HealthPartners®

Population Health (Medical Home 2.0)

AMGA Annual Conference

March 16, 2013

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Associate Medical Director, Primary Care
HealthPartners Medical Group

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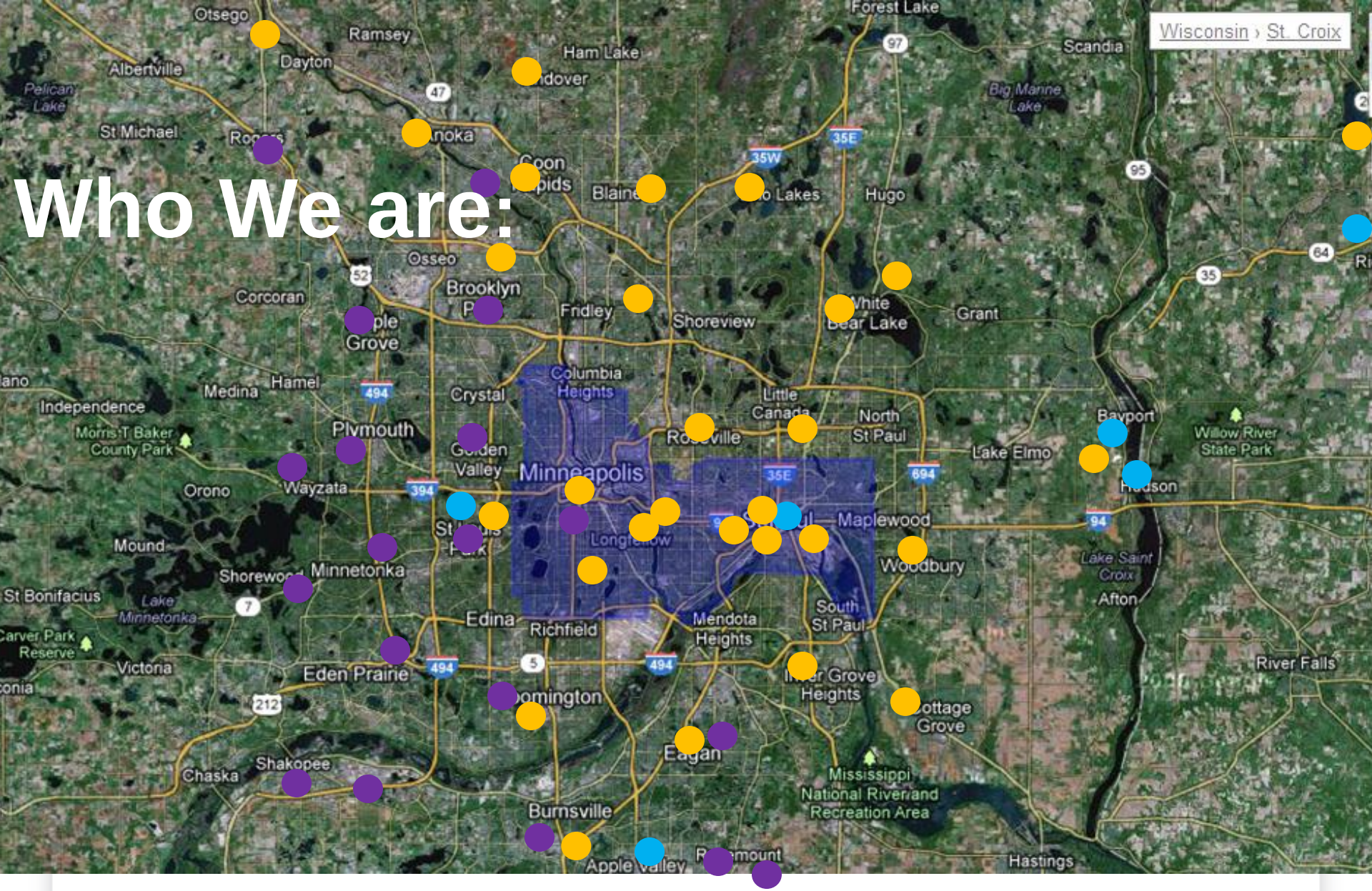
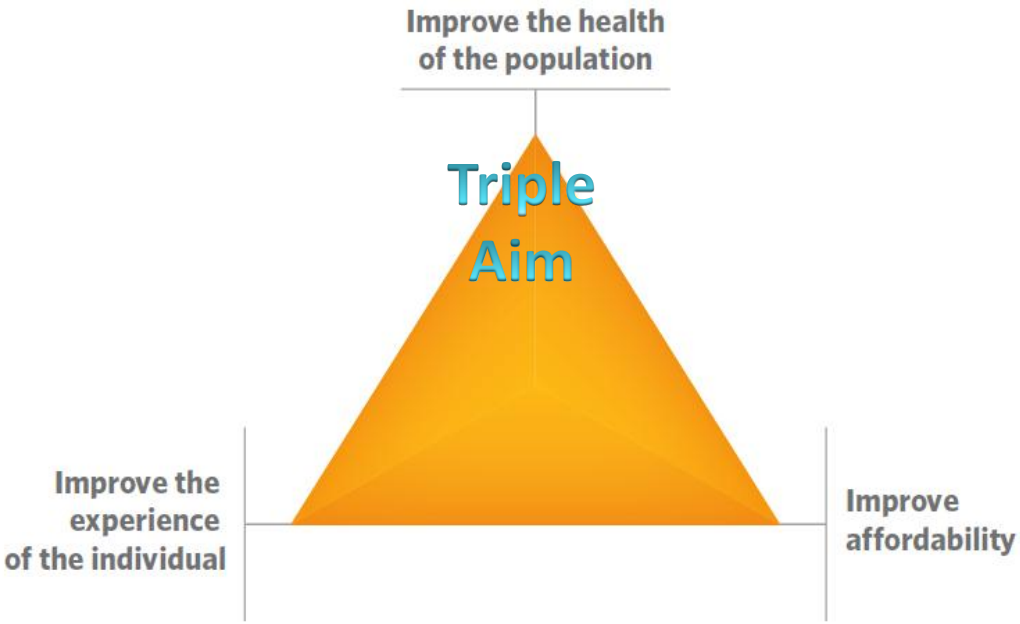
Regional Clinic Director
HealthPartners Medical Group

Who We are:



- Hospitals
- Park Nicollet Health Services
- HealthPartners Medical Group Clinics

HealthPartners: Aspiring for our Best with Triple Aim



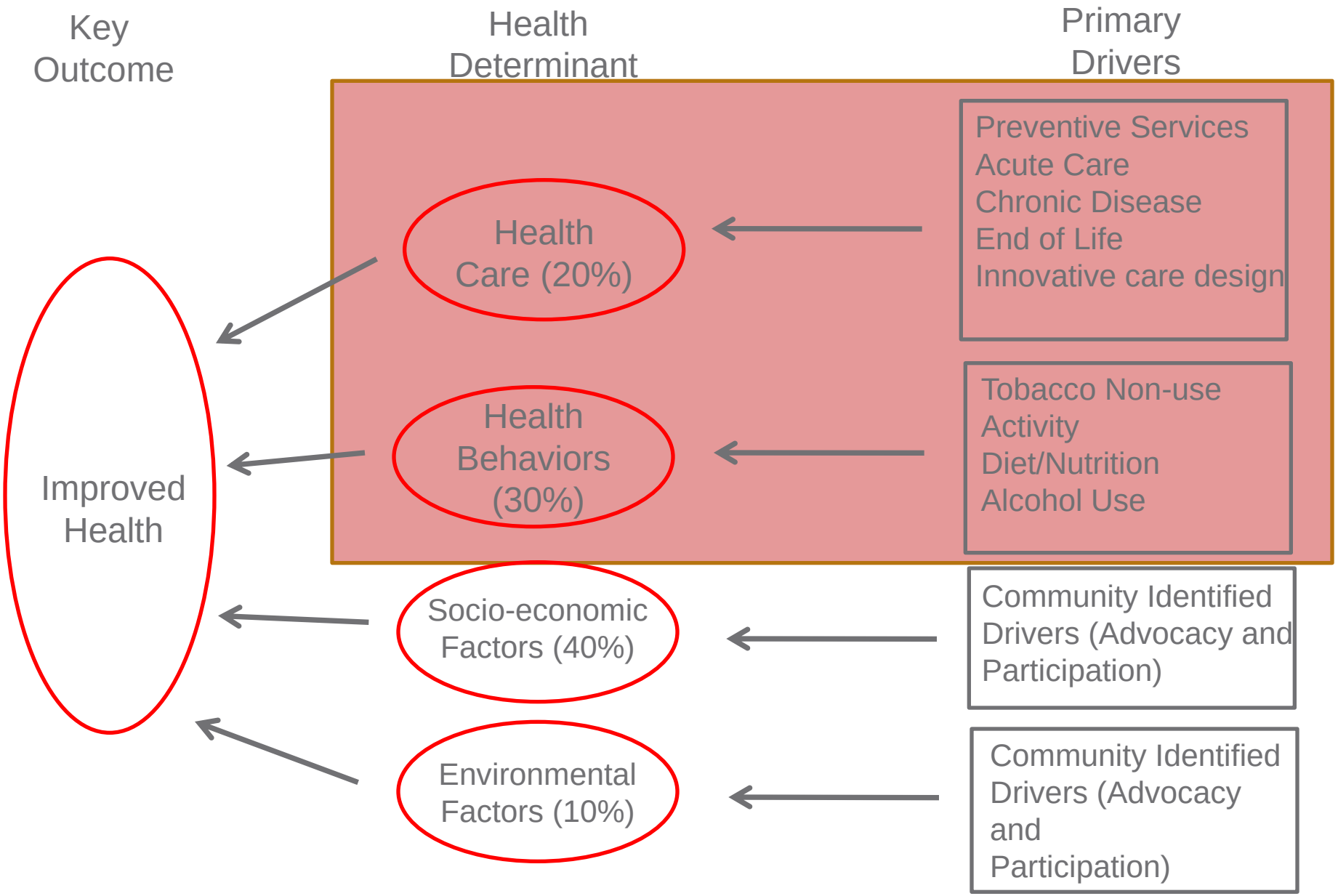
Mission	Vision	Values
Improve the health of our members, our patients and the community.	Through our innovative solutions that improve health and offer a consistently exceptional experience at an affordable cost, we will transform health care. We will be the best and most trusted partner in health care, health promotion and health plan services in the country.	Passion, Teamwork, Integrity, Respect

Agenda

- Population Health Drivers & Cost
- Transforming Care
  - Culture
  - Care Design
- Supporting patients with complex care
- Keeping people healthy

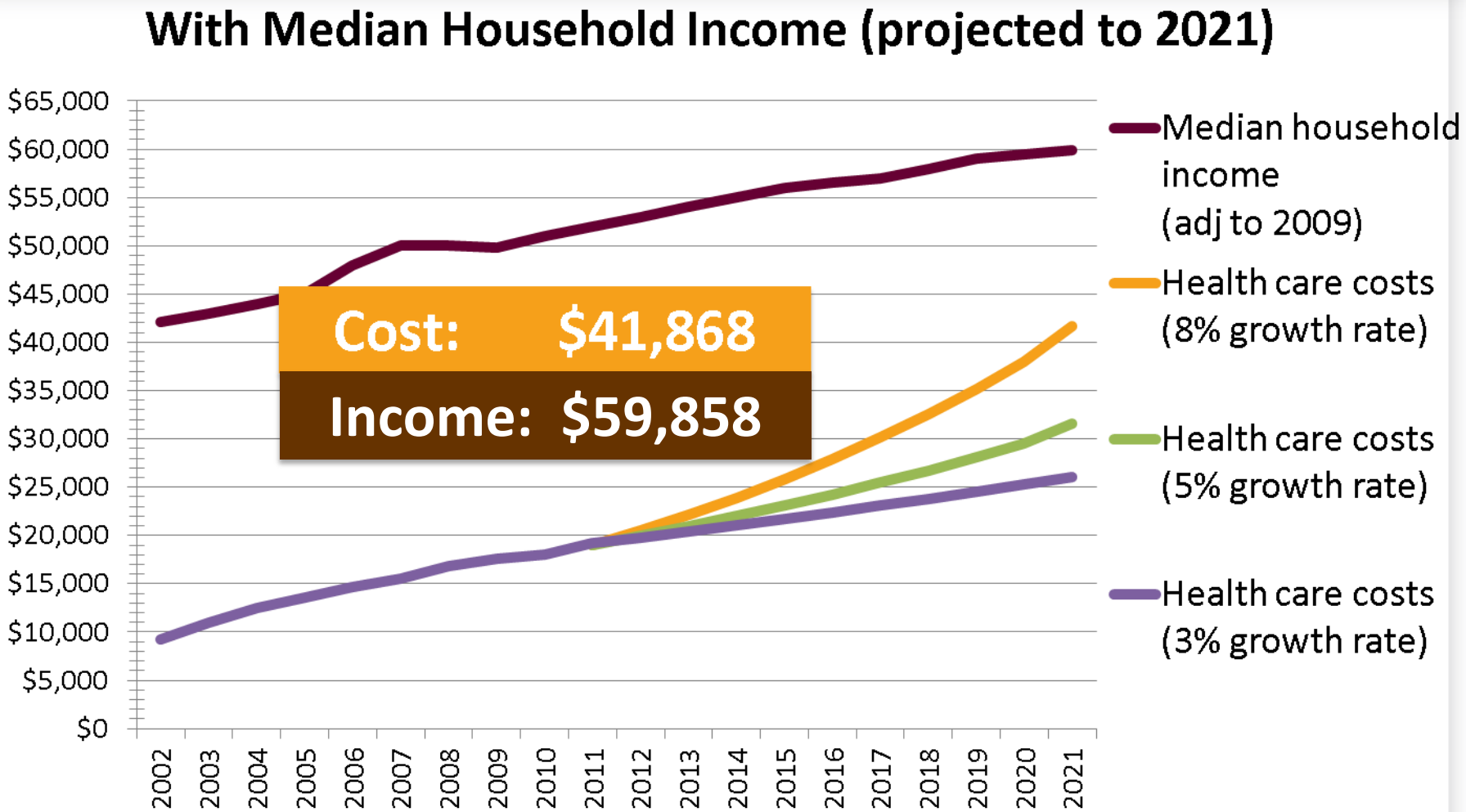

14,467 patients with diabetes
18% have opioid prescriptions
2000 frail elderly with 16+ prescriptions
25% have a mental illness

