina Health Care Management
Identification Tool

<table>
<thead>
<tr>
<th>Location</th>
<th>Samples Discharge Planning Patient List</th>
<th>Data Currency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>New Patient List</td>
<td>12/5</td>
</tr>
<tr>
<td>Department/Unit</td>
<td>Allina Health Care Management Identification Tool</td>
<td>Medical Record (Hours): 76</td>
</tr>
</tbody>
</table>

Primary Problem | Readmit Risk | Expired LOS Days | Actual LOS Days | Prior ID Visits in 12 Months | Observation Status | RAC Status | SHF Status | Palliative Care Status | MyChart Status | Transition Conference Status |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>High</td>
<td>&gt; 10</td>
<td>11.5</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Acute Renal Failure</td>
<td>High</td>
<td>&gt; 10</td>
<td>10.4</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sepsis</td>
<td>High</td>
<td>5 - 6</td>
<td>1.2</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Acute Cholecystitis</td>
<td>Moderate-High</td>
<td>7 - 9</td>
<td>2.2</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Acute Renal Failure</td>
<td>Moderate-High</td>
<td>7 - 9</td>
<td>0.6</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Moderate-High</td>
<td>7 - 9</td>
<td>11.3</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Moderate-High</td>
<td>5 - 6</td>
<td>9.4</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Acute Pneumonia</td>
<td>Moderate-High</td>
<td>&gt; 10</td>
<td>10.1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sepsis Associated Hypotension</td>
<td>Moderate-High</td>
<td>7 - 9</td>
<td>5.5</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Congestive Heart Failure With Acute CHF</td>
<td>Moderate-High</td>
<td>&gt; 10</td>
<td>5.6</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>COPD With Acute Exacerbation</td>
<td>Moderate-High</td>
<td>5 - 6</td>
<td>2.5</td>
<td>&gt;3 HFS</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Suicide Attempt By Chg Exp.</td>
<td>Low</td>
<td>7 - 9</td>
<td>4.2</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
TCOC Improvement Opportunities
Span the Care Continuum

ACO Populations Vary
By Market Segment

- These ACO populations equate to nearly 100,000 members attributed to Allina Health with benefit plans designed to keep care in the AIM Network
- Interventions must be designed for the population (ex., pediatrics, maternity, mental health, chronic health conditions)
Identifying High-Risk

- Overlapping data is okay
- Identify & stratify patients based on risk

Predictive Modeling

An input to identify those patients with the highest risk of acute care needs

Configured a predictive model to leverage our integrated capabilities

1. Electronic Health Record (EHR) data is the sole input into the model
2. Electronic Health Record (EHR) data is supplemented with the claims data

Benefits beyond only using claims data
- Added layers of severity of condition (labs, assessments, etc.)
- Enhanced social history documentation
- Diagnoses otherwise not captured in claims (i.e. problem list)
- Prescription orders that are not filled
- Surgical and procedure history
## Ambulatory Predictive Modeling

<table>
<thead>
<tr>
<th>Name/ Age/ Gender</th>
<th>Tier 4</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>Tier 4</td>
<td>![Green Circle]</td>
<td>12/30/2014</td>
<td>Yes</td>
<td>4/08/2014</td>
</tr>
<tr>
<td>Paula Brown</td>
<td>Tier 4</td>
<td>![Red Circle]</td>
<td>01/15/2015</td>
<td>No</td>
<td>3/15/2015</td>
</tr>
<tr>
<td>Sally Adams</td>
<td>Tier 4</td>
<td>![Yellow Circle]</td>
<td>02/23/2015</td>
<td>Yes</td>
<td>5/02/2015</td>
</tr>
</tbody>
</table>

## High Impact Measures

**WHAT IS 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
- National Quality Forum-endorsed

\[
\text{Total Cost of Care} = \text{Resource Use} \times \text{Price}
\]
Total Cost of Care

More than 160 licensees across 35 states and the District of Columbia

Total Cost of Care Data

<table>
<thead>
<tr>
<th></th>
<th>TCI</th>
<th>Price Index</th>
<th>Resource Use Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Group XYZ</td>
<td>1.01</td>
<td>1.00</td>
<td>1.02</td>
</tr>
<tr>
<td>Metro Total</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

High Cost Utilization Measures

<table>
<thead>
<tr>
<th></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>600</td>
<td>1.02</td>
<td>1.02</td>
<td>1.03</td>
</tr>
<tr>
<td>Asthma</td>
<td>1,500</td>
<td>1.05</td>
<td>1.05</td>
<td>1.05</td>
</tr>
<tr>
<td>Back Pain</td>
<td>3,500</td>
<td>1.03</td>
<td>0.99</td>
<td>1.04</td>
</tr>
<tr>
<td>CHF</td>
<td>90</td>
<td>1.03</td>
<td>1.00</td>
<td>0.99</td>
</tr>
<tr>
<td>Chronic Renal Failure</td>
<td>105</td>
<td>0.91</td>
<td>1.03</td>
<td>0.99</td>
</tr>
<tr>
<td>COPD</td>
<td>175</td>
<td>0.91</td>
<td>1.08</td>
<td>0.85</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>
</tr>
<tr>
<td>Hypertension</td>
<td>3,500</td>
<td>1.06</td>
<td>1.02</td>
<td>1.04</td>
</tr>
<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>