HealthPartners Health Driver Diagram



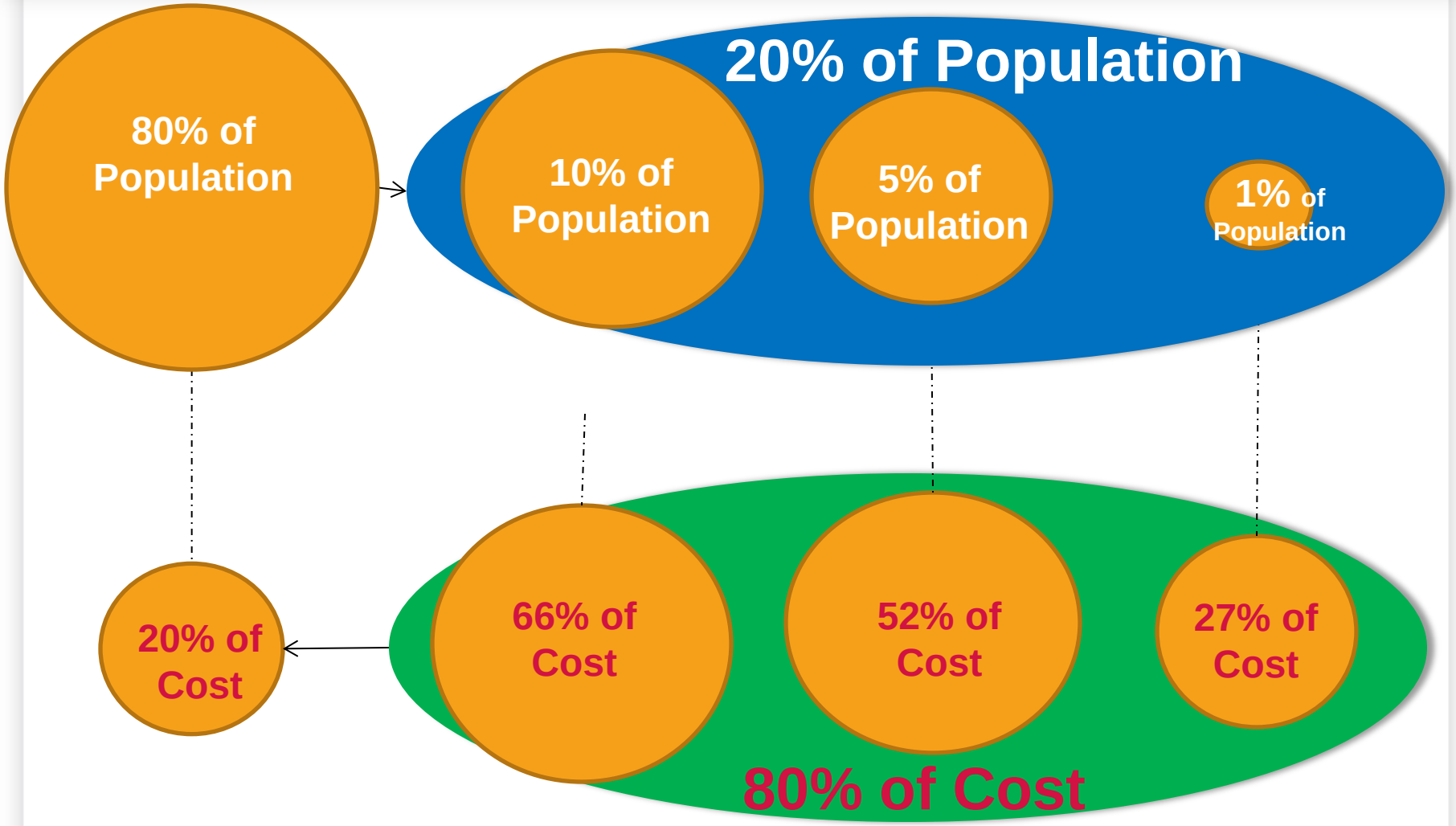
Modified from HealthPartners Board of Directors Retreat, October 2010. Based on work by David Kindig, PhD, UWPHI

Why cost is a real issue



Source: Alliance of Community Health Plans

Population and Cost Distribution



Primary Care Vision

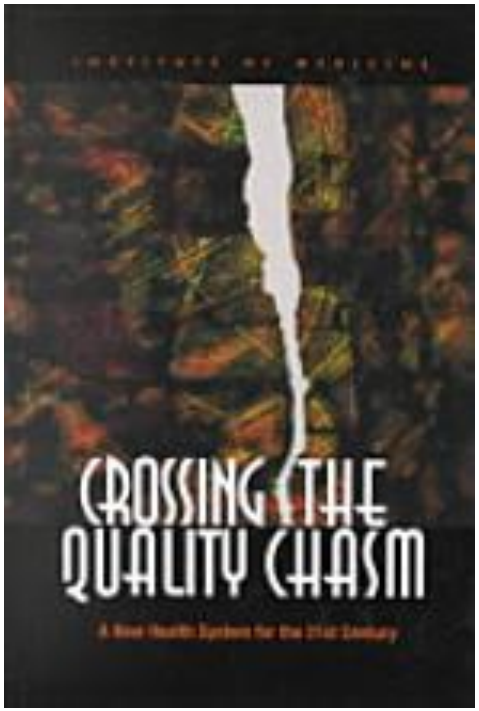
- Care is ***patient and family centered*** where ***patients will choose from options for access***
- Care is ***team based***
- Care is ***coordinated***
- We offer ***an exceptional work/life balance for providers and staff***
- We provide ***better health and experience outcomes at a lower cost*** that are national benchmarks

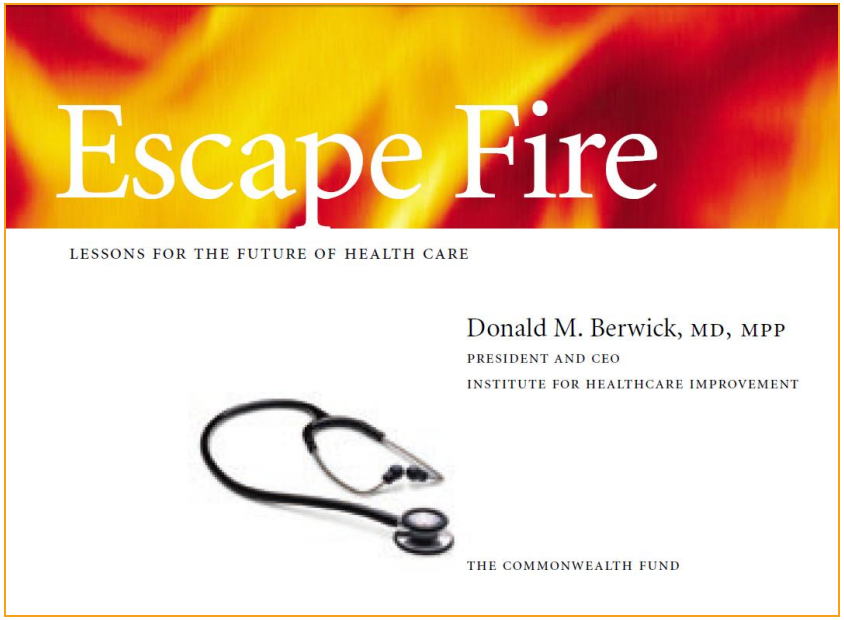
HealthPartners®

How:

- Culture
- Care Design

Our Physician Culture





PERSPECTIVE

Zen and the Art of Physician Autonomy Maintenance

James L. Reinertsen, MD

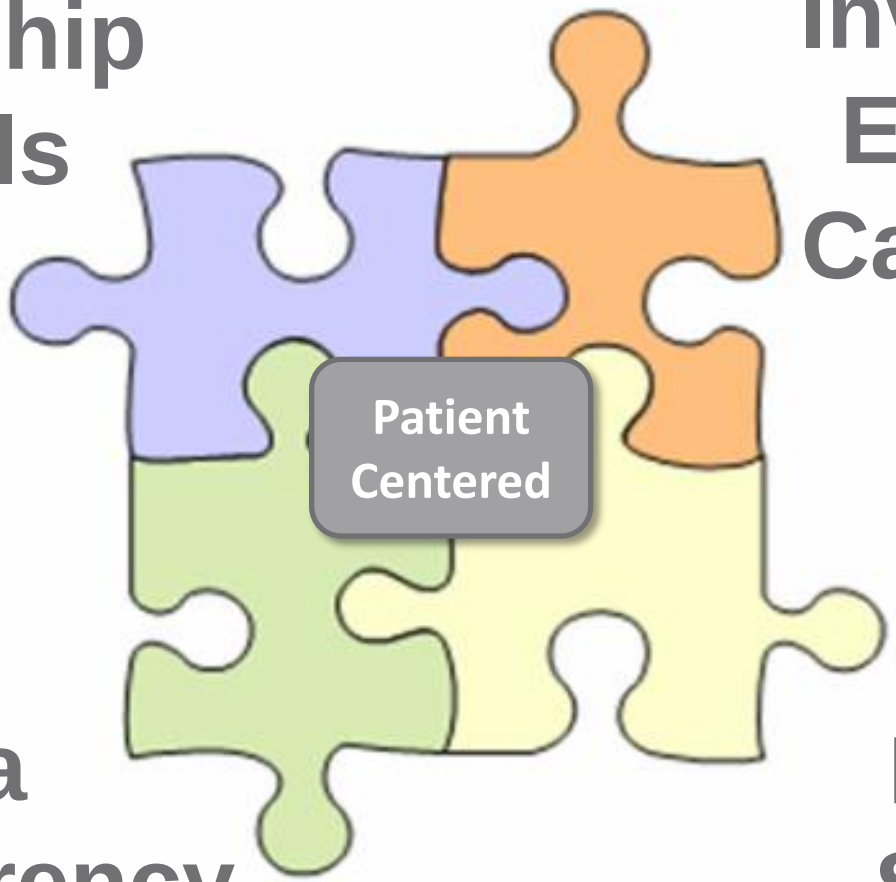
The miracles of scientific medicine propelled physicians to an unparalleled level of clinical autonomy during the 20th century. During the past 20 years, physician autonomy has been declining, in part because the public has become aware that physicians are not consistently applying all of the science they know. One of medicine's most cherished professional values, individual clinical autonomy, is an important cause of the sometimes suboptimal performance in the timely and consistent application of clinical science; thus, it contributes to the decline in overall professional autonomy. This paper calls for physicians to practice the science of medicine as a profession so that society will allow physicians to continue practicing the art of medicine as individual professionals. In a Zen-like paradox, physicians must give up autonomy in order to regain it.

Ann Intern Med. 2003;138:992-995. www.annals.org
For author affiliation, see end of text.

Pieces of the Culture Puzzle

Leadership & Goals

Involved & Engaged Care Team



Data Transparency

Reliable Systems

Culture of Improvement in Care Design

New Idea

Design

Implement

Test Small

Pilot
1-3 Sites

Spread

Audit

Redesign
based on learning
from all sites

Care Design Principles

We use the following design principles to ensure our care achieves health, experience & affordability results.

Four Care Design Principles

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

Involving Patients

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

Care Design Principles

Reliability | Customization | Access | Coordination

- **Throughout our system we develop consistent approaches to deliver reliable, standardized care focused on the patient:**
  - Evidence-based
  - Decision support in electronic medical record
  - Processes are standardized
  - Defined roles and responsibilities
  - Every member of the care team contributes to their maximum potential
  - Waste and rework eliminated

Why Standardize?

27* Clinics x ~~60~~ 80 Measures

(PEOPLE, HEALTH EXPERIENCE & STEWARDSHIP) =

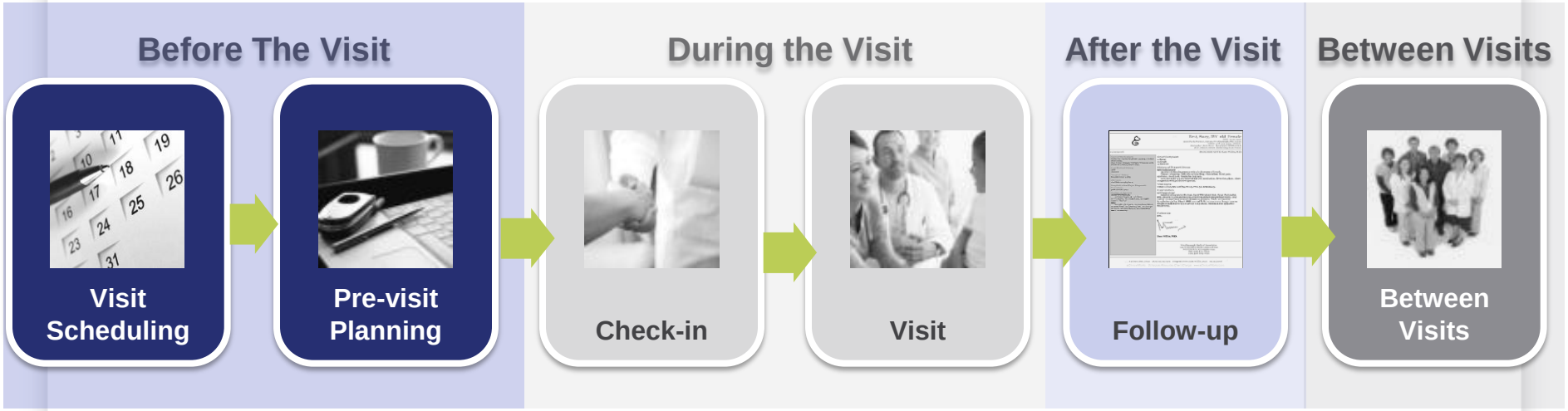
~~1,560~~ 2160 Processes

300 Primary Care Teams x ~~60~~ 80 Measures =

~~18,000~~ 24,000 Processes

*HealthPartners Medical Group clinics

Reliability
Care Model Process Visit Cycle



- Determined for each workflow:
  - What – must be done – the task
  - Where – where will the task be done
  - Who – appropriate role to complete the task
  - How – tools needed to support the task
  - When – what part of the visit

Care Model Process: Biannual Upgrades

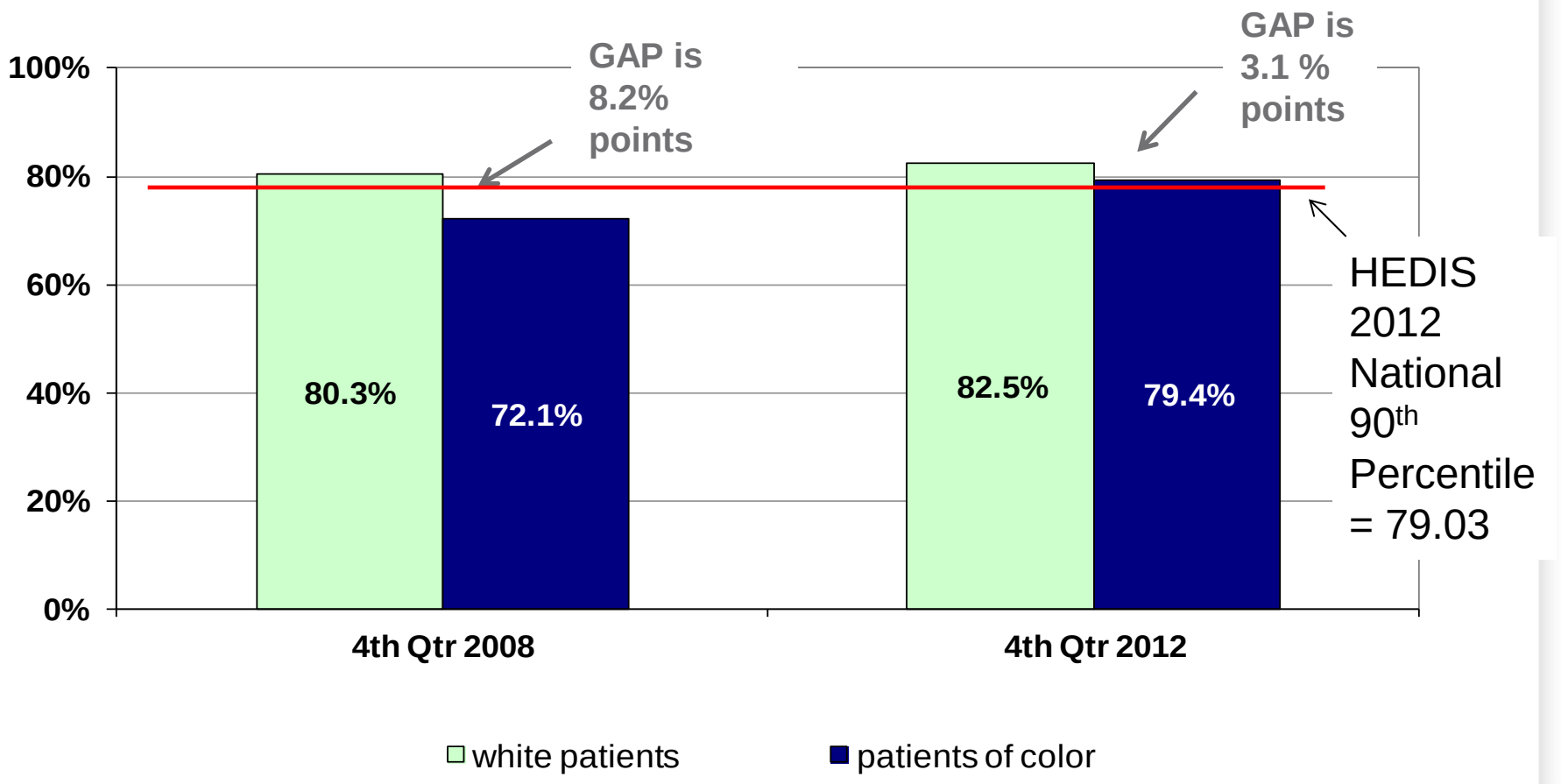
- Improvement requires change
- We get great ideas from the Care Teams we want to spread
  - Changes to existing modules
  - New workflows to develop
- Keep workflows up to date
  - EHR Upgrades may effect workflow
  - Provide accurate tools for orientation
- Increase work efficiency
- Re-evaluate responsibilities and reduce waste – are all tasks value added?
- Improve Patient Experience
- Doing the same thing gets you the same result!

Care Design Principles

Reliability | **Customization** | Access | Coordination

- First we standardize to the science; then we customize care to individual patient preferences and values and unique individual characteristics

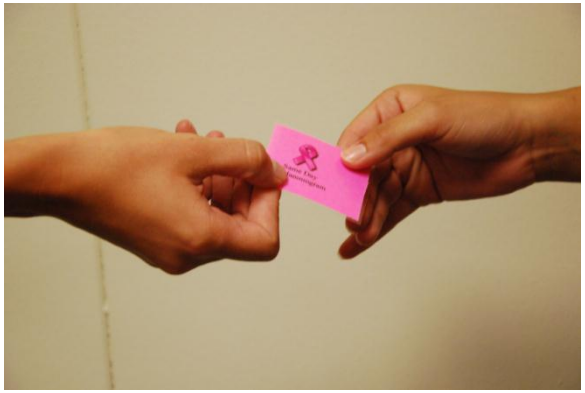
Reducing the Gap: Breast Cancer Screening



Reducing the Gap: How

Breast Cancer Screening

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



Care Design Principles

Reliability | Customization | **Access** | Coordination

We design ways to make care and information

- More convenient
- Easy to access; and
- Affordable

Call
Talk to your doctor or a nurse.

Click
Get care online or via email.

Come In
Visit your doctor or a clinic.

HealthPartners Family of Care

Current Wait Times

Urgent Care Clinics

virtuwell	Always Open
Apple Valley	Closed
Arden Hills	0 min
Brooklyn Center	Closed
Como (St. Paul)	45 min
Cottage Grove	Closed
Eagan	Closed
Nokomis	Closed
Riverside (Mpls)	Closed
Riverway Andover	15 min
Riverway Elk River	Closed
St. Paul	Closed
West	15 min
Woodbury	15 min

Quick Clinic

Apple Valley

Woodbury

Wait times vary by condition. Estimated times update every 15 minutes and can change without notice.

Call

CareLine℠ or Clinic Nurse

Unsure what to do? Get advice and treatment for some conditions from a nurse 24/7 by calling 612-339-3663. Or call your clinic nurse during normal hours.

Click here for common conditions

Free

Scheduled Phone Visit

As a HealthPartners clinic patient, you can speak with your doctor by scheduling a phone call in advance.

Click here for common conditions

Co-pay or starting at $55

Schedule online Go ›

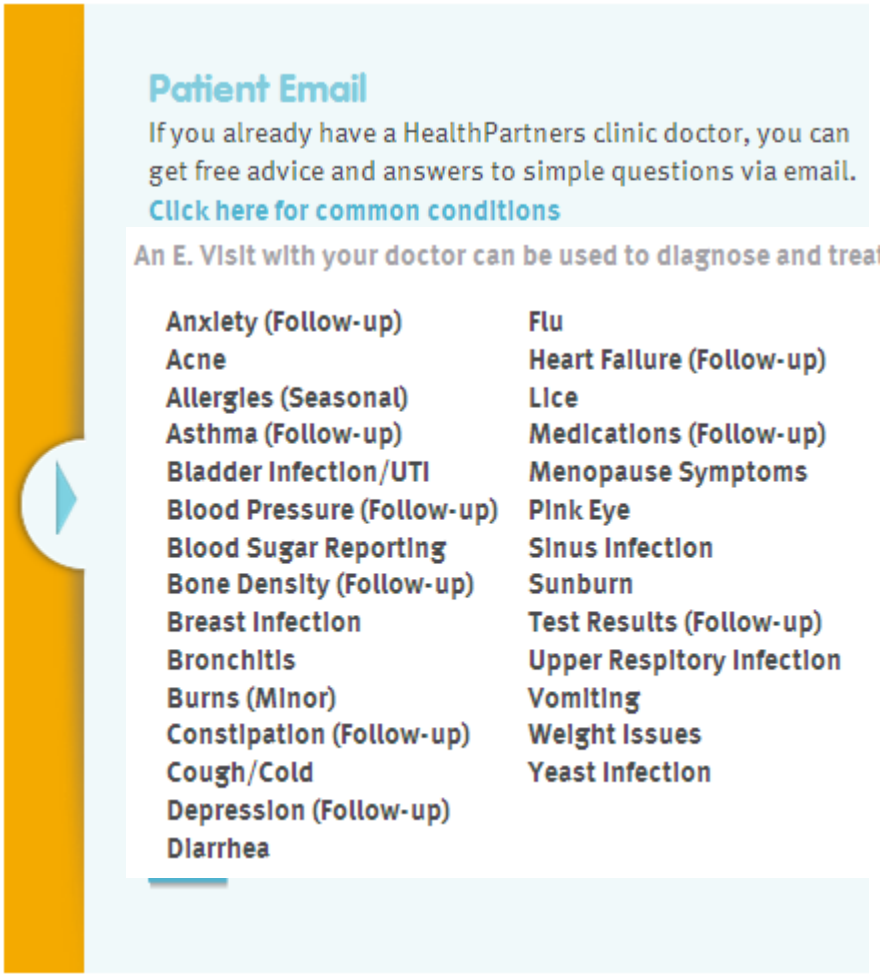
Call your clinic Go ›

Call

Talk to your doctor or a nurse.