### Triple Aim Improvement Project Portfolio

- Preventable inpatient admissions
- Avoidable ER visits
- Prescribe generics, when possible
- Unnecessary labs & hi-tech diagnostics
- Place of service awareness
- Price increases

- Keep people healthy
- Avoid harm
- Be efficient
- Engage patients and communities
- Practice evidence-based care
- Offer convenient and affordable options
- Coordinate care for chronic/complex conditions
DEVELOP A CARE MODEL TO FIT THE NEEDS AND STRENGTHS OF THE TARGET POPULATION

Choose your macro population and learn its segments

Identify individuals who are good candidates for your enhanced care design

Develop a care model to fit the needs and strengths of the target population

Recruit people into care

Engage people into care

Partner within and outside your organization

Learn to operate sustainably at full scale: 5 to 25 then 5X

“Be well” Moment
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

Care Model Process (CMP)

**Before the Visit**
- Visit Scheduling
- Pre-Visit Planning

**During the Visit**
- Check-in
- Visit

**After the Visit**
- Follow-up

**Between Visits**
- Between Visits

**Reception**
- Insurance verification
- Check-in
- Scheduling
- Message triage
- Forms

**CMA/LPN**
- Registry
- Message triage
- LPN standing orders
- Test results
- Immunization

**RN’s**
- Phone triage
- Protocol driven care
- Warfarin management
- Medication refill
- Abnormal test triage
- Care Coordination
- Action Plan

**Physician / Clinician**
- Leader of care team
- Diagnosis and treatment
- Engaging patients in their care
- Directing members of care team
- Care plans
Care Model Process Upgrade

Clinic upgrade training sessions 2X yearly
- Two, 4 hour sessions
- **Re-evaluate & reduce**
- Improvement requires change
- Train **everyone**!

### Module Overview

<table>
<thead>
<tr>
<th>Modules</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7 Core Modules</strong></td>
</tr>
<tr>
<td><strong>12 Resource Modules</strong></td>
</tr>
<tr>
<td><strong>8 Population Health Modules</strong></td>
</tr>
<tr>
<td><strong>11 Clinical Content Modules</strong></td>
</tr>
</tbody>
</table>

### Modules

<table>
<thead>
<tr>
<th>Core Modules</th>
<th>Resource Modules</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Visit scheduling</td>
<td>• Prior authorization</td>
</tr>
<tr>
<td>• Check-in</td>
<td>• Scheduled telephone visits</td>
</tr>
<tr>
<td>• Pre-visit planning</td>
<td>• InBasket folder definitions</td>
</tr>
<tr>
<td>• Visit (rooming, check-out)</td>
<td>• InBasket flags</td>
</tr>
<tr>
<td>• Test results</td>
<td>• InBasket coverage for out of office clinicians</td>
</tr>
<tr>
<td>• Patient communication</td>
<td>• External records</td>
</tr>
<tr>
<td>• Medication refills</td>
<td>• Forms</td>
</tr>
<tr>
<td></td>
<td>• Advance directives</td>
</tr>
<tr>
<td></td>
<td>• Clinician to clinician communication</td>
</tr>
<tr>
<td></td>
<td>• Paperwork and RightFax flow</td>
</tr>
<tr>
<td></td>
<td>• REF order module</td>
</tr>
<tr>
<td></td>
<td>• Hospital and emergency department follow-up</td>
</tr>
</tbody>
</table>
Modules

<table>
<thead>
<tr>
<th>Population Health</th>
<th>Clinical Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient care coordination</td>
<td>• Expert Panel: Diabetes and vascular clinical content</td>
</tr>
<tr>
<td>• Disease registry</td>
<td>• Expert Panel: Hypertension clinical content</td>
</tr>
<tr>
<td>• Opioid management</td>
<td>• Expert Panel: Asthma clinical content</td>
</tr>
<tr>
<td>• Care plan documentation</td>
<td>• Expert Panel: Immunization clinical content</td>
</tr>
<tr>
<td>• Centralized anticoagulation clinic</td>
<td>• Expert Panel: Preventive services</td>
</tr>
<tr>
<td>• Co-management between D&amp;CM and primary care patients</td>
<td>• Depression care management (no formal expert panel)</td>
</tr>
<tr>
<td>• Social services tackle box</td>
<td></td>
</tr>
<tr>
<td>• Behavioral health “How to access guide”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatrics</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adolescent mental health screening</td>
<td>• Collaborative documentation</td>
</tr>
<tr>
<td>• ASQ-SE (12 &amp; 36 months)</td>
<td></td>
</tr>
<tr>
<td>• Expert Panel: Pediatric ADHD</td>
<td></td>
</tr>
<tr>
<td>• Expert Panel: Child and Teen Check-up clinical content</td>
<td></td>
</tr>
</tbody>
</table>

Implementation Results

[Chart showing improvement in various clinical results from 1st Qtr 2006 to 3rd Qtr 2007]
Cost of Care by Site

Alternate care venues cost less for routine and minor care

Source: PwC Health Research Institute

*Minor illnesses include sinusitis, urinary tract infections, common cold, or flu.

Free!