- 3,700 scheduled phone visits this year
- 2 slots/week/provider minimum
- Examples: depression, anxiety, osteoporosis, ADHD, diabetes

Click



- 1,700 e.visits
- 71,000 patient emails

virtuwell™ at a Glance

virtuwell
by HealthPartners

- Available around the clock – 24/7/365
- Custom treatment plan with prevention advice
- A simple $40 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

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 $180

Find Urgent Care ›

Clinic Visit

Schedule an appointment to see your family doctor or a specialist.

Co-pay or starting at $180

Find A Clinic ›

Come In

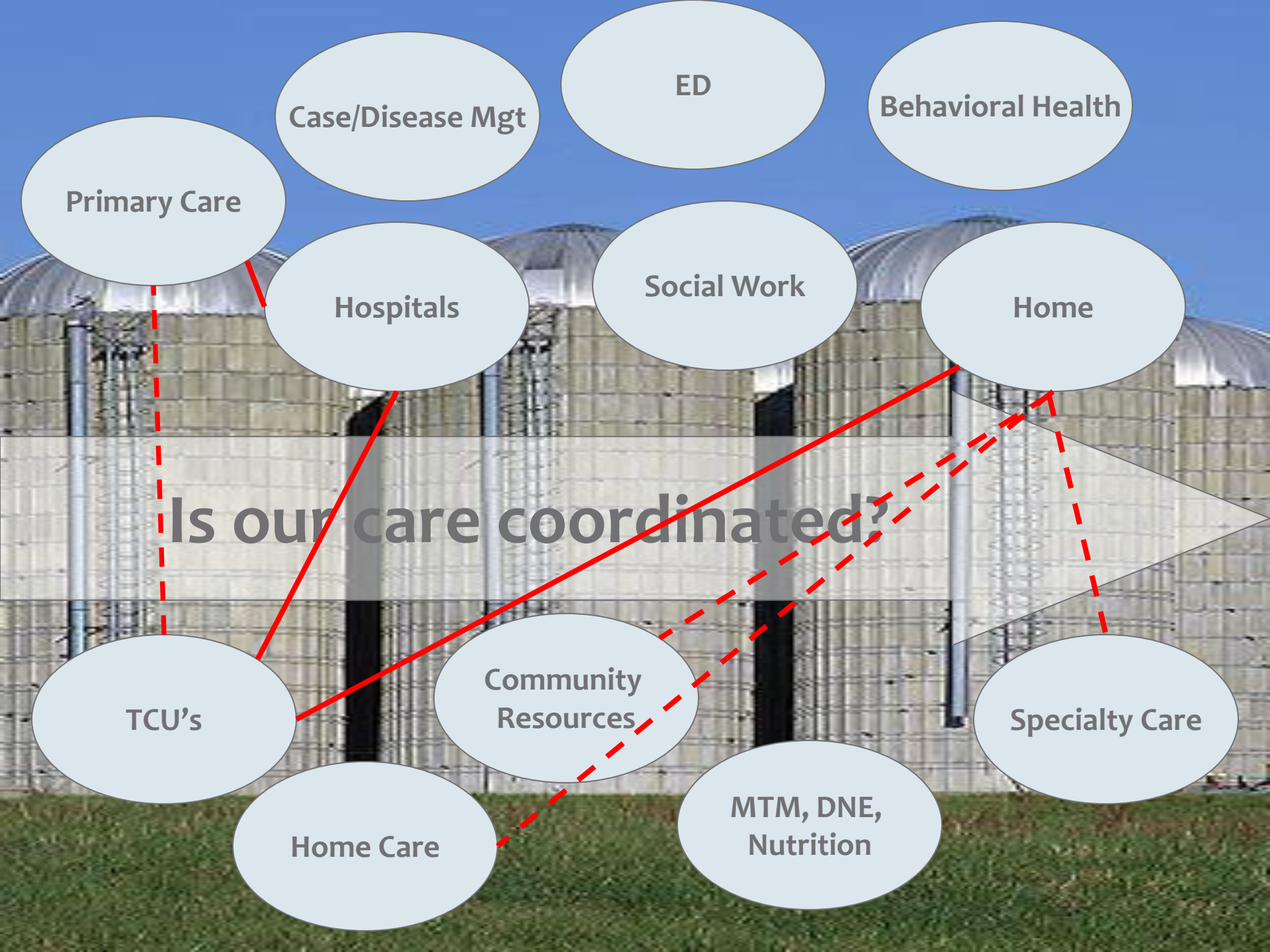
Visit your doctor or a clinic.

- 30% same day access
- 360 flu-shots given during our 'drive-through flu shot' offering
- 64% of patients saw their primary care physician

Care Design Principles

Reliability | Customization | Access | **Coordination**

We coordinate care across sites, specialties, conditions and time


Case/Disease Mgt
ED
Behavioral Health
Primary Care
Hospitals
Social Work
Home
Is our care coordinated?
TCU's
Community Resources
Specialty Care
Home Care
MTM, DNE, Nutrition

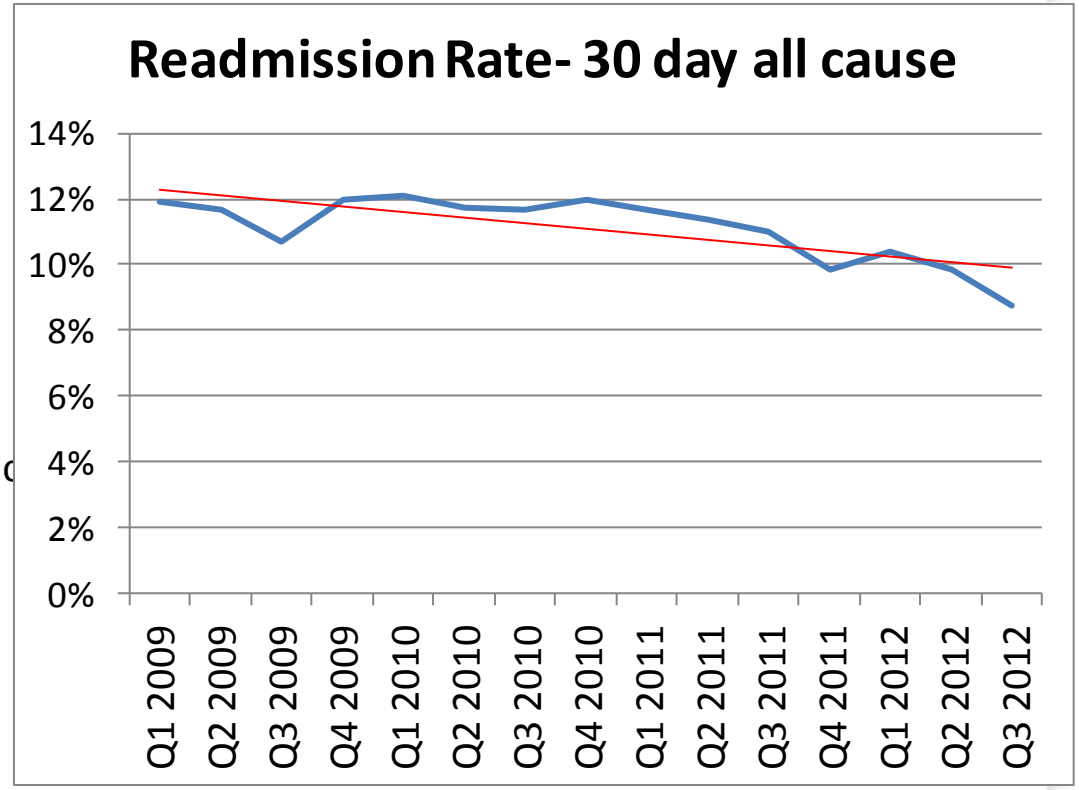
Care Coordination

- **Primary Care to Specialty Care**
  - Standardized referral template
  - Specialty assumes accountability for appointments
  - Hotline (standardized process and service expectations)
  - Access guarantees
- **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**

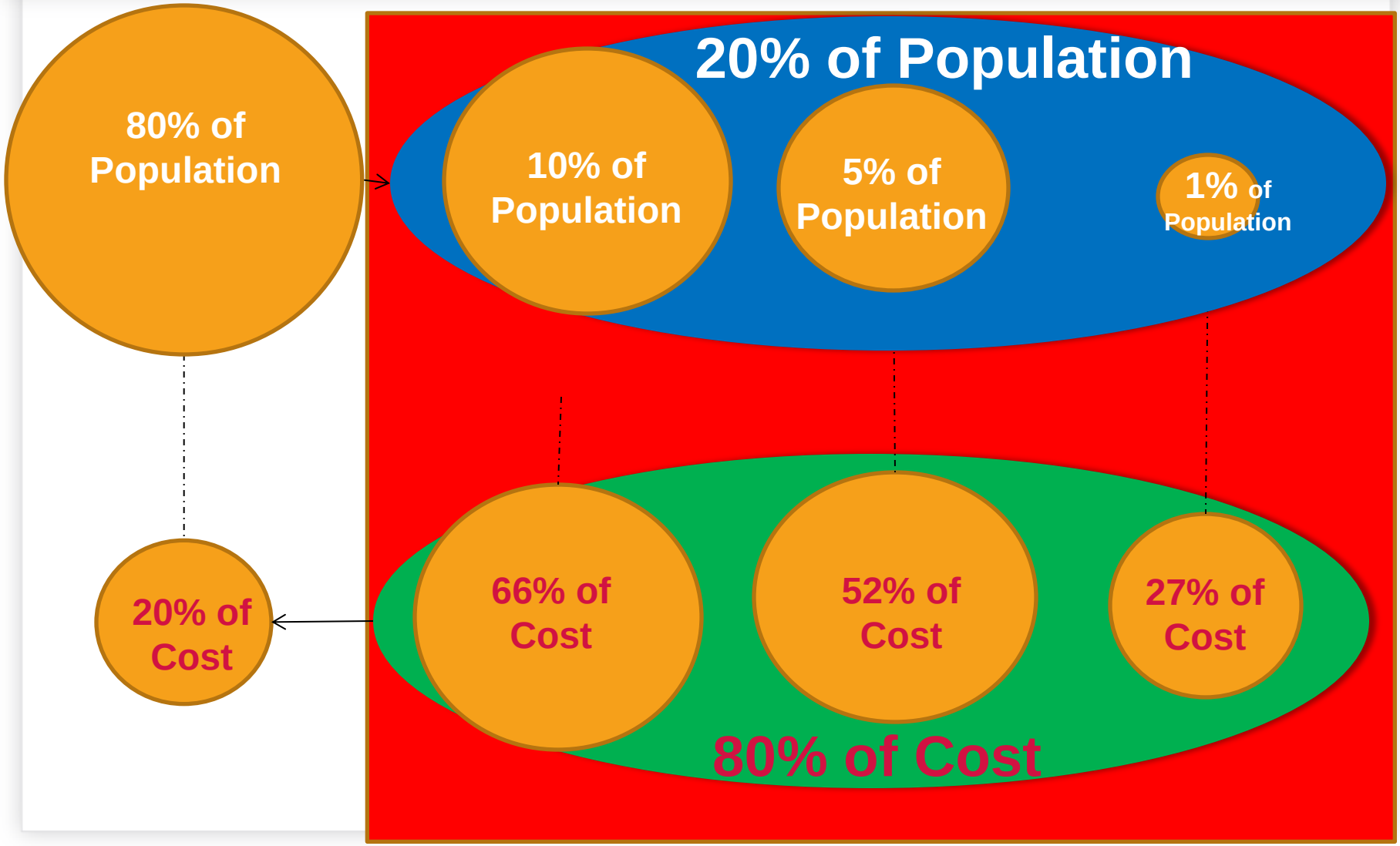
Reducing Readmissions

Reduce readmissions through collaboration of our hospital, clinics, care management and pharmacy services:

- Identify high risk patients
- Create care plans and implement health coaching
- Participate in medication “boot camp”
- Schedule orders for follow-up clinic appointment
- Coordinate care with home care and other resources
- Simplify patient discharge instructions
- Engage patients in “teach back” methods
- Call patients post discharge



Supporting patients with complex care



Medical Home Evolution

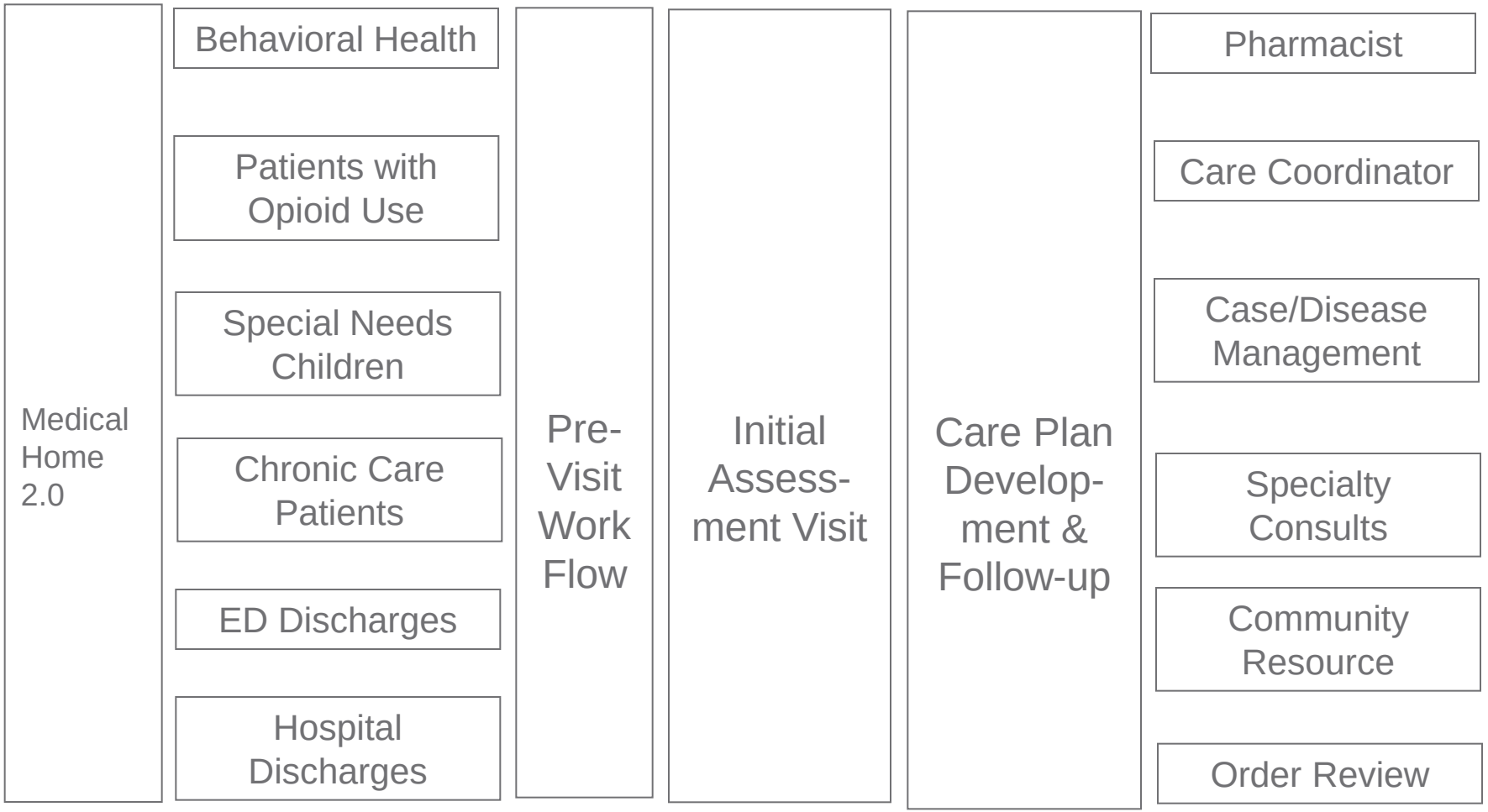
Medical Home 1.0

- Patient initiates care
- Individual
- Clinic Care team
- Treatment-based

Medical Home 2.0

- Care team initiates care
- Population
- Community care team
- Prevention-based
- Stratification

Population Health Framework



Risk Assessment Tools

- Inpatient
  - Manual
  - Days since admission
  - High risk factors
- Outpatient
  - Electronic Health Record & Claims
  - Stratifies based on patient conditions and use
  - Probability of admission in 6 months

Identifying Complex/Chronic Patients

- Stratification List

Patient	Tier	Inpatient Hospitalizations	Last Inpatient Hospitalization	Emergency Department Visits	Last Emergency Department Visit	Care Manager Assigned?
Smith, J	3	5	11/17/2010	6	9/9/2010	Yes
Brown, L	2	2	8/29/2011	4	7/15/2012	No
John, M	4	8	2/5/2012	11	9/8/2012	Yes

- Hospital discharge & Emergency Room discharge
- Who do I worry about at night?
- Who is coming in already?

Linked RN Visit

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

Linking with Health Plan Services and the Community

- Electronic referral to disease and case management
- Alcohol and substance use counseling
- Hotline for social services
  - Health Plan
  - United Way
- Resources listed geographically and linked to electronic medical record
- Address socio-economic barriers
  - Hospital to Home
  - Promise Neighborhood

Keeping People out of the ER

- Primary Care team is notified of patient's Emergency Department visit
  - Average of 4 patient visits, per clinic, per day
  - Care team calls patient to assess status & follow-up, and schedule appointment if needed
  - Identify missed appointments
  - Educating patients regarding options
  - Making a personal connection in the clinics
  - Recognizing cultural norms

Behavioral Health

- Same day walk-in access
- Hotline
- Televideo visits
- Supporting Seriously Mentally Ill

Opioids

- Chronic Use
  - 40 minute initial appointment
  - Assessment
  - Review of State Prescription Monitoring Program
  - Opioid agreement
  - Urine drug testing
  - Care Plan

Opioids

- Acute Pain
  - Default low number of pills if prescribed
  - Patient education
  - Surgery “owns procedure episode”
- ED/Inpatient Restriction Care Plans
  - IV narcotics not to be given to ED patients unless medical emergency unrelated to chronic pain
  - Emphasizes ED not to be used for routine medical care or management of chronic pain
  - 65% reduction in ED visits resulting in an admission

How do we know “2.0” works?

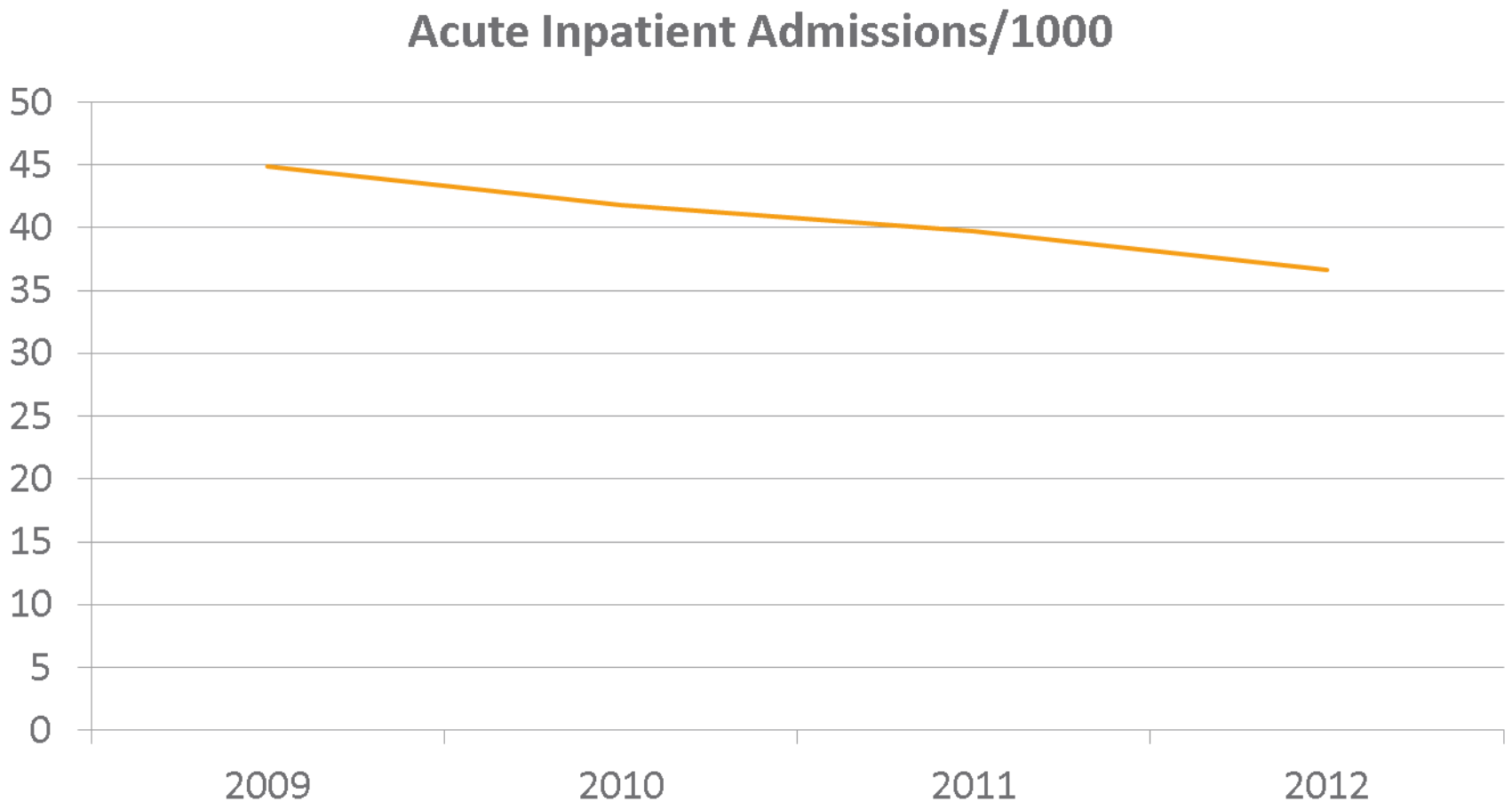
- 50% of patients have a tier assessed
- 7,000 Linked RN Visits
- 3,500 care plans
- 23% of patients meet ‘optimal’ opioid medication measure, up from 10% in April 2012
- 30 completed Tele-video visits in Behavioral Health
- Tier 4 patients (4% of patients)
  - 15% have participated in a shared visit
  - 25% have care plans
- Costs 10% lower than state average

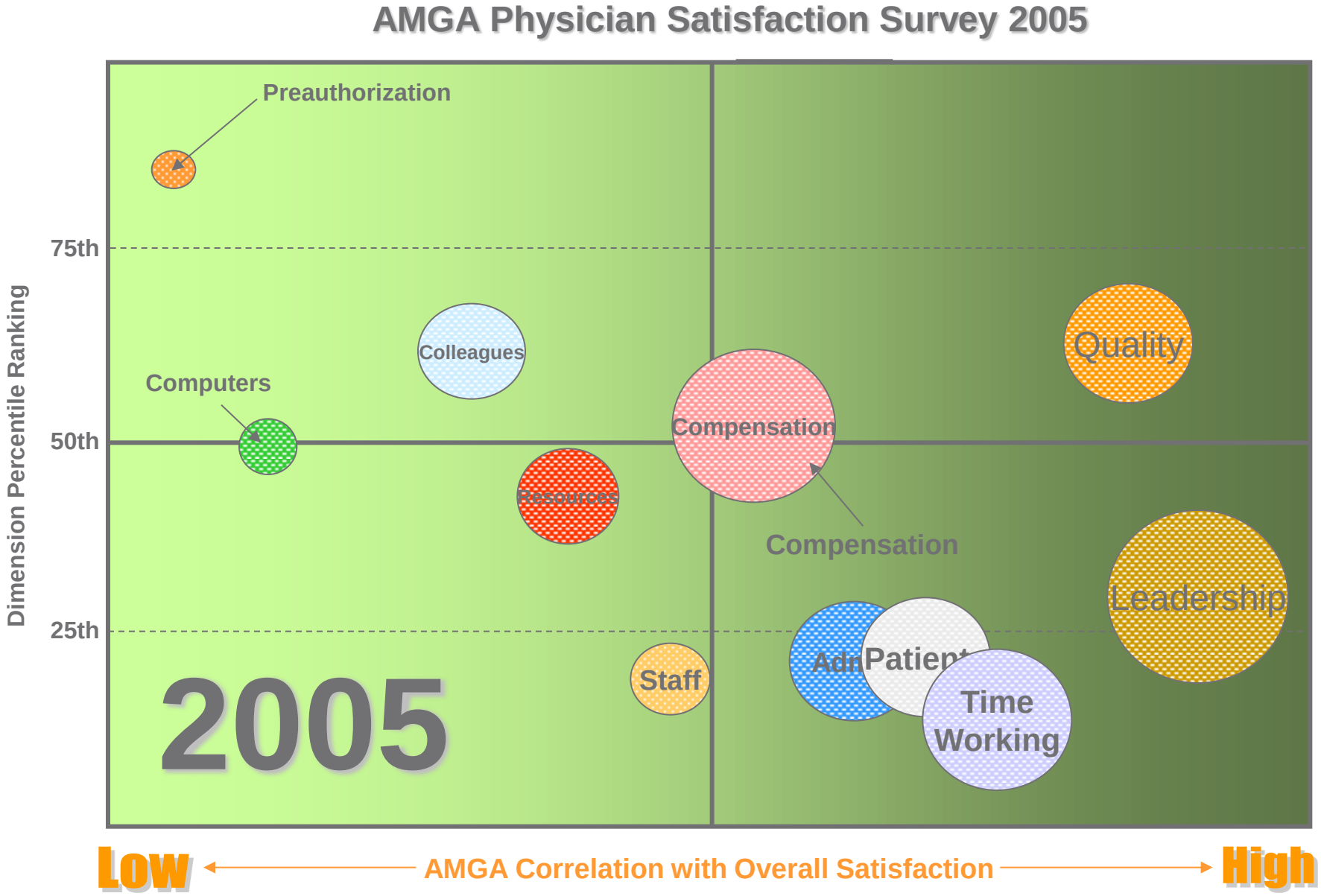
Minnesota Community Measures High Performing Medical Groups in 2011 (Primary Care)