HP Nurse Line

Call, Click, Come In

Urgent Care
When care can’t wait, drop in to get treated without an appointment.
Click here for common conditions
Co-pay or starting at $80
Find Urgent Care>

Clinic Visit
Schedule an appointment to see your family doctor or a specialist. Call the appointment center at 912-967-7676
Co-pay or starting at $80
Find A Clinic>

Call
Talk to your doctor or a nurse.

Click
Get care online or via email.

Come In
Visit your doctor or a clinic.
Call, Click, Come In

Call – ER, Urgent Care, Clinic Visit, Quick Clinic, Well At Work, Walmart Video Visit

Click – Phone Visit, Care Line

Visit – E-Visit, Video Visit, virtuwell E-Mail

Condition simplicity/Convenience

Condition complexity/Cost

BREAK – 20 MIN
RECRUIT PEOPLE INTO CARE/ENGAGE PEOPLE INTO CARE

Quiz

How many lakes does the state of Minnesota have?

A. 10,000
B. 5,000
C. 11,842
D. 9,378
Allina Health Care Management

Support for Complex Patients

- A team approach
- Evidenced based
- Helping patients and their caregivers manage and understand illness
- Coordinate care and resources
- Focus on the patient's goals for care

Advanced Care Team Core Competencies:
- Motivational Interviewing
- Mental Health Care
- Complex and Chronic Illness
- Medication Management
- Advanced Care Planning
- Care Transitions
- Home Safety Assessment
- Activating Community Resources
- Technology
- Specialty Care Coordination:
  - Oncology
  - Heart Failure
  - Mental Health

Medical Director: Dr. Steve Bergeson
- Leads the interdisciplinary team
- Guides risk stratification
- Develops protocols for better care, better health & lower costs
Allina Health
Advanced Care Team

Registered Nurse Care Coordinator
- Coordinate care across the continuum with specialties in cancer, mental health, heart failure, hospital transitions and disabilities
- Create care plans and goals with the patient and their Primary Care Provider (PCP)
- Manage medical conditions and medications with the patient and PCP
- Provide education

Social Worker
- Perform psychosocial assessments
- Identify mental health issues and coordinate care for these conditions
- Find and coordinate community resources for patients to meet psychosocial, emotional, financial, and environmental needs

Pharmacist
- Conduct comprehensive medication review (CMR)
- Collaborate with the patient and primary care physician to manage and optimize medications
- Provide education and ongoing management of medications across all care settings

Care Guide
- Help patients work towards their health care goals with motivational interviewing
- Coordinate care under the direction of licensed staff

Allina Health
Advanced Care Team

Referral or Transition visit at the Hospital, SNF/TCU or clinic
Home visit within 72 hours of transition by RN or SW
Co-visit with Primary Care Provider within 5 days of transition
Weekly outreach by RN or SW for 4 weeks with consultation by pharmacist
Ongoing weekly follow-up by the Care Guide until goals met

Average 90 day enrollment
Patients to Refer to Pharmacist

I am so confused about my meds?

I don’t know if I am taking my meds correctly?

How do my meds work?

I am having too many side effects

Care Management Interventions:

1. Holistic assessment (physical, emotional, social, spiritual)
2. Self care education
3. Individualized patient centered goals
4. Plan for ongoing intervention/interactions
5. Financial counseling & benefit coordination
6. Follow up appointments after hospital and ED visits
7. Medication management
8. Hospital discharge planning to the right level of care
9. Referrals to Home Health, Palliative Care, Hospice, Community Resources
10. Advanced Care Planning

Care Guide
RN Care Coordinator
Social Worker
Pharmacist
Coordinating Care

Primary Care
Hospitals
Social Work
Home
Case/Disease Mgt
Emergency Department
Behavioral Health
Transitional Care Units
Community Resources
Nutrition
Specialty Care
Home Care
Medication Therapy Management
Diabetes Nurse Educators

Care Coordination Support

Consistent approach across clinics & hospitals:
- Identify those most at risk
- Proactive outreach
- Care Plans
  - Shared visits (MD & RN)
  - Access for mental health
  - Link to health plan and community resources

<table>
<thead>
<tr>
<th>% of Population</th>
<th>% of Total Healthcare Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>29%</td>
</tr>
<tr>
<td>9%</td>
<td>39%</td>
</tr>
<tr>
<td>20%</td>
<td>21%</td>
</tr>
<tr>
<td>70%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Data Source: Thomson Reuters Market Scan Database
National Sample of 21 million insured Americans, 2003-2007
Care Coordination Examples

- 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

Linked RN Visit

- Patient and Nurse: Pre-Assessment, Initial history
- Patient and Physician: Diagnosis, Care Plan
- Patient and Nurse: Close the loop, Action Plan, Link to resources

Modeled after The Everett Clinic
Plan of care
Includes the full scope of patient centered care including the action plan and care plan.

Care Plan
Patient specific strategies designed to guide health care professionals involved with the patient’s care. Includes brief pertinent history and recommendations/goals for care.

Action Plan
A written plan that contains patient centered/driven goals, specific tasks or actions to be completed, timelines, identifies resources and builds on successes.

Plan of Care Example

Date: 4/14/15—Signed: J. Smith, MD

Care Coordination

<table>
<thead>
<tr>
<th>Center Clinic</th>
<th>Contact Name</th>
<th>Phone Number</th>
<th>Role in Care</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthPartners Brooklyn</td>
<td>Sherry Johnson, RN</td>
<td>763-111-4444</td>
<td>Assessing symptoms and concerns</td>
<td>Monday-Friday 8am-5pm</td>
</tr>
<tr>
<td>&amp; Dr. Smith</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HealthPartners Careline</td>
<td>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>James Brown, RN</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 2015
BREAKOUT ACTIVITY: CARE TEAM STRUCTURE

Choose your macro population and learn its segments.
Identify individuals who are good candidates for your enhanced care design.
Develop a care model to fit the needs and strengths of the target population.
Recruit people into care.
Engage people into care.
Partner within and outside your organization.

Learn to operate sustainably at full scale: 5 to 25 then 5X.

RECRUIT PEOPLE INTO CARE/ENGAGE PEOPLE INTO CARE CONTINUED...
Recruiting People for Resources

Care Management Intake

- Community Resources
- Advanced Care Team
- Primary Care

Health Plan
- Claims
- Utilization
- Pharmacy
- Online Health Assessments

Allina Health
- Hands-on assessment
- Referral
- Predictive models
- Screening tools
- Diagnostics

Complexity, Costs & Resources Increases

Healthy
- Education
- Screening
- 24/7 Access to Care

Rising Risk
- Primary Care: Early follow-up after Hospital or ED visit Registries Prevention/Wellness Outreach Health Coaching

High Risk
- Advanced Care Team 2.5% of Population
ACO Identifier across Allina Health

ACO header and banner:

Longitudinal Plan of Care (LPOC)
Care Coordination Note

Patient Care Coordination Note

Amb, Md, MD 2/15/2016 9:45 AM

This patient is a 74 year old widower who is very involved in her local senior center.
She:
Lives alone with some limited services (Meals on Wheels)
Has two children and 5 grandchildren – all live out of state.
Is mildly hearing impaired
Is ambulatory without assist and continues to drive

Care Management Tools

- Care Management dashboard (screenshot below)
- ACO report with external data links to claims data
- Patient Outreach Encounter
- Care management navigator includes commonly used assessments (PHQ, GAD, PROMIS)
Frail/Elderly Home Visits

- **Goal**
  - Develop and build a robust community home visit program in collaboration with primary care health care homes, primarily to serve the frail homebound elderly in the community who are at risk for hospitalization or nursing home placement

- **Outcomes**
  - Provide patients, who are frail or with complex chronic conditions, with effective care and coordination that is both effective and safe
  - Help patient/family activate engagement in their care
  - Development of a triple aim oriented care plan
### Advanced Illness

**Inpatient - Advanced Illness Supportive Care Model - SP SLS.09.15**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Initial</th>
<th>Psychological</th>
<th>Palliative</th>
<th>Discharge</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Consultant</td>
<td>Initial</td>
<td>Collaborative</td>
<td>Patient discussion</td>
<td>Discharge from hospital</td>
<td>Collaborative</td>
</tr>
<tr>
<td>MD</td>
<td>Initial</td>
<td>Collaborative</td>
<td>Patient discussion</td>
<td>Discharge from hospital</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Initial</td>
<td>Collaborative</td>
<td>Patient discussion</td>
<td>Discharge from hospital</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Chaplain</td>
<td>Initial</td>
<td>Collaborative</td>
<td>Patient discussion</td>
<td>Discharge from hospital</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>Initial</td>
<td>Collaborative</td>
<td>Patient discussion</td>
<td>Discharge from hospital</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Care Integration</td>
<td>Initial</td>
<td>Collaborative</td>
<td>Patient discussion</td>
<td>Discharge from hospital</td>
<td>Collaborative</td>
</tr>
<tr>
<td>ER</td>
<td>Initial</td>
<td>Collaborative</td>
<td>Patient discussion</td>
<td>Discharge from hospital</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Caregiver</td>
<td>Initial</td>
<td>Collaborative</td>
<td>Patient discussion</td>
<td>Discharge from hospital</td>
<td>Collaborative</td>
</tr>
<tr>
<td>TCU</td>
<td>Initial</td>
<td>Collaborative</td>
<td>Patient discussion</td>
<td>Discharge from hospital</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Health Care Home</td>
<td>Inpatient stay</td>
<td>Collaborative</td>
<td>Patient discussion</td>
<td>Discharge from hospital</td>
<td>Collaborative</td>
</tr>
</tbody>
</table>

### SPOTLIGHT: CLINICIAN ENGAGEMENT
ACO Work

Improve Quality: 33 measures including patient experience.

Reduce costs by:

a. ↓Potentially Preventable Readmissions (PPR) – lots of work here (5d Post Hosp. FU; ROP; TCM; Transition conferences)
b. ↓Potentially Preventable Admissions
c. ↓ ED use
d. ↑Advanced Care Plans (ACP)
e. Adherence to care plans
f. Medication Optimization
ACO Work requires changes

- Care coordination matters in FFS and is even more important in an ACO
- ‘Leakage’ or care in other systems is counted in our ACO
- Reducing inpatient services and replacing them with strategies/care to keep people at home
- SNF 3 Day Waiver – patients do not need a three day stay to have a SNF placement paid for under CMS
  - Piloted at CRMC; MERCY and UNITY, expanding to "all" in 2016
- Care management is the foundation
- Care Team redesign - PPCT