Measure	HealthPartners Clinics 13 out of 15	CentraCare Health Systems 10 out of 15	Health East Clinics 9 out of 15	Park Nicollet Health Services 9 out of 15	Affiliated Community Medical Centers 8 out of 15	HealthPartners Central MN Clinics 8 out of 15	Allina Medical Clinic 7 out of 15	Family Health Services of Minnesota 7 out of 15
ADHD								
Breast Cancer Screening	●	●		●	●	●	●	
Bronchitis	●							●
Cervical Cancer Screening	●	●	●	●	●	●		
Childhood Immunization Status (Combo 3)	●	●			●			
Chlamydia Screening	●	●	●	●		●	●	●
Colorectal Cancer Screening	●	●	●	●	●	●		●
Controlling High Blood Pressure			●	●	●	●	●	●
COPD	●			●				
Pharyngitis	●	●	●	●		●	●	
Optimal Asthma Care-Children	●	●	●					
Optimal Asthma Care-Adults	●	●	●					●
Optimal Diabetes Care	●	●	●	●	●		●	●
Optimal Vascular Care	●		●	●	●	●	●	●
URI	●	●			●	●	●	

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

Inpatient admissions




AMGA Physician Satisfaction Survey 2005
Preauthorization
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Colleagues
Computers
Quality
50th
Compensation
Resources
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Leadership
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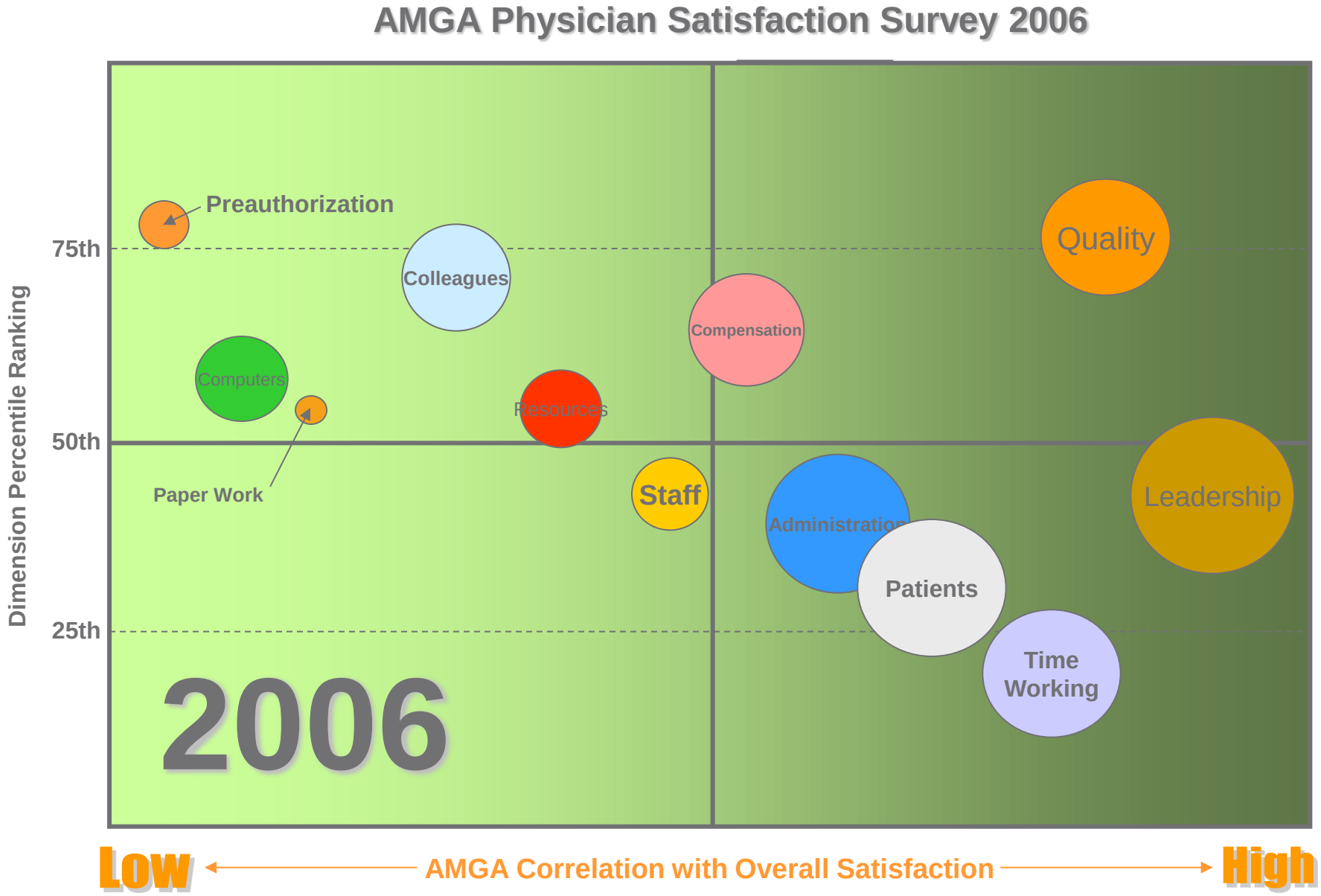
Staff
Time
Working
2005
Dimension Percentile Ranking
Low
AMGA Correlation with Overall Satisfaction
High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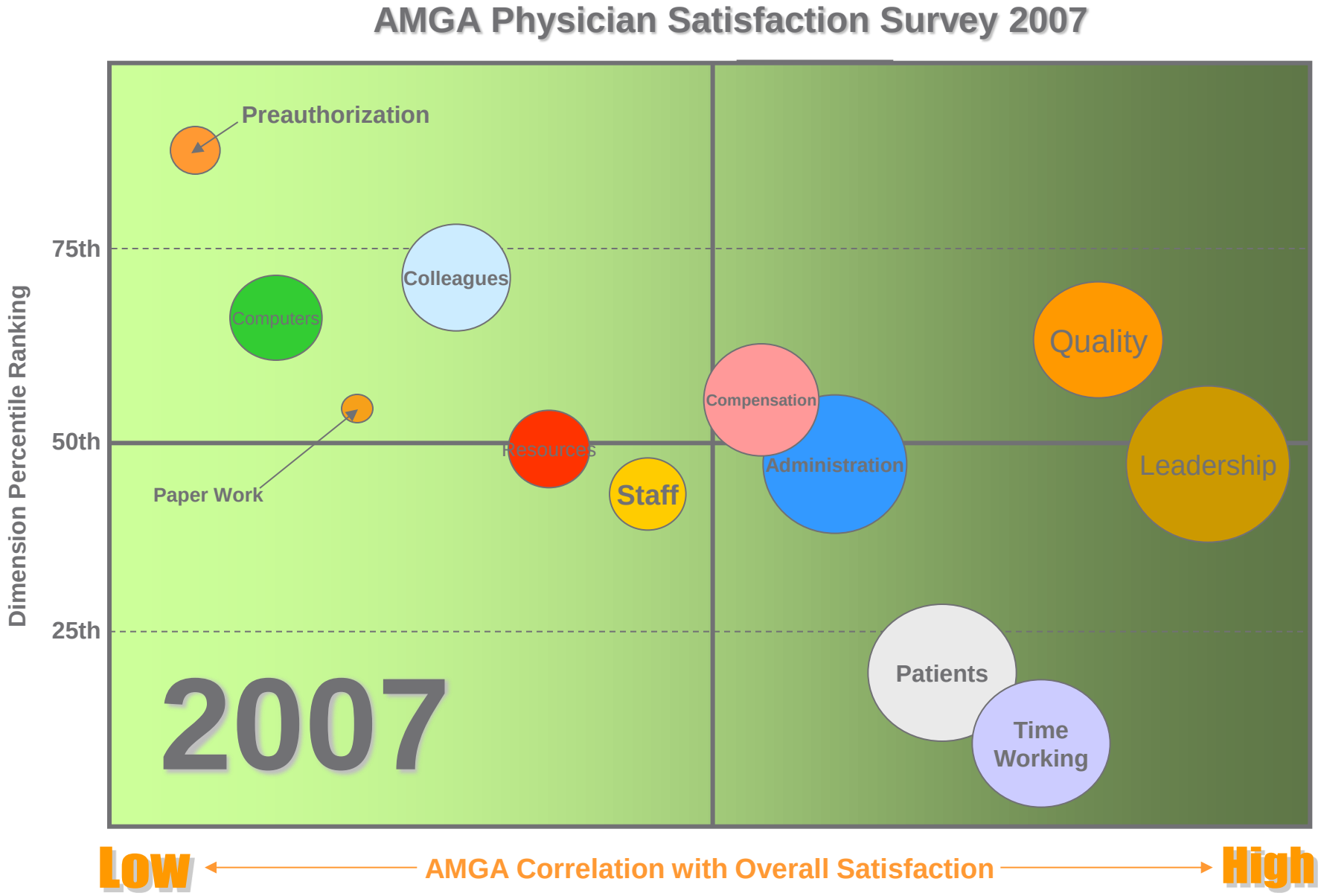
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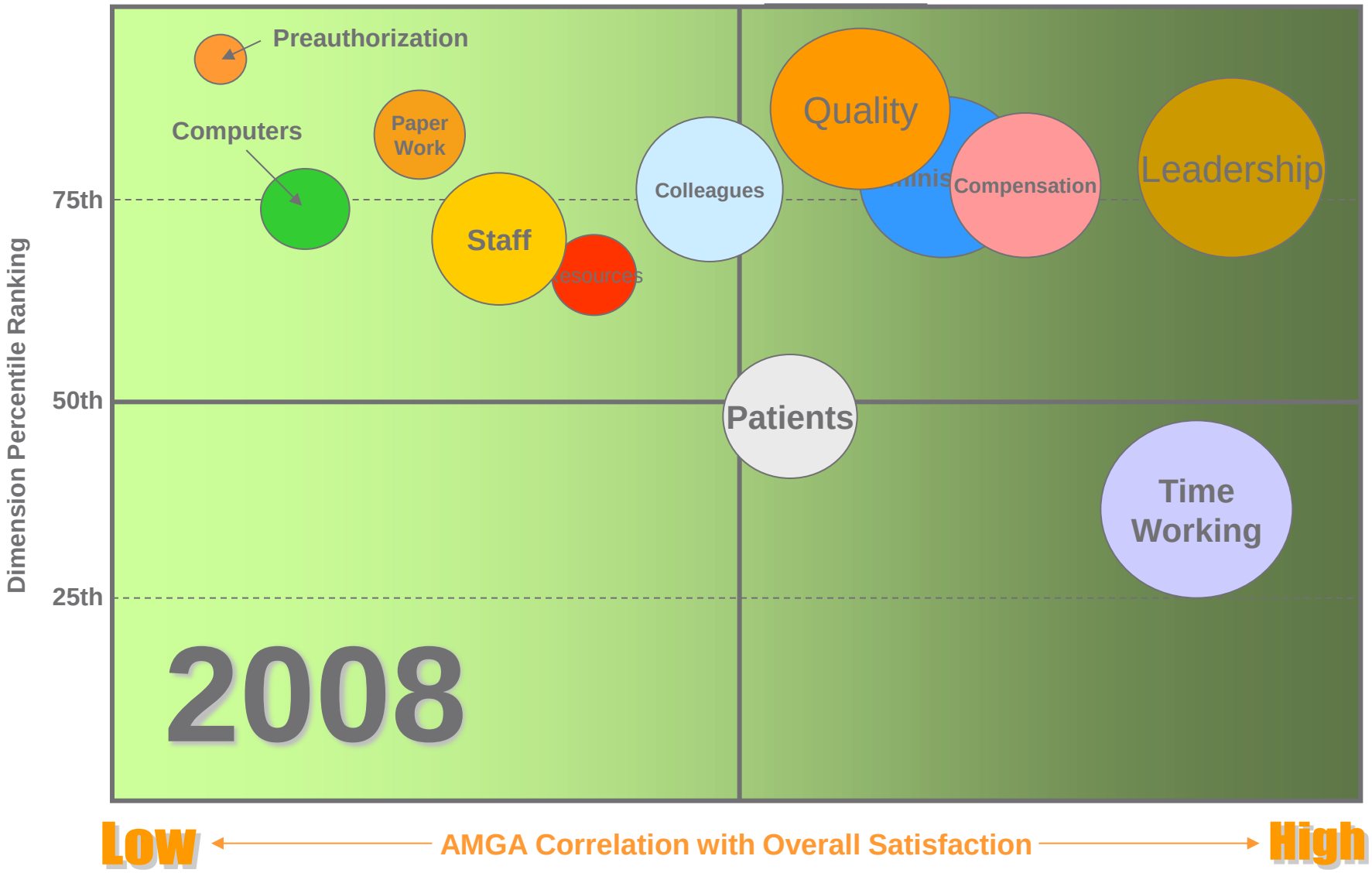
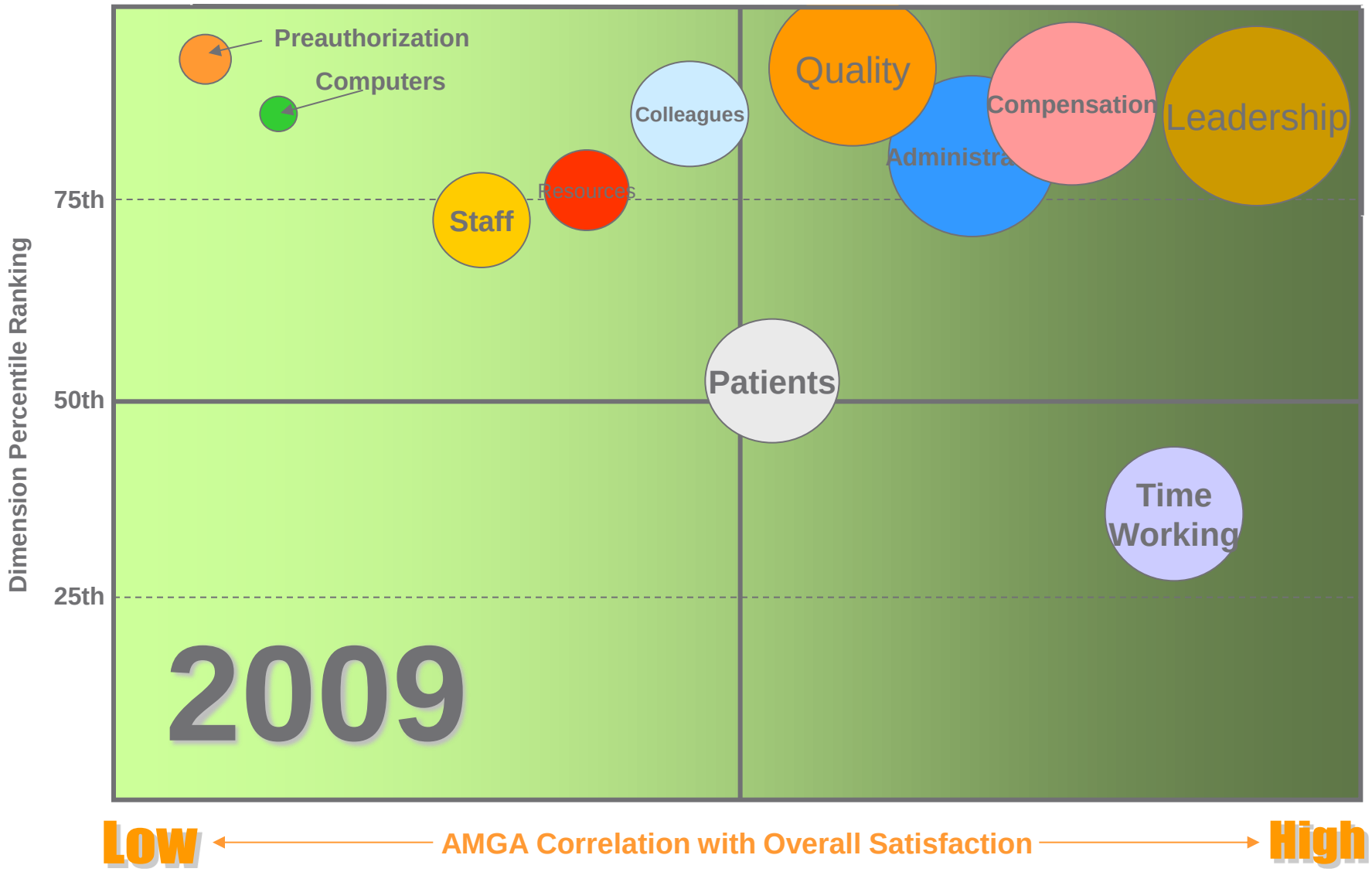
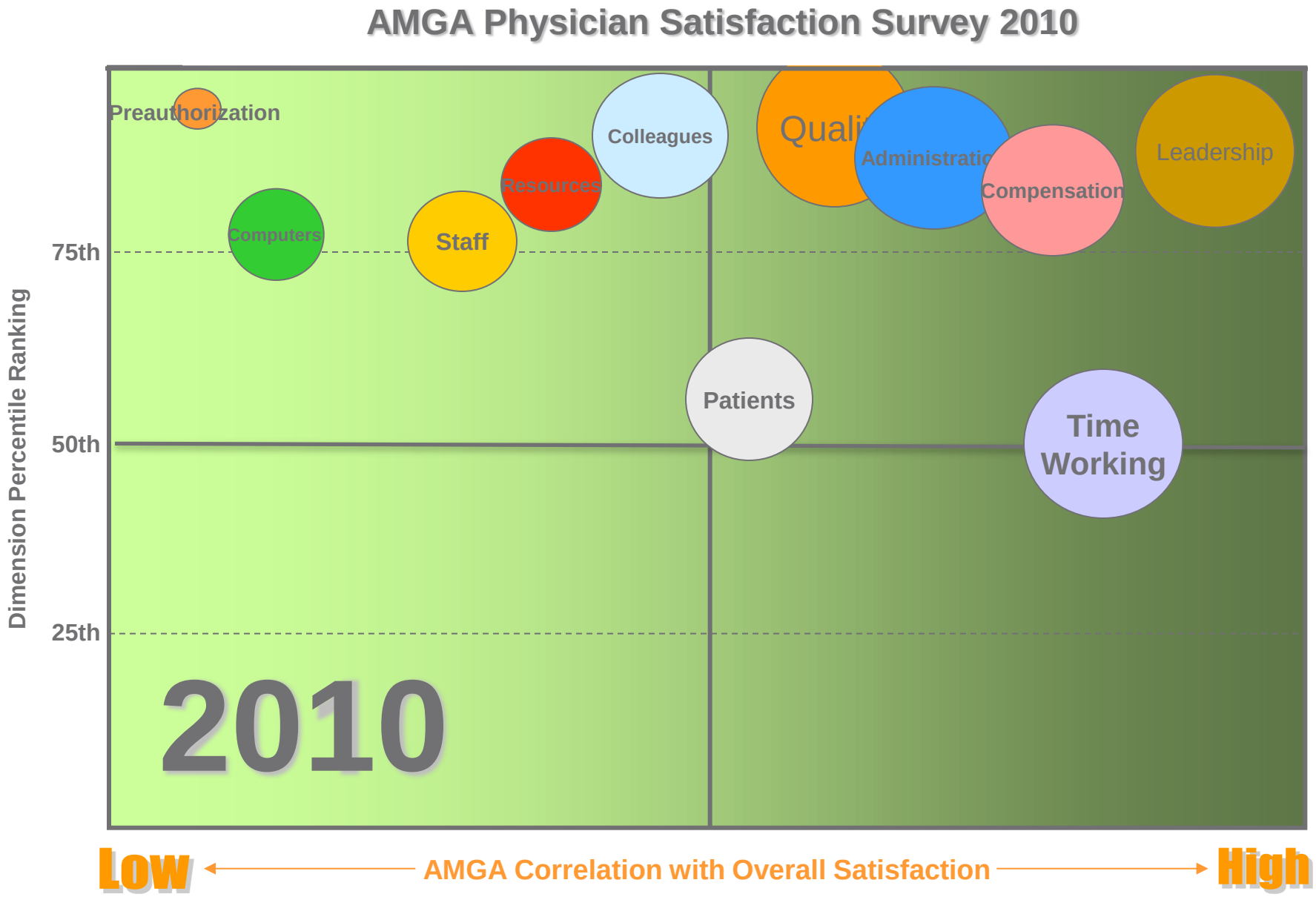
AMGA Physician Satisfaction Survey 2008