ACO Work requires changes

- Build on the foundation already there
  - Readmissions
  - Registry and Quality work
  - Patient Experience
- The Challenge
  - Managing TCOC is relatively new
  - Care Management traditionally delivered by health plans
  - Clinicians are insulated from TCOC ramifications
  - Any given clinician has few ‘at bats’ with the ACT in a year.
  - ACT team not co-located
  - Care Management is new to patients
Communications for Clinicians

November-February
- Webinars for clinic leaders (2)
- The Bulletin (2 times)
- Letters to clinicians
  - Re: Pioneer Expansion
  - With lists of patients attributed to individual clinicians
- Regional Meetings (2)
- Rounding (many)
- Call-in to site meetings (many)
- Inbox messages from ACT re: care
- Co-visits – academic detailing

Actual/Expected ED Visits by Allina Health PCP Location

*All ED Visits
Significant Variation Exists In Allina Health’s ED Utilization Patterns

*Reflects severity-adjusted utilization using a different model for each population.

Enhanced patient access to the right care at the right time can impact ED utilization rates

Majority of AIMN Groups Fall Below 50th %tile Compared to Specialty Peer Groups

Source: Benchmarks from Press Ganey; Specialty percentile performance from AIMN Groups
Allina Health Patients With HP Insurance Have Above Average Utilization

- Admits 6% higher than market average
- ED visits 2% higher than market average
- Surgeries 4% higher than market average
- HTDI 7% higher than market average

Northwest Alliance Results:
- Admits 16% higher and ED visits 17% higher than HP attributed patients

*HP data for our patients’ severity-adjusted utilization

Our Physician Culture

- Escaping Fire
- Crossing the Quality Chasm
- Zen and the Art of Physician Autonomy Maintenance
HealthPartners Doctor & Clinician Partnership Agreement

<table>
<thead>
<tr>
<th>ORGANIZATIONAL COMMITMENTS</th>
<th>DOCTOR/CLINICIAN COMMITMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROFESSIONAL</td>
<td>PROVIDE GROWTH</td>
</tr>
<tr>
<td>• Assume good intent</td>
<td>• Assume good intent; ability to identify, prioritize, and communicate in writing and in person with colleagues</td>
</tr>
<tr>
<td>• Involve and engage doctors/clinicians on matters impacting the practice</td>
<td>• Support potential for career development and advancement opportunities</td>
</tr>
<tr>
<td>• Promote partnership between doctors/clinicians, staff, the organization, and the community</td>
<td>• Be a team leader by demonstrating and taking responsibility for the care team</td>
</tr>
<tr>
<td>• Listen and be influenced by doctors/clinicians input</td>
<td>• Solve problems by identifying critical issues and then address the issues</td>
</tr>
<tr>
<td>GROW STRONG &amp; SUSTAINABLE CLINICAL PRACTICE</td>
<td>GROW STRONG &amp; SUSTAINABLE CLINICAL PRACTICE</td>
</tr>
<tr>
<td>• Recruit and retain the best people</td>
<td>• Support the multi-specialty group practice and its growth</td>
</tr>
<tr>
<td>• Aggressively market the practice of doctors/clinicians</td>
<td>• Pursue clinical practice consistent with the Triple Aim (Health, Experience, Stewardship)</td>
</tr>
<tr>
<td>• Acknowledge, promote, and reward contributions to care, teaching, research and organizational goals</td>
<td>• Advance personal and care team expertise and excellence</td>
</tr>
<tr>
<td>• Evaluate the impact of changes to the sustainability of clinical practice</td>
<td>• Demonstrate passion and commitment to our practice and our multi-specialty medical and dental group</td>
</tr>
<tr>
<td>• Minimize interruptions and demands that impact patient care</td>
<td>• Collaborate within and across disciplines to improve patient care</td>
</tr>
<tr>
<td>• Minimize variations in care with patient customization</td>
<td>• Support Care Model Process (small workflows)</td>
</tr>
<tr>
<td>• Provide and support an environment and systems that make it easy to deliver exceptional care at all locations</td>
<td>• Standardize care to the science and customize care based on patient needs</td>
</tr>
<tr>
<td>• Support doctors/clinicians with tools for improvement</td>
<td>• Organize</td>
</tr>
<tr>
<td>• Develop ways to measure clinical practice effectiveness</td>
<td>• Support physicians</td>
</tr>
<tr>
<td>• Provide adequate resources and space for effective clinical practice</td>
<td>• Support nurses</td>
</tr>
<tr>
<td>• Promote and support a health work-life balance</td>
<td>• Support radiology</td>
</tr>
<tr>
<td>• Provide and support systems that effectively create exceptional patient satisfaction and engagement</td>
<td>• Support pharmacists</td>
</tr>
<tr>
<td>DEMONSTRATE EFFECTIVE LEADERSHIP</td>
<td>DEMONSTRATE EFFECTIVE LEADERSHIP</td>
</tr>
<tr>
<td>• Keep clinicians informed and knowledgeable about changes in health care delivery and partner with them to produce effective results</td>
<td>• Be a team leader by demonstrating and taking responsibility for the care team</td>
</tr>
<tr>
<td>• Seek to understand the clinical perspective</td>
<td>• Demonstrate support of colleagues and partners</td>
</tr>
<tr>
<td>• Clearly communicate our mission, vision, values, strategies, goals, and measurement of results</td>
<td>• Solve problems by identifying critical issues and then address the issues</td>
</tr>
<tr>
<td>• Provide performance feedback that supports improvement and learning</td>
<td>• Be open and flexible change</td>
</tr>
<tr>
<td>• Resolve conflict with openness and empathy</td>
<td>• Participate in and support medical/dental group decisions</td>
</tr>
<tr>
<td>• Provide leadership training to enhance doctors’ skills</td>
<td>• Seek ways to continually develop leadership and influence skills</td>
</tr>
</tbody>
</table>

Partnership Agreement Example

**ORGANIZATIONAL COMMITMENTS**
- Be Patient-Centered
- Support a practice model that works for both patients and doctors
- Provide an environment and tools to ensure satisfying and sustainable practices
- Promote work-life accountability within teams and within the medical/dental group
- Minimize variation in care to support quality, reliability, and customized care based on patients’ needs

**DOCTOR/CLINICIAN COMMITMENTS**
- Be Patient-Centered
- Support a practice model that works for both patients and doctors
- Reduce unnecessary variation in care to support quality, reliability, and customized care based on patients’ needs

**EHR Design Principle**
- "With any changes: simplify"
- Quantify "click reductions"
Partnership Agreement “Refresh”

- Guiding Coalition
- Direction to department/site leaders
- Local meetings to discuss:

What do you want for the future of our organization-wide Group Practice culture?
For our patients? For each other? For yourself?

What do we need to do to help this culture move forward?
What do we need from our organization? From each other? From you?

What can you do to help us succeed in achieving this future?
How can you help us be successful? What’s critical to you to have in this new culture?

Outcome: New document with practice commitments (instead of “gives and gets”)

AMGA Physician Satisfaction Survey

2005

AMGA Correlation with Overall Satisfaction

Low ← AMGA Correlation with Overall Satisfaction → High
AMGA Physician Satisfaction Survey

2015

Low → AMGA Correlation with Overall Satisfaction → High

Combined (HP, PN, SMG)

Choose your macro population and learn its segments.
Identify individuals who are good candidates for your enhanced care design.
Develop a care model to fit the needs and strengths of the target population.
Recruit people into care.
Engage people into care.
Partner within and outside your organization.

Learn to operate sustainably at full scale: 5 to 25 then 5X

PARTNER WITHIN AND OUTSIDE YOUR ORGANIZATION
### Partnering @ Allina Health

<table>
<thead>
<tr>
<th>“Outside”</th>
<th>“Within”</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Coleman Care Transitions Intervention</td>
<td>• Hospital Transitions of Care Program</td>
</tr>
<tr>
<td>• Minnesota RARE Campaign</td>
<td>• Hospital &amp; Community Palliative Care</td>
</tr>
<tr>
<td>• Twin Cities Aging</td>
<td>• Home Health</td>
</tr>
<tr>
<td>• Stratis Health (CMS QIO)</td>
<td>• Community Paramedics</td>
</tr>
<tr>
<td>• MN Epic User Groups</td>
<td>• Senior Care Transitions</td>
</tr>
<tr>
<td>• Press Ganey</td>
<td>• AIM Network</td>
</tr>
<tr>
<td>• 3M Potentially Preventable Events</td>
<td>• Hospitals &amp; Primary Care</td>
</tr>
<tr>
<td>• Payers ~Commercial &amp; CMS</td>
<td>• Home Health Transitions of Care</td>
</tr>
</tbody>
</table>

---

### Honoring Choices (MN)

- Shared development and updating of educational materials
  - Multicultural and interpreter best practices
  - Sharing background, content, learnings (and videos)
- Support for Honoring Choices Minnesota (HCM) to receive state grant funding
- Community collaboration
  - National Healthcare Decisions Day (NHDD) events
  - Support Honoring Choices Minnesota’s (HCM) First Annual Run/Walk
- Provide yearly data for Honoring Choices Minnesota (HCM) collectively; ongoing resource to HCM for questions from developing programs
**Post Acute Care Network**

- Preferred Transitional Care Networks
  - E. Metro, W. Metro, & Valley Strategy
- Valley Swing Bed/TCU Strategy
- Respite Care Beds
- Community Medicine
  - Paramedic/Firefighter Visit Program
  - Home-Based Medicine/Hospital @ Home

**Fire Department/Paramedic Partnerships**

Home visit the day after hospital discharge.

Key elements of the visit:
- Physical exam
- Vital signs
- Medication checks and reconciliation
- Home safety/food security evaluation
- Patient education
- Physician orders
- Resource referrals
Regions Hospital: LIFE Team

- Leadership Impacting the Family Environment (LIFE)
- At-risk individuals are identified, and encouraged to participate in beginning a positive life transformation
- Multiple intervention techniques focus on stabilizing lives
  - Physically
  - Socially
  - Economically
  - Renewing each individual’s bond to the community

Northwest Metro Alliance Background

- HealthPartners and Allina Health care for nearly 300,000 people in the Northwest Metro together.
- Long term agreement to enable strategic integration and partnership in the Northwest Metro
- Align and improve clinical strategies between primary care, specialty care and the hospital
- Serves as a learning lab for Accountable Care to move forward the Triple Aim
- Economic integration optimizes the performance of capital intensive services and moderate total cost of care