AMGA Physician Satisfaction Survey 2009

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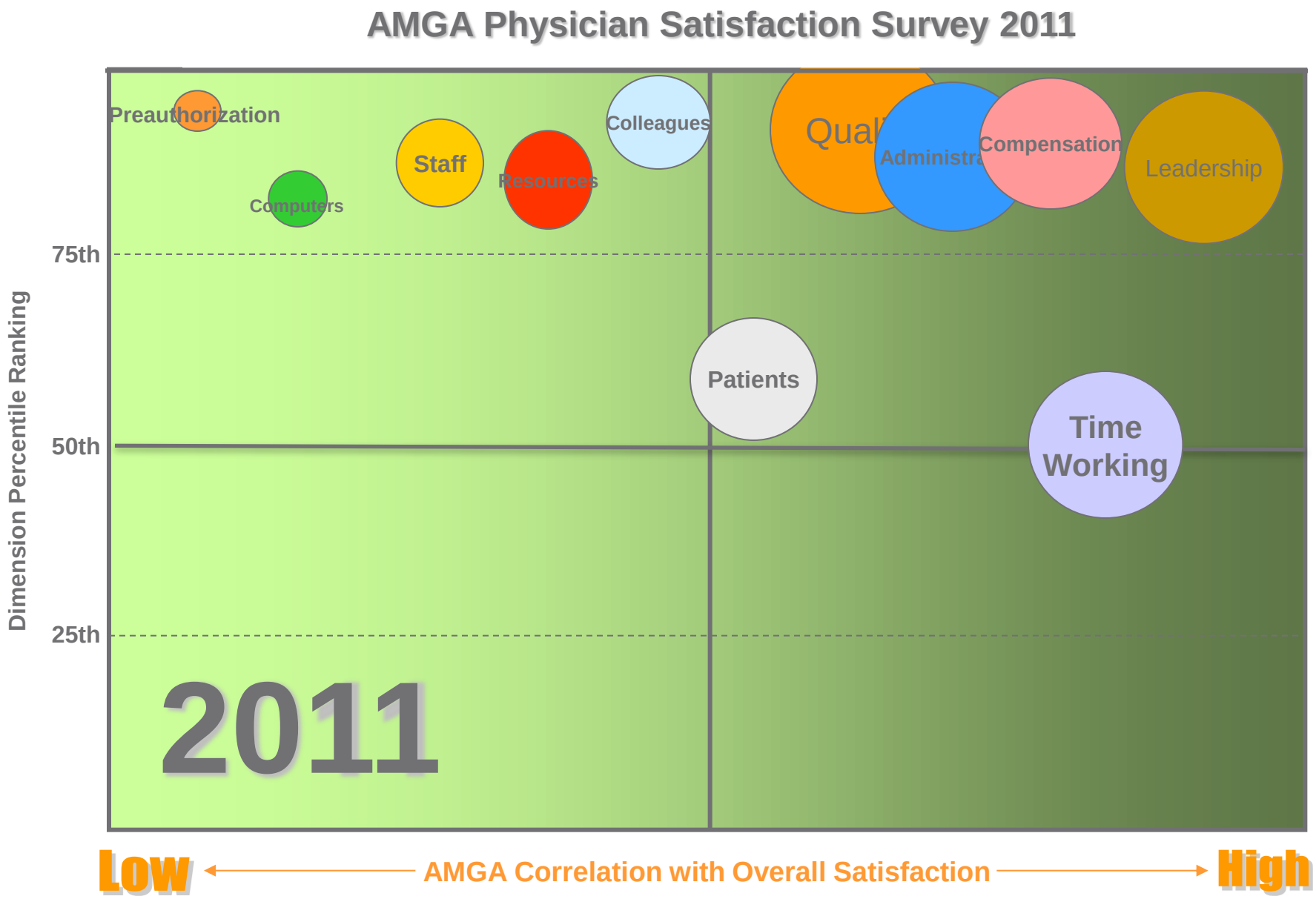
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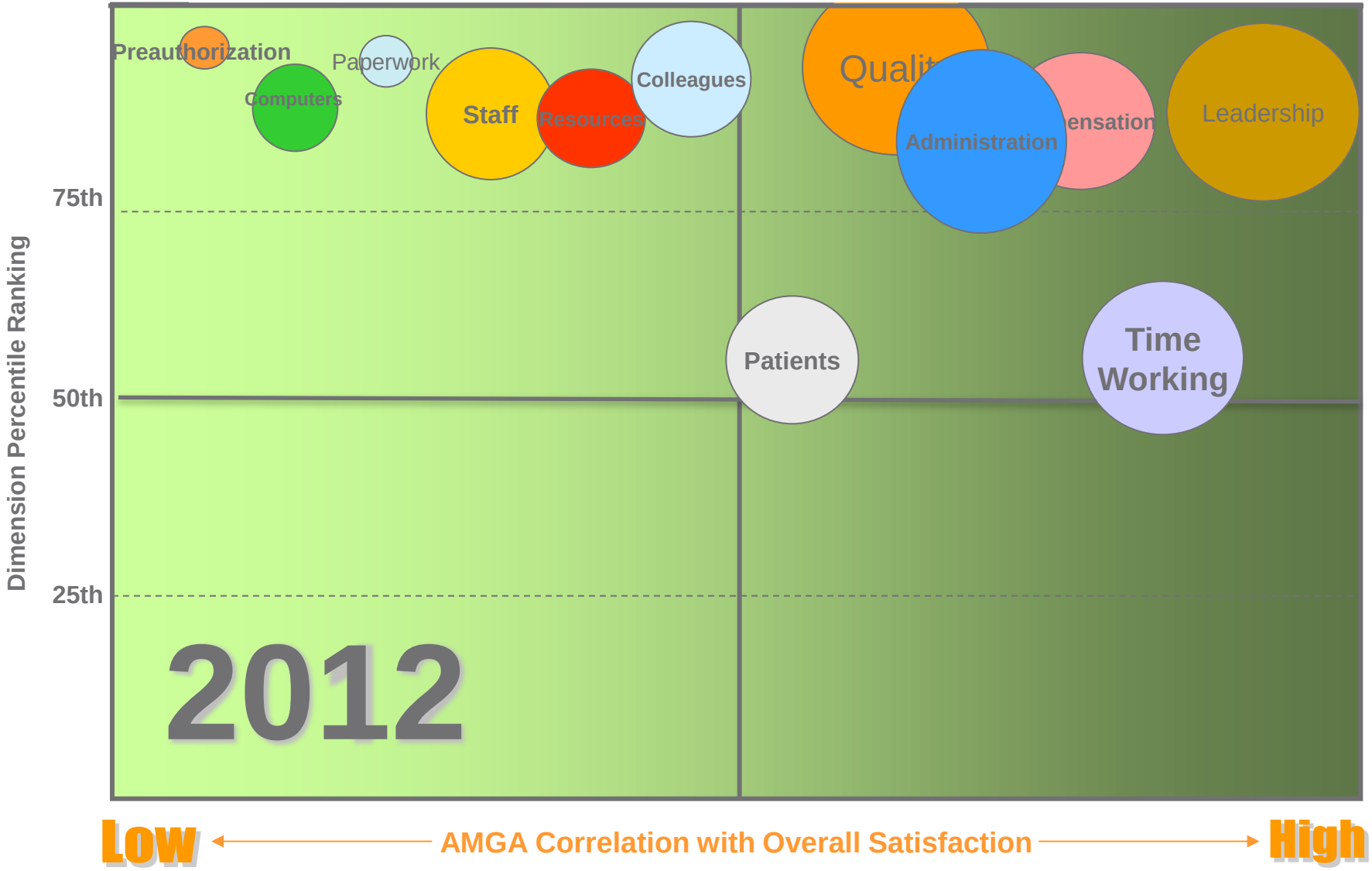
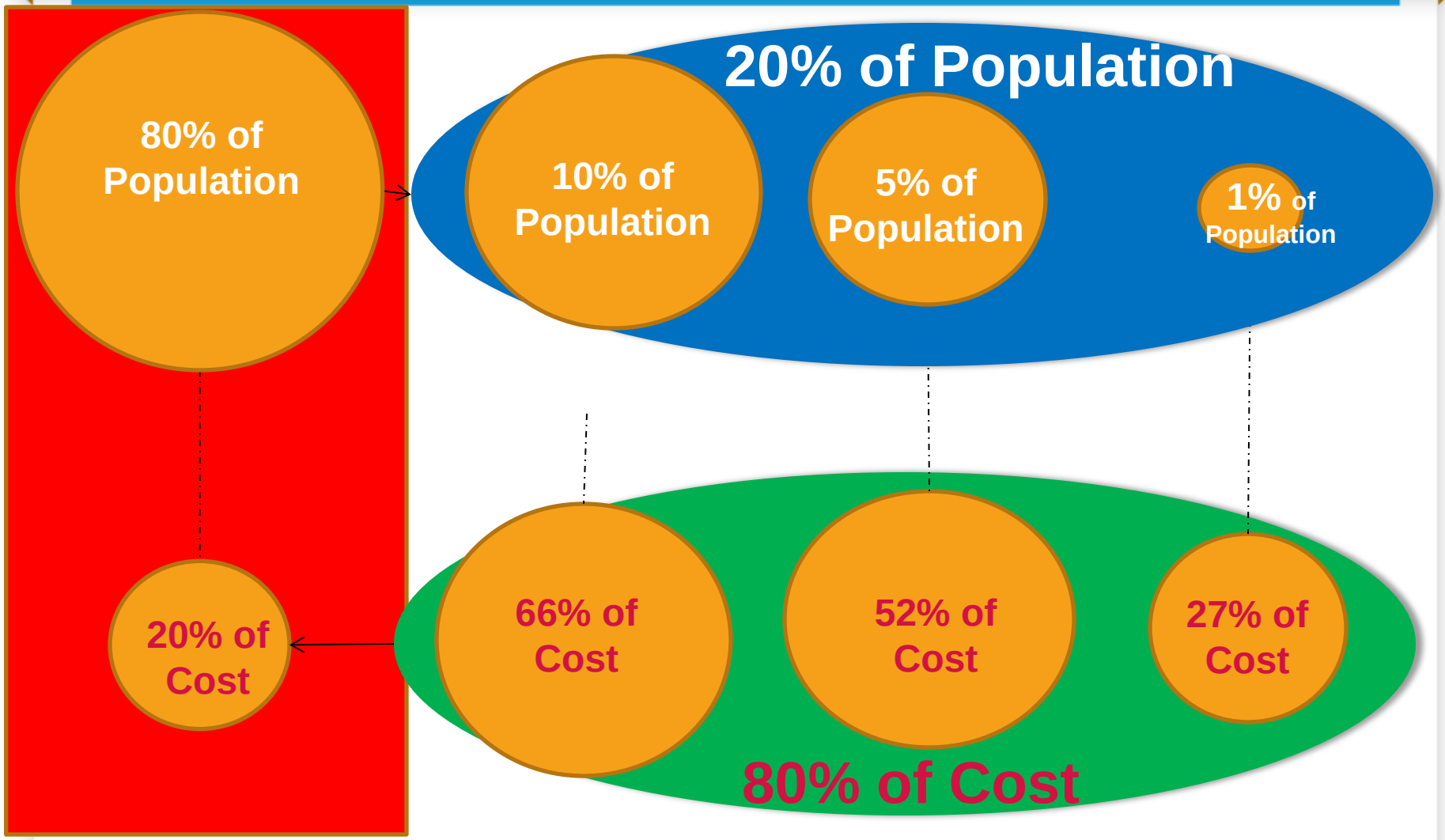


Keeping People Healthy

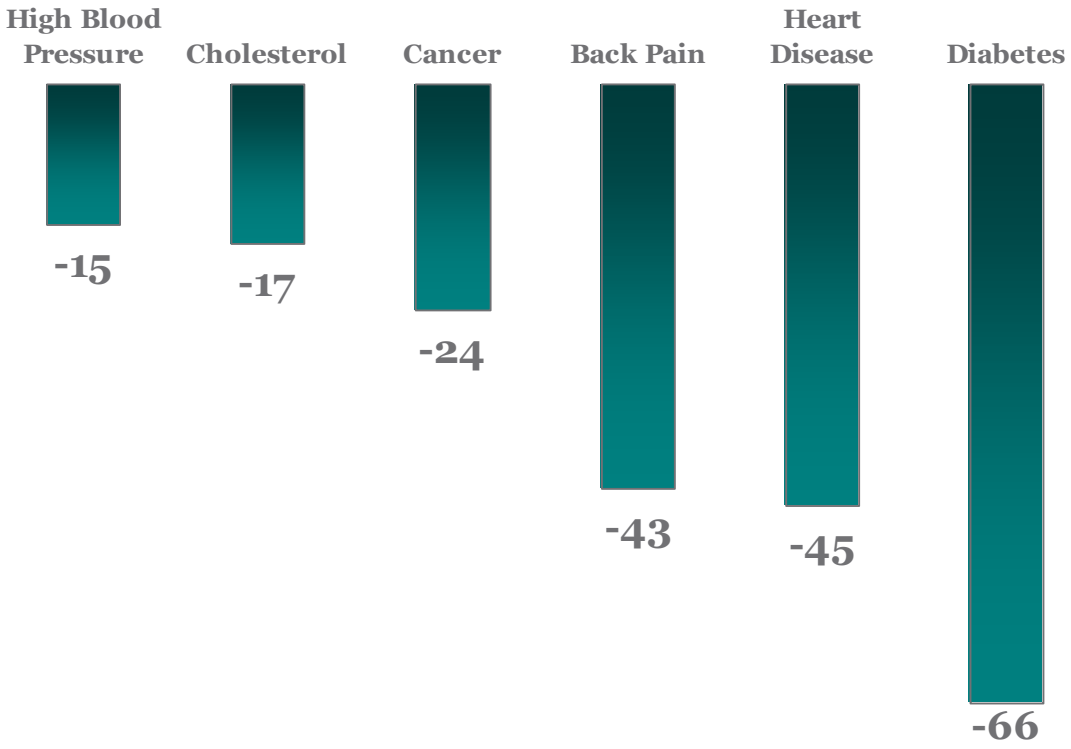


Keeping People Healthy

- Lead by example
- Healthy Lifestyle
- Health Assessment
- Well at Work
- Medicare Wellness
- yumPower
- Community Outreach

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

Health & Wellness

Get and stay healthy with your one-stop spot for health and wellness resources.

2010-11 Flu Season
Get important updates on the flu and flu shots.

Save

Frequent Fitness
Save $20 on your gym membership every month.

GlobalFit
Save up to 60% on monthly dues for gym memberships nationwide.

View all Healthy Discounts

Follow us on

Eat smart

Be tobacco free

Get moving

Rethinking drinking

If you have a special health need or condition, your most powerful tool for managing it is reliable information and quality care. Find special programs to support you in managing your health needs:

- Asthma and COPD
- Behavioral health
- Child and teen health
- Case management
- Disease management
- Diabetes
- Depression
- Heart health
- Low back pain
- Pregnancy
- Weight control

Resources

- Virtual coach
- Health Information Library
- Decision support tools
- Health classes
- Preventive guidelines
- Advance directives

Radio Disney

LIFE HAPPENS IN THE KITCHEN
COOKS OF CROCUS HILL

yum power

MINNESOTA STATE FAIR

facebook

twitter

Google

YouTube
Broadcast Yourself

Community outreach

Where to start

- Understand and shape your culture
  - Team based care
  - Involving patients
  - Transparency of results
- Identify & support high-risk, high-cost populations
  - Behavioral Health, Opioids, Complex patients, ER, Inpatient discharge
  - Identify a partner (payer, community resource)
- Health Behaviors
  - Healthy eating, exercise, moderate alcohol, no tobacco (www.healthpartners.com/yumpower)

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Thank You and Questions?