Critical shift in mindset from competition to cooperation
2015 NW Alliance Focus Areas

- Prevention and Community Health Initiatives
- Care Integration Initiatives
- Care Management and Coordination
- Primary Care Access and Affordability Engagement
- Specialty Care Partnerships in Northwest Metro
- Continuum of Care and Alternative Venues of Care
- Mental Health Continuum of Care
- Pain Management in Northwest Metro
- Continued engagement of physicians, staff and leaders

NW Metro Alliance Destination

Patients and Community
- Provide the highest levels of quality and experience at an affordable price

HealthPartners
- Support Triple Aim
- Lead Health Care Reform
- Ensure success of Clinics and Health Plan

Allina Health
- Support Triple Aim
- Lead Health Care Reform
- Ensure success of Clinics and Mercy Hospital
NW Metro Alliance Results

Improved care lowers costs
Northwest Metro Alliance
Twin Cities average

Medicaid costs $7 million lower
In 2013, the Northwest Metro Alliance was among the first organizations in Minnesota to join a state demonstration project to deliver high-value care for more than 15,000 Medicaid patients.

Northwest Metro Alliance
Expected costs

Northwest Metro Alliance medical cost increases were more than 31 percent lower than the Twin Cities metropolitan average for patients with private insurance.

Medical costs* for Northwest Metro Alliance Medicaid patients decreased nearly 2 percent, saving taxpayers more than $7 million.

*Costs are risk-adjusted.

BREAK – 20 MIN
Quiz

Which snack costs more money per portion?
Build a Hybrid Care Management Model

- Health systems are moving from volume to value based payments
- Health plans must meet quality targets
- The consumer is shopping for the best value at the lowest cost
- Coordinating the capabilities of a health plan with the health system should improve the members experience and meet the triple aim
- Care management can reduce unnecessary care
- Using data in new ways can improve health outcomes

Care Management Models

The Historic Model

- Uncoordinated and duplicate services leads to confusion for members
- Data is reviewed in one dimension, claims or medical record
- Outreach is primarily telephonic from the health plan
- Payment is directed to the plan
- Goal is the Triple Aim
Care Management Models

The Hybrid Model
- Care coordination at the right time for the right care
- Interaction is face-to-face visits, telephonic or telehealth
- Data is integrated from multiple sources including medical records, claims and member’s home monitoring
- Improved member engagement
- Payment is aligned to the resources
- Goal is the Triple Aim

Building a Hybrid Care Management Model
- Leadership must be collaborative and innovative - “stronger together than apart”
- Guiding principle is to provide care management via the Health System
- Streamline and eliminate duplication for the member and each organization
  - Workflows, care conferences, just in time exchange, NCQA “auto credit”
- Integrate identification & risk stratification proprietary algorithms from both organizations
- Provide timely and reliable data
- Utilize evidenced based protocols
- Align payment and provider incentives
- Design the product to promote wellness and chronic disease management
- Establish oversite of the hybrid care management model to evaluate impact
Future for Hybrid Care Management

- Increase AIM Network membership with value based contracts
- Enhance the care management model by population
- Optimize “point of care” tools for the health care team to communicate within the network
- Improve network access
- Promote patient & caregiver digital portals
- Design analytics to measure ROI

![AIM Network Members per Year]

Hospital At Home

- **Focus:**
  - Address hospital capacity issues
  - Promote admission based on acuity
  - Reduce hospital acquired conditions
  - Reduce total cost of care by providing home-based acute hospital level care

- Inception point = Emergency room
**Project ECHO**

**Moving knowledge and information, not patients.**

A new approach to diabetes care in Endocrinology:

- Share knowledge and best practices through the use of tele-video
- Discuss difficult diabetes cases with experts and other providers
- Build relationships with colleagues

Potentially spread to other specialties/conditions:

- Hypertension management
- Psychiatry
- Nephrology
- Cardiology
- Chronic pain

---

**Children’s Health**

Improve the health and well-being of children that we serve from pregnancy through age 5

<table>
<thead>
<tr>
<th>Aim</th>
<th>Areas of Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoting Early Brain Development</td>
<td>Read, Talk, Sing</td>
</tr>
<tr>
<td></td>
<td>Healthy Beginnings</td>
</tr>
<tr>
<td></td>
<td>Social Emotional Development</td>
</tr>
<tr>
<td></td>
<td>Breastfeeding Promotion</td>
</tr>
<tr>
<td></td>
<td>Postpartum Depression</td>
</tr>
<tr>
<td></td>
<td>Standard Workflows</td>
</tr>
<tr>
<td>Providing Family Centered Care</td>
<td>OB-Peds-FM Collaboration</td>
</tr>
<tr>
<td></td>
<td>Supporting At-Risk Families</td>
</tr>
<tr>
<td>Strengthening Communities</td>
<td>Teen Pregnancy Prevention</td>
</tr>
<tr>
<td></td>
<td>Early Childhood Experience</td>
</tr>
</tbody>
</table>
Pioneer > Next Generation ACO

2012 - Started with 32 Pioneer ACO's, Allina, Fairview, and Park Nicollet in MN
2015 - 19 Pioneer ACO's
2016 - 9 Pioneer ACO's + 21 Next Generation ACOs

Source: Centers for Medicare & Medicaid Services

Park Nicollet Pioneer ACO Results

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Aligned Beneficiaries</th>
<th>Aggregate Savings/Losses</th>
<th>Quality</th>
<th>Total Shared Savings/Losses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 PY1</td>
<td>14,240</td>
<td>($782K)</td>
<td>100% (pay to report)</td>
<td>$0</td>
</tr>
<tr>
<td>2013 PY2</td>
<td>12,405</td>
<td>$3.1M</td>
<td>89.17% (6 PR)</td>
<td>$2.1M</td>
</tr>
<tr>
<td>2014 PY3</td>
<td>13,195</td>
<td>$2.9M</td>
<td>84.61% (4 PR)</td>
<td>$1.8M</td>
</tr>
</tbody>
</table>

Cost Savings  x  Contracted Shared Risk %  x  Quality Measure %  =  Bonus Payment
### ACO Comparison

<table>
<thead>
<tr>
<th>Pioneer ACO Model</th>
<th>Next Generation ACO Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retrospective financial benchmark</td>
<td>Prospective financial benchmark</td>
</tr>
<tr>
<td>Minimum savings rate (MSR) (1% to 3%; PNHS chose 1%)</td>
<td>A discount will be applied to the benchmark (.5% to 4.5%)</td>
</tr>
<tr>
<td>75% Risk</td>
<td>80% risk PY1-3, 85% risk PY4 &amp; PY5</td>
</tr>
<tr>
<td>Quality score taken into account after shared savings achieved</td>
<td>Quality score taken into account upfront</td>
</tr>
<tr>
<td>1 waiver</td>
<td>3 waivers plus additional patient engagement</td>
</tr>
</tbody>
</table>

### Next Generation – Care Coordination Waivers

<table>
<thead>
<tr>
<th>3-Day SNF Waiver</th>
<th>Telehealth Expansion</th>
<th>Post-Discharge Home Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waives 3-Day hospital stay rule before transferring to a SNF.</td>
<td>Can be used in rural and urban areas. Patient can receive telehealth services at their place of residence.</td>
<td>One visit within 10 days of discharge from a facility and another within 20 days.</td>
</tr>
</tbody>
</table>
MEASURING SUCCESS

How do you measure success?
Allina Health Historical Savings & Losses in Pioneer ACO

Savings/Losses

Minimum Savings Rate

Maximum savings/losses = 15%*

*15% applies to 2015 only

Pioneer Results:

• Quality: Improved from 85th percentile to 90th

• CMS has incorporated several recommended changes into the program
Potentially Preventable Readmissions

![Graph showing potentially preventable readmissions over time.](image)

Potentially Preventable Readmissions – Pioneer ACO members

![Graph showing potentially preventable readmission A/E ratio by rolling 3 months for Pioneer ACO members.](image)
Challenges

- Design, Implement, Measure, Assess
- Hiring Staff
- Staff Turnover
- Adjustments in model make measurement a challenge
- Clinician culture and practice change
- Patient engagement
- Audits – external and internal

Lessons Learned

- To successfully manage a population, we need tactics for the whole population
- We should move forward and not delay in taking action while we develop our new data analytics tools and capabilities
- Our initial experience with a small, volatile population should only encourage us to take broader action
### Minnesota Community Measurement High Performing Medical Groups in 2015 (Primary Care)

<table>
<thead>
<tr>
<th>Measure</th>
<th>HealthPartners Clinics 16 out of 20</th>
<th>Park Nicollet Health Services 15 out of 20</th>
<th>Allina Health 13 out of 20</th>
<th>HealthEast Medical Group 13 out of 20</th>
<th>Mankato Clinic, Ltd. 11 out of 20</th>
<th>Essentia Health – East Region 10 out of 20</th>
<th>Mayo Clinic 10 out of 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Adolescent Immunizations</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Childhood Immunization Status (Combo 3)</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>COPD</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Depression Remission at 6 months</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Depression Remission at 12 months</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Maternity Care: Primary C-Section Rate</td>
<td>●</td>
<td>●</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>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Optimal Asthma Care - Children</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Optimal Asthma Care - Adults</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Optimal Diabetes Care</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Optimal Vascular Care</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>URI</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Pediatric Mental Health Screening</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Pediatric Overweight Counseling</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
</tbody>
</table>

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

---

### Health Equity of Care

- Minnesota Community Measurement Report
Web and Mobile Transparency

Medical Group and Hospital Ratings

High-cost doctors consistently deliver high-quality care. HealthPartners cost and quality ratings for primary care, specialists, and hospitals help consumers have a better understanding of health care value.

<table>
<thead>
<tr>
<th>Provider group</th>
<th>Overall Cost</th>
<th>Overall Quality</th>
<th>Getting Care</th>
<th>Communication</th>
<th>Staying Healthy</th>
<th>Chronic Care</th>
<th>Tech &amp; Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medical Group</td>
<td>$5.00</td>
<td>4.50</td>
<td>4.00</td>
<td>4.50</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>$5.00</td>
<td>4.50</td>
<td>4.00</td>
<td>4.50</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Primary Care</td>
<td>$5.00</td>
<td>4.50</td>
<td>4.00</td>
<td>4.50</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
</tr>
</tbody>
</table>

QUESTIONS